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SOME EMPIRICAL EVIDENCE OF SARBANES-OXLEY IMPLEMENTATION IN THE HOSPITAL SECTOR

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ABSTRACT

In the eight years since the American Competitiveness and Corporate Accountability Act of 2002, or the Sarbanes-Oxley Act (SOX) was passed to regulate corporate oversight of for-profit entities, many nonprofit firms: including hospitals and health systems have adopted SOX provisions as best practices even though in most states they are not legally bound to comply with these regulations. Public scrutiny, pressure from bond agencies and insurers, and a desire to adopt best practices are moving hospitals in the direction of adopting SOX practices. Based on a survey of a representative sample of hospitals in New York State, this exploratory study specifically examined whether acute care short-term hospitals are adopting select provisions of Sarbanes Oxley regulation. The majority of sample hospitals have whistleblower policies, codes of conduct or ethics and separate audit committees; however only a third received recommendations from auditors for adjustments.

INTRODUCTION

Largely because of Enron, Congress enacted the American Competitiveness and Corporate Accountability Act of 2002, or the Sarbanes-Oxley Act (SOX) to regulate corporate oversight of for-profit entities (Wiehl, 2004). SOX required strict and significant reporting obligations on the CEOs and CFOs of publicly traded companies as well as whistleblower protection provisions (Porter, 2003; Shillam, 2004; Wiehl, 2004). These restrictions were intended to limit the ability of senior officers to claim ignorance of accounting irregularities and internal control problems of their companies (Shillam, 2004; Wiehl, 2004). Financial irregularities have been disclosed in companies like Tyco, World Com, and, of course, Enron (Bolton, Scheinkman, & Xiong, 2005; Wiehl, 2004). Numerous articles have been written in major newspapers around the country claiming inadequate provision of charity care, aggressive billing and collection practices that violate their charity obligations, and excessive compensation of executives. Some of these concerns have been evidenced by issues with Quorum Health Resources, Hospital Corporation of America (HCA), Health South, and Allegheny Health, Education, and Research Foundation (AHERF), the largest health care bankruptcy in the nation (Bolton, et al., 2005; Porter, 2003; Wiehl, 2004).

This increased level of heightened scrutiny on the role of the board and corporate governance and the improved transparency and integrity of financial statements has not been lost on the not-for-profit hospital sector (Styles & Koprowski, 2008; Vermeer, Raghunandan, & Forgione, 2006; Wiehl, 2004). Hospitals in New York State that do not have public equity are not required to comply with the principles of SOX. However, many boards of not-for-profit hospitals have taken notice and are, at the very least, investigating what is involved in order to become compliant (Shillam, 2004; Wiehl, 2004).

Some hospitals have adopted SOX policies as best practices even though they are not legally bound to comply with most of its regulations (Griffith, 2009). Similarly, some bond rating agencies, particularly Fitch,

now include a section on governance in their evaluation of debt ratings. In fact, Fitch published a report in 2005 endorsing the idea that not-for-profit hospitals and health systems completely adopt the financial oversight and governance standards of SOX (Barr, 2005). Many organizations have declined to take the steps required for voluntary compliance due to the cost and complexity of the law (Vermeer, et al., 2006).

The University of Pittsburgh Medical Center (UPMC), a 19 hospital system in Western Pennsylvania was the first not-for-profit hospital system in the nation to be fully compliant with the strict reporting and internal control requirements of the Sarbanes-Oxley Act of 2002 (Becker, 2006). Other hospitals such as St Vincent Health and Clarian Health Partners in Indianapolis, Indiana have implemented parts of the act (Murphy, 2006).

In light of these changes in corporate accounting, this paper presents the results of an exploratory study that identifies the status of the implementation of SOX provisions in acute care hospitals in New York State.

LITERATURE REVIEW

Edwards, Kusel, and Oxner (2003) conducted an analysis of surveys administered in 1996 and 2002 to internal auditors of hospitals. The purpose of their research was to compare the roles of those within the hospital industry to the roles of those outside of the industry. A secondary purpose was to study the evolution of the internal auditor's role within the industry. They concluded that the current focus of internal auditor functions is more operational than financial or compliance-oriented and that salaries within the industry tend to be higher than those outside of the industry.

George (2005) discussed the role of audit committees within publicly traded firms. Primarily, this discussion centers on the requirements of Sarbanes-Oxley and the studies executed by the Government Accountability Office (GAO). He advocates independence for audit committees in order to create or maintain an organizational culture of accountability. A significant part of the accountability and independence components involve examining the quality of communication with the audit committee.

It is well known that the hospital industry almost uniformly suffers from financial insecurities. As such, there is some controversy and concern about the necessity for implementing certain SOX requirements. This is confirmed by a study by Waldman, Smith, Hood, and Pappelbaum (2006). They conducted a survey of CEOs within the healthcare system to explore the CEOs' concerns about the future. The respondents stated that they believe the limited resources available to the hospitals are insufficient to provide all of the necessary services to the patients. Furthermore, they maintain that these resources are being diverted and squandered to address regulatory requirements that often create contradictions within the requirements due to lack of uniform national health policy.

The burden created by government regulations on hospitals is supported by Vermeer, et al (2006). In 2004, they conducted a broad survey of non-profit audit committees with the intention of creating a baseline for future research and also providing policy makers with feedback on the need for additional SOX style regulations within the non-profit sector. They found that many non-profit firms do not have independent audit committees

despite evidence that the independence complements other monitoring mechanisms. This lack of independence is attributed to a lack of resources and, possibly, a lack of a firm-level perception of possible benefits derived from such independence.

Academics, regulators, and others have been calling for increased financial transparency within the healthcare sector. Styles and Koprowski (2008) examined financial transparency within the top 100 most wired hospitals realizing that any financial transparency found would most likely overstate the industry's true state. They found that hospitals are reluctant to utilize the Internet as a tool to address the financial transparency issue. They attributed part of this reluctance to the increased costs associated with improved financial transparency by providing reports useful to the stakeholders. Specifically, they cited the Medicare Cost Report and IRS Form 990 reporting methods as two examples of required accounting reports that yield little useful information to the stakeholders within a hospital's community.

O'Neil and Cutting (2005) conducted a case study to determine best practices related to SOX compliance within medical centers. They found that the keys to success include: board and management acceptance, advisory consultations with the internal auditor, independence of internal audit function, and certification of financial statements by the CEO and CFO.

Others have advocated the adherence to SOX regulation in the hospital sector. Giniat and Saporito (2007) add to George's (2005) discussion by illustrating how voluntary compliance with SOX contributes to the success of healthcare firms within the non-profit sector. Specifically, they maintain that SOX compliance "allows greater creativity and flexibility" (p. 68) because it plays a more significant role within the Enterprise Risk Management (ERM) process of the firm.

The literature heralds the direction of the industry with respect to compliance. Public attention is now swinging in the direction toward greater scrutiny of not-for-profit hospitals. Grunewald (2008) and Royo and Nash (2008) believe that compliance with SOX provisions within the non-profit sector will become more common as many benefits of SOX compliance are realized within the sector. They attribute this to the focused application within the legislation. This will result in an increased level of integrity and trust in the non-profit governance process for those firms that elect to adopt the SOX provisions and the related doctrines.

Griffith (2009) examined several qualitative aspects of 34 U.S. community hospitals that are located in nine states. He found the recipients of the Malcolm Baldrige National Quality Award operate differently than those that focus on a tradition. Evidence was found of each recipient's practices to broadly communicate its mission, establish and support its learning cultures, implement "universal measurement and benchmarking" (p. 57) practices, and ensure "systematic process improvement" (p. 57). The acceptance and implementation of SOX provisions within each of the organizations is one of several reasons cited for each recipient's superior performance.

The purpose of this study is to explore the adoption of SOX regulation in the not for profit sector in New York state. More broadly, the present research forms a base for analyzing the differences between the hospital who adopts provisions and those who do not and serves as a baseline for further research in this specific financial sector.

METHODOLOGY

Survey Sample and Design

This is a study of the status of selected portions of SOX implementation in short term general hospitals operated in New York State in 2009. Data for this cross-sectional examination were obtained from a mail survey to hospital Chief Financial Officers (CFO's) in October 2009. Governmental and specialty hospitals were eliminated from the sample. The list of CFO's was obtained from the 2009 American Hospital Association Data Book. The survey was piloted with a small group of experts including a CFO, a Certified Public Accountant, and a Specialist in Corporate Governance and then revised to clarify questions.

Sampling Methodology

A survey instrument containing questions about SOX compliance was developed and pretested. CFO's were asked to answer 6 questions on a yes/no scale. Demographic characteristics such as bed size were obtained from a secondary data source.

Mailing labels were created for the New York state hospitals listed in the 2009 Edition of the American Hospital Association (AHA) Guide. Surveys with an explanatory cover letter were mailed to all CFO's. Respondents were to return the survey by mail and a prepaid envelope was included for convenience. One survey was returned as non-deliverable. Approximately one month after the survey was mailed, telephone calls were made to a random sample of non respondents in order to increase the response rate.

Response Bias Analysis

Since this study examined New York State acute care short term hospitals, the question of whether the 42 responding hospitals were different from the remaining 143 non-respondent hospitals was addressed by comparing bed size. The average bed size for the responding hospitals was 290 beds as compared to 315 beds for the non-respondent hospitals. The variation is not significantly different, supporting the contention that the respondent and non-respondent hospitals are comparable.

RESULTS

A total of 186 hospitals were identified as falling into the category of acute care, short term, non-governmental hospitals in New York State and were surveyed in the fall of 2009. One survey was returned as being non-deliverable. Of the remaining 185 surveys, 42 completed surveys were returned for a 23% response rate. Table 1 provides a summary of the responses.

Table 1: Summary Statistics for Sample Hospitals in New York State
Compliance with Select Provisions of Sarbanes-Oxley 2002

Question	Yes (%)	No (%)
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1. Does the board have a separate audit committee?	25 (60)	17(40)
2. Has the hospital adopted a code of conduct or a code of ethics for the CEO and CFO?	34(81)	8(19)
3. Does the institution have a whistleblower policy that allows for anonymous submission of complaints regarding accounting, internal controls, and financial matters?	40(95)	2(5)
4. Do the CEO and CFO certify the accuracy of the financial documents?	22(52)	20(48)
5. Does the auditor routinely recommend adjustments?	15(36)	27(64)
6. Does the institution have any publicly traded equity or debt?	14(33)	28(67)

p-value	3.41234E-10
Df	5
Chi-sq	52.96941176

DISCUSSION

The chi-square test for summarized data was applied to the results of this survey. This indicated that the responses for these questions are statistically significant. A discussion related to the responses of each question follows.

SOX mandates that for-profit firms establish independent audit committees and the related policies and practices that govern these committees. However, this does not currently apply to not-for-profit organizations (Herman, 2009; Iyer & Watkins, 2008). Vermeer, et al (2006) found that 75% of their sample of the largest 1000 non-profit firms have established an audit committee. They also concluded that universities and hospitals would be the most likely to establish audit committees. These two groups accounted for 76% of their respondents. In a similar study of more than 1400 non-federal hospitals, Culica and Prezio (2009) found 55% have standing audit committees. The results of our study indicate that 25 out of 42 hospitals (60%) in New York State have established audit committees.

The audit committee has different responsibilities from the finance committee. It is generally agreed that the role of the audit committee is to assist the board in the selection of auditors, and to provide oversight for ensuring that audit reports are received, monitored, and disseminated appropriately. An important role for the audit committee is to ensure that independent oversight occurs. Since management is not considered independent from the organization, it is important to improve independence by having an audit committee whose members have opportunities to communicate directly with the auditors. Our study found that only 25 hospitals out of 42 or 60% of those surveyed had a separate audit committee. New York State does not currently require by law that nonprofits have an audit committee and only 15 or 36% of auditors recommend

routine adjustments. Forming such a committee now, before it becomes mandated, demonstrates the independence of the audit function, and sets a higher standard of board governance and public transparency. With shrinking public contributions and endowments, having an audit committee can influence skeptical donors as they decide where to pledge their charitable contributions. Further, independent audit committees would demand a higher level of assurance and would be less likely to dismiss their auditors following an unfavorable audit opinion.

The establishment of a Code of Ethics or a Code of Conduct is another SOX provision that applies to for-profit firms but is not mandatory for not-for-profit organizations (Iyer & Watkins, 2008). Its relative importance relates to greater accountability for board members and managers. The results of our study indicate that 34 out of 42 hospitals (81%) have a Code of Ethics or a Code of Conduct in place. All nonprofit hospitals need to pay attention to ethical issues. Writing a code of ethics will help an organization think through the issues, reinforce their values, and offer opportunities to discuss hypothetical situations.

A prudent and key defense against fraud in an organization is the availability of a means for employees and other constituents to anonymously report suspected wrongdoing. This practice should be open to not only employees but suppliers, patients and others. In fact, employee generated tips have been identified as a leading method for detecting fraud (Association of Certified Fraud Examiners, 2008). Whistleblower programs are required of not-for-profit organizations (Herman, 2009; Iyer & Watkins, 2008; Mattie & Ben-Chitrit, 2009). The results of our study confirm this as 40 out of 42 hospitals (95%) indicate that they have a whistleblower policy in place. This tool can be used by the audit committee and management to review any complaints received regarding internal accounting controls or auditing matters, and to track complaints received to an appropriate resolution.

Another requirement of SOX that applies to for-profit firms and is not mandated for not-for-profit organizations is the certification of the financial statements by the CEO and the CFO. Narain (2009) argues that management's certifying the financial statements of a not-for-profit organization indicates the "importance top management attaches to understanding the nonprofits' financial condition" (p. 17). Yallapragada, Roe and Toma (2010) document that several states are pursuing legislation mandating the certification of financial statements by the CFO and CEO of the not-for-profit organization. The results of our study indicate that 22 out of 42 hospitals (52%) have the CFO and the CEO certify the accuracy of the financial documents. It is recommended that all CEO's and CFO's should sign off on all financial statements either formally or in practice.

Gordon and Khumawala (1999) describe a high level of involvement with the financial statements by the auditor of a not-for-profit organization as a "comfort to current and prospective donors" (p. 54). They present a conceptual framework that describes the various influences on the decision-making factors that influence giving to not-for-profit organizations. The role played by the auditor has a potential to impact some donors' decisions. The results of our study indicate that 15 out of 42 hospitals (36%) have auditors that routinely recommend adjustments to the financial statements.

Owens (2005) argues that credit ratings can be a proxy for a comparison of the financial performance between for-profit and not-for profit hospitals. As a result, many not-for-profit hospitals have linked the

compensation of management to the financial performance of the firm (Owens, 2005). Cheh and Frank (2009) have documented that a firm's disclosure of internal control weaknesses has an impact on its credit rating. The results of our study indicate that 14 out of 42 hospitals (33%) have some form of publicly traded debt or equity. The hospitals that have the publicly traded debt or equity are required by law in New York State to adopt the SOX provisions. Further studies should identify whether hospitals with publicly traded debt are compliant with SOX provisions.

CONCLUSIONS

This paper explored the adoption of some of the Sarbanes-Oxley provisions by New York's acute care short-term hospital sector. Compliance with the provisions in New York State is generally not mandated but is recommended as a best practice and is scrutinized by bond rating agencies when evaluating to ascertain a bond rating. Hospitals in New York State have made mixed progress in adopting these regulations. More than half of the hospitals in the state have a separate audit committee, a Code of Conduct or a Code of Ethics, a whistleblower program, and certification of the financial statements by the CFO and CEO. Several hospitals have not yet moved to adopt these SOX provisions. In particular, increased adoption of policies that require CEO/CFO certification of financial documents is recommended. Voluntary adoption of SOX provisions will strengthen governance through increased accountability and can lend significant credibility to a hospital's financial reporting. This is particularly important to hospitals whose constituents include investors, bond insurers, and credit enhancers. In an era of increased public scrutiny and corporate accountability, full compliance with these measures is recommended to improve transparency and to meet best practices for corporate governance. Additional research needs to be conducted to determine if the hospitals have a document retention and destruction policy that complies with the Sarbanes-Oxley Act of 2002 and reasons for not adopting its various provisions. The issue of cost-effectiveness in the hospital sector has been raised as a rationale for not adopting certain provisions. Further research on this area should also be considered.

REFERENCES

- Association of Certified Fraud Examiners. (2008). 2008 Report to the Nation on Occupational Fraud & Abuse. Austin: Association of Certified Fraud Examiners.
- Barr, P. (2005). Higher standards. *Modern Healthcare*, 35(33), 9-10.
- Becker, C. (2006). Transparent motives. *Modern Healthcare*, 36(30), 28-29.
- Bolton, P., Scheinkman, J., & Xiong, W. (2005). Pay for Short-Term Performance: Executive Compensation in Speculative Markets. *Journal of Corporation Law*, 30(4), 721-747. doi: 10.2139/ssrn.691142
- Cheh, J. J., & Frank, G. B. (2009). Bond ratings and the ephemeral effect of reporting internal control weaknesses. *Corporate Finance Review*, 13(4), 22.
- Culica, D., & Prezio, E. (2009). Hospital Board Infrastructure and Functions: The Role of Governance in Financial Performance. *International Journal of Environmental Research and Public Health*, 6(3), 862-873. doi: 10.3390/ijerph6030862
- Edwards, D., Kusel, J., & Oxner, T. (2003). Internal Auditing in Hospitals. *Hospital Topics*, 81(4), 13-18. doi: 10.1080/00185860309598029
- George, N. (2005). The Role of Audit Committees in the Public Sector. *The CPA Journal*, 75(8), 42-43.

- Giniat, E., & Saporito, J. (2007). Sarbanes-Oxley: impetus for enterprise risk management. *Healthcare Financial Management*, 61(8), 64-70.
- Gordon, T. P., & Khumawala, S. B. (1999). The demand for not-for-profit financial statements: A model of individual giving. *Journal of Accounting Literature*, 18, 31-56.
- Griffith, J. R. (2009). Finding the Frontier of Hospital Management. *Journal of Healthcare Management*, 54(1), 57-72.
- Grunewald, D. (2008). The Sarbanes-Oxley Act Will Change the Governance of Non Profit Organizations. *Journal of Business Ethics*, 80(3), 399-401. doi: 10.1007/s10551-007-9450-0
- Herman, R. D. (2009). Are Public Service Nonprofit Boards Meeting Their Responsibilities? *Public Administration Review*, 69(3), 387-390. doi: 10.1111/j.1540-6210.2009.01986.x
- Iyer, V. M., & Watkins, A. L. (2008). Adoption of Sarbanes-Oxley Measures by Nonprofit Organizations: An Empirical Study. *Accounting Horizons*, 22(3), 255-277. doi: 10.2308/acch.2008.22.3.255
- Mattie, A., & Ben-Chitrit, R. (2009). The Federal False Claims Act and Qui Tam Actions: What every healthcare manager should know. *Journal of Legal, Ethical and Regulatory Issues*, 12(2), 49-68.
- Murphy, T. (2006). Sarbanes-Oxley spreads beyond public companies. *Indianapolis Business Journal*, 26(49), A11.
- Narain, L. S. (2009). Implications of the Sarbanes-Oxley Act for Nonprofit Organizations. *The Business Review, Cambridge*, 13(2), 16-23.
- O'Neil, P. S., & Cutting, T. C. (2005). Bondholder disclosure and Sarbanes-Oxley; how one medical center aligned best practices. *Healthcare Financial Management*, 59(8), 68(65). Retrieved from ABI/INFORM Global. (Document ID: 878184721).
- Owens, B. (2005). The Plight of the Not-for-Profit. *Journal of Healthcare Management*, 50(4), 237-250.
- Porter, G. L. (2003). Whistleblowers a rare breed. *Strategic Finance*, 85(2), 50-53.
- Royo, M. B., & Nash, D. B. (2008). Sarbanes-Oxley and not-for-profit hospitals: current issues and future prospects. *American Journal of Medical Quality* 23(1), 70-72. doi: 10.1177/1062860607311687
- Shillam, P. L. (2004). Top-Down Consulting to Not-for-Profits. *Consulting to Management*, 15(3), 50-53.
- Styles, A. K., & Koprowski, W. R. (2008). The disclosure of financial information via the Internet by the 100 "Most Wired" healthcare systems. *Journal of Public Budgeting, Accounting & Financial Management*, 20(3), 387-404.
- Vermeer, T. E., Raghunandan, K., & Forgione, D. A. (2006). The Composition of Nonprofit Audit Committees. *Accounting Horizons*, 20(1), 75-90. doi: 10.2308/acch.2006.20.1.75
- Waldman, J. D., Smith, H. L., Hood, J. N., & Pappelbaum, S. J. (2006). Healthcare CEOs and Physicians: Reaching Common Ground. *Journal of Healthcare Management*, 51(3), 171-183.
- Wiehl, J. G. (2004). Roles and responsibilities of nonprofit health care board members in the post-Enron era. *Journal of Legal Medicine*, 25(4), 411-439. doi: 10.1080/01947640490887553
- Yallapragada, R. R., Roe, C. W., & Toma, A. G. (2010). Sarbanes-Oxley Act Of 2002 And Non-Profit Organizations. *Journal of Business & Economics Research*, 8(2), 89-93.

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