



June 7, 2011

**TO:** Mary Wakefield, Ph.D., R.N.  
Administrator  
Health Resources and Services Administration

**FROM:** /Lori S. Pilcher/  
Assistant Inspector General for Grants, Internal Activities,  
and Information Technology Audits

**SUBJECT:** Results of Limited Scope Review at The Floating Hospital, a Health Resources  
and Services Administration Grantee (A-02-10-02008)

The attached final report provides the results of our limited scope review of The Floating Hospital, a Health Resources and Services Administration Grantee. This review is part of an ongoing series of reviews performed by the Office of Inspector General (OIG) to provide oversight of funds provided by the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act).

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

Please send us your final management decision, including any action plan, as appropriate, within 6 months. If you have any questions or comments about this report, please do not hesitate to call me at (202) 619-1175 or through email at [Lori.Pilcher@oig.hhs.gov](mailto:Lori.Pilcher@oig.hhs.gov). Please refer to report number A-02-10-02008 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**RESULTS OF LIMITED SCOPE  
REVIEW AT  
THE FLOATING HOSPITAL, A  
HEALTH RESOURCES AND SERVICES  
ADMINISTRATION GRANTEE**



Daniel R. Levinson  
Inspector General

June 2011  
A-02-10-02008

# *Office of Inspector General*

<http://oig.hhs.gov>

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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# *Notices*

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

The Health Centers Consolidation Act of 1996 (P.L. No. 104–299) consolidated the Health Center Program under Section 330 of the Public Health Service Act, codified at 42 U.S.C. § 254(b). Pursuant to 42 U.S.C. § 254(b), the Health Center Program is a national program designed to provide comprehensive primary health care services to medically underserved populations through planning and operating grants to health centers. Within the U.S. Department of Health & Human Services, the Health Resources and Services Administration (HRSA) administers the Health Center Program. The HRSA health centers are community-based and patient-directed organizations that serve populations with limited access to health care.

Under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, HRSA received \$2.5 billion, including \$2 billion to expand the Health Center Program to serve more patients, stimulate new jobs, and meet the significant increase in demand for primary health care services among the Nation’s uninsured and underserved populations.

The Floating Hospital (the hospital), a non-profit agency, is a freestanding diagnostic and treatment center that provides medical, dental, and mental health services to residents of Long Island City, a neighborhood in New York City, without regard to income or insurance status.

The hospital is primarily funded by patient service revenues and Federal and New York City grants. During calendar year 2009, HRSA awarded Recovery Act funds to the hospital totaling \$3,728,766. Of that amount, \$1,491,800 was allocated for capital improvements and \$2,236,966 was allocated for increasing the number of patients served by expanding the health center location and employing additional health care professionals.

### **OBJECTIVE**

Our objective was to assess The Hospital’s financial viability, capacity to manage and account for Federal funds, and capability to operate a health center in accordance with Federal regulations.

### **SUMMARY OF FINDINGS**

Based on our assessment, we believe the hospital is financially viable and is generally capable of operating a health center in accordance with Federal regulations. However, we noted certain weaknesses in its ability to properly account for and manage Federal funds. Specifically, the hospital’s accounting software is not currently programmed to properly segregate operating expenses between Federal and non-Federal expenditures, and internal controls over access to the accounting software are inadequate. We also noted issues related to the hospital’s safeguarding of assets, procurement practices, and whistleblower protection. Finally, the hospital does not currently maintain inventory records for all equipment or perform adequate physical inventories.

## **RECOMMENDATION**

When monitoring the Recovery Act funds, we recommend that HRSA consider the information presented in this report in assessing the hospital's ability to account for and manage Federal funds and to operate a community health center in accordance with Federal regulations.

## **THE FLOATING HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the hospital agreed with our findings regarding its safeguarding and accounting for assets, and its whistleblower process, and described actions that it has taken or planned to take to address these deficiencies. The hospital disagreed with our remaining findings. The hospital stated that its accounting system properly segregates revenue and expenses by Federal program and that program expenditures can be covered by both Federal grants and program income. The hospital also stated that certain purchases did not require competitive bids or cost or price analyses. Lastly, the hospital stated that it should not be cited for performing inventories that were in accordance with its standard business practices.

After reviewing the hospital's comments, we maintain our findings regarding its ability to properly manage and account for Federal funds.

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## **INTRODUCTION**

### **BACKGROUND**

#### **The Health Center Program**

The Health Centers Consolidation Act of 1996 (P.L. No. 104–299) consolidated the Health Center Program under Section 330 of the Public Health Service Act, codified at 42 U.S.C. § 254b. Pursuant to 42 U.S.C. § 254b, the Health Center Program is a national program designed to provide comprehensive primary health care services to medically underserved populations through planning and operating grants to health centers. Within the U.S. Department of Health & Human Services (HHS), the Health Resources and Services Administration (HRSA) administers the Health Center Program.

The Health Center Program provides grants to nonprofit private or public entities that serve designated medically underserved populations and areas, and vulnerable populations composed of migrant and seasonal farm workers, the homeless, and residents of public housing. Health centers funded by HRSA are community-based and patient-directed organizations meeting the definition of “health center” under 42 U.S.C. § 254b.

Under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, HRSA received \$2.5 billion, including \$2 billion to expand the Health Center Program to serve more patients, stimulate new jobs, and meet the significant increase in demand for primary health care services among the Nation’s uninsured and underserved populations.

#### **The Floating Hospital**

The Floating Hospital (the hospital), a non-profit agency, is a freestanding diagnostic and treatment center that provides medical, dental, and mental health services to residents of Long Island City, a neighborhood within New York City, without regard to income or insurance status.

The hospital is primarily funded by patient service revenues and Federal and New York City grants. During calendar year 2009, HRSA awarded Recovery Act funds to the hospital totaling \$3,728,766. Of that amount, \$1,491,800 was allocated for capital improvements under the Capital Improvement Program (CIP) grant and \$2,236,966 was allocated for increasing the number of patients served by expanding the health center location and employing additional health care professionals under the New Access Point (NAP) grant and the Increased Demand for Services (IDS) grant.

#### **Requirements for Federal Grantees**

Nonprofit organizations that receive HRSA funds must comply with Federal cost principles found at 2 CFR pt. 230, *Cost Principles for Non-Profit Organizations* (formerly Office of Management and Budget (OMB) Circular A-122), pursuant to 45 CFR§ 74.27(a). In addition, 42 U.S.C. § 254b and implementing regulations at 42 CFR pt. 51c define requirements for health centers under the Health Center Program.



The Standards for Financial Management Systems found at 45 CFR § 74.21, establish regulations for grantees to maintain financial management systems. Grantees' financial management systems must provide for accurate, current, and complete disclosure of the financial results of each HHS-sponsored project or program (45 CFR § 74.21(b)(1)); must ensure that accounting records are supported by source documentation (§ 74.21(b)(7)); and must provide effective control over and accountability of all funds, property, and other assets so that recipients adequately safeguard all such assets and assure they are used solely for authorized purposes (§ 74.21(b)(3)). Grantees also must have written procedures for determining the reasonableness, allocability, and allowability of costs in accordance with the provisions of the applicable Federal cost principles and the terms and conditions of the award (§ 74.21(b)(6)).

In addition, grantees must establish written procurement procedures that include certain provisions as set forth in 45 CFR § 74.44. In addition, the Recovery Act requires grantees to establish procedures related to whistleblower protection. Finally, grantees are required to maintain inventory control systems and take a periodic inventory of grant related equipment (45 CFR 74.34(f)).

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to assess the hospital's financial viability, capacity to manage and account for Federal funds, and capability to operate a health center in accordance with Federal regulations.

### **Scope**

We conducted a limited review of the hospital's financial viability, financial management system, and related policies and procedures. Therefore, we did not perform an overall assessment of the hospital's internal control structure. Rather, we performed limited tests and other auditing procedures on the hospital's financial management system to assess its ability to administer federally funded projects.

We performed our fieldwork at the hospital's administrative office in Long Island City, New York during April 2010.

### **Methodology**

To accomplish our objective, we:

- reviewed relevant Federal laws, regulations, and guidance;
- reviewed the hospital's HRSA grant application packages and supporting documentation;
- interviewed the hospital's personnel to gain an understanding of its accounting system and internal controls;

- reviewed the hospital’s financial management procedures related to accounting documentation, preparation of financial reports, procurement, drawdown of Federal funds, inventory, and other financial matters;
- reviewed subjectively selected procurement transactions for detailed review;
- reviewed the hospital’s independent audit reports and related financial statements for fiscal years 2006 through 2008;
- performed ratio analyses of the hospital’s financial statements; and
- reviewed the hospital’s administrative procedures related to personnel, conflict resolution, whistleblower protection, and other non-financial matters.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATION**

Based on our assessment, we believe the hospital is financially viable and is generally capable of operating a health center in accordance with Federal regulations. However, we noted certain weaknesses in its ability to properly manage and account for Federal funds. Specifically, the hospital’s accounting software is not currently programmed to properly segregate operating expenses between Federal and non-Federal expenditures, and internal controls over access to the accounting software are inadequate. We also noted issues related to the hospital’s safeguarding of assets, procurement practices, and whistleblower protection. Finally, the hospital does not currently maintain inventory records for all equipment or perform adequate physical inventories.

### **ACCOUNTING SYSTEM**

Pursuant to 45 CFR § 74.21(b)(1), grantees must maintain financial systems that provide for accurate and complete reporting of grant-related financial data. Contrary to these requirements, the hospital’s electronic accounting software is not currently programmed to allow the organization’s operating expenses (except for equipment purchased with Recovery Act grant funds) to be properly segregated between Federal and non-Federal expenditures.<sup>1</sup> As a result, the hospital cannot accurately identify Federal grant expenses before withdrawing funds from the HHS payment management system (payment system). Rather, the hospital withdraws funds from the payment system based on a monthly review of total expenditures and estimates the amount of expenditures that correspond to the Federal grant. As a result, it is possible that the

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<sup>1</sup> Recovery Act equipment purchases, consisting of new medical and dental equipment were properly accounted for. This was due to the equipment purchases not being considered operating expenses.

hospital could use Federal funds to pay for non-Federal expenses and, consequently, quarterly status reports submitted to the Federal Government may not provide for accurate and complete reporting of grant-related financial data.<sup>2</sup>

Pursuant to 45 CFR § 74.22(b)(2), cash advances to grant recipients shall be limited to the minimum amounts needed and be timed to be in accordance with the actual, immediate cash requirements of the recipient organization in carrying out the purpose of the approved program or project. Contrary to these requirements, the hospital does not have procedures to limit how long it maintains Federal funds prior to disbursing them. Pursuant to 45 CFR § 74.21(b)(3), grantees' financial management systems must provide effective control over and accountability of all funds, property, and other assets so the grantees can adequately safeguard all such assets and assure they are used solely for authorized purposes. Contrary to these requirements, the hospital's internal controls over access to its accounting software functions are inadequate. Specifically, individuals have full access to *all* accounting software functions. For example, one individual with procurement responsibility improperly has access to the accounting software's accounts receivable, accounts payable, and general ledger functions.

Pursuant to 2 CFR, pt. 230, App. A, § A.4.a(1) (OMB Circular A-122, Att. A, § A.4.a(1)), grant expenses are allocable to a grant award if they are incurred specifically for the grant award. Contrary to these requirements, the hospital improperly charged indirect costs totaling \$17,438 to the IDS grant. These costs were not allowable for Federal reimbursement under the grant award.

## **SAFEGUARDING AND ACCOUNTING FOR ASSETS**

Pursuant to 45 CFR § 74.21(b)(3), grantees' financial management systems must provide effective control over and accountability of all funds, property, and other assets so that grantees can adequately safeguard all such assets and assure they are used solely for authorized purposes. Pursuant to 45 CFR § 74.21(b)(6), grantees must have written procedures for determining the reasonableness, allocability, and allowability of costs in accordance with the provisions of the applicable Federal costs principles and the terms and conditions of the award.

The hospital has written fiscal procedures; however, it does not have procedures for transferring funds between bank accounts and for the use of credit cards. Moreover, the hospital does not have procedures to ensure that grant costs are reasonable, allocable, and allowable. Finally, the hospital's accounts payable department improperly maintains the supply of the organization's unused checks, while also being responsible for performing all accounts payable functions—including the issuing of checks to vendors and entering of accounts payable journal entries.

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<sup>2</sup> The hospital submits a Standard Form 269, Financial Status Report and a Health Center Quarterly Report to HRSA via a secure website, as well as a Recovery Act report via a Federal government website for reporting Recovery Act funding data.

## **PROCUREMENT PRACTICES**

Pursuant to 45 CFR § 74.44, grantees are required to establish written procurement procedures, which require solicitations for goods and services to provide a clear and accurate description of the technical requirements for the material, product or service to be procured, requirements which the bidder/offeror must fulfill and all other factors to be used in evaluating bids or proposals, and the specific features of “brand name or equal” descriptions that bidders are required to meet when such items are included in the solicitation. Pursuant to 45 CFR § 74.45, grantees must document that every procurement action is supported by some form of cost or price analysis.

The hospital’s written procurement procedures require that procurement records be maintained for all acquisitions and that competitive bids be obtained or cost analyses performed for all acquisitions of \$5,000 or more. Further, procurement records for sole source acquisitions must contain a written explanation of the unique situation and why only one vendor could meet the hospital’s need. However, the hospital did not always follow its procedures. Specifically:

- The hospital purchased \$15,800 of furniture and \$23,196 of dental equipment without documenting that it performed cost analyses.
- The hospital did not obtain competitive bids for the purchase of the dental equipment.
- The hospital entered into a sole source contract for the installation of a fire alarm system, totaling \$25,865. However, the explanation for the acquisition was undated and did not contain a cost analysis.
- The hospital made numerous purchases at a local paint and a local lumber store for renovations that, in total, exceeded its \$5,000 competitive bid threshold.<sup>3</sup> However, competitive bids were not obtained and cost analyses were not performed for these purchases.

Because the hospital did not always follow its procedures, it may not have made these purchases in the most economical, practical, and competitive manner.

## **WHISTLEBLOWER PROCESS**

Section 1553(a) of the Recovery Act prohibits reprisals against employees of an organization awarded Recovery Act funds for disclosing to appropriate authorities any credible evidence of (1) gross mismanagement of an agency contract or grant relating to covered funds; (2) a gross waste of covered funds; (3) a substantial and specific danger to public health or safety related to the implementation or use of covered funds; (4) an abuse of authority related to the implementation or use of covered funds; or (5) a violation of law, rule, or regulation related to an agency contract (including the competition for or negotiation of a contract) or grant awarded or issued relating to covered funds. Pursuant to section 1553(e) of the Recovery Act, any employer

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<sup>3</sup> The renovations were part of the hospital’s CIP grant and were performed in-house.

receiving covered funds shall post notice of the rights and remedies provided for the protection of employees under this section.

The hospital has written whistleblower procedures that explain how employees can communicate instances of wrongdoing to Hospital officials or the hospital's integrity hotline. These procedures also protect whistleblowers from any form of retaliation. However, the policy does not address the right of a whistleblower to report wrongdoing to all appropriate authorities.

## **INVENTORY RECORDS**

Pursuant to 45 CFR § 74.34(f), grantees must maintain inventory records that contain the following information for equipment acquired with Federal funds: a description of the equipment, an identification number, its location, acquisition and disposition data, condition of property, and whether title vests with the grantee or the Federal Government. In addition, grantees must perform a physical inventory and reconcile the results of its inventory with existing records at least once every two years.

Hospital written inventory procedures do not require information on: (1) acquisition and disposition data, (2) condition of property, or (3) whether title vests with the grantee or the Federal Government. The hospital does have written procedures which require that equipment inventory records be maintained and updated annually. However, the hospital does not currently maintain inventory records for all equipment or perform adequate physical inventories. As of December 31, 2009, the hospital's equipment was valued at \$1,058,729.

## **RECOMMENDATION**

When monitoring the Recovery Act funds, we recommend that HRSA consider the information presented in this report in assessing the hospital's ability to account for and manage Federal funds and to operate a community health center in accordance with Federal regulations.

## **THE FLOATING HOSPITAL COMMENTS**

In written comments on our draft report, the hospital agreed with our findings regarding its safeguarding and accounting for assets, and its whistleblower process, and described actions that it has taken or planned to take to address these deficiencies. The hospital disagreed with our remaining findings. The hospital's comments are included in their entirety as the Appendix.

### **Accounting System**

The hospital stated that its accounting system properly segregates revenue and expenses by Federal program and that program expenditures can be covered by both Federal grants and program income (e.g., donations, patient revenue). The hospital stated that its accounting system has a single cost center that "contains both revenue and expenses covered by both the Federal grant as well as program income." The hospital further stated that grant funds are "not spent on

a line-item basis” and are, instead, spent after program income is applied.<sup>4</sup> The hospital described this practice as “the total grant concept” and stated that Federal expenses are not separately identified. The hospital also stated that its indirect expenses for the IDS grant were applied as an expense for non-Federal expenses, which is consistent with what it described as “the HRSA approved ‘total grant concept.’” Lastly, the hospital stated that it does not agree that it is inappropriate for an individual with procurement responsibility to also have access to its accounting system. Specifically, the hospital stated that it has a modest accounting staff and that the individual described in our finding is responsible for supervising accounting staff when the hospital’s Director of Finance is on leave.

### **Procurement Practices**

The hospital stated that, pursuant to its procurement policies, its purchase of \$15,800 in furniture did not require a cost analysis because its procurement procedures were not intended to require a cost analysis for every capital purchase. The hospital further stated that the \$23,196 of dental equipment it purchased was less expensive than similar items purchased under a competitive bid from 2005. The hospital also stated that purchases made from a local paint and hardware store were “of a routine nature” for an “overall renovation” that occurred over many months and were dependent upon cash flow and available credit and that their “competitive bid threshold is applied by vendor.”

### **Inventory Records**

The hospital stated that, at the time of our review, equipment purchased with Federal funds that was less than 10 months old would normally be inventoried before its program’s annual anniversary. The hospital stated that it should not be cited for not inventorying these items because we should show deference to standard business practices.

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<sup>4</sup> The hospital described how it applied program income in an attachment to its comments. In it, the hospital contends that its application of program income is in accordance with section 330(e)(5)(D) of the Public Health Service Act (42 USC § 254b(e)(5)(D)) and HRSA guidance.

## OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the hospital's comments, we maintain our findings regarding its ability to properly manage and account for Federal funds.

### Accounting System

In its written comments, the hospital contends that section 330(e)(5)(D) of the Public Health Service Act (42 USC § 254b(e)(5)(D)) (the statute) and HRSA guidance permit Federal grantees to expend program income for any broad purpose that supports the health center program, including expenditures that are unallowable for Federal reimbursement.<sup>5</sup> Furthermore, the hospital implies that the statute and HRSA guidance permit the comingling of Federal and non-Federal expenditures, regardless of their allowability or whether they are paid for with Federal grant funds or program income.

We agree that the hospital may use Federal grant funds or program income to cover all allowable program expenditures. However, Federal grant funds may not be used to cover unallowable program expenditures which may be covered by program income. The statute only provides that non-grant funds, which include program income, “may be used for such other purposes as are not specifically prohibited under this section if such use furthers the objectives of the project.” This provision does not authorize Federal grant funds to be used for unallowable program expenditures. To ensure that Federal funds are expended only for allowable costs and that cash advances to grant recipients are limited to the minimum amounts needed to carry out the purpose of the approved program in accordance with 45 CFR § 74.22(b)(2), Federal grantees must:

- maintain financial systems that provide for accurate and complete reporting of grant-related financial data (45 CFR § 74.21(b)(1));
- account for all grant payments separately from all other funds, including funds derived from other grant awards and account for the sum total of all amounts paid as well as other funds and in-kind contributions for each approved project (42 CFR § 51c.112(a)); and
- comply with the NAP and IDS grant award terms and conditions, which require grantees to separately account for each Recovery Act award and prohibits the pooling of these funds with other funds for drawdown or other purposes.

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<sup>5</sup> In accordance with the HHS Grants Policy Statement (pp. II-62-63) and 45 CFR § 74.24, the regular uses of program income are limited to allowable costs in accordance with the applicable OMB cost principles and the terms and conditions of the grant award. Depending on the terms and conditions stated in the award, program income would either be added to funds committed to the project, deducted from the total allowable costs to determine the net Federal reimbursement, or used to satisfy the non-Federal share matching requirements. However, pursuant to Section 330(e)(5)(D) of the Public Health Service Act (42 USC § 254b(e)(5)(D)), program income may be used for broader purposes that support the health center program. These broader purposes could include expenses that are not allowable for federal reimbursement, such as specific costs not included in the grant budget and other costs such as entertainment expenses (i.e. employee holiday parties). The terms and condition of the grant award specifies when this alternative use is allowed.

The hospital's accounting system did not adequately provide information to determine whether a particular expenditure was paid for with Federal grant funds or program income. Because the hospital did not separately track Federal and non-Federal expenditures, the hospital cannot accurately and completely report that indirect expenses for the IDS grant were not paid for with Federal grant funds.

If the hospital had appropriately tracked program expenditures as required, it could have demonstrated that unallowable indirect costs were charged to program income or other non-grant funds (i.e., not the Federal grant). Absent a system which tracks that Federal funds are only spent for allowable grant costs, the grantee cannot properly account for how Federal funds are expended.

Finally, we maintain that it is not appropriate for a procurement official (who is not a member of the accounting staff) to have full access to the hospital's accounting system.

### **Procurement Practices**

Pursuant to 45 CFR § 74.45, Federal grantees must document that every procurement action is supported by some form of cost or price analysis. Therefore, we maintain that the hospital's purchase of \$15,800 in furniture required such an analysis. Regarding the hospital's statements concerning its purchases from a local paint and hardware store, the statements are contrary to those made to us during our fieldwork. During our fieldwork, hospital officials stated in interviews that the local paint and hardware store purchases were expedited because HRSA awarded the hospital a CIP grant in June 2009 and informed the hospital that its renovations needed to be completed by July 2009. Hospital officials told us that, because they only had a few weeks to complete the renovations, they purchased supplies from local stores without competitive bids, or a cost or price analysis.

### **Inventory Records**

Pursuant to 45 CFR § 74.34(f)(3), Federal grant recipients shall take a physical inventory of equipment and the results reconciled with the equipment records at least once every 2 years. Contrary to the hospital's assertion that it is standard business practice to only inventory equipment on the annual anniversary of its program, we believe that standard business practices—to comply with Federal Regulations—would be for the hospital to initially inventory equipment upon purchase so that equipment records are up-to-date and accurate. For an inventory system to function as intended, all equipment should be tagged or marked with an inventory number and entered into an inventory system database at the time of purchase. The assigned inventory number may then serve as the basis for subsequent physical inventories. If items are not entered into the inventory system at the time of purchase, it would be difficult to identify if new equipment had been lost or stolen. At the time of our fieldwork, we noted that numerous items listed on the hospital's records did not have an assigned inventory number.



# **APPENDIX**

## APPENDIX: THE FLOATING HOSPITAL COMMENTS



New York's Ship of Health Established 1886

### The Floating Hospital

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February 11, 2011

U.S. Department of Health & Human Services  
Office of Inspector General  
Office of Audit Services  
Jacob Javits Federal Building  
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New York, NY 10278

Re: Report Number A-02-10-02008

Below is the Response to the OIG Audit of ARRA Funding. It is our understanding that this response will be attached to the OIG final audit posted on your website and forwarded to our funder, the Health Resources Services Administration (HRSA).

As to the Findings and Recommendations, we respond:

#### **Accounting System**

The findings relative to the accounting system makes reference to 45 CFR Part 74 and specifically states that the accounting system must segregate operating expenses between Federal and non-Federal programs. Our accounting system does, in fact, segregate revenue and expenses by Federal program and, in our case, the Community Health Center (CHC) program.

Consistent with guidance and accounting practices recognized by the Community Health Center funding agency, Health Resources and Services Administration (HRSA), the cost center maintained in our accounting system for the Community Health Center program contains the total Federal program expenditures as approved by HRSA in our grant application and Notice of Grant Award. The one unique feature of the Community Health Center program is that the Federal program expenditures include both those covered by the Federal grant as well as those covered by program income. This accounting treatment is

consistent with guidance issued by HRSA in the past and is utilized nationwide by the Community Health Center industry.

The Community Health Center program has a unique method by which the Federal grant is spent, driven by the manner in which program income is applied. This method is described in detail in Attachment 1. This unique methodology for earning the Federal grant is clearly defined in Federal statute as well as the Notice of Grant Award, and the manner in which we maintain our accounting records is consistent with this methodology as well. Because of this methodology, the Community Health Center cost center includes the total expenditures of the Federal program, including those covered by program income.

Accordingly, we do not concur with most of the findings relative to the Accounting System as we believe we are accounting for the use and spending of the Community Health Center Federal grant consistent with Federal statute, as more clearly explained in Attachment 1.

CHC's track all CHC program expenses, from both Federal and non-Federal resources. Federal CHC dollars are not spent on a line-item basis. Instead, Federal CHC grant funds are spent after program income (non-Federal resources), up to budget, and are applied to the total CHC program expenses. This is the total grant concept. As such, the CHC Federal grant is a "modified" deficit-funding type grant and Federal expenses are not separately identified. Total CHC expenses are tracked, and then the order of spending formula applied to determine the amount of Federal funds spent. This also applies to IDS grants as program income was budgeted.

The basis for withdrawing from the HHS system is that HRSA's funds are the last funds to be accessed, as noted in your audit comments after a month end review. This assures that federal funds are not drawn down in an amount higher than allowed. Indeed the cost centers each had negative balances with receivables due. This is an indication that excess federal fund were not drawn down. In fact, the organization's method is a reimbursement model. Nevertheless the organization has implemented a procedure limiting how long Federal funds can be maintained prior to disbursing them.

Further, the audit conclusion that controls over accounting information are inadequate is patently incorrect. The organization is a charity hospital with a modest accounting staff. The majority of the accounting staff does not have access to all aspects of the accounting software. The individual at the origin of this comment is a director currently charged with procurement and has been a finance director at the hospital and other organizations. He is

integrally involved in the preparation for audits at the hospital. He serves as supervisor of accounting staff when the Director of Finance is on leave. Therefore he has access to the accounting system as a back-up to the current Director of Finance during her absences.

Contrary to the audit citation, the IDS grant was not improperly charged an overhead rate. In fact, in practice, the indirect expenses for IDS are applied as an expense for the non-federal expenses. This is consistent with the HRSA approved "total grant concept", as previously described, and it is appropriate to calculate indirect costs by applying a rate to total CHC expenses.

Finally, HRSA is a large intricately sophisticated health services administration with strict financial, programmatic, governance and reporting requirements. Its staff are experts in the provision of care to underserved communities. Our organization has had two thorough financial reviews, aside from the annual independent financial review its independent auditors are required to perform for HRSA since becoming a grantee in 2002. The "total grant concept" is a HRSA-known and approved format for managing HRSA grants.

† By contrast, the OIG audit team acknowledged during the audit that they had never performed a hospital *nor* CHC audit and was applying what they felt were standard, analogous, audit models to a CHC-fiscal environment. Our organization's senior staff, independent auditors, and senior HRSA managers all met with the OIG audit team to explain the "total grant concept" to the OIG audit team to no avail.

The net result is that the organization is following the budgeting process imposed by the funding agency (HRSA) and being cited for doing so (OIG).

#### **Safeguarding and Accounting for Assets**

Intra-fund bank transfer and credit card policies have been adopted and approved by organization's board. It is important to note that the organization has one credit card account with a maximum limit of \$20,000 for the entire agency (out of a \$14 million dollar budget).

The unused checks have been moved from the accounts payable office.

We have also implemented procedures to assure that costs are reasonable, allocable, and allowable.

† Office of Inspector General note: Audit team members did not acknowledge that they had never performed a hospital or CHC audit. Contrary to The Hospital's assertion, the audit team conducted three identical audits of HRSA-funded health centers prior to this review. Further, the audit team did not participate in a joint meeting with The Hospital's senior staff and independent auditors, and senior HRSA managers to discuss the "total grant concept," as The Hospital's comments imply. Rather, the audit team's meetings with HRSA managers were conducted independent of The Hospital.

### **Procurement Practices**

We do not agree with the audit conclusions in this section.

The \$15,800 in furniture purchases does not require a cost analysis under the organization procurement policies.

The organization originally purchased dental equipment in 2005 pursuant to a bidding procedure. The bid was won by [REDACTED] who provided defective equipment and then refused to provide service (under warranty or otherwise) for it. We contracted with [REDACTED] to have the equipment repaired and asked it for a price quote when purchasing the upgraded equipment at issue here. The line item expenses by [REDACTED] were less expensive than the items purchased in 2005.

The organization's procurement procedures were not intended to demand that a cost analysis cover memo be completed for every capital purchase in addition to collecting bids, only those of a complex nature. In the future, we will write fuller explanations for such purchases.

The organization's CHC is located in an older, pre-war building in Queens, NY. Its landlord is strict about the use of contractors and supplied the name of a contractor with whom he was familiar to work on the electricity and install the fire alarm. The purchase reviewed by OIG was an extension of the original fire alarm system, and therefore, changing vendors would generally not be recommended. This was written but not dated, but will be in the future.

The OIG audit team added up purchases over many months of a routine nature from more than one vendor -- the local paint and hardware store, and in their hindsight, decided that this should have been subject to bid. The purchases were part of an overall renovation that occurred in stages. It was dependent upon cash flow (since HRSA funds are drawn down under a reimbursement models) and available credit. Furthermore, our competitive bid threshold is applied by vendor.

### **Whistleblower Process**

We contacted the law firm that created its whistleblower policy and asked it to update the policy based upon the OIG audit team recommendations.

Office of Inspector General note: The deleted text has been redacted because it contains the names of dental equipment vendors who were not subject to this audit.

**Inventory Records**

As the equipment purchased with federal CIP funds was less than 10 months old at the time of the audit and the CIP funding was not even fully spent, the audit comments on inventory are not realistic. Our annual review would normally occur closer to the annual anniversary of the program

Physical inventories are completed by cost center. We completed an inventory of one cost center's equipment in June 2009 and of another cost center's equipment in August 2009 and have continued to do so periodically with other cost centers.

The organization should not be cited for lack of inventory simply because the inventory did not occur as quickly as the auditors preferred. Instead, some deference to standard business practices should have been employed in the auditors' comments.

The hospital has added the additional categories regarding disposition data, condition of property, and title to its inventory procedures.

Sincerely,

Sean T. Granahan  
President and General Counsel

Attachment

Attachment 1

**SPENDING OF PROGRAM INCOME IN THE  
COMMUNITY HEALTH CENTER PROGRAM**

Overview – Use of Program Income:

In general, many Federal grant programs result in the generation of program income. Program income is defined in the OMB Compliance Supplement as “gross income received that is directly generated by the federally funded project during the grant period.”

The Compliance Supplement goes on to state that “Program income may be used in one of three methods: deducted from outlays, added to the project budget, or used to meet matching requirements. Unless specified in the Federal awarding agency regulations or the terms and conditions of the award, program income shall be deducted from program outlays.”

Use of Program Income in the Community Health Center Program:

Given that Section 330, the Community Health Center program’s authorizing statute, explicitly cites an alternative definition for the use of program income, and such alternative is carried forward by the Health Resources and Services Administration (HRSA) in the typical health center Notice of Grant Award, this alternative governs the health center’s use of program income and the uses set forth in 45 CFR Part 74 do not apply. Section 330(e)(5)(D); 42 USC 254b(e)(5)(D) governs the use of program income in the Community Health Center program –

*(D) Use of nongrant funds*

*Nongrant funds described in clauses (i) and (ii) of subparagraph (A), including any such funds in excess of those originally expected, shall be used as permitted under this section, and may be used for such other purposes as are not specifically prohibited under this section if such use furthers the objectives of the project.*

Clauses (i) and (ii) of subparagraph (A) define program income as follows:

- (i) State, local, and other operational funding provided to the center; and*
- (ii) the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year.*

The unique use of program income in the Community Health Center program is also clearly noted on the Notice of Grant Awards issued by HRSA. The cover page of the initial Notice of Grant Award clearly denotes in Box 15 that program income shall be used in accordance with an “Other” method, and not the typical addition, deduction or cost sharing/matching alternatives found in most other Federal grant programs. See copy below from an actual Community Health Center – Notice of Grant Award:

**15. PROGRAM INCOME SUBJECT TO 45 CFR Part 74.24 OR 45 CFR 92.25 SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:  
A=Addition B=Deduction C=Cost Sharing or Matching D=Other  
[D]**

This use of an “Other” methodology is not atypical; rather, health centers nationwide use this methodology and have done so for years. Included in the Program Terms section of the Notice of Grant Award (continuation page) is a general overview of the “Other” alternative that is used to spend program income under a Community Health Center grant award. The following is a copy of the Program Terms, which mirrors the statutory language set forth in Section 330 and quoted above:

Program income (item 15(d)) – Non-grant funds (State, local, and other operational funding and fees, premiums, and third-party reimbursements which the project may reasonably be expected to receive, including any such funds in excess of those originally expected), shall be used as permitted under the law and may be used for such other purposes as are not specifically prohibited under the law if such use furthers the objectives of the project.

As such, the definition of the use of program income in Federal statute governs and 45 CFR Part 74 is not applicable.

Spending of Program Income on Community Health Center Federal Reports:

The unique use of program income in the Community Health Center program has created a concept called the “total grant concept”. In general, in order to determine the spending of the Community Health Center grant funds, the following steps are required:

1. Determine the total amount of Community Health Center expenditures, including those covered by Federal funds and program income.
2. Program income, up to the amount budgeted, is then spent and applied against the total amount of Community Health Center expenditures calculated in step 1.
3. After program income is applied to the total amount of Community Health Center expenditures, the remaining expenditures are applied against the Federal funds.
  - a. If there are more Federal funds available than the remaining Community Health Center expenditures, then the excess funds represent Unobligated Balance of Federal Funds.



- b. If there are more remaining Community Health Center expenditures than Federal funds awarded, then the balance of the Community Health Center expenditures can be covered by program income generated over and above what was budgeted.
- c. NOTE: Federal funds specifically earmarked for specific purposes are earned/spent as the restricted expenditures are incurred.

Recognizing the unique method by which program income in the Community Health Center program is utilized and how the Federal grant is spent, HRSA issued two (2) Regional Program Guidance Memorandums to clarify this methodology.

Conclusion:

Given the above, recipients of Federal grant funds under the Community Health Center program are required to maintain in their accounting records a separate cost center covering the Community Health Center "total grant concept". As such, this cost center contains both revenue and expenses covered by both the Federal grant as well as program income. As Federal funds are drawn-down and when Federal reports are prepared, the "order of spending" described above is utilized, consistent with the underlying Federal statute.