DELIVERY OF HEALTH CARE: CALIFORNIA PHP'S

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

ON

THE SUBCOMMITTEE'S ONGOING INQUIRY INTO COST AND QUALITY ISSUES CONCERNING THE DELIVERY OF HEALTH CARE IN THE UNITED STATES

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DELIVERY OF HEALTH CARE: CALIFORNIA PHP'S

MONDAY, NOVEMBER 22, 1976

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Sacramento, Calif.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2545, 650 Capitol Mall, Hon. John E. Moss, chairman, presiding.

Mr. MOSS. The subcommittee will be in order.

The Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce will today continue its ongoing inquiry into cost and quality issues concerning the delivery of health care in this country.

During this Congress, the subcommittee has examined specific problems in the health area. Issues have included unnecessary surgery and children's health care, particularly the Government's role in these areas. The subcommittee has completed two major reports entitled "Cost and Quality of Health Care: Unnecessary Surgery" and "Department of Health, Education, and Welfare's Administration of Health Programs: Shortchanging Children." Unfortunately, those studies found that the outgoing administration in the Department of Health, Education, and Welfare did an inadequate job in carrying out mandated programs, particularly the medicaid program.

The subcommittee has also undertaken an evaluation of the lack of public accountability and abusive practices within currently mandated health programs. To the extent our studies demonstrate defects in existing statutes, we will have to suggest the enactment of new legislation. To the extent that the problems are found to be poor management, inadequate regulations, or improper enforcement activities, we will recommend appropriate remedies.

The subcommittee has conducted previous hearings in New York City concerning fraud and abuse in the medicaid program. We heard testimony about problems associated with the so-called medicaid mills where recipients of care were found to receive unnecessary care and often ping-ponged from one set of providers to another, thereby raising the cost of care that may never have been needed in the first place.

We are also in the process of examining kickbacks in nursing homes, particularly within the States of Texas and New York and have also examined the problems of clinical laboratories in New Jersey.

Today, we hope to gather more information concerning the problems of three very important Federal laws. One is title 19 of the Social Security Act, the medicaid provisions. Medicaid program costs continue to escalate at an extremely rapid rate. Current projections for

next year are that $19 billion in governmental funds will be expended for the medicaid program, up from $14 billion in 1975.

State of California's estimated cost for fiscal year 1977 is $2.4 billion, well over 10 percent of the entire national program.

To the extent that we can begin to understand and find remedies to these runaway costs under the medicaid program, we would hope that the State of California would be able to provide us with important leads on how to get a handle on such complicated programs. We also intend to find out whether taxpayer dollars are being used properly and are going to services of high quality at a reasonable cost.

Second, the subcommittee will be examining the Health Maintenance Organization, or HMO, Amendments of 1976, Public Law 94–460, recently enacted by the present Congress. Many of us feel that the concepts embodied within HMO's, particularly their emphasis upon prepayment, thereby establishing ceilings on health care costs, are mechanisms that should provide both good health care principles and allow for a handle toward curbing runaway health care costs.

The prepaid health plan movement which has been functioning in California since 1971 and funded under the medicaid program should be able to provide us with insight into how the HMO program can be expected to operate nationally and what kinds of standards and preventive steps must be taken in order to allow this program to be implemented in the manner that Congress intended.

A third important set of laws that relate to our hearing today are those enforced by the Securities and Exchange Commission. The SEC is charged with the monitoring of the Federal securities laws and has the authority to enforce those laws by commencing civil proceedings, as they have done, regarding prepaid health plans in California. We will be looking at these activities in the course of our hearings, since the new HMO amendments may spawn new public corporations in health care. We will also explore the adequacy of existing SEC statutes.

I am pleased to note that we have here today three of the most active and knowledgeable Members of Congress in these legislative areas.

Shortly to join us at this dais is Congressman Richard Ottinger from New York, the chairman of our congressional hearings concerning the child health programs. Those hearings recently resulted in a report that has pointed out the lack of rapid implementation by HEW of needed child health programs, particularly the early screening and treatment program. This has resulted in a redirected emphasis by HEW just within the last few months to carry out the mandate of Congress.

We are also pleased to have Congressman James Scheuer representing New York City. He chaired the medicaid fraud and abuse hearings concerning activities in New York and New Jersey. Those hearings led Congressman Scheuer to introduce legislation designed to curb fraud and abuse this past Congress. That legislation was incorporated in Public Law 94–505, creating an Inspector General to rout out fraud and abuse within HEW programs. Congressman Scheuer has also introduced legislation which will certainly be reintroduced and receive consideration during the upcoming 95th Congress, calling

for the creation of a comprehensive and far-reaching child health insurance program.

Finally, Congressman Henry Waxman from Los Angeles requires little introduction here in Sacramento. In addition to the Federal laws that we will be considering today, one need not look any further than the California Waxman-Duffy Prepaid Health Plan Act authorizing prepaid health plans such as we will be discussing today to realize the large impact Congressman Waxman has made in the California as well as national health care scene. In 2 short years in Washington, Congressman Waxman has demonstrated that he is one of the most knowledgeable members of the Health and the Environment Subcommittee of the Committee on Interstate and Foreign Commerce, as well as this Oversight and Investigations Subcommittee.

He has played a very active role in several pieces of important health legislation, as well as in the enactment of the Clean Air Act.

I am pleased to have all three of these knowledgeable gentlemen with us today. We look forward to a productive hearing.

At this time I would like to call as our first witness, Mr. Ralph Ferrara, the executive assistant to Chairman Roderick Hills of the Securities and Exchange Commission.

Mr. Ferrara, will you stand and be sworn.

Do you solemnly swear the testimony you are about to give this subcommittee shall be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. FERRARA. I do.

Mr. MOSS. Would you identify yourself for the hearing record?

TESTIMONY OF RALPH FERRARA, EXECUTIVE ASSISTANT TO RODERICK M. HILLS, CHAIRMAN, SECURITIES AND EXCHANGE COMMISSION

Mr. FERRARA. Thank you, Mr. Chairman.

My name is Ralph Ferrara. I am executive assistant to Roderick M. Hills, Chairman of the Securities and Exchange Commission.

I am pleased to appear before the subcommittee and be of assistance in the matter under inquiry. It is my understanding that the subcommittee has a specific interest in the Commission's enforcement action against Omni-Rx Health Systems, which is currently pending in the U.S. District Court for the District of Columbia.

As the subcommittee is aware, because that action is pending, the Code of Professional Responsibility and the local court rules require that my comments be limited to the matters alleged in the Commission's complaint. However, consistent with the code and the court rules, I will be of whatever assistance I can to the subcommittee.

We, of course, recognize the authority and responsibility of the subcommittee to inquire into matters such as these and our only hope is to protect the integrity of our enforcement action in rendering you assistance.

Mr. Chairman, Omni-Rx is a corporation which was incorporated under the laws of the State of California in 1971 and has its principal place of business at 11616 South Hawthorne Boulevard, Hawthorne, Calif. At all times relevant to the Commission's complaint, Omni-Rx engaged in the business of providing administrative and ancillary

services to affiliated medical groups, including the Imperial West Medical Group, patients of such affiliated medical groups, and other persons. Prior to August 1972, Omni-Rx was known as Imperial General Corp.

According to the Commission's complaint, Mr. Chairman, a registration statement filed by Omni-Rx under the Securities Act of 1933 with the Commission in connection with its initial public offering of common stock was declared effective by the Commission in December of 1972. As a consequence of that public offering Omni-Rx required to and has filed annual, quarterly, and other periodic reports with the Commission which are available to the investing public. Included in these reports were financial statements of Omni-Rx and other information.

Mr. Moss. Mr. Ferrara, would you like to include the entirety of your statement in this record at this point and summarize for the purposes of the committee.

Mr. FERRARA. I will proceed however the chairman wishes. I had intended, Mr. Chairman, to read the first few paragraphs of the prepared statement, as an introduction.

Mr. Moss. Proceed as you desire. If it is your intent to shorten the statement, at this point I ask unanimous consent that the statement be incorporated into the record following your summary.

Is there any objection?

Hearing none, the statement will be inserted [see p. 5].

Mr. FERRARA. I can then proceed with a general description of our enforcement action and the related enforcement action and then be available for questions from the subcommittee and its counsel.

In one of four related enforcement actions, the Commission on September 1 of this year filed a complaint in the U.S. district court for the District of Columbia, seeking injunctive and ancillary relief against Omni-Rx and six other defendants.

The defendants have not as yet filed answers to the complaint, although certain of the defendants recently filed a motion to dismiss the action for lack of venue or, in the alternative, to transfer the action to the U.S. district court for the central district of California.

The related actions, also filed on September 1, included an administrative proceeding under rule 2(e) of the Commission's rules of practice against Seidman & Seidman, a nationwide accounting firm, which has been Omni-Rx's auditors. This administrative proceeding was simultaneously terminated on the same day through the entry of a Commission opinion and order based on consents.

In the 58-page opinion and order, which has been issued as accounting series release No. 196, the Commission found, among other things, that the accounting firm conducted deficient audits with respect to certain financial statements of four clients—Cenco, Inc.; Equity Funding Corp. of America; Omni-Rx, and SaCom. Certain remedial sanctions were entered against the accounting firm.

Also on September 1 the Commission instituted three actions in the U.S. district court against Cenco, Inc.; Omni Rx; and Sacom; certain officers of each of these companies, as well as other persons. Our complaints in these enforcement actions are summarized in our litigation releases, Nos. 7538, 7540, and 7539, respectively. Action had been previously taken regarding Equity Funding Corp.

That, Mr. Chairman, is a brief summary of the actions taken by the Securities and Exchange Commission. I would be pleased to review in detail the allegations contained in the Omni-Rx complaint or, in the alternative, respond to questions by the members of subcommittee or its counsel.

[Mr. Ferrara's prepared statement follows:]

STATEMENT OF RALPH FERRARA, EXECUTIVE ASSISTANT TO THE CHAIRMAN, SECURITIES AND EXCHANGE COMMISSION

1. PRELIMINARY STATEMENT

My name is Ralph Ferrara and I am Executive Assistant to the Chairman of the Securities and Exchange Commission. I am pleased to appear before the Subcommittee and be of assistance in the matter under inquiry. It is my understanding that the Subcommittee has a specific interest in the Commission's enforcement action against Omni-Rx Health Systems which is currently pending in the United States District Court for the District of Columbia. As the Subcommittee is aware, because that action is pending, the code of professional responsibilities and the local court rules require that my comments be limited to the matters alleged in the Commission's Complaint.

However, consistent with code and the court rules, I will be of whatever assistance I can to the Subcommittee. We of course recognize the authority and responsibility of the Subcommittee and only wish to protect the integrity of the Commission's enforcement efforts.

A registration statement filed by Omni-Rx under the Securities Act of 1933 with the Commission in connection with the initial public offering of its common stock was declared effective by the Commission in December 1972. As a result of the registration statement being declared effective Omni-Rx was required to, and has since the public offering, filed annual, quarterly and other periodic reports with the Commission. These reports are available to the public. Included in these reports were financial statements of Omni-Rx and other information.

In one of four related enforcement actions, the Commission on September 1st of this year filed a complaint in the U.S. District Court for the District of Columbia seeking injunctive and ancillary relief against Omni-Rx and six other defendants. The defendants have not as yet filed answers to the complaint, although certain of the defendants recently filed a motion to dismiss the action for lack of venue, or, in the alternative, to transfer the action to the United States District Court for the Central District of California.

2. THE RELATED ENFORCEMENT ACTIONS

The related actions also filed on September 1st included an administrative proceeding under Rule 2(e) of the Commission's Rules of Practice against Seidman & Seidman, a nation-wide accounting firm which had been Omni-Rx's auditors. This administrative proceeding was simultaneously terminated on the same day through entry of the Commission's Opinion and Order based on consents. In the 58-page Opinion and Order (which has been issued as Accounting Series Release No. 196) the Commission found, among other things, that the accounting firm conducted deficient audits with respect to certain financial statements of 4 clients: Cenco, Incorporated; Equity Funding Corporation of America; Omni-Rx; and SaCom. Certain remedial sanctions were entered against the accounting firm.

Also on September 1st, the Commission instituted three actions in the U.S. district courts against Cenco, Incorporated; Omni-Rx and SaCom, certain officers of each of these companies as well as other persons. (Our complaints in these enforcement actions are summarized in our Litigation Releases Nos. 7538, 7540 and 7539 respectively.) Action had previously been taken regarding Equity Funding Corporation of America.

3. THE OMNI-RX COMPLAINT

The defendants named in our Omni-Rx complaint are Edward R. Dickstein, Chairman and President of Omni-Rx; Alvin Markovitz, corporate secretary and director; Myron Koch, treasurer, assistant secretary and director; Merv Newell, vice-president for corporate finance and director; Imperial West Medical Group,

a medical partnership composed of Dickstein, Markovitz and Koch; and the Farmers and Merchants Bank of Long Beach, a state chartered bank.

It is alleged that the defendants Dickstein, Markovitz and Koch, who were founders of Omni-Rx, directly or indirectly own 59.1 percent of Omni-Rx's outstanding common stock on a cumulative basis. It is also alleged that Omni-Rx was dependent on Imperial West Medical Group and another affiliated medical partnership controlled by Dickstein, Markovitz and Koch for substantially all of its revenues.

The complaint alleges violations of Section 17(a) and Rule 463 under the Securities Act of 1933 and Sections 10(b) and 13(a) of the Securities Exchange Act of 1934 and Rules 10b–5, 12b–20, 13a–1, 13a–11 and 13a–13 thereunder. Speaking generally, Section 10(b) of the Securities Exchange Act and Rule 10b–5 promulgated thereunder and Section 17(a) of the Securities Act, which are anti-fraud provisions, make it unlawful through use of jurisdictional means to make false or misleading statements of material facts or to otherwise engage in fraud in connection with transactions in securities. Section 13(a) of the Securities Exchange Act and Rules 13a–1, 13a–11 and 13a–13 thereunder require certain public companies to file annual, quarterly and current reports with the Commission containing prescribed information. Rule 12b–20 adopted under the Securities Exchange Act requires reporting companies to supplement the required disclosures in the periodic reports with such further material information as may be necessary to make the required disclosures not misleading. Finally, Rule 463 adopted under the Securities Act requires issuers having filed an initial registration statement to file a report disclosing certain prescribed information concerning the sales of securities and uses made of the proceeds therefrom.

A. Allegations in complaint regarding uses of proceeds and cover-up

The public offering of 200,000 shares of Omni-Rx common stock at 7½ was conducted in December 1972 pursuant to the registration statement. Of the 200,000 shares offered, 175,000 were sold for Omni-Rx and the remaining 25,000 for certain individuals, including the defendants Dickstein, Markovitz, Koch and Newell Included in the registration statement were disclosures relating to the proposed uses of the proceeds of the offering.

The complaint alleges that prior to the public offering Omni-Rx's auditors indicated an unwillingness to give an unqualified report on Omni-Rx's financial statements unless certain debt due to Omni-Rx from its affiliated medical groups was substantially reduced. This debt was presented in Omni-Rx balance sheets in the registration statement as "accounts receivable from affiliates."

In order to complete the offering and for other purposes, according to the complaint, Dickstein, Markovitz, and Koch, singly or doing business as Imperial West Medical Group, borrowed about $450,000 from the Farmers and Merchants Bank and $100,000 from a second bank. These funds were transferred to Omni-Rx to reduce the accounts receivable from affiliates and Omni-Rx, in turn, transferred the funds back to the banks in order to pay off certain overdue short term debts.

The offering took place on or about December 21, 1972 with the closing on or about January 9, 1973. It is alleged that at that time Omni-Rx received its portion of the proceeds of the offering and transferred about $570,000 of those proceeds to Dickstein, Markovitz and Koch, singly or doing business as Imperial West Medical Group. About $559,000 of these funds were, it is alleged, then transferred to the Farmers and Merchants Bank to pay off the earlier pre-effective date loans. According to the Complaint Omni-Rx transferred an additional $100,000 of its portion of the proceeds of the public offering to pay off the pre-effective date loans to Dickstein, Markovitz and Koch at the second bank. An additional $30,000 of the proceeds was paid to the defendant Newell. About 20 days after these transfers of the proceeds, Imperial West Medical Group gave Omni-Rx a note for $570,000 secured by $800,000 of receivables from medical patients.

The complaint alleges that the defendant Omni-Rx, the individual defendants, and the Farmers and Merchants Bank covered up the alleged misuse of the proceeds.

Omni-Rx was required by Rule 463 adopted under the Securities Act to file with the Commission a Report on Form S–R to disclose, among other things, the uses of the proceeds of the public offering from December 21, 1972 (the effective date of the offering) to March 21, 1973. The complaint alleges that as part of the alleged cover-up, on or about March 30, 1973 Omni-Rx borrowed $600,000 in a

sham loan transaction from Farmers & Merchants Bank for three days at 6% interest and used the proceeds from the loan to purchase from Farmers & Merchants Bank a certificate of deposit in the same amount paying 4% interest. The Farmers & Merchants Bank held the certificate of deposit as collateral for the loan and Omni-Rx endorsed the certificate of deposit back to the bank at the time of the loan. On or about March 30, 1973, Omni-Rx filed with the Commission a Report on Form S–R dated March 30, 1973.

The complaint alleges that the March 30, 1973 Form S–R was false and misleading in that:

(1) It stated that as of March 21, 1973 $670,000 of the proceeds of the offering has been invested in short term interest bearing certificates of deposit when in fact this was not true;

(2) It stated that a stated amount of the proceeds of the public offering were used as initial working capital when in fact this was not true;

(3) It failed to disclose the actual uses of a substantial portion of the proceeds; and

(4) It stated that a part of the proceeds were used to pay auditing expenses, other expenses of the offering and for certain equipment and building improvements, when in fact a substantial portion of these expenses were paid prior to the offering from funds other than proceeds of the public offering.

A subsequently filed quarterly report on Form 10–Q which allegedly misstated short term indebtedness is also alleged to have been a part of the cover-up.

On or about November 5, 1973, Omni-Rx filed an Annual Report on Form 10–K for its fiscal year ended June 30, 1973. An annual report to shareholders for the fiscal year was also issued. The Complaint alleges that on the day before the end of its fiscal year, Omni-Rx borrowed $570,000 from Farmers & Merchants Bank agreeing to pay 12% interest on the loan and used the proceeds of the loan to purchase from Farmers & Merchants Bank, a certificate of deposit in the amount of $570,000 paying 5% interest. The Form 10–K and annual report to shareholders disclosed that Omni-Rx had $670,000 of certificates of deposit but failed to disclose the facts and circumstances surrounding the certificate purchase of June 29, 1972.

On or about October 4, 1973, Omni-Rx filed with the Commission a second Report on Form S–R dated October 2, 1973, which contained disclosures concerning the uses made of the proceeds of the public offering from December 21, 1972 (the effective date of the public offering) to September 21, 1973. The Report on Form S–R is alleged to be materially false and misleading in that:

(1) It stated that as of September 21, 1973, $570,000 of the proceeds of the offering had been invested in short term interest bearing certificates of deposit when in fact this was not true;

(2) It stated that $23,067 of the proceeds of the public offering were used as initial working capital when in fact this was not true;

(3) It failed to disclose the actual uses of a substantial portion of the proceeds; and

(4) It again stated that a part of the proceeds were used to pay auditors and other expenses of the offering and for certain equipment and building improvements, when in fact, a substantial portion of these expenses were paid prior to the offering from funds other than proceeds of the public offering.

On or about December 17, 1973, Omni-Rx filed with the Commission a Current Report on Form 8–K for the month of November, 1973. The Current Report on Form 8–K is alleged to be false and misleading in that it represented that proceeds of the public offering were still available for use by Omni-Rx when in fact this was not true.

In approximately April 1974, Omni-Rx filed with the Commission a Report on Form S–R dated March 29, 1974, which contained disclosures concerning uses made of the proceeds from the December 21, 1972, public offering to March 21, 1974. The March 1974 Report on Form S–R is also alleged to be materially false and misleading.

The complaint alleges that as part of the cover-up an information statement was distributed in connection with a shareholders meeting in 1973. In addition to the specified misstatements or omissions the complaint alleged that the periodic reports, Forms S–R and information statement were false and misleading in that they did not disclose the alleged fraudulent course of business.

Part of the relief being sought by the Commission in its action is a Court order that the defendants Dickstein, Markovitz, Koch and Imperial West Medical Group file an accounting of and disgorge monies or assets of Omni-Rx wrongfully diverted, withheld or used for their account or benefit.

B. The registration statement

The complaint alleges that the registration statement was false and misleading for reasons in addition to disclosures relating to anticipated uses of the proceeds of the offering. It contained, among other things, balance sheets and income statements of Omni-Rx of and for the year ended June 30, 1972 and three months ended September 30, 1972. The registration statement is alleged to be false and misleading in that these balance sheets:

(1) Overstated current assets by classifying the accounts receivables from affiliates as a current asset when in fact it was a non-current asset;

(2) Overstated current assets and accounts receivables from affiliates by failing to offset against the accounts receivable from affiliates a substantial allowance for doubtful accounts;

(3) Reported as an asset substantial deferred costs including auditing and accounting fees and consulting fees when in fact those costs should have been expensed and charged against income; and

(4) Overstated retained earnings.

It is alleged that income was overstated in the income statements in the registration statement by:

(1) Failing to charge income for a substantial allowance for the non-collection of the accounts receivable from affiliates; and

(2) Failing to expense the deferred costs which I previously mentioned.

The Commission alleged that the registration statement was also false and misleading in that it failed to disclose that Omni-Rx's affiliated medical groups had sustained net losses in excess of the reported income of Omni-Rx and the existence of a prior security interest in the accounts receivable of the affiliated medical groups prior in time to that of Omni-Rx.

In addition it is alleged that contrary to representations in the registration statements, Omni-Rx's outside auditors were not independent in connection with their audit of the fiscal 1972 financial statements. It is also alleged that Omni-Rx entered into an arrangement with its outside auditors pursuant to which Omni-Rx stated in the December 1972 registration statement that estimated accounting fees and expenses in connection with the public offering of its securities were $180,000 when in fact such fees and expenses were $211,000 and Omni-Rx had agreed to pay its auditors that amount after the public offering was completed.

C. Report on Form 10–Q for 9 months ended March 31, 1973

On May 1, 1973 Omni-Rx filed a quarterly report on Form 10Q with the Commission for the nine months ended March 31, 1973. The complaint alleged that income for the nine months as reported in this filing was overstated due to the failure to expense a substantial part of the deferred costs alleged to have been incurred in connection with the public offering and failure to charge income for an allowance for non-collection of the accounts receivable from affiliates.

D. Report on Form 10–K for fiscal year ended June 30, 1973

On or about November 5, 1973 Omni-Rx filed an Annual Report on Form 10–K for its fiscal year ended June 30, 1973. An annual report to shareholders for the fiscal year was also disseminated. These reports contained, among other things, a balance sheet and an income statement of and for the fiscal year. In addition to reasons previously discussed, these reports are alleged to be false and misleading because:

(1) They failed to disclose that Omni-Rx had given a bank two documents by which it purported to sell to the bank all of its receivables;

(2) While disclosing in notes to the financial statements that the medical groups transferred approximately $1,219,000 of patient receivables to Omni-Rx with recourse in exchange for accounts receivables for affiliates, they failed to disclose that the exchange took place on a one for one basis despite the fact that a substantial provision for uncollectibility was necessary against the patient receivables but no such provision was made against the accounts receivables from affiliates;

(3) While disclosing in notes to the financial statements that Dickstein, Markovitz and Koch pledged personal real estate with an appraised value of approximately $725,000 and executed their personal guarantees to guarantee payment of the accounts receivables from affiliates, it failed to disclose that Newell had made the appraisal of the real estate and that Dickstein, Markovitz and Koch had given similar guarantees in the prior year and had not honored them;

(4) Net income was overstated by reason of:

(a) the failure to charge income for a substantial allowance for the non-collection of the accounts receivable from affiliates; and

(b) the failure to expense substantial costs allegedly incurred in connection with the public offering;

(5) Assets were overstated by reason of:

(a) Substantial costs allegedly incurred in connection with the public offering were improperly deferred; and

(b) The failure to provide a substantial allowance for the non-collection of the accounts receivable from affiliates; and

(6) It represented that the outside auditors were independent when this was not the case.

E. Allegations concerning manipulation

The complaint also alleges that from on or about August 1, 1973 to on or about October 30, 1973, a registered representative of a New York brokerage firm, aided and abetted by Omni-Rx and the individual defendants, maintained, dominated, controlled and manipulated the market in the common stock of Omni-Rx, and, as a part of such activities, entered purchase orders for Omni-Rx common stock for customer accounts of the New York brokerage firm and other persons without authorization from such customers and other persons. The complaint alleges that Omni-Rx and the individual defendants knew or should have known of such activities, failed to take action to halt such activities and never disclosed the bases of the increase in the market price of Omni-Rx common stock. It was also alleged that the 1973 fiscal year report to the Commission on Form 10–K and annual report to shareholders were false and misleading in that they failed to disclose these matters.

The individual defendants are alleged to have directly or indirectly participated in the preparation of the documents filed with the Commission or sent to shareholders which I have mentioned this morning.

F. Prayer for relief

The Commission is requesting that the District Court issue an order enjoining the defendants from violating anti-fraud provisions or from preparing or filing with the Commission false or misleading documents or documents not in compliance with the Securities Act and Securities Exchange Act or the rules and regulations thereunder. In addition we are seeking an order requiring Imperial West Medical Group, Dickstein, Markovitz and Koch to file an accounting with the District Court and disgorge monies or assets of Omni-Rx wrongfully diverted, withheld or used for their account or benefit. We also request such other and further relief as the Court may deem just and appropriate.

This concludes my prepared statement regarding the allegations in the complaint.

Mr. Moss. Thank you.

Mr. Waxman.

Mr. WAXMAN. Mr. Ferrera, the complaint alleges the defendants were violating antifraud and other provisions of the Federal securities law. Would you please tell the subcommittee the nature of these provisions, what they require?

Mr. FERRARA. Mr. Waxman, specifically the complaint alleges violations of 17(a) and rule 463 under the Securities Act of 1933, and sections 10(b) and 13(a) of the Securities Exchange Act of 1934, rules 10b–5, 12b–20, 13a–1, 13a–11, and 13a–13 thereunder.

Speaking generally, sections 10(b) of the Securities Exchange Act and rule 10b–5 thereunder and 17(a) under the Securities Act are antifraud provisions. These make it unlawful, through the use of jurisdictional means, to make false or misleading statements of material facts or to otherwise engage in fraud in connection with transactions in securities.

Section 13(a) of the Securities Exchange Act and rules 13a–1, 13a–11, and 13a–13 thereunder, on the other hand, require public com-

panies to file annual, quarterly, and current reports with the Commission containing prescribed information.

Rule 12b–20 adopted under the Securities Exchange Act requires reporting companies to supplement the required disclosures and periodic reports with such further material information as may be necessary to make the required disclosures not misleading.

Finally, rule 463 adopted under the Securities Act requires issuers having filed an initial registration statement to file a report disclosing certain prescribed information containing sales of securities and uses made of the proceeds therefrom.

Those are the sections that were alleged in the complaint, Mr. Waxman, and that is generally what those sections provide for.

Mr. WAXMAN. The complaint against Omni-Rx related primarily to activities taken subsequent to the public offering of 200,000 shares of Omni-Rx sold in December 1972; is that not correct?

Mr. FERRARA. That is correct.

Mr. WAXMAN. And the Commission is charging the three principal officers of Omni-Rx, Drs. Dickstein, Markovitz, and Koch, with the improper use of the proceeds of that sale.

Can you tell us exactly what was done with the proceeds of that offering in the nature of this charge?

Mr. FERRARA. The complaint alleges, Mr. Waxman, that prior to the public offering, Omni-Rx's auditors indicated an unwillingness to give an unqualified report on Omni-Rx's financial statements, unless certain debt due Omni-Rx from its affiliated medical groups was substantially reduced. The debt was presented on Omni-Rx's balance sheet as accounts receivable from affiliates. Those affiliates, I understand, were the medical groups in which the three individual defendants had an interest.

In order to complete the offering, according to the complaint, Drs. Dickstein, Markovitz, and Koch, singly and doing business as Imperial West Medical Group, borrowed $450,000 from Farmers & Merchants Bank and $100,000 from a second bank to reduce the accounts receivable from affiliates and Omni-Rx transferred the funds back to the banks in order to pay off certain short-term notes.

The offering thereafter took place on or about December 21, 1972, with the closing held, I believe, on January 9, 1973. The complaint then alleges that at the time Omni-Rx received its portion of the proceeds from the offering, it transferred about $570,000 of those proceeds to Dickstein, Markovitz, and Koch, singly and doing business as Imperial Medical Group. About $559,000 of these funds were, it is alleged, again, in the complaint, then transferred to the Farmers & Merchants Bank to pay off the earlier preeffective loans that I described a moment ago.

According to the complaint, Omni-Rx transferred an additional $100,000 of the use of the proceeds from the public offering to pay off the preeffective date loans of Dickstein, Markovitz, and Koch at the second bank. In addition, $30,000 of the proceeds was paid to defendant Newell.

About 20 days after the transfer of the proceeds, Imperial West Medical Group gave Omni-Rx a note for $570,000 secured by $800,000 of receivables from medical payments.

Now, that generally describes how the accounts receivable were paid down by the individual loans drawn by the doctors, as alleged in the complaint, and how the proceeds of the public offering were, in turn, used to pay down the personal loans of the individual defendants.

The allegations of violations of the antifraud provisions with respect to the registration statement concern the disclosure contained therein relating to the use of the proceeds of the offering and the transactions that I have just described to you.

The allegations of reporting violations—those are the violations of section 13(a) of the Securities Exchange Act and the rules promulgated thereunder—relate to the disclosures of these matters contained in the quarterly and annual reports filed by Omni-Rx in the years thereafter. The allegations concerning rule 463 under the Securities Act also relate to the same basic transaction. That rule, as I said a moment ago, requires disclosure on a periodic basis after a public offering of how, in fact, the proceeds of the offering have been disposed of.

Mr. WAXMAN. As far as the SEC is concerned, you are primarily talking about the disclosure that must be made to potential purchasers of common stock regarding the solvency of the corporation from which the stock would be offered, is that correct?

Mr. FERRARA. That is one important matter of disclosure, Mr. Waxman. Of course, the disclosures contained in a Securities Act registration statement go far beyond the question of solvency and information concerning the financial condition of the issuer. The one aspect of the complaint does speak to a balance sheet item, accounts receivable and the quality of those accounts receivable. However, other items of disclosure required by Federal securities laws concern the question of how the proceeds of the offering are actually going to be used and the integrity of the 1934 act—that is the Securities and Exchange Act of 1934—reports that are filed thereafter. Solvency, of course, is one critical aspect, but only one of the important disclosures required by the Federal securities laws.

Mr. WAXMAN. So your complaint is not merely about the disclosures of the financial conditions and the various business transactions, but your complaint is about the possible diversion of funds, is that correct?

Mr. FERRARA. That is correct—the complaint speaks to the various transactions I have described. I did not, however, mean to suggest that the complaint spoke to matters other than these. I was merely suggesting, a moment ago. that required disclosures relate to more than the narrow question of solvency.

Mr. WAXMAN. So you are saying that there is a potential fraud in the failure to disclose the truth of the various financial transactions of the various parties involved that make up Omni-Rx's subsidiaries but, in addition to that, you are saying there were funds that were diverted from the business itself. What have these funds been used for and where do you allege they occur?

Mr. FERRARA. The complaint alleges, as I said a moment ago, that funds from the offering were transferred to some of the individual defendants to pay down bank loans incurred by the individual defendants to, in turn, pay down the accounts receivable of Omni-Rx. That is generally what the allegations of the complaint concern.

However, I might add that, beyond the allegations of the complaint, the Commission has asked in its prayer for relief not only for an injunction but also for an accounting to be made to the court by the individual defendants and we have invoked the equitable powers of the court to order whatever additional relief the court deems appropriate.

Now, should the court, at the conclusion of the trial, determine that, in fact, funds had been diverted by the individual defendants away from Omni-Rx Health Systems, the registrant, the court could order additional equitable relief, such as disgorgement, restitution, or whatever other ancillary relief the judge thought appropriate.

An equity court, as the subcommittee knows, has broad discretion in matters such as this to remedy any wrong that it perceives has been done.

Mr. WAXMAN. So we clearly understand the nature of the SEC action, that is a civil matter not criminal, is that correct?

Mr. FERRARA. That is correct. The action that is pending is a civil action.

Mr. WAXMAN. And you are asking for injunctive relief which would accomplish what purposes?

Mr. FERRARA. The injunction would prohibit those subject to its terms, from violating the Federal securities laws in the future.

Mr. WAXMAN. Have you determined whether there are possible criminal violations in addition to the violations of the SEC laws? Have you made any referral of this matter to the appropriate authorities?

Mr. FERRARA. As the subcommittee is aware, a willful violation of any of the provisions of the Securities Exchange Act, for example—and that would encompass the allegations of reporting violations here—could result in both civil and criminal liability. That result is reached by operation of section 32 of the Securities Exchange Act of 1934 which provides criminal liability for anyone who willfully engages in a violation of any provision of the Exchange Act, including the reporting provisions. The other Federal securities laws operate similarly.

Conceivably, when you are talking about criminal violations generally, you could be referring both to violations of the provisions of title 18 of the U.S. Criminal Code, as well as any willful violation of any provision of the Federal securities laws.

I can tell you that there has not been a formal referral of the facts in the *Omni-Rx* litigation to the U.S. Department of Justice. As you are aware, sir, the normal procedure for the Commission to follow in matters such as this is to receive a recommendation from the staff as to whether or not a particular matter is appropriate for referral to the Department of Justice. Thereafter, the Commission makes a determination whether or not the matter should be referred. If the Commission determines that it should be referred, it can do so with or without recommendation and then it is in the hands of the Department of Justice to determine whether or not to initiate a criminal prosecution.

The Commission disposes of all of its own civil litigation, but the Department of Justice handles any potential criminal violation. There has not to date been any formal referral from the Commission to the Department of Justice in this case; although, as you quite correctly

point out, any willful violation of the Federal securities laws could conceivably result in a criminal referral or a criminal prosecution. That process is not unique to this case and applies in any case brought by the Commission.

Mr. WAXMAN. Is it the opinion of the Commission that the matter is not one that they would feel deserving of being referred to the Department of Justice? Has there been a decision by the Commission in the negative, that this is not really a matter for their review of a possible criminal violation?

Mr. FERRARA. It is my understanding, Mr. Waxman, that not only has there not been a decision by the Commission on this matter, but the staff has not, to date, made a recommendation to the Commission that it should be referred. The Commission, as best I know, has not had an opportunity to consider whether or not there should be a criminal referral in this case.

Mr. WAXMAN. Thank you.

Mr. Moss. Mr. Scheuer.

Mr. SCHEUER. People hear a great deal about the disclosure requirements under the 1934 act and the failure to disclose to stockholders details about the corporation and, of course, this has been particularly true in the area of illegal and questionable foreign and domestic payments, the bribes we have all heard about in the papers.

Can you give us a thumbnail description of why the business of disclosure is so important and what does disclosure or failure to disclose really mean to the average investor in terms of the protection that he needs to invest judiciously and know what his corporation is doing?

Mr. FERRARA. Mr. Scheuer, as the subcommittee is aware, and as you are personally aware, we are now talking about a question of philosophy and a philosophy that was first adopted by the Congress in 1933.

If the committee would bear with me for a moment, I will go through some of that. I think that will help answer the question.

The predatory practices that were uncovered in congressional hearings subsequent to the market crash of 1929, suggested that a strong congressional initiative was required and that a variety of alternative courses of action were available. One alternative would have been to delineate in code fashion a comprehensive set of prescriptions as to how one should conduct business in a market environment. The Congress could also have chosen at that time to authorize a major Federal intervention into the internal affairs of corporations.

Another alternative that the Congress had before it was to adopt what I like to call a self-regulatory approach rather than have a major Federal intrusion into the internal activities of corporations.

The Congress felt, however, that the integrity of a self-regulatory process could only be maintained, if there was full disclosure to the investing public as to how public corporations were governing themselves. Corporate accountability could only be insured if the public had the capacity to peer over the shoulders of corporate managers on a regular basis.

I believe it was Mr. Justice Brandeis who once said that sunlight is the best disinfectant. I believe that is the philosophy that Congress chose here.

Mr. SCHEUER. It also had to be timely.

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Mr. FERRARA. That is correct, sir.

Mr. SCHEUER. What is the SEC doing in cases like this and others to insure that the disclosure is made in a timely fashion so that the stockholders can act on the information that they have before irreparable harm has been suffered by the corporation in their interest?

Mr. FERRARA. I will address that from the perspective of the Securities Act of 1933 and the Securities Exchange Act of 1934, both of which are involved in the *Omni-Rx* case.

Under the Securities Act of 1933, the Congress provided what I think is the best triggering device for timely disclosure. Pursuant to section 5 of the Securities Act, no security can be delivered after sale unless it is first preceded or accompanied by a statutory prospectus containing prescribed information regarding the transaction. Accordingly, when there is a public offering of securities subject to the Securities Act, disclosure precedes or accompanies the delivery of the securities and there is an absolute requirement that such a disclosure document be provided.

Now, let us move into the Exchange Act. There the Congress gave the Commission more latitude than it did in the Securities Act. The Congress said certain issuers of securities should be subject to regular reporting requirements, and the Commission was given broad discretion to interpret and flesh out those reporting requirements. Pursuant to that delegation of authority, the Commission adopted the so-called Exchange Act continuous reporting scheme. Within that scheme, public companies meeting the statutory requirements are required to file with the Commission an annual report on form 10–K, containing a detailed discussion of their business and operations. Now, that report is filed only on an annual basis.

Secondly, Mr. Scheuer, the Commission requires that on a quarterly basis those companies subject to the reporting requirements of the Exchange Act file with the Commission financial information on form 10–Q which is available to the investigating public, but, again, that is only on a quarterly basis.

Additionally, the Commission requires that certain material events must be the subject of a report filed on a monthly basis on form 8–K with the Commission. That is a limited report and it is only done on a monthly basis. Beyond that, when shareholders of a corporation are called upon to exercise their franchise to elect directors to direct their enterprise, the Commission requires managements' proxy soliciting materials, prepared in accordance with statutory schedules, be distributed to those solicited.

Now, beyond the standard reporting requirements, the Commission has in public releases continuously urged publicly held companies to promptly report material information. When I say promptly report, I do not mean waiting for the annual report on 10–K, waiting for the quarterly report on 10–Q, or possibly even waiting for the monthly report on form 8–K, but rather getting that material information out now.

The Commission has continually urged the prompt dissemination of material information and the Commission's lead in this area has been picked up by the courts who have held, particularly, if there is trading by corporate insiders, that failure to promptly disclose material information trading can be considered violative of the antifraud

provision of the Federal securities. That is basically the disclosure scheme and basically the scheme we utilize to make sure there is prompt disclosure of material information.

Ideally, of course, a disclosure system would provide not only the big institutional investors in the large cities but also the individual investors and small broker dealers in the small communities across this country with access to all material information about all trading companies at the same time. That would be the optimally equitable marketplace. I do not think that we are there yet, but I think that is the ultimate answer to your question.

Mr. SCHEUER. I thank you very much for your responsive answers. That's all.

Mr. Moss. Mr. Ottinger.

Mr. OTTINGER. Thank you.

Relating to the *Omni-Rx* case, there was one concerning the account firm of Omni-Rx, the firm of Seidman & Seidman. I wonder if you could tell us what the charges were against the firm relative to their activities in Omni-Rx.

Mr. FERRARA. Mr. Ottinger, the conduct of Seidman & Seidman is not specifically the subject of the civil action brought against Omni-Rx. However, the Commission's opinion and order involving Seidman & Seidman, one of the related actions I talked about at the beginning of my testimony, is reported in the Securities and Exchange Act release of 1934, No. 12752. That is a lengthy release of some 60 or so pages, which discusses the conduct of Seidman & Seidman with respect to each of the cases I mentioned to you.

Briefly, I can provide you some information regarding Seidman & Seidman conduct in the Omni-Rx matter from the public release that I mentioned before, and I will submit a copy of the release to the subcommittee for its consideration.

Before or during its audit of Omni-Rx's 1973 financial statements, Seidman & Seidman became aware that $570,000 of the proceeds of the offering had been misused, and that Omni-Rx was engaged in an attempt to conceal the actual use of proceeds in the offering. Yet no disclosure was made of these facts, which would have been of utmost importance to the shareholders of Omni-Rx and to other users of its financial statements. Knowledge of the actual use of the offering of the proceeds also should have put Seidman & Seidman on notice that the reduction of the affiliate receivables, on which it had conditioned use of the audit report in the registration statement, was also a shame. "We believe"—the Commission is speaking now, in the course of its release—"We believe that Seidman & Seidman had no reasonable justification for failure to take some action in this matter."

The Commission's release also went on to discuss the conduct of Seidman & Seidman in connection with transactions involving a certificate of deposit that was purchased by the company prior to the filing of its annual report. There the Commission said that in connection with the fiscal year end purchases of $570,000 certificates of deposit, Omni-Rx gave two written instruments to the first bank, which was the bank we talked about earlier. Both of these documents by their terms purported to sell all of Omni-Rx's receivables of $1.7 million to the bank. Notwithstanding the terms of the instruments, both Omni-Rx and the bank treated these instruments as loans. Omni-

Rx should have disclosed the terms of the written instrument between itself and the first bank in its notes to the financial statements, which disclosure would have been significant, since the receivables purportedly relayed to the bank constituted about 32 percent of Omni-Rx's assets. The successful assertion of title to these receivables by tne bank would have required their immediate recognition of a loss in excess of $1 million.

Here the Commission said specifically with respect to Seidman & Seidman that the firm was aware of the terms of these agreements.

Finally, the Commission noted in its release, it concluded that Seidman & Seidman was not independent, as that term is used in the Federal securities laws, with respect to Omni-Rx during its audit engagements in the 1972 and 1973 financial statements.

Independence, as you are aware, Mr. Ottinger, is the absolute critical feature in dealing with public auditors and the relationship of public auditors to public corporations. I think, if my recollection serves me correctly with respect to the *Omni-Rx* case, Seidman & Seidman had acquired another accounting firm styled Wolfson, Weiner, and that is the firm that actually conducted the audits at the time. Rather than go from my recollection of details of sometimes complicated accounting matters, however, it would be best to refer to the Commission's release. That's what I have been referring to and reading from.

Mr. Moss. If you want the release placed in the record at this point, that would be a good idea.

With no objection, it is now so ordered.

[Testimony resumes on p. 86.]

[The document referred to follows:]

UNITED STATES OF AMERICA
Before the
SECURITIES AND EXCHANGE COMMISSION

SECURITIES EXCHANGE ACT OF 1934
Release No.12752 /September 1, 1976

ACCOUNTING SERIES
Release No. 196 /September 1, 1976

ADMINISTRATIVE PROCEEDING File No. 3-5072

In the Matter of	:	OPINION AND ORDER
	:	PURSUANT TO RULE 2(e)
SEIDMAN & SEIDMAN et al.	:	OF THE COMMISSION's
	:	RULES OF PRACTICE

This Opinion and Order under Rule 2(e)(1) 1/ of the Commission's Rules of Practice [17 C.F.R. 201.2(e)(1)] arises out of: (1) the conduct of Seidman & Seidman and certain of its partners and employees in connection with its combination of practices in February, 1972 with the Los Angeles, California office of Wolfson, Weiner, Ratoff & Lapin ("Wolfson/Weiner") and of the audits of certain financial statements of three former Wolfson/Weiner clients--Equity Funding Corporation of America ("Equity"), Omni-Rx Health Systems ("Omni-Rx") and SaCom, and (2) certain of the audits of financial statements of Cenco, Incorporated ("Cenco").

1/ Rule 2(e)(1) provides as follows:

> The Commission may deny temporarily or permanently, the privilege of appearing or practicing before it in any way to any person who is found by the Commission after notice of and the opportunity for hearing in the matter (i) not to possess the requisite qualifications to represent others, or, (ii) to be lacking in character or integrity or to have engaged in unethical or improper professional conduct, or (iii) to have willfully violated, or willfully aided and abetted the violation of any provision of the Federal securities laws [15 U.S.C. 77a to 80b-20], or the rules and regulations thereunder.

Seidman & Seidman is a partnership engaged in the practice of public accounting. It has more than 150 partners located in 43 offices throughout the United States and is affiliated with a number of accounting firms outside the United States. Since its creation in 1910, the firm has performed a variety of auditing, tax, advisory and related services in the United States and abroad.

Seidman & Seidman has submitted an offer of settlement, described in detail below, which we have considered and determined to accept. As contemplated by the settlement offer, Seidman & Seidman has waived institution of formal administrative proceedings under Rule 2(e) and, without admitting or denying any of the statements or conclusions set forth herein, has consented to the issuance of this Opinion and Order. The facts developed in the staff investigations and the related accounting and auditing issues are set forth in some detail below.

SUMMARY

The matters giving rise to these proceedings are the result of two unrelated areas of inquiry conducted by the Commission staff. These matters involved fraudulent conduct by the client companies in which Seidman & Seidman was deceived. Nevertheless, we have concluded that Seidman & Seidman did not fulfill its responsibilities in the manner required by the standards of the profession.

Three of the audit engagements which are the subject of this Opinion and Order concern clients obtained by Seidman & Seidman through its February 1972 combination of practices with the Los Angeles, California office of Wolfson/Weiner. As a result of the staff's investigation we have found that the audit practices employed by Wolfson/Weiner's Los Angeles office were far below professional standards and that employees of that office engaged in acts and practices in flagrant violation of rules of the Commission and standards of the accounting profession relating to independence.

Seidman & Seidman failed to undertake a reasonable investigation prior to the combination of the firms and failed to properly review practices and professional qualifications of staff members of the Wolfson/Weiner office or to adequately inquire into factors bearing on their independence from clients. After the combination, Seidman & Seidman failed to take reasonable steps to ensure the maintenance of

professional audit review practices and independence in connection with former Wolfson/Weiner clients.

In Equity 2/ certain former Wolfson/Weiner and management personnel were criminally convicted following disclosure of a massive financial fraud. 3/ Over approximately ten years, Equity falsified its financial statements by reporting bogus assets and earnings in the tens of millions of dollars. Approximately one month after consummation of the Wolfson/Weiner combination, Seidman & Seidman issued an unqualified opinion on the December 31, 1971 Equity financial statements although no pre-combination Seidman and Seidman personnel had worked on or reviewed the audit and Seidman & Seidman was aware that Wolfson/Weiner partners generally did not review audit engagements.

In Omni-Rx 4/, Seidman & Seidman audited financial statements for inclusion in a registration statement for a public offering and financial statements for a subsequent reporting period which were included in an Annual Report on Form 10-K. Seidman & Seidman learned after the offering that a substantial amount of the offering proceeds had been used to pay debts of persons in management who were in effective control of Omni-Rx and that statements by Omni-Rx in a report filed with the Commission concerning use of proceeds were false. Seidman & Seidman subsequently issued an opinion on Omni-Rx's financial

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2/ In April 1973, the Commission filed a complaint in the United States District Court for the Central District of California seeking injunctive and other relief against Equity and others, not including Seidman & Seidman. See Litigation Release No. 5849/April 16, 1973.

3/ Julian S.H. Weiner and Solomon Block, both formerly associated with the Wolfson/Weiner firm, were convicted in the United States District Court for the Central District of California of certain criminal violations of the federal securities laws. Under the provisions of Rule 2(e)(2) of the Commission's Rules of Practice, their right to practice before the Commission was automatically suspended following that conviction.

4/ The Commission has filed a complaint in the United States District Court for the District of Columbia seeking injunctive relief against Omni-Rx and others,not including Seidman & Seidman. See Litigation Release No. 7540 September 1, 1976.

statements for the year in which these events occurred which omitted to disclose these facts. In addition, Seidman & Seidman issued an opinion on the financial statements included in the registration statement which financial statements failed to reflect necessary provisions for losses on accounts receivable due from affiliates and failed to disclose the adverse financial condition of the affiliates of Omni-Rx.

In SaCom 5/, Seidman & Seidman audited financial statements included in a registration statement, and financial statements for a subsequent reporting period included in an Annual Report on Form 10-K. In these audits the firm accepted management decisions to capitalize material amounts of costs and to record, without necessary loss allowances, the full amounts of claims for certain government contract work without substantial evidential support for such accounting treatment.

The second, and unrelated area of inquiry is the Cenco case. 6/ In that case, the staff investigation indicates that certain members of the former management group and others engaged in a calculated scheme to falsify Cenco's financial statements. This was accomplished in large part by inflation of the quantities and cost of items of inventory. We have concluded that Seidman & Seidman failed to conduct the examinations in question in accordance with generally accepted auditing standards, including ignoring or failing to adequately pursue significant facts which came to its attention. In our view the examinations were not properly planned and staffed and the audit work performed provided an insufficient basis to support opinions that the financial statements were fairly presented.

The audits of financial statements of Equity, Omni-Rx, SaCom and Cenco, the particulars of which are detailed below, involve serious deficiencies in audit performance, review, supervision and, except with respect to Cenco,

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5/ The Commission has filed a complaint in the United States District Court for the District of Columbia seeking injunctive relief against SaCom and others, not including Seidman & Seidman. See Litigation Release No. 7539 September 1, 1976.

6/ The Commission has filed a complaint in the United States District Court for the Northern District of Illinois seeking injunctive relief against certain members of the former management of Cenco and others, not including Seidman & Seidman. See Litigation Release No. 7538 September 1, 1976.

independence. The financial statements of these issuers were not prepared in conformity with generally accepted accounting principles and the audits were not conducted in accordance with generally accepted auditing standards as was represented by Seidman & Seidman in its reports. In several instances Seidman & Seidman failed to obtain sufficient competent evidential matter to afford a reasonable basis for its opinions, permitted the examination of critical audit areas to be performed by persons having inadequate training or proficiency in audit work, and placed unwarranted reliance upon management representations.

A firm engaged in practice before the Commission and persons who undertake responsible positions in such firms must take appropriate measures to insure the maintenance of professional standards and independence in the conduct, review and supervision of audit work on financial statements to be filed with the Commission. Investors and other users of financial statements properly rely upon reports of auditors for protection and have a right to assume that such reports are based upon examinations conducted in accordance with high professional standards by independent auditors. Under the circumstances of these cases, we find that Seidman & Seidman's conduct represented a breach of its ethical and professional responsibilities in practicing before the Commission.

CENCO INCORPORATED

Cenco is a Delaware corporation with its principal offices in Chicago, Illinois. It is a diversified company with sales of almost $300 million for its fiscal year ended April 30, 1975. At that time through numerous divisions and subsidiaries, Cenco engaged in the manufacture and distribution of products and services in five general areas: health care, education, water pollution abatement, technology and nursing homes. Its common stock is listed for trading (although trading is currently halted) on the New York and Pacific stock exchanges. Seidman & Seidman, through its Chicago office, was the independent auditor of Cenco for approximately 15 years. During that time Cenco grew to be one of the largest of Seidman & Seidman's accounts. Since February 1976, Seidman & Seidman has ceased to act as independent auditors for Cenco.

An investigation conducted by the Commission staff has revealed false financial reporting by Cenco of substantial proportions with respect to its audited annual financial statements from about 1970 to 1974. 7/ Throughout that period Seidman & Seidman issued unqualified reports with respect to Cenco's annual financial statements. 8/ The staff's investigation indicates that the false financial reporting was the result of a calculated scheme directed and conducted by certain officers of Cenco and its subsidiaries and others. During 1975 substantial changes were made in the management and board of directors of Cenco. Under its new management, Cenco is in the process of divesting itself of its health care and certain other businesses.

Cenco's false financial reporting was accomplished in large part through manipulations of the financial statements of certain subsidiaries in its Health Care Group. Predominant among these was Cenco Medical Health/Supply Corporation ("CMH"). During the years 1973 and 1974, CMH was primarily in the business of distributing health and medical products to hospitals and other institutional customers through a network of approximately 20 branch warehouses and marketing facilities located throughout the United States. The reported sales of CMH, included in the consolidated financial statements, were approximately $32.8 million and $41.8 million for the fiscal years ended April 30, 1973 and April 30, 1974, respectively. The reported inventory of CMH as included in the Cenco consolidated financial statements was approximately $32.1 million and $39.0 million for the fiscal years ended April 30, 1973 and April 30, 1974, respectively.

The staff's investigation as discussed herein addressed principally the audits for the 1973 and 1974 fiscal years. The investigation indicates that intentional inflation of

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7/ Some details of the scheme were brought to light in part through the cooperation of Seidman & Seidman during the staff's investigation.

8/ In June 1975 the reports for the years 1973 and 1974 were withdrawn.

inventory quantities and values was among the means used to accomplish the fraud during those years. This was carried out by Cenco management assisted by lower level employees, primarily by altering the quantities recorded on the prenumbered, two-part inventory tags used by CMH in counting the inventory; by altering quantities reflected on computer listings prepared to compile the physical count of inventory; and by creating inventory tags to record quantities of nonexistent inventory.

The staff's investigation reveals that Cenco personnel at various levels and in various operational areas engaged in certain activities for the apparent purpose of concealing the falsification of the financial statements from Seidman & Seidman. Notwithstanding such concealment, the remedial sanctions described below are based in part on our findings that in conducting its audits of Cenco's fiscal 1973 and 1974 financial statements, Seidman & Seidman failed to comply with applicable professional standards with respect to obtaining sufficient, competent evidence to afford a reasonable basis for its opinions and failed to take adequate measures to assure appropriate supervision of professional staff conducting the field work.

1973 Fiscal Year

For the fiscal year ended April 30, 1973 Cenco reported pretax income of $27.3 million. Consolidated inventory valued at $104.4 million represented about 33% of total assets at fiscal year end. The valuation of year end inventory and cost of goods sold was based primarily on a physical inventory taken in May 1973. It appears that about 50% of the $32.1 million reported CMH portion of year end inventory was in fact non-existent. This overstatement of inventory substantially inflated Cenco's consolidated pre-tax income.

During the 1973 audit of CMH, Seidman & Seidman reached two significant audit conclusions which pertained to the CMH inventory accounting system. The first was that the CMH internal controls over inventory continued to be inadequate. The second was that as in prior years, CMH did not have reliable general ledger inventory balances or perpetual inventory systems. The auditors therefore believed that CMH was forced to rely almost entirely on the results of the physical inventory. In our opinion, the conditions as they believed them to exist required extensive audit testing of inventory. It is our judgment that Seidman & Seidman did not give adequate audit effect to the clear requirements

of these conclusions. Under the circumstances, the Commission also believes that the audit program for CMH inventory should have expressly noted these internal control deficiencies and included appropriately detailed instructions concerning the nature and scope of audit tests.

The CMH inventory was physically counted by CMH personnel during the first part of May 1973. Pursuant to written instructions, client personnel were directed to use two-part, prenumbered inventory tags to record the results of the count in pencil; to post the results of the count from the tags to the branch inventory control cards; and to send the used, unused and voided tags to Chicago for processing. The CMH written instructions, which were available to Seidman & Seidman prior to April 30, 1973, did not otherwise instruct CMH personnel in the control of inventory tags. In Chicago, the tags used were processed to computer cards from which were prepared listings purportedly reflecting for each branch the results of the physical count taken.

As a part of its audit procedures, Seidman & Seidman observed the physical inventory count at nine of the twenty CMH warehouses, representing about 65% of the total CMH inventory. The engagement instructions transmitted from the Chicago office of Seidman & Seidman to the auditors conducting the observations directed the observing auditors to use their discretion with regard to the extent of audit testing during the observation. These instructions did not inform the field auditors of inadequacies in CMH internal controls or the reliance by CMH on the results of the physical count. 9/ As a result, most of the observing auditors were required and permitted to exercise discretion over the extent of testing without being informed of all relevant information bearing on the extent of testing appropriate in the circumstances.

The Seidman & Seidman instructions to the auditors observing the inventory count required the auditor to either obtain or prepare a document for control of the inventory tags used, unused or voided. The program also required that after completion of the counting, the document be tested for accuracy. However, Seidman & Seidman did not obtain or prepare tag control documents at four of the nine branches observed. It is our judgment that in failing to comply with its own audit

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9/ The workpapers indicate that Seidman & Seidman did not sign off on its study and evaluation of the CMH internal controls until after the physical count (although, as noted, deficiencies in the internal controls were known to exist).

requirements at four of the nine branches, the auditors did not properly assure themselves that control of the inventory tags was adequate and that the conclusion reached by Seidman & Seidman that tags had been properly controlled did not reflect an objective review of the results of that audit work.

As a part of the observation of the physical count of inventory, Seidman & Seidman auditors checked the accuracy of the CMH counting procedures by test counting the results recorded by CMH personnel. Seidman & Seidman recorded certain of these test counts on schedules which were included in the observation workpapers. 10/ The purpose of recording these test counts was to provide evidential matter upon which the auditors could reach a conclusion on the reliability of the CMH representations of the quantities reflected in the computer listings.

In regard to quantities of inventory, our investigation indicates that Seidman & Seidman generated evidential matter from two principal sources. These sources were the procedures pertaining to control of the inventory tags and the comparison of recorded test counts taken during the observation to the final computer listings. As previously concluded, Seidman & Seidman did not generate sufficient evidential matter to conclude that inventory tags had been adequately controlled. Therefore the principal source of evidential matter which provided a reasonable basis for concluding that CMH was reliably representing its inventory quantities, was the comparison of test counts to inventory listings. It is our opinion that Seidman & Seidman unreasonably relied on this procedure and that the results of this procedure in fact provided substantial indications that CMH was not accurately stating its inventory quantities.

The comparison of recorded test counts to the computer listings in the nine warehouse locations in which the inventory count was observed indicated error rates ranging from .9% to 38.8% of the test counts, with error rates in excess of 10% in several locations. 11/ It is our opinion that the number and percentage of test count differences warranted additional procedures to determine the reasons for the differences and the possible effect on the inventory computations. This is particularly so in light of the large number of tags used to count the inventory. Seidman & Seidman did attempt to ascertain the reasons for the differences in the Miami

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10/ As is customary, not all test counts were recorded.

11/ In some cases, test counts were higher than the listings, in others lower.

comparisons, following discovery that the bulk of the differences were uniformly an increase by a multiple of ten. A similar pattern also appeared in another comparison. The auditors first demanded an explanation from Cenco management and were informed by the former director of CMH operations that the pattern of differences was attributable to errors made by a key-punch operator. The auditors then asked to see the inventory tags, but the same CMH official stated that the tags had been destroyed. Seidman & Seidman did not ascertain the extent to which such "keypunch errors" might have affected the untested portion of the inventory listing. The Seidman & Seidman workpapers do not contain any reference to this investigation. Without attempting any further procedures, the auditors apparently accepted management's explanation and concluded that no adjustments to the bulk of the Miami inventory were required. 12/

Seidman & Seidman undertook alternative procedures in another audit area which was in part related to the CMH quantity representations. The Seidman & Seidman auditor who performed the price testing of the CMH inventory determined that, as in previous years, in numerous instances CMH was unable to produce sufficient vendor invoices to support the purchase by CMH of the quantities being price tested. This was true even though Seidman & Seidman ultimately accepted vendor invoices reflecting the purchase of the item by any CMH branch, regardless of the location of the inventory actually being price tested. 13/ The alternative procedure utilized in this instance suggested that even if CMH had sold none of the inventory items during the preceding year, CMH could not account for the increase in quantity between April 30, 1972 and April 30, 1973. While Seidman & Seidman's records indicate that substantial time was devoted to the CMH inventory, the auditors did not, as we believe they should have, further extend their procedures in view of these results.

12/ It is the view of Seidman & Seidman that nothing short of a recount would have provided substantial additional assurance that the Miami inventory was fairly stated and that the degree of uncertainty did not warrant so drastic a measure.

13/ Seidman & Seidman asserted that this approach was justified since the merchandise found at any one branch might have been purchased by and shipped from other branches and that CMH required a large number of interbranch transfers because of Cenco's refusal, despite suggestions by the auditors, to adopt a central purchasing system instead of permitting each branch to make its own purchases.

The Seidman & Seidman workpapers contain a memorandum in which an auditor concluded that he was satisfied that the quantities stated in the CMH inventory were accurate. It is our judgment that this conclusion was not supported by sufficient competent evidential matter. In addition, the conclusion was that of an individual with no prior audit experience and whose technical training was limited to certain accounting courses taken in college. He was, at that time, a college student employed by Seidman & Seidman as a summer intern. The fact that Seidman & Seidman required and permitted an inexperienced individual to express an opinion going to the accuracy of critical inventory representations is a further indication of poor audit planning with respect to the engagement.

The intern had been required by Seidman & Seidman to perform a substantial part of the inventory audit work, and it was the intern who made an audit judgment on the sufficiency of the sum of evidential matter obtained with respect to inventory. Although the intern testified that he was closely supervised, the workpapers do not reflect any supervision of the intern during the course of the audit or the extent to which the foundations for his conclusions were reviewed.

Seidman & Seidman utilized a standardized audit program in connection with its inventory procedures. This program required certain audit steps which Seidman & Seidman determined could not be performed based on its knowledge of the CMH accounting system. Seidman & Seidman did not, as we believe it should have, adequately substitute procedures to take the place of audit program steps which were not performed.

Although Seidman & Seidman was aware of a significant overstock problem, it did not, as its audit program required, perform any documented analysis of the rate of turnover of the CMH inventory and did no other similar testing. 14/ Based on the results of the physical inventory the staff has calculated that the rate of inventory turnover was significantly below industry standards. Although we recognize that the function of an independent auditor is not to review the appropriateness of management business decisions, we believe that an analysis of the rate of inventory turnover as well as appropriate

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14/ Seidman & Seidman has stated that it was told by CMH management that the overstock problem was attributable to inefficient purchasing and other factors which resulted from CMH's not having a centralized purchasing system. The workpapers do not reflect this.

comparison of the rate to industry standards and other suitable tests are important audit procedures which generate significant evidential matter regarding the salability of goods on hand.

Seidman & Seidman prepared a schedule which set forth the comparative inventory balances at April 30, 1972 and April 30, 1973 for a number of the CMH branches. This schedule reflected significant increases from the prior year. A CMH financial officer wrote on this schedule management's explanations for the increases in inventory amounts. 15/ Seidman & Seidman did not attempt to determine the reasonableness or credibility of these explanations. 16/ It is our opinion that Seidman & Seidman unduly relied on these explanations and did not take those steps necessary under the circumstances to verify their reasonableness. This is particularly so in light of the fact that the amount of increase in inventory was substantially greater than the corresponding increase in sales.

It is our further opinion that Seidman & Seidman did not adequately ascertain the reasonableness of the CMH year end cut-off procedures. Our investigation indicates that the extent of evidential matter generated in this regard was more appropriate to the audit of an accounting system where purchase and sales data including invoicing, shipping, and receiving documentation were adequately controlled. This was not the case at CMH where neither pre-numbered purchase orders nor shipping documents were utilized and where other serious weaknesses existed in the internal control system.

1974 Fiscal Year

Cenco reported pre-tax net income of $13.3 million for its 1974 fiscal year. Consolidated inventory valued at $119.4 million represented about 34% of total assets at fiscal year end. It

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15/ For example, an increase of 80% (about $400,000) was explained by "larger warehouse". An increase of 35% amounting to $400,000 was explained by "poor purchasing". An increase of more than 50% amounting to $350,000 was explained by "new warehouse". An increase of more than 100% amounting to $550,000 was explained by "volume doubled ($625,000 increase)."

16/ In the auditors' view the credibility of the management explanations was enhanced by the belief that the financial officer's responsibilities were not in the area of inventories.

appears that about 50% of the reported $39.0 million CMH inventory was in fact non-existent. This overstatement of inventory substantially inflated Cenco's consolidated pre-tax income.

There was a recurrence during the 1974 audit of many of the deficiencies noted with respect to the prior engagement. Again substantial hours were devoted to the CMH inventory and in contrast to 1973, Seidman & Seidman did complete its evaluation of the CMH internal control system and reach a conclusion of inadequacy prior to the close of the fiscal year. Nevertheless, Seidman & Seidman again left the extent of various observation testing to the discretion of auditors not all of whom were aware of significant audit conclusions which related directly to the extent of such testing. Observation of inventory counts at year end was confined to six locations (representing about 40% of total CMH inventory) as opposed to nine in the preceding year. The field auditors again did not adequately control the inventory tags and Seidman & Seidman did not detect the creation of bogus inventory tags which were inserted in the final inventory computations. No substantial steps were taken to test the reasonableness of explanations for significant changes from the prior year's final inventory balances at certain locations. Once again, Seidman & Seidman did not substitute adequate procedures to replace certain impracticable standardized audit steps.

During the course of the fiscal 1974 audit, Seidman & Seidman encountered two specific audit problems bearing on the validity of the reported quantities of inventory. In both instances, in our judgment, Seidman & Seidman failed to adequately resolve the audit problems presented.

During the course of price testing certain large dollar volume inventory items represented by CMH to be contained in the Hamden, Connecticut warehouse, the auditor involved was informed that vendor invoices could not be produced for use in the price testing. Instead, Seidman & Seidman asserts that the CMH operations manager and the Hamden branch manager explained that two salesmen had incorrectly counted the items in question. The correct quantity when extended to a total dollar amount was below the price test scope. In addition, Seidman & Seidman was informed that the salesmen had counted only those items being tested, supposedly located in one section of the warehouse. In our opinion, by relying solely on these representations without seeking independent evidential matter, Seidman & Seidman did not adequately resolve the questions raised.

In the second instance Seidman & Seidman became aware of a discrepancy between the number of tags reflected as used on the computer listing for the Miami warehouse and the number of tags reflected as used on the Seidman & Seidman tag control document. The computer listing contained a series of almost 1,000 tags, covering about 1/5 of the tags purportedly used and more than 50% of the total reported value of the Miami inventory, which were recorded as being unused on the tag control document obtained by Seidman & Seidman during its observation work. 17/ In response to this discrepancy Seidman & Seidman instituted certain additional audit procedures. After giving advance notice to the client, the field auditor was initially instructed to attempt a "roll-forward" of certain inventory items, reconciling quantities on hand at the time with purported quantities at April 30, 1974. 18/ This turned out to be impracticable, since inventory from the Tampa warehouse had been combined with that in Miami during the intervening period and the necessary perpetual inventory records had been purportedly destroyed. The auditor was then instructed to attempt to search the warehouse for any of the second parts of the two part tags with numbers within the suspect series. He initially found only five such tags. His initial memorandum covering this work stated:

> "I am unable to definitely say that the inventory is being inflated, but there are a few things about the new tags which bother me."

His reference was to the lack of location indications on these tags and the fact that they were found in widely scattered spots throughout the warehouse. The tags which he had reviewed immediately after the physical inventory had uniformly reflected locations. His initial memorandum went on to state that it was ". . .quite impossible, considering the heavy test counts that I performed, that I would not have come across at least one of the additional tags during my observation."

17/ Seidman & Seidman obtained its tag control document over the telephone, after completion of its inventory observation, and did not obtain the final inventory listing for Miami until June 16, 1974. Prior to discovery of this discrepancy Seidman & Seidman had initially concluded that it had properly controlled the CMH inventory tags.

18/ This would have involved use of the perpetual inventory records which Seidman & Seidman believed to be unreliable.

In a subsequent search of the warehouse, the Miami auditor discovered three additional tags of the suspect series, for a total of 8 tags of that series found. These were sent to the auditors in Chicago. The auditor reported that he had located a total of 46 tags of all series in the two return trips to the warehouse. In a memorandum following the latter search, the Miami auditor concluded that the tag control he had obtained by telephone at April 30, 1974, was in error. In reaching this conclusion, the auditor pointed out, among other things, that the Tampa inventory had been moved to the Miami warehouse (with the consequence that the inventory had been relocated and the tags were not found in locations corresponding to the placement of inventory at April 30, 1974), and that a CMH employee had asserted that the inventory level at April 30, 1974 was about the same as that of the previous year. In addition, the Chicago auditors had received what purported to be a Miami tag control document from the then CMH chief financial officer, who said that he had been in Miami at the time of the inventory count and had compiled his own list of used tags. This "tag control" consisted of a single, undated sheet of paper which failed to note unused or void tags but which did list the suspect series of tags as having been used. Seidman & Seidman auditors in Chicago subsequently concluded that the CMH inventory overall was fairly stated. 19/ In our opinion, these additional procedures were inadequate under the circumstances and Seidman & Seidman did not resolve the audit problem of the Miami inventory tags.

During the fiscal 1974 audit, Seidman & Seidman failed to perform extended procedures in several instances where, in our view, such procedures were warranted by information received. Seidman & Seidman prepared an inventory summary schedule which indicated that at four branches observed by Seidman & Seidman the general ledger balance was materially greater than the

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19/ Seidman & Seidman's workpapers contain no contemporaneous indication of resolution of the problem presented by the suspect series. It was not until the subsequent 1975 audit that a Seidman & Seidman auditor, reviewing the 1974 workpapers under the direction of a partner, made an entry in the 1974 workpapers expressing a conclusion reached in 1974 that the discrepancy had been investigated and satisfactorily resolved.

physical inventory balance, 20/ and at most branches not observed by Seidman & Seidman the general ledger balance was materially less than the physical inventory. In our opinion, this pattern was a cause for suspicion and an explanation was required.

It is also our opinion that Seidman & Seidman could not reasonably have concluded that inventory was properly stated at the lower of cost or market on a FIFO basis. Because CMH management did not provide sufficient invoices as requested, Seidman & Seidman relied primarily on vendor catalogues, price lists and vendor invoices to test the accuracy of the CMH inventory pricing representations. Before catalogues and price lists were used they were tested by vendor invoices. In our opinion, given its conclusion that CMH had unreliable internal controls, Seidman & Seidman did not give adequate consideration to the fact that CMH was unable to produce sufficient vendor invoices to support the quantity of inventory being price tested. This is particularly so in light of the procedure followed by Seidman & Seidman of accepting invoices reflecting the purchase of inventory by any CMH branch to price test the inventory at any one specific branch.

To test the reliability of CMH representations concerning inventory pricing, Seidman & Seidman employed both weighted average and simple average methods of computing a unit cost from the vendor invoices. In other instances Seidman & Seidman simply averaged the highest and lowest cost apparently without regard for the impact of other invoices in the same sample. While Seidman & Seidman believes these methods to have been appropriate in the circumstances, it is our judgment that these procedures were inadequate to test whether inventory was being valued on a FIFO basis and that there was no appropriate justification for utilizing different methods of cost verification in drawing conclusions from the sample.

The deficiencies in the fiscal 1973 and 1974 audits of Cenco appear to have been caused in large part by a lack of appropriate audit planning and failure to adequately consider the potential for misstatement inherent in the CMH inventory. There were extreme delays in receiving key documents necessary

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20/ Due to a computer merging of inventory files, it was not possible to analyze the difference at one of the branches observed.

to perform important aspects of the audit work which resulted in the need to perform substantial work, particularly with respect to inventory, during the last weeks of the engagements. Efficient audit procedures are often dependent in large part on early production of required documents by the client. A delay in document production should not in itself be the cause of a reduction in the scope or completeness of an accountant's examination and should not cause a deviation from established procedures. We do not think that Seidman & Seidman approached the audits of the CMH inventory with the skeptical attitude necessary to properly achieve the purposes of the audits.

COMBINATION OF PRACTICES

Seidman & Seidman was founded in 1910 by M. L. Seidman with a single office in New York, New York. By 1968, the firm had developed into a diverse, nationwide practice. At that time the firm had ten general partners (six Seidman family members and four unrelated persons). In 1968 Seidman & Seidman reorganized into six geographic regions, each under the supervision of a regional partner, and entered upon a program of rapid expansion through combinations of practices with other smaller firms. Since 1968 the number of Seidman & Seidman offices has increased from 24 to 43. It is indicative of the pace of expansion that during the nine years from 1960 to 1969 the firm engaged in only three combinations while in the five years from 1969 to 1973 there were 26 such combinations.

The Wolfson/Weiner firm was founded in about 1957 in Los Angeles by Julian S. H. Weiner and Phillip J. Wolfson. Ten years later this firm and certain other firms scattered throughout the country entered into a loosely affiliated national organization. In 1971, Wolfson/Weiner had 18 partners and about 200 employees in six offices across the United States. Each office was substantially independent of the others. In the Los Angeles office one of the two partners acted principally as the administrative partner while the other was primarily engaged in practice development and in seeking financing and similar activities on behalf of clients of Wolfson/Weiner.

Although Equity was Wolfson/Weiner's major client, a substantial portion of annual revenues resulted from audit work by Wolfson/Weiner for companies in the process of

going public through registered public offerings or offerings under Regulation A. Wolfson/Weiner had a reputation in the Los Angeles area for its ability to groom companies for public offerings and assist them in obtaining financing and underwriting arrangements. The Wolfson/Weiner clientele thus consisted largely of unseasoned companies, some of which were apparently formed for the purpose of going public. The officers of these companies had little if any knowledge or experience in the reporting requirements of the Commission, and the companies frequently had accounting systems unsuited to such public reporting requirements. Many were undergoing audits for the first time. Such a practice and clientele required a high degree of skill and judgment in auditing which Wolfson/Weiner lacked.

The staff's investigation indicates that Wolfson/Weiner's Los Angeles office did not meet the professional standards necessary for investor protection in many of its client audit engagements. While on occasion the two partners were engaged in critical decision making on audit engagements, they were not familiar with the details of audits and generally did not review workpapers. In addition many members of Wolfson/Weiner's audit staff failed to meet the standards of the profession with respect to qualifications and competence. Audit managers, some of whom were not certified public accountants, were permitted to sign the firm's name to audit reports. The Wolfson/Weiner workpapers examined by the staff in its investigation were replete with audit conclusions which were not supported by either the audit procedures or the audit findings, open points left unanswered and statements by the field auditors disputing conclusions on material matters reached by the partners or managers of the engagements. In addition, numerous and gross departures by Wolfson/Weiner partners and staff from the independence standards of the profession and requirements of the Commission were found.

After initial contact by Wolfson/Weiner, discussions occurred in 1970 concerning a possible combination of the two firms but Seidman & Seidman rejected the Wolfson/Weiner proposal. Wolfson/Weiner reopened the discussions in 1971. Several meetings occurred in late 1971 and early 1972 between Wolfson/Weiner partners and certain members of the Seidman & Seidman Policy Group. Seidman & Seidman declined a combination with the entire Wolfson/Weiner firm and reached an agreement

to combine with only its successful Los Angeles practice. 21/ A formal agreement between the parties was completed on February 18, 1972 and was made retroactive to February 1, 1972. The separate offices were physically combined during the Summer of 1972.

It was the policy of Seidman & Seidman that the regional partner supervise the pre-merger investigation and that the results of the investigation together with his recommendation be presented for the consideration and vote of the Policy Group of Seidman & Seidman. 22/ Seidman & Seidman had, at the time, established procedures for the investigation and evaluation of combination of practice candidates. These procedures were set forth in two outlines included in a merger kit which consisted substantially of information about Seidman & Seidman. While the merger kit did not specify the manner in which such reviews were to be conducted it required that investigations be conducted into, among other things, the audit practices and procedures and qualifications of personnel of the firm to be acquired.

The Commission believes that the pre-combination examination procedures used by Seidman & Seidman were inadequate. For example, the Seidman & Seidman procedures contemplated some investigation of the audit procedures of the combination candidate, but did not specify the scope of this investigation or the manner in which it was to be conducted. In this instance, Seidman & Seidman performed a cursory review for one day of two of Wolfson/Weiner's audit clients and one non-audit client. Further, Seidman & Seidman erred in unduly relying upon oral

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21/ In April of 1972, Seidman & Seidman, in a separate transaction, combined practices with the Ratoff & Lapin firm in White Plains, New York, which had been a part of the Wolfson/Weiner affiliated group.

22/ The western regional partner of Seidman & Seidman at the time was Robert Spencer. As such, he supervised the pre-combination investigation of the Los Angeles office of the Wolfson/Weiner firm. In October 1973, he became a senior partner of the firm and since then has not been involved in the investigation of possible combination of practice candidates for Seidman & Seidman. He has assured the Commission that he will not be involved in such activities in the future. The Commission accepts his assurance and directs him to comply therewith.

representations by the partners of Wolfson/Weiner with respect to the nature and quality of its practice.

Moreover, an inadequate investigation was made of the qualifications of the Wolfson/Weiner staff. During its investigation Seidman & Seidman did learn of the lack of participation of tne two Wolfson/Weiner partners in the conduct and review of audit engagements as well as of certain concerns as to the qualifications of one senior member of the firm's staff.

Despite these matters the Policy Group approved the combination of practices on the recommendation of the regional partner. The vote of the Policy Group on the combination was taken by telephone and mail instead of at a regularly scheduled meeting as was the general practice.

After the combination and until mid 1973, one of the Wolfson/Weiner partners was assigned the responsibility for the audit engagements of former Wolfson/Weiner clients. This partner continued his former practice of rarely participating in review of audit engagements, a fact known to Seidman & Seidman. The deficiencies in the audit practice of Wolfson/Weiner as discussed above also continued. Over a period of time after the combination of practices, Seidman & Seidman became increasingly aware of material deficiencies in the work product and qualifications of members of the former Wolfson/Weiner staff and failed to adequately supervise the conduct of the continuing audit engagements.

The Commission has become increasingly concerned that the trend in the accounting profession toward growth accomplished through combinations may sometimes weaken professional standards in audit engagements. In situations such as these, the Commission believes that a rigorous examination of the procedures and previous audit work as well as the independence of a candidate are required. Such examinations, while not a perfect safeguard against false statements made by principals of a combination candidate, should be sufficient in scope to permit the acquiring firm to know with a reasonable degree of confidence the quality of the practice it proposes to acquire. A combination of practices should be fully discussed and analyzed by the decision making authorities of the acquiring firm.

Furthermore, the Commission believes that accounting firms should be hesitant to rush into combinations of practice. In this instance, there appears to have been a desire by Wolfson/Weiner, pressed by Equity's management, to conclude the combination so that the 1971 year-end Equity financial statements could carry the name of Seidman & Seidman. The desire to obtain the public relations benefits of financial statements audited by a major accounting firm is not a reasonable excuse for shortening the deliberative process before effecting a combination.

Seidman & Seidman's investigation of Wolfson/Weiner revealed that the two Wolfson/Weiner partners, while actively involved in client relations and some aspects of audit work, did not customarily involve themselves in the review aspects of audits. The involvement of partners in the review of audits is, in the Commission's view, a necessary element of sound auditing practice. Where no partner of a combination candidate regularly performs review functions, it is incumbent upon the acquiring firm to investigate closely the manner in which review functions are performed within the combination candidate. The Commission is not satisfied with the examination by Seidman & Seidman of Wolfson/Weiner in this regard.

Post-combination procedures for assimilation of combined practices are no less important than appropriate and adequate pre-combination examination standards and procedures. Firms which choose to expand through combinations with other practitioners have an obligation to maintain and enforce a high level of professionalism throughout the enlarged practice.

INDEPENDENCE 23/

Various partners and employees in the Seidman & Seidman Los Angeles Office who had previously been employed by Wolfson/Weiner had direct and indirect financial interests in clients

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23/ Rule 2.01 of Regulation S-X, promulgated by the Commission, provides in part:

(b) The Commission will not recognize any certified public accountant or public accountant as independent who is not in fact independent. For example, an accountant will be considered not independent with respect to any person or any of its parents, its subsidiaries, or other affiliates (1) in which, during the period of his professional engagement to examine the financial statements

Footnote continued on next page.

and also engaged in various promotional and financial activities on behalf of those clients. For those reasons and others specified below, we have found that Seidman & Seidman was not independent with respect to its audit of certain financial statements of of Equity, Omni-Rx, SaCom and certain other clients served by the Los Angeles Office of that firm. 24/ In two instances, audit fees were "adjusted" for the sole purpose of reducing related offering costs shown in a registration statement. In at least one instance, a finder's fee was paid to secure an issuer as a client.

It is also the Commission's view that the firm's independence was compromised in certain instances by the facts and circumstances of the engagement itself. An accounting firm cannot be considered independent when the judgment of the auditors is subordinated to the views of the client, or where the auditors consciously acquiesce in the concealment of material information. Similarly, a firm cannot be viewed as independent where it does not take action with respect to serious past deficiencies arising out of intentional misconduct by the client.

The staff found evidence of a lack of independence with respect to other issuers. The two partners entering Seidman &

Footnote continued from preceding page.

being reported on or at the date of his report he or his firm or a member thereof had, or was committed to acquire, any direct financial interest or any material indirect financial interest or (2) with which, during the period of his professional engagement to examine the financial statements being reported on, he or his firm or a member thereof was connected as a promoter, underwriter, voting trustee, director, officer, or employee, except that a firm will not be deemed not independent in regard to a particular person if a former officer or employee of such person is employed by the firm and such individual has completely dissociated himself from the person and its affiliates and does not participate in auditing financial statements of the person or its affiliates covering any period of his employment by the person. For the purpose of Rule 2.01 the term "member" means all partners in the firm and all professional employees participating in the audit or located in an office of the firm participating in a significant portion of the audit.

24/ The independence issues with respect to Omni-Rx and SaCom are discussed below in the sections relating to those companies.

Seidman as a result of the combination of practices were instrumental in the founding of a number of their audit clients. These partners, as well as former Wolfson/Weiner employees, held securities of several publicly held client companies prior to the combination of practices. 25/

The former Wolfson/weiner partner assigned as audit partner to each of that firm's former clients frequently engaged in promotional activity and attempts to secure financing on behalf of those clients. 26/ These activities included several instances where he solicited underwriters to join underwriting syndicates and made calls on banks on behalf of the client. He also proposed acquisitions to the issuers and made representations to prospective investors and lenders concerning the managements and future prospects of these issuers, and otherwise acted as their agents. All of these activities are inconsistent with the concept of independence.

EQUITY FUNDING CORPORATION OF AMERICA 27/

Equity began inauspiciously in the early 1960's when it pioneered the "equity funding"concept, involving the sale of mutual fund shares which were then pledged by the investor to secure a loan which financed life insurance premiums. By recording fictitious assets and earnings, Equity showed

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25/ In some cases the two partners held such securities indirectly in the name of a corporation. The partners and employees continued to hold client securities in certain instances following the combination of practices. In certain instances, independence questionnaires were given to Seidman & Seidman which did not disclose such holdings.

26/ The Commission does not suggest that independence is impaired when an auditor participates with his client in meetings with underwriters and lenders for the purpose of assisting the client in explaining his financial data. When he represents the client in financing negotiations, however, he is assuming a management role.

27/ Equity recently emerged from Chapter X bankruptcy and has been renamed Orion Corporation.

tremendous growth over a short period of time. Following its first public offering of common stock in November 1964, Equity became listed on the American Stock Exchange in 1966 and the Pacific and New York exchanges in late 1970. The company was constantly in registration from 1965 through its collapse in 1973, during which time it made numerous acquisitions (often by issuing common stock) and numerous public offerings.

By the time the massive fraud was disclosed, Equity had in excess of $120 million (net of deferred taxes) in fictitious or fraudulently inflated assets on its books. In contrast to the millions of dollars of reported earnings over the years, Equity appears never to have earned more than a nominal profit in its entire corporate life. It was in fact struggling to remain viable at the very time Seidman & Seidman succeeded to the audit engagement in 1972. 28/

Seidman & Seidman issued an unqualified opinion on the December 31, 1971 Equity financial statements although the audit work was performed by Wolfson/Weiner personnel. The Commission's investigation has indicated that the audit of Equity's 1971 financial statements (as well as examinations in prior years) were conducted in a grossly deficient manner. The 1971 working papers, as in the case of working papers for every year dating back to 1964, failed to reflect sufficient competent evidential matter to support the unqualified opinions given, and in fact clearly evidenced the deficient performance of the examination.

When Seidman & Seidman combined practices with Wolfson/Weiner in February of 1972, the 1971 audit of Equity was substantially complete. Although nearly all the personnel conducting the 1971 audit were persons originally associated with the Wolfson/Weiner firm, Seidman & Seidman, which was aware that prior audits had not been reviewed by Wolfson/Weiner partners, made no review of its own. Seidman & Seidman incorrectly assumed, on the basis of Wolfson/Weiner's representations, that the

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28/ For information concerning the fraud and the manner in which it was perpetrated see: "Report(s) of the Trustee of Equity Funding Corporation", Robert M. Loeffler, Trustee. (October 31, 1974 and February 22, 1974).

1971 Equity audit had been conducted properly, and allowed its name to appear on the 1971 Equity financial statements.

The staff's investigation has indicated many serious audit deficiencies in the 1971 engagement, as described in part below. Among the deficiencies was the virtual absence of review of audit work by competent senior level personnel, although this deficiency was concealed from Seidman & Seidman. Nevertheless, the Commission is of the view that Seidman & Seidman should have reviewed the 1971 Equity workpapers before lending the Seidman & Seidman name to the audit report, rather than relying upon the representation of Wolfson/Weiner personnel that the audit had been conducted properly.

Funded Receivables

Historically, the largest single asset on Equity's consolidated balance sheet was the "funded receivables" account. These receivables were generated when a program participant pledged mutual fund shares and borrowed money from Equity to finance life insurance premiums. Most of these receivables were carried on the books of one of Equity's wholly owned subsidiaries, Equity Funding Corporation -- California ("EFC-Cal"). The mutual fund shares were sold through another subsidiary, Equity Funding Securities Corporation ("EFSC"). Although EFC-Cal marketed the related life insurance policies, the insurance in most instances was issued by Equity Funding Life Insurance Company ("EFLIC"), a subsidiary of Equity which was not audited by Wolfson/Weiner.

By December 31, 1971, EFC-Cal had recorded approximately $34 million of fictitious funded receivables (and related collateral). The only substantive auditing procedure used in verifying the existence and valuation of this asset was a wholly inadequate attempt to confirm selected balances with program participants. This began with a computer prepared list provided by the client of customer accounts from which the first two digits of the five digit account number had been dropped. This device allowed Equity employees to "account" for the approximate general ledger balance by the simple expedient of having legitimate accounts appear two or three times on the list. 29/ No

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29/ The auditors were told that the computer "wasn't programmed" to print all five digits. The Wolfson/Weiner staff was not proficient in the area of electronic data processing and the client's explanation was accepted.

conscientious attempt was made by the Wolfson/Weiner auditors to verify the accuracy of the listing by testing it to the underlying accounting records or otherwise. In fact, documentation for the fictitious funded receivables was created only if and when requested by the auditors. 30/ The auditors then permitted Equity employees to prepare confirmations and supply the missing two digits for the selected accounts to be confirmed. When duplicates appeared in the sample, Equity employees supplied two fictitious digits and the names and addresses of confederates. The client's work was neither supervised nor tested by the auditors.

Client Contractual Receivables

In early 1969, Equity acquired Investors Planning Corporation ("IPC"), a mutual fund sales operation whose sales were largely in the form of so-called contractual plans. These plans established a continuing obligation on the part of the seller to charge decreasing sales commissions after the first year of the agreement. The purchaser had no continuing obligations or duties, but did have an incentive to continue to purchase mutual fund shares over the life of the agreement because of the favorable commission rate in the later years of the contract, called a "trail commission".

Equity paid approximately $12 million for IPC of which about $5 million reflected the fair value of assets acquired and $7 million was attributed to "goodwill". The goodwill in effect reflected what Equity was willing to pay in order to acquire the approximately 100 mutual fund salesmen who worked for IPC and the right to receive trail commissions from previously sold contractual plans.

Near the end of 1969, Equity decided to take into current income all the revenue that would ever be received from trail commissions on existing purchase plans. This recognition of income was effected by booking "receivables" which were grouped with the Funded Loans Receivable in the consolidated financial statements.

Over $17 million of these "receivables" were included in the December 31, 1969 balance sheet. No disclosure was made of their inclusion in the Funded Loan Receivable balance. Recording the sale of the commission as an asset duplicated assets already on the books, since the value of the trail commissions had

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30/ Internal control at Equity was so poor that documentation even for legitimate receivables was often missing.

originally been recognized as goodwill at the date of purchase. In addition, the initial recording of these spurious assets was made for an amount far in excess of the value of the commissions, where the right to collect depended on the entirely voluntary continued participation by customers in the plans.

In 1970 the trail commissions were "sold" to a non-existent company, Compania de Estudios y Asuntos ("Estudios"), for $13.5 million, but the bogus receivables continued to be carried in the the "Funded Loan Receivable" account. The $2 million "down payment" for the sale was provided by Equity itself. The 1970 Wolfson/Weiner workpapers show the "receivable" as $14.5 million but there is no indication that a copy of the contract of sale to Estudios or other supporting documentation was obtained. Further, no effort was made to determine the nature of the Estudios company or its financial condition, nor was any attempt made to confirm the existence of the contractual "receivables" with the individual plan participants.

The 1971 audit workpapers reflect the Estudios receivable at $13.5 million. As in the prior year, there was no apparent attempt to confirm the supposed obligation of Estudios nor to confirm the contractual receivables with the individual plan investors.

Establissement Grandson

In 1970, Equity recorded a fictitious receivable from Establissement Grandson ("Grandson"), a company secretly controlled by Equity. This "receivable" was inappropriately used to offset a previously undisclosed liability of about $9 million. 31/ The receivable was documented by two spurious notes which were due February 10 and February 14, 1972 and which were shown to the Wolfson/Weiner auditors. Although confirmations were mailed during the 1970 audit, they were intercepted by Equity personnel and fictitious responses were returned. During the 1971 audit, it appears that no attempt

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31/ The liability (a loan from an international brokerage firm) had originally been intentionally mis-recorded as a credit to the funded receivables account, but was later properly recorded when the lender noted its absence from financial statements.

was made to confirm the two notes; nor was any investigation made of payments on the notes, despite the fact that both supposedly matured before the financial statements were issued.

Agent Receivables

Receivables from agents (on the books of EPC-Cal) consisted of advances made to sales agents and items that had been paid on their behalf. By the end of 1969, EFC-Cal had lost control of the detail of the amounts making up the balances; where the company did have detail, a large percentage was uncollectible. When agents were terminated, the amounts due from them were not deleted from the receivable account. By the end of 1971 the amount of valid receivables from agents was approximately $1.2 million but the amount shown on the books was approximately $3.4 million. Throughout the years, it appears that no auditor ever asked for supporting documentation for this asset account, nor did the auditors ever confirm with outside sources the existence of the balances.

Exploration Costs

In September 1970, Equity used a journal entry to decrease the Grandson receivable and recorded "Exploration Costs" (supposedly intangible drilling costs) in the amount of $1,750,000. This totally fictitious asset was put on Equity's books because management did not want the oil and gas subsidiary to know about it. No documentation for the entry was ever prepared.

A 1970 workpaper schedule shows the item, but there is no indication of any work performed by the Wolfson/Weiner auditors regarding the source of the item, the details behind it, any examination of supporting documents, or any other substantive audit work. During 1971, additions, some of which were fictitious, were made to the account. Again a workpaper schedule shows the item and the additions, but again no audit work was performed.

Insurance Agency Profits

An Equity subsidiary, Equity Casualty Insurance Agency, ("ECIA") sold casualty insurance and had shown only minimal profits through 1970. In 1971 the company's future profits for the period January 1, 1972 through December 31, 1980, were "sold" to a non-affiliated insurance company. Consideration for the

sale consisted of a note in the amount of $2.5 million, $800,000 of which was included in income for 1971. The remaining credit of $1.7 million was used to reduce a fictitious accounts receivable and an improper suspense asset account on the books of Equity itself.

The written agreement, entered into as of December 31, 1971, provided that the note was to be paid in equal annual installments of $367,556 through March 31, 1981, at which time all interest and principal then unpaid would become due and payable. Each year as an installment payment came due there was to be credited against the installment the greater of (1) ECIA's net income or (2) $365,000. Thus, if net income was zero, $365,000 of the then current installment payment would be forgiven and the installment would be only $2,556. The maximum installment payment was therefore $2,556 and the minimum was zero, giving the note a miniscule current value. The 1971 workpapers contain a journal entry with respect to this transaction, but no audit work appears to have been performed.

Commissions Receivable

The books of EFC-Cal for the year ended December 31, 1971 contained an account called "Commissions Receivable" in the amount of $2.9 million which dated back to the year 1968. Although the account was carried as a current asset on the balance sheet, there had been no collection since 1968. The account was in fact, occasionally used to record non-existent assets as an alternative to the constant fraudulent inflation of Funded Loans Receivable. There was no audit evidence whatsoever reflected in the 1971 audit workpapers.

Commercial Paper

Equity transferred cash to EFLIC in 1971 because of problems EFLIC had in covering its own non-existent assets. 32/ Instead of recording a receivable from EFLIC, Equity recorded an investment in non-existent commercial paper. Over $19 million of bogus commercial paper was on the books at December 31, 1971. Equity had created documentation for the alleged investments, but the auditors never asked to see it.

The workpapers for the 1971 audit show a listing of commercial paper investments supposedly held by Equity in the amount of $28,115,000. There was no indication in the workpapers

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32/ Principally non-existent life insurance policies which had been reinsured with unaffiliated insurers.

of any maturity date for most of the commercial paper, and the auditors made no attempt to confirm it with any custodian. Most of the supposed "redemptions" were not traced to cash receipts or otherwise verified.

In December 1971, Equity recorded an "investment" in the amount of $2,000,000 supposedly in the commercial paper of a company called Apatex. The paper was purportedly due to mature on April 17, 1972, and was carried on the books and records of Equity as a part of approximately $3,700,000 in other securities and investments.

The 1971 audit workpapers show no indication that the auditors verified the existence of these investments by observation or confirmation.

The Wolfson/Weiner audit work discussed above is so obviously deficient that elaboration seems superfluous. With respect to Seidman & Seidman's conduct, it should be noted that a comparison of the recorded assets to the workpapers makes the total inadequacy of the audit evidence conspicuously clear. Yet Seidman & Seidman substituted its imprimatur for that of the Wolfson/Weiner firm on Equity's 1971 financial statements, without any review of the Wolfson/Weiner audit workpapers.

OMNI-RX HEALTH SYSTEMS

Omni-Rx, with headquarters in Hawthorne, California, is engaged in providing management, technical and financing services to certain affiliated medical groups as well as ancillary health services to patients of those medical groups. The affiliated medical groups are actively engaged in the practice of medicine and specialize in workman's compensation, welfare, insurance and group medical plan cases. Omni-Rx and the affiliated medical groups are under the common control of three doctors who serve as principal officers of Omni-Rx and as partners of the medical groups. In its financial statements for its fiscal year ended June 30, 1975, Omni-Rx reported net income of $348,939 and total assets of $6,632,965. The financial data with respect to the affiliated medical groups is not reflected in Omni-Rx's financial statements. Its common stock is traded over the counter.

Omni-Rx was organized in 1971 as a consolidation of various entities then performing services for the medical groups. It offers a package of services including billing,

collection, office and equipment leasing, hiring and supervision of employees, transcribing, pharmacy and other services designed to encompass most of the business aspects of medical practice. Since its inception it has not attracted any significant medical groups as clients other than those controlled by the three doctors and has served as a vehicle for financing the rapidly expanding practices of these medical groups. Such financing was needed by the medical groups principally because of the long term nature of the patient receivables generated by their practices.

From the Company's inception it was the intention of the founders to conduct a public offering and Wolfson/Weiner was hired because of its reputation in that field. Omni-Rx continued as a Seidman & Seidman client after the combination of practices. An underwritten public offering of 200,000 shares of Omni-Rx common stock at $7.50 per share was conducted on December 21, 1972. Of the 200,000 shares, 175,000 were sold by the issuer and 25,000 were sold by certain shareholders. The registration statement included financial statements of Omni-Rx for the year ended June 30, 1972 and the unqualified opinion of Seidman & Seidman.

A substantial portion of the net proceeds from the public offering were used in a manner inconsistent with representations in the registration statement as to the use of the proceeds and in order to conceal this use of the proceeds, sham transactions were entered into with a bank and false reports were filed by Omni-Rx with the Commission. Although Seidman & Seidman learned later of these activities, it issued a report covering the 1973 fiscal year financial statements of Omni-Rx which failed to disclose these facts.

The registration statement filed in connection with the public offering contained false and misleading statements and omitted material disclosures. In the financial statements net income, accounts receivable due from the affiliated medical groups, and deferred costs in connection with the offering were overstated by reason of the failure to provide necessary provisions for losses on the receivables and the improper capitalization of certain accounting and auditing fees. The receivables from affiliates were improperly presented as a current asset on the balance sheet. Omni-Rx failed to disclose that the affiliated medical groups had incurred losses greater than the profits reported by Omni-Rx. The use of proceeds section in the registration statement was false. In addition, a false statement was made in the registration statement with respect to estimated accounting fees. The Omni-Rx Annual

Report on Form 10-K reflected similar deficiencies in accounting and disclosure.

The reports of Seidman & Seidman appeared in the registration statement and in the Annual Report on Form 10-K for Omni-Rx's 1973 fiscal year. Many of the facts underlying the deficiencies in the registration statement and Form 10-K were known to Seidman & Seidman. Moreover, the audits were not conducted in accordance with generally accepted auditing standards. In addition we have found that Seidman & Seidman was not independent of Omni-Rx. Omni-Rx terminated Seidman & Seidman as its auditors in early 1974.

The public offering

A former Wolfson/Weiner partner was assigned as audit partner for the audit of the financial statements included in the Omni-Rx registration statement. This partner played little part in the conduct of the audit and did not review workpapers to any significant extent. The field work was under the supervision of an acting-manager who, like all the other auditors performing the field work, was not a certified public accountant.

The registration statement included audited financial statements for the fiscal year ended June 30, 1972 and unaudited financial statements for the quarter ended September 30, 1972. Of total assets of $3.7 million as of June 30, 1972 $1.1 million represented accounts receivable from the affiliated medical groups. The balance of this account stood at $1.3 million at September 30, 1972, classified as a current asset. At both dates, these receivables were Omni-Rx's most significant asset and at neither date was a provision for losses made.

Omni-Rx was dependent on the affiliates for substantially all of its revenue. Omni-Rx collected the patient billings of the affiliates and, in turn, paid substantially all of the expenses of the affiliated groups. In addition to funds obtained from Omni-Rx to pay expenses, substantial sums were paid to the affiliated medical groups by Omni-Rx to pay the three doctors as partners' drawings. Whenever funds were needed by the affiliates they were drawn from Omni-Rx, apparently without regard to the amount of funds held by Omni-Rx on their behalf.

As a result of an inability to collect sufficient patient billings, the expenses of the affiliated medical groups and the drawings of the doctors, the affiliates were unable to pay Omni-Rx for its services to them. As a result, the affiliates' debt to Omni-Rx rose steadily.

The poor cash flow situation of Omni-Rx at the time of the offering was not apparent from the financial statements, in which Omni-Rx reported net income of $312,340 for the year ended June 30, 1972. There was no information in the registration statement concerning the financial results of the affiliates, notwithstanding the substantial dependence on them, which was disclosed. During the 1972 audit the auditors reviewed unaudited income statements for the affiliates for the years ended June 30, 1971 and June 30, 1972. The income statements indicated a loss for the year ended June 30, 1972 of $362,590 before partners draw and $839,823 after partners draw as compared with a profit of $18,355 before draw and a loss of $232,566 after draw as of June 30, 1971. The auditors also prepared combined income statements showing the operating results of Omni-Rx together with those of the affiliates. The combined figures showed a loss of $60,179 before draw and $537,412 after draw as of June 30, 1972 as compared with a profit of $338,763 before draw and $87,842 after draw as of June 30, 1971.

A primary reason for the losses of the affiliates was that the management fees charged by Omni-Rx, when added to other affiliate expenses, were greater than the revenues of the affiliates. The income statements of the affiliates revealed losses greater than the reported profits of Omni-Rx and moreover, a deteriorating financial condition. Disclosure of such facts would have been important to prospective purchasers of the stock because of the dependence of Omni-Rx on the affiliates for revenues and because of the effect the losses would have on their ability to pay and therefore, to the very viability of Omni-Rx itself.

Omni-Rx should have had a substantial provision for losses on the affiliate receivables to properly reflect that account on the balance sheet. Such a provision was necessary because the debtors--the medical groups--had suffered substantial and increasing losses, had net partnership deficits and negative working capital. Omni-Rx knew the financial condition of the affiliates because of the common control by the doctors

and because it had possession of the affiliates' books and records. The need to establish bad debt allowances against the amounts due should have been emphasized by the fact that Omni-Rx's own patient receivables were carried net of bad debt allowances of about 33%. Similar types of patient receivables were the only assets of the affiliates and their only substantial source for paying Omni-Rx in the normal course of business. Payment of a substantial portion of the affiliate receivables was delinquent.

Seidman & Seidman recognized potential problems inherent in the affiliate receivables and requested that balance sheets of the affiliates and two of the three doctors as of June 30, 1972 be prepared for their use. The third doctor declined to provide Seidman & Seidman with financial information. The balance sheets as of June 30, 1972 for the affiliates and one of the doctors indicated deficit working capital while that of the second doctor indicated working capital of only about $9,000. Neither the financial condition of the affiliates nor of the doctors justified treating the receivables as a current asset.

The auditors were concerned about the nature of and lack of payments on the receivables and the financial condition of the affiliates. Following discussions between the Company and the auditors, the medical groups gave a security interest on all of their patient receivables of $850,344 (less allowance for doubtful accounts of $160,513) as security against the debt. In addition, the doctors agreed to make substantial payments against the debt before the effective date of the offering. The doctors also gave the auditors a letter stating their intention to pay off the debt by the end of the 1973 fiscal year through cash and/or an exchange for their own patient receivables. The affiliates provided the auditors with cash flow and income projections covering the 1973 fiscal year. The security interest in the affiliates' receivables was of little benefit to Omni-Rx since the primary bank lender of both Omni-Rx and the affiliates had a prior security interest in all receivables of the medical groups, arising from prior loans. At the time of the public offering the trade receivables of the affiliates were approximately sufficient to cover the bank debt on a one-for-one basis, after a reasonable provision for doubtful accounts. The reliance upon representations of the doctors was, in the Commission's view, unwarranted given the circumstances known to the auditors. The affiliates' projections, even if accepted as accurate, indicated that the affiliates would be unable to pay off the debt.

As a result of their continuing concern over the cash flow situation and the valuation and classification of the amounts due from affiliates, the auditors were unwilling to consent to the inclusion of their opinion in the registration statement unless substantial payments were made. In addition, approximately $450,000 of short term debt owed by Omni-Rx to its two banks was overdue. In response to this situation, the doctors, Omni-Rx, the affiliates, and Omni-Rx's principal bank entered into a series of transactions designed to create an appearance of an improved working capital situation.

The bank loaned approximately $450,000 to the doctors in October and December 1972. The funds were used to reduce the debt due Omni-Rx from the affiliates. Omni-Rx then used $350,253 of this money to pay off its own prior loan to the Bank. These transactions were completed before the effective date of the registration statement. The auditors consented to the inclusion of their opinion in the registration statement upon being shown proof of the transfer of the funds to Omni-Rx. The registration statement disclosed that the affiliated medical groups had reduced their indebtedness to Omni-Rx but not the source of the funds or the terms of repayment. In fact, Omni-Rx used part of the offering proceeds to repay the above described borrowings by the doctors. These transactions and efforts to disguise the misuse of the proceeds are described more fully below.

The Company's balance sheet at June 30, 1972 reflected as an asset approximately $240,000 of deferred costs purportedly related to the public offering, including outside auditing and accounting fees of about $177,000. Of that amount, over $150,000 was in fact for routine audit and accounting work for Omni-Rx and the affiliates. The Commission is of the view that not all of these fees could properly be deferred. The costs of public offerings which may properly be deferred are those which relate directly to the registration statement, are non-recurring and are clearly not identifiable with continuing the issuer's usual or typical business operations. Charges for the preparation and audit of annual financial statements and related costs as well as charges for interim financial statements are costs attributable to the year incurred, since they are not directly related to the registration statement and will recur in the following years. Only a portion of the audit and accounting fees appear to have been properly deferred. In addition to

the improper capitalization of audit and accounting fees, consulting fees of about $23,000 were improperly deferred. Seidman & Seidman knew of the facts concerning these costs.

Item #23 in the registration statement on Form S-1 disclosed that estimated accounting costs in connection with the offering were $180,000. This figure was inserted in the registration statement as a result of a complaint by the managing underwriter about the size of Seidman & Seidman's billings to Omni-Rx, which by then totalled $211,000. In response to that complaint Seidman & Seidman advised Omni-Rx that $31,000 would be ostensibly forgiven, in order to show reduced costs in the registration statement, but that Seidman & Seidman expected to recoup the $31,000 after the offering. The Company was further advised that it was required to comply with a payment plan covering all of the accounting fees, including the amount ostensibly forgiven, or Seidman & Seidman would not deliver the required "cold comfort letter" at the closing. Omni-Rx acquiesced in this arrangement after learning from the underwriters that they would not close without the cold comfort letter.

As a result of the foregoing arrangement false statements concerning estimated accounting fees were made in the registration statement and to the managing underwriter. Omni-Rx had paid Seidman & Seidman about $54,000 prior to the offering for various services. In accordance with the arrangement, Omni-Rx paid $125,000 to Seidman & Seidman at the closing and received the cold comfort letter; thus total payments were about $180,000. Several additional payments were made in mid 1973. Disputes arose in late 1973 over Seidman & Seidman's charges and Omni-Rx discontinued payments.

Misuse of Proceeds

On the closing date of the offering in early January, 1973 Omni-Rx received a check from the underwriters representing the proceeds of the offering. About $800,000 was available for use after expenses. The check was immediately taken to the bank. On the day this check was delivered to the bank, an Omni-Rx check for $570,000 was drawn payable to the Imperial West Medical Group, one of the affiliated medical groups, which then transferred the funds by check to the doctors. Simultaneously, the doctors paid $559,000 of that amount over

to the bank. On January 29, 1973, twenty days after the transfer, the three doctors gave Omni-Rx a note for $570,000 together with a security interest in about $800,000 of patient receivables. The registration statement had stated that the proceeds of the offering were to be used for improvements to medical buildings and for new equipment, programs and facilities.

The doctors had borrowed $75,000 from a second bank just before the offering. They transferred this money to Omni-Rx to further reduce the due from affiliate debt and Omni-Rx in turn used it to pay off its own short term debt at the second bank. After the public offering Omni-Rx transferred $200,000 of the proceeds over to its account at the second bank. Of the $200,000, $100,000 was used to purchase a certificate of deposit and $100,000 was used to pay off the doctors' loan at that bank.

Omni-Rx began an attempt to disguise the misuse of the proceeds immediately after they were transferred to the doctors. The effort at concealment has continued to the present time and has involved false and misleading filings with the Commission, including false reports on Forms S-R, 10-Q, 10-K and 8-K.

The first false filing was of a Form S-R which purported to cover the uses of the proceeds from the effective date of the registration statement (December 21, 1972) through March 21, 1973. 33/ In this filing Omni-Rx falsely asserted that the $670,000 of the proceeds of the offering had been used to buy certificates of deposit. In order to carry out this deception Omni-Rx, on March 30, 1973, purchased a $600,000 certificate of deposit from a bank. The certificate was purchased with the proceeds of a new loan at that bank made on the same date. Three days after the loan and the purchase of the certificate of deposit, the certificate of deposit was redeemed and the proceeds used to pay off the loan. Omni-Rx paid 6% interest on the loan and received 4% interest on the certificate. The bank had physical possession of the certificate during the three day period and required that it be endorsed back to the bank at the time the loan was

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33/ Form S-R is a required filing pursuant to Rule 463 under the Securities Act of 1933. The Form requires a statement of the the uses made of the proceeds, and was designed in part to detect misuse of the proceeds of public offerings.

made. The entry on the Form S-R with respect to the certificates was false because the Company did not own the certificates as of March 21, 1973, the cutoff date for the Form S-R, and because the certificates were not purchased with proceeds of the offering. The Form S-R was also false because the Company included in a description of the uses of proceeds of the offering about $180,000 for accounting and other expenses and building and equipment expenses some of which had been paid well before the public offering.

1973 Fiscal Year Financial Statements

Neither the audit partner nor the senior assigned to the 1973 fiscal year engagement had previously been associated with Wolfson/Weiner.

In its financial statements for the fiscal year ended June 30, 1973, included in an annual report to the Commission on Form 10-K, Omni-Rx reported net income of $348,874 on revenues of $2,716,356. The Omni-Rx Annual Report on Form 10-K included a qualified opinion of Seidman & Seidman on the fiscal 1972 and 1973 financial statements. The opinion was qualified subject to either the obtaining of successful operations by the affiliates or the development of prepaid health plans and obtaining of contracts with other unaffiliated medical groups. The method by which Seidman & Seidman qualified its 1972 opinion was inadequate. In our view, that opinion should have been withdrawn and the 1973 report should have noted such withdrawal. Omni-Rx did not classify the accounts receivable from affiliates as a current asset in its 1973 fiscal year balance sheet. Footnote disclosure was made however, that Omni-Rx had loaned Imperial West Medical Group $570,000.

The efforts to conceal the mis-use of the net proceeds continued in connection with the Form 10-K and annual report to shareholders for the 1973 fiscal year. On the day before the end of the fiscal year Omni-Rx purchased a $570,000 certificate of deposit from the first bank with the proceeds of a new loan at the bank. The Company paid 12% on the loan and received 5% interest on the certificate, which this time was given over to the Company. The 1973 fiscal year balance sheet presented the certificates as part of the cash balance with a parenthetical notation that $670,000 in certificates were held. The $570,000 loan was presented as part of notes payable, a current liability, but there was no disclosure that it was incurred in order to purchase the certificates. The June 29

transaction involving the purchase of the new certificate with proceeds of a bank loan was apparently done in order to create the illusion that the certificates, reported in the Form S-R to have been purchased with the proceeds of the offering, were still held by the Company.

Before or during its audit of Omni-Rx's fiscal 1973 financial statements Seidman & Seidman became aware that $570,000 of the proceeds of the offering had been mis-used and that Omni-Rx was engaged in an attempt to conceal the actual use of the proceeds of the offering. Yet no disclosure was made of these facts which would have been of utmost importance to the shareholders of Omni-Rx and to other users of its financial statements. Knowledge of the actual use of the offering proceeds also should have put Seidman & Seidman on notice that the reduction of the affiliate receivables, on which it had conditioned use of the audit report in the registration statement, was also a sham. We believe that Seidman & Seidman had no reasonable justification for failure to take some action in connection with these matters.

The Annual Report on Form 10-K was in our judgment false and misleading in a number of other respects. Omni-Rx failed to disclose that it had entered into written instruments with the first bank in which it purported to sell its receivables to the bank in exchange for the $570,000 used to purchase the certificate of deposit of June 29, 1973. The Company over stated income and assets through the continued failure to provide provisions for losses on the due from affiliate receivables and failed to note changes in presentation in the 1972 fiscal year balance sheet. Unjustified deferral of accounting fees also continued to be reflected in its financial statements.

In connection with the fiscal year end purchase of the $570,000 certificate of deposit, Omni-Rx gave two written instruments to the first bank. Both of these documents by their terms purported to sell all of Omni-Rx's receivables of $1.7 million to the bank. Notwithstanding the terms of the instruments both Omni-Rx and the bank treated these arrangements as loans. Omni-Rx should have disclosed the terms of the written instruments between itself and the first bank in the notes to the financial statements. Such disclosure would have been significant since the receivables purportedly conveyed to the bank constituted about 32% of Omni-Rx's assets and the successful assertion of title to these receivables by the bank would have required the immediate recognition of a loss in excess of a million dollars. Seidman & Seidman was aware of the terms of these agreements.

In the fiscal 1973 balance sheet Omni-Rx carried receivables due from affiliates of $2,243,112 as compared with $1,075,693 in the prior year. As in the prior year, there was no provision for losses. Substantial provisions for losses should have been made since each of the factors previously noted in that respect regarding the 1972 fiscal year financial statements continued to exist at June 30, 1973. The Form 10-K disclosed that unaudited financial statements of the affiliates showed a combined partnership deficit of $964,000 at June 30, 1973 and a net loss (after deduction of partners' drawings) of $589,000 for the year then ended. Moreover, the Seidman & Seidman opinion on the 1973 financial statements contained a qualification in part because of the losses of the affiliates. A provision for losses on the due from affiliate receivables would appear all the more necessary if the Company's continued operation was in question because of the affiliates' financial condition.

In the notes to the fiscal 1973 financial statements Omni-Rx disclosed that the medical groups transferred $1,219,035 of their patient receivables to Omni-Rx, with recourse, in exchange for receivables due from the affiliated medical groups. The notes failed to disclose that the exchange took place on a one for one basis at face value, notwithstanding the fact that similar patient receivables were carried by Omni-Rx net of a substantial bad debt allowance (about 32%) and the due from affiliate debt was carried with no such allowance at all.

Independence

We have concluded that Seidman & Seidman was not independent with respect to Omni-Rx during its audit engagements on the 1972 and 1973 financial statements. Independence is at the very foundation of the audit process and is a significant factor in the credibility of the profession. The conduct of Seidman & Seidman in the two audit engagements after learning of the numerous deficiencies noted above, warrants a conclusion that they were not independent.

In addition, Wolfson/Weiner was involved in the organization of, and obtaining financing for Omni-Rx. After the combination the same people continued to engage in similar activities. One of these persons--the audit partner for the fiscal 1972 engagement--attempted to interest broker-dealers in participating in the public offering and in effecting private placements on behalf of Omni-Rx, assisted Omni-Rx in securing the service of two managing underwriters, and sought financing on behalf of Omni-Rx. Participation in the inclusion of the false representation concerning estimated

accounting fees in the registration statement is a further indication of lack of independence. Moreover, $2,500 was paid in January 1973 as compensation for introducing Wolfson/Weiner to Omni-Rx.

SACOM

SaCom is a California corporation with its principal place of business in Sun Valley, California. Through subsidiaries it was until recently engaged in the manufacture and sale of electronic and other equipment. Its common stock was traded over-the-counter. In 1975 it filed a petition under the federal bankruptcy laws.

SaCom became a Wolfson/Weiner client in contemplation of a Regulation A offering, which took place in 1968, and remained a client of Wolfson/Weiner and later of Seidman & Seidman until 1973, when it terminated the relationship. SaCom filed a registration statement under the Securities Act of 1933 with the Commission in June, 1972 which, as amended, was declared effective on October 31, 1972. On that date an underwritten public offering of 200,000 shares of SaCom common stock took place at $6.00 per share. 34/ Seidman & Seidman gave unqualified opinions on SaCom's financial statements for the 6 months ended March 31, 1972, which appeared in the registration statement, and for the 1972 fiscal year, which appeared in an Annual Report on Form 10-K. In its income statements, SaCom reported net income of $313,430 for the 6 months ended March 31, 1972 and $542,784 before extraordinary items for the fiscal year ended September 30, 1972 respectively. The audits of SaCom's financial statements involved audit practices and attitudes which, in our view, were far below applicable standards of professional conduct.

Audits Prior To The Combination Of Practices

While we do not hold Seidman & Seidman responsible for acts and practices which occurred in connection with the audits of SaCom's financial statements prior to the combination of practices, Seidman & Seidman, independent of its former

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34/ In 1974 the Commission instituted public administrative proceedings In the Matter of Laidlaw & Co., Inc., et. al. against 21 respondents, not including Seidman & Seidman. The order for public proceedings in the matter alleged, among other things, that SaCom's common stock was the subject of a manipulation before, during and after the public offering. These proceedings were concluded in June 1976. See Securities Exchange Act of 1934 Release No. 10875/June 25, 1974.

Wolfson/Weiner personnel, should have known of them, through examination of the Wolfson/Weiner workpapers and otherwise. Accordingly we consider a brief description of certain prior events appropriate.

After the end of its 1969 fiscal year SaCom ascertained that its earnings for the year were substantially below expectations. In order to reach targeted earnings SaCom reclassified about $98,000 of costs, primarily accounting fees, as paid in capital and deferred registration costs. These costs had been expensed during the year. The effect of this adjustment was to increase SaCom's reported net income by about $50,000 or 30%. The capitalization was made through a consolidation entry, not appearing on SaCom's books. The Wolfson/Weiner workpapers indicate that this entry was made without a reasonable basis. Yet Wolfson/Weiner issued an unqualified opinion on the fiscal 1969 financial statements. During the 1969 fiscal year, the then manager of the Wolfson/Weiner audit team on the SaCom engagements and an associate at Wolfson/Weiner jointly purchased 600 shares of SaCom common stock. They owned this stock until about mid 1974.

After the end of the 1970 fiscal year, about $170,000 which had originally been charged to cost of goods sold was reclassified as tooling, leasehold improvements, contract award and acquisition costs and deferred. The capitalization of these costs had the effect of substantially reducing SaCom's pre-tax net loss and was again done without any reasonable basis. In order to provide supporting documentation for the capitalization, SaCom altered its labor time records, a fact known to the auditors. Substantially all of the Wolfson/Weiner staff participating in the audit recommended that an opinion qualified with respect to these costs be issued. However one of the partners, who had little if any audit experience, instructed the field auditors to issue an opinion not so qualified. This partner had acquired 300 shares of SaCom common stock in about March 1970 and sold the stock at about the time the fiscal 1970 financial statements were released. These shares were purchased and held by the partner in the name of a relative, without the consent or knowledge of the relative.

The workpapers for the 1970 engagement (which were not reviewed by Seidman & Seidman personnel) contain numerous comments, including those below, indicating that substantial audit problems were not resolved.

On capitalization of labor costs on defense contracts:

"No detail record of time spent is available. Above percentages were reported to be those of the employee's best estimate. Certification is to be obtained from the employees, but it is my opinion that such nonsense is only a part of the last minute conspiracy to induce false profits. Only a grossly mismanaged company would ignore costs at the time they were incurred and try arbitrarily to recreate them later."

On the capitalization of costs of leasehold improvements:

"Above amounts [$30,699.24] were taken from gross payroll earnings & represent 100% of the employees' earnings for the month except for [name omitted]. However, employees charged other accounts & jobs in process. There is no detail substantiation to the above capitalization. As a result of inadequate records, no justification can be found for removing the above from expense already charged."

General comment by newly assigned audit manager:

"Particularly troublesome to us has been the client's utter contempt for accounting principles and our professional requirements."

March 31, 1972 Stub Period

For the six months ended March 31, 1972 SaCom reported net income of $313,430 on sales of $2,460,594 compared with net income of $1,754 on sales of $1,230,620 in the first six months of the preceding year. 35/ The financial statements for this 6 month period were the most current financial information in the registration statement. Our investigation indicates that SaCom's income and certain balance sheet accounts in this period were substantially overstated through the improper capitalization of costs related to test equipment, research and development, work in process inventory and by invalid claims against the Defense Department in connection with a

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35/ The opinion on the stub period financial statements was in the name of Seidman & Seidman as successors to the Wolfson/Weiner practice, although all of the audit work and review work was performed by former Wolfson/Weiner personnel.

defense contract. SaCom also recorded sales of merchandise which was shipped in April 1972 as sales in the 6 months ended March 31, 1972 and failed to disclose about $50,000 of bank overdrafts.

The improper capitalization of costs occurred primarily in the financial statements of Technical Products Engineering Co. ("TPE"), a wholly owned, consolidated subsidiary of SaCom. These TPE cost deferrals consisted of approximately $140,000 relating to constructed test equipment and $125,000 relating to research and development projects. In addition, about $55,000 was transferred from cost of goods sold to work-in-process inventory. The reclassifications were recorded by journal entry at the end of the 6 month period and were not identified as deferrable costs when incurred. The effect of this journal entry was to substantially increase consolidated income.

Our review of the workpapers indicates that the propriety of capitalizing these costs was not determinable by the audit steps performed. Several analyses prepared suggested that the costs were improperly capitalized and the audit senior concluded on the basis of the work performed by him that they were indeed improper and that SaCom could not substantiate this treatment. SaCom did not have adequate supporting documents for research and development costs. There was no backup for labor costs incurred on projects and most job costs capitalized were actually closed jobs in which the costs had already been charged to cost of goods sold. Forty-four percent of all TPE direct labor costs in the 6 month period was capitalized.

SaCom's most significant contract during this period was with the Defense Department. The financial statements for the 6 months reflected a claim of $378,050 related to this contract which increased consolidated net income significantly. Revenue was recognized under this contract on the percentage of completion method. Using this method of accounting, when costs incurred plus estimated costs to complete exceed the contract price, a loss should be recognized. The claim, first asserted in a letter to the Defense Department dated April 21, 1972 (after the end of the stub period), was for "equitable" adjustments.

Recognition of the claim as an asset would have been proper only where the costs underlying the claim could be specifically identified and where there was sufficient factual evidence to indicate that a claim was both justified and recoverable.

The costs attributed by SaCom to the claim could not be identified because the company had no supporting documentation for the claim. During the audit SaCom officials assured the auditors that the claims were valid and that supporting documents would be prepared at a future date. The auditors were unable to even audit the company's estimate of costs to complete the contract, since supporting data for the estimates was not available. An audit workpaper, in referring to the estimate, stated that " . . . these are all estimates as there wasn't any supporting data to examine or review". There was no disclosure in the prospectus that there was a claim against the government, that the claim was based on estimates, or that it was for unauthorized work. Although a portion of the claim was collected in 1973, most of it was subsequently written off.

In addition to the above, SaCom recorded about $46,000 of sales in connection with merchandise shipped after the cut off date and failed to disclose outstanding bank overdrafts as of March 31, 1972 of about $50,000. SaCom, its officers and the auditors were aware of both of these matters at the time of the audit.

Several days before the effective date, the managing underwriter discovered that Seidman & Seidman had billed SaCom for $125,000 in connection with the offering. Upon learning of the amount of the billings, the managing underwriter advised Seidman & Seidman that it would not proceed with the offering unless accounting fees were reduced to not more than $55,000. SaCom was advised that in order for the offering to proceed, $70,000 of the billings would be ostensibly forgiven on condition that SaCom repay that amount in the following fiscal year. The Company then inserted the $55,000 estimate in the registration statement as estimated accounting fees in connection with the offering. The offering took place and Seidman & Seidman was paid $55,000 out of the proceeds on or about the date of closing. In January 1973, a memorandum was prepared at Seidman & Seidman setting forth a plan to recoup the forgiven fee in part through billing SaCom for future work at 150% of standard rates. A substantial amount was subsequently billed in this manner. SaCom later complained of excessive billing and the plan was aborted.

1972 Fiscal Year

SaCom reported net income of $542,782 before extraordinary items on sales of $4,924,473 for the fiscal year ended September 30, 1972 as compared with $211,156 net income on $3,603,922 in sales for the prior fiscal year. The financial statements for the 1972 fiscal year were included in an Annual Report on Form 10-K filed with the Commission. The fiscal 1972 financial statements in our opinion materially misstated income and balance sheet accounts by continuing the improper deferral of costs in connection with test equipment, research and development, work in process inventory and the defense contract claim. Research and development costs and the contract claim were further increased in the six months following March 31, 1972. In addition, SaCom should have but did not, record liabilities in connection with the audit fee recoupment scheme and overbillings in connection with certain contracts.

The capitalization of research and development increased materially in fiscal 1972 from a beginning balance of $163,725 to $676,512. Consolidated net income was increased by over 50% as a result of not expensing these costs. The capitalization of research and development was based primarily on management estimates and Seidman & Seidman relied on management estimates and analysis in auditing the financial statements. Because the costs were co-mingled with cost of goods sold in the cost ledger, both labor and materials charged to research and development had to be estimated.

As of September 30, 1972 SaCom's balance sheet reflected a claim against the government of $508,032 in connection with the defense contract which consisted, according to the Company, of direct labor charges incurred while repairing defective government supplied parts, correcting blue-print errors and solving other problems allegedly caused by the government. Additional claims were made after the end of the fiscal year. No provision for loss was recognized with respect to the claim. In September 1974 SaCom accepted $121,000 in full settlement of all the claims. SaCom failed to disclose that the claim was based on estimates and was for unauthorized work. 36/

36/ A note to the financial statements described the claim as based on constructive change requests and stated that management believed the claim to be collectible. In our view, the note was misleading.

SaCom could not establish from its records that the costs claimed were allocable to the project. The initial claim was made at a time when SaCom apparently was in default on the contract in that it had not delivered the project on the scheduled date for completion. In May 1972, the Defense Department suspended all progress payments on the project, as required by military procurement regulations, because the fair value of the project did not exceed the contract price of the project less the estimated cost to complete. In July 1972, SaCom advised the Defense Department that it would suspend work on the project unless progress payments were resumed. The Defense Department did not resume the progress payments but SaCom continued the work.

In August 1972, SaCom submitted a revised claim and the Defense Contract Audit Agency (DCAA) offered to conduct an immediate audit of the claim. SaCom requested that DCAA postpone their audit until after the public offering, indicating that their personnel and records were tied up in connection with the registration statement work. The subsequent DCAA audit resulted in a report dated December 1, 1972 in which DCAA found that SaCom had not segregated the claimed costs on its books and that no supporting detail could be found which was susceptible to audit verification. In addition the report found SaCom's estimates unreasonable. The auditors apparently did not see the DCAA report.

The Seidman & Seidman auditors could not by audit means verify the amount of the claim because of the insufficiency of the supporting documentation. The auditors should have known that the government auditors likewise would not be able to verify the amount of the claims by auditing the company's records and that there was no justification for assuming that the claim would be completely reimbursed by the government.

During the audit of the 1972 fiscal year financial statements Seidman & Seidman discovered that SaCom had overbilled the Defense Department about $112,000 in the last quarter of the fiscal year on progress payments under two other contracts. SaCom was to receive progress payments under the contracts based on a percentage of costs incurred. The overbilling was accomplished by overstating costs incurred on Defense Department progress payment forms. Overbilling in this instance involved false filings with the Defense Department. SaCom should have reflected the overbilling in its balance sheet as a liability. The Company declined to adopt a proposal by the audit manager

for an adjusting journal entry which would have recognized the overbilling as a liability and Seidman & Seidman gave an unqualified opinion despite that failure.

Substantially all of the auditors performing the field work in connection with audit of the fiscal 1972 financial statements recommended that a qualified opinion be issued. Notwithstanding such recommendation partners with general responsibility in Seidman & Seidman's Los Angeles office, several of whom had little active participation in the conduct of the audit, determined to issue an unqualified opinion and such an opinion was issued. 37/

In early March 1972, at a meeting of the principal officers of SaCom, its counsel, the managing underwriter and its counsel and Seidman & Seidman, 38/ an issue had arisen concerning Seidman & Seidman's independence due to the amount of unpaid fees for prior work. A decision was reached at the meeting for SaCom to borrow $105,000 with which to pay the past due fees. The audit partner assigned to the SaCom audits solicited a bank, with whom he had arranged loans in the past for clients, to lend the funds to SaCom. The bank was unwilling to do so unless payment was guaranteed. The audit partner and his wife and another partner and his wife then signed continuing guarantee agreements. 39/ The continuing guarantees, dated March 31, 1972, provided, among other things, that the bank could proceed against the guarantors for payment without proceeding against SaCom. SaCom used the proceeds to pay the overdue fees. The loan and the guarantees remained outstanding until late 1972. During the course of the 1972 fiscal year audit, the bank disclosed the existence of the continuing guarantees in its response to a standard bank confirmation request by Seidman & Seidman. The existence of the continuing guarantees and of the bank confirmation then became known to other Seidman &

37/ One of the auditors who initially recommended a qualified opinion subsequently recommended an unqualified opinion supposedly after performing additional work. The asserted additional work is not corroborated by the workpapers or otherwise and there appears to be no reasonable basis for this change of opinion.

38/ The Seidman & Seidman personnel in attendance were all formerly with Wolfson/Weiner.

39/ Both partners were formerly with Wolfson/Weiner.

Seidman personnel not previously associated with Wolfson/ Weiner who subsequently approved issuance of the unqualified report. 40/ The only action apparently taken with respect to the independence issue thus raised was the destruction of the bank confirmation and elimination of reference to the confirmation in the workpapers.

Also, during the course of the 1972 audit the Seidman & Seidman auditors uncovered a scheme to overstate income by recording as revenue in the 1972 fiscal year the proceeds of a bank loan. As a part of the scheme, false sales entries were made in the 1972 fiscal year sales journals and false entries were made in the accounting records for the 1973 fiscal year, in which the repayment of the loan was recorded as an expense for legal services. In addition false representations were made by management to the auditors. The scheme involved the top management of SaCom including its financial officers. At Seidman & Seidman's insistence, the entries through which the scheme had been accomplished were reversed. Shortly thereafter, when a Seidman & Seidman principal confronted a SaCom officer with the scheme, SaCom terminated Seidman & Seidman's services. Certain partners requested that the principal apologize to the SaCom officer and after he had in effect done so, Seidman & Seidman was rehired. It was under such circumstances that Seidman & Seidman relied on representations of management in connection with the audit problems concerning the deferral of costs and treatment of the contract claim.

THE POST-AUDIT REVIEWS

During the summer and fall of 1973, Seidman & Seidman sent a number of its experienced partners who had not been involved in audits of former Wolfson/Weiner clients to the Los Angeles office to review Seidman & Seidman engagements for publicly held companies which became clients as a result of the combination of practices, including Omni-Rx and SaCom. It appears that the review by these partners was precipitated by a number of factors including the Equity debacle, alleged threats of a former Wolfson/Weiner partner to reveal information concerning certain of the billing practices described

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40/ The bank loan was paid off prior to the issuance of the report.

herein 41/ and, Seidman & Seidman asserts, as an aspect of its own internal review procedures. The reviews were ordered by the Seidman & Seidman Executive Committee and a member of the Executive Committee was responsible for their supervision. In certain instances partners and staff members who had participated in the audits under review were interviewed. The reviewers prepared detailed reports of their findings from which major deficiencies were summarized.

The review of the audit of the 1972 fiscal year Omni-Rx financial statements was completed prior to the completion of the audit of Omni-Rx's 1973 fiscal year financial statements. Seidman & Seidman conducted two separate investigations in 1973 of its prior audits of SaCom's financial statements. The first was conducted in July and August 1973 as part of the firm's routine quality control review procedure. It covered the SaCom financial statements for the fiscal year ended September 30, 1972. The second was conducted in October 1973 as part of the special review of audits of former Wolfson/Weiner clients. These reviews uncovered substantially all of the significant deficiencies discussed in this Opinion, and as a result, to varying degrees, such deficiencies came to the attention of the members of the Executive Committee and several members of the Policy Group who were not members of the Executive Committee.

Notwithstanding the knowledge gained following these reviews, Seidman & Seidman took no further significant action with respect to almost all of the reports. In particular, Seidman & Seidman did not then withdraw its prior reports on SaCom and Omni-Rx and in fact subsequently issued a report on the 1973 financial statements of Omni-Rx.

On the basis of the foregoing, the Commission finds that Seidman & Seidman should have withdrawn or withheld its reports on the financial statements of SaCom and Omni-Rx and taken other appropriate action. 42/

41/ Seidman & Seidman promptly informed the staff of these alleged threats.

42/ The Commission encourages auditing firms to conduct post audit reviews as part of quality control procedures. The problems in this case arose not from the conduct of the reviews but rather from the failure to make appropriate use of the information so gained.

WORKPAPERS

The staff's investigations have indicated that in a number of instances certain workpapers prepared in connection with the engagements discussed herein were improperly altered or removed from the files during the course of post-audit work. This was purportedly done to reflect work which the audit staff asserted had been performed prior to the issuance of the report but which had not been documented at the time. In some instances, post-audit entries were not dated or otherwise distinguishable from documentation created during the course of the audit. Some alterations were made subsequent to the time that Seidman & Seidman became aware of the Commission staff's investigation.

We believe strongly that audit workpapers should clearly reflect the evidential matter on which the report is based as well as compliance with other applicable generally accepted auditing standards. Changes made after a report is issued, for whatever reason, should themselves be properly documented. Failure to do so may have the effect, among other things, of tending to raise serious questions following an inquiry by the Commission or any other law enforcement agency.

CERTAIN LOS ANGELES PERSONNEL

Al A. Finci ("Finci") is a partner of Seidman & Seidman and was the managing partner of the Los Angeles office of Seidman & Seidman from October 1969 to October 1973. At the time of the firm's combination with Wolfson/Weiner, Finci was a member of Seidman & Seidman's Policy Group. Thereafter he was Regional Technical Director and the National Director of Planning and Research. Finci assisted others in the pre-combination investigation of Wolfson/Weiner and as a member of the Policy Group voted to approve the combination. As previously noted, we find that the investigation was inadequate and Finci bore a share of the responsibility since he, along with others, was aware of the underlying facts concerning the investigation described above. After the combination with Wolfson/Weiner, Finci, as managing partner did not require review of workpapers by personnel not formerly affiliated with Wolfson/Weiner or any persons not involved in the actual audit work, prior to the issuance of the unqualified opinion on Equity Funding's 1971 financial statements. During the course of the fiscal 1973 audit of Omni-Rx, Finci was consulted by the audit partner concerning the misapplication of the proceeds of

the public offering and related matters and, after consulting with others, consented to the treatment and the disclosure given to these matters in the financial statements. In SaCom, Finci concurred in the issuance of Seidman & Seidman's unqualified report for SaCom's 1972 financial statements. In that connection, Finci was consulted with respect to problems relating to the capitalization of the research and development costs and recognition of the defense contract claim and should have been aware of the inadequate support for the accounting treatment given these matters. Finally, the Commission is of the view that Finci, as managing partner, was made aware of the improper billing practices of Seidman & Seidman established in connection with the SaCom and Omni-Rx registration statements and knew or should have known of the bank confirmation of the guarantee of the bank loan to SaCom by former Wolfson/Weiner partners, but did not take appropriate action with respect thereto.

Joseph De Armas ("De Armas"), a Seidman & Seidman audit partner, was from 1971 through July 1973, the Director of Accounting and Auditing of the Los Angeles office. As Director of Accounting and Auditing, De Armas was responsible for seeing that financial statements were in proper format and demonstrable compliance with applicable rules of the Commission and practices of Seidman & Seidman. In this role, De Armas became involved in the review of the audit of the 1972 fiscal year financial statements of Omni-Rx and was aware of some of the problems encountered, including the problem of classification and valuation of receivables due from affiliates and the substantial losses sustained by the affiliates. He was aware that there were unpaid fees as of June 30, 1972 and should have determined the amount and considered the effect this would have on his firm's independence. De Armas in his capacity of Director of Accounting and Auditing approved the issuance of the firm's unqualified report on Omni-Rx's 1972 fiscal year financial statements. In the SaCom case, De Armas similarly became involved in the review of the audit of the financial statements for the 1972 fiscal year. He learned from the manager on the engagement of a continuing guarantee of a bank loan to SaCom by the audit partner assigned to the engagement and a second partner. De Armas was unaware of all the details with respect thereto and directed the engagement manager to ascertain the facts from the audit partner. In the Commission's view, De Armas did not pursue the matter further as he should have. In

addition, De Armas approved issuance of his firm's unqualified report even though he, in the Commission's view, should have realized on the basis of information given to him, the lack of sufficient evidential support for the capitalization of the research and development costs and full recognition of the claim in connection with the defense contract.

In May of 1973, Arthur Glatzer ("Glatzer"), a partner in Seidman & Seidman's Los Angeles office, was appointed audit partner assigned to the audit of the 1973 financial statements of Omni-Rx, replacing a former Wolfson/Weiner partner. 43/ Shortly after his appointment Glatzer learned of the pre-offering pay down of the receivables from affiliates and its significance to the firm's previous decision to issue an unqualified report with respect to the 1972 fiscal year financial statements, the post-offering use of a part of the proceeds of the public offering and of the falsity in the Form S-R relating to the certificates of deposit. Glatzer participated and concurred in the decision to issue the firm's opinion with respect to the 1973 fiscal year financial statements. 44/ Glatzer, in addition, knew of the underlying facts with respect to many of the other deficiencies in these financial statements.

Neill W. Freeman ("Freeman") presently employed by another accounting firm, acted in a special review capacity in connection with the audit of 1972 fiscal year financial statements of SaCom. At the time of his assignment in January 1973, Freeman was a partner-elect. Freeman participated and concurred in the issuance of the unqualified report on SaCom's 1972 fiscal year financial statements. At that time, he possessed information which, in the Commission's view, should have alerted him to the deficiencies in accounting treatment and the disclosure with respect to the capitalization of the research and development, test equipment and work in process costs; the full recognition of the defense contract claims and the overbillings in connection with certain contracts. During the course of the audit, he became aware of a bank confirmation indicating guarantees of a bank loan to SaCom by the two Seidman & Seidman partners. Thus,

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43/ Glatzer was not involved in the audit of the 1972 fiscal year financial statements or in the Omni-Rx registration statement.

44/ As previously noted, this opinion was qualified with respect to the dependence of Omni-Rx on the affiliates' attaining successful operations.

in the Commission's view, he was aware of the significant problems this raised with respect to Seidman & Seidman's independence and failed to obtain a satisfactory resolution of the matter. A subsequent letter was received from the bank which, while disclosing the loan, contained no reference to the guarantees and Freeman instructed the audit manager to remove the bank confirmation reflecting the guarantees from the audit workpapers. This, in the Commission's view, was improper.

The above persons, none of whom were associated with Wolfson/Weiner, have undertaken, commencing with the date of this Opinion and Order, that they will not perform any audit work which would involve any filings with the Commission, except for audit work on behalf of clients to which they are currently assigned on the date of this Opinion and Order, with such audit work being independently reviewed by another partner of the firm. Specifically, the undertakings shall be in effect as to these persons until the following dates: Finci (February 27, 1977), De Armas (December 31, 1976), Glatzer (October 31, 1976) and Freeman (February 27, 1977).

CONCLUSION

As contemplated by its settlement offer, Seidman & Seidman has agreed to an examination of the manner in which it conducts its audit practice with respect to clients whose financial statements reported upon by Seidman & Seidman are filed with the Commission. That comprehensive examination, which has commenced, is being conducted by a committee whose members have been agreed upon by Seidman & Seidman and the Commission staff and whose compensation and expenses will be borne by Seidman & Seidman. The nature and scope of this committee's examination is outlined in a memorandum addressed to the committee which has been agreed upon by the Commission and Seidman & Seidman and which is attached to the offer of settlement. Seidman & Seidman has also agreed to implement any reasonable recommendations of the committee regarding Seidman & Seidman's SEC audit practice and procedures. 45/

45/ In the event that Seidman & Seidman demonstrates to the satisfaction of the Commission that a recommendation of the committee is not reasonable or need not be implemented either in the form recommended or with reasonable modification, then it has been agreed that such recommendation need not be adopted.

The offer of settlement further contemplates that following the issuance of the committee's report, Seidman & Seidman will voluntarily submit to a review to determine whether Seidman & Seidman has reasonably implemented the recommendations of the committee, and that in connection with such review to be conducted in 1977, Seidman & Seidman will cause a report to be made available to the Commission.

During discussions with the staff, Seidman & Seidman agreed not to accept or negotiate the acceptance of audit engagements for new SEC clients for a period of six months, or the end of the examination by the committee, whichever is sooner. 46/ Seidman & Seidman commenced this undertaking prior to the date of this Order and will continue not to accept or negotiate the acceptance of audit engagements for new SEC clients until December 15, 1976. This new business restriction does not affect in any way Seidman & Seidman's ability to serve its existing clients nor does it affect other aspects of Seidman & Seidman's practice such as tax and management consulting. During the pendency of the committee's review, Seidman & Seidman, will not merge or combine practices with another accounting

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46/ For the period through December 15, 1976, Seidman & Seidman has not accepted and will not accept audit engagements from new audit clients which contemplate the issuance by Seidman & Seidman of an auditor's opinion, in respect of financial statements which it is expected by Seidman & Seidman will be filed with the Commission within the next succeeding 12 month period. Such limitation shall not include an audit client (i) in which a significant equity or debt interest is held or acquired by a present client of Seidman & Seidman; (ii) for which Seidman & Seidman has provided professional services since January 1, 1975 and prior to the date on which Seidman & Seidman voluntarily ceased accepting new audit clients; (iii) if its acceptance by Seidman & Seidman as an audit client is approved in the particular circumstances by the Chief Accountant of the Commission; (iv) which is controlled by a foreign entity, provided the financial statements of the client are not separately filed with the Commission; and (v) which is a client or a subsidiary or a division of a client of a foreign affiliated firm of Seidman & Seidman.

firm without prior consultation with the Chief Accountant of the Commission.

In determining to accept Seidman & Seidman's offer of settlement the Commission recognizes that the controversies relate to audit engagements for a few clients out of a large number of audit engagements conducted by Seidman & Seidman over the years in question. The Commission also recognizes that, with the exception of Cenco, a major portion of the professional deficiencies found as a result of our investigations were related to the conduct of former Wolfson/Weiner personnel. We believe that the provisions of the settlement offer will provide Seidman & Seidman and the Commission with independent assurance of the quality of Seidman & Seidman's practice before the Commission.

For the foregoing reasons, it is hereby ORDERED,

(1) This proceeding under Rule 2(e) of the Commission's Rules of Practice is instituted and Seidman & Seidman's offer of settlement, dated August 26, 1976 is hereby accepted.

(2) An examination of the manner in which Seidman & Seidman conducts its practice with respect to audit clients whose financial statements reported upon by Seidman & Seidman are filed with the Commission will continue.

(a) This examination is being conducted by a committee (the "Committee") whose compensation and expenses are being borne by Seidman & Seidman. The members of the Committee have been selected by Seidman & Seidman from a list of persons acceptable to the staff of the Commission;

(b) The joint understanding of the Commission and Seidman & Seidman concerning this examination is outlined in a memorandum addressed to the Committee. The memorandum is attached to Seidman & Seidman's offer of settlement as Annex B;

(c) Seidman & Seidman will promptly take all steps reasonably necessary and appropriate to implement any reasonable recommendations the Committee may make with respect to the manner in which such audit practice is conducted, provided, however, that if Seidman & Seidman demonstrates to the

satisfaction of the Commission that a recommendation of the Committee is not reasonable or need not be implemented either in the form recommended or with reasonable modifications, such recommendations need not be adopted;

(d) It is contemplated by the Commission and by Seidman & Seidman that the examination can be completed and the report of the Committee submitted by December 15, 1976; and

(e) The contents of the examination, the working papers, files and other documentation (except the Committee's report) and the deliberations of the Committee will be held confidential except from Seidman & Seidman and the Commission, to the extent permitted by law.

(3) From the date of this order until December 15, 1976, Seidman & Seidman will comply with its undertaking not to accept audit engagements from new audit clients which contemplate the issuance by Seidman & Seidman of an auditor's report, in respect of financial statements which it is expected by Seidman & Seidman will be filed with the Commission within the next succeeding twelve-month period. Such limitation shall not include an audit client (i) in which a significant equity or debt interest is held or acquired by a present client of Seidman & Seidman; (ii) for which Seidman & Seidman has provided professional services since January 1, 1975 and prior to the date on which Seidman & Seidman voluntarily ceased accepting new audit clients; (iii) if its acceptance by Seidman & Seidman as an audit client is approved in the particular circumstances by the Chief Accountant of the Commission; (iv) which is controlled by a foreign entity, provided the financial statements of the client are not separately filed with the Commission; and (v) which is a client, or a subsidiary or a division of a client, of a foreign affiliated firm of Seidman & Seidman.

(4) During the pendency of the Committee examination, Seidman & Seidman will not merge or combine practices with another accounting firm without prior consultation with the Chief Accountant of the Commission.

(5) A review will be conducted in 1977, at Seidman & Seidman's expense, to determine whether Seidman & Seidman has reasonably implemented the recommendations of the Committee (subject to the proviso stated in paragraph (2)(c) above). The review will be conducted by the Committee or not less than three accountant members thereof, or (if the Committee or three of its members are not prepared to act) by a group of not less than three certified public accountants chosen by Seidman & Seidman from a list acceptable to the staff of the Commission.

(6) In connection with the review described in paragraph 5, the results will be reported to the Commission and Seidman & Seidman. The contents of the review, the working papers, files and other documentation (except the report) and the deliberations of the reviewers will be held confidential to the extent permitted by law.

(7) Each of the individuals discussed in the section of the Opinion entitled "Certain Los Angeles Personnel" shall comply with his respective undertaking.

(8) With respect to Seidman & Seidman, the Commission retains jurisdiction of this proceeding until completion of the review described in paragraph 5 above, and for 60 days after the submission of the report thereon.

By the Commission.

George A. Fitzsimmons
Secretary

34-12752
ANNEX A

UNITED STATES OF AMERICA

Before the

SECURITIES AND EXCHANGE COMMISSION

August 26, 1976

In the Matter of SEIDMAN & SEIDMAN, et al.	OFFER OF SETTLEMENT ON BEHALF OF SEIDMAN & SEIDMAN

Respondent Seidman & Seidman ("Respondent") herewith submits this Offer of Settlement ("Offer") for consideration by the Securities and Exchange Commission ("Commission") pursuant to Rule 8 of the Commission's Rules of Practice, 17 C.F.R. Sec. 201.8. Respondent hereby waives entry by the Commission of an Order for Public Proceedings in this proceeding and its right to file an Answer responsive thereto.

I

Respondent submits this Offer solely for the purpose of concluding expeditiously a complete settlement of this

proceeding and without admitting or denying anything contained in the Commission's Opinion and Order to be issued in this proceeding.

Whether accepted or rejected by the Commission, this Offer does not constitute any evidence or admission by Respondent of any wrongdoing or liability for any purpose whatsoever. If this Offer is not accepted, it is withdrawn and shall not become a part of the record of this proceeding.

II

If this Offer is accepted by the Commission, respondent consents to the issuance of an Opinion and Order in the form attached hereto as Annex A. Also attached, as Annex B, is a memorandum addressed to the Committee contemplated by the proposed Opinion and Order attached hereto.

III

For purposes of this Offer and only if it is accepted on the basis and limitations set forth above, Respondent hereby accepts the jurisdiction of the Commission over it in this matter and hereby waives:

A. Further hearings in this proceeding;

B. The filing of proposed findings of fact and conclusions of Law;

C. An initial Decision by a Hearing Examiner pursuant to Rule 16 (b) of the Commission's Rules of Practice, and exceptions and briefs with respect thereto;

D. All post-hearing procedures;

E. Judicial review by any court; and

F. Objections to participation by the Division of Enforcement and the Office of the Chief Accountant in the preparation of the Opinion and Order to be issued.

IV

Respondent states that no promise of any kind or nature whatsoever was made to induce it to make this Offer or to agree to the waivers and consents set forth herein, and that the submission of this Offer is a voluntary act on its part.

Respectfully submitted,

SEIDMAN & SEIDMAN

By _____

Bernard Z. Lee
Managing Partner

34-12752

ANNEX B - MEMORANDUM TO THE COMMITTEE

The purpose of this memorandum is to outline for you the joint understanding of the Securities and Exchange Commission (the "Commission") and of Seidman & Seidman ("S&S") concerning the examination you are to make of the manner in which the audit practice of S&S is conducted in respect of clients whose financial statements are reported upon by S&S and filed with the Commission. S&S has executed an engagement letter to the Committee in accordance with the terms of this memorandum.

The examination will be conducted pursuant to an order of the Commission entered September 1, 1976, a copy of which is attached hereto as Exhibit A, and is intended to be a comprehensive examination of S&S's SEC audit practice.

1. You are to assess the policies, procedures and practices followed by S&S in the conduct of its SEC audit practice, to point out weaknesses, if any, and to make recommendations for the correction of any such weaknesses. It is contemplated that your examination can be completed and your final report rendered by December 15, 1976.

2. You are to determine the scope of your examination based upon your professional experience and insights. Attached hereto as Exhibit B is a listing of areas of inquiry which the staff of the Commission and S&S have agreed are pertinent to your examination. It is expected that you will carefully consider these areas in determining the scope of your examination but your judgment as to the nature and extent of your examination into any area shall be determinative.

3. As part of your examination, it is expected that you will inquire into the matters which are the subjects of the Commission's Rule 2(e) opinion. It is not expected that you will form judgments concerning the merits of the Commission's position. Rather you should consider, assuming arguendo that the Commission's position is correct, whether the circumstances indicate weaknesses (other than on the part of individuals) in the policies, procedures and practices with which S&S conducts its SEC audit practice or suggest areas where the strengthening of quality control procedures, if it has not occurred, should be recommended.

4. The methods to be followed in and the staffing required for the examination are to be determined by you.

It is assumed that pertinent documentary material such as audit guides and programs and quality control procedures will be reviewed, that Executive Office and operating office personnel will be interviewed, that the functioning of selected operating offices representative of S&S's practice will be reviewed and that selected audit engagements (including working papers) will be reviewed. The specific audit engagements to be reviewed will be at your discretion.

Although the AICPA program for review of quality control procedures of multi-office firms may be useful, the scope and methods of your examination are not limited to those of the AICPA review program, but should be conducted as you deem appropriate. Your examination also differs from the AICPA review program in that your report will be submitted both to the Commission's staff and to S&S and your working papers will be available for examination upon request by the Commission's staff and by S&S.

Your examination and working papers are subject to the confidentiality requirement of the Commission's order. The identity of the S&S clients involved in particular audit engagements reviewed by you should not be disclosed in your working papers or reports, but should be disclosed to counsel for S&S and will, of course, be known to S&S. Although you will have no responsibility for the adequacy of S&S's examinations or the correctness of its opinions in such engagements, it is expected that you will bring to the attention of S&S any apparent material deficiencies. Your working papers should note such instances, without client identification,* and the disposition thereof by S&S.

5. Any description of the details of the matters inquired into by you will form part of your working papers. Your report will summarize your work, state your overall conclusions, and describe any recommendations made by you.

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* The Commission and S&S have agreed to have counsel for S&S maintain a system for identifying such audit clients and that such clients will be identified to the Commission upon request.

6. While it is not contemplated that you will render any interim reports, you will advise the staff of the Commission and S&S of the progress of your examination. It is contemplated that the scope of your examination as outlined above will not be altered without the prior approval of both S&S and the Commission. However, it is contemplated that you will be free to discuss your examination with S&S or the Commission's staff on such basis as you deem appropriate.

For the foregoing reasons, it is hereby ORDERED,

(1) This proceeding under Rule 2(e) of the Commission's Rules of Practice is instituted and Seidman & Seidman's offer of settlement, dated August 26, 1976 is hereby accepted.

(2) An examination of the manner in which Seidman & Seidman conducts its practice with respect to audit clients whose financial statements reported upon by Seidman & Seidman are filed with the Commission will continue.

(a) This examination is being conducted by a committee (the "Committee") whose compensation and expenses are being borne by Seidman & Seidman. The members of the Committee have been selected by Seidman & Seidman from a list of persons acceptable to the staff of the Commission;

(b) The joint understanding of the Commission and Seidman & Seidman concerning this examination is outlined in a memorandum addressed to the Committee. The memorandum is attached to Seidman & Seidman's offer of settlement as Annex B;

(c) Seidman & Seidman will promptly take all steps reasonably necessary and appropriate to implement any reasonable recommendations the Committee may make with respect to the manner in which such audit practice in conducted, provided, however, that if Seidman & Seidman demonstrates to the satisfaction of the Commission that a recommendation of the Committee is not reasonable or need not be implemented either in the form recommended or with reasonable modifications, such recommendations need not be adopted;

(d) It is contemplated by the Commission and by Seidman & Seidman that the examination can be completed and the report of the Committee submitted by December 15, 1976; and

(e) The contents of the examination, the working papers, files and other documentation (except the Committee's be held confidential except from Seidman & Seidman and the Commission, to the extent permitted by law.

(3) From the date of this order until December 15, 1976, Seidman & Seidman will comply with its undertaking not to accept audit engagements from new audit clients which contemplate the issuance by Seidman & Seidman of an auditor's report, in respect of financial statements which it is expected by Seidman & Seidman will be filed with the Commission within the next succeeding twelve-month period. Such limitation shall not include an audit client (i) in which a significant equity or debt interest is held or acquired by a present client of Seidman & Seidman; (ii) for which Seidman & Seidman has provided professional services since January 1, 1975 and prior to the date on which Seidman & Seidman voluntarily ceased accepting new audit clients; (iii) if its acceptance by Seidman & Seidman as and audit client is approved in the particular circumstances by the Chief Accountant of the Commission; (iv) which is controlled by a foreign entity, provided the financial statements of the client are not separately filed with the Commission; and (v) which is a client, or a subsidiary or a division of a client, of a foreign affiliated firm of Seidman & Seidman.

(4) During the pendency of the Committee examination, Seidman & Seidman will not merge or combine practices with another accounting firm without prior consultation with the Chief Accountant of the Commission.

(5) A review will be conducted in 1977, at Seidman & Seidman's expense, to determine whether Seidman & Seidman has reasonably implemented the recommendations of the Committee (subject to the proviso stated in paragraph (2)(c) above). The review will be conducted by the Committee or not less than three accountant members thereof, or (if the Committee or three of its members are not prepared to act) by a group of not less than three certified public accountants chosen by Seidman & Seidman from a list acceptable to the staff of the Commission.

(6) In connection with the review described in paragraph 5, the results will be reported to the Commission and Seidman & Seidman. The contents of the review, the working papers, files and other documentation (except the report) and the deliberations of the reviewers will be held confidential to the extent permitted by law.

(7) Each of the individuals discussed in the section of the Opinion entitled "Certain Los Angeles Personnel" shall comply with his respective undertaking.

(8) With respect to Seidman & Seidman, the Commission retains jurisdiction of this proceeding until completion of the review described in paragraph 5 above, and for 60 days after the submission of the report thereon.

By the Commission.

George A. Fitzsimmons
Secretary

EXHIBIT B

Specific areas, as they relate to the audit practice:

1. Hiring practices for all professionals (partners and employees).

2. Training and continuing education of all professionals.

3. Promotion and compensation of all professionals.

4. Acceptance and retention of clients.

5. Setting and recovering audit engagement fees.

6. Allocation of professional responsibilities within the firm.

7. Professional staffing of offices.

8. Maintaining professional independence.

9. Conduct of audit practice engagements.

   a. Professional staffing and allocation of responsibilities.

   b. Audit program and workpaper preparation and review.

   c. Interoffice communications in the case of multi-office engagements.

   d. Identification and resolution of problems during the course of an audit.

   e. Independence.

   f. Review procedures.

   g. Availability and application of industry expertise.

10. Formulating and communicating firm practices, procedures and policies to professionals.

11. Current procedures for creating and implementing quality controls.

12. Firm-wide corrective or improvement measures.

13. Criteria and procedures followed in connection with analysis of potential merger or combination of practice candidates and with absorption of an acquired practice into S&S's practice.

14. Responsibilities and exercise thereof by the Policy Group, Executive Committee and other relevant committees of S&S.

Mr. OTTINGER. The thing that concerns me is that the Commission entered into a consent order with Seidman & Seidman, which does not require admission of guilt. As I understand, it only involves injunctive relief for the future. I wonder why that was entered into, considering, that Mr. Seidman is presently economic adviser to the President, a high administration official. I wonder whether there was any pressure on the Commission from anybody in the White House to have a consent decree rather than pursuing the complaint.

Mr. FERRARA. Let me answer the last question first.

The last question is, was there any influence upon the Commission in any way by any person to dispose of the Seidman & Seidman matter in any particular fashion.

I can tell you categorically, I'm aware of no such influence.

Now, let me go to the first question.

Mr. OTTINGER. Could this influence have been exercised without your being aware of it?

Mr. FERRARA. Mr. Ottinger, I do not want to avoid your question, but let me respond by saying that I have been with the Commission for 6 years now, I have served in three different offices of the Commission. I have served as the personal lawyer to two chairmen of the Commission and I have never seen a matter where the Commission has been pressured by any interest group, the administration, or the Congress, to dispose of an action a certain way.

Let me answer the question specifically.

Mr. OTTINGER. Certainly, that sounds incredible to me. Nobody on the Commission has ever heard from anybody in the administration or anybody in Congress respecting disposition of the case?

Mr. FERRARA. I am afraid I have overstated—you are quite correct. As I think back now, my defense of the Commission, I may have been too vigorous.

It is much safer to answer your question specifically. I suppose conceivably pressure could have been brought on the Commission that I was not aware of, although I would certainly hope not. I would hope the Commission's record in dealing with various parties would support that in this specific case.

Mr. OTTINGER. Why does that——

Mr. FERRARA. May I go back for a moment to the first part of your question? You asked why an injunction was entered by consent. Unless my understanding of the record is incorrect, the action brought against Seidman & Seidman did not involve an injunctive order. It involved an order by the Commission pursuant to rule 2(e) promulgated under the Securities and Exchange Act. Rule 2(e), Mr. Ottinger, is the Commission's Rule of Professional Practice. It empowers the Commission to take disciplinary action against professionals who practice before it, principally accountants and attorneys.

That is the context in which the *Seidman & Seidman* case was disposed of. In that context, then, quite correctly the disposition of the action, the 2(e) proceeding, was done without an admission of guilt by Seidman & Seidman. However, one has to look at the purpose and function of rule 2(e) and that is to maintain the integrity of professionals who practice before the Commission.

The result of that action was a detailed order which provided for, among other things, a restriction on Seidman & Seidman with respect

to its new SEC business and a detailed peer review of Seidman & Seidman by its colleagues with a subsequent report. It is that kind of creative work, I think, by our enforcement division that goes much further in maintaining and upgrading the integrity of those who practice before us professionally than would just the mere finding of guilt or innocence. Findings of guilt do not necessarily advance the cause of investor protection. What advances the cause of investor protection, I think, is remedial action which has the effect of upgrading the process.

Mr. OTTINGER. Under section 2(e) your ultimate sanction is to remove the qualification of a professional to practice before the Commission?

Mr. FERRARA. That is correct, sir.

Mr. OTTINGER. And you don't think that exercising that power in an aggravated case such as this would have more salutary effects on the conduct of other professionals than a mere consent order?

Mr. FERRARA. Well, exercising the full limit of the Commission's authority under rule 2(e) to bar an accounting firm or a law firm from practice before the Commission obviously would have the ultimate salutary effect with respect to that firm and might have a deterrent effect with respect to other firms.

All I can offer, sir, is that I am sure the Commission, when it considered the Seidman & Seidman matter, had before it the full range of remedial alternatives and I can only suggest that, given the cases that were reported by the Division of Enforcement to the Commission, the gravity of the cases, the public interest factors involved and the more philosophical matters that I raised to you a moment ago; namely, maintaining the integrity of the profession, the Commission determined to proceed the way it has. Now, whether or not the Commission exercised the best judgment and whether or not by completely barring Seidman & Seidman from ever appearing before the Securities and Exchange Commission we could have had a better prophylactic effect on the markets and greater protection for investors is anyone's guess.

I think the Commission acted on all the information it had before it.

Mr. OTTINGER. I assume the Commission has the power to suspend a professional for a limited period of time.

Mr. FERRARA. That is correct, sir, and that is in essence what one of the provisions of the Seidman & Seidman order provided for. One of the provisions could be characterized as a type of suspension and I will read you that paragraph.

It says:

> From the date of this order until December 15, 1976, Seidman & Seidman will comply with this undertaking not to accept audit engagements from new audit clients which contemplate the issuance by Seidman & Seidman of an auditor's report in respect to financial statements which it is expected by Seidman & Seidman will be filed with the Commission within the next succeeding 12-month period.

Then the limitations have some exceptions. That is, in essence, a kind of suspension.

I think, Mr. Ottinger, we have to recognize that, when you are dealing with an accounting firm which has a continuing responsibility for several clients and a relationship with several clients, to take that firm and either bar it from business or suspend it for a period of 12 months

may have a punitive effect on the firm, which some may feel desirable, and may have a deterrent effect on the community which others will see as desirable. We have to also remember, however, that there may be scores of other clients not involved in the particular action who would have been adversely affected by a total suspension, and their investors ultimately would be the ones to lose.

I think those are the kinds of considerations the Commission should probably take into account when it is determining how it should proceed. But there was a ban on new business here and that would not have hurt public investors of existing clients.

Mr. OTTINGER. You have a very serious situation here with a major accounting firm involved, participating in improper activities with full knowledge, and the failure to pursue that, to make a finding of guilt and to impose a penalty formally, I think, is simply a severe question.

Mr. FERRARA. I respect the Congressman's views. This is a formal finding and order. It was publicly released. It is a formal opinion by the Commission. As I say, it runs some 60 pages. It amounts to a rather substantial presentation of the Commission's views in this matter, a rather substantial statement with respect to the conduct of Seidman & Seidman. It is not an inconsequential thing for a major professional firm to receive this kind of a public order but, at the same time, I respect the views of the Congressman as to the Commission's power to do more.

Mr. OTTINGER. I have no further questions on this.

Mr. Moss. I have just a brief question: Has the Federal Accounting Standards Board been requested to start working on the development of generally acceptable accounting standards for organizations of this type now with the HMO program moving forward? Clearly we are going to have many instances across the Nation.

As you know, for quite a number of years, I have been concerned with the need for the development of acceptable accounting standards for various industries regulated by the Securities and Exchange Commission. In the past we have tried to catch up. Here we have an opportunity, almost at the beginning, to lay down the kind of standards that we will expect to be met.

Mr. FERRARA. I take that as a very good suggestion, Mr. Chairman. I am afraid I cannot respond to the question. However, I will get an answer to it and supply it subsequently in writing to the subcommittee.

Mr. Moss. We will hold the record open at this point to receive that response. I feel it is most important that this move forward.

[The following letter was subsequently received for the record:]

SECURITIES AND EXCHANGE COMMISSION,
OFFICE OF THE EXECUTIVE ASSISTANT TO THE CHAIRMAN,
Washington, D.C., December 15, 1976.

Hon. JOHN E. MOSS,
Chairman, Subcommittee on Oversight and Investigations, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR CHAIRMAN MOSS: On November 22, 1976, I testified before the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce in connection with its ongoing inquiry into cost and quality issues concerning the delivery of health care services in this country. During the course of my testimony you asked whether the Federal Accounting Standards Board had been requested by the Commission to begin developing generally accepted accounting standards for Health Maintenance Organizations. Rather

than respond directly to your inquiry at that time, I indicated that I would subsequently provide an answer for the record.

I have now been advised by the Commission's Office of the Chief Accountant that the Commission has not requested the FASB to begin developing accounting standards for HMOs. Although the Commission is aware that there have been problems associated with HMOs, it does not appear that the problems which have emerged to date relate to deficiencies in accounting standards. Rather, as illustrated by the allegations contained in the Omni-Rx complaint, the deficiencies appear to relate more to questions of fraud under the federal securities laws and apparent conflict of interest situations. The Office of the Chief Accountant believes that careful auditing and the work currently underway by the FASB in the development of accounting standards generally should be adequate to serve the interest of the investing public in Health Maintenance Organizations.

Nonetheless, as you are aware, the FASB has a program to identify emerging problem areas which may require action on their part and Chairman Hills has asked the Office of the Chief Accountant to alert the FASB to your expressions of concern.

If I can be of any further assistance please do not hesitate to contact me.

Sincerely,

RALPH FERRARA,
Executive Assistant.

Mr. Moss. I think the Accounting Standards Board is the one to undertake the task.

Mr. FERRARA. I will relate the chairman's views to the Commission and I will respond specifically to the question on my return to Washington.

Mr. Moss. Thank you.

Mr. Segal.

Mr. SEGAL. Just to complete the record concerning a portion of the allegation, you charged that, after the diversion of the proceeds Omni-Rx filed a series of false and misleading reports in an attempt to conceal the diversion. Also involved was a sham transaction relating to certificates of deposit. What is the fact relative to this allegation?

Mr. FERRARA. Let me try to respond, Mr. Segal, from the Commission's action.

The complaint alleges in connection with your question that as part of the alleged coverup, on or about March 30, 1973, Omni-Rx borrowed $600,000 in a sham loan transaction from Farmers and Merchants Bank for 3 days at 6 percent interest and used the proceeds of the loan to purchase from Farmers and Merchants Bank a certificate of deposit in the same amount, paying 4 percent interest.

The Farmers and Merchants Bank held the certificate of deposit as collateral for the loan and Omni-Rx endorsed the certificate of deposit back to the bank at the time of the loan.

On or about March 30, 1973, Omni-Rx filed with the Commission a report on form S–R which I described to the subcommittee earlier in my testimony. That report, on form S–R, we say, was false and misleading for failing to accurately disclose the use of proceeds for the offering.

I can be more specific as to why it was false and misleading, but a similar practice was engaged in on or about November 5, 1973, when Omni-Rx filed an annual report on form 10–K for its fiscal year ended June 30, 1973.

Also, about that same time an annual report to shareholders was issued. Now, the Commission's complaint alleges in this part that on the day before the end of the fiscal year Omni-Rx borrowed $570,000 from Farmers and Merchants Bank, agreeing to pay 12 percent inter-

est on the loan and used the proceeds of the loan to purchase from Farmers and Merchants Bank a certificate of deposit in the amount of $570,000 paying 5 percent interest. That form 10–K and the report to shareholders disclosed that Omni-Rx had $670,000 in certificates of deposit, but failed to disclose the facts and circumstances surrounding the purchase of the certificate on June 29.

I think in both instances what we are saying is that a certificate of deposit was purchased just before the filing of a report. Those are all facts, again, that are part of the Commission's complaint.

Mr. SEGAL. The Commission alleges that Omni-Rx filed false and misleading reports for fiscal year 1973. What did they find was alleged to be false and misleading with that annual report?

Mr. FERRARA. You said the 1973 annual report?

Mr. SEGAL. Yes.

Mr. FERRARA. I think that is the answer I just gave. Specifically, the complaint alleged that the form 10–K and annual report to shareholders disclosed that Omni-Rx had borrowed $670,000 in certificates of deposit but failed to disclose the facts and circumstances surrounding the certificate purchased on June 29. I think that was the heart of the disclosure problem there. I do not have the complaint in front of me, but I think that was the essence of it.

Mr. SEGAL. What type of relief is the Commission seeking in its case against Omni-Rx?

Mr. FERRARA. The Commission is seeking an injunction from future violations of the specified sections of Federal securities laws, and also is asking that the individual defendants of Omni-Rx provide a full accounting to the court for the disposition of corporate funds from the offering.

As you are aware, Mr. Segal, should the Commission prevail in this action, the Court, when it receives an accounting from the individual defendants, could determine to exercise its equitable powers to grant such other necessary and further relief as may be in the public interest. And the court has a full panoply of remedies that it can then employ. What we have specifically sought is the injunction and the accounting.

Mr. SEGAL. With respect to the question before about criminal referrals, you mentioned there was no formal issuance of a complaint or a memorandum or documents to the U.S. attorney. Has there been an informal referral or discussions or exchanges?

Mr. FERRARA. The question to which I responded earlier, Mr. Segal, was whether there had been a determination by the Commission to institute criminal proceedings here and you are quite correct that I responded that there had been no formal referral and explained the referral process for the benefit of the subcommittee and the record. However, as the subcommittee is aware, there is a continuing relationship between the Securities and Exchange Commission and the Department of Justice and oftentimes individual U.S. attorneys on matters of mutual interest and concern to both agencies.

I am advised that in this case there have been some informal staff discussions between the staff of the Division of Enforcement and a U.S. attorney, I believe here on the west coast. But I am not aware of what the nature of those discussions are. I know there has been no referral. I am told there has been no referral of documents or matters to the

U.S. attorney and certainly no referral by the Commission to the Department of Justice. I do not think, from what I can gather from my discussions with the staff, that the discussions which have taken place with the Department or the U.S. attorney in this instance are uncharacteristic of the free flow of open communications that often accompany the work of the two agencies.

Mr. SEGAL. Thank you.

Mr. Moss. Are there any further questions?

If not, we excuse the witness with our thanks and ask that you supply the material indicated for the record as requested.

Mr. FERRARA. Thank you, Mr. Chairman.

Mr. Moss. The next witnesses we will ask to appear as a panel, Mr. Herschel Elkins, deputy attorney general of the State of California; Willie Barnes of the department of corporations.

Will you gentlemen come forward.

Do each of you solemnly swear that the testimony you are about to give to this subcommittee shall be the truth, the whole truth and nothing but the truth, so help you God?

Mr. ELKINS. I do.

Mr. BARNES. I do.

Mr. Moss. Identify yourself for the record.

TESTIMONY OF HERSCHEL ELKINS, DEPUTY ATTORNEY GENERAL, DEPARTMENT OF JUSTICE, STATE OF CALIFORNIA, AND WILLIE BARNES, COMMISSIONER, DEPARTMENT OF CORPORATIONS, STATE OF CALIFORNIA

Mr. ELKINS. I am Herschel Elkins, deputy attorney general, State of California.

Mr. BARNES. I am Willie Barnes, commissioner of corporations.

Mr. Moss. Mr. Elkins, do you have a statement?

Mr. ELKINS. I have no written statement, Mr. Chairman, because I only received a request a few days ago.

I would like to make an oral statement in regard to the general history of the participation by the attorney general in the State of California in this field and then provide any written statement which the chairman then wishes. I would reply to any questions that I can answer now and those questions that I cannot answer, we will supply in writing shortly.

Mr. Moss. You may proceed and, if you would like to supplement your statement with a written addition, you may, and the record will be held at this point to receive it.

Mr. ELKINS. Thank you, Mr. Chairman.

[Mr. Elkins declined to submit a written statement.]

Mr. ELKINS. In the early 1960's the California Supreme Court determined that organizations such as Blue Shield and others were not insurance companies because they were not basically indemnification plans. The distinctions were rather hazy but the Supreme Court decision then meant that a number of California companies were unregulated and so in 1965 the Knox-Mills Act was passed in California which attempted to regulate those organizations, such familiar ones as Blue Shield, Kaiser, Ross-Loos, and a number of smaller ones.

Some of them were very specialized and provided only ambulance service in rural areas. Some provided dental care and some general care.

There was some concern by those who were regulated in regard to supervision by the insurance commissioner and there was objection by various people to all of the other agencies at that time, the corporation commission and other agencies. So, as a compromise, the regulation was placed in the attorney general's office, somewhat to the surprise of the attorney general's office.

We were not a regulatory agency; we have never had that function. We are essentially the attorneys for regulatory agencies, but it was placed with us with a statute that did not really cover very much. This was not licensing; it was registration. That is, we did not have the authority to reject a company; they simply had to file the various forms with us.

We were also not permitted to engage in any medical problems; in fact, the statute specifically said that we shall not determine the adequacy of services rendered pursuant to contracts and, in fact, were not also to have the function of adjusting claims based upon contractual interpretation.

There was a small filing fee and the 6 cents per family unit to pay for the operation; however, it was not a special fund so the money went to the State treasury and we then asked the department of finance for staff. We received a small amount of staff in regard to attorneys and to clerical help, and we received one auditor. During the entire administration of the act, we have never at any time received any more than one auditor.

There weren't very many plans at that time. The essential obligation of the companies that were registered with us, and this involved all health care service plans; that is, virtually everyone who was not covered by the insurance commissioner, although there were certain exceptions having to do with negotiated plans of labor unions and employers and so forth, the plan was, first of all, to submit to us their advertising in advance for approval and that was accomplished. They also were to give to us the contracts which were to go to the public and to the providers so that we could examine them to determine whether these were fair, whether they were just too tricky to be accepted, and we did that. In addition, there were financial obligations the company had to maintain, such as a $10,000 tangible net equity and that was the only financial requirement.

Then, there were also a few provisions that had to be in the contract. There were a few items having to do with dependents. If you did allow dependents, it has to be from birth and you can't leave out that expensive first 6 months. If the dependent reached the age at that time of 21 and was disabled mentally and physically, it had to continue the policy and so forth.

The procedures for administration continued. We passed regulations and in those regulations we required the companies to file annual audited statements and to file quarterly unaudited statements so we could have some idea as to whether the company at least quarterly was maintaining its tangible $10,000 net equity.

Then in 1970 we asked for additional assistance legislatively as we began to see that there were substantial problems. We realized the

$10,000 tangible net equity was not adequate. That was maintained at $10,000 but was increased for some of the larger plans of up to 5,500 members and that went up to $30,000.

We also put in provisions which had to do with cash or equivalents, which didn't occur before. One of the problems is that some of these plans operate essentially on capitation fees. Money is paid to the doctors in advance and/or on a projected scale each month and they take care of the patients no matter what.

Other plans were fee for service and in many of those circumstances there was no contract between the provider and the plan so that, if the plan went under, the individuals who had that care might be subjected to lawsuits. So we put a provision, a suggested provision that went into the legislation, which would require the company to keep cash or equivalence to cover at least 3 months of claims for noncontracting of doctors. We also put another provision in in regard to some accounting methods. We were unable to get further than that.

Additional problems began to occur because in California a new system was created in addition to the medi-cal program. The State, through the health department, presented to various companies the opportunity to take care of medi-cal patients for a specified fee. These companies would go around and advertise and get people who were on medi-cal. They would have to provide to them at least as much service as medi-cal gave, but in order to obtain these individuals they would have to give more, obviously, and then the State would pay those individuals, that is, those companies, for the care of the medi-cal patients, supposedly at a savings of at least 10 percent off the amount that they would be otherwise paying.

Those companies began to arise and began to form and suddenly we discovered that we were inundated by health plans because, in addition to their contracts with the State, in addition to all of the regulations that they would have with the department of health, they would also have to register with our office and be under our supervision, the limited supervision that is described.

In 1975, with the problems increasing and with the problems connected essentially with many of these companies going under, there were attempts—this is, I guess, the second or third attempt by our office—to get the legislation really handled by an agency that would have the expertise to handle these continuing sophisticated problems, and, in 1975, to take care of some of the problems that we had discovered, new regulations were enacted.

Then July 1 of 1976, the Knox-Keene Act was passed by the legislature which put in some extraordinary new remedies and it was placed in the department of corporations. Some of the key changes we did not have was a means of a sort of additional insurance, that is, in addition to the requirement for tangible net equity, there had to be a provision so that, in case the company went under, there would be the responsibility for care taken by another company. That type of additional insurance was not there before, and there were many other new features which I am sure Commissioner Barnes will inform you of.

So on July 1, 1976, we terminated our supervision of the plans and that supervision has since been in the hands of the corporation commissioner.

Mr. Moss. Mr. Barnes, would you like to make a statement at this time?

Mr. BARNES. Not a general statement, Mr. Chairman. We certainly welcome the opportunity to be here and provide whatever assistance we can to this subcommittee.

Mr. BARNES. As you know, the department has had under investigation Omni-Rx and some of the related companies for several months. Because that investigation is ongoing and is not yet complete, there are some restraints on some of the information that we can disclose. We fully recognize the power of this subcommittee and we certainly hope that you appreciate some of the practical problems we have in maintaining the integrity of the investigation and avoiding premature public disclosure which might tend to impede that investigation.

Mr. Moss. I would give you the assurance of the committee that we will do nothing that will interfere with the ongoing investigation unless it reaches the point where the need of this committee for that information in the judgment of the committee is greater than the need for the nondisclosure.

Mr. BARNES. Thank you, Mr. Chairman.

Mr. Moss. Mr. Waxman.

Mr. WAXMAN. Before I ask any questions of the witnesses, I want to comment that California spends an estimated, in 1977, $2.4 billion for the medicaid program, of which $1.2 billion were Federal funds and for the prepaid health plan program an expenditure of $100 million for 260,000 recipients who are a part of these programs.

I think the important function we have in these hearings today is to monitor how the State of California has managed the PHP program as an indication of how they are running the medicaid program. Until July 1, 1976, the attorney general, Evelle J. Younger, was charged by the Knox-Mills Health Plan Act with registering PHP's. I think this registration was not just a procedural act of receiving papers and putting them on file, but it was to protect the public to be sure that the prepaid health plans were financially solvent so that they could conduct business and provide services for the recipients under the medicaid program.

The attorney general's office had the responsibility to see that the tangible net equity was met in order to assure the financial stability under the Knox-Mills Act and see that excessive administrative costs were not using up the money that should be used for services for recipients.

Mr. Elkins, what I want to explore with you is the job done by Attorney General Younger in carrying out the Knox-Mills Act so we can see how well the people of California have been protected and the people of this country in using the tax moneys to pay for the medicaid program.

On December 11, 1975, the attorney general's office informed Omni-Rx that they did not meet the requirements for tangible net equity and unless Omni-Rx provided documenation that the violation was cured, an order to cease and desist operations would be issued in 15 days.

Was such an order issued?

Mr. ELKINS. The letter referred to by you, Mr. Waxman, had to do with an audit report filed by Omni-Rx as of August 31, 1975, and which was received in our office somewhere between December 8 and 10. On the 11th we wrote the letter you have just shown to us. It says that the auditors' notes create a doubt as to the collectibility of money in the amount of $324,000. That was an accounts receivable from the Department of Health that was listed in a note in the plan's report.

It states further that the department maintains the amount is not owed and therefore the asset is not acceptable. It says unless this office receives notice that the violation has been cured, supported by the documentation, the order to cease and desist operations will be issued.

The letter did not say that, if that $324,000 was not all permitted, the company would be in violation of the tangible net equity requirements. The problem created here was the question of the asset listed in the annual audit, whether we could accept that. The amount of money that is referred to is an amount of money which they claimed the Department of Health owed them.

There were a series of letters that followed that. If you have these letters, I assume you have the others also.

Mr. WAXMAN. Let me interrupt you. I didn't understand your answer. You say this didn't affect the tangible net equity. I read from the letter itself, and this is from the Department of Justice, Evelle J. Younger, Attorney General, talking about the collectibility of the amount from the Department of Health and it says.

> Therefore, that asset is not acceptable for the computation of required tangible net equity, placing the health plan in violation of Government Code section 12539.

Isn't that a clear statement by the Attorney General's office that they were not meeting the requirements of tangible net equity which is to protect the financial viability of the plan and the Attorney General's office very rightly stated in this letter in December that, unless this violation had been cured, they were going to issue an order to cease and desist operations.

What I want to know is was such an order given pursuant to the letter of December 11, 1975?

Mr. ELKINS. There was no order to cease and desist operations. There is a series of letters following this communication in regard to the plan and its determination of how it would remedy that $324,000 provision. I do not have copies of those letters; you apparently do have.

Mr. MOSS. We will be very happy to supply you with copies of the letters.

Will the staff see that copies of all the letters of this series are made available to the witness?

Mr. WAXMAN. Mr. Chairman, I am sort of taken aback. This was a hearing to discuss the prepaid health plans and the guidance that has been given by the Attorney General's office regarding the obligation they had under the law, and Mr. Elkins from the Attorney General's office doesn't have the file from the Attorney General's office for dealing with Omni-Rx. How can I pursue questions about their conduct if they don't even know the file and don't have the information?

Mr. ELKINS. Mr. Waxman, 3 days ago a request was made by this subcommittee for us to make a general statement in regard to the general establishment of the policies of the Attorney General in regard

to prepaid health plans. I received that information, it was finally directed to me, I guess, on Thursday, on Thursday or Friday.

Mr. Moss. The Chair is going to correct the record.

The Attorney General's office and the State of California were informed by telephone in advance of a notice going out more than a week ago of these hearings and the desire of the subcommittee to have a witness. The fact you may have received the information only 3 days ago reflects a failure within your organization and not the organization of this subcommittee.

I think the record should clearly reflect that part.

Mr. ELKINS. Let me ask this in response to that because I don't know what telephone calls may have occurred. Is there some indication in your communication to our office that we were either to comment on an investigation with regard to Omni-Rx or to supply or even examine records, which we no longer have, of course, in regard to Omni-Rx? Was there some indication that Omni-Rx was concerned with this testimony? I was certainly not advised of it.

Mr. Moss. The entire subject matter of the hearings, and particularly the case now before you, was discussed with the Attorney General's representative who talked with my staff from Washington, D.C. We would not call a witness without giving the precise nature of the area of inquiry that the subcommittee intended to direct its attention to.

Mr. WAXMAN. Mr. Chairman, I'm very disappointed that Mr. Younger isn't here. I thought it was made clear that we were going to discuss his office's handling of the Omni-Rx matter as an indication of how they were carrying out the law, had carried out their obligation under the law to be sure that these plans were financially solvent and, from the record I see, it appears that the Attorney General's office either deviated from their usual procedure or intentionally failed to carry out their responsibilities for a period of nearly 3 years with regard to Omni-Rx.

I want to pursue questions along those lines. I want to find out why this matter has been handled the way it has been handled by the Attorney General's office and hear whatever explanation they might have to give with regard to what I think looks like a very dismal record on the part of the Attorney General.

Mr. Moss. Will the gentleman yield briefly?

Mr. WAXMAN. Yes, sir.

Mr. Moss. In amplification of the statement I just made, Mr. McLain tells me that in October he talked with you and you indicated you did not then have the answer. The question of tangible net equity was discussed, so that you were aware of the interest of the subcommittee, and that occurred in October when Mr. McLain tells me the conversation was held.

Mr. ELKINS. The conversation that was had with me in October was for the subpenaing of records that we had in regard to Omni-Rx in regard to certain letters we sent to and received from and conversations with the Department of Health.

I informed your representative at that time that we did not have those records in our possession since they had been transferred over to the Department of Corporations. I stated in a following conversation that he understood that we thought we might have some records and hence asked for them. Also we stated that the records we had hav-

ing to do with the financial filings by any other company to our office was, by statute, confidential and we could not release them if we had them but we would welcome a subpena from this subcommittee, because from that subpena we would certainly follow up. There was no conversation had with me at any time in reference to supplying at any future occasion testimony of me or the office I represent in regard to this matter.

I would like to challenge that anyone spoke to me in regard to testifying here in relation to these particular documents. I'm sure Mr. Segal and Mr. McLain would state they did not have the conversation with me.

Mr. Moss. You discussed the letter, as a matter of fact, and the letter will be placed in the record that was directed to the attorney general.

[The letter referred to follows:]

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., October 13, 1976.

Mr. EVELLE J. YOUNGER,
Attorney General, Department of Justice, State of California, Los Angeles, Calif.

DEAR MR. ATTORNEY GENERAL: The Subcommittee on Oversight and Investigations is examining aspects of prepaid health plans in the State of California. This inquiry is being conducted pursuant to Rules X and XI of the Rules of the House of Representatives.

In this regard, we would most appreciate your providing the Subcommittee with the following information:

(1) Copies of all memoranda, correspondence or other documentation which supported the statement, "This office does not concur with the computation of tangible net equity in the schedule which accompanies this statement.", contained in your letter of January 13, 1976 to Ms. Shirley Dorsey, Controller, Omni-Rx Health Care, Inc.

(2) A copy of the letter, referred to in the January 13, 1976 letter, from your office to Gordon F. Benson, General Counsel, Omni-Rx Health Care, Inc., dated December 29, 1975.

(3) Copies of all correspondence and documentation supplied by Omni-Rx Health Care, Inc. in response to the December 29, 1975 letter described in (2) above.

(4) Copies of all memoranda, correspondence or other papers between your office and the Department of Health, State of California, relating to the tangible net equity statement contained in financial statements of Omni-Rx Health Care, Inc.

We would appreciate receiving the information requested in this letter no later than Tuesday, October 19, 1976.

Thank you for your cooperation.

Sincerely,

JOHN E. MOSS,
Chairman, Oversight and Investigations Subcommittee.

Mr. Moss. I think the important question now before us is, are you familiar with the correspondence which has been placed in front of you, because at the time the correspondence was originated the Department of Justice, the attorney general of California, had jurisdiction over the registration of these plans?

Mr. ELKINS. In October of 1976 in the conversation with me or the letters?

Mr. Moss. I just stated, the material now before you, are you familiar with it? Are you prepared to discuss it?

Mr. ELKINS. No; I'm not prepared to discuss them since——

Mr. Moss. You have not seen them previously?

Mr. ELKINS. Of course I've seen them.

Mr. Moss. Are you conversant with the subject matter?

Mr. ELKINS. What I have here are a series of letters. What I can testify to is that these letters were sent if they appear to have been sent and were received if they appear to have been received. However, I am not prepared to testify in regard to the particular transactions, the dates, and what occurred in the rest of the material because I have not recently examined them and I'm not prepared to testify under oath as to what happened in regard to these transactions.

I will be happy to supply either answers in writing to all of the questions you have just stated, or I would be happy, after having an opportunity to examine these things, to reappear and answer the questions orally but, you know, just suddenly to be thrust with these particular series of letters and to be asked to comment on everything that occurred, I do not believe I can do that.

However, we certainly do not intend to evade the questions. We will answer either in written form or orally subsequent to the reexamination of them. I have no problems with that.

Mr. WAXMAN. Mr. Chairman, I think it would be unfair to pursue the line of questioning I wanted to pursue with this witness if he is not familiar with the transactions.

I think it might be appropriate that we subpena Mr. Younger himself. He is in charge of this office. He has the responsibility for enforcing the law and it seems to me that the attorney general's office did not do the job it should have done in enforcing the law to insure that these plans had the tangible net equity to be solvent.

It seems to me that he failed to enforce the law to insure that excessive amounts of money didn't go to administrative expenses. I think we deserve an explanation from Mr. Younger as to why his office didn't do the job they were mandated under the law to do. I would like to know whether it was intentional or whether it was some inability of his office to carry out because of his own negligence and the responsibilities placed upon it by the law.

I would suggest that, if a subpena is necessary to get these files and if a subpena is necessary to get Mr. Younger, that we issue that kind of subpena and get to the bottom of it.

Mr. ELKINS. Mr. Waxman, during the entire time that the Knox-Mills Act was enforced by the office of the attorney general—that is, at least since 1968—it was my responsibility to enforce that act in the office. Everything that occurred here occurred under my supervision. I will be happy, upon any questions that you have, to answer fully and completely why everything was done that was done by the office and I am sure that following that explanation this committee will be satisfied that the attorney general, in fact, did supervise to the extent that he was allowed to by the legislature and, in fact, the 40 or 50 cease-and-desist orders that were issued and the 6 actions that we brought in court and the hundreds of warnings that we brought in these matters would fully show that we were, in fact, supervising.

What I am saying, however, is that I am unprepared, and as far as I know the letters our office received would not indicate that I could be so prepared, to answer specifically as to specific cases. We will be happy to answer those specifically and I believe those specific answers will show that there wasn't any negligence in our office and I would, then, request this office and certainly it doesn't need a subpena for representatives of our office to appear.

The subpena that we were indicating was necessary because we had particular financial statements that were filed with our office which by statute are confidential. That's all we stated to the committee on several occasions, as we did with the IRS in one particular case and the FBI in another, that, upon supena, we would certainly be happy to supply and cooperate with this committee. We would be most willing to cooperate with this committee and answer every question that you have. But it is difficult under these circumstances to answer the questions with the specificity you have in mind because in the conversations that I have received from other people in our office and from the communications I have received from the members of your staff and from the letter I received, there was no indication that that type of specificity would occur here, that it was essentially background information.

If we were incorrect, I certainly apologize for that and we will attempt to remedy it in any way we can.

Mr. Moss. The Chair will convene the subcommittee during the week of December 6 for the purpose of considering the request of the gentleman from California, Mr. Waxman, and in the meantime we will proceed to examine areas where you should be prepared to inform the committee.

Is that agreeable?

Mr. WAXMAN. Yes; it is.

Mr. Moss. Mr. Ottinger.

Mr. OTTINGER. It is agreeable.

Mr. WAXMAN. So that you will know at least what my expectations are at the hearing in December, from looking at the correspondence with the Attorney General's office between the office and Omni-Rx, there are letters advising Omni-Rx that they did not meet the requirements of tangible net equity, which means that they were not solvent under the law to carry out a plan and advising them they had to do something to meet that requirement with warnings that the Attorney General's office was going to issue an order to cease and desist operations.

I want to know why no such order was ever made, despite repeated warnings and why the requirement by law was never met.

I would also want to know whether the Attorney General's office deviated from their usual practice and procedures with regard to Omni-Rx. There is very suspicious language in one of the letters where the Attorney General's office indicates:

> We have deviated from our usual procedure and accepted the registration statement without requiring you to first submit all promotional literature and all contracts with members and the providers of services because we are aware that these materials are not yet available,

et cetera, et cetera.

I want to know to what extent the Attorney General's office deviated from its requirements by law with regard to Omni-Rx, whether they were handled separately and differently from other plans, whether they were handled the same as other plans or were not required to meet the requirements by law.

Mr. ELKINS. You are referring to the 1973 letter where the registration statement was required without the promotional literature.

Mr. WAXMAN. I am talking about the language they're talking about treating Omni-Rx differently than others. I want to know to what extent they were treated differently from other plans and whether the treatment of Omni-Rx not mandating them to meet the requirements by law was indicative of the way the Attorney General's office handled the other cases.

These are specifically what I hope we will have answers to when we reconvene the hearing in December in Washington.

Mr. ELKINS. We will be happy to do so.

For the record, I want to indicate that you have stated as to whether we had deviated from a provision in regard to the tangible net equity, in regard to the law, as to whether the tangible net equity requirements were or were not met. I'll answer more fully, obviously, on December 6. It has been the position, of course, of Omni-Rx that they were not at any time in violation of that tangible net equity requirement.

Mr. WAXMAN. Not the position of the attorney general?

Mr. ELKINS. Not the position of our office. However, what I will do is certainly describe for this committee the normal procedure that we used in regard to this and in regard to many of the other plans that we had, the huge number of letters that were written.

I will provide for the committee some standard type of letters that we had in regard to other plans so that we may see how these things differed, try to explain what the procedure was so you can get a full story, a full picture. We will try to present on December 6 as much as we possibly can. If there are further questions beyond December 6, we'll certainly go even deeper, but we will attempt to get as much information as we possibly can to attempt to answer those questions.

I would like to indicate that I do not believe our office was negligent in regard to those transactions.

Mr. WAXMAN. I very much hope that that wasn't the case. I'm looking for a fuller explanation.

Mr. ELKINS. I will be happy to give it.

Mr. Moss. Mr. Ottinger.

Mr. OTTINGER. Thank you, Mr. Chairman.

I am just a little bit confused. In your opening statement, you indicated that during that time you had responsibilities under the law for registration, that the powers given to you by the State legislature were very limited. I didn't, however, happen to look into the adequacies of service.

What is your view in general, since you can't answer specifically, as to what your authority and responsibility was with respect to those registrations? What powers did you have to examine their accuracy and what power did you have to take action against companies in general where you became aware from one source or another of inaccurate representations that might have been made in those statements? I take it that whatever these authorities are, they have now been transferred to the corporation counsel's office. What responsibilities do they now have under this program?

Mr. ELKINS. In regard to our responsibilities under this act, although the act was rather limited, the attorney general of the State of California has rather broad powers. Hence we utilized our regular attorney general's powers in investigation.

For example, we have received a large number of complaints, obviously, through the years about the type of service that was given or whether the contracts were fair or problems having to do with solicitation. In each of those instances, we did one of two things. We either contacted the company for their determination as to what they did, examined the file. If there was more than a single complaint covering a particular problem, we investigated.

Mr. OTTINGER. Did you just respond to complaints or did you look at the registrations that were filed with you and examine them with respect to their accuracy?

Mr. ELKINS. Yes. We looked at the registrations. The registration would show, for example, contracts. We examined the contracts and said, "This particular contract isn't fair, it is wrong, people wouldn't normally find what their rights are until the last page. That isn't fair, you had better redo it. If you don't redo it, we will bring the necessary action to cause you to do so."

We examined all of those contracts to determine whether they were fair. We also went farther than was even allowed under the Knox-Mills act with regard to the type of medical care as we could see from the face of the contract under our normal attorney general's power. So anything that would appear on the face of the contract or anything that would result from a complaint coming into our office was handled.

In regard to advertising, we took, during several years, the majority of the advertising submitted to us, and it was rejected, was changed or modified until it was acceptable to our office. That sort of thing was fairly easy to handle.

One of the big problems, however, connected with medical care is that a lot of material does not appear from the face, unless you audit the medical procedures, unless you have some kind of peer review so that people can see really what is occurring behind those closed doors, it is very difficult to find out what is really occurring. What is the plan, for example, not doing? Are they really trying to save money by not sending people to hospitals? That is very difficult to handle and we didn't have that expertise.

Under the new act, first of all, there was an advisory committee for the department of corporations which goes into those questions of medical care, of medical accuracy, of peer review. All of those sorts of things are covered by this act. They conduct audits not only for financial statements but also conduct medical surveys. That is another aspect.

The second aspect, in regard to financial statements, a great number, the vast majority of financial statements on their face appear to be perfectly good. We had one auditor, we could not obtain from the department of finance additional auditing help. Therefore, it was very difficult to go through the 140 companies we were examining to really take a look behind what appeared on the paper. The department of corporations is vastly experienced in this field. They have loads of auditors, a great deal of responsibility, more money to handle this type of thing. The auditor is paid for by companies, there is a $2,500 fee. There is 18 cents per family in it and so forth.

So there is now, I believe, adequate help to be able to take a look beyond the surface, below the surface. Things that appeared on the

surface we could handle; things beneath the surface we had difficulty with.

Mr. OTTINGER. I have no further questions.

Mr. MOSS. Mr. McLain.

Mr. MCLAIN. Thank you, Mr. Chairman.

Commissioner Barnes, you spoke earlier in your opening statement about the investigation your department is carrying out now relative to prepaid health plans in California. Although you chose not to get into the specifics of that investigation, I wonder if you would tell the committee what the scope of that investigation is, what its purpose is, and what kinds of things you are looking at in that investigation.

Mr. BARNES. Mr. McLain, on approximately August 9 the Governor gave the department of corporations a specific mandate, in fact, several mandates, one of which was to determine whether or not all prepaid health plans in California were complying with the tangible net equity requirements. The second mandate relating specifically to Omni-Rx was to investigate all of the allegations contained in the transcript of the California Assembly subcommittee's hearings, which I believe were conducted in July and October of this year. Specifically, we were to determine whether or not the operations of Omni-Rx should be suspended.

The public transcripts and the assembled subcommittee's hearings enumerate some 9 or 10 specific allegations ranging from disenrollment, enrollment problems, grievances problems, financial problems. All of those allegations are in the process of being investigated.

Mr. MCLAIN. You spoke in the first instance, looking at the tangible net equity requirements, you are looking at that as per all of the prepaid health plans in California; is that right?

Mr. BARNES. Yes. Actually, we commenced that process sometime prior to the Governor's mandate. As Mr. Elkins indicated, Knox-Keene superseded Knox-Mills. We assumed jurisdiction under Knox-Keene on July 1, 1976. In order to continue to operate under Knox-Mills prior to becoming registered under Knox-Keene, plans had to file with the department of corporations a notice of intent which basically indicated we will file an application by September 30. That notice of intent contained financial statements as of March 31, 1976, I believe.

We have reviewed financial statements of approximately 115 plans, including approximately 109 plans of the Knox-Mills registrants.

Mr. MCLAIN. What is the state of your examination right now? Is that completed?

Mr. BARNES. With respect to the determinations going back over a 3-month period, of those 115 plans, our initial examination indicated some 30 plans had deficiencies in tangible net equity.

Mr. MCLAIN. Under both Knox-Keene and Knox-Mills?

Mr. BARNES. This is basically under Knox-Mills. The figures are slightly different under Knox-Keene. With respect to the 30 that had deficiencies, 24 of those have now made the necessary adjustments, put in additional assets so that they are in compliance with T.N.E. Only about six which are still being investigated are in possible noncompliance.

Mr. MCLAIN. One of those that you found initially not to be in compliance with the requirement was Omni-Rx health care; is that not correct?

Mr. BARNES. That is correct.

Mr. MCLAIN. And you so informed the Governor?

Mr. BARNES. Yes, the Governor was aware of that.

Mr. MCLAIN. Along with recommendations by the commission on what action should be taken?

Mr. BARNES. Actually, Mr. McLain, what we did, we treated Omni-Rx no differently than the other 150 plans. We sent out letters to each of those plans which appeared to be in noncompliance, indicating the reasons therefor.

Mr. MCLAIN. As the committee has seen with the correspondence relative to the Department of Justice, those letters can carry on for a long time without any action being taken.

Is it not true that your initial recommendation to the Governor, based on the status of Omni-Rx health care's tangible net equity position, to either (1), issue an order to cease and desist their operations, or (2), to make an analysis of their proposed consolidation, the consolidation between Omni-Rx health systems and Omni-Rx health care?

Mr. BARNES. No, that is not correct. Our posture with respect to Omni-Rx was to indicate to the company the specific deficiencies in their financial statements, to give them an opportunity to respond to those deficiencies, to which they have.

Mr. MCLAIN. And you now have found them in compliance?

Mr. BARNES. Subject to some qualifications, which I think I should enumerate. First of all, the review of the tangible net equity determination of Omni-Rx is based upon unaudited financial statements as of June 30, 1976. As you know, unaudited financial statements are not quite the same as having statements prepared and certified by CPA's. The most recent audited financial statement is, I believe, August 1975. Consequently, you are comparing financials as of different dates.

The additional qualification is the fact that the financial condition may or may not be affected by the results of our investigation which has been concluded.

With those two general conditions, there were two adjustments which the company made in its financial statements. One was to delete an item of $400,000 which represented some letter of credit. A second reduction from the financial statement was the elimination of a receivable from the Department of Health of approximately $500,000.

Essentially what happened there is that systems purchased the receivable for $350,000 cash which was an offsetting amount, and with that cash the plan itself purchased a certificate of deposit which now appears on the balance sheet.

Subject to those general reservations, those deletions from the financial statement, we have preliminarily concluded, based on the unaudited financial statements, Omni-Rx health care does comply with T.N.E.

Mr. MCLAIN. That raises the point that the committee has been concerned with; that is, the availability of statements in order that all of us can do our work with regard to Omni-Rx, amongst other things.

You have the authority, do you not, to require audited financial statements of Omni-Rx health care and of the ancillary groups; is that not correct?

Mr. BARNES. That's correct.

Mr. McLAIN. Are you going to acquire those, have you received those, do you intend to ask for them and receive them?

Mr. BARNES. We intend, in fact, the rules do require the submission of audited financial statements. We have not received the audited financial statements of Omni-Rx health care primarily because I understand the accounting firm has not completed its work.

Mr. McLAIN. Another point you spoke of earlier was your investigation, based upon the allegations raised in the hearings before Assemblyman Keene's committee, do you have a time frame in which the department is going to complete that examination and, upon completion, what form will your findings take?

Mr. BARNES. We have a general time frame, Mr. McLain. I think I indicated during the course of Barry Keene's subcommittee's hearings that it is somewhat difficult to estimate precisely because you go where the information leads you. Frequently that leads to other sources.

With that reservation, it is our expectation that we will be in a position to make some recommendations and some conclusions by the end of December. What particular direction that will take, I just don't know until all of the information has been reviewed.

Mr. McLAIN. What are the possibilities that that conclusion might take? Could it end in the form of a report to the Governor? Could it end in the form of sanctions imposed in the courts of California or administrative proceedings before your department, either or all of those?

Mr. BARNES. It could take either or all of those particular options. Obviously, if the facts indicate that there have been some violations of the law, appropriate civil administrative remedies may be in order.

We also anticipate that as a part of this overall investigation and review, and not just of Omni-Rx, but we anticipate that there might be some further legislative recommendations.

Mr. McLAIN. Another point that I will address to both of you gentlemen is the requirement that is contained in both the Knox-Mills Act as well as the Knox-Keene Act and the regulations under both of those acts, and that is the prohibition against what are called excessive administrative costs. I assume you will not be prepared to respond to that today, maybe so.

Have either of your departments looked at that section as they apply to the acts that you enforce as regarding Omni-Rx health care?

Mr. ELKINS. I don't recall.

Mr. McLAIN. Mr. Chairman, might I ask that, if any such analysis has been completed by either of the departments, that it be supplied to the committee?

Mr. Moss. Yes; and let the record be held at this point to receive that without objection.

[The department of corporations analysis of Omni-Rx may be found in the subcommittee's files.]

Mr. ELKINS. The statute just referred to excessive cost. We then put a regulation in which had an assumption of 25 percent, but I will take a look at that.

Do you want only Omni-Rx, or more specific information on other plans?

Mr. McLAIN. Omni-Rx health care.

Mr. ELKINS. Fine.

Mr. MCLAIN. That's all I have.

Mr. MOSS. Does Mr. Barnes have any information on Knox-Keene?

Mr. MCLAIN. Can you comment now under those Knox-Keene requirements?

Mr. BARNES. No, I cannot at this time.

Mr. MOSS. Do you have an analysis in progress?

Mr. BARNES. Not a specific analysis, although I would anticipate, as part of the general investigation, that information with respect to the level of G.N.A. will be considered and to the extent we come up with a specific analysis we will be happy to give it to this committee.

Mr. MOSS. Do you employ the same criteria in determining excessive administrative costs as employed by the Attorney General under the Knox-Mills?

Mr. BARNES. The standard is slightly different. Basically we have promulgated a rule which is a flexible rule, which draws a distinction between a new company or a developing company and an established company. An established company is one which has been in operation more than 5 years and the limitation of the administrative expenses there, I believe, is 10 percent.

Mr. MOSS. How many of the plans have been operated more than 5 years?

Mr. BARNES. I could not give you that answer, I do not know.

Mr. MOSS. Could you supply for the record the number over 5 years and the range of their administrative costs, the permissible range, and then a list of those under 5 years in operation and the permissible range of administrative costs for those companies?

[As stated on p. 106 of these hearings, this material will be forwarded to the Subcommittee as it becomes available.]

Mr. ELKINS. May I ask, Mr. Chairman, there also has been a problem, and I'll try to relate to that on December 6, as to what is administrative costs. There are all sorts of factors, for example, as to whether insurance which may be covered for doctors is an administrative cost and so forth. It has been somewhat difficult, and I know that the Department of Health has some problems connected with that, too, to define the term.

Mr. MOSS. That's why I recommended to the SEC that they have the proper accounting standards board's generally accepted accounting principles in plans of this type.

Mr. ELKINS. We had that problem, too. Under the Knox-Mills Act, for example, in two specific areas, in regard to the type of assets, some of the assets which companies had were in real estate or in some long term leases which may be assets or might not be, but they certainly were not convertible to cash within any reasonable period of time and they would not help the people that the statute intended to help.

The other problem was connected with the type of investments under the Knox-Mills Act. If a company had investments and did not trade them periodically but, for example, long-term bonds and the market price was now way down, they kept that at the initial price, the price at which they bought the bonds. That was somewhat unrealistic in regard to the protection that individuals might have if there had to be a sudden selling. But under the normal accounting procedures as now developed, those would be counted.

There are many other similar circumstances such as that.

Mr. Moss. We were confronted with that in the rewrite of the Federal Securities and Exchange Commission Act in considering the net asset requirement for broker dealers and one of the things we required was a haircutting operation to trim the bonds and other holdings down to reflect current market, not a fictional market of the past. But these would be items properly considered in adopting accounting standards, but would it be the judgment of you gentlemen that such standards would be helpful to the States in supervising plans of these types?

Mr. BARNES. I would certainly say yes. Mr. Chairman. There are several efforts being made, I understand, to develop uniform accounting standards.

We are are addressing those problems as part of the continuing promulgation of rules.

I would like to go back very briefly to your request that we provide you with specific information on the administrative expense level for all plans, both 5 years or older and 5 years or less. I have no hesitation in providing that information, only to advise you that it will take some time.

Mr. Moss. I recognize that.

Mr. BARNES. We are making that determination in connection with the review of the application for licensure under Knox-Keene, and we are talking about something like 100 applications with a rather substantial time period, so we can provide you the information.

Mr. Moss. Can you give us your best judgment as to the time involved in supplying the material?

Mr. BARNES. I think we are probably talking about 3 to 4 months. We can provide you information as we obtain it.

Mr. Moss. We are on the verge of starting a new session of Congress and that time period is not unreasonable. It will accommodate the needs of the committee.

Mr. ELKINS. One question, Mr. Chairman. In regard to the material which we will be supplying on the 6th, we have no problem in regard to the letters back forth and so forth. We do still have the confidentiality problem related to the financial material that was given to us. Is it possible for us to obtain a subpena for those records so that we can take care of that problem?

Mr. Moss. Let me clarify the purpose of the meeting on the 6th. It will be to convene the committee for the purpose of considering the questions of Mr. Waxman for the issuance of subpenas and for the further scheduling relating to receiving the return of those subpenas.

Following that meeting, notices will then be sent out for the date of a hearing where the subpenaed material will be considered.

Mr. ELKINS. Our problem as we indicated before, is that the statutes say it is confidential except for administrative or judicial cases and we would obviously honor a subpena from the committee.

Mr. Moss. The Chair recognizes the problem you have. The Chair has been advised that a series of opinions drafted independent and arriving at the same conclusion that the need of Congress in this area gives it a legitimate and sovereign right to receive the material, but we will protect you through the issuance of a subpena.

Mr. ELKINS. Thank you very much.

Mr. Moss. Are there further questions of the witness at this time?

Mr. Segal.

Mr. Segal. Mr. Barnes, you indicated that there are plans that are outstanding more than 5 years, did you include Omni-Rx within that category?

Mr. Barnes. I was not intending to include any plans particularly within that category, just indicating the line of demarcation the rules make between 10 and 25 percent administrative expenses. I don't recall exactly the date Omni-Rx commenced business.

Mr. Segal. Did you intend to indicate that Omni-Rx should be, in fact, grandfathered in by previously being an outstanding plan and, through all of the steps and not just tangible net equity?

Mr. Barnes. No. We are not talking about tangible net equity. We are talking about overhead, general administrative expenses. There is no grandfathering.

Mr. Segal. Was it not true that on July 1, if the plan was not considered in existence as a fully approved plan, it would have to go through all of the steps and not just tangible net equity?

Mr. Barnes. That's true, but I still don't understand your question.

Mr. Segal. The point being that on July 1, 1976, you determined only tangible net equity; is that correct? Does that not mean that in order for it to be able to continue in business under Knox-Mills during the 6-month interim period between July 1, 1976, and January 1, 1977, that it has to come into compliance with the entire provisions of the Knox-Mills statutes?

Mr. Barnes. That is correct. I will restate my prior statement regarding no grandfathering. I thought you were referring to grandfathering with respect to administrative expenses.

Knox-Keene specifically includes a grandfather clause which says that until the commissioner of corporations grants or denies an application under the Knox-Keene, a plan which has filed that notice of intent and is registered under Knox-Mills and can continue to operate under Knox-Mills as it existed prior to being repealed. That would require that plan to meet all of those conditions and requirements of Knox-Mills.

Mr. Segal. But is not testimony here today that as of July 1, 1976, Omni-Rx did not meet the provisions of Knox-Mills as of that date?

Mr. Barnes. No, that's not my testimony. My testimony was that we made a determination of Knox-Mills T.N.E. of Omni-Rx subsequent to July 1 when we obtained jurisdiction based upon financial statements dated as of June 30, 1976, and during the course of raising issues in resolving uncertainties in that financial presentation, ultimately we put some reservations and qualifications on it.

Mr. Segal. But as of July 1 they did not?

Mr. Barnes. I cannot make a determination as to whether or not they met it as of July 1 or not. The only time we looked at Omni-Rx was when we assumed jurisdiction as of July 1 and the only final determination which has been made with respect to those financial statements is this preliminary determination they do meet T.N.E.

Mr. Segal. When you reported to the Governor, August 20, 1976, it has a file number for Omni-Rx Health Care, Inc., No. 1081, under the category "does no meet T.N.E.," there is an X. Does that not signify that at that time, August 20, 1976, it does not meet the T.N.E.?

Mr. BARNES. I don't think so, Mr. Segal. I think you have to read that entire report in context and also understand the procedures with which issues are raised and resolved. The report to the Governor was made after only 14 days. He gave us specific instructions to report back to him within 14 days. Many of our conclusions with respect to a particular plan were preliminary conclusions requiring further audit, further detailed work. Consequently, merely indicating that plan—I think you'll find it says "may or may not meet T.N.E." Merely because we indicated that a plan may not meet the T.N.E., that is based upon a preliminary determination subsequently resolved to our satisfaction.

Mr. OTTINGER. For those of us not familiar with your procedures, what is a T.N.E.?

Mr. BARNES. T.N.E. refers to tangible net equity which is a shorthand for net worth. It means total assets over total liabilities.

Mr. Moss. In order that the Chair understands the chart, I note going down the headings, "meets T.N.E.," "does not meet T.N.E." and that's under a general heading of "current status of DOC determination." I find two plans listed as "does not meet T.N.E.," one of them Omni-Rx.

I follow that chart over to Knox-Keene T.N.E. and I find "may or may not meet T.N.E." Now, the question of Mr. Segal was, had a determination been made that Omni-Rx did not under the current status of the DOC determination meet T.N.E.? The chart says it does not.

Mr. BARNES. Let me try again, Mr. Chairman.

With respect to Omni-Rx, that reference you are referring to in the Governor's report refers to the first review we made of the March 31, 1976, financial statement. Based upon our rejection of the letter of credit of approximately $400,000 and the DOH receivables, eliminating those two items, technically Omni-Rx would not have met T.N.E. Those issues were still being tested, still being analyzed. That is only a preliminary determination. That formed the basis for the adjustment subsequently made by the company.

Mr. Moss. How many of the total of 115 plans, 109 of them, I assume, being old plans, had the same determination? I notice one other here listed as does not meet T.N.E. and may not meet Knox-Keene T.N.E.

I notice on the summary I have three instances where recommended act was a notice of cease and desist, unequivocal in one instance, conditional in the case of Omni-Rx and one other plan. Omni-Rx, notice of cease and desist or analyze effective proposed consolidation. Which course has been pursued?

Mr. BARNES. Actually, neither course has been pursued because Omni-Rx has put in an additional $350,000 by way of a certificate of deposit. With that adjustment and with the elimination of the letter of credit, that is reflected on the financial statements.

Mr. Moss. Have you gone beyond the certificate of deposit in view of the obligations contained in the filing of complaint by the Securities and Exchange Commission?

Perhaps I should ask, are you familiar with the filing by the Securities and Exchange Commission?

Mr. BARNES. Yes, I am.

Mr. Moss. And the enumerated charges that are contained in that file?

Mr. BARNES. Yes, I am.

Mr. MOSS. Have you then examined the certificate of deposit in context with the allegations contained in the SEC file?

Mr. BARNES. As a matter of fact, we have. We have raised several questions upon receipt of the certificate of deposit. We have gotten specific responses from the company as well as from the bank indicating there is no setoff or other claim against that certificate of deposit that the bank is aware of. We specifically pursued various areas to determine that it was, in fact, a bona fide transaction.

Mr. MOSS. How many of your reviews were found, apparently on a tentative basis, not to meet tangible net equity requirements?

Mr. BARNES. My figure will probably be a little different than the figure reported on my first report to the Governor because of the submission of quarterly financial statements which also cause some——

Mr. MOSS. Would you then supply for the hearing record your more current evaluation?

Mr. BARNES. I believe you have that, Mr. Chairman, as a result of a letter we sent you several weeks ago, but specifically approximately 30 plans preliminarily have been determined not to be in compliance with T.N.E.

Mr. MOSS. Have you proceeded against any of the plans with a cease and desist?

Mr. BARNES. We have issued—first, let me state this. Of that 30, there are only 6 now that may still have T.N.E. problems. We have issued perhaps two cease and desist orders against plans but not necessarily related to T.N.E.

Mr. MOSS. You talk of the more recent report, is that the report of September 30?

Mr. BARNES. Yes.

Mr. MOSS. That, then, the committee may rely upon this report as reflecting your most current thinking or at least your most current conclusions?

Mr. BARNES. Perhaps, Mr. Chairman, I should give you one additional document which would bring this committee up to date, probably to October 30.

Mr. MOSS. I think it would be most helpful. Without objection, the record will be held to receive that.

[The Department of Corporation's report on Omni-Rx tangible net equity may be found in the subcommittee's files.]

Mr. BARNES. My figure of 30 is based upon, I believe, information subsequent to that September 30 report.

Mr. MOSS. We will make it very clear we are as interested in each of the other plans administered by the State of California as we are in Omni-Rx, because each illustrates a facet of the problems which this committee feels it must assist in solving before we recommend additional legislation to the House of Representatives.

Are there further questions?

Mr. SEGAL. One last question, Mr. Barnes.

In your preliminary determination, and we are aware of the caveat you proposed before, you said currently unaudited statements, et cetera, did you take into consideration an outstanding request to Omni-Rx from the county of Los Angeles to the extent of approximately $176,000 in emergency claims?

Mr. BARNES. That was a fact we were aware of. I understand a lawsuit has been filed by the county of Los Angeles. One of the difficulties here is that the specific amount of liability cannot be ascertained. So consequently, in all probability, you do have a question here as to whether or not this should be reported on the financial statements.

The amount is such that we were not able to determine what was material or not material and, again, that's one of those areas that will be pursued as part of the investigation. That's why I gave you that general reservation, because there are several questions which——

Mr. Moss. Is there any form of contingent account to take care of a claim of some magnitude if it should ultimately prove valid?

Mr. BARNES. There are several ways to take care of a claim.

Mr. Moss. I mean within the limits of the filing by Omni-Rx of its financial statement with the corporation commission.

Mr. BARNES. I'm sorry, sir. I did not understand that.

Mr. Moss. You have a statement filed with your office reflecting the financial condition of Omni-Rx, is that correct?

Mr. BARNES. That's correct.

Mr. Moss. Does that statement reflect a contingent liability created because of the claim of the city or county of Los Angeles for reimbursement service?

Mr. BARNES. It does not.

Mr. Moss. It does not?

Mr. BARNES. No.

Mr. Moss. But the corporation commission is aware of it?

Mr. BARNES. We are aware that the county of Los Angeles has filed a suit with respect to some of these items which I believe related primarily to emergency services. We have raised the question as to whether or not proper accounting would require those financial statements to reflect that as a contingent liability.

Mr. Moss. But you have not resolved them?

Mr. BARNES. It has not been resolved, if you mean do we have financial statements which now reflect that as a contingent liability, the answer is no, we do not.

Mr. Moss. When I say that, what I mean is the corporation commissioner's office has not determined whether the financial statement should reflect that it has a contingent liability?

Mr. BARNES. OK. We would certainly be of the view that properly prepared financial statements, prepared in accordance with GAAP, generally accepted accounting principles, should have one or two treatments with respect to this item, either a footnote treatment or a specific indication that there is a possible contingent liability.

Mr. Moss. Are you now requiring, then, the plans over which you have jurisdiction to give notice of any such contingency in that filing with the corporation commission?

Mr. BARNES. We would challenge financial statements, Mr. Chairman, which did not reflect where there is some certainty of a possible contingent liability. We would challenge a statement which did not reflect that contingent liability.

Mr. Moss. Have you challenged such?

Mr. BARNES. We have raised this question and, as I indicated to you earlier, there are several issues, including this, which are part of the continuing financial examination where we can get substantiation as opposed to relying upon the documents we receive.

Mr. Moss. Will you inform the subcommittee when you have concluded the review of this and reached a decision as to the kind of reporting requirement which you will promulgate for these plans?

Mr. BARNES. Certainly.

Mr. Moss. Mr. Segal.

Mr. SEGAL. No questions.

Mr. Moss. Further questions?

Mr. OTTINGER. I have a general question.

You gentlemen have had experience now with the plans operated in California under medicaid. I wonder whether, from your experience, you think it is possible to devise a health insurance program through the Federal Government, operated by private carriers, under which the public will not be ripped off, and, if so, what kind of protective measures have to be provided by Congress, in addition to those presently provided in order to give the public some protection?

We are getting exposure to medicaid frauds all over the country, dramatic ones in New York State which Mr. Scheuer and I represent, raising in my mind increasing concern over whether this ought to or indeed can be done through the private sector. With so much money in question, is it possible to institute controls to see to it that advantage won't be taken of it? Should this be assumed as a function of Government?

I would just like to see what is your reaction, either one or both of you.

Mr. BARNES. You have raised certainly a very fundamental question that I think everyone who has been involved in the industry has probably asked at one time or another, which is what are the controls that you can place on this whole area to assure some reasonable protection for the public. Certainly some of the abuses we have seen have related to lack of financial integrity, the conflict of interest and the overlap of numerous financial entities, all involved in the same transactions.

One thing I think has been done, certainly at the Federal level and which is probably also occurring at the State level, is to try to provide some ratio of public patients to private patients, 50–50 under the HMO Act, again designed in part to eliminate a plan's total reliance on public dollars and encourage participation in the private sector.

I think another area that certainly has to be addressed is the conflict of interest, the fact that you have related affiliates wearing two hats, as employer or employee, and the absence of bargaining between all of these entities is, I think, one of the real problems. I think, if you can provide ways to eliminate or certainly limit impermissible conflicts of interest, that will be one of the things I think would help.

Mr. OTTINGER. In the system as it is presently established, the Federal Government provides the money and the State system is protected. Do you think it would be advisable for the Federal Government to have, say, the GAO make audits, or provide funds for the States to make more extensive audits?

Mr. BARNES. I have some personal reservations as to the effectiveness of not just GAO but the effectiveness of any agency that is located in Washington, D.C., to be effective in providing what I call financial audits because I think the key there is access and being close to the

particular companies or plans you are interested in conducting onsight inspections.

Knox-Keene does achieve that. One of the additional requirements in the Knox-Keene is that we must conduct a periodic financial onsight examination of all plans. The statute talks in terms of once every 5 years. We contemplate doing it at least once every 12 months.

Mr. Moss. I think it would be helpful to clarify, and I always grasp the opportunity to clarify, the fact that we are not remote in Washington. The General Accounting Office has a very adequate staff in California, many Californians residing in the area, who are able to give the same input. It is just the question of who bears the cost and whether there is a uniformity in auditing between the States. I think that is the point Mr. Ottinger was addressing himself to, uniformity.

There has been on this record this morning the statement by the Attorney General's office of the history prior to July 1, of inadequate funds for auditing. Now, it has been my experience that many States have greater difficulty getting funds than the agencies and departments in California. So I think in that context that one should consider the question of Mr. Ottinger not to remove it. We are not 3,000 miles away. We are right here in this building and in a number of other buildings scattered throughout the State and we are able to exercise a very current oversight.

Mr. BARNES. Mr. Chairman, don't misunderstand my comments. I was referring to financial audits of individual plans as opposed to a broad audit of the use of public dollars.

Mr. OTTINGER. I just wonder, do you think under the present procedures, under this Knox-Keene bill, which I have not had the opportunity to read, in the ordinary course of things you would catch the kinds of abuses that were alleged to have occurred with respect to this particular Omni-Rx situation or do these kinds of things still get by you?

Mr. BARNES. When you say the particular kinds of abuses in Omni-Rx, I'm not sure whether you are referring to the SEC complaint or just some of the various allegations which previously have appeared in public.

Mr. OTTINGER. Well, there are a whole series of allegations made by the State legislative committee and made by the SEC. Not judging their accuracy, it would indicate serious deficiencies in both the division of health care, financial division and in the charges that are made to the people of California and in the charges that are made to the people of California for participation in this program and the excessive costs that are being allocated.

Without judging whether those are true or not, is your present system adequately funded with adequate personnel in order to be able to catch this kind of a situation?

Mr. BARNES. Again, I would answer that in a truthful manner, which is, one, we are adequately funded. Eventually, under Knox-Keene when we are fully implemented we are talking about approximately 74 employees, in contrast to, I believe, the attorney general had four or five employees to adminster Knox-Mills. This will include people experienced in financial examination, medical surveys, and the department of corporations has a staff or some 50 lawyers who are experienced in reviewing business transactions and we think we have

the capability and the funding, coupled with the rules, to deal with the kinds of problems we have been hearing about recently, but I will not fool you in expecting you to believe we won't miss anything.

This department, like the SEC, the mere fact that you have so many investigations certainly is an indication that there are ways to circumvent regulation, but we try our best to plug those loopholes.

Mr. OTTINGER. On the bottom line, do you think the Federal Government should continue to operate this kind of program or do you think the Federal Government should get out of this business?

Mr. BARNES. My personal belief is that the Federal Government should not go into this business directly. I believe the State of California has the capability of eliminating the kinds of abuses you are concerned with. I think Knox-Keene was specifically promulgated to address the problems which had not been addressed in the past and I think the difference in the nature of the statute is what I call a normative type statute with substantive regulations, substantial funding and qualified people, I think the State of California can do the job.

Mr. OTTINGER. Thank you.

Mr. MOSS. Mr. Scheuer.

Mr. SCHEUER. Yes. I think that our minds are open on this subcommittee and on the health subcommittee as to whether there is a role for private enterprise in the delivery of health services.

In New York City, they discovered a doctor who took about $900,000 out of the medicaid system in the course of 3 years. Everybody thought that was quite scandalous. Then they found that he was operating a rather efficient, mass-production clinic with a number of assistants and physician extenders. He apparently was clean as a hound's tooth and a number of people thought that, while he probably took out more than we would have liked, he probably took out somewhere between $100,000 and $150,000 a year himself, still he was giving health services in a poor neighborhood that, without this type of program, would not have been delivered there at all.

The Government has a great deal of difficulty getting physicians into these neighborhoods as well as into rural areas. The graduates of medical schools, both black and white, do not like to go into these poor neighborhoods and the financial incentive of making $100,000 or $150,000 apparently was a real one in his case. He delivered health services that were vitally needed, which apparently we do not have a way of producing.

So maybe there is a role for the free enterprise system in health services, although many of us have a feeling it is all right to make a profit for the guy building a building but out of the delivery of health services it doesn't seem appropriate.

But, anyway, I think the books are still open. It is obvious that neither at the State nor the Federal level have we learned how to monitor and audit these private enterprise health delivery systems and to squeeze out whatever ripoff may be inherent in the program. We have certainly failed to do that in a gross way in New York. I suspect that in California the situation is not much better.

Are you familiar with the letter that was written by this group that we are talking about, Omni-Rx Health Care, on September 7, a long, 20-page letter to the Governor?

Mr. BARNES. Yes. I believe I have seen that.

Mr. SCHEUER. They lay out a long list of grievances against the investigating committee of the State legislature and on pages 9 through 13 they also lay out a long list of grievances against your department. They talk about repeated repetitive audits on the same subject that just continued ad infinitum.

Mr. BARNES. Is that not the Department of Health rather than the Department of Corporations?

Mr. SCHEUER. Oh, that's the Department of Health, I see. So I can't talk to you about that, all right. Then I have the wrong party. I appreciate the correction.

Mr. Chairman, I have no further questions. I appreciate the witness's testimony.

Mr. OTTINGER [presiding]. Does anybody else have any further questions of the witness?

If not, we would like to thank you very much for your time and patience. We would look forward to hearing further from you both on December 6 on the question of the subpenas.

You are excused.

I understand that Mr. Herbert Witt of the HEW Audit Agency has fairly brief testimony. We promised him time this morning if my colleagues have no objections. I understand the testimony is short.

Mr. Witt, would you like to come forward.

Stand and be sworn.

Do you promise the testimony you are about to give is the truth, the whole truth and nothing but the truth, so help you God?

Mr. WITT. I do.

Mr. OTTINGER. Without objection, your statement will be included in the record. You may read that or summarize it as you wish.

You may proceed.

STATEMENT OF HERBERT WITT, REGIONAL AUDIT DIRECTOR, HEW REGION IX AUDIT AGENCY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. WITT. Mr. Chairman, we are pleased to be here today to discuss our ongoing review of the prepaid health plans in California. As part of our planned audit schedule for fiscal year 1976, region IX commenced an audit of the administration of the prepaid health plan (PHP) program by the State of California. This audit, with field work still in process, is directed at the overall state administration of the PHP program. Fifty percent of these costs are reimbursed with federal funds provided by title XIX of the Social Security Act—medicaid, or as it is known in California, Medi-Cal. Our audit is not directed at any particular PHP's, but to the overall program in general.

One of the objectives of the audit is to determine whether the state had adequate controls to assure that payments were not made on a fee-for-service basis for Medi-Cal recipients during a period when they were entitled to the same services as enrollees in a PHP. Without adequate controls, it would be possible for an individual to obtain care on a fee-for-service basis from a provider when the state had already made a capitation payment to a PHP to cover the same service. This would constitute a duplication in payments of Medi-Cal funds.

Mr. SCHEUER. Why would a patient want to do that? Why would he have an incentive to do that if he had been assigned and if he had voluntarily opted to become part of a prepaid system? Why would he then go to another doctor on a fee-for-service basis?

Mr. WITT. There are various reasons. We are looking into these at this point. One might be that he wanted to drop out of a prepaid health plan and he at the same time had applied for a temporary Medi-Cal card. There might be a breakdown in procedures whereby he was allowed to use the card. One possibility might be drugs. He might feel that he could get drugs elsewhere, regardless of the complex controls. We are trying to nail down those causes.

The information on both fee-for-service payments and PHP enrollment is on computer files. In order to make our tests of the data on these files, we used a computer software package developed by the HEW Audit Agency, known as the HEW computer audit system. Using this system, a computer program was developed to compare data on one file of magnetic tape to another file of magnetic tape and print out the results when they matched.

To make the tests, we selected the period September through December 1975. The tests—which covered all PHP's—were made of the State's computer files through the use of the computer operated by the State Department of Health (DOH). State DOH personnel provided assistance to us in applying our computer program.

The comparison of data on the fee-for-service and the PHP enrollment files for the above 4-month period resulted in a printout showing that 6,288 persons had received fee-for-service care during that period at a cost of $1,092,245. However, until we complete our analysis of this data, we will be unable to state how much, if any, of this amount represent an overpayment.

Our initial analysis of the printout showed that 1,544 persons, with payments of $100,867, received services which were allowable as fee-for-service because they were not covered by the PHP's. For example, some plans do not cover dental services and the enrollees are given a special Medi-Cal identification card to cover these services.

Our analysis of the listing is continuing and there may be other payments which are proper. For instance, PHP's are limited under their contracts to $10,000 in services to enrollees in a 12-month period, and any services over that amount would be authorized on a fee-for-service basis. For those payments that are found to be improper, we will determine the causes as a basis for recommending corrective action by the State and any necessary refunds.

I recognize, Mr. Chairman, that my statement is inconclusive at this time as to overpayments. This is because the audit is, as previously indicated, still in process. When it is finished, we will issue an audit report in accordance with our usual procedures. In the meantime, I will be glad to try to answer any questions you may have concerning our work done to date.

Mr. WAXMAN. Your audit was not just about the amount of duplication of payment by those who might well have been paid for under a PHP and then have paid on their behalf fee-for-service, but your audit was over the administration of the program by the State of California. Have you been able to reach any conclusions about the ad-

ministration of the program by the State of California to prevent this kind of duplication of fees?

Mr. WITT. At this point we haven't obtained conclusive evidence. However, the State recognizes that there is a problem with respect to control over this program.

Mr. WAXMAN. In that recognition, they are doing something about it. Is that to be inferred?

Mr. WITT. Yes. The State has undertaken certain efforts at this point.

Mr. WAXMAN. For clarification with regard to the question Mr. Scheuer asked you, the primary reason, as I would understand it, why a patient would be charged for capitation payment as well as a fee-for-service was not the patient's choice but the provider's choice in order to get that, isn't that correct?

Mr. WITT. If the patient decides to use the providers, say, that are not in the prepaid health plan he would go outside of the prepaid health system to obtain the provider.

Mr. WAXMAN. Do you suspect that that's the situation with the majority of the patients who end up going to fee-for-service while under PHP?

Mr. WITT. We haven't nailed it down exactly, however, based on preliminary work, it appears that there are what they call temporary Medi-Cal cards which have been issued to the PHP patients or recipients, who are using these at the same time that they belong to the prepaid health plan.

Mr. WAXMAN. Where would these cards come from? Wouldn't it be because they were temporarily disenrolled by the plan so they could go for expensive service to a fee-for-service?

Mr. WITT. No. At this point, as I say, our results are inconclusive. However, there could be various reasons why this is being done and I could not say at this point that that is the only reason.

Mr. WAXMAN. When do you expect to conclude your audit?

Mr. WITT. Our audit work should be done within the next 2 to 3 months. One of the problems we have is quantifying the amounts that have been overpaid and recommending refunds. As part of this, we have to visit to the counties and since there are 58 counties involved, plus need to review the State's administration, plus Blue Cross and Blue Shield, we estimate that the audit will be completed in 2 to 3 months.

Mr. WAXMAN. Are you aware of any problems with the prepaid health plans in California where there have been disenrollment periods and patients referred to either hospitals or physicians for service on a fee-for-service basis?

Mr. WITT. No. At this point I can't comment on that.

Mr. WAXMAN. That is all.

Mr. SCHEUER. When you do an audit, can you monitor the quality and type of services given to the enrolled patients? For example, we have information that when the Einstein Medical School gave their report on Omni-Rx, they found that some 27 percent of the children covered by the plan had received no immunizations. They found that a substantial number of children, 3,500 of them, had never been seen by Omni-Rx although they were covered by the contract to provide total care for them. They did not even have patient records for them. Forty

percent of them weren't completely immunized, I don't understand what that means, against such things as polio and diphtheria. Twenty-seven percent didn't get any immunization.

Does the audit include whether or not the provider is sustaining the length and breadth of health care services in the contract that should be offered to all of the enrollees?

Mr. WITT. Normally, our audit doesn't check specifically on the quality of care. However, one of the areas——

Mr. SCHEUER. Do you check into whether the care is being given at all?

Mr. WITT. Yes. One of the areas we have checked on is the quality of care reviews by DOH to assure that the recipients are getting adequate care. This is one of the areas we are looking at. We are looking at the Einstein report and would hope to report on any deficiencies when our report is issued.

Mr. SCHEUER. It seems to me that the Federal Government ought to have some way; a computer ought to pop up a red flag when there are thousands and thousands of enrollees who are getting no health services at all and for whom patient files aren't even being kept. The computer ought to be able to identify when that has happened and it seems to me something is wrong with the Federal HEW oversight system with thousands and thousands of patients having no files kept on them and having no visits of any kind. If as many as 27 percent of the kids have no immunization at all, it seems to me that the computer ought to be instructed to track children into the zero to 5 age category and there ought to be an early warning signal when those kids are absolutely not getting what they were contracted for.

I'm not talking about the quality of care, whether it is good, bad, or indifferent when it is given. I'm talking about the vast numbers of enrollees being given no care at all, not having any file set up for them. Shouldn't the computer be able to identify that? Isn't the Federal oversight function to be able to identify it?

Mr. WITT. I would say in answer to your question that currently the computer doesn't. However, it has capabilities and it may or may not be applicable in this case. I would say the way we were able to arrive at this finding on duplication was using a more advanced computer audit program.

Mr. SCHEUER. I'm not talking about duplication; I'm talking about——

Mr. WITT. I realize that. But I'm saying a specialized computer audit program might be able to detect this.

Mr. OTTINGER. Is there a human being involved in your audit or is this entirely a computer operation? Does somebody actually go out and take a look at these operations?

Mr. WITT. Yes, there is. This was just a special program that would enable us to make the comparison on a 100 percent basis.

Mr. OTTINGER. I don't know that the Federal Government should. Maybe the Federal Government should see that the State procedures are adequate. I was wondering if the Federal Government does this or sees that it is done.

Mr. WITT. Yes. Actually, the reason we specifically hit this duplication of payments was there have been numerous audits made by the State in the past, by the Auditor General's office and the Department

of Finance mentioning duplicate payments, but no action had been taken in terms of correcting the problem. This is the one reason we stepped into this area.

Mr. OTTINGER. Do you have any type of norms like the Internal Revenue Service has to raise flags when things look wrong? The Omni-Rx study, indicates that 53 percent of the public dollar is going to profits. This seems to be on the surface something which requires examination. Does your audit flag excessive administrative costs, excessive profits so that an investigation can be conducted in detail as to the causes?

Mr. WITT. Our audit is also following up on the monitoring of the financial status of the PHP's and the administrative cost.

Mr. SCHEUER. How come these abuses went on so long and without being noticed by you?

Mr. WITT. Well, the state has made audits in the area. The Auditor General's report pointed out, for example, the excessive administrative cost. We relied where possible on the audits performed by the Auditor General, the Department of Finance, and the General Accounting Office.

Mr. SCHEUER. Do you have any standard audit forms and procedures that you apply to all 50 States? Do you require them to show for example, whether required services are being given, whether they operate within some permissible or appropriate range of profits? It gets to the point where over half of the taxpayers' dollars go for profits, not for services, where at the same time thousands of children aren't being served at all, don't even have files kept on them.

Don't you think that's the kind of a situation where the Federal Government should establish audit procedures for the States to carry out, all of the 50 States to carry out, in order to identify these rather horrendous gaps?

Mr. WITT. In some of the programs we have general audit guides to be carried out. In something like an area of profit or administrative costs there are no specific tolerances set up or standards.

Mr. OTTINGER. I think there had better be. That sounds incredible, to get up as high as 50 percent going to profits and this doesn't touch off any kind of warning signal within the Auditing Department that there needs to be a closer look. I think some kind of guidelines ought to be established without any question.

Mr. SCHEUER. I'm not at all hostile at this point in time to finding a role for the free enterprise system in the delivery of health services. As I said, maybe we have to provide a very real incentive to get health professionals to serve in the ghetto area and the rural areas. Maybe there has to be a real reward there. But it seems to me that, even admitting that or even assuming that, there ought to be limits. When you start knocking off profits of over 50 percent of the total dollars, I think that's unacceptable.

It seems to me from the sort of fuzzy answers you have given, sir, that the Department of HEW ought to go back to the drawing board and design audit procedures for the 50 States to follow. If their policy is for the auditing to be done at the State level, there should be a method that will identify possible or potential abuses and send up a red flag so State or Federal investigators can zero in when it looks as if there is something rotten in Denmark.

It seems to me that you don't have those procedures, you don't have a computer set up that would identify easily double billing, that would identify nonkeeping of records for thousands of enrollees, that would identify nonperformance of services for a substantial proportion of these children. It seems to me you have a long way to go.

Mr. WITT. Let me just answer in terms of this.

Some of the areas, yes, you can tighten up in terms of regulations and procedures. In other areas, like profit, the basic management-type concept of return on investment and what is considered to be unreasonable profits are generally used by auditors, and it is intended that the auditors flag unreasonable profits whether on Department of Health contracts or Department of Defense contracts. But generally there are some areas, yes, where regulations can be tightened up.

Mr. OTTINGER. Mr. Segal.

Mr. SEGAL. In the interest of time, Mr. Witt, I will just ask one question. Within your review for the 4-month period that showed duplicate billings at slightly less than $1 million which can be prorated at 2.8 million annually. What kinds of causes or reasons might there be for a plan, in one case people who were enrolled by Omni-Rx for that entire 3-month period, that there were also fee-for-service bills submitted by ancillary providers of care under the Omni-Rx Health Systems Co.?

For example in the printout here, there is an Av-El Medical Group, an El Segundo Lab, a Regency Pharmacy, all fully owned ancillary service companies of Omni-Rx, where capitation for those very same individuals was paid for by the States.

Mr. WITT. As I say, we haven't finished our review with respect to causes. You can hypothesize and state some of the types of causes we are checking into. One of them is that inadequate enrollment information went to the counties. That's a possibility because the counties are the ones who give out the temporary cards.

One is that the counties may not have checked the PHP data that is available. In some cases it might be that older people do not understand when they are enrolled in the plan. Maybe in certain of the cases someone is trying to get drugs.

Thus there are these various causes. The main point is, however, that what we are trying to do in the audit is specifically identify the causes as a basis for coming up with specific recommendations for corrective action.

Now, as I said before, in the prior audits being done by the state there is just a statement that there were these potential duplicates and no action had been taken. We are trying to identify the causes at this point.

Mr. SEGAL. Thank you, Mr. Chairman.

Mr. OTTINGER. Thank you very much, Mr. Witt. I do hope that some improved method of being able to signal the typical kinds of things that are coming up such as medicaid abuses will be developed. You have a considerable track record in the 50 States at the present time. To me it ought to be quite simple to identify the most frequently observed instances of improper activities that have a system whereby those which would come up, whether it be on a computer or the processing of an audit, then there would be an in-depth investigation when the

danger sign occurred. The fact that there doesn't seem to be that kind of a system I find most disturbing.

The hearing is recessed until 2:15.

[Whereupon, at 12:45 p.m., the hearing was recessed to reconvene at 2:15 p.m., the same day.]

AFTER RECESS

[The subcommittee reconvened at 2:15 p.m., Hon. John E. Moss, chairman, presiding.]

Mr. Moss. The subcommittee will be in order.

At this time we would like to call Mr. Ed Murphy with the General Accounting Office, who will explain for the record the 53-percent figure which was questioned just before adjourning for the noon hour.

Identify yourself for the hearing record.

STATEMENT OF EDWARD MURPHY, AUDITOR ECONOMIST, GENERAL ACCOUNTING OFFICE

Mr. MURPHY. I am Edward Murphy, with the General Accounting Office in Washington, D.C.

Mr. Moss. Mr. Segal.

Mr. SEGAL. Mr. Murphy, there was a question raised this morning about a 53-percent profit from Omni-Rx Health Ancillary Services Division. Could you please explain to the committee how that 53-percent figure was derived?

Mr. MURPHY. Yes, Mr. Segal. I do have, I must point out, one small problem, and that is that I don't have a copy of the chart. Copies are being made and they will be done shortly.

But, basically, I had access to some unaudited financial statements for a 6-month period for Omni-Rx Health Systems. These were reasonably detailed, although incomplete. That is to say, they did not cover the entire ancillary service area and did not cover all of the ancillary services.

Mr. Moss. I think it might be well to suspend briefly until the material is brought down from upstairs. We will just suspend until the material is here.

[Brief recess.]

Mr. Moss. The subcommittee will be in order.

We now have the figures, and for the benefit of the media, we will have copies of the figures very shortly. The Xerox is limited to the number of copies it can kick out at a time.

[The material referred to follows:]

Date: November 17, 1976.
Memorandum to: Staff of the Subcommittee on Oversight and Investigations.
From: E.J. Murphy.
Subject: Results of examination of Omni-Rx financial information.

In my analysis of the Omni-Rx data when the lack of sufficient detail made it necessary to assume something, the assumption was always made in favor of Omni-Rx. For example, in trying to determine whether certain reported costs were health-related or not, the assumption in cases of doubt was that the costs were health-related. Therefore, the results of the analysis may be considered to be conservative. I have documented in my workpapers all sources of numbers used and these can be reproduced if needed.

(1) I have identified how much of each dollar received by most of Omni-Rx Health Systems, Inc.'s ancillary service divisions is spent for health care, other

expenses, and pre-tax profit. The weighted average for those activities for which data was available was 29% for health care, 18% for other expenses, and 53% for profit. This suggests that the ancillary services divisions are overcharging all customers, including Medi-Cal. The criteria used to define health-related costs was the California regulations under the Knox-Keene Act.

(2) Omni-Rx Health Care, Inc. has exceeded the 25% of revenue threshold for administrative costs for fiscal years 1974, 1975, and 1976. This fact is not apparent by examining the financial statement; it was discovered by comparing two different presentations of the same basic data. Some administrative costs were buried in health care costs. Due to the lack of detail in the financial records, I cannot be certain that I found all the administrative costs but I am certain that everything identified as an administrative costs is in fact administrative as defined by California regulations.

(3) Comparing two presumably audited sources of information about fiscal year 1975 for Omni-Rx Health Systems, Inc., one source reports both revenues and expenses higher (by $999,296) than the other source. I can find no explanation for this in the records I had access to. The most usual reason is the exclusion of one or more revenue producing activities but that brings up additional questions. Why the exclusion in the first place? How could it possibly happen that whatever was left out had revenues and expenses exactly equal? Why no explanation of the difference in at least one source?

HOW EACH MEDICAL CARE DOLLAR IS SPENT IN OMNI-Rx HEALTH SYSTEM'S ANCILLARY SERVICE DIVISIONS

For each $1 received by—	Amount in cents		
	Health-related expenses	Other expenses	Net profit (before taxes)
Neurodiagnostic [1] testing service	7.8	14.6	77.6
El Segundo lab No. 1 [2]	15.7	26.3	58.0
Cardiopulmonary [3] function testing service	16.5	1.3	82.2
National X-ray No. 2 [4] (Av-El Med)	11.1	29.5	59.4
Regency Pharmacy (No. 1—IWMG) [5] (No. 2—Av-El Med) [6]	59.5	6.3	34.2
Weighted average	29.2	17.7	53.1

[1] Omni-Rx health systems income statement for the 6 mo ended Dec. 31, 1975, p. 13.
[2] Ibid., p. 25.
[3] Ibid., p. 22.
[4] Ibid., p. 29.
[5] Ibid., p. 16.
[6] Ibid., p. 18.

Mr. Moss. Mr. Segal.

Mr. SEGEL. Just to repeat the question, Mr. Murphy. Attached is a chart that answers the point raised earlier about the net profit before taxes for Omni-Rx Health Systems ancillary services. Could you identify the manner in which this chart was completed?

Mr. MURPHY. Yes, sir. I began my analysis by looking at a consolidated income statement for the 6 months ended December 31, 1975. This was for Omni-Rx Health Systems. There were supporting schedules, income and expense statements, for several of the entities but not all of the entities in the Ancillary Health Services Division. All that I had were included on the table. None that I had were omitted, but some were omitted from the material supplied to me by the subcommittee staff.

What I did was simply break out on a percentage basis or, as I put it on this table, for each $1 received by a certain division, so much was spent for health-related expenses, so much for other expenses, and so much for net profit. The net profit figure came from the supporting schedules attached to the consolidated income statement for that 6-month period. I checked the figures on the supporting schedules back

to the consolidated statement, and to the extent that I had supporting schedules they did, in fact, check back in precise dollar amounts.

Mr. SEGEL. And these consolidated income statements were put together by Omni-Rx Health Systems as exhibits that they submitted to the State Health Department?

Mr. MURPHY. That is very likely. All I know for certain is that the subcommittee staff furnished me with certain financial data and asked me to analyze it.

Mr. SEGEL. I think it is appropriate to state for the record that the materials that we presented to Mr. Murphy, the ones he alluded to here, the health systems consolidated income statement, this was presented to the subcommittee by Dr. Lackner, director of the State Health Department. That was the source of these consolidated income statements.

Mr. Moss. The record will so reflect.

Mr. SEGEL. Mr. Murphy, for the record, could you indicate your position at GAO and your qualifications? Is it true that you've been an auditor concerned with evaluating health care plans for the last 3 years in a variety of capacities?

Mr. MURPHY. That is correct, sir.

Mr. SEGEL. Could you identify who, and when you did these evaluations? Was it for GAO?

Mr. MURPHY. Not entirely. My initial experience in this area came immediately after I got a master's degree in economics. I went to the cost-of-living council and there, for a period in excess of a year, I evaluated requests for exceptions to the wage and price guidelines for institutional health providers. That's what we called hospitals and nursing homes.

What we were asked to do in the council was to evaluate whether or not the economic stabilization program was causing either hardship or inequity or both to providers. This required us to get quite deeply into health care provider accounting. Even though my academic training did not consist of a degree in accounting, I rapidly learned a very great deal about health care accounting.

After I left the cost-of-living council I went with the General Accounting Office, and for a period somewhat in excess of a year I evaluated health programs on the Federal budget level. Then, approximately the first of this year, I moved to an audit site where I am auditing certain aspects of the medicaid program.

Mr. SEGAL. What is your title?

Mr. MURPHY. Auditor economist.

Mr. SEGAL. Thank you.

Mr. Moss. Are there any further questions of this witness?

Mr. SCHEUER. Mr. Murphy, you see the problem that we are faced with. On the right hand, near the right-hand column are the net profit before taxes. We are rather open-minded on this subject of for-profit entities providing health services and participating in the delivery of health services. It has been our experience that it is extremely difficult to get health services delivered in the ghettos and in the rural areas, and maybe you do have to have a significant financial incentive, but somehow or other there ought to be some kind of rule of reason. Do you know of any criteria or any normal range of what seems to be an acceptable, permissible range of profit for these various functions?

Mr. MURPHY. I'm aware of no such criteria.

Mr. SCHEUER. Well, don't you think that somehow or other HEW ought to begin to get a handle on these problems? I mean, most businesses, if they make anywhere from 2 to 10 percent of gross sales, they are doing awfully well, super market businesses, maybe a fraction of 1 percent. I don't know what the figure is for health services, but I'm sure it isn't over half the dollars that the Government spends. What kind of advice would you give us on where we ought to look to have these standards developed? The second thing would be, how do we get some kind of a computer monitoring service, either at the Federal level or perhaps better yet the State level, that could monitor on a monthly or quarterly basis all of the providers, both as to their administrative costs, their overhead, their profit before taxes, and also as to whether they were providing the services they contracted to provide.

Now, we heard this morning in connection with this Omi-Rx Group that 40 percent of the children didn't get the vaccinations they were supposed to get for polio, diphtheria, and the rest; 27 percent of the sample of these children received no immunizations at all. There are about 3,500 children who had never been seen by Omni-Rx although they contracted to provide total care for kids, and apparently for thousands of them there aren't even patient records. Now, couldn't a computer tracking system be devised that would check out whether enrollees have received their requisite health services? If they didn't there would be a red flag signal. Certainly if patients' records weren't there for patients that they were being paid to serve, there would be a red flag signal. If their overhead costs or other expenses or profits before taxes went way out of line, again, there would be a red flag signal. Don't you think that the Congress and the American people are entitled to such ongoing scrutiny? How do you think we should make sure that it is devised?

Mr. MURPHY. Well, first of all, I might mention what the staff is aware of, and that is that I came out, not to speak on policy issues as a spokesman for the General Accounting Office, but rather to provide such technical help in the accounting area, auditing areas, as I might.

But I don't believe, personally, that it is beyond the state of the art to make such computer auditing, if you want to call it that, such as you mentioned.

Mr. SCHEUER. Now, if it isn't beyond the state of the art, could the General Accounting Office help us design such a system? Where would we go for that expertise?

Mr. MURPHY. Well, I think the automatic data processing people in the General Accounting Office would be one excellent source.

Mr. SCHEUER. For example, last summer we had a long investigation in hearings on the administration of the Export Administration Act by the Department of Commerce. When we got their figures and their reports from the thousands of companies that had filed, we asked the General Accounting Office to come in and help us examine them, and they gave us some very sophisticated and very helpful analyses of the reporting system, and they were very critical of the reporting system that the Commerce Department had established. They felt that the report forms themselves were almost designed to produce ineffectual information, and that the systems for information storage, information retrieval, were poorly designed, so that there was almost no

way under the system of the design of the forms themselves and the computer system for storing and retrieving the information on the forms that the Commerce Department really could get a handle on who was reporting and who wasn't reporting and to the degree to which the reporting was inadequate. The General Accounting Office gave us what I consider a very workmanlike and professional analysis of the whole reporting and computer setup.

Wouldn't you agree with that, Mr. Chairman?

Mr. Moss. Indeed, I would.

Mr. SCHEUER. We were very grateful for that and we are going to take effective action as a result of that.

Now, couldn't the General Accounting Office do the same kind of thing here, look at the problem, the almost total absence of monitoring, not only of fraud but of general waste, of exorbitant profits, of people not being served?

It seems to me that particularly when you are talking about children from birth to 5, and you know they're going to set certain specific inoculations at certain age points, that this would be particularly susceptible to tracking by a computer. Do you think we could request the General Accounting Office to give us a comprehensive survey of the systems by which HEW is currently monitoring both the services and costs of medicaid, and come up with the same kind of creative analysis they did for us last year?

Mr. MURPHY. Well, we have ongoing a number of inquiries in the medicaid program. One of them is looking into what is known as the medicaid management information system.

There is one problem, a rather serious problem, and that is with medicaid. Medicaid is a State program and the program is different from one State to another. This was done for very good reasons by the Congress when the medicaid program was established. It does give auditors some problems, but then we are looking at just one portion of the problem you mentioned. Our convenience is one thing and the intent of Congress may well be something else.

Mr. SCHEUER. Well, Mr. Murphy, I sympathize with what you're saying, and I sympathize with your bona fides, but the business of cost in the medicaid program has turned out to be a monster, and it could poison the whole principle of government as a major deliverer of health services. It has gotten totally out of control. The ripoff, the fraud, and abuses are endangering the system. Before we can even dream of going ahead to a comprehensive national health plan of any kind we've got to get a handle on costs in the two elements that we have in place, medicare for the elderly and medicaid for the poor. So whereas Congress might have had different priorities a decade ago when it passed the medicare and medicaid program, I think we have come to the sad realization that if we don't get a handle on costs, if we don't bring the program under rational control, if we don't have some way of monitoring the flow of funds, the vast flow of funds, for efficiency and for productivity and for cost effectiveness, the public is going to rebel and we're going to rebel.

Mr. MURPHY. Personnally I couldn't agree with you more.

Mr. SCHEUER. So I think the question of cost is really on the front bumper, really our primary concern. If need be, I believe that Congress would be at the point of willingness to make changes in the

legislative structure of the program if that were necessary to get a handle on costs. I don't know where to head at this point.

Mr. Moss. Would you like to have the Chair prepare a letter to the Comptroller General transmitting the transplant of discussion just concluded and ask would the Comptroller General recommend to the committee suggestions you made on the record?

Mr. SCHEUER. I would be very grateful for that.

Mr. Moss. Without objection, the record will be held to receive such a letter and the staff is instructed to prepare that letter.

Mr. SCHEUER. I want to thank the witness for his very thoughtful testimony.

Mr. Moss. Are there any further questions?

We thank you, Mr. Murphy, for your appearance. You are excused.

[The following letter was subsequently received for the record:]

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., December 17, 1976.

HON. ELMER STAATS,
Comptroller General, General Accounting Office, Washington, D.C.

DEAR MR. STAATS: The Subcommittee on Oversight and investigations held a hearing concerning prepaid health plans on November 22, 1976, at which Mr. Edward Murphy, auditor economist for the General Accounting Office, testified. In the course of his testimony, Congressman Scheuer discussed with him the various methods by which the Department of Health, Education, and Welfare monitors Medicaid fraud and abuse, along with suggested alternatives.

In order to follow up on this discussion, the Subcommittee requests that the General Accounting Office study and make recommendations on the methods of monitoring Medicaid fraud and abuse in the Department of Health, Education, and Welfare.

Sincerely,

JOHN E. MOSS,
Chairman, Subcommittee on Oversight and Investigations.

Mr. Moss. Will counsel be testifying?

Mr. RESNIK. I don't intend at this time to testify, unless there possibly may be some information which the committee desires that I may be able to provide.

[At this time Mark A. Resnik and Dr. Edward Dickstein were duly sworn.]

Mr. Moss. Will you identify yourself for the hearing record?

TESTIMONY OF DR. EDWARD DICKSTEIN, PRESIDENT, OMNI-RX HEALTH CARE, AND CHAIRMAN, BOARD OF DIRECTORS, OMNI-RX HEALTH SYSTEMS, ACCOMPANIED BY MARK A. RESNIK, COUNSEL

Dr. DICKSTEIN. I am Edward Dickstein, D-i-c-k-s-t-e-i-n.

Since there seems to be some confusion on the committee, I would indicate I hold two positions. Omni-Rx Health Systems, I am chairman of the board and president and Omni-Rx Health Care, I am secretary of the corporation.

Mr. Moss. Do you have a statement?

Dr. DICKSTEIN. None that I have prepared. I will indicate that we have had short notice for this, without very much indication of what information the committee might desire to hear. I will try to answer those questions as best I can. But I would indicate there are some

areas in which my expertise is not great and in which I may wish to submit clarification if the committee will allow me to.

Mr. Moss. Because of the fact that twice today we have had a question of adequacy of notice, the committee has, in keeping with the rules of Congress, extended in the case of each witness the same notice as all others. We, in other words, have the rule requiring a specific number of days, and that rule has been complied with. Congress has not always gone beyond that rule in acquainting witnesses. We expect that they may be able to prepare within the period of time, which is relatively reasonable.

In connection with that, I now have had sent from Washington, D.C., a copy of a letter which was sent to the attorney general of the State of California and a copy of that will be delivered to the clerk to be incorporated into the hearing record to inform that the recommendation was made, the administration of, the degree of detail that the committee acquainted the attorney general with. It is correspondence of the preceding telephone discussion, followed by a confirming letter.

[The letter to Hon. Evelle J. Younger, California Attorney General, is to be found on p. 97, this hearing.]

Mr. Moss. Mr. Segal.

Mr. Segal. Dr. Dickstein, you were given a copy of the backup sheets that Mr. Murphy used in putting together his profit statement for the ancillary divisions of Omni-Rx; is that correct?

Dr. Dickstein. Yes.

Mr. Segal. Would you verify for the committee that those backup statements identified as Omni-Rx Health Systems consolidated income statement for the 6 months ended December 31, 1975, are statements that were prepared by Omni-Rx and sent to the State Health Department?

Dr. Dickstein. I have not seen these. I am not the accountant for the corporation. They are labeled Omni-Rx Health Systems. At the bottom it says "For internal use only," so I do not believe that these would have been delivered to the health department.

Mr. Segal. You believe that they were not delivered to the health department?

Dr. Dickstein. They would not normally be delivered to the health department; no.

Mr. Segal. Would they normally have been asked for in an audit that the health department might have made of Omni-Rx, therefore copied in that context?

Dr. Dickstein. No; not to my knowledge. These are statements of Omni-Rx Health Systems, which has nothing to do with the health department. The health department contracts are with Omni-Rx HealthCare and normally would ask for statements relative to that portion.

Mr. Segal. We have two questions. The first question is whether or not these are accurate reflections of the five ancillary service divisions of Omni-Rx? We would like to have an answer from you as to whether or not that accurately reflects these five ancillary divisions.

Dr. Dickstein. This would relate to it. It would be the initial computer runs. This would be a sort of trial balance. This would not be the final statement. This would be an operating statement from which

final statements would be approved after adjustments were made. These are working papers.

Mr. SEGAL. Would you provide the final copies to the State Health Department?

Dr. DICKSTEIN. The final copies would have been used in the audit of Omni-Rx Health Systems, and it would have prepared its quarterly statements or annual statements by the certified auditors. I don't think we would have provided these to the health department.

Mr. Moss. I think the important question here is whether or not you accept these as being what counsel has represented them to be, or do you challenge them?

Dr. DICKSTEIN. I am indicating what these are or appear to be since I have not seen them. They appear to be initial trial balances of raw material put out by the computer at the end of that period.

Mr. Moss. Do you have final balance statements for this period?

Dr. DICKSTEIN. I don't have them with me.

Mr. Moss. If you have them and they are different than this, would you supply them for the record at this point, not in time but in this record. We would give you adequate time to supply them.

Dr. DICKSTEIN. Yes, if we have them, we certainly shall.

[This material may be found on p. 147.]

Mr. Moss. We would assume that you would have, would you not, in the usual routine of business, you would have not a preliminary statement you worked with but a finalized statement?

Dr. DICKSTEIN. We do not prepare our statements for publication in this form, to my knowledge, and I don't know exactly how these come out in the end. Our complete statement as to the profitability of Omni-Rx health systems, the financial position of Omni-Rx Health Care, Inc., I think there is a separate notation as to the ancillary income, and I think these would be used in the preparation of that portion of the final statement, but I don't think that they would be listed necessarily in the from that they are computed out here in the raw form.

Mr. Moss. This would be essential for the preparation of any final consolidated balance.

Dr. DICKSTEIN. My feeling is it is a trial balance of some sort.

Mr. Moss. A trial balance is relatively close to a final balance, is it not?

Dr. DICKSTEIN. It may or may not be, depending on what adjustments are made.

Mr. Moss. If accepted or acceptable standards of accounting were employed, it would be very close?

Dr. DICKSTEIN. You are out of my area of expertise.

Mr. Moss. Could it be a matter of condition where with reasonable diligence that there would be any great departure in the final document from that of the preliminary?

Dr. DICKSTEIN. I can see where a large piece of income or an expense might not have been properly entered or might be somebody might make an adjustment and try to put it back into this period. I've seen things like this occur. So on one of these statements, say, the sum of $999.000 was questioned, that, in fact, is an income expense transfer that was made this year and the auditors, I believe, mentioned it in the report. It sticks in my head the figure of $999,000 which was picked up

here, so I mean that's a very sizable kind of adjustment. So the answer is "Yes." I can imagine it.

Mr. Moss. To take it from one account to another, one category to another, wouldn't totally obliterate it?

Dr. DICKSTEIN. I think in this instance it changed the total sales of one portion of the company as opposed to another. It did not change——

Mr. Moss. You say usually one adjustment affects another?

Dr. DICKSTEIN. Yes.

Mr. Moss. All right, proceed.

Mr. SEGAL. To change the subject for a moment, I would like to, Mr. Chairman, ask permission to insert in the record at this point a letter that is dated October 28, 1976, from the Los Angeles County Department of Health Service, which concerns nonpayment to L.A. County hospitals for emergency care that was given to enrollees of Omni-Rx health plan.

Mr. Moss. Is there any objection to the request?

Hearing none, the request will be granted.

[The letter referred to follows:]

COUNTY OF LOS ANGELES,
DEPARTMENT OF HEALTH SERVICE,
Los Angeles, Calif., October 28, 1976.

Hon. JOHN E. MOSS,
Chairman, Subcommittee on Oversights and Investments, Committee on Interstate and Foreign Commerce, Washington, D.C.
(Attention: Mr. Lester Brown).

DEAR MR. CHAIRMAN: This letter is in response to your request for information regarding specific instances of non-payment to Los Angeles County hospitals for emergency care provided to enrollees of Omni-Rx Health Plan. Attached are several grams sent to me by our Department of Collections providing summary information on cases which our physicians have deemed emergent. The information is quite sketchy because it was drawn from the billing files. Since file space is limited we do not maintain copies of all medical information which accompanies claims to Prepaid Health Plans. Should you require more detailed information we can obtain it from the medical charts at the hospitals. However, we would need a week or two to locate, review, and summarize the charts.

One of the grams attached is for non-emergency care. This case was referred to us by Omni-Rx. The Prepaid Health Plan has denied payment on the basis of a bill which did not include a copy of the referral letter. We are now resubmitting the claim with a copy of the referal. However, this is largely a formality; we are not anticipating payment.

I have also enclosed a copy of recent Prepaid Health Plan regulations[1] which the State Department of Health has proposed to adopt. You can see by comparing the proposed regulations with the existing regulations that the Department of Health has not proposed major regulatory changes in response to the problems addressed in the Los Angeles County issue paper. That paper was in their possession during the drafting of the regulations.

Nevertheless, the Department of Health has been working with us in other ways to the limit of what they perceive to be their legislative authority. This is particularly true with regard to the issue of unpaid emergency claims. To resolve this problem the State is attempting to provide physicians to arbitrate disputed claims. The snag is that the State has no budget allocations for this function and apparently no ability to withhold capitation from Plans which refuse to pay. Los Angeles County is now drafting legislation which would expand the authority of the Department of Health. No commitment to support such legislation has been received from the State administration.

I hope this information will be helpful in your hearings. If I can be of any further assistance in the investigations of the Subcommittee, please let me know.

Very truly yours,

JOHN MANTLE,
Legislation and Government Programs.

Attachments.

[1] EDITOR'S NOTE.—Not printed.

[Los Angeles County Lettergram, Oct. 26, 1976]

Doc. No. 1598423

15-year-old—Male—Negro.
Admitted : May 19, 1973.
Discharged : June 18, 1973.
Amount of bill : $6,225.00.
Hospital : Harbor General Hospital.
Admission authorized by : Barbara Wright, telephone 649–2562.
Diagnosis : Gunshot wound to the head.
Payments : None.
Hospital care : All emergency per medical review.

NOTE.—Patient originally given emergency treatment at Martin Luther King and immediately transferred to Harbor General.

Doc. No. 1644397

14-year-old—Male—Mexican American.
Admitted : October 21, 1973.
Discharged : October 27, 1973.
Amount of bill : $1,244.00.
Hospital : Martin Luther King.
Admission authorized by : Ms. Coutee, telephone 757–9357.
Diagnosis : Gunshot wound to the head.
Payments : None.

NOTE.—2 days emergency care, patient could have been transferred on Oct. 23, 1973.

Doc. No. 1605301

19-year-old—Female—Negro.
Admitted : February 5, 1974.
Discharged : February 11, 1974.
Amount of bill : $1,104.00.
Hospital : LAC/USC Medical Center.
Admission authorized by : Ms .Degasparin, telephone 676–1135.
Diagnosis : Pulmonary Embolus, Left.
Payments : None.

NOTE.—Patient ready for transfer Feb. 8, 1974 but held to Feb. 11, 1974 at specific request of Dr. Scott, codirector of Omni-Rx Hospital Care.

Doc. No. 1632191

17-year-old—Female—Negro.
Admitted : September 9, 1974.
Discharged : September 11, 1974.
Amount of bill : $542.00.
Hospital : LAC/USC Medical Center.
Diagnosis : Intrauterine pregnancy.
Payments : None.
Hospital care : Emergency.

NOTE.—Spontaneous delivery. Newborn infant delivered in hospital parking lot.

Doc. No. 1587229

17-year-old—Male—Negro.
Admitted : July 29, 1973.
Discharged : July 31, 1973.
Amount of bill : $432.00.
Hospital : LAC/USC Medical Center.
Admission authorized by : Barbara Wright, telephone 776–8066.

Diagnosis : Gunshot wound to neck.
Omni-Rx : Paid $216.00.
Admission & stay : All emergency care.
Balance due : $216.00.

Doc. No. 1634242

44-year-old—Female—Negro.
Admission : March 21, 1974.
Discharged : March 25 ,1974.
Amount of bill : $772.00.
Hospital : Martin Luther King.
Admission authorized by : Mrs. Tunstell, telephone 757–9352.
Diagnosis : Congestive heart failure.
Payments : None.
Hospital care : All emergency per medical review.

Doc. No. 1635543

27-year-old—Female—Negro.
Admitted : May 3, 1974.
Discharged : May 11, 1974.
Amount of bill : $2,052.00.
Hospital : Martin Luther King.
Admission authorized by : None.
Diagnosis : (1) Blunt abdominal trauma ; (2) Repair of ruptured ligament of the liver.
Payments : None.
Hospital care : All emergency care per medical review.

Doc. No. 1689314

49-year-old—Female—Negro.
Admitted : February 7, 1976.
Discharged : March 24, 1976.
Amount of bill : $9,320.00.
Hospital : Rancho Los Amigos.
Authorized by : See attached letter.
Diagnosis : Multiple Scoliosis.
Payments : None.

Doc. No. 1634206

22-year-old—Female—Negro.
Admitted : June 23, 1974.
Discharged : June 29, 1974.
Amount of bill : $1,524.00.
Hospital : Martin Luther King.
Admission authorized by : Avel Medical Group, telephone 777–8385.
Diagnosis : Stab wound of the chest with tension pneumothorax.
Payments : None.
Hospital care : All emergency per medical review.

Doc. No. 1635505

One-year-old—Female—Negro.
Admitted : August 3, 1974.
Discharged : August 22, 1974.
Amount of bill : $4,161.00.
Hospital : Martin Luther King.
Admission authorized by : Mrs. Degasparin.
Diagnosis : Second-degree burns of the chest and right arm.
Payments : None.

NOTE.—Per medical review, patient could have been transferred Aug. 9, 1974. Mrs. Degasparin claims Omni-Rx having problems transferring patient because of possible child abuse.

Doc. No. 1651664

15-year-old—Male—Negro.
Admitted: July 6, 1974.
Discharged: July 7, 1974.
Amount of bill: $219.00.
Hospital: Martin Luther King.
Admission authorized by: Barbara Rogul, telephone 676–1135.
Diagnosis: Gun shot wound to right hip.
Payments: None.
Hospital care: All emergency care per medical review.

Doc. No. 1634804

31–year-old—Female—Negro.
Admitted: June 23, 1974.
Discharged: July 31, 1974.
Amount of bill: $11,652.00.
Hospital: Martin Luther King.
Admission authorized by: Mrs. Degasparin, telephone 676–1135.
Diagnosis: Multiple fractures 2nd to auto accident.
Payments: None.
Hospital care: All emergency care per medical review.

MANHATTAN MEDICAL GROUP,
Gardena, Calif., July 24, 1975.

HARRY FONG, M.D.,
Rancho Los Amigos Hospital,
Downey, Calif.

DEAR DR. FONG: I have contacted the Rancho Los Amigos Hospital in reference to a patient that has been treated at the Manhattan Medical Group. I was instructed to send a resume of the patient's problem to your attention.

The patient was initially seen at this clinic early this year. On the initial visit she was having some problem with an ear infection. She indicated to us at that time that she was under the care of a neurologist for a growth on the spinal column for several years. She described a gradually advancing paresis of the lower extremities. The patient has been evaluated at the White Memorial Clinic approximately two (2) to three (3) years ago.

She was treated as this office mainly for recurring complaints of discomfort in the lower extremities and episodic illnesses such as U.R.I.s., sore throats, abdominal pain and urinary tract infections.

Just recently she was complaining of episodes of falling and difficulty in driving her car.

A recent examination indicates what appears to be increased weakness of the lower extremities. Her diagnosis and treatment is beyond the scope of this office at this time and it was suggested to the patient that she might seek evaluation and possible treatment at your facility.

Enclosed are copies of the patient's past medical records forwarded to us from the White Memorial Hospital and Clinic.

If possible, could you have your secretary contact this office or the patient for an appointment if you feel you can be of some assistance to ——— ———.

Sincerely,

PAUL COHEN, M.D.

Chief complaint: Weakness of both lower extremities times five or six years.

History of present illness: Patient is a 45-year-old Negro female who has a five to six year history of progressive paresis which began initially in the left lower extremity with the onset of shooting pains which decreased to be followed by weakness and then the pains began in the right lower extremity, shooting character, followed by weakness of the right lower extremity. At the present time, patient denies pain in the left lower extremity. However, the left lower extremity is weaker than the right. There is hypasthesia below the costal margin. Patient has difficulty in voiding but denies constipation. She states that she has seen numerous physicians but has never yet received a satisfactory explanation for her difficulty. Patient has a past history of venereal disease, but recent VDRL is negative. Patient denies headache, diplopia, seizures, difficulty talking or hearing. She denies allergies.

Surgery: Hystorectomy in 1948 for tubal pregnancy. Patient denies diabetes mollitue tuberculosic, cardiac or renal disease.

Physical examination: Vital signs: Blood pressure 90/60. Pulse 96 and regular. Temperature 98.6. Respirations 20. The patient's weight at the present time is 98 pounds. She stated that at one time she weighed 197 pounds. Height five feet 6½ inches.

Patient appears to be her stated age. However, she appears poorly nourished, adequately hydrated.

Examination of the head is negative.

Eyes: Pupils are equal. They are round and react to light and accommodation. Extraocular muscles intact. Visual fields are intact to confrontation.

Ears: Negative.

Nose and throat: Negative.

Trachea is in the midline.

Chest: Symmetrical.

Lungs: Clear to percussion and auscultation.

Heart: Has a regular sinus rhythm. There is no murmer.

Abdomen: Has striae but is flat, soft, nontender, no palpable organs or masses.

Examination of the extremities: There is atrophy of disuse in both lower extremities, left greater than the right. The hands appear normal, although the patient is very thin. There is no pedal edema.

Neurological examination: Sencorium: Patient is awake, alert, oriented, times four. The patient exhibits a glib and at times histronic behavior.

Cranial nerves II intact. III IV and VI extraocular muscles are intact. V: Motor and soncory intact. VII: There is no facial palsy. Hearing grossly intact on testing VIII, IX, X, Xi, and XII grossly intact.

Motor examination: There is severe atrophy of disuse in both lower extremities, left greater than the right. There is moderate to servere paresis of the left lower extremity and moderate paresis of the right lower extremity. It appears to be in all muscle groups. No fasciculations were noted.

Cerebellar examination: Of the upper extremity there was no dysmetria, or disdiadochokinesis. Because of the paresis the lower extremities could not be examined. Gait was not examined. Romberg sign could not be examined. Vibratory sense seemed to be intact.

Sensory examination: There is decreased pin prick sensation below the level of the costal margin. Pain and temperature, however, are intact but seem to be more acute in the upper half of the body than the lower. Position sense is intact.

Deep tendon reflexes three plus in the lower extremities but equal bilaterally, two plus in the upper extremity to three plus in the upper extremities. The too signs are moot but appear to be upgoing.

Summary impression: Cord degeneraton with a sensory level about T7 tertiary aiphil, multiple sclerosis, Vitamin deficiencies as well as cord tumor must be considered.

PATRICK J. WADE, M.D.
Resident Neurosurgery.
JOHN J. HOLLY, M.D.
Attending Physician.

Mr. SEGAL. Attached to that letter, Dr. Dickstein, is a chart that indicates that overall there is an outstanding balance of approximately $2.8 million for prepaid health plans for Los Angeles County hospitals. Included within that is $176,407 from Omni-Rx Health Care, Inc. Why did you not pay the county this money?

Dr. DICKSTEIN. Because we don't owe it to the county. The money that is due—our contract covers emergency services which are given to people outside of our system. The accounts from the county hospital have been reviewed. They are not, in fact, emergencies. A great deal of elective treatment, people came in, should have been referred to the system. The county has made no effort to identify these individuals.

Mr. SEGAL. You claim that these are elective procedures. Could I read a couple of them to you and see if you feel that these are elective? If you look on page 3—I would like to give you the opportunity to read along. There is a lettergram. It was sent in October 1976. It is a

case that begins October 21, 1973; 14-year-old male; Mexican-American; admission authorized by diagnosis; gunshot wound to the head; 2-day emergency care; patient could have been transferred on October 23.

The next one is a 15-year-old male, Negro, May 19, 1973, gunshot wound to the head. Patient originally given emergency treatment at Martin Luther King; immediately transferred to Harbor General.

Next page. Pulmonary embolism left patient ready to transfer February 8, 1974, but held to February 11, 1974; specific request of Dr. Scott, codirector of Omni-Rx Hospital Care.

Next one. Congestive heart failure.

Are these not emergencies, Dr. Dickstein?

Dr. DICKSTEIN. Well, let me say that some money has been paid. We have adjudicated some of these where some emergencies existed.

Mr. SEGAL. That was $2,000 out of $178,000, correct?

Dr. DICKSTEIN. I don't know what the amount was, but the entire matter is under court review at the present time, and the health plans as a whole of the county have decided to hold up payment pending whatever adjudicating of this entire plan. The county of Los Angeles, they have not, in fact, proceeded with that lawsuit.

Mr. SEGAL. Do you believe these are not emergencies, gunshot wound to the head, pulmonary embolus, instant heart failure? There was one instance where there was a new born infant delivered in a hospital parking lot. Should they have waited until Monday morning for the clinic to open, Dr. Dickstein?

Dr. DICKSTEIN. Well, I think you are being a little bit emotional. We are reviewing here what are summaries of——

Mr. MOSS. The Chair wants to admonish the witness that at all times here he will respond to the question and not characterize in any way the comments of the members or of the staff.

Dr. DICKSTEIN. We were reviewing summaries of the charts. I would need the records here to see what the actual facts were. In a number of instances where I've reviewed charts where diagnoses like these occurred, these were not, in fact, the medical facts which had occurred.

Mr. SEGAL. Mr. Chairman, might I request that we ask that Dr. Marvin Gasster, who does have the medical charts and is here available today, to step forward and describe a few of these cases in a little more detail?

Mr. MOSS. Yes.

Dr. Gasster, would you come forward.

[At this time Dr. Marvin Gasster was duly sworn.]

Mr. MOSS. Would you identify yourself for the hearing record?

TESTIMONY OF DR. MARVIN GASSTER, PHYSICIAN, HARBOR GENERAL HOSPITAL, COUNTY OF LOS ANGELES, ACCOMPANIED BY DR. MARVIN L. ROZOFSKY, PHYSICIAN, HARBOR GENERAL HOSPITAL, COUNTY OF LOS ANGELES, AND FURTHER TESTIMONY OF DR. EDWARD DICKSTEIN, ACCOMPANIED BY MARK A. RESNIK

Dr. GASSTER. My name is Marvin Gasster, physician, county of Los Angeles.

Mr. Chairman, I wonder if I could have one of my associates be sworn in.

Mr. Moss. Indeed, you may.

[At this time Dr. Marvin L. Rozofsky was duly sworn.]

Mr. Moss. Will you identify yourself for the hearing record, please?

Dr. Rozofsky. I am Marvin L. Rozofsky. I am also associated with Harbor General Hospital. I am the hospital liaison with the PHP's. I'm a medical consultant, and a host of other things.

These charts were given to us for review by the Los Angeles County Health Services Administration.

Mr. Moss. OK. You may be seated.

Mr. Segal. Dr. Gasster, could you, for the record, identify your qualifications? Are you associated with any medical school, have you had previous experience in utilization review that would have involved any medical records? Are you a board certified physician?

Dr. Gasster. I am associated with the University of California at Los Angeles. I am an associate professor of medicine, certified in internal medicine by the American Board of Internal Medicine. I am a diplomat of the National Board of Medical Examiners. I have been chairman of the Medical Records and Utilization Committee at Harbor General Hospital for almost 9 years. I had been in private practice, and had been chairman of the Medical Records and Utilization Committee of the Harvard Community Hospital. I am, on an ongoing basis, continually reviewing charts for utilization, along with Dr. Rozofsky.

Mr. Segal. Have you had an opportunity to look at some of the patients' records that were listed as emergency by Los Angeles County and deemed by Omni-Rx to be nonemergent?

Dr. Gasster. Yes, sir, I have. I have some of the charts here.

Mr. Segal. Could you describe a few of them?

Dr. Gasster. Surely. This (indicating) is a case of a 27-year-old woman who was involved in an automobile accident. She was brought to the Martin Luther King Hospital. Because of a sudden drop in vital signs and hematocrit was transferred to Harbor General Hospital. At that time Martin Luther King Hospital was not prepared to give emergency care. Examination at the hospital revealed blood in the abdomen. The patient had emergency surgery, and was found to have an avulsion laceration of the liver. She was admitted on May 3, 1974. She was discharged May 10, 1974. Final diagnosis was abdominal trauma ruptured liver. The liver was bleeding. The Los Angeles County's Bureau of Resources and Collections billed Omni-Rx for these services on July 5, 1974, there was no response from Omni-Rx.

Mr. Segal. Dr. Dickstein, did you review or do you know of anybody in Omni-Rx who reviewed this case who was a physician and indicated that this case was not an emergency service?

Dr. Dickstein. I'm not aware of that specific case. I would make one comment, though, which is that under our contract where third party liability exists the collection is supposed to come through the third party, who probably made request for payment through that source.

Mr. Segal. Dr. Gasster, would you indicate in your considered opinion whether or not this is an emergency?

Dr. Gasster. Absolutely.

Mr. Segal. Was there a review of this at the hospital that would also corroborate the fact that this was an emergency?

Dr. GASSTER. This particular chart was not reviewed at Harbor General Hospital. This chart was reviewed by me at the request of the Department of Health Services of Los Angeles County. The entire chart was reviewed, but because the charts did not belong to our hospital I could only bring the summary and some progress notes and Xerox copies, but the fact that the patient was found initially to have blood in the abdomen by needle tap and then explored, obviously it was an emergency.

There were three cases from Martin Luther King.

The second one was an automobile accident in which the patient sustained fractured right clavicle, commuted fracture of the distal radius and ulna—forearm bones—fractured plevis—I'll make some of these lay terms—midshaft fracture of the right femur, a compound fracture of the tibia and fibula, and was anemic.

Mr. SEGAL. Could you explain to the committee what a compound fracture of the tibia and fibula is? Are those broken bones?

Dr. GASSTER. When a bone is broken and penetrates through the skin it is considered a compound fracture; possibly infected wound.

Mr. SEGAL. Would you determine that to be an emergency, doctor?

Dr. GASSTER. Yes, sir. Multiple fractures in itself predisposes to many conditions, shock, et cetera. The Omni-Rx PHP was billed by the county December 5, 1974, for $11,652, with no response.

There is another case from the Martin Luther King Hospital, a 2-year-old child who had a 1-day history of fever, vomiting, which occurred during the day. The child became increasingly lethargic and unresponsive and was brought to the hospital. He was found to have meningitis.

Mr. SEGAL. Meningitis?

Dr. GASSTER. Yes, sir; bacterial meningitis.

Mr. SEGAL. Is there any question, do you think, by any group of physicians but that this would be an emergency case?

Dr. GASSTER. I do not believe so, sir.

This patient was admitted to Harbor Hospital, female pregnant, fourth pregnancy, and she was in the emergency room with bulging membranes, which indicated that she was about to deliver the baby. She was seen earlier that day, sent back home, came back with bulging membranes, contractions, and delivered shortly thereafter.

Mr. SEGAL. How much was the hospital expense on that?

Dr. GASSTER. I don't think we have the figures here. The PHP was contacted and there was no authorization given.

Mr. SEGAL. There would be no question, then, but that this was a medical emergency, is that correct?

Dr. GASSTER. Yes. I think the fact that she was having contractions and bulging membranes, which could have ruptured at any moment. When she becomes at greater risk, the baby is at greater risk. The fact that she delivered shortly thereafter confirmed that.

Mr. SEGAL. Could I ask you a question at this point, Dr. Gasster? If Omni-Rx does not pay for these, does that mean that, the equivalent is that, the taxpayers are having to pay double for the case, that there is prepayment made to Omni-Rx in order to cover emergency care but it is not given from that budget and the county of Los Angeles, therefore, has to provide that care out of its budget?

Dr. GASSTER. Every patient coming to the county of Los Angeles hospital system is billed, they have private insurance, they may have medicare, medi-cal or some aid program, but if they belong to a PHP, we can't disenroll them. We have to pay for it out of general funds.

Mr. SEGAL. How much does this amount to totally as far as you know?

Dr. GASSTER. To the best of my knowledge, speaking with one of the gentlemen in the Health Administration, outstanding bills of about $4 million at the present time.

Mr. SEGAL. $4 million for all PHP's in Los Angeles County?

Dr. GASSTER. Yes, sir.

Mr. SEGAL. This is care that should be reimbursed by prepaid plans but it nevertheless happens the county has to pay for it out of its own budget because it is not being reimbursed?

Dr. GASSTER. That is correct, sir.

Mr. SEGAL. How much is it for Omni-Rx?

Dr. GASSTER. I have the figures. You may have a copy.

Mr. SEGAL. We have in the record a letter that indicated as of June 1976 it was $176,407, and that Omni-Rx has agreed to pay $2,238 out of an overall total of $178,645.

Dr. GASSTER. Those are the same figures I have, sir. There are some more cases.

Mr. SEGAL. I think in the interest of time, if we might, we would just like to, without going through the rest of them, see if you have some general comments or conclusions. Do you have the feeling that these basically are emergency cases?

Dr. GASSTER. These charts were very carefully reviewed by both Dr. Rozofsky and myself, and there is no doubt in my mind, and I don't think that of any physician, after reviewing the charts, but that these were definite emergencies.

Mr. SEGAL. Is this a prevalent pattern that exists throughout all of the health plans or is this unique?

Dr. GASSTER. I really don't think I'm qualified to answer that question. I'm not that deeply involved in the administrative aspect. I review these charts at the request of the department. I have the same figures you have. Obviously, there is a large deficit—$4 million comes out of the taxpayers' pocket.

Mr. SEGAL. Dr. Rozofsky, have you had an opportunity to review a broader sample of charts that you come to any conclusions about these cases?

Dr. ROZOFSKY. Because of these hearings, I presume, and because of a great deal of pressure that's been brought to bear on PHP's the last year or so, and because since July I have been actively trying to get authorizations from PHP's, I would say that in the recent past, a period of 4 months, we have been able to get more authorizations, but that doesn't mean we get paid. In other words, of some 60 or so cases in the recent past, there has been not 1 payment made as yet, in other words, there are phone authorizations which we can't translate into cash.

Actually there was one case very recently that involved Omni-Rx. Since this is the subject today, we had an ileo-femoral thrombosis, a clotting in the thigh area, which was admitted on October 11, which was a holiday. I was aware of it on the 12th. We tried to get authori-

zation. We were told that the patient could have been transferred. I subsequently spoke to Dr. Scott and suggested to him that I had spoken to the resident and that the patient was an emergency, that the chief of our service, the chief of the surgical service, had stated that it would be unsafe to transfer the patient for 48 hours at least. That got us nowhere until I finally called back and suggested I was going to call the Health Services Administration and see if we could check with the State, and in about 30 minutes we got authorization on that case, but we still haven't been paid on it.

There is a tendency, I think, to feel that you just let the thing ride. All of these cases were emergencies. We had many, many. In fact, that's the nature of our hospital. In other words, we see, L.A. General sees, 1,000 people in the emergency room a day. We see 300. These people come to us so ill that frequently you are unable to obtain PHP information. They are either unconscious or they're in such state that you can't go into detail, do you belong to this or that. Many of them don't know. We have to take care of them right now, as I think that issue paper pointed out. This is what makes it difficult. We may not be able to even know for 3 days or a week as to whether they belong to any system. Nevertheless, I think by law the PHP is supposed to take care of them, reimburse us if it is an emergency, and these are bona fide emergencies.

Mr. SEGAL. You are prepared to say that these cases are bona fide emergencies?

Dr. ROZOFSKY. Yes. We have some cases where people have been admitted on an elective basis, but we just couldn't identify them in time. We have some cases which may not be emergencies, but as soon as we identify these, we inform the PHP and we try to effect the transfer. It is the case of our emergencies that provides the bulk of this outstanding debt.

Mr. MOSS. Did the committee have any questions of these two witnesses?

Mr. SCHEUER. I would like to hear Dr. Dickstein respond. Maybe he has some explanation for all of this.

Mr. RESNIK. I think at this time it would be appropriate for me to respond.

Mr. SCHEUER. Wait a minute.

Mr. MOSS. Let me again acquaint you and put before you the rule book of the House of Representatives. You are here as counsel to the doctor; you are privileged to advise him on any matter of a constitutional nature but you may not testify in his stead.

Mr. RESNIK. May we have a moment to counsel?

Mr. MOSS. Are you advising him on the matter of a constitutional question?

Mr. RESNIK. No, I am not at this point.

Mr. MOSS. Then we will assume that Dr. Dickstein can go ahead and respond.

Mr. WAXMAN. Mr. Chairman, I haven't looked at the rules, but I would hate to have a client denied the opportunity to talk to his lawyer even if it were beyond the scope of a constitutional question.

Mr. MOSS. If the gentleman from California desires that the counsel be permitted, the Chair will indulge him and permit that, but the rules are rather clear.

Mr. WAXMAN. It may well be so, but just my sense of fairness indicates to me as an attorney myself I would certainly want to be able to talk to my client. I think the client has the right to have his attorney present.

Mr. Moss. You may consult with your attorney.

Dr. DICKSTEIN. There are several points that I would like to cover in response to that for the committee's interest. First, there has been a large problem with the PHP's and the outside hospitals. There has been talk of perhaps some unfair practices, but the hospitals have tended to use the PHP patients for their own purposes and to admit them in an attempt to extract money for treatment that was not required. We have in our possession, in fact, an internal memo from the county hospital system indicating precisely that. The PHP papers should be admitted to the county hosptials. They should be used to practice on and they will attempt to get the payment later. In spite of that——

Mr. SCHEUER. Mr. Chairman, could we ask the witness to produce that memo?

Mr. Moss. Yes, indeed; I would expect that it will be reproduced for the record.

Dr. DICKSTEIN. I will make a note of that and you will have a copy.

Mr. Moss. The record will be held open at this point to receive it.

[The following memo was received for the record:]

DEPARTMENTAL POLICY FOR HANDLING OF PREPAID HEALTH PLAN ENROLLEES

The legal authority for billing Prepaid Health Plans comes from the Welfare and Institutions Code, Section 14305, which states:

"The prepaid health plan shall be liable for all in-area and out-of-area emergency services as defined by the director which are required by the contract and rendered by another provider. Payment for such services shall cover treatment of emergency conditions and management of the enrollee until such time as he may reasonably be transferred to the prepaid health plan."

It is further stated under Title 22, Section 51841:

"The (Prepaid Health Plan) contractor is responsible for payment for covered emergency services and related medical care rendered to an enrollee whether or not such services are provided at the contractor's facilities. The contractor is also responsible to arrange for the transfer of the enrollee's medical management to his own providers."

The Prepaid Health Plans are obligated to pay for emergency services provided to its enrollees by another provider. The Prepaid Health Plans will not assume responsibility for payment of costs for other services provided (elective services) unless prior authorization has been obtained.

Los Angeles County Administrative Code, Section 150.14, requires that County hospitals provide non-emergency services to persons who cannot themselves or otherwise arrange for health services through a private provider. Arrangements have been made for Prepaid Health Plan enrollees to receive necessary health care through their Prepaid Health Plan providers: therefore, the County is not required to care for persons enrolled in private Prepaid Health Plans. Further, we are unable to claim payment from the State under Medi-Cal as the Prepaid Health Plans are under contract with the State to provide, directly or indirectly, the full range of Medi-Cal benefits in return for prepayment from the State.

In order to effect more efficient control of necessary services being provided to Prepaid Health Plan members by County facilities, the following policy is being adopted:

1. Every effort will be made to identify Prepaid Health Plan members before treating them.

2. Where applicable, the Prepaid Health Plan shall be contacted and an attempt made to obtain prior authorization for treatment.

TREATMENT POLICY (INPATIENT)

A. *Emergency care.*—County facilities will provide necessary inpatient medical services to all Prepaid Health Plan enrollees who present themselves at our facilities requiring emergency care. An emergency is constituted under the following conditions:

1. Medical services are necessary to alleviate pain and suffering, arrest bleeding, or to preserve life until it is medically practical for the patient to be transferred to the facilities of the Prepaid Health Plan.
2. Immediate care is required in order to prevent the occurrence of serious or permanent disability.
3. Patient's medical condition requires immediate hospitalization.
4. The physician on duty considers it medically unsafe to transfer patient.

B. *Nonemergency care.*—Prepaid Health Plan patients, who in the opinion of the physician on duty, require medical care of a non-emergent nature, will be referred to the Prepaid Health Plan facility. Exceptions to this policy may be made at the discretion of the County physician, subject to authorization by the Medical Director, when the following conditions occur:

1. Patient requires medical care but refuses to go to the Prepaid Health Plan facility.
2. The patient's unique illness will provide an excellent training device.
3. Patient is involved in a specialized treatment protocol.
4. The nature of the patient's illness is such that could only be treated at a major medical facility.
5. Plan refers patients to the County facility along with written authorization for treatment.

Note: In all of the above instances (except Nos. 2 and 3), the Plan will be contacted and every effort shall be made to obtain appropriate authorizations for such treatment.

C. *No plan responsibility.*—Prepaid Health Plans are not required to furnish the following services:

1. Chronic hemodialysis.
2. Cosmetic surgery, not resulting from birth defects or accident.
3. Major organ transplants.
4. Long-term care in any Federal, State or County hospital for the purposes of treating mental illness, tuberculosis, alcoholism, or narcoticism.

The above services will be provided, and costs recovered from the State Department of Health.

Mental Health services provided, beyond those that the Prepaid Health Plans are required by their contract to provide, will continue to be processed through Short-Doyle/Medi-Cal.

D. *Transfer of patients to the prepaid health plan facility.*—Arrangements will be made through the Prepaid Health Plan for the transfer of patients to the Prepaid Health Plan facility in the following instances:

1. Inpatients whose emergency status has been stabilized and transfer can be safely made.
2. Outpatients who require immediate transfer from the emergency room.

The determination as to when a patient should be transferred will be made by the County physician on duty.

BILLING AND COLLECTION POLICY (INPATIENT)

Due to the nature of Prepaid Health Plan billing, (submission of billing for many patients to one source) all inpatient Prepaid Health Plan collections will be processed through our central collection agency, the Bureau of Resources and Collections (BRC). Handling of Prepaid Health Plan claims through a central agency will allow us to maintain, by Plan, better fiscal control and more accurate records, i.e., revenue; outstanding balances; denials; Prepaid Health Plan patient volume, etc.

Accordingly, the following procedure for processing inpatient Prepaid Health Plan bills is being adopted:

1. Hospitals will prepare Prepaid Health Plan bills as soon after discharge as feasibly possible, ideally within 30 days.
2. Hospitals will forward to the Bureau of Resources and Collections all Prepaid Health Plan bills accompanied by a discharge summary. This will facilitate the procedure of obtaining dispositions from the Prepaid Health Plans on claims payable.

3. The Bureau of Resources and Collections will mail the bills to the Prepaid Health Plans with a request for payment within 30 days.

4. A monthly list will be prepared and forwarded to the hopsitals for medical review on all claims for which the Prepaid Health Plan has not responded within 30 days. This medical review should determine whether or not the care was of an emergent nature.

5. Based on the disposition made by the medical review team, the Bureau of Resources and Collections will either suspend collection efforts (in the case of non-emergent care and no authorization from the Plans) ; or refers cases to County Counsel for appropriate action.

Dr. DICKSTEIN. In spite of this the problems arose and we've indicated that we do wish to make payments. Since then the county counsel, then, for his signature, a stipulation which would indicate that we would make payments on debts owed for emergency cases if this would not prejudice our rights in the total lawsuit. This was forwarded to him over a year ago for signature. He has not responded or sent that back. So for this reason I think that it has been the opinion of the prepaid health plans, and the attorneys have advised them, that these payments should not be made pending such a stipulation because it would prejudice their rights. It is not a matter of not wanting to pay for emergencies. Such things as these gentlemen brought up certainly appear to be emergencies, although I am not familiar with each and all of these cases.

It also appears that this type of emergency is a small amount of the medical services that I review. I saw them for perhaps the first year, year and a half of existence of the prepaid health plan, and the vast majority of them were rather routine matters, patients coming in for hypertension, admitted to the hospital, things of this type. So there's really two sides to this. I think it is a matter that is under adjudication at the present time, and we will make settlement with the county when the attorneys are able to reach some agreement on the way and the terms of the payment, and on some additional way of controlling the use of the patients in the hospital system.

Many of the patients do not understand that they have joined the prepaid health plan. They think they have the right to continue using the county hospitals, using the physicians in the neighborhood. It is a large education problem that we have; it is a large internal control problem that we have. It certainly hasn't been solved. I think it gives rise to inequities on both sides. But insofar as these specific cases are concerned, they appear to be emergencies; yes.

Mr. SEGAL. Dr. Dickstein, are you aware of the contract that exists between Omni-Rx Health Care, Inc., and the State of California, one that provides, in section 26, a description of emergency services, are you offhand familiar with it enough to know that your requirement is to reimburse a plan on a priority basis for these kinds of emergencies?

Dr. DICKSTEIN. Which contract are you referring to?

Mr. SEGAL. I'm talking about the contract of Omi-Rx Health Care with the State of California, the PHP contract.

Dr. DICKSTEIN. Which section?

Mr. SEGAL. Section 26, emergency services. I might read it, just to help clarify. It says:

Provider arrange to pay for emergency services defined in section G of article 2 received by an enrollee whether or not such services are provided within the service area and whether or not the contractor's own facilities of services are

available at the place where the illness or injury occurs. Such payment to nonparticipating facilities provided shall include treatment for emergency conditions and shall continue until such time as the enrollee is transferred to an appropriate provider of PHP.

Payment for and provision for emergency service shall not be subject to prior authorization by PHP"—the point that was raised before—"and properly documented claims for emergency services rendered by nonparticipating providers shall have priority for payment by the contractor over other claims for service.

Dr. DICKSTEIN. I'm not familiar with the last portion of that. But I think the thing hinges in many instances on the question of what constitutes an emergency.

Emergency services means those services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions, which if not immediately diagnosed and treated would lead to disability or death.

Now, we have had testimony, expert testimony, here today that these cases were emergencies. By your own admission you say that these appear to be even though you haven't reviewed them. The burden of determining that is not on you. It is a determination to be made by, in this case, the county hospital. They have determined it to be an emergency. They should be receiving the money on a priority basis. You have not provided them that money. Can you explain why?

Dr. DICKSTEIN. I think my previous answer is still standing, which is that we have made that offer, pending their stipulation, not to prejudice of their other claims, but not admit liability in claims where the emergency nature of this service was under contest.

Mr. SEGAL. The contract says that you would provide this money on a priority basis. It doesn't say without prejudicing any kind of case, does it?

Dr. DICKSTEIN. I understand that. I'm not familiar with the legal reason why this hasn't occurred.

Mr. SEGAL. What about the administrative reason? You are president and chairman of the board of health systems, which is the group that manages and pays for these bills, are you not?

Dr. DICKSTEIN. Health systems provides management services. It does not do the internal review of the claims nor the claims adjustments. That's a function of the health care itself. So systems would not have any specific knowledge of that.

Mr. SEGAL. You have indicated in the past that health systems prepares and pays bills. Is that not one of the management services that systems provides?

Dr. DICKSTEIN. Once a bill is cleared internally within health care for payment, then it would be sent to the accounting department and systems would seek payment of it, that's correct.

Mr. SEGAL. So you have not provided the money on a priority basis, is that right?

Dr. DICKSTEIN. It would appear not, yes, sir.

Mr. SEGAL. I would just like to develop one additional line of questions if I might, Mr. Chairman, and that is, there was an evaluation report of Omni-Rx performed by an Albert Einstein School of Medicine group, led by Dr. Mildred Morehead, that indicated, among other things, that there were 3,068 children treated over the last 18 months. These are children under the age of 15 years. You have also, in your submissions, indicated that there are 6,500 children enrolled under the age of 15 under your PHP contract. Are both those statements cor-

rect, the Dr. Mildred Morehead determination of the number of children treated and the total number?

Dr. DICKSTEIN. I'm not sure. I think she took a statistical sample and multiplied. I don't really know how she reached that number. The total number of 6,500 children may be right; sounds about right.

Mr. SEGAL. Well, that 6,565 are between the ages of birth and age 15, which was one of the pages submitted by you as part of your HMO qualification application.

Dr. DICKSTEIN. Then that's correct.

Mr. SEGAL. And the number of——

Mr. Moss. For the record, again, is the figure then correct that was submitted as a basis for qualifying as an HMO? Is the figure correct?

Dr. DICKSTEIN. Yes; I would think so.

Mr. SEGAL. The number 3,068 is on page 90 of her report, pediatric services, and I quote, "Based on data from the systematic sample there are 3,068 children under 15 years of age, who have been seen at least once in the past 18 months."

Dr. DICKSTEIN. What page?

Mr. SEGAL. Page 90.

She determined the number of children who had been treated over the last 18 months. Would you agree with that?

Dr. DICKSTEIN. It says what I said, it is a systematic sample. So if she took a sample of patients and evidently multiplied to reach that——

Mr. SEGAL. Do you agree that that is approximately correct, an approximately correct figure?

Dr. DICKSTEIN. I don't have our own internal utilization figures. It may well be.

Mr. Moss. Will you supply those internal utilization figures for this record?

Dr. DICKSTEIN. Yes.

Mr. Moss. Without objection, the record will be held open to receive them.

[The following information was received for the record:]

The following figures on pediatric utilization were provided by lawyers for Omi-Rx in a letter dated December 23, 1976:

	Patient encounters
June through December, 1974	5,410
January through December, 1975	12,218
January through November, 1976	12,111

These figures represent patient encounters at the Imperial West and Av-El clinics only, and do not reflect patient encounters with outside providers.

Mr. SEGAL. Now, assuming 3,100 is substantially correct and 6,500 is the number of children you were responsible for under the age of 15, does that not mean that over the past 18 months more than 3,500, and this is a minimum figure because of the turnover, over 3,500 children under contract have not received care at Omni-Rx?

Dr. DICKSTEIN. Most certainly, but there's no expectation in any health plan that 100 percent of the people will show up. We know statistically that a great number will not. It is on that expected basis that the capitation rates are, in fact, set.

Mr. SCHEUER. Well, now, wait a minute. That may be true of adults, but when you are talking about children from birth up to 5, you know

they are going to come in for certain innoculations. All of those children are going to be treated, are they not?

Dr. DICKSTEIN. No, sir. We have at times attempted to get all the people in. We had a plan which went on for, oh, over a year in which every person who signed into the prepaid health plan was given a time for an appointment and an offer of transportation to come in for a complete physical examination, including dental review, eye review. Eighty percent of those people failed to show up for that appointment. There was nothing we could do to get more than 20 percent of the people who joined the prepaid health plan to come in for that type of examination. And, in addition, people who make appointments, at least 50 percent——

Mr. SCHEUER. When you talk about people, are you talking about children or are you talking about adults?

Dr. DICKSTEIN. Talking about the entire population. You have to depend on the child's mother to keep the appointment to bring him in. There are many people who join the prepaid health plan who never utilize it for any reason. We have no way of getting hold of them, forcing them to come in. Even though it may be desirable to have every child to do these things, we cannot force the parent to bring them in. And where we did attempt it, made a very concerted effort to do it, then the people were threatening to disenroll from the prepaid health plan.

Mr. SEGAL. Dr. Dickstein, do you not feel compelled to provide what was agreed to in the contract between Omni-Rx and the State? I would like to quote a section of the contract that reads as follows, it says, "Financial basis for providing the service, provide the covered service on the basis of a periodic capitation payment for each enrollee." It then says, and I might point out that this is the 1975 contract which was amended in August of this past year. But it did not change this section, although it is no longer called medi-screen needs, and second, it also happens to be the contractual time at which we are looking, namely, the past 18 months that Dr. Mildred Morehead studied. The contract says, "All medi-screen services which have not been previously provided and recorded in the enrollee's medical record shall be provided within the capitation payment for each enrollee under age 21." Can you tell the subcommittee, Dr. Dickstein, how many enrollees out of that 3,500 untreated you have in your PHP's have not had previously recorded medi-screen services?

Dr. DICKSTEIN. You mean of the unseen 3,500?

Mr. SEGAL. Of the unseen 3,500 under the age of 15.

Dr. DICKSTEIN. I have no idea. It doesn't say that we must get them, that they have to come in in some fashion.

Mr. SEGAL. It says, all medi-screen which have not been previously provided and recorded the enrollee's medical record. Have you determined or tried to find the medical records from the people who enrolled in your plan? You've taken on a contractual responsibility, a legal obligation, to provide those services that have not already been previously supplied.

Dr. DICKSTEIN. Those people who come in get the complete examination. We make an effort to get every person in who has enrolled in the program, and if a person shows up, we attempt to get prior medical

records that may exist, but it is not possible to get records of people who do not or will not come in. There is no compulsion in that contract to see 100 percent of the people. If, in fact, 100 percent of all the people did come in and utilize the service, then the plan would certainly not be able to function financially.

Mr. SEGAL. But for each of these 3,500 individuals you received well over $300 a year, which means over $1 million for all of these recipients. What did you do for that $1 million? Did you make any attempt to find out the patient's record from their previous provider of health care?

Dr. DICKSTEIN. I don't really understand your question.

Mr. Moss. I think the question really is, you have x number of enrollees, do you have x number of medical records and have you attempted to establish for these enrollees any kind of medical record or history?

Dr. DICKSTEIN. When a person enrolls in the prepaid health plan a chart is made up in his name and then it is kept for use at the time that he appears. We attempt to get every person in.

Mr. Moss. Made up from what information?

Dr. DICKSTEIN. From the enrollment information.

Mr. Moss. From the enrollment information.

Dr. DICKSTEIN. But what the person gets when he enrolls is a letter welcoming him to the prepaid health plan, an invitation to come in and utilize these services, a description of how these services are available. Some people will utilize them; some people will not utilize them.

Mr. WAXMAN. It seems like there might be some confusion; 3,500 under the age of 15, I assume you are not talking about a letter to someone under the age of 15, welcoming him to the program, expecting that they will come in on their own volition.

Dr. DICKSTEIN. No. The letter goes to the parents or guardian.

Mr. WAXMAN. But isn't there an obligation on the part of the prepaid health plan to provide a report of some sort of screening purposes and for vaccination purposes for every single one of the enrollees who is under the age of 15?

Dr. DICKSTEIN. I don't think that's contemplated under the contract, no. I'm not saying it wouldn't be ideally desirable. I just don't think it is possible.

Mr. Moss. Would you refresh my recollection on the public schools of Los Angeles County, are they not required to have certain shots or immunizing them against a set number of diseases that they would ordinarily be exposed to?

Dr. DICKSTEIN. Right. That's one of the reasons we get the kids in, because they have to have this.

Mr. Moss. But 3,500 did not come in. Are we to assume that they have not been immunized at all?

Dr. DICKSTEIN. No. We're assuming they cover an age group of zero to 15. If those 3,500 all happened to be 6 years of age and about to enter their school, I'm sure we'd see them all in there because they would need this kind of letter from us.

Mr. Moss. Do you know whether—do the records reflect it?

Dr. DICKSTEIN. I believe so. I don't know to total accuracy. I'm not custodian of each and every record. We have something like 100,000 records of various patients.

Mr. Moss. You have 100,000 records but you have 10,000-plus enrollees, is that correct?

Dr. DICKSTEIN. We have a mixed practice, which covers both private practice and prepaid. We have had over the years about 25,000 or 26,000 people who have enrolled in the prepaid and gone out and that's——

Mr. Moss. That volume of records does not impress me because this committee has custody of literally millions of records and we have to be somewhat conversant with the contents of a great many of them, covering a wide spectrum of activities, from energy to health, corporate financing, and all the rest of the things that fall within the jurisdiction of the committee.

Dr. DICKSTEIN. You appear to be asking——

Mr. Moss. Here's a very significant area of concern to management operating under a contract and 3,500 of the prepaid and health plan members where there is an obligation and an assumption that they should have certain immunizations to determine whether or not they have had them.

Dr. DICKSTEIN. If we did get the patients, we'd make a devoted effort to get them into the practice. I do not know how to force a mother to bring her child in and insist that it be immunized if she does not, in fact, do that. We have many, many problems aside from the problems of convincing the parents to bring the children in. We have a tremendous problem of communication.

Mr. Moss. What is the advantage, then, in enrolling in the plan if they're not going to utilize it? What is the incentive to get them into the plan?

Dr. DICKSTEIN. The fact that the wide range of services are available if they do happen to need them.

Mr. Moss. This very large percentage are totally disinterested in utilizing it?

Dr. DICKSTEIN. That's correct.

Mr. Moss. What we are told elsewhere around the country is that we're constantly weighted down with people who demand these services. We may have an entirely different phenomena here.

Dr. DICKSTEIN. No; it is not different. The small percentage of people who utilize the services weight us down because they come in every day. The vast number of people whom we try to interest in getting preventive health services and bringing their children in just won't do it, they don't come around. So what you get is a small number of people who have a tremendous velocity through the system. They are in day in and day out, making all kinds of demands on the system. You have a fairly large number who will not or do not utilize the system for any reason.

Mr. Moss. Before I go back to counsel, I would like to ask one question. This matter of your controversy with the County of Los Angeles, obviously you are not the only PHP that's involved because we're talking about $176,000 in your plan and talking about $4 million. What kind of contingency have you set up on your books for this $176,000 and how is it reflected in your financial statement?

Dr. DICKSTEIN. I think it is being reflected as a footnote in the new statement.

Mr. Moss. Previously, did you have any kind of indication?

Dr. DICKSTEIN. I'm not certain. I think so, but I'm not sure.

Mr. MOSS. Would you then supply us with the material that would illustrate whether or not it would be, the statement was footnoted, giving us a copy of the statement prior to the 1st of November and a copy of the form after?

Dr. DICKSTEIN. We are completing our health care audit. It should be done in the next week or so. So I will supply the committee with a copy of that audit plus the prior audit.

Mr. MOSS. Without objection, the record will be held open to receive it.

[Testimony resumes on p. 188.]

[The following material was received for the record:]

OMNI-RX HEALTH SYSTEMS

ANNUAL REPORT - FORM 10-K

TWO YEARS ENDED JUNE 30, 1976

FINANCIAL STATEMENTS

AND

ACCOUNTANTS' REPORT

OMNI-RX HEALTH SYSTEMS

INDEX TO FINANCIAL STATEMENTS AND SCHEDULES

All other schedules have been omitted since the information required by such schedules is not applicable, not required or the information has been otherwise supplied.

GOLD, KIPNIS & KOHN
AN ACCOUNTANCY CORPORATION
10880 WEST PICO BOULEVARD
LOS ANGELES, CALIFORNIA 90064
(213) 836-2424

IRVING I. GOLD, C.P.A.
MIKE KIPNIS, C.P.A.
MELVYN A. KOHN, C.P.A.

Board of Directors
Omni-Rx Health Systems
11616 S. Hawthorne Boulevard
Hawthorne, California 90250

We have examined the balance sheets of Omni-Rx Health Systems as of June 30, 1975, and June 30, 1976, and the related statements of income and retained earnings and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our report dated September 30, 1975, relating to the financial statements for June 30, 1975, our opinion was subject to the continuing collection of amounts due from affiliates referred to in Note 3. This qualification was made because insufficient information was available at June 30, 1975 relative to the net worth of officers-stockholders who are responsible for payment of amounts due from affiliates. At June 30, 1976, we were furnished with audited data to satisfy us that sufficient assets were available for collection of these obligations (See Note 3) and we are therefore of the opinion that the above qualification does not apply to the financial statements of June 30, 1976.

As described in Notes 6f. (1) and 9b., the company has been named in a complaint by the Securities and Exchange Commission and is presently the subject of an investigation by the California Department of Corporations. The final outcome of these matters or of any action arising as a result of these matters is not presently determinable and the effect, if any, on present and future financial statements of the company is not presently determinable.

In our opinion, subject to the effect, if any, on the financial statements of the ultimate resolution of the matters discussed in the preceding paragraph, the accompanying financial statements present fairly the financial position of Omni-Rx Health Systems as of June 30, 1975 and June 30, 1976 and the results of their operations and the changes in their financial position for the years then ended in conformity with generally accepted accounting principles consistently applied after reclassification and restatement of changes for fiscal year ended June 30,1975, with which we concur, as described in Note 8.

Gold, Kipnis & Kohn
GOLD, KIPNIS & KOHN
An Accountancy Corporation

November 19, 1976, except
for Note 8b, the date of
which is November 23, 1976.

OMNI-RX HEALTH SYSTEMS

BALANCE SHEET

ASSETS	June 30, 1976	1975
CURRENT		
Cash	$--------	$ 86,470
Accounts receivable, less allowance of $601,837 and $365,544 for possible losses and discounts (Note 2a) (Schedule XII)	1,735,022	1,565,191
Other Current Assets	70,162	51,985
TOTAL CURRENT ASSETS	1,805,184	1,703,646
AMOUNTS DUE FROM AFFILIATES (Note 3 and 10) (Schedule IV)	2,258,435	2,180,672
PROPERTY AND EQUIPMENT, at cost (Note 1a)		
Land	210,000	210,000
Buildings	615,747	615,747
Office equipment	233,759	211,398
Medical equipment	320,840	313,912
Leasehold improvements	311,857	215,897
(Schedule V)	1,692,203	1,566,954
Less accumulated depreciation and amortization (Schedule VI)	408,171	305,587
NET PROPERTY AND EQUIPMENT	1,284,032	1,261,367
OTHER		
Accounts receivable, non-current portion less allowance of $461,828 and $366,323 for possible losses and discounts (Note 2b) (Schedule XII)	1,738,421	1,456,104
Miscellaneous (Note 1 (b) and 10)	36,242	31,176
TOTAL OTHER ASSETS	1,774,663	1,487,280
	$7,122,314	$6,632,965

LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT		
Bank overdraft	$ 16,132	$---------
Notes payable, bank, collateralized by accounts receivable	350,691	675,220
Accrued expenses due to officers-stockholders (Note 8b)	400,672	235,713
Accounts payable and accrued expenses (Note 7)	914,746	739,813
Current maturities of long-term debt (Note 4a and b)	62,589	71,226
TOTAL CURRENT LIABILITIES	1,744,830	1,721,972
LONG-TERM DEBT, less current maturities (Note 4a)	673,621	730,249
DEFERRED INCOME TAXES (Note 1 (c))	1,867,525	1,621,097
	4,285,976	4,073,318
COMMITMENTS AND CONTINGENT LIABILITIES (Note 6)		
STOCKHOLDERS' EQUITY		
Common stock, $.10 par, 2,000,000 shares authorized, 685,653 issued and outstanding	68,565	68,565
Additional paid-in capital	1,493,353	1,493,353
Retained earnings	1,274,420	997,729
TOTAL STOCKHOLDERS' EQUITY	2,836,338	2,559,647
	$7,122,314	$6,632,965

See accompanying notes to financial statements.

OMNI-RX HEALTH SYSTEMS

STATEMENT OF INCOME

	Year Ended June 30, 1976	1975
REVENUE		
Logistical support services (A) (Note 8a)	$2,019,880	$1,617,918
Ancillary health services (B)	1,930,648	1,600,849
Other miscellaneous income	213	20,278
	3,950,741	3,239,045
OPERATING COSTS AND EXPENSES		
Direct (Note 8a)	1,134,561	870,158
Administrative and general (Note 8b)	1,893,299	1,397,181
Provision for possible losses	235,019	146,705
Interest (Note 8b)	132,171	169,214
	3,395,050	2,583,258
INCOME BEFORE TAXES ON INCOME (Note 8)	555,691	655,787
PROVISION FOR INCOME TAXES (Notes 1c and 8)	279,000	332,000
NET INCOME (E) (Note 8)	$ 276,691	$ 323,787
AVERAGE NUMBER OF COMMON SHARES OUTSTANDING		
Primary	685,653	685,653
Fully diluted (Note 7)	701,877	694,908
EARNINGS PER SHARE OF COMMON STOCK (C) (Note 8)		
Primary	$0.40	$0.47
Fully diluted (Note 7)	$0.39	$0.47

(A) Revenue from logistical support services consists of billings to affiliates under management contracts (Notes 3 and 6a).

(B) Revenue from ancillary health services consists of clinical lab, X-ray, neurodiagnostic testing service, pharmacy billings, cardio-pulmonary testing service.

(C) Earnings per common share have been computed based on the average number of shares outstanding during each period, giving effect to primary earnings per share and fully diluted earnings per share (Note 7).

(D) No dividends have been declared or paid in the above periods.

(E) The net loss of a 67% owned subsidiary, Vocational Rehabilitation Associates, Inc. a California Corporation, has not been consolidated into the Net Income above (Note 10).

See accompanying notes to financial statements.

OMNI-RX HEALTH SYSTEMS

STATEMENT OF STOCKHOLDERS' EQUITY

	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Total
BALANCE, JUNE 30, 1972	498,423	$ 49,842	$ 735,163	$ 142,424	$ 927,429
Stock issued upon exercise of stock option	5,000	500	9,500		10,000
Stock issued for cash	3,000	300			300
10% stock dividend on shares issued since July 1, 1972	800	80	2,920	(3,000)	
Net proceeds from sale of common stock	175,000	17,500	733,229		750,729
Stock issued for services rendered	3,430	343	12,541		12,884
Net income for the year				348,874	348,874
BALANCE, JUNE 30, 1973	685,653	68,565	1,493,353	488,298	2,050,216
Net income for the year				185,644	185,644
BALANCE, JUNE 30, 1974	685,653	68,565	1,493,353	673,942	2,235,860
Net income for the year (Restated - Note 8b)				323,787	323,787
BALANCE, JUNE 30, 1975	685,653	68,565	1,493,353	997,729	2,559,647
Net income for the year				276,691	276,691
BALANCE, JUNE 30, 1976	685,653	$ 68,565	$1,493,353	$1,274,420	$2,836,338

See accompanying notes to financial statements.

OMNI-RX HEALTH SYSTEMS

STATEMENT OF CHANGES IN FINANCIAL POSITION

	Year Ended June 30, 1976	1975
SOURCE OF WORKING CAPITAL		
Net income	$ 276,691	$ 323,787
Add items not requiring outlay of working capital:		
Depreciation and amortization	102,584	94,716
Amortization of miscellaneous assets	-0-	23,449
Deferred income taxes	279,000	332,000
TOTAL DERIVED FROM OPERATIONS	658,275	773,952
USE OF WORKING CAPITAL		
Additions to property and equipment	125,249	86,749
Increase in accounts receivable, non-current	282,317	286,586
Increase in miscellaneous assets	5,066	-0-
Decrease in long-term debt	56,628	37,977
Increase in amounts due from affilitates	77,763	240,391
Decrease in deferred income taxes	32,572	-0-
TOTAL	579,595	651,703
INCREASE (DECREASE) IN WORKING CAPITAL	$ 78,680	$ 122,249
COMPONENT INCREASE (DECREASE) IN WORKING CAPITAL		
Cash	$ (102,602)	$ 64,449
Accounts receivable	169,831	130,089
Other current assets	18,177	(8,644)
Notes payable, bank	324,529	184,113
Accounts payable and accrued expenses	(174,933)	(110,717)
Accrued expenses due to officers - stockholders	(164,959)	(134,349)
Current maturities of long-term debt	8,637	(2,692)
INCREASE (DECREASE) IN WORKING CAPITAL	$ 78,680	$ 122,249

See accompanying notes to financial statements.

OMNI-RX HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

NOTE 1: SUMMARY OF ACCOUNTING POLICIES:

a. Depreciation and Amortization

This computation by the Company is based on the straight-line method over the below estimated useful lives:

Buildings	25 years
Office furniture and fixtures	10 years
Medical equipment	10 years
Leasehold improvements	10 years

The Company held an option on a medical building that is presently under a lease agreement. The option is for the purchase of land and building for $625,000 which expires November 30, 1976 and in which certain officer-shareholders presently own an 85% interest. This property has been capitalized and is shown on the balance sheet at the discounted amount to the present value of the future lease rental payments to the expected exercise date of the option and the option purchase price (Note 4).

b. Research and Development Costs

The costs of developing data processing software systems, which amounted to $12,671 at June 30, 1975, net of amortization and other intangible assets, had been amortized over a three to five year period. The Company changed its method of accounting for such costs for fiscal years beginning July 1, 1975, and charges such costs to expense when incurred along with the unamortized balance of $12,671 remaining at June 30, 1975.

c. Income Taxes

Deferred income taxes have been provided for on the difference in earnings determined for tax and for financial reporting purposes. These differences result primarily from the timing difference between the cash basis of reporting revenues for income tax purposes and the accrual basis for financial reporting. An unused net operating loss of approximately $423,000, determined by the cash basis of tax reporting, is available at June 30, 1976 for offset against possible subsequent years' federal taxable income computed on a cash basis.

Note 1c to Financial Statements for fiscal year ended June 30, 1975 stated that "An unused net operating loss of approximately $1,571,000" was available at that time. This was based on estimates of cash basis taxable income losses for the prior years which were in error. The correct operating loss available at June 30, 1975 was approximately $725,000, after having applied a portion of the previous year's losses to that year's cash basis taxable income of $331,000, as follows:

Year		Amount	Year of Expiration
1972	Loss	$ (260,000)	1977
1973	Loss	(470,000)	1978
1974	Loss	(326,000)	1979
1975	Income	331,000	
Balance Available		(725,000)	
1976	Income	302,000	
Unused net operating loss balance		$ (423,000)	

Components of Provision for Income Taxes reported on the Statement of Income are approximately as follows:

	June 30, 1976	1975 (Note 8)
Federal	$ 229,000	$ 273,000
State of California	50,000	59,000

Income taxes payable on a cash basis to the State of California were $32,572 for fiscal year June 30, 1975 and are estimated to be approximately $30,000 for fiscal year June 30, 1976.

NOTES TO FINANCIAL STATEMENTS
(Continued)

Federal Investment tax credits are accounted for on the "flow through" method which recognizes the benefit in the year in which the related assets are placed in service. Unused investment tax credits of approximately $33,000 are available to reduce future years' federal income tax, if any, and which expire in varying amounts through 1980.

d. Vacation, Personal Leave & Sick Pay

The company policy is to not accrue liabilities for vacation personal leave and sick pay as earned, but to record the expense when paid.

NOTE 2: ACCOUNTS RECEIVABLE

a. Accounts Receivable arising from services rendered to individuals include charges for interest on delinquent accounts in the amount of $378,687. Allowance for possible loss has been established at 100% of this balance ($378,687), thus eliminating these charges from income. The Company's policy is to assess interest charges at the rate of 1-1/2% per month on delinquent accounts and to recognize income from the charges only when collected.

b. Accounts Receivable, Non-Current

This classification includes the following receivables which are not expected to be collected by the Company within one year:

	June 30, 1976	1975
Individual services	$1,313,445	$1,081,674
Management services	325,079	323,365
Other receivables	99,897	51,065
Totals	$1,738,421	$1,456,104

NOTE 3: AMOUNTS DUE FROM AFFILIATES:

The related entities or groups consist of the following:

Omni-Rx Health Care, Inc., a California non-profit corporation.
Imperial West Medical Group, a partnership.
Av-El Medical Group, a partnership.
Hawthorne Doctors, individual supporting doctors with Imperial West Medical Group.
Av-El Doctors, individual supporting doctors with Av-El Medical Group. (Effective January 1, 1975 all doctors identified as Hawthorne doctors and Av-El doctors became part of Imperial West Medical Group).
Vocational Rehabilitation Associates, Inc., a California corporation.
Omni-Rx Health Systems of Nevada, a Nevada corporation, incorporated June 25, 1976, a wholly owned subsidiary. Omni-Rx Health Systems of Nevada, subsequent to June 30, 1976, entered into a management agreement with Family Doctors, Chartered, a Nevada professional corporation.

The Company has entered into management contracts with the above entities or groups to provide a full range of management services. Three of the persons who serve as officers, directors and are shareholders of the Company, are also partners of Imperial West Medical Group and Av-El Medical Group. Three of the directors of the Company also serve as directors of Omni-Rx Health Care, Inc. Five of the officers and directors of the Company are also officers or directo of Vocational Rehabilitation Associates, Inc. The amounts due from these entities or groups constitute those unpaid balances arising from the charges and advances by the Company to or on behalf of the following:

	June 30, 1976	1975
Omni-Rx Health Care, Inc.	$ 157,782	$ 77,061
Imperial West Medical Group	1,135,055	1,107,591
Av-El Medical Group	620,542	648,134
Individual doctors	320,412	343,242
Vocational Rehabilitation Assoc., Inc. (Note 10)	23,634	4,644
Total (Schedule IV)	$2,258,435	$2,130,672

OMNI-RX HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS
(Continued)

The above balance for June 30, 1976 reflects the net amounts due for management services and advances to these entities or groups after transfer to the Company of outstanding patient accounts receivable in the net amount of $1,972,517 (after an allowance for possible uncollectible accounts in the amount of ($358,607) as partial payment of their indebtedness. (Note 6a)

In addition to the above transfers of accounts receivable, three principal partners of Imperial West Medical Group and Av-El Medical Group are jointly and individually responsible for the obligations of Imperial West Medical Group; Av-El Medical Group and associated individual doctors. Audited personal financial statements of the three partners at June 30, 1976 show combined net assets of approximately $2,284,000 before allowance for the above obligations.

At June 30, 1976, unaudited records of Imperial West Medical Group and Av-El Medical Group indicated a combined partnership capital deficit of approximately $1,516,000.

At June 30, 1976, unaudited records of individual doctor's groups indicated a combined capital deficit of approximately $320,000.

At June 30, 1976, unaudited records of Omni-Rx Health Care, Inc. indicated a capital surplus of approximately $74,000.

At June 30, 1976, audited records of Vocational Rehabilitation Associates, Inc. show a capital deficit of $12,325 (Note 10).

NOTE 4: LONG-TERM DEBTS:

a. Long-term debt consisted of the following capitalized lease obligations and contracts:

	June 30, 1976	June 30, 1975
(1) Hawthorne Medical Building, a partnership, to November 30, 1976 plus the option price (discount is based on imputed interest rate of 7% per annum) (Note 1(a)	$646,323	$682,374
(2) Equipment contracts, payable in monthly installments of $2,689 and $1,342, including interest ranging from 5-1-1/2% to 10% per annum	89,887	119,101
	736,210	801,475
Less: current portion	62,589	71,226
	$673,621	$730,249

b. Long-term debt maturities during each of the five years subsequent to June 30, 1976 and June 30, 1975, are as follows:

Fiscal Year Ending	June 30, 1976	June 30, 1975
1976	$ 62,589	$ 71,226
1977	740,504	663,014
1978	112,980	9,660
1979	112,980	9,660
1980	34,467	9,660
1981	9,660	
	(Note 9a)	

OMNI-RX HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS
(Continued)

NOTE 5: OTHER NON-CURRENT ASSETS

a. The company has been engaged in litigation against a dentist for breach of a management, service and lease agreement. A judgment was recently entered in favor of the Company for $62,500, with dismissal of both the dentist's original cross-complaint and a motion of his to set the Judgment aside.

Gross amount receivable	$150,845
Less: provision for uncollectability	88,345
Net Judgment receivable	$ 62,500

b. The Company remains a participant in several lawsuits, including acting as one of the petitioning creditors in two involuntary bankruptcy petitions: all are related to transactions and agreements between itself and a prepaid health plan contractor not affiliated with the company.

In all, six actions are being pursued as multiple sources for recovery of accounts receivable due the Company of approximately $286,000.

It is counsel's opinion that the Company will prevail through one or more of the lawsuits, and that there will be ultimate recovery of the receivable. (Note 6f (5)).

NOTE 6: COMMITMENTS AND CONTINGENT LIABILITIES:

a. The Company has executed management, service and lease agreements with a partnership consolidating Imperial West Medical Group and Av-El Medical Group and with Omni-Rx Health Care, Inc. Three officers, directors and shareholders of the Company also serve as Directors of Omni-Rx Health Care, Inc. Three directors of the Company are also partners in Imperial West Medical Group and Av-El Medical Group. These agreements expire in 1981. Under the terms of the agreement, the company is required, among other things, to provide space, equipment, furnishings and administrative personnel to maintain all medical and financial records, including collections of patients receivables and to render transcribing, data processing and financial management services (Note 3).

The Company has similar agreements with individual supporting doctors, dentists and optometrists.

b. Employment contracts with five principal officers of the Company expire in 1978. Compensation of officers in excess of $40,000 per year is as follows:

Edward R. Dickstein, M.D. President and Chairman of Board	$44,948
Harry Standers, Vice President	51,510
Merv Newell, Vice President	59,808

OMNI-RX HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS
(Continued)

c. Minimum annual rentals payable by the Company under real estate lease agreements with officer-stockholders are:

Year	Amount
1977	$174,012
1978	147,432
1979	147,432
1980	147,432
1981-1985	700,200
1986-1990	686,760
1990-1992	194,582

Minimum rentals payable by the Company under other non-cancellable real estate agreements are:

1977	$ 8,550
1978	3,600
1979	3,600
1980	3,600

In addition to the minimum rentals, the Company is required to pay for real estate taxes, insurance and building maintenance costs. The minimum rentals are subject to increases, when applicable, based on the Consumer Price Index reports published by the Bureau of Labor Statistics. (Note 8b)

d. The Company has guaranteed two letters of credit on behalf of Omni-Rx Health Care, Inc. issued by the Farmers & Merchants Bank of Long Beach, California, to the State of California, in the amount of $400,000, and to Hawthorne Community Hospital, Inc, in the amount of $97,520. (Note 6f (4)

e. On June 30, 1976, the Board of Directors, at a special meeting, resolved to purchase the Av-El Medical Building at an independently appraised price of approximately $1,200,000. It was further resolved that any cash payment required by the Company to owners of the building who are affiliated with the Company be applied as a reduction of obligations to the Company by those owners. It is estimated that approximately 85% of any such cash payments would be applied against receivables due from affiliates.

f. Litigation

(1) The Company was the subject of a private investigation by the Securities and Exchange Commission (SEC).

This investigation has resulted in a complaint filed in the United States District Court by the SEC, on September 1, 1976, against the Company, four principal officers, Imperial West Medical Group, and the Farmers and Merchants Bank of Long Beach, California.

The action is a civil injunctive action seeking to stop the Company from future violations of certain provisions of federal securities laws, and seeks "such other and further relief as the court may deem just and appropriate". The complaint alleges purported violations in connection with the Company's first public offering in December, 197[illegible] as well as annual and other reports filed in 1972 and 1973. The SEC seeks disgorgement of assets from those principals - not from the Company - allegedly wrongfully diverted.

Since this litigation with the SEC is in the earliest stages of proceedings, Counsel is not yet able to express an opinion as to the eventual outcome of the action except to state that it appears remote that the Company will suffer any financial loss.

OMNI-RX HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS
(Continued)

(2) The Company is a defendant in an action filed by two doctors seeking recovery in the total amount of $42,085 for alleged conversion of monies owed for services rendered. It is the opinion of counsel, based on the facts as presented that the Company will suffer no substantial liability.

(3) A lawsuit for $300,000 in combined damages has been brought against the Company and Imperial West Medical Group, by a doctor formerly associated with them. The suit alleges breach of contract, fraud and negligent misrepresentation. In the opinion of counsel the liability, if any, will rest with Imperial West Medical Group and not with the Company.

(4) The Company is a named defendant in an action brought by a local hospital against Omni-Rx Health Care, Inc. who is the primary defendant. In August, 1975, the Superior Court of the State of California issued an order granting a writ of attachment against Omni-Rx Health Systems, Inc. and Omni-Rx Health Care, Inc. in the amount of $98,764. The Company and Omni-Rx Health Care, Inc. are appealing the court order. Counsel believes that the Company will ultimately suffer no liability in this matter, but $1,264 has been paid and $97,520 guaranteed (Note 6d) in this matter.

(5) The United States Internal Revenue Service has proposed an assessment against the Company for payment of certain taxes of Marvin Medical Group, Inc., Western Health Management Services, Inc. and Marvin X-Ray and Laboratories, Inc. The total amount of the proposed assessment is approximately $30,000. The proposed assessments were made based on the IRS' theory that the Company was required to collect and pay the subject taxes of the aforementioned entities. The Company has formally denied all responsibility for the payment and collection of the subject taxes, and no formal assessment has yet been made against the Company. If the IRS should be successful in its action, it is likely that the claim will be paid from funds impounded by the court in one of the litigation matters referred to in Note 5b.

NOTE 7: EARNINGS PER SHARE - FULLY DILUTED:

The Company has entered into an agreement with the consulting director of an ancillary services laboratory for compensation to the director based on 10% of the gross sales of the laboratory. At the discretion of the Company, payment may be made in the form of common stock of the company with the stock pledged at a price not less than the book value of the company, or $7.50 per share if the market value of the stock is in excess of $7.50 per share. The amount of compensation due the director under this agreement was $69,413 at June 30, 1975 and $121,682 at June 30, 1976. These amounts are included in liabilities on the balance sheet as accrued expenses.

In order to give effect to potential dilution of earnings per share if The Company exercises its option to make payment in the form of common stock at the price of $7.50 per share, fully diluted earnings per share are shown as if 9,255 additional share of common stock were issued at June 30, 1975 and 16,224 additional shares were issued at June 30, 1976.

NOTE 8: RECLASSIFICATION AND RESTATEMENT:

a. As a result of a change in the company's method of charging for logistical support services effective January 1, 1975, reclassifications have been made in certain income statement accounts for fiscal year ended June 30, 1975 to conform to statement classifications for June 30, 1976.

OMNI-RX HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS
(Continued)

In fiscal year 1975, gross revenues included charges for certain reimbursable expenses in the amount of $999,296 which were offset by an equivalent amount included in direct costs. Such charges were eliminated subsequent to January 1, 1975 and were replaced by management service fees which are all - inclusive for services rendered.

As a result of reclassification due to the above change in billing methods, the Statement of Income for fiscal year ended June 30, 1975 is restated as follows:

	Original Presentation	Reclassif-ications	Restated Presentations
Revenue			
Logistical support services	$2,617,214	$(999,296)	$1,617,918
Ancillary health services	1,600,849		1,600,849
Other miscellaneous income	20,278		20,278
	4,238,341	(999,296)	3,239,045
Operating Costs and Expense			
Direct	1,869,454	(999,296)	870,158
Administrative and general	1,357,952		1,357,952
Provision for possible losses	146,705		146,705
Interest	165,291		165,291
	3,539,402	(999,296)	2,540,106
Income before taxes	698,939		698,939

None of the above reclassifications have had any effect on net income or assets for 1975.

b. Minimum annual rentals payable by the Company under real estate lease agreements with officer - stockholders are subject to increases based on Consumer Price Index changes for Los Angeles, California as determined by the Bureau of Labor Statistics of the United States Department of Labor.

The Consumer Price Index changes affecting the fiscal year ended June 30, 1975 resulted in an increase in rentals amounting to 19.6% over base minimum rentals causing an increase in rents for such fiscal year amounting to $39,229.

Unpaid additional rents under the agreements are subject to interest charges of 10% per annum amounting to $3,923 for fiscal year ended June 30, 1975.

In order to properly reflect the above additional costs, affected portions of the financial statements for fiscal year ended June 30, 1975 have been restated as follows:

OMNI-RX HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS
(Continued)

BALANCE SHEET	Reclassified Presentation Per Note 8a	Prior Period Adjustment	Restated Presentation
CURRENT LIABILITIES			
Notes payable, bank collateralized by accounts receivable	$ 675,220	$	$ 675,220
Accrued expenses due to officers - stockholders	192,561	43,152	235,713
Accounts payable and accrued expenses	739,813		739,813
Current maturities of long-term debt	71,226		71,226
Total Current Liabilities	1,678,820	43,152	1,721,972
LONG-TERM DEBT, less current maturities	730,249		730,249
DEFERRED INCOME TAXES	1,639,097	(18,000)	1,621,097
	4,048,166	25,152	4,073,318
STOCKHOLDERS' EQUITY			
Common stock, $.10 par, 2,000,000 shares authorized, 685,653 issued and outstanding	68,565		68,565
Additional paid-in capital	1,493,353		1,493,353
Retained earnings	1,022,881	(25,152)	997,729
	$6,632,965	$	$6,632,965
STATEMENT OF INCOME			
Revenue	$3,239,045	$	$3,239,045
Operating Costs and Expenses			
Direct	870,158		870,158
Administrative and general	1,357,952	39,229	1,397,181
Provision for possible losses	146,705		146,705
Interest	165,291	3,923	169,214
	2,540,106	43,152	2,583,258
Income Before Taxes	698,939	(43,152)	655,787
Provision for Income Taxes	350,000	(18,000)	332,000
Net Income	$ 348,939	$ (25,152)	$ 323,787
Earnings Per Share of Common Stock			
Primary	.51	(.04)	.47
Fully diluted	.50	(.03)	.47

The Consumer Price Index changes affecting the fiscal year ended June 30, 1976 resulted in an increase in rentals amounting to 30.7% causing an increase in rents for such fiscal year amounting to $70,490 plus interest at 10% of $7,049. These increases are included herein in appropriate accounts as reported in the Balance Sheet for June 30, 1976 and Statement of Income for the year then ended.

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OMNI-RX HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS
(Continued)

NOTE 9: SUBSEQUENT EVENTS:

a. On July 13, 1976, the Company financed the acquisition of new IBM data processing equipment with a loan from its bank payable over a 36 month period at $8,610 per month including interest at 12.83% per annum, commencing September 20, 1976. The total amount to be paid as a result of this financing agreement will be $309,960. The Company's long-term liability in connection with this contract is reflected in the schedule of long-term commitments in Note 4b.

b. In recent months, Omni-Rx Health Care, Inc., the affiliated pre-paid health plan, and the Company have been the subject of investigations by the California Department of Health, California Assembly Sub-Committee on Health Care and the California Department of Corporations, the latter of which is continuing. These investigations have primarily centered on the operations of Omni-Rx Health Care, Inc. The pre-paid health care contract between Omni-Rx Health Care, Inc. and the State of California accounted for approximately 25% of the Company's gross revenues during the fiscal year ended June 30, 1976. This contract expires December 31, 1976, and application for renewal has been submitted.

Since the investigation by the California Department of Corporations is still in progress, no determination can be made of the outcome thereof, including what action, if any, may result.

c. On October 7, 1976, The Board of Directors resolved to "explore as soon as possible a method by which the Company could purchase from Dr. Markovitz and/or Dr. Koch and/or Dr. Dickstein their respective stock ownership in the Company".

Such offer of purchase will be contingent upon the execution of a long-term management agreement with the company by any of said individuals who accept such offer.

d. On October 13, 1976, the Company purchased from Omni-Rx Health Care, Inc. all of its right, title and interest in proceeds of two actions pending in the Superior Court of the State of California against the State Department of Health. Said actions seek recovery of monies due and monies which will become due to Omni-Rx Health Care, Inc. The purchase of this receivable was financed by a bank loan of $350,000.

NOTE 10: Commencing May 10, 1976 the Company owned 67% of the common stock of Vocational Rehabilitation Associates, Inc. (VRA). This subsidiary investment is reflected in Other Miscellaneous Assets at the Company's par value cost basis of $4,500. VRA's gross sales income for its first fiscal year ended June 30, 1976 was approximately $41,000; its audited net operating loss was ($19,075) for the year.

The subsidiary's loss has not been consolidated into the Company's Statement of Income; nor has its pro-rata share of VRA's loss ($12,797) been applied to reduce its $4,500 equity investment nor has it been included in the $23,634 amount due from VRA (Note 3 & Schedule IV).

NOTE 11: SUPPLEMENTARY INCOME STATEMENT INFORMATION:

The following are amounts of certain costs and expenses chared to operations:

Item	1976	1975
Maintenance and repairs	$ 74,001	$ 67,744
Depreciation and amortization of property and equipment	99,995	90,697
Depreciation and amortization of intangible assets	15,809	21,222
Taxes, other than income taxes:		
Payroll	104,352	62,171
Property	54,606	40,256
Other	55	------
Rents	353,887	324,892

OMNI-RX HEALTH SYSTEMS

SCHEDULE IV - INDEBTEDNESS OF AFFILIATES
AND OTHER PERSONS - NOT CURRENT

Column A Name of affiliate	Column B Balance at beginning of period	Column C Balance at end of period	
Year ended June 30, 1975:			
Imperial West Medical Group	$1,071,837	$1,107,591	(a
Av-El Medical Group	760,859	648,134	
Omni-Rx Health Care, Inc.	13,645	77,061	(a
Individual Doctors	93,940	343,242	(a
Vocational Rehabilitation Associates, Inc.	-	4,644	(a
	$1,940,281	$2,180,672	
Year ended June 30, 1976:			
Imperial West Medical Group	$1,107,591	$1,136,065	(a
Av-El Medical Group	648,134	620,542	
Omni-Rx Health Care, Inc.	77,061	157,782	(a
Individual Doctors	343,242	320,412	
Vocational Rehabilitation Associates, Inc. (Note 10)	4,644	23,634	(a
(Note 3)	$2,180,672	$2,258,435	

(a) Increases are attributable to advances to, expenses incurred for, and management fees due from affiliates.

As to columns omitted the answer is "none".

ONNI-RX HEALTH SYSTEMS

SCHEDULE VI - ACCUMULATED DEPRECIATION, DEPLETION AND AMORTIZATION OF PROPERTY AND EQUIPMENT

COLUMN A DESCRIPTION	COLUMN B Balance at Beginning of Period	COLUMN C Additions Charged to Profit & Loss	 Charged to Other Accounts (a)	COLUMN D Retirements	COLUMN E Other Changes	COLUMN F Balance at Close of Period
Year ended June 30, 1975:						
Buildings	$ 82,015	$21,641	$ 6,110		$(11,268)(b)	$ 98,498
Office equipment	38,085	20,437	829			59,351
Medical equipment	64,712	30,138	1,224	$3,714		92,360
Leasehold improvements	34,994	18,481	1,903			55,378
	$219,806	$90,697	$10,066	$3,714	$(11,268)	$305,587
Year Ended June 30, 1976:						
Buildings	$ 98,498	$24,630	$	$		$123,128
Office equipment	59,351	22,602		428		81,525
Medical equipment	92,360	32,291		83		124,568
Leasehold improvements	55,378	26,406		2,834		78,950
	$305,587	$105,929	$------	$3,345	$-------	$408,171

a. Pro-rata depreciation charged to related entities.

b. See Note (a) of Schedule V, Property, Plant and Equipment.

OMNI-RX HEALTH SYSTEMS

SCHEDULE XII - VALUATION AND QUALIFYING ACCOUNTS AND RESERVES

Column A	Column B	Column C Additions		Column D	Column E
	Balance at beginning of period	(1) Charged to profit and loss or income	(2) Charged to Other Accounts	Deductions from reserves	Balance at close of period
Year ended June 30, 1975: Allowance for possible losses on accounts receivable and discounts	$572,476	$146,705	$361,527 (b)	$348,841 (a)	$731,867
Year ended June 30, 1976: Allowance for possible losses on accounts receivable and discounts	$731,867	$235,019	$570,941 (b)	$474,162 (a)	$1,063,665

(a) Accounts receivable written off.

	1975	1976
(b) Attributable to related entities	$152,312	$401,469
Interest charges per Note 2 (a) of financial statement	209,215	169,472
Totals	$361,527	$570,941

As to columns omitted the answer is "none".

OMNI-RX HEALTH CARE, INC.

FINANCIAL REPORT
AUGUST 31, 1976

GOLD, KIPNIS & KOHN, AN ACCOUNTANCY CORPORATION
LOS ANGELES, CALIFORNIA

OMNI-RX HEALTH CARE, INC.

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IRVING I. GOLD, C.P.A.
MIKE KIPNIS, C.P.A.
MELVYN A. KOHN, C.P.A.

(213) 839-2494

Board of Directors
Omni-Rx Health Care, Inc.
11616 S. Hawthorne Boulevard
Hawthorne, California 90250

We have examined the balance sheets of Omni-Rx Health Care, Inc. as of August 31, 1975, and August 31, 1976, and the related statements of income and retained earnings and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As described in Note 6, the Company is presently the subject of an investigation by the California Department of Corporations. The final outcome of this and other litigation matters, or of any action arising as a result of these matters, is not presently determinable; and the effect, if any, on present and future financial statements of the company is not presently determinable.

In our opinion, subject to the effect,if any, on the financial statements of the ultimate resolution of the matters discussed in the preceding paragraph, the accompanying financial statements present fairly the financial position of Omni-Rx Health Care, Inc. as of August 31, 1975 and August 31, 1976 and the results of their operations and the changes in their financial position for the years then ended in conformity with generally accepted accounting principles.

GOLD, KIPNIS & KOHN
An Accountancy Corporation

December , 1976

OMNI-RX HEALTH CARE, INC.
BALANCE SHEET
AUGUST 31, 1976
(WITH COMPARATIVE FIGURES FOR 1975)

ASSETS	CURRENT UNRESTRICTED FUNDS 1976	1975
Cash	$ 5,132	$ 1,059
Accounts receivable:		
Medi-Cal, net after reserve of $54,564	18,188	
California State Department of Health (Note 3)	350,000	323,962
Cash advances to enroller		29,819
Prepaid expenses	3,173	1,062
Total	$376,493	$355,902
LIABILITIES AND FUND BALANCES		
Accounts payable	$284,475	$197,062
Advances from agent (Note 4)	43,511	55,193
	327,986	252,255
Commitments and contingencies (Note 6)		
Fund balance (Note 9)	48,507	103,647
Total	$376,493	$355,902

The accompanying notes are an integral part of these financial statements.

OMNI-RX HEALTH CARE, INC.
STATEMENT OF REVENUE AND EXPENSES
AND CHANGES IN FUND BALANCES
YEAR ENDED AUGUST 31, 1976
(WITH COMPARATIVE FIGURES FOR 1975)

	CURRENT UNRESTRICTED FUND	
	1976	1975
Revenue		
Government contract (Note 2)	$3,879,086	$3,409,254
Contributions		58,874
	3,879,086	3,468,128
Expenses		
Health and care:		
Provider costs, per capita (Note 7)	2,358,689	2,015,540
Provider costs, fee for services	319,806	298,050
Salaries	21,500	29,207
Others	406,126	321,948
	3,106,121	2,664,745
Management and general (Notes 8 and 9)	828,105	702,397
	3,934,226	3,367,142
Excess of revenue or (expenses)	(55,140)	100,986
Fund balance (deficit) at beginning of year	103,647	2,661
Fund balance at end of year	$ 48,507	$ 103,647

The accompanying notes are an integral part of these financial statements.

OMNI-RX HEALTH CARE, INC.
STATEMENT OF CHANGES IN FINANCIAL POSITION
YEAR ENDED AUGUST 31, 1976
(WITH COMPARATIVE FIGURES FOR 1975)

	1976	1975
Funds provided by:		
Excess revenue or (expenses)	$(55,140)	$100,986
Increase or (decrease) in working capital	$(55,140)	$100,986
Changes in working capital:		
Increase (decrease) in current assets:		
Cash	$ 4,073	$ 973
Accounts receivable:		
Medi-Cal	18,188	-0-
Agent	-0-	(73,149)
California State Department of Health	26,038	299,375
Cash advances to enroller	(29,819)	29,819
Prepaid expenses	2,111	(11,438)
	20,591	245,580
Increase (decrease) in current liabilities:		
Accounts payable	87,413	148,275
Advances from agent	(11,682)	55,193
Notes payable, subordinated		(58,874)
	75,731	144,594
Increase or (decrease) in working capital	$(55,140)	$100,986

The accompanying notes are an integral part of these financial statements.

OMNI-RX HEALTH CARE, INC.
NOTES TO FINANCIAL STATEMENTS
AUGUST 31, 1976

NOTE 1: ORGANIZATION

Omni-Rx Health Care, Inc. is a non-profit corporation engaged in the marketing, promoting, managing, and administering of a pre-paid medical health care and service plan. The organization was incorporated in the State of California on May 2, 1972. It is tax exempt pursuant to Section 501 (c)(4) of the Internal Revenue Code and Section 23701d of the California Revenue and Taxation Code; consequently no provision for income taxes has been taken into the financial statements.

NOTE 2: GOVERNMENT CONTRACT

Effective September 1, 1972, the company entered into a contract with the State of California to provide health care services to eligible Medi-Cal beneficiaries who elect to enroll in Omni-Rx Health Care, Inc. In consideration of medical services provided, the State of California agreed to prepay monthly amounts based on the members category in the plan. Effective January 1, 1976 the company entered into a new agreement that provided an increase in the monthly prepayment through December 31, 1976.

The existing contract shall continue in full force and effect from January 1, 1976 to December 31, 1976. Realized revenue from the foregoing contract aggregated $3,779,231 during the year ended August 31, 1976 carried under revenue - government contract.

In connection with the regulations of the Social Security Act, and the Welfare and Institutions Code, (see Note 3) additional revenue amounting to $99,855 was recorded during the year.

NOTE 3: ACCOUNTS RECEIVABLE

At August 31, 1975, the Organization has claims against the California State Department of Health aggregating $323,962 composed of the following:

Under Section 209a of the Social Security Act and related provisions of the State Enabling Act, the company is entitled to receive four monthly payments from the State, at the regular rate, after disenrollment of certain classes of enrollees, effective January 1, 1974. The claim for the period January 1 through August 31, 1975 amounted to	$194,281
Under category 5's of the Welfare and Institutions Code, claims for the period from January 1, 1973 to August 31, 1975 amounted to	129,681
Total	$323,962

OMNI-RX HEALTH CARE, INC.
NOTES TO FINANCIAL STATEMENTS CONT.
AUGUST 31, 1976

The original amount of capitation fees considered collectible from the California State Department of Health aggregated:	$607,047
of which the following amount was initially placed in deferred income, and then written-off:	(257,047)
the balance of which was purchased by Omni-Rx Health Systems on October 13, 1976 and secured by a cash deposit from Farmers and Merchants Bank in the amount of:	$350,000

NOTE 4: ADVANCES FROM AGENT

The company has contracted with Omni-Rx Health Systems for management services. Monies transferred on account are charged to accounts receivable, and payments or accruals by the management service are credited to this account. As at August 31, 1976, credits exceeded charges to accounts receivable in the amount of $43,511.

NOTE 5: RELATIONSHIP BETWEEN OMNI-RX HEALTH SYSTEMS, INC. AND OMNI-RX HEALTH CARE, INC.

Omni-Rx Health Systems, Inc. and Omni-Rx Health Care, Inc. entered into a written management contract whereby Omni-Rx Health Systems, Inc. provides full management services for Omni-Rx Health Care, Inc. Three of the directors of Omni-Rx Health Systems, Inc. also serve on the Board of Directors of Omni-Rx Health Care, Inc.

NOTE 6: COMMITMENTS AND CONTINGENCIES

a. Certain claims for services rendered have been submitted to the Organization. The total actual amount of liability is estimated by management to be $25,500.

b. A bank has issued a letter of credit in favor of the State of California on behalf of Omni-Rx Health Care, Inc. in the amount of $400,000. At August 31, 1976, no drafts have been drawn against it. The letter of credit which expires on December 31, 1976 is guaranteed by Omni-Rx Health Systems.

c. In recent months, the Company has been the subject of investigations by the California Department of Health, California Assembly Sub-Committee on Health Care and the California Department of Corporations, the latter of which is continuing. These investigations have primarily centered on the pre-paid health care contract between Omni-Rx Health Care, Inc. and the State of California which expires December 31, 1976, and for which application for renewal has been submitted.

Since the investigation by the California Department of Corporations is still in progress, no determination can be made of the outcome thereof, including what action, if any, may result.

d. The Company is a named defendant in two actions brought by County of Los Angeles.

The plaintiff seeks damages in the sum of $38,217 together with interest thereon and additional damages which it alleges will continue to accrue. The Company filed its answer to plaintiff's Complaint denying any and all liability to plaintiff. Counsel believes that valid factual and legal defenses exist with respect to the Companys' ultimate liability to pay for a substantial portion of the County's claim.

Also, the Company was named as a defendant in a class action filed by the County of Los Angeles against some 18 prepaid health plans. The plaintiff seeks damages against the Company in the total sum of $89,963 together with interest thereon and additional damages which it alleges will continue to accrue.

The second case is a duplicate of the first case. Accordingly, the Company filed a demurrer to plaintiff's complaint. The demurrer was taken off-calendar prior to schedule hearing based upon the County's agreement to dismiss case. Although the County has agreed to dismiss the matter, it has not taken appropriate steps to do so, nor has it taken any action to further prosecute. Counsel is of the opinion that if recalendered, the demurrer will be sustained without leave.

NOTE 7: PROVIDER COSTS, PER CAPITA

The Organization has contractual arrangement with various medical groups to furnish complete medical care related services to the subscribing members of Omni-Rx Health Care, Inc. At the time of enrollment, the subscribing member shall be entitled to choose from the participating medical groups from which he wishes to receive services. The medical group and the physicians comprising the medical group shall be solely responsible for all medical advice and services performed or prescribed by them.

Under the terms of the respective contractual arrangement, base monthly compensations are made to the medical groups depending on the aid category of Omni-Rx Health Care, Inc. members. Such compensation amounted to $2,358,689 during the year.

OMNI-RX HEALTH CARE, INC.
NOTES TO FINANCIAL STATEMENTS CONT.
AUGUST 31, 1976

NOTE 8: MANAGEMENT AND GENERAL EXPENSES

Management and general expenses consists of the following;

	1976	1975
Management fees	$375,319	$340,925
Enrollment fees	166,850	223,746
Workmen's compensation and group insurance	18,381	10,183
Meetings and conventions	613	3,753
Promotion and entertainment	1,027	1,742
Salaries and payroll taxes (Note 9)	180,787	122,048
Provision for bad debts	80,064	-0-
Miscellaneous - Jarupa Valley	5,064	-0-
	$828,105	$702,397

NOTE 9: SUBSEQUENT EVENT

After the conclusion of audit field work, it was noted that salaries and payroll tax expenses (Note 8) were overstated in 1975 in the amount of $15,472. The effect on the 1975 statement is as follows:

	Original Presentation	Adjustment	Restated Presentation
Management fees	$340,925	$	$340,925
Enrollment fees	223,746		223,746
Workmen's compensation and group insurance	10,183		10,183
Meetings and conventions	3,753		3,753
Promotion and entertainment	1,742		1,742
Salaries and payroll taxes (Note 9)	94,610	27,438	122,048
Management and General Restated	$674,959	27,438	$702,397
Salaries	$ 57,843	(28,636)	$ 29,207
Other Expenses	$336,222	(14,274)	$321,948
Total 1975 Effect		$(15,472)	

These changes are reflected in Note 8 above and in the statement of Revenue and Expenses and Changes in Fund Balances for August 31, 1975 on Page 3.

The accompanying notes are an integral part of these financial statements.

OMNI-RX HEALTH CARE, INC.
REQUIREMENTS UNDER THE KNOX-MILLS HEALTH CARE ACT
AUGUST 31, 1976

12539	TANGIBLE NET EQUITY		
	Fund balance, August 31, 1976		$ 48,507
12539.1	CASH OR EQUIVALENTS		
	Non-contracted health care		$ 319,806
	Total health care		$3,106,121
	Ratio of non-contracted health care to total health care		10.30%
	Cash equivalent: Cash		$ 5,132
	Fee for service for year Excess over 10%	$319,806	.30%
12539.3	ADJUSTMENT OF TANGIBLE NET EQUITY		
	Tangible net equity		$ 48,507
	Less: Estimated liabilities		25,000
			$ 23,007
12539.4	ADMINISTRATIVE COSTS		
	Total income		$3,879,086
	Administrative costs (includes $116,850 enrollment fees) — 166,850		$ 828,105
	Percent		21.35%

The accompanying notes are an integral part of these financial statements.

IMPERIAL WEST MEDICAL GROUP

FINANCIAL REPORT
JUNE 30, 1976

GOLD, KIPNIS & KOHN, AN ACCOUNTANCY CORPORATION
LOS ANGELES, CALIFORNIA

IMPERIAL WEST MEDICAL GROUP

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MELVYN A. KOHN, C.P.A.

(213) 839-2494

The Partners
Imperial West Medical Group
Hawthorne, California

We have examined the Consolidated Partnership balance sheet of Imperial West Medical Group (Note 1) as of June 30, 1976 and the related statements of income and changes in equity balances, and changes in financial position for the six months then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the Consolidated Partnership financial position of Imperial West Medical Group at June 30, 1976, and the results of its operations and the changes in its financial position for the six months then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Gold Kipnis + Kohn
GOLD, KIPNIS & KOHN
An Accountancy Corporation

December 2, 1976

IMPERIAL WEST MEDICAL GROUP
CONSOLIDATING PARTNERSHIP BALANCE SHEET (Note 1)
JUNE 30, 1976

ASSETS	Imperial West Medical Group	Av-El Medical Group
Investment - Hawthorne Medical Building	$ 21,500	
Advances	245	
Total Assets	$ 21,745	$ None
LIABILITIES & PARTNERS' EQUITY		
Due to Omni-Rx Health Systems (Note 2)	$1,136,419	$ 613,822
Loans Payable	33,000	
Total Liabilities	1,169,419	613,822
Partners' Net Equity (Deficit)	(1,147,674)	(613,822)
Total Liabilities & Partners' Equity	$ 21,745	$ None

LITIGATION, CONTINGENCIES AND COMMITMENTS (Note 3)

The accompanying notes are an integral part of these financial statements.

GOLD, KIPNIS & KOHN, AN ACCOUNTANCY CORPORATION
LOS ANGELES, CALIFORNIA

Hawthorne Independent Doctors	Av-El Independent Doctors	Consolidated Partnership	
		$ 21,500	
		245	
$ None	$ None		$ 21,745
$ 115,157	$ 204,349	$2,069,747	
		33,000	
115,157	204,349		2,102,747
(115,157)	(204,349)		(2,081,002)
$ None	$ None		$ 21,745

IMPERIAL WEST MEDICAL GROUP
STATEMENT OF CHANGES IN PARTNERS' EQUITY BALANCES
JUNE 30, 1976

	Profit & Loss Ratio (%)	Capital Balances (Deficits) Year Ended 12-31-74	Net Profit Before Draw Year Ended 12-31-75	Partners Draw Year Ended 12-31-75	Net Profit Before Draw Six Months Ended 6-30-76	Partners Draw Six Months Ended 6-30-76	Capital Balances (Deficits) Six Months Ended 6-30-76
Koch Orthopedic Medical Group, Inc	15	$(847,615)	$143,346	$(109,900)	$72,917	$(75,231)	$(816,483)
Edward Dickstein, M.D., Inc.	15	(720,471)	143,346	(109,900)	72,917	(75,229)	(689,337)
Alvin Markovitz, M.D., Inc.	15	(720,471)	143,346	(109,900)	72,917	(75,229)	(689,337)
Robert Higginbotham, M.D.	15		131,346	(97,900)	48,917	(51,230)	31,133
Cranford Scott, M.D., Inc.	10		96,198	(73,901)	37,688	(39,230)	20,755
Anitha Mitchell, M.D.	10		72,197	(49,900)	25,688	(27,230)	20,755
Kenneth Geiger, M.D.	10		97,115	(74,817)	37,688	(39,230)	20,756
Barney Grier, M.D.	10		74,968	(52,670)	25,688	(27,230)	20,756
Total	100	$(2,288,557)	$(901,862)	$(678,888)	$394,420	$(409,839)	$(2,081,002)

The accompanying notes are an integral part of these financial statements.

Hawthorne Independent Doctors	Av-El Independent Doctors	Consolidated Partnership	
$ 497,010	$ 134,922	$1,265,405	
41,664	393,918	531,884	
538,674	528,840		$1,797,289
213,617	258,224	805,936	
139,573	33,730	251,609	
3,946	491	6,942	
		1,247	
2,075		2,225	
28,019	27,446	73,902	
		3,450	
		3,726	
		219	
		144	
		500	
		1,000	
		1,652	
98,389	151,442	249,831	
	485	485	
485,619	471,818		1,402,868
$ 53,055	$ 57,022		394,421
			(409,840
			$ (15,419

IMPERIAL WEST MEDICAL GROUP
STATEMENT OF CHANGES IN FINANCIAL POSITION
SIX MONTHS ENDED JUNE 30, 1976

SOURCE OF WORKING CAPITAL	
Net income (or loss) for period after partners' withdrawals (page 4)	$(15,419)
Add items not requiring outlay of capital:	
Reversal of prior period accrual	9,747
Current period accruals	5,672
USE OF WORKING CAPITAL	
Increase in amounts drawn by partners' on cash basis	(123,511)
Increase in long-term debt	(21,500)
(DECREASE) IN WORKING CAPITAL	$(145,011)

COMPONENT INCREASE (DECREASE) IN WORKING CAPITAL

	12/31/75	6/30/76	Increase or (Decrease)
Cash	$ 37	$	$(37)
Note receivable	150,000		(150,000)
Loan receivable	21,500		(21,500)
Advances		245	245
Loan payable	14,936		14,936
Due to affiliate	1,147,764	1,136,419	11,345
(DECREASE) IN WORKING CAPITAL			$ 145,011

IMPERIAL WEST MEDICAL GROUP
NOTES TO FINANCIAL STATEMENTS
JUNE 30, 1976

NOTE 1: ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES:

a. Organization - Imperial West Medical Group is a partnership of physicians licensed to practice medicine in California. The present partnership was formed on January 1, 1975, combining the partners of Imperial West Medical Group, Av-El Medical Group, Hawthorne Independent Doctors and Av-El Independent Doctors. The partnership has entered into a management and lease agreement with Omni-Rx Health Systems, Inc., a California public corporation, providing for a full range of management services by Omni-Rx which includes among other services, the furnishing of space, equipment, administrative personnel to maintain all medical and financial records including collection of patient receivables, data processing and financial management services. The partnership provides fee-for-service health care services and provides medical care to enrollees of Omni-Rx Health Care, Inc., a California non-profit corporation, affiliated with Omni-Rx Health Systems, Inc., which operates as a prepaid health plan.

The partnership is considered to be an affiliate of Omni-Rx Health Systems, Inc. by virtue of the fact that three of its partners' (Drs. Dickstein, Markovitz, and Koch) are majority stockholders and serve as officers and directors of the above corporation.

b. Summary of Significant Accounting Policies

Partnership books and records are maintained for bookkeeping purposes in accordance with the prior partnership entities (Note 1a) and are consolidated in this financial report. Books are kept on an accrual basis and converted to a cash basis at calendar year end for tax purposes.

The partnership does not hold the usual assets and liabilities since all cash accounts, patient accounts receivables and trade accounts payable are held in trust and accounted for by Omni-Rx Health Systems,Inc., under the management agreement.

Provision for State and Federal Income Tax is not made by the partnership as each partner is individually responsible for his pro-rata share of such taxes in accordance with prevailing tax regulations.

NOTE 2: Amounts due to Omni-Rx Health Systems, Inc. are primarily for advances and management service fees charged to the partnership after transfer to Omni-Rx of outstanding patient receivables in the net amount of $1,972,517 (net of an allowance for possible uncollectible accounts in the amount of $358,607) as partial payment of the indebtedness. The three principal partners (Dickstein, Markovitz and Koch) are jointly and individually responsible for payment of the indebtedness to the extent that it exceeds the equity deficits of the other partners.

IMPERIAL WEST MEDICAL GROUP
NOTES TO FINANCIAL STATEMENTS CONT.
JUNE 30, 1976

NOTE 3: LITIGATION, CONTINGENT LIABILITIES AND COMMITMENTS:

a. The partnership has entered into a management and lease agreement with Omni-Rx Health Systems, Inc. (Note 1a) which expires in 1981. Under the agreement, the partnership is responsible for payment to Omni-Rx of 57% of patient accounts receivable as collected as well as payment for certain extraordinary costs that may be advanced by Omni-Rx.

b. As a result of a private investigation by the Securities and Exchange Commission (SEC) of Omni-Rx Health Systems, Inc. a complaint was filed on September 1, 1976 against Omni-Rx, Imperial West Medical Group and other parties including Drs. Dickstein, Markovitz and Koch.

The action is a civil injunctive action seeking to stop Omni-Rx from purported violations of certain provisions of federal securities laws and seeks "such other and further relief as the court may deem just and appropriate". The SEC further seeks disgorgement of assets from Omni-Rx principals (including Dickstein, Markovitz and Koch) that were allegedly wrongfully diverted.

Since this litigation with the SEC is in the earliest stages of proceedings, Counsel is not yet able to express an opinion as to the eventual outcome of the action.

c. On May 9, 1975, a lawsuit for $300,000 in combined damages was brought against Omni-Rx, the former partnership of Imperial West Medical Group, the constituent partners thereof, and others. The suit, brought by a doctor formerly associated with the previous partnership, alleges breach of contract, fraud and negligent misrepresentation. On September 2, 1975, defendant Imperial West Medical Group filed a cross-complaint against the plaintiff. It is counsel's opinion that the cross-complaint should result in set-offs against the damages claimed by the plaintiff.

IMPERIAL WEST MEDICAL GROUP
CONSOLIDATING PARTNERSHIP STATEMENT OF INCOME (Note 1)
SIX MONTHS ENDED JUNE 30, 1976

	Imperial West Medical Group	Av-El Medical Group
INCOME		
Fees	$ 636,154	$ (2,681)
Capitation	46,065	50,237
Total Income	682,219	47,556
EXPENSES		
Management fee	302,664	31,431
Provision for bad debts	78,306	
Patient refunds	2,505	
Returned checks	1,099	148
Dues and subscriptions	150	
Malpractice insurance	18,437	
Consulting fees	3,450	
General insurance	3,726	
Office supplies	219	
Meetings and conferences	144	
Entertainment and promotion	500	
Director salaries	1,000	
Interest expense	1,652	
Associate doctors fees		
Miscellaneous expense		
Total Expenses	413,852	31,579
Net Income for Period before Partners' Withdrawals	$ 268,367	$ 15,977
Less Partners' Withdrawals for Period		
Net (Loss) for Period after Partners' Withdrawals		

The accompanying notes are an integral part of these financial statements.

GOLD, KIPNIS & KOHN, AN ACCOUNTANCY CORPORATION
LOS ANGELES, CALIFORNIA

Mr. Moss. Mr. Waxman.

Mr. WAXMAN. I wanted to clarify a few points that I didn't quite understand. Going back to the 3,500 figure, the 3,500 figure represents, as I understood the line of questioning, the number of young people under the age of 15, from birth to 15, that were enrolled in your plan, the family was enrolled in the plan, for whom there were no records indicating that they had been screened under the medi-screen program, which is to provide that every child shall be checked to be sure that thye're vaccinated and screened in some way in those early years, isn't that correct?

Dr. DICKSTEIN. I think so, but I think the——

Mr. WAXMAN. Well, let me finish, please. Now, your discussion with the chairman about prepaid health plan having a certain number of enrollees, some of whom were utilizing the services and others of whom were not; it is philosophically correct, as I understand the concept of your health plan maintenance organization, for the general population, but your contract with the State of California provides that all children will be screened, so that it can be determined that they receive the porper vaccinations and have the screening to see if there are any problems. This was by virtue of law that was passed so that we can prevent future illnesses with children, and so you contracted to provide that every single one of those you people under the age of 15—I'm looking at the provisions of your contract—every single one of them will have medi-screening and thereafter the plan would provide, upon capitation payment, all diagnostic and treatment services necessary as a result of conditions discovered during the screening under the medi-screen regulations. I'm referring to item 22 of the contract of Omni-Rx Health Care, Inc., with the State of California.

Dr. DICKSTEIN. Prior to this year, medi-screen services were offered but were paid separately from the prepaid contract. We had a medi-screen program under that. As of January 1, 1976, it was indicated that medi-screen would no longer be paid as a separate payment but would be included among the covered services of the prepaid contract, and that is the way it was written. And the intent, even if the wording says that, is not that every child must under all circumstances be subjected to a medi-screen. It is that this medi-screen must be available and should be done to all children who come into the program under the age of 21, I believe it is.

Mr. WAXMAN. Well, it is my understanding—you will have some judgment, I suppose, as to what is the correct division—that you get $28 a month for each of those enrollees under the age of 15 for which you have an obligation to be sure that they have undergone the medi-screening and not that it is available if they come in and take advantage of it, that's fine, but, if not, you receive the money for those particular services. I wanted to point that out because that was my understanding of the line of questioning. It was very different from the philosophical concept of a group of enrollees in a plan, some of whom may take advantage of the plan and others not, for which you do receive capitation. As I understand it, it is supposed to provide the screening for the young people, and the basis for your getting a capitation for those young people is that you will have on record an indication that they have received the screening for their health conditions and that it will be provided for each one of those in that record.

Dr. DICKSTEIN. What I'm indicating is that I think that the committee is wrong in its interpretation. What has happened is mediscreen has been made part of the covering services instead of being paid separately and that it is not a requirement. There is no practical way that I know that I can guarantee to get ahold of those 6,500 children and be sure that these are done. Just as a practical matter, I know it isn't going to happen, even if we make an attempt to.

Mr. WAXMAN. It is not your understanding that you're not entitled to the enrollment fee for that child if in an 18-month period of the capitation grant you don't have a record of whether they've gone there for that screening?

Dr. DICKSTEIN. No. We are entitled to it, just as I'm entitled to it if an adult signs up, I get the capitation if he never shows up for treatment.

Mr. WAXMAN. I want to ask you another question about the statement you made about emergency services. You indicated some memo internally in the county hospitals that indicated that they wanted to do some experimentation on patients that were members of prepaid health plans so that they could get the PHP's to pay for it? Am I correct in understanding your testimony?

Dr. DICKSTEIN. I'm not sure the word "experimentation" is proper there. Their indication was that these patients should be hospitalized and utilized for the teaching purposes of the hospital, as I recall the memo. We will get the memo and show it to you so you can see it directly.

Mr. WAXMAN. Now, if a patient showed up at the county hospital for an emergency service, even if that patient were then used for observation for learning purposes for other doctors, that wouldn't mean that you wouldn't have to pay for the emergency care rendered that patient if it was enrolled in your clinic?

Dr. DICKSTEIN. No. Again, I've indicated that emergency treatment is to be paid for, and if some agreement could be made with the county on the matter of these pending motions in the lawsuit, it would go forward and start making that—

Mr. WAXMAN. What lawsuit are you referring to?

Dr. DICKSTEIN. I'm not an expert. They have filed, I think, two kinds of lawsuits. One was that the county—one was against the prepaid health plans individually and one was as a group, and I'm not sure—I don't think it has ever come to issue.

Mr. WAXMAN. The lawsuit was to collect the money that they feel is due them because they handled the cases as emergency?

Dr. DICKSTEIN. That's correct.

Mr. WAXMAN. And you deny that those were emergencies or deny that you're to pay them that money for some other reason?

Dr. DICKSTEIN. We're denying the total amount in terms of a complete accounting in the system. This was done as a group for all the prepaid health plans. It wasn't Omni-Rx in particular. It was a matter of attempting to control what appeared to be in many instances overtreatment within the county system of PHP patients for teaching purposes.

Mr. WAXMAN. You think when they get a patient that comes in for emergency purposes that they overtreat that patient and then try to

charge him more than you think you're entitled to pay, is that your testimony?

Dr. DICKSTEIN. This would appear to be the instance in many cases. There are cases, for instance, where the woman will come and deliver the baby, and she would be told to come back a week later to have her tubes tied, which clearly is not an emergency procedure but one which should have been referred back to the prepaid health clinic.

Mr. WAXMAN. Where is that lawsuit now? Have you sorted out some kind of accounting? You know that in some of these cases you are obligated by law to pay, they are emergency cases, and they are services for which you are legally obligated. Why is it necessary to have a lawsuit? Why can't you go through and have an accounting and say this one we're obligated to pay but this one we have some question about?

Dr. DICKSTEIN. The plans have had meetings with the county for over, I guess, a year or two periods, in which they attempted to work this out, unsuccessfully, and finally the lawsuit was filed, and we still attempted to work it out. We asked for the signing of that stipulation, as I mentioned, which has never been signed.

Mr. WAXMAN. Maybe Dr. Gasster has some comment on that.

Dr. GASSTER. I would like to say I have no direct knowledge that the figures in the form you have represent all acute care. It could very well be possible that someone came in, had a delivery, and was asked to come back for a tubal libation. That is a real possibility. I was asked to review charts on the cases of whether or not they were emergencies, and all of the charts that I reviewed were emergencies. I think some people may be asked to return for follow-up care. Many of these people, to our knowledge, are not enrolled in a PHP, and since we are providers of the last resort we are obligated to see and examine those patients. Many patients come into the emergency room and are not admitted to the hospital, but many of them receive hours of extensive medical care and laboratory tests to be 100 percent certain that no emergency does exist. Those cases, we feel, we should be paid for.

Mr. WAXMAN. Should you get paid by the plan if they're enrolled in the plan?

Dr. GASSTER. Well, if they are enrolled in the plan and Harbor General Hospital examines that patient in the emergency room, in good faith, if they complained of abdominal pain, and after examination, laboratory and X-ray studies we feel that it is not an emergency and do not admit the patient but subsequently find out that he is a PHP enrollee, then we feel we should be able to bill for those services.

I think one of the difficulties we face, as Dr. Rozofsky said, the people we see in our emergency room are sick people. It would be great if we could have a microfilm system so that we knew every patient that came in, whether he was a Medi-Cal patient or PHP patient, that they were not acutely ill, we could refer them right over to the PHP, and we do that when we know.

Other than that, I have no further comments to make to these figures.

Mr. WAXMAN. Dr. Dickstein, did you have something?

Dr. Rozofsky, did you have something that you wanted to add?

Dr. ROZOFSKY. These figures, I'm sure, don't represent any of the outpatients claims at all; inpatient days may run to $300 or more per day, large numbers of the outpatient claims are obviously smaller, $50, $75

per claim, et cetera. The screening of them becomes an intense thing. The patient has already gotten his emergency care and is gone before we even know if it is a PHP patient or make contact with him, et cetera.

The other thing I was going to say was that in some 4 months, in which I have been watching these things very carefully, at our county teaching hospital—whereas we would take care of an unusual case requiring unusual skill and of teaching interest, that case would not be billed to the PHP. Our board of supervisors' policy specifically states that.

We also do not bill PHP's for cases where the PHP patient says, "I don't want to go to the PHP," we simply have to take care of them because we are the hospital of last resort or the care of last resort, so we take care of them regardless. In that case the PHP also is not billed. And where we know that the patient is a PHP and can be transferred, we tell the patient that he will pay the bill, that he will be billed since he belongs to the PHP, so that the bills that are listed here, the money owed, are primarily, on emergency cases, and as I said, I have for 4 months watched very, very closely, and we've had not even one case specifically for teaching purposes. We have had some who refused to go to the PHP. The PHP was not billed in those cases because, obviously, it is not their fault. Nevertheless, we have to take care of the patient.

What's here and what we have submitted bills to PHP's for, are primarily, and it would be way up into the high percentages, emergency care, and in some cases, as a matter of fact, where, you know, the care would only be able to be gotten at some such facility. But it is emergency care that we have to take care of. That's what this represents, and that's what the county is trying to get reimbursed for.

We will eventually try to do this on the outpatient cases, but at the moment the amount of screening and the cost of doing this, it is a cost accounting figure as to whether we would be further ahead.

But this is essentially inpatient emergency care—at Los Angeles General, Martin Luther King, Rancho, and our hospital.

Mr. WAXMAN. Thank you.

Dr. Dickstein, I think——

Dr. DICKSTEIN. May I make one comment?

Mr. WAXMAN. Let me ask a question, otherwise we go back and forth. I'm trying to focus on specifics.

I gather what is really at issue here is whether the taxpayers on the various levels of government are paying twice, maybe three times for the same treatment that an individual gets, because if you get a capitation payment in advance to take care of certain medical needs that might come up for an enrollee and tha enrollee is treated by L.A. County General Hospital, and that the county taxpayers or the property tax is paying for that service, while the State taxpayers and the Federal taxpayers are paying for your capitation grants, then the taxpayers are paying more than once for the same service. But also what relates to all this is the question of whether your company is solvent and if you owe all of these bills that is not reflected in your financial statement, then your net equity may not be satisfactory to meet the standards set forth in the law.

Dr. DICKSTEIN. You are asking two questions. Maybe I can answer one of them, too. This relates, and I think the doctor has mentioned that if they could have a microfiche of some kind that had all of these

and then determine the status of the patients, that a lot of these problems would not arise.

One of the major problems we have relates to this recordkeeping problem that was brought up this morning in terms of certain patients getting care, apparently, with Medi-Cal cards who are enrolled in PHP or something of this kind. Last year in this State there were 700,000 temporary Medi-Cal cards issued in a population of about 2½ million. That means that there was a screw-up of some kind, people couldn't be identified for some reason, and what it basically relates to is that the county recordkeeping system—they are the ones that enroll the people in the Medi-Cal system—is not compatible with the State program. They don't communicate with each other. Frequently they are not able to identify the correct status of a patient for any given month. So what we find in our rolls is the patients go on and off. The county will lose them for a month or two, and then our payment will be denied even though the patient is still elegible for care.

There are certain categories of patients, under section 209(a) of the HMO Act, where we should be getting payment for a certain period of time where this payment has not been forthcoming, up to 1,000 patients at a time are carried. This kind of thing means tremendous amounts of money. So in those instances the money is being taken away incorrectly from us, and in the other instances where the patient has been issued a Medi-Cal card, they may choose to use it with some provider, then the government is making a double payment. I don't know how the dollars work out back and forth, but it is basically a recordkeeping problem. It has to be resolved between the county and the State. As long as this exists we're going to have this discrepancy, and as long as they're unable to make this identification, continue to issue that number of temporary Medi-Cal cards, the system is just ripe for all kinds of problems. We can't tell who the patients are. We have a mixed kind of practice. Somebody wanders in and says, "I am your PHP patient." We check the list and his name is on there. The next person wanders in and presents a Medi-Cal card, that Medi-Cal card is accepted. Once the patient gets by that admitting desk, the provider has no way of knowing what the payment mechanism is. He is seeing a patient. He does whatever is required for that patient. It just doesn't get picked up. So the possibilities are the patients can get—or the State may be billed for patients who have, in fact, gotten the second Medi-Cal card from the State or from the county in error.

Mr. WAXMAN. Do you know which patients are enrolled in your plan which are involved in——

Dr. DICKSTEIN. Well, if the patient comes in and says, "I am enrolled in the plan," we check and say yes, but, you know, we don't know.

Mr. WAXMAN. When you get a bill from county hospital that they treated Mr. X, can't you check to see if Mr. X is, in fact, enrolled?

Dr. DICKSTEIN. Oh, yes. That's not the problem, not the total recordkeeping. At this time, if the recordkeeping were available, then the county would be able to identify many of these patients and send them to the proper hospital for treatment, not provide that care. For instance, the patient with an acute abdominal problem would have to be transferred from Martin Luther King Hospital. The hospital we were using is just a few blocks from Martin Luther King. The patient can just as easily be transferred there. So in that sense it is an emer-

gency but could have been treated by the plan if we had been alerted. It is a sloppy system that I think nobody particularly likes. There are problems which arise which don't necessarily represent ill will or an attempt to evade a responsibiilty. I mean, there are just problems inherent within the system in the way it is constructed at the present time.

Mr. WAXMAN. Problems where the taxpayers are paying at least twice for and in addition to that paying bureaucratic costs. Perhaps it's not your fault, but nevertheless, as I see it, the problems have to be resolved if we are going to have a health care system as medicaid.

Dr. DICKSTEIN. I have 1,000 patients that are not identified. They tell me they simply can't find them and will not pay me, so I've lost $30,000 to $40,000 that month because I haven't access to the county enrollment system. I know the patients belong to me. They said they cannot identify them and they will not pay the bill.

Mr. WAXMAN. I want to ask you another line of questioning. I'll be very brief.

Mr. Moss. Very briefly, let me interrupt to say that unless there are additional questions for the two gentlemen on my right, why, the Chair will excuse you.

Are there any questions?

You may be excused. I understand you have a plane to catch.

Dr. GASSTER. Thank you, Mr. Chairman.

Mr. Moss. We thank you for your appearance.

Mr. WAXMAN. Dr. Dickstein, earlier Mr. Segal asked you about some statements that you have that you claim were provided by the Department of Health that showed computer printouts, indicating a profit for your organization of a weighted average of 53.1 cents out of each dollar going to net profit and not going to the services for patients. What are your responses to that figure? Is that an accurate figure, amount of profit, that you receive for the payments, each dollar payment, for the treatment of a person enrolled in your prepaid health plan?

Dr. DICKSTEIN. Unfortunately it is not accurate at all. I wish we could make money like that. Our actual profit on the Medi-Cal dollar is about 3 percent. What has happened here is that they have picked out evidently the one most profitable segment of the internal use of the dollar and they have then attribtuted.

Mr. WAXMAN. Let me correct it. These are ancillary services, talking about a number of categories. Is it accurate for ancillary services to say that you receive 53 cents out of each dollar by way of profit for those services?

Dr. DICKSTEIN. No; because we don't figure our profit that way. We make an internal, arbitrary capitation division of how we spend the dollar, but the entire use of the money is spent in the operation of the system. In other words, if those dollars were not available, then probably the system would not be able to operate.

Mr. WAXMAN. Aside from whatever way you might want to handle it internally, is it safe to say, after you subtract the actual cost of care, that there is a leftover 53 cents of a dollar that you then deal with in some other way?

Dr. DICKSTEIN. No; I don't think that's correct.

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Mr. WAXMAN. You indicated that those computer printouts were not available to the Department of Health. I couldn't understand where they came from. Do you have any notion about that?

Dr. DICKSTEIN. They have been supplied to 100 people that have come through our office to investigate something or other. Those were given to the GAO. The auditors may have requested them at some point. They are certainly not secret documents.

Mr. WAXMAN. But they are documents that have come from your plan?

Dr. DICKSTEIN. These are raw figures unadjusted. I can look at them and immediately see some errors, things that were not taken into account. I don't think that the 53 percent is a correct figure. The total profitability on medicaid dollars appears to be 3 percent.

Mr. WAXMAN. 3 percent?

Mr. DICKSTEIN. 3 percent.

Mr. Moss. Do you yield at this point?

Mr. WAXMAN. Yes.

Mr. Moss. The questions here, of course, go to PHP health, which is different than Medicaid health.

Dr. DICKSTEIN. That's almost the total number of medicaid dollars in the system.

Mr. Moss. And you talk of the very preliminary nature of these figures. Now, I can accept that there may be some adjustments before a final statement is prepared, but I cannot accept the contention that you could incorporate it into a consolidated income figure, which would be very far off base. You might determine that account A should carry the figure rather than account B. But you're going to allocate it again before the final statement is drafted. In order that we may properly evaluate this material, we will ask that the final statement for this period will be supplied to the subcommittee, and at this time I would ask that the record be held open to receive it.

I would expect that we would have access to such working papers as necessary to make a proper determination.

Dr. DICKSTEIN. Everybody has access to all of our papers. We have no secrets.

Mr. Moss. Well, now, doctor, obviously, that isn't so because you have some marked for internal use, and when you first took the stand you disclaimed knowledge in detail of the material, and we had a question as to whether or not they did actually come from the Omni-Rx health systems, and so everyone does not have access. I merely want to make very certain that, at least, those of us here have access. And I am holding the record to receive that material.

Now, if you need a refinement of the request, the staff will be available to you for the purpose of making very clear precisely what it is you seek.

Dr. DICKSTEIN. Certainly.

[The material described above was subpenaed by the subcommittee and examined by the subcommittee staff.]

Mr. Moss. All right. I was just handed a letter here signed by Merv Newell, vice-president of Omni-Rx Health Care, Inc. There the statement is made, "We do not possess financial statements for the remainder of the providers and subcontractors included on the enclosed list." And then the statement further made is "We do not possess financial

statements for the remainder" and then the statement that you cannot assure that some persons will be willing to provide the financial statements. They are the Av-el Medical Clinic, Imperial West Medical Group, Physicians Outside Providers.

Dr. DICKSTEIN. I believe you probably have the Av-el and Imperial West because those are within our control.

Mr. MOSS. All affiliated groups.

Dr. DICKSTEIN. Yes. So that you would have. What we do not have are providers. We have some contracts—

Mr. MOSS. We would ask that that material be provided for the record.

Dr. DICKSTEIN. I don't know how to get it, sir.

Mr. MOSS. You just indicated that you have it.

Dr. DICKSTEIN. That which we have internal control of, but these various outside providers I——

Mr. MOSS. Let's first deal with that over which you have internal control.

Dr. DICKSTEIN. Yes.

Mr. MOSS. And then that we will expect you to supply.

Dr. DICKSTEIN. Yes.

Mr. MOSS. The other we will discuss——

Dr. DICKSTEIN. My counsel informs me that it was sent to you, so you should already have it.

Mr. SEGAL. Are you claiming you've sent us the audited statement of Av-el and Imperial West Medical Groups?

Dr. DICKSTEIN. They were not audited, no.

Mr. SEGAL. You have not sent us unaudited statements of one of the medical groups. You have only sent us an unaudited statement for one group.

Dr. DICKSTEIN. Av-el has not done any business. All the business was consolidated into Imperial West Medical Group in the past year, so all the figures would be reflected in the statements of Imperial West Medical Group.

Mr. SEGAL. Av-el has received money from the prepaid application contract, has it not?

Dr. DICKSTEIN. Not in the last calendar year, not since January 1, 1975.

Mr. SEGAL. The letter to the Governor, of which you have a copy—I saw it on your desk—you have an approximately $70,000 to primary physicians of Av-el Medical Group, is that not correct?

Dr. DICKSTEIN. If it was for the 6-month period before January 1, 1976, then there would be figures for Av-el——

Mr. MOSS. We would want to go back and get the material reflected in payments which involve the shared funding by the State and Federal Government.

Dr. DICKSTEIN. Yes. OK, that's available.

Mr. WAXMAN. I have no more questions.

Mr. MOSS. Mr. Scheuer.

Mr. SCHEUER. Dr. Dickstein, I take it you are familiar with the 20-page letter written by your vice-president to the governor of this State.

Dr. DICKSTEIN. Yes.

Mr. SCHEUER. Apparently, there are a number of officials in this State, of the county organization, the department, the committee of the assembly, in addition to that the officials of the Securities and Exchange Commission, who feel that in general that your operation requires a great deal of scrutiny. It is perfectly obvious that they think, each in their own way, that there is considerable wrongdoing going on. You get the impression that they think there is pervasive, systematic wrongdoing. There's no other explanation for the fact that all of these agencies of the government seem to be focusing on you and your organization. Do you have any explanation for why you are getting all of this attention?

Dr. DICKSTEIN. Well, yes, I think I could go into that.

First, the matter of the Securities and Exchange Commission was brought up this morning. As the counsel indicated, this is something to which we are answering that complaint. We have not entered into any consent at this time, and it is our intention to specifically deny these allegations of the Securities and Exchange Commission.

I am not surprised that this kind of problem arose. When I originally spoke to the Securities and Exchange Commission sometime in 1971 or early 1972, when we first filed our submission, I indicated to them and I thought that we had an unnecessarily complex type of operation in the handling of multiple corporations. They didn't understand the original financial presentation that we made to them, and they insisted that it be presented in a different way, that I indicated to them was not, in my opinion, proper; it would be misleading to the public. They, nevertheless, insisted that it be presented in that particular fashion. In order to get the issue out, we did, in fact, do so. It was a difficult issue to get out. This was the first medical company of this type that has ever gotten an S–1 issued through the SEC, and where they have nothing to go back and look at before. The staff was very confused, and we had many problems. I told them at that time that I felt difficulties would arise, and I told the people in the State that I thought difficulties would arise, the corporations people and the legislators, at subsequent times.

My feeling has always been that there should be a law that says that a corporation may practice medicine, and if this type of law were in existence, then none of the problems that we've been talking about today, or most of them, would not exist. The odd financial kinds of transactions would disappear. As intercompany accounts they would not have occurred, they would not have stood out. This is specifically what that single monetary transaction of the SEC questioned was, it was an intercompany transaction with the funds subsequently returned back into the system. They never, in fact, left that system. We have told the SEC this; we are able to demonstrate it; we will do that to their satisfaction, I am certain of it. Discussions are still underway on that point.

I think this is extremely important, that I managed to get a partial provision for corporate practice in medicine into the new Knox-Keene Act. The corporate commission before made reference to the fact that we had presented proposal for partial consolidation of the company. We had always wanted to do that. This type of measure would allow us to do at least partially. It doesn't cover the fee for service items unfortunately. That still forces us to maintain some type of complex

organization. The organization we chose was not because we wanted it that way or to obfuscate anything. It was dictated to us by the Department of Health at the time we got our initial prepaid contract. They told us they wanted us to have this type of series of organization, which we did, in fact, establish.

I might say further that the Omni-Rx health systems, came into being. The concept existed prior to our obtaining any medicaid contract, and the problems had nothing to do with the fact that we subsequently went into the medicaid program, may be an additional complication which has aroused your interest, but it had nothing to do with our operations as such. So if things were simpler, I think that we would not see problems like this. To the extent that the law remains complicated and corporate medicine is not allowed to practice, and I think we are going to see more problems like this. Medicaid dollars would be very difficult to follow through that. We could do it with single company with that single change in the law, and that would be my plea to this committee.

Mr. SCHEUER. What I'm trying to say, Dr. Dickstein, is there seems to be a broad-spread feeling that there's systematic wrongdoing going on in your organization, the SEC is after you, the State investigating committee of the assembly is after you, you've had problems with the corporation, I don't know, you obviously have problems with the county board of health. Why is it that everybody seems to think that you're a bad apple in the barrel?

Dr. DICKSTEIN. I don't think everybody thinks that. We are not a bad apple in the barrel. In spite of intense investigation that's now been going on over a year, no single one of these allegations has been proved. They keep cropping up as long as investigating bodies insist on talking to disgruntled employees who have been fired who make anonymous charges or people within the bureaucracy or within the legislative system that may have some self-interests served when they're going to get stories that serve those self-interests. I think we have stepped on some large toes along the line, possibly unknowingly, and have ended up at the point where a lot of people are just after us. We intend, if necessary, to pursue this and clear ourselves. My feeling is that none of these allegations will be substantiated. No significant charge made against us at this period of time has been substantiated.

Mr. Moss. You're not suggesting that this committee is moving from any such motivation or as a result of pressure from persons, disgruntled or otherwise.

Dr. DICKSTEIN. My unhappiness with this particular hearing is that it comes at a time when so many issues are presently pending before regulatory agencies which are not yet resolved.

Mr. Moss. It also comes at a time when the Congress is increasingly concerned with the escalating costs of medical services, and the Congress is under some pressure and criticism by the public because of escalating costs, and the committee is charged with determining the facts and recommending to the Subcommittee on Health and the Environment, which will be writing additional legislation. It comes at a time when we are starting to implement the recently enacted HMO programs and is illustrative of some of the problems that we can anticipate as HMO's are formed and move forward to provide medical service.

If you have any information to the contrary, why, the Chair feels constrained to permit you to lay it fully on this record because I want no innuendo. This committee does not operate that way, it has not operated that way, nor shall it, as long as I am chairing it. I don't think that my colleagues would tolerate it if I were to pursue any other course. So, if you have anything that would indicate to the contrary, then you place it on this record and place it now.

Dr. DICKSTEIN. The problems with Medi-Cal moneys, I think, have existed for many years, and the deliberations of all of these agencies, including the corporations commissioner and the HEW and the Department of Health has been largely concluded. I think it will be finished in a few weeks and provide many of the answers that could have made a lot of this questioning during this day unnecessary. On the other hand, the HMO certification before HEW is pending, and I believe is being held up pending the completion of this hearing. I don't know what the action of that will be.

Mr. MOSS. Therefore you should welcome the hearing in order that it no longer be held up, if that is your conclusion, should you not?

Dr. DICKSTEIN. I would hope that's true, yes, sir. If it is no longer held up, then I will be happy.

Mr. MOSS. We must schedule business as it is possible to secure the time and the Members and as cases develop. The Congress cannot base itself for the convenience of individuals when it is studying broad problems or we would never get our work done, and we do try rather diligently to see that the public business is transacted.

Dr. DICKSTEIN. I appreciate that, but at the same time I couldn't help but being impressed by the fact that this hearing is held at the same day as a contract renewal hearing is being held in Los Angeles and HMO.

Mr. MOSS. Are you implying that there was collusion, Doctor?

Dr. DICKSTEIN. I'm not making any implication whatsoever, sir.

Mr. MOSS. Do you think there was?

Dr. DICKSTEIN. I have no information to that effect.

Mr. MOSS. Let me disabuse you, there wasn't. You were not required to be present at that hearing. I went to the length of contacting Dr. Luckner, and I have a letter from him stating that the appearance of you on behalf of Omni-Rx before the State department of health would not be necessary in any way. So we are not prejudicing your rights before that body.

At this point I would place in the hearing record the letter I received from Dr. Luckner confirming to me that your appearance there would not be required.

We don't attempt to deprive you of anything because of your appearance before this committee of the House.

[The letter referred to follows:]

STATE OF CALIFORNIA,
DEPARTMENT OF HEALTH,
Sacramento, Calif., November 18, 1976.

Hon. JOHN E. MOSS,
Chairman, Subcommittee on Oversight and Investigations, District Office, Sacramento, Calif.

Dear CHAIRMAN MOSS: As you are aware, a public hearing is set for Monday, November 22, in Los Angeles on the question whether to renew the prepaid health plan contract of Omni-Rx Hea'th Care, Inc. I understand that your Subcommittee is holding hearings on that same day in Sacramento. Your Subcommittee has

subpoenaed Dr. Dickstein of Omni-Rx to appear at your hearing, and I have been advised that he has expressed some hesitance to do so on the basis that he must appear at the Omni-Rx renewal hearing in Los Angeles.

This is to advise you that, although Omni-Rx is expected to make some presentation at the public hearings, neither Dr. Dickstein nor any other particular member of the Omni-Rx organization is required to appear there, nor have any subpoenas been issued to any individuals from Omni-Rx. On Thursday, November 18, 1976, Quin Denvir, the Department's Deputy Director for Legal Affairs, telephoned Dr. Dickstein to inform him that the Department did not require his presence at the Los Angeles hearing.

As I have advised your staff, notices of the Los Angeles renewal hearing were mailed out on October 26 to some 8–10,000 people, and, accordingly, we are reluctant to postpone the hearing. I regret any inconvenience which the scheduling of our hearing has caused you and your Subcommittee.

Sincerely,

JEROME A. LACKNER, M.D.,
Director of Health.

Dr. DICKSTEIN. He told me of the letter. I would simply submit that the Department of Health may not be the best judge of the best interests of the Omni-Rx Health Care.

Mr. MOSS. Well, I must submit that there are points where I shall become the best judge of how we shall operate the committee, and I will accept that responsibility, and I do it on this record, and if there's any quarrel with it I'm willing to entertain that now because I don't want to deprive you, but I don't think you've been prejudiced as a result of your appearance here today.

Dr. DICKSTEIN. I have accepted that and I have appeared at your request and hopefully have answered all questions put to me to your satisfaction.

Mr. MOSS. Are there any other questions?

We have no further questions, doctor, at this time, and you are——

Mr. SCHEUER. May I ask one?

Mr. MOSS. Yes.

Mr. SCHEUER. Dr. Dickstein, you must be aware from your activities in the prepaid health systems of the many criticisms of the system, the abuses that have taken place, the overuse, the overcharges, the duplications. You must also be aware of the abuses that have taken place in other parts of the country in the medicaid system. Do you feel that looking at it from an entrepreneur in the private sector in health services delivery, that it is even theoretically possible for the Federal Government to design a federally financed program for the delivery of health services which includes the participation of the private sector on a full profit basis, on a reimbursable basis, or on a prepaid basis, that will not be subject to the kind of systematic abuse and fraud and ripoff that you have read about in the paper and that have taken place in all parts of the country?

Dr. DICKSTEIN. I don't believe any perfect system is possible. There are two principles in physics which you may be aware of. One is called Goedel's law, which says that no system is perfect, it is either incomplete or inconsistent. The other is the Heisenberg principle, which says that you can't determine both the position and the velocity of the particles at the same time. Simply looking at something changes the way that it is done. I think the more the Federal Government becomes involved and looks at the system, it is going to effect the operation of the system.

If it is your intention to create a system that will never have any abuses, I think you are doomed to failure. If you have a system in which there is a reasonable degree of latitude of the entrepreneur so-called is allowed and they are given some free rein in which to practice good medicine and given parameters in which to practice and are told the amounts of money that you wish to spend and what you should get for it, and both sides stick to the contract, I think it is capable of getting a very good system. I have very little faith in the ability of the public sector itself to provide these services because it lacks a cost consciousness because they are always dealing with other people's money. There's very little ability to conserve that. If it is our money, then we work to see that the system is working as efficiently as possible.

I think there will always be problems. There is no way of satisfying all the people, all the entrepreneurs, all the legislators.

I think that the profit system probably represents a very good way to go and, at least, demonstrates a measuring rod against which other types of systems can be compared. If you knock out all private, then you really haven't any way to judge the efficiency of our public system. We will need both. We will need continuation of the private practice sector in medicine. My conception is that once a national health system is legislated, that within perhaps 20, 25 years we will see 75 percent of the people in the United States enrolled in a system of that kind. We will see good medical care.

Mr. SCHEUER. Thank you.

Mr. MOSS. If there are no further questions, you are excused at this time, and we ask that the material requested be supplied to the committee. The staff will be in touch with you for determining that.

At this time we will be hearing from Mr. McLeod, Director of the Office of HMO Qualification and Compliance.

[At this time William J. McLeod was duly sworn.]

Mr. MOSS. Will you identify yourself for the record?

TESTIMONY OF WILLIAM J. McLEOD, DIRECTOR, OFFICE OF HMO QUALIFICATION AND COMPLIANCE, OFFICE OF ASSISTANT SECRETARY OF HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. MCLEOD. Mr. Chairman, I am William J. McLeod, Director of the Office of HMO Qualification and Compliance, Office of Assistant Secretary of Health, U.S. Department of Health, Education, and Welfare.

I was asked to come here today to review with you the progress that we have made in reviewing the application of Omni-Rx Health Care, Inc., to be recognized as a federally qualified health maintenance organization under the provisions of title 13 of the Public Health Service Act.

Before I get into the review of that act I would like, very quickly, to review with your committee the activity that our office encompasses in its relationship to the other parts of HEW with respect to Omni-Rx.

Title 13 is one of the more recently enacted titles that provides for a systematic program of financial support, market assistance through a mandatory offering of the qualified agent to employers and a pro-

gram of continued regulation of organizations that have been recognized as qualified agents.

At the present time Omni-Rx Health Care Systems, along with some 73 other organizations, have applied to our office for recognition under that title.

At this time Omni-Rx is the oldest of the applications that have not yet received a determination. Our original application was received from Omni-Rx on November 17, 1975, just over 1 year and 5 days ago. Our review process is a complicated one, one that involves the use of a multiple disciplinary routine, one involving a legal review, a marketing review, a financial review, and a medical care review. Our review also encompasses both a desk review of written applications, as well as an onsite inspection, once we have been satisfied that the written material adequately documents that there is likelihood that the organization has complied with all provisions of title 13. As I mentioned earlier, the original application was received in November and we completed our desk review in late March 1976.

On April 9, 1976, a letter was sent by my office to Merv. Newell of Omni-Rx Health Care, indicating that our desk review of their written application had covered so many deficiencies that we suggested that they withdraw their application, following the advice we had in our letter, and to formulate a new written application for qualification. By return mail we were informed by Omni-Rx Health Care that they had no intentions of withdrawing their application and instead were going to cure the deficiencies that we had cited as a result of our desk review.

In fact, on June 23, 1976, additional materials were provided by Omni-Rx Health Care in an attempt to correct the deficiencies that were being cited in our April 9 letter. We completed our desk review of that additional material, and despite some continuing reservations, decided to continue through with a site visit to see if a face-to-face meeting with the principals of Omni-Rx Health Care might answer some of our questions. Beginning on September 23, 1976, a site visit was conducted on the premise of Omni-Rx Health Care in Hawthorne, Calif.

As a result of the information we gathered on the site visit, we were still unable to determine whether or not the organization complied with the provisions of title 13 of the Public Health Service Act.

On October 4 we sent a letter once again to Omni-Rx Health Care, citing 19 additional pieces of information that we needed to complete our review. On October 26 of this year, additional material was provided by Omni-Rx Health Care in an attempt to answer the additional questions that we had raised in our October 4 letter.

This week another letter will be going back to Omni-Rx indicating that their October 26 reply was not responsive to the issues that we had raised and we are still in need of at least three or four additional pieces of information.

At the present time our review is open and continuing.

I would be happy to answer any questions you and the members may have.

Mr. Moss. Mr. Segal.

Mr. Segal. Mr. McLeod, is it the case that Omni-Rx is not only asking for designation as a health maintenance organization but is also seeking a loan from the Federal Government?

Mr. McLeod. Yes. These are two separate procedures within HEW. But they have requested a loan to assist in meeting operational expenses. The loan requested was received shortly after the application for qualification was received back in 1975.

Mr. Segal. And how substantial is this loan? Is it for three-quarters of a million dollars?

Mr. McLeod. I believe it is in that range, yes, sir.

Mr. Segal. Do they indicate the problems in their organization that cause them to need this money, to apply to the Federal Government for it?

Mr. McLeod. As I mentioned, a review of loans is handled by another agency within the Public Health Service, but it is my understanding that the purpose of the loan was to meet operational deficits that would be caused by operating as a qualified HMO.

Mr. Segal. OK. In your review, Mr. McLeod, you asked the accounting firm of Arthur Young & Co. to review the Omni-Rx application. There was documentation, according to a July 28 letter, that they did not find adequate information to complete such an analysis. Has Omni-Rx supplied you with the additional material necessary?

Mr. McLeod. No.

Mr. Segal. Has Arthur Young looked at the additional material that was sent?

Mr. McLeod. Yes. The letter that you refer to was in response to their evaluation of the additional materials submitted on June 23. Arthur Young & Co. made a site visit in September and have been in receipt of the material that we received from Omni-Rx on October 26. As recently as Friday I had communicated with the Arthur Young folks and they indicated that they still were lacking the necessary information to make a firm determination on the fiscal soundness of the organization.

Mr. Segal. So, based on all of the information that Omni-Rx has supplied to date, they are not able to recommend that Omni-Rx meets the fiscal soundness requirements of the Federal law, is that correct?

Mr. McLeod. Yes. I feel I perhaps should expand on that a bit, since when we referred to Omni-Rx—this refers not only to Omni-Rx Health Systems, Av-el Medical Group and Imperial West Medical Group, three very closely related activity organizations, which we feel must be reviewed if we are to make a determination for the fiscal soundness of Omni-Rx Health Care.

Mr. Segal. My next question goes specifically to one of those points. Are you not required under the HMO regulations 110.604–B–2 to review the audited statements of medical groups?

Mr. McLeod. Yes, we are. The statements for the two medical groups, Av-El and Imperial West Medical Group, are two of the items which we have found to be deficient in their October 26 response and will be the subject of our letter coming up this week to them asking for the statements.

Mr. Segal. So they have not yet supplied you with audited statements of those two medical groups?

Mr. McLeod. That is true.

Mr. Segal. Is it possible for them, Omni-Rx, to be an approved, qualified HMO and receive a three-quarter of a million dollar Federal grant without such approval, without such submission of audited statements, as a determination of their soundness?

Mr. McLeod. It is not possible to offer a determination that they would be qualified without receipt of those audited statements.

Mr. Segal. Moving to another area. You mentioned that you were undertaking a legal review. Did your legal review find that originally the information presented was confusing and contradictory and that some important material was left out?

Mr. McLeod. Yes, it did.

Mr. Segal. Has additional necessary information been supplied to you?

Mr. McLeod. In not all cases. We are still not in receipt of a proposed contract that would represent the benefit package that would be required to be offered if an organization were to be qualified, and we are still not in total receipt of current, accurate partnership records.

Mr. Segal. Was there a subsequent legal review to the last set of materials sent to you by Omni-Rx?

Mr. McLeod. Yes.

Mr. Segal. And you are saying that your statement here today reflects a legal evaluation of that final material that was supplied?

Mr. McLeod. Yes; we're still deficient.

Mr. Segal. Would Omni-Rx be legally able to qualify as an HMO to receive three-quarters of a million dollars on a loan based on the information sent to you?

Mr. McLeod. There are two separate questions. The first is, would they be able to be qualified based on the information we have received at this time? The answer would be no. The second part of the question was, would they be able to get a loan? I only speak for my knowledge of the operation of the division of HMO which awards loans, and that is that when there are outstanding cases which may affect the fiscal soundness, such as th SEC action or the lawsuit by the Health Departmeent, County of Los Angeles, both of which would threaten the financial standing of the organization, it has been their past practice not to award direct loans. So the answer to that one would appear to be no, also.

Mr. Segal. Is it your understanding, Mr. McLeod, that Omni-Rx Health Care, Inc., a not-for-profit plan, intends to merge, with the for-profit corporation, Omni-Rx Health Systems?

Mr. McLeod. I have heard that it was discussed, and the material that we have received did not reflect that that has, in fact, been accomplished at this time.

Mr. Segal. Have they indicated that they intend to merge before the completion of your HMO qualifications?

Mr. McLeod. I've not received that notification.

Mr. Segal. We have a copy of the letter, dated October 4, which you alluded to, from you to Omni-Rx, and it lists the 19 specific deficiencies. How many of those 19 deficiencies still exist?

Mr. McLeod. Well, recognizing that some have been partially answered, the ones that are most glaring at this time would be requests with respect to the benefit package they propose to offer once they are qualified. The Av-El audited statements for Av-El and Omni-Rx and Imperial West material that was supplied in October, October 26, were not responsive in those areas. A complete analysis of all the others is only now coming to a conclusion and would be culminating

in a letter this week, so I am not fully aware of how they complied with the other 16, 15 items.

Mr. SEGAL. I would like to develop just one last series of questions. Relating to the 50-percent requirement in the Federal legislation that says that 50 percent of the enrollees should be nonmedicaid—in the State of California, Medi-Cal recipients—I ask you if they have submitted sufficient information to allow you to make a determination that they, Omni-Rx, will be, indeed, able to meet that?

Mr. MCLEOD. As you know, we contract with outsiders who have had experience in marketing. In the case of Omni-Rx, our marketing consultant has informed us that they have grave concerns about Omni-Rx's ability to market the private sector. Therefore, it would seem reasonable to conclude that the ability of Omni-Rx to exceed the 50 percent private patient ratio and their prepaid enrollment would be highly questionable.

Mr. SEGAL. In the materials, that you have studied of Omni-Rx, did they include information indicating that a portion of this 50 percent of the nonmedicaid recipients would be coming from Riverside, Calif.?

Mr. MCLEOD. Yes; their marketing strategy that was presented indicated that the entire private or, I shouldn't say the entire, but the vast majority of the private sector would be coming from the Riverside area.

Mr. SEGAL. Did that include that provision of health care at the Riverside facilities, would include services by Midtown Family Group?

Mr. MCLEOD. Yes. That was represented as part of their delivery capability in the Riverside area.

Mr. SEGAL. And that group was to provide backup service?

Mr. MCLEOD. Backup services to one Dr. Hall, who is a partner in the Imperial West Medical Group.

Mr. SEGAL. Are you familiar, Mr. McLeod, with a letter that is addressed to Miss Jacquie Carrie Wilkinson from Ronald Heumann, an attorney at law, withdrawing the contract proposal by Midtown Family Medical Group to Omni-Rx?

Mr. MCLEOD. Yes; I am familiar with that letter. That would seem to remove a substantial portion of the delivery capability of Omni-Rx health care in the Riverside area.

Mr. SEGAL. Does that mean in terms of their application that the major provider indicated to provide care to this plan has now indicated they will not do so?

Mr. MCLEOD. Yes; in the Riverside area.

Mr. SEGAL. In Riverside, the area that they indicated would be predominantly confined to nonmedicaid recipients?

Mr. MCLEOD. Yes.

Mr. SEGAL. Is it your conclusion at this point that there seems to be severe questions about Omni-Rx's ability to be able to meet all of the outstanding deficienices in their application before the turn of this year?

Mr. MCLEOD. Based upon the materials that we have in hand and the length of time that it normally takes to achieve an audited, a financial statement, it would appear highly questionable that Omni-Rx would

be able to satisfy our open information needs by the end of December 1976.

Mr. SEGAL. Mr. Chairman, I have no further questions.

Mr. MOSS. Mr. Scheuer.

Mr. SCHEUER. Let me ask you to take us to the mountain top. What should we be doing from all of these insights, what should we have gleaned from this whole experience and others like it? What should we be doing to get a handle on health costs and, in specific, what should HEW be doing? Is there any legislative authority that they need to do a far better job than they're doing now in getting some beginnings of control over health costs?

Mr. MCLEOD. Mr. Scheuer, recognizing that I am speaking from my own observation point and not speaking for the Department, I feel that the experience of prepayment is one that has shown that organized systems of care, operating in a prepayment mode, can be very efficient and effective in controlling the rate in which health care costs escalate. It does not immunize them from the impact of inflation, yet I feel that the inherent organizational structure, one which alines the professional and economic interest of the provider and the patient, have merit which certainly should be sponsored and continued. I believe the HMO amendments that most recently were enacted are a step in that direction.

At the same time I feel, from my own observation point, that many of the alleged abuses that we hear about and many that we see are the results of the juxtaposition of tax codes which make it impossible for foundations to provide capital financing to nonprofit health organizations; of State and Federal laws which seem to make it attractive for organizations or necessary for organizations to operate as nonprofit entities; and a virtual lack of borrowing capital generation capability of nonprofit organizations, bringing us back to a point where the only source of capital financing is from those providers who stand to benefit from contracting with the organization as a result of these various factors working in concert. I don't find it at all surprising that we have providers who are benefiting from their contractual relationships with the nonprofit health plans, meaning essentially the provider of capital of last resort, all other avenues having been closed off.

I think the greatest benefit that the prepaid organizational movement could stand right now would be an examination of the tax codes with this thought in mind. I realize this falls within the jurisdiction of another committee. But the interaction between the capital needs of delivery organizations and the ability of those organizations to generate capital are perhaps the greatest unexamined opportunity for improvement that I know of.

Mr. SCHEUER. I think probably in years gone by, when capital was easier to come by for nonprofit organizations, either through direct Government funding or through their own ability to raise money, there was a great deal of capital investment that was unwise and probably very wasteful. We are overhospital bedded in this country for one thing——

Mr. MCLEOD. No question.

Mr. SCHEUER [continuing]. And secondly we have a poor distribution of the hospital beds that we do have.

Do you think the fact that we are leaning into the free enterprise market to provide capital means that the market mechanism is working well to ration capital for health purposes and to direct it? Does the market work in a fine tool fashion in rationing capital and directing it to those areas in the health service delivery system where it is most needed or should we really feel that the market mechanism isn't very appropriate here and doesn't fine tool—doesn't fine tool the allocation of capital and the rationing of capital. Should we go back to some kind of direct Government funding a la Hill-Burton, or create a more favorable climate for foundations to raise money for health service purposes and leave it to them to make the allocation and the rationing decisions?

Mr. McLeod. I would not be the first to jump on the bandwagon and say that the private allocation system has failed. I would, however, point out that we have gone through the past 6- to 8-year period of varying degrees of availability for capital for any purposes, not only nonprofits but even for profit ventures have had extremes that were unexperienced in the past 20, 25 years.

The direct Federal funding of programs, I think, is something that will have to be examined and should be examined as part of a balanced program. I believe that a totally private dependency is probably unrealistic; at the same time I don't think a total Federal or public sponsorship is a reality.

So I do feel that a combination of public and private generation of capital, the potential favorable revision of the tax codes to permit foundations to make capital available for organizations like HMO's, and operated within the enlightened structure of perhaps an improved health systems agency environment, will go a long ways toward avoiding the uses of excessive overbuilding hospital beds as in the past and at the same time give the private market a chance to respond to the need through the philanthropic organizations which are created for that purpose.

Mr. Scheuer. Thank you very much.

Mr. Moss. Mr. McLeod, I want to thank you for really a very excellent summation. I would ask that when the letter is drafted later this week that a copy be submitted to the committee.

I ask for unanimous consent to hold the hearing record open until receipt of this letter.

Is there any objection?

Hearing none, it will be so ordered.

[The letter was not available to the subcommittee at the time of printing.]

Mr. Moss. We excuse you with our thanks.

There being no further business, the subcommittee will stand adjourned.

[Whereupon, at 4:45 o'clock p.m., the subcommittee was adjourned.]

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