Assessment of Professional Competence
November 2015

Pre-released information

EMAIL FROM AUDIT ENGAGEMENT PARTNER TO AUDIT SENIOR

From: Joe Tick **Sent:** Fri 6 November 2015 10:20am
To: Andrew Hart
Subject: Audit of Arubah Healthcare (Pty) Ltd

Dear Andrew

Following your recent assignment to act as the audit senior on the 2015 audit of Arubah Healthcare (Pty) Ltd ('Arubah'), I would like to meet with you within the next few days to discuss the planning of this audit – please set up a time for such a meeting with my secretary.

By way of background (since you have not been involved with this audit previously), D Artz & Co. has been the Registered Auditor of Arubah for the past three years, and after our re-appointment at the company's most recent annual general meeting, a team was assigned during September 2015 to commence with the planning of the audit for the financial year ended 30 September 2015.

To date the following workpapers have been prepared for the audit of Arubah (see attached):

- Understanding of the entity and its environment (A-100); and
- Arubah's information system (A-320).

At the request of Arubah, the audit team only spent two weeks at the client in September 2015, because there were staff constraints in the accounting department and the client's focus was on preparing the 2015 annual financial statements. However, this team has now been assigned to another client, and hence a new team (including you) has been assigned to this audit.

As the client would like the audit report issued by mid-January 2016, it is essential that we start soon with the assessment of the risk of material misstatement. I would like you to prioritise the risk assessment for the revenue class of transactions, as the audit fee overruns last year were the result of our risk assessment being 'high' for a number of revenue-related assertions. Needless to say, the client was not particularly happy with this.

During a recent meeting the client also indicated in passing that there are certain additional services that it would like us to perform (but without giving any further detail), and so we will have to meet with them soon to get a better understanding of what is envisaged. It would be fantastic if we could be of assistance, but we may have staffing constraints until the end of December 2015 which may affect our taking on any new work.

By the way, the profession is being criticised for allowing the use of 'boilerplate' disclosures. I recently stumbled on an interesting article on the web (at https://www.accountancylive.com/investors-reject-boilerplate-accounting-policy-disclosures) and wonder if this should not receive more attention in our future audits. Your thoughts?

Kind regards
Joe

Joe Tick CA(SA)
Registered Auditor
Partner: D Artz & Co.
Tel no.: 011 555 5555

Client: Arubah Healthcare (Pty) Ltd	**Year end:** 30 September 2015	**A-100**
Prepared by: B Clarke	**Date:** 18 September 2015	
Reviewed by:	**Date:**	
Subject: Understanding of the entity and its environment		

1 COMPANY HISTORY

Arubah was founded in 1997 by Dr Michael Kennedy and his family trust remains a key shareholder. At that time the vision for Arubah was to establish a private hospital group providing high-quality care for patients in the Gauteng Province.

2 NATURE OF BUSINESS

Arubah provides acute care at its two hospitals in Pretoria and at another situated in Kempton Park. The company has a total of 345 general ward beds and 24 intensive care unit (ICU) beds. The focus is on providing services to patients who belong to medical schemes and require inpatient care. Approximately 75% of patients admitted in the 2014 financial year ('FY2014') required surgery at Arubah's hospitals.

The three hospitals (including the pharmacies located in each) operate as divisions of the same company and are not incorporated as separate companies.

The Arubah hospitals do not have casualty and trauma units but do offer the following specialties:

- Dermatology
- Ear, nose and throat
- Gastroenterology
- General surgery
- Gynaecology
- Maxillofacial surgery
- Neurology
- Ophthalmology
- Orthopaedics
- Urology.

The private hospital industry is interesting in that patient relationships are initially indirect. Doctors refer patients for treatment at hospitals and hence admission levels are influenced by relationships with doctors. Arubah does not employ doctors but instead leases office space in its hospitals to general practitioners and medical specialist doctors (doctors who have completed advanced education and practical training in specific medical areas). Pathology and radiology practices also lease space in Arubah's facilities.

Arubah attracts doctors and their patients to its facilities based on its reputation, location of hospitals, the quality of equipment and theatres, and service provided. Dr Kennedy made the strategic decision in 1997 to offer shareholdings in Arubah to specialist doctors operating from its facilities. While the criteria for offering shareholdings to specialist doctors are left to the board of directors of Arubah, the long-standing practice has been to offer shares to specialist doctors who –

- have leased space from Arubah for at least five years;
- refer most of their patients requiring surgery or inpatient care to Arubah's hospitals; and
- deliver high-quality services to patients.

The above practice of having specialist doctors as shareholders in Arubah has resulted in a captive market for the company.

Arubah has relationships with all the major medical aid scheme administrators in South Africa who administer medical aid schemes. Medical aid scheme administrators have the power to influence where patient care occurs. Tariffs are negotiated annually with these administrators with regard to charges for the forthcoming year for care to be provided to insured patients. The vast majority of patient bills are settled directly by medical aid schemes and hence relationships with medical aid scheme administrators are critical to the on-going success of the company. Arubah is fortunate that it has a well-established reputation with most medical aid schemes for providing high-quality healthcare services while keeping medical costs under control.

Arubah does not own the properties from which its hospitals operate. These are leased from Arubah Properties (Pty) Ltd ('Arubah Properties'), a property company controlled by the Kennedy Family Trust.

3 REVENUE MODEL

Arubah charges for patient care according to two different models:

3.1 Fixed fee for service – a flat rate for specified treatments where the expected course of treatment is highly predictable. The fixed fee for service includes the theatre cost, pharmaceuticals, surgical supplies, equipment usage and ward fees. In this revenue model Arubah bears the risk of deviations in the cost of surgical procedures (except for the price of pharmaceuticals) and length of stay.

3.2 Fee for service – Arubah charges the patient for all the costs of care, including ward fees, theatre charges, equipment usage, pharmaceuticals and surgical supplies used. Arubah bears no risk relating to the length of stay of patients or the cost of surgical procedures.

Approximately 50% of Arubah's revenue is derived from fixed fee for service arrangements and the balance from fee for service arrangements.

The accounting treatment of revenue will be a focus area in this year's audit, in view of the Arubah management concerns about its revenue system and a planned new information system.

Arubah has decided not to adopt IFRS 15 *Revenue from Contracts with Customers* earlier than the mandatory effective date of 1 January 2018.

4 SHAREHOLDERS AND DIRECTORS

The shareholders of Arubah at 31 August 2015:

Shareholders	Number of shares held	% shareholding
Ordinary no par value shares		
Kennedy Family Trust	425 350	50,1%
Dr Harlan Connelly	45 000	5,3%
Dr Douglas Finder	39 903	4,7%
Dr Joseph Coben	39 903	4,7%
Dr Julius Sexwale	39 903	4,7%
Dr Precious Njeke	35 000	4,1%
Other specialist doctors	223 941	26,4%
	849 000	100,0%
Class A ordinary shares		
DOC Investment Holdings Ltd	151 000	100,0%

DOC Investment Holdings Ltd ('DOC') is a consortium of high-profile black businessmen and businesswomen who are not employed by Arubah nor are they medical specialist doctors who provide services at Arubah hospitals. They are simply strategic investors who are able to add value.

Specialist doctors who own shares in Arubah are required to offer their shares to the remaining shareholders upon their retirement or relocation to hospitals outside Arubah. The memorandum of incorporation and shareholders' agreement of Arubah regulate the subscription for shares in the company and the purchase and sale of its shares.

The directors of Arubah are as follows:

Non-executive directors	**Beneficial interest?***	**Length of service**
Dr Michael Kennedy (Chairman)	Yes	19 years
Dr Harlan Connelly	Yes	15 years
Dr Douglas Finder	Yes	8 years
Dr Joseph Coben	Yes	8 years
Dr Julius Sexwale	Yes	8 years
Dr Precious Njeke	Yes	4 years
Ms Nicola Inkqayi**	Yes	3 years
Mr Peter Mabohlale**	Yes	3 years
Executive directors	**Beneficial interest?***	**Length of service**
Mr Brendan Malcolm (CEO)	No	1 year
Ms Joanne Needham (CFO)	No	1 year

* Owns shares directly or indirectly in Arubah.

** Ms Nicola Inkqayi and Mr Peter Mabohlale are shareholders of DOC who represent DOC on the board of directors of Arubah. They do not own any ordinary shares directly in Arubah.

5 B-BBEE STRUCTURING

Specialist doctors owning 10% in aggregate of the ordinary shares in issue of Arubah meet the definition of 'black' in terms of the Broad-Based Black Economic Empowerment (B-BBEE) Act.

Arubah implemented a B-BBEE scheme in 2012 to increase its black shareholding to 25,1%. Because DOC did not have the financial resources to subscribe for ordinary shares in Arubah at fair value, the B-BBEE deal was structured in the following manner:

- First Regional Bank advanced a loan of R30 200 000 directly to Arubah on 30 September 2012. This loan bears interest at a nominal fixed rate of 9% per annum payable monthly in arrears;
- Arubah declared a special dividend to its ordinary shareholders of R25 million on 30 September 2012;
- The capital portion of the loan from First Regional Bank is repayable in four equal annual instalments. The first payment was made on 30 September 2013; and
- DOC subscribed for 151 000 Class A ordinary shares in Arubah for R1 million in cash on 1 October 2012.

The Class A ordinary shares have voting rights equivalent to that of ordinary shares in issue, thus entitling DOC to 15,1% of the total votes at any shareholders' meeting.

The Class A ordinary shareholders are not entitled to any dividends, but are entitled to convert each Class A ordinary share into one ordinary share as soon as the ordinary shareholders have received cumulative dividends of R199 million as measured from 1 October 2012.

6 COMPETITORS

Three large groups, namely Life Healthcare, Mediclinic and Netcare, dominate the private healthcare sector in South Africa. These groups are able to negotiate preferred network arrangements with the major medical aid schemes and attract higher volumes of patient admissions. Arubah is fortunate that its hospitals are situated in favourable locations and the doctors operating from its hospitals continue to draw patients to its facilities.

Arubah closely monitors Life Healthcare's published information on an on-going basis as it deems this group to be most similar to the nature of its business. Netcare and Mediclinic have significant international operations and these tend to obscure any meaningful comparison for Arubah's purposes.

7 INDUSTRY DEVELOPMENTS

The board of directors of Arubah has noted the Competition Commission's current market inquiry into the private healthcare sector. Although the board has indicated that it welcomes the inquiry to establish whether there are any features of the sector that distort, prevent or restrict competition in the hospital industry, it is of the opinion that the Competition Commission should rather investigate medical aid scheme administrators, as they are the 'gatekeepers' of private medical expenditure. Arubah will not be making any voluntary submissions to the Competition Commission.

The shortage of skilled medical staff remains a challenge for the private healthcare industry. Particularly the shortage of general practitioners, certain types of medical specialist doctors and nursing staff will place increasing pressure on wage costs.

8 FUTURE STRATEGY

Arubah is unable to expand its existing hospital facilities due to space constraints. Future revenue growth will be restricted to increasing patient admissions and inflationary increases in fees. Expansion into day clinics, which are hospital facilities that provide same-day surgery or outpatient surgery, was discussed at length at the company's February 2015 board meeting, and both Dr Kennedy (board chairman) and Mr Malcolm (CEO) argued strongly in favour of the need to pursue this new line of business.

There has been significant growth in the number of day clinics in South Africa. This is mainly in response to medical aid scheme administrators who promote the use of day clinics, as opposed to acute care hospitals, for their insured patients needing to undergo 'minor' surgical procedures. Day clinic rates are much lower than rates at acute hospitals and this makes it an attractive option for surgery that does not require patients to remain in hospital for post-operative care overnight.

The major benefits of day clinics versus acute hospitals include the following:

- Lower infrastructure requirements – day clinics do not need a vast array of equipment for complex surgery;
- No overnight stays – patients can return home after surgery and nursing staff are not generally required to work after six in the evenings; and
- Convenience – surgeons can plan their day with more accuracy, as the length of surgeries is largely predictable. Patients also benefit by not having to wait too long before being admitted to theatre.

Arubah has identified a potential site for a day clinic in Pretoria close to its existing hospitals.

At the June 2015 board meeting a proposal to establish a 25-bed facility, located on property that will be acquired by Arubah, was evaluated. It was noted that the clinic would require a licence from the Director-General of Health and the Provincial Head of Health before it can commence operations.

The board of directors of Arubah resolved that Ms Joanne Needham be tasked with preparing a capital budget for the proposed day clinic to evaluate the potential financial returns thereof. Mr Malcolm has indicated that the new day clinic could leverage off the existing head office infrastructure and the only additional costs of running the new clinic would be the direct administration and operating costs.

Client: Arubah Healthcare (Pty) Ltd	**Year end:** 30 September 2015	**A-320**
Prepared by: B Clarke	**Date:** 25 September 2015	
Reviewed by:	**Date:**	
Subject: Arubah's information system		

Most of Arubah's accounting and administration functions are performed at its head office in Pretoria. However, each hospital is responsible for patient admissions and discharges, usage of consumables and theatre and pharmacy operations. As many of these transactions are first recorded on paper-based source documents, such data have to be captured onto the computer system by employees at the hospitals. Thereafter all hospital-related transaction data are uploaded in batches to the head office information system every night. Once uploaded, the data are processed to the company's computerised accounting records and used, amongst others, for the billing of medical aid schemes.

From the minutes of the August 2015 board meeting it is apparent that the board of directors of Arubah is becoming increasingly anxious about the efficiency and effectiveness of the current information system. The following points were specifically noted:

- The current system is labour intensive and involves the duplication of processes. A system which facilitates the following is therefore considered essential:
    - The centralisation of patient data (which will obviate the need for patients to complete patient administration forms on repeat visits and also enhance the inpatient care provided); and
    - The real-time and paperless capturing and processing of details relating to patient hospital stay, dispensing of pharmaceuticals, theatre activities and use of surgical supplies.
- Medical aid scheme administrators are demanding more information from hospitals to enable them to manage their healthcare costs, but with the current information system this cannot be provided as it is not readily available from the system.

The CEO of Arubah, Mr Brendan Malcolm, has previously worked with an enterprise resource planning ('ERP') system in the hospital environment and noted the following key benefits of such systems:

- The centralisation of information for use by multiple departments and users;
- Improvement in patient care by maintaining a database of individual patients and capturing aggregate data on the treatment of common ailments;
- Improved human resource management;
- Reduced operational costs by minimising human intervention in different tasks, such as admissions, discharges, capturing of facility usage and billings; and
- Improved front office management by having real-time information on bed availability, doctors' schedules and patient locations.

Mr Malcolm plans to seek approval from the board of directors of Arubah to task a group of suitable Arubah employees to perform a feasibility study regarding the possible introduction of an ERP system. However, the implementation of the new system (if approved) is only likely to take place at some point during FY2017.

ATTACHMENT A
SUMMARISED MANAGEMENT ACCOUNTS AND BUDGET

The CFO of Arubah, Ms Joanne Needham, has revised the budget for the year ending 30 September 2016 based on the feedback from operational managers and the board of directors at its last meeting. The final budget is summarised below together with brief explanatory notes. The final budget is to be confirmed by the board of directors of Arubah at the next scheduled board meeting later in November 2015.

Arubah Healthcare (Pty) Ltd Management accounts and budget				
	Actual	**Actual**	**Actual**	**Budget**
September year end	***2013***	***2014***	***2015***	***2016***
	R'000	**R'000**	**R'000**	**R'000**
INCOME STATEMENTS				
Revenue	456 870	474 871	505 160	554 685
Theatre	139 193	144 335	148 601	163 737
Accommodation	155 562	164 223	175 843	195 050
Pharmaceuticals and surgical supplies	117 902	120 338	133 022	143 515
Equipment income	44 213	45 975	47 693	52 383
Other income	3 198	3 419	3 435	3 994
Pharmaceuticals and surgical supplies	(106 112)	(109 507)	(118 390)	(129 163)
Direct operating costs				
Employee costs	(160 818)	(165 730)	(178 321)	(194 140)
Catering	(11 667)	(12 809)	(14 067)	(15 604)
Laundry	(2 645)	(2 874)	(3 165)	(3 511)
Indirect operating costs				
Premises rental	(29 470)	(31 828)	(34 374)	(37 124)
Cleaning	(10 490)	(11 172)	(11 898)	(12 671)
Electricity and water	(5 800)	(6 757)	(7 804)	(8 975)
Other indirect costs	(27 000)	(28 917)	(30 912)	(33 076)
Administration costs	(36 500)	(39 128)	(41 828)	(44 756)
EBITDA	69 567	69 568	67 835	79 659
Depreciation	(13 590)	(14 770)	(14 900)	(15 200)
EBIT	55 977	54 798	52 935	64 459
Interest income	375	593	316	81
Finance charges	(3 760)	(3 828)	(2 997)	(2 087)
Profit before tax	52 592	51 563	50 254	62 453
Tax	(14 726)	(14 438)	(14 071)	(17 487)
Profit for the year	37 866	37 125	36 183	44 966

Arubah Healthcare (Pty) Ltd Management accounts and budget				
	Actual	**Actual**	**Actual**	**Budget**
September year end	***2013***	***2014***	***2015***	***2016***
	R'000	**R'000**	**R'000**	**R'000**
BALANCE SHEETS				
Non-current assets	75 950	73 450	70 300	70 150
Leasehold improvements	15 200	14 850	13 100	12 150
Medical and other equipment	59 500	57 500	56 000	57 000
Motor vehicles	1 250	1 100	1 200	1 000
Current assets	83 843	83 613	82 846	81 358
Inventories	7 268	8 101	9 082	8 847
Trade receivables	47 565	46 837	55 360	53 188
Other receivables	17 020	16 950	17 500	17 000
Cash and cash equivalents	11 990	11 725	904	2 323
Total assets	159 793	157 063	153 146	151 508
Share capital	10 000	10 000	10 000	10 000
Retained earnings	48 861	60 986	69 669	84 385
Total equity	58 861	70 986	79 669	94 385
Non-current liabilities	50 970	33 842	15 804	4 320
Instalment sale liabilities	31 550	21 972	11 484	0
First Regional Bank loan	15 100	7 550	0	0
Deferred taxation	4 320	4 320	4 320	4 320
Current liabilities	49 962	52 235	57 673	52 803
Trade payables	18 897	20 101	23 678	24 770
Accruals and value-added tax	9 500	10 200	10 750	11 000
Provisions	3 500	3 650	3 800	3 800
Income tax liabilities	1 767	1 156	1 407	1 749
Short-term portion: First Regional Bank loan	7 550	7 550	7 550	0
Short-term portion: Instalment sale liabilities	8 748	9 578	10 488	11 484
Total equity and liabilities	159 793	157 063	153 146	151 508

Arubah Healthcare (Pty) Ltd Management accounts and budget				
	Actual	**Actual**	**Actual**	**Budget**
September year end	***2013***	***2014***	***2015***	***2016***
Key assumptions				
a. Revenue				
Number of active beds				
General ward	345	345	345	345
ICU	24	24	24	24
Paid patient days	94 280	92 260	91 585	94 000
Occupancy	70,0%	68,5%	68,0%	69,8%
Average length of stay (days)	3,3	3,4	3,3	3,3
Number of admissions	28 570	27 135	27 750	28 250
Average ward fee per patient day	R1 650	R1 780	R1 920	R2 075
Average charge per theatre minute	R145	R157	R170	R184
Operating theatre cases/admissions	80,0%	77,0%	75,0%	75,0%
Average revenue per paid patient day	R4 846	R5 147	R5 516	R5 901
Other income/revenue	0,7%	0,7%	0,7%	0,7%
b. Operating costs				
Direct operating costs				
Employee costs/revenue	35,2%	34,9%	35,3%	35,0%
Catering/accommodation income	7,5%	7,8%	8,0%	8,0%
Laundry/accommodation income	1,7%	1,8%	1,8%	1,8%
Increase in indirect costs				
Premises rental		8,0%	8,0%	8,0%
Cleaning		6,5%	6,5%	6,5%
Electricity and water		16,5%	15,5%	15,0%
Other indirect costs		7,1%	6,9%	7,0%
Increase in administration costs		7,2%	6,9%	7,0%

Notes to the final (abridged) budget FY2016

1 The historical management accounts and the FY2016 budget do not necessarily comply with the presentation and disclosure requirements of IFRS. The following adjustments, amongst others, have not been made to the historical management accounts and the FY2016 budget:

- Provision for deferred taxation;
- Equalisation of premises rental costs;
- Impairments (if any) of inventories and trade receivables;
- Adjustments to accrue for leave pay; and
- Any adjustments to record the B-BBEE transaction entered into in 2012.

During the course of the audit, the external auditor suggests the adjusting journal entries required to correctly account for any material misstatements detected. This assists the Arubah finance team with ensuring that the financial statements are free from material misstatement, specifically in relation to the more complex IFRS requirements (including accounting for the historical B-BBEE transaction). The B-BBEE transaction was correctly accounted for in previous annual financial statements.

2 Equipment income represents the charges for use of Arubah's specialised equipment during surgery and in post-operative care.

3 Other income represents rental income derived from leasing space to coffee shop operators, radiologists, pathologists, general practitioners and specialist doctors.

4 The budget has been prepared on the basis that Arubah will continue to outsource the catering, laundry and cleaning functions to independent operators. Laundry and cleaning service providers charge fixed fees per month for services rendered irrespective of activity levels. The catering service provider charges a set fee per day per patient and hence this cost varies with occupancy levels.

5 Premises rental costs are forecast to increase by 8% in FY2016 in accordance with the rent escalation clauses in the lease agreements. The premises rental agreements covering all three hospitals are due for renewal in September 2017. These are 15-year agreements but this is negotiable.

6 Electricity cost increases are estimated based on media reports regarding Eskom's price increases for 2016. Approximately 90% of water and electricity costs are forecast to be variable in nature in FY2016.

7 Other indirect costs (R33 076 000) and administration costs of R44 756 000 are predominantly fixed in nature.

ATTACHMENT B
EMAIL FROM NEEDHAM TO MALCOLM

From:	Joanne Needham	**Sent:** Wed 4 November 2015 7:39pm
To:	Brendan Malcolm	
Subject:	SARS	

Hi Brendan

I meant to mention earlier that I received a letter from SARS this morning. It was a formal request for information in respect of the 2012, 2013 and 2014 tax returns that were submitted. SARS has listed a whole lot of questions around the B-BBEE deal we did in 2012. The questions include the following:

- Did Arubah issue the Class A ordinary shares at fair value?
- The commercial purpose of obtaining the loan from First Regional Bank in 2012?
- The tax treatment of the interest incurred in respect of the loan obtained from First Regional Bank in 2012, 2013 and 2014?
- Do any of the ordinary shareholders have an interest in DOC Investment Holdings Ltd?
- Did Arubah declare any dividends during 2012, 2013 and/or 2014?
- If so, how were the dividends declared treated for dividend withholding tax purposes?

I am a bit concerned that SARS may start sniffing around the B-BBEE deal and claim that the interest on the First Regional Bank loan is not deductible.

Have a good evening.

Regards
Jo

ATTACHMENT C
EMAIL FROM NEEDHAM TO FINANCIAL ACCOUNTANT

From:	Joanne Needham	**Sent:** Thurs 5 November 2015 6:01am
To:	Financial Accountant	
Subject:	Revenue systems	

Hi there

Once again, welcome to the team. We are so pleased to have you on board and look forward to you flourishing at Arubah!

Attached please find a summary of our revenue billing system, which was compiled by your predecessor in 2012. At the time the external auditors wanted a system description about how we capture and process information for the purposes of billing patients. I would like you to review this and make sure there are no problems in our systems – it's always good to get fresh eyes to review this stuff.

My personal view is that there is too much paperwork in our system and too much human intervention. For example, when a patient is admitted, a patient file is completed at reception. This file is then used in the ward to keep documents relating to the treatment of the patient (e.g. medication and equipment used) which are written up by the doctors and nurses treating the patient. These documents are then captured for billing purposes when the patient is discharged. So many errors could be made at various points in the process! Can't wait to hear your views.

This task should keep you out of mischief for a while. Please give me some feedback by mid-November. Thanks.

Regards
Joanne

ATTACHMENT TO EMAIL
REVENUE BILLING SYSTEM

Document number: Rev 04
Prepared by: Financial Accountant
Date: 15 October 2012

Purpose: The purpose of this document is to summarise the system used for capturing and processing information for the purposes of billing medical aid schemes. It forms part of the larger revenue/receipts cycle description.

A ADMISSION OF PATIENTS

This is the responsibility of the admission clerks located at reception.

1 Admission of new patients
- 1.1 The patient completes the cover of a sequentially numbered patient file on which, amongst others, personal and medical aid scheme details are noted.
- 1.2 The admission clerk makes photocopies of the patient's identity document and medical aid scheme card and adds these to the patient file.
- 1.3 The admission clerk then captures all information from the patient file cover on the computer system. The computer system uses this information, amongst others, for generating admission forms and creating patient accounts.
- 1.4 The admission clerk prints two copies of the admission form from the system, both of which are signed by the person who takes responsibility for the account (e.g. main member of the medical aid scheme).
- 1.5 A number of stickers containing patient information are also printed from the system. One is pasted on the front of the patient file and two others on each printed admission form. The rest of the stickers are kept in the file and are used later by the ward staff on other forms.

2 Medical aid scheme authorisation
- 2.1 The patient's doctor/surgeon makes the primary diagnosis.
- 2.2 Based on the diagnosis the admission clerk looks up the relevant ICD-10 code for the primary diagnosis and enters this into the system. (ICD-10 is a standard list of diagnosis codes that is used by medical aid schemes.) Accurate coding is crucial for ensuring that medical aid schemes settle the accounts.
- 2.3 The admission clerk contacts the relevant medical aid scheme with the diagnosis code and obtains the necessary initial authorisation from the medical aid scheme, unless the patient already obtained pre-authorisation. The authorisation number is written on the admission forms.
- 2.4 One copy of the admission form is inserted in the patient file (which is then transferred to the ward) and the other is given to the relevant case manager.

B CASE MANAGEMENT

A number of staff nurses are responsible for case management, with each being responsible for patients of different medical aid schemes. Case management involves the following:

1 The relevant case manager obtains the admission form of the patient from the admission clerks and checks that the necessary authorisation has been obtained from the medical aid scheme. The case manager also verifies the patient's medical aid scheme benefits in respect of the treatment that will be provided.

2 The case manager further ascertains the charge type (fixed fee for service or fee for service) depending on the medical aid scheme and the type of procedure, and enters the applicable 'types' into the computer system.
3 The case manager is also responsible for obtaining authorisations for any additional procedures during the patient's stay.
4 The case manager enters authorisation information in the system (e.g. authorisation number, the number of days for which authorisation has been granted, authorised amounts (limits), etc.). This applies to the initial authorisation as well as subsequent updates. All documentation and correspondence regarding authorisations are kept in the patient file.
5 The case is managed throughout the patient's stay to ensure that whatever is billed is as far as possible within medical aid scheme authorised limits.
6 Authorisation updates entail the case manager regularly visiting the patient and documenting clinical information required by the medical aid scheme, including medication, blood test results, X-ray results, blood pressure, temperature, heart rate and symptoms. This information is communicated to the medical aid scheme as required.
7 The case manager also obtains motivation letters and progress reports from the doctor/surgeon as and when needed and sends these to the medical aid scheme.

C PATIENT DISCHARGE AND CODING

1 Before discharge the doctor/surgeon writes the final diagnosis and all secondary diagnoses on the patient file.
2 The patient signs a discharge form, which is added to his/her file.
3 The ward clerk processes the discharge of the patient on the system and checks the date and time of discharge for accuracy. A discharge document is printed from the system and included in the patient file.
4 The case manager next collects the files of discharged patients and initiates the billing process. This also involves looking up the relevant ICD-10 codes (for diagnoses) and current procedural terminology (CPT) codes (for services and procedures, e.g. theatre procedures) and then entering the relevant codes into the system. This step is called 'coding'. The relevant diagnoses and procedures that later appear on the patient account are based on these codes. If omissions are identified, the case manager follows this up with the relevant staff members.
5 Once all information is available, the case manager submits the final discharge information to the medical aid scheme. This includes the admission date and time, discharge date and time, number of days in hospital, ICD-10 and CPT codes and the final amount of the account.

D TRACKING AND RECORDING AMOUNTS TO BE BILLED

1 Medication / other stock issued to patients

The different wards and theatres each have their own storerooms containing pharmaceuticals (medicine), surgical items and consumables supplied by the pharmacies and outside suppliers. Throughout the patient's stay the nurses draw stock from the storerooms and use them for patients as needed. (Note: Pharmaceuticals are not dispensed directly by the pharmacies to patients as they operate only during normal business hours and wards and theatres must have stock available right through the night and in close proximity to the patients.)

Compiling and billing of medication / other stock involve two processes:

1.1 Compiling: Throughout the patient's stay doctors and nurses who dispense items to patients write the relevant item information on a medication summary sheet

which is included in the patient file. As these sheets are rather disorganised, on the patient's discharge, the ward clerk thoroughly reviews the medication summary sheets and records all medicine, surgical items, gases and other items used for the patient on a separate medication charge sheet that forms the basis for billing the patient or his/her medical aid scheme. During this process the ward clerk also checks that the stock and quantities indicated on the medication charge sheet are reasonable given the patient's diagnoses and procedures performed.

1.2 Invoicing: The case manager captures information from the medication charge sheet on the system so that it can be billed to the patient's account. Only the quantities of each item on the charge sheet are captured as unit prices are automatically extracted from the relevant master file.

2 Ward usage

2.1 The time spent in the ward is automatically computed by the system based on the admission and discharge times recorded on the system.

2.2 The system multiplies the time computed with the applicable rate (extracted from the relevant master file) which is then used to bill the patient.

2.3 The case manager reviews the billed amount (per the system) to ensure it agrees with the data in the patient file, and if necessary, makes adjustments to correct any mistakes.

3 Theatre usage

3.1 If the patient spent time in the theatre, a theatre time charge sheet is included in the patient file in addition to the medication charge sheet. The theatre nurse dealing with the case writes the relevant information on this theatre time charge sheet.

3.2 Following a patient's discharge and upon receipt of the patient file, the case manager reviews the theatre time charge sheet and checks this against the theatre register in respect of minutes spent in theatre, the diagnosis and, for reasonableness, the volume of gases used during the procedure (as reflected on the theatre medication summary sheet), and initials the charge sheet as evidence of this check.

3.3 The case manager then captures the information from the theatre time charge sheet on the system in order to bill the patient.

E FINALISING THE BILLING

1 Upon completion of the billing process for each patient, the billing data captured by the staff at each particular hospital are uploaded to head office at midnight each night.

2 If a fixed fee for service is applicable, the computer system at head office automatically determines the fixed price from the relevant master file and the medical aid scheme is billed accordingly. The necessary adjustments are automatically made, and reports of the variances (between what was recorded on the system and the fixed price) are produced by the system.

3 After these adjustments have been processed for fixed fee for services, invoices for fees for service and fixed fee for services are generated and submitted to the medical aid schemes via electronic data interchange and the revenue is recorded in the general ledger.

4 The accounts receivable staff are responsible for investigating and resolving queries from medical aid schemes.

ATTACHMENT D
EMAIL FROM NEEDHAM TO FINANCIAL ACCOUNTANT

From:	Joanne Needham	**Sent:** Thurs 12 November 2015 9:29pm
To:	Financial Accountant	
Subject:	Day clinics	

Hi there

I know you are under work pressure but there is another issue on which I need your input. The board is seriously considering starting a day clinic in Pretoria next year. What I need from you is to review the attached Excel spreadsheet to ensure that I have prepared it in a technically correct manner and have not missed any issues.

I compiled the Excel spreadsheet based on the information provided by an independent hospital expert that we use from time to time. She is a guru on new licence applications and the day clinic industry. So I trust her inputs but I am not sure how to include all the stuff in a capital budget. The board wants some preliminary feedback by next Wednesday, so you may have to do a bit of work this weekend.

We may have to calculate the breakeven revenue for the board re the new day clinic. They will probably want to know when this venture will start making profits and how sensitive profits are to revenue levels. Perhaps give that some thought too.

Anyway, happy reading and I look forward to your inputs next week.

Regards
Joanne

EMAIL ATTACHMENT

New Arubah day clinic							
Summarised capital budget	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
Acquisition of property, including transfer duty	(3 500)	0	0	0	0	0	0
Licence application and consulting fees	(450)	0	0	0	0	0	0
Renovations to existing building	0	(2 500)	0	0	0	0	0
Borrowing costs: Land and buildings before opening	0	(810)	0	0	0	0	0
Medical and theatre equipment purchased	0	(5 000)	0	0	0	0	0
Revenue*	0	2 689	11 510	15 394	19 766	24 675	26 402
Pharmaceuticals and surgical supplies	0	(538)	(2 302)	(3 079)	(3 953)	(4 935)	(5 280)
Direct operating costs	0	(2 950)	(3 157)	(3 377)	(3 614)	(3 867)	(4 138)
Indirect operating costs	0	(2 625)	(2 809)	(3 005)	(3 216)	(3 441)	(3 682)
Administration costs	0	(2 400)	(2 568)	(2 748)	(2 940)	(3 146)	(3 366)
Head office costs	0	(750)	(1 605)	(1 717)	(1 838)	(1 966)	(2 104)
Depreciation	0	0	0	0	0	0	0
Finance charges	0	(540)	(450)	(351)	(244)	(127)	0
Net cash flow from operations	(3 950)	(15 424)	(1 380)	1 117	3 962	7 193	7 833
Annual revaluation of land and buildings	0	360	382	404	429	454	482
Sale of business (5 x EBITDA in year 6)	0	0	0	0	0	0	39 163
Net cash flow	(3 950)	(15 064)	(999)	1 521	4 391	7 648	47 477
IRR	26,4%						
NPV @ 12% hurdle rate	12 562						
Note							
** Assumes clinic will open halfway through year 1*							
Assumptions	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
Number of surgical procedures		747	2 988	3 735	4 482	5 229	5 229
Maximum capacity – surgical procedures		7 470	7 470	7 470	7 470	7 470	7 470
Occupancy			40,0%	50,0%	60,0%	70,0%	70,0%
Average fixed fee for service per surgery		R3 600	R3 852	R4 122	R4 410	R4 719	R5 049

ATTACHMENT E
EMAIL FROM MALCOLM TO NEEDHAM

From:	Brendan Malcolm	**Sent:** Fri 13 November 2015 6:05am
To:	Joanne Needham	
Subject:	Attorney's letter	

Hi again Jo

I just received the attached letter from the attorneys of Prof. Mokoena. We knew this was coming, but now that it's here I feel like running away! What a bummer for a Friday.

I have a busy day ahead and don't have the strength to worry about this now. Let's talk Monday about the way forward?

Regards
Brendan

EMAIL ATTACHMENT

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Attorneys, notaries & conveyancers
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Fax: 012 456 4323
Email: info@bno.co.za

The Chief Executive Officer
Arubah Healthcare (Pty) Ltd
Private Bag X101
Pretoria, 0182

Our Ref:
PN 843 // Mokoena // Arubah

12 November 2015

Dear Sir/Madam

RE: DEATH OF MR TN MOKOENA DURING SURGERY ON 13 OCTOBER 2015

1 We refer to the abovementioned matter and confirm that we are acting herein on behalf of our client, Prof. NJ Mokoena, an esteemed professor of law.

2 It is our instructions that one of the surgeons at your hospital, Dr H Connelly, operated on Mr TN Mokoena, the 23-year-old son of our client, on the afternoon of 13 October 2015 during which Mr Mokoena passed away. Mr Mokoena was pronounced dead during surgery at 15:34. Mr Mokoena was due to finish his law studies at the end of 2015 before commencing articles with the largest law firm on the African continent.

3 Prof. Mokoena and his wife were waiting outside the theatre during the operation and witnessed that a power failure occurred during surgery, which lasted approximately ten minutes according to Prof. and Mrs Mokoena and other eyewitnesses.

4 When Dr Connelly informed Prof. Mokoena and his wife of the outcome of the operation at around 16:00, he explained that complications occurred during surgery, which caused the death of their son.

5 While Prof. and Mrs Mokoena were leaving the hospital at around 16:30, they heard one of the theatre sisters telling another sister that the main generator did not start up during the power failure and that some medical equipment was rendered temporary unusable.

6 The next day (14 October 2015) at around 10:15 Prof. Mokoena telephoned the hospital anonymously to enquire about the power failure and was informed by the receptionist that, based on what she was told, the main generator had been low on fuel and technicians only managed to start up the generator after some time. The

receptionist further said that the back-up generator had not worked for the past six months as it had not been serviced or repaired for some time.

7 Prof. Mokoena then went to see Dr Connelly at his consulting rooms at the hospital at around 12:10 on the same day to discuss this matter with him. Dr Connelly denied that the main generator was low on fuel and alleged that the generator takes a short while to start up and that Mr Mokoena died of natural complications due to his frail condition.

8 According to our client, when Dr Connelly informed him and his wife of the death of their son directly after surgery on 13 October, Dr Connelly appeared unsettled and his breath smelt of alcohol. This is a relevant observation in the light of earlier media reports that Dr Connelly was arrested for drunken driving on the evening of 27 April 2015.

9 Taking into consideration the abovementioned, there appears to be sufficient grounds for negligence in that the hospital, even in this time of load shedding, was not sufficiently prepared for the power failure and that the resultant temporary failure of medical equipment may have caused or contributed to the death of Mr Mokoena, especially given that he underwent major surgery. Moreover, the hospital allowed Dr Connelly to operate on Mr Mokoena despite his history of alcohol abuse.

10 It is our instructions to claim from you the payment of the sum of R25 000 000 (TWENTY-FIVE MILLION RAND) within 30 days hereof, being damages for the negligent loss of the life of our client's son. This amount can be paid into the following account:

Account holder:	Brown, Naidoo & Oosthuyzen
Account number:	408 659 4430
Bank:	ABSA
Branch name:	Pretoria
Payment reference:	PN 843

11 Should this amount not be paid within the specified time limit, further legal action may be taken and summons be issued against the hospital.

YOURS FAITHFULLY

P Naidoo

BROWN, NAIDOO & OOSTHUYZEN
PER: P NAIDOO