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THE NEWSLETTER OF THE BDO HEALTHCARE PRACTICE

BDO KNOWS HEALTHCARE

CONTENTS

THE "STATE" OF MEDICAID REIMBURSEMENT

THE AMERICAN HEALTH CARE ASSOCIATION (AHCA) RECENTLY RELEASED ITS ANNUAL REPORT ON THE "STATE" OF MEDICAID REIMBURSEMENT. AHCA ENGAGED ELJAY, LLC[1] TO CONDUCT WHAT IS THE EIGHTH SUCH STUDY WHICH IS ENTITLED "A REPORT ON SHORTFALLS IN MEDICAID FUNDING FOR NURSING HOME CARE."

By Randy Severson

Data was obtained from 39 states and the District of Columbia from 2007 cost reports. This data was used to determine the shortfall in Medicaid funding in 2007 as well as to project the shortfall in 2009. Those unfamiliar with Medicaid funding of nursing homes might very well be shocked by what the report reveals. Unfortunately, those of us who have been involved in the industry for many years are not.

The average shortfall in Medicaid reimbursement for nursing homes was $14.00 per Medicaid resident day in 2007 while the Medicaid shortfall in 2009 was projected to be $14.17. Based on past study results, the actual shortfall in 2009 will likely be higher than initially projected due to greater than projected inflationary pressures on nursing

1 The President of Eljay, LLC is Joseph Lubarsky, a retired BDO Seidman, LLP partner. For a copy of "A Report on Shortfalls in Medicaid Funding for Nursing Home Care", contact the American Health Care Association.

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MEDICAID REIMBURSEMENT

home costs. The projected 2009 shortfall represents unreimbursed allowable costs of over $4.6 billion.

Unlike Medicare, Medicaid programs are state-specific. As a result, there are wide variations in the shortfall when comparing different states. I find it a dubious honor that my home state of Wisconsin ranks dead last in terms of the projected Medicaid shortfall in 2009. I guess in some strange way Wisconsin really ranks #1 in that it's projected shortfall in 2009 is $28.41 per Medicaid resident day. Wisconsin is followed by the States of New Jersey ($25.13), Massachusetts ($24.95) and New York ($24.10). In contrast, the States of Michigan, Oregon and the District of Columbia are projected to provide small profit margins.

The future outlook for Medicaid payment, at least in the near term, does not alter this somber "state." The domino effect of higher unemployment, increased Medicaid enrollment and lower state tax revenues has resulted in huge state deficits. As a result, nursing home providers will likely face rate freezes, if not rate reductions. This is further exacerbated by the states continuing to redirect more of their Medicaid budgets to home and community-based services. The report notes that over the last nine years, Medicaid expenditures on nursing home care have been reduced by 24.5 percent while spending on home and community-based services has increased by 67 percent.

> Since 2004, Medicaid rate increases have generally kept pace with nursing home cost increases. However, it appears that this trend has ended.

Provider taxes are a major funding source for rate increases in many states. Overall, provider taxes generate over $4.5 billion in federal matching funds and in those states where implemented, reimburse an average of $16 per resident day in allowable Medicaid costs. However, provider taxes cannot be counted on to provide nursing home rate increases as they have in the past. Most states with high Medicaid volumes have already implemented such programs and many programs are at or near the upper limit of revenues that can be raised through such programs. It appears that most states with provider tax programs have used newly generated funds or enhanced funding as a result of the American Recovery and Reinvestment Act of 2009 to reduce state budget deficits as opposed to increasing rates.

Medicare continues to subsidize the shortfall in Medicaid funding. According to the Medicare Payment Advisory Commission, the average margin on Medicare payments to nursing homes in 2007 was 14.5 percent. For those providers with their "fair share" of Medicare residents, the margin on Medicare residents significantly reduces the Medicaid shortfall. Clearly, the future viability of nursing home providers hinges not only on future Medicaid shortfalls but the preservation of Medicare margins as well.

Since 2004, Medicaid rate increases have generally kept pace with nursing home cost increases. However, it appears that this trend has ended. As a result, the report predicts that the shortfall between Medicaid rates and allowable costs will increase significantly in FY 2010 and FY 2011. The impact of the President's health care budget proposals and health care reform add additional elements of uncertainty to the future of the industry. Stay tuned.

For more information contact Randy Severson, Assurance Director, Healthcare Practice, at rseverson@bdo.com.

FIN 48 UPDATE FOR NONPROFIT ORGANIZATIONS

By Laura Kalick

Nonprofit organizations are now beginning the process of documenting tax positions. Material uncertain tax positions will have to be disclosed in a footnote to the financial statements and that footnote is now required to appear on Schedule D of Form 990.

What does the organization have to document? Since tax exemption itself is a tax position, an organization must document the certainty of exemption. Since the IRS granted exempt status based on representations made in the application for exemption, a good place to start might be to look at the original Form 1023 or 1024 and document that the organization is doing what it said it was going to do. An inventory of revenue streams can be found on the Form 990 in the section that describes income producing activities. An organization should document that the characterization of those items is appropriate and that it would be more likely than not to be sustained if the organization was audited by taxing authorities. FIN 48 (now referred to as ASC 740-10) is applicable to tax positions at the federal, state and local and international levels. Alternative investments should be reviewed not only for federal unrelated business income tax issues but should also be reviewed for state tax issues. Finally, an organization should look closely at the expenses that have been used offset unrelated trade or business income, especially when those expenses come from activities that consistently generate losses.

Also, see http://www.bdo.com/industries/nonprofit/FIN48UpdateforTaxExempt.pdf

For more information contact Laura Kalick, Tax Director, Institute for Nonprofit Excellence at lkalick@bdo.com.

403(B) PLANS

By Bob Lavenberg

Many nonprofit organizations are sponsors of 403(b) plans. For the 2009 plan year, the Department of Labor ("DOL") has amended the instructions to the Form 5500 – Annual Return/Report of Employee Benefit Plan to eliminate the exemption previously granted to Internal Revenue Code ("IRC") §403(b) retirement plans of IRC §501(c)(3) tax-exempt organizations, from the Form 5500 reporting, disclosure and audit requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The removal of this exemption subjects ERISA-covered 403(b) plans to the same Form 5500 reporting and audit requirements as §401(k)-type plans. Generally, 403(b) plans sponsored by tax exempt organizations are subject to ERISA whereas 403(b) plans sponsored by governments and most religious organizations are not covered under ERISA. For large plans, (those with more than 100 participants at the beginning of the plan year), full completion of the 5500 will generally also require the plan administrator to engage an independent public accountant to audit the accompanying financial statements.

Many of these plans have been in existence since the late 1950s and organizations will be faced with numerous challenges in preparing for the audit, such as gathering plan accounting records, identifying all current and former participant accounts to be included as plan assets, determining the beginning account balances, and obtaining other financial information to be included in the plan's financial statements.

On July 20, 2009, the DOL's Employee Benefits Security Administration ("EBSA") issued Field Assistance Bulletin ("FAB") 2009-02 *Annual Reporting Requirements for 403(b) Plans* which provides some relief with regard to the reporting requirements for 403(b) plans beginning with the 2009 plan year. (See http://www.dol.gov/ebsa/regs/fab2009-2.html). This could significantly impact not only the determination of the number of participants in the plan at the beginning of the plan year, but also whether the financial information being reported is materially correct. FAB 2009-02, recognizing these challenges, may allow plan sponsors to disregard certain pre-2009 contracts and accounts, provided the contracts or accounts meet certain criteria including: the contract or account was issued before January 1, 2009; the employee is 100 percent vested in and can enforce the contract or account, and no contributions were made to the contract or account after December 31, 2008. As such, it is highly recommended that plan sponsors embark on gathering the necessary information as soon as possible in order to be able to meet the new requirements.

In response to these changes, the AICPA created a 403(b) Plan Audit Task Force which is chaired by BDO Partner Bob Lavenberg. The Task Force has issued several tools that may be useful to 403(b) plan sponsors as they prepare to comply with the new rules. (See http://ebpaqc.aicpa.org/)

Also see *EBP Commentator* Special Edition – 403(b) Plans: http://www.bdo.com/download/1220

BDO's Employee Benefit Plan specialists are available to assist plan sponsors in understanding and implementing these new rules.

For more information contact Bob Lavenberg, National Employee Benefit Plan Practice Leader, at rlavenberg@bdo.com.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE "ACT")

What will the Act do and when?

WITHIN ONE YEAR
- It will provide a $250 rebate to Medicare prescription drug plan beneficiaries whose initial benefits run out.

AFTER 90 DAYS
- It will provide immediate access to high-risk insurance pools for people who have no insurance because of preexisting conditions.

AFTER SIX MONTHS
- It will bar insurers from denying people coverage when they get sick.
- It will prevent insurers from denying coverage to children who have preexisting conditions.
- It will bar insurers from imposing lifetime caps on coverage.
- It will require insurers to allow young people to stay on their parents' policies until age 26.

BY 2011
- It will require individuals and small group insurance plans to spend at least 80 percent of premium dollars on medical services. Large group plans would have to spend at least 85 percent.

BY 2013
- There will be increases in the Medicare payroll tax and it will be expanded to dividends, interest and other unearned income for singles earning more than $200,000 a year and joint filers making more than $250,000.

BY 2014
- It will provide subsidies for families earning up to 400 percent of the poverty level to purchase health insurance.
- States would be required to set up new "exchanges," or insurance marketplaces, that would offer a variety of health care plans for small businesses and individuals who do not get coverage from their employers
- The Act will require most employers to provide coverage or face penalties.
- The Act will require most people to provide coverage or face penalties.

BY 2019
- The Act will have expanded insurance to an estimated 32 million people.

IN HEALTHCARE, NOW MORE THAN EVER – CASH IS KING

IT IS NO SECRET THAT THE CAPITAL MARKET IMPLOSION OF 2008 AND THE ONGOING RECESSION HAVE HAD A FAR REACHING IMPACT ON MANY COMPANIES.

By Rich Davis

For healthcare providers, especially those that generate a high percentage of revenues from Medicaid and Medicare, the weakened economy is only part of the story. As noted in the lead article entitled "The State of Medicaid Reimbursement," healthcare providers are not only subject to future reductions in Medicaid (and Medicare) reimbursement, but there is potentially more somber news to come. In the current environment, it is now more critical than ever to squeeze cash out of operations. We've all heard the familiar phrase "Cash is King," but where does one look for cash? Let's take a brief look at one real example involving a healthcare provider and its billing process.

The Business Restructuring Service of BDO Consulting "BRS" was retained as an advisor to a healthcare provider operating in Chapter 11. During the bankruptcy, the company continued to report negative cash flow which is not uncommon in a bankruptcy. However, BRS noticed that the level of cash flow was considerably worse than expected based on the actual operating results. BRS also noticed that actual cash flow was considerably worse than levels estimated in the cash flow projections. This was all the more alarming since the cash flow projections were being relied upon by management in determining which vendors to pay and when to pay them. Furthermore, cash availability was tight and the company was already past due with many post-petition vendors. Something seemed amiss, so BRS rolled up their sleeves and started digging.

BRS analyzed the company's 12-month trailing revenues and subsequent cash collections. Our findings revealed that cash collections from third party-payers were considerably less than the associated billings. BRS brought this to the attention of the CFO and, after further inquiry, found there were problems including inadequate supervision of the billing cycle. Specific deficiencies are more fully described as follows:

First, on the front-end of the billing cycle, the company was using improper DRG billing codes (DRG is a measure of acuity – the higher the acuity, the higher the related billing rate). Use of improper codes resulted from inconsistent interpretation of codes in patient files and the subsequent application to the DRG codes in the billing system. Second, the company did not update codes in the billing system with periodically revised rates on a timely basis. Third, bottlenecks existed on the back-end of the billing cycle causing delays of up to three weeks in delivering paperwork to third party payers. Aside from this, delays worsened when paperwork normally processed by one clerk – on sick leave for an extended period - was stuffed into file cabinets, the dollar value of which was 20 percent of revenue. In the following months, cash availability became even more constricted.

What about the cash flow projections?

Unfortunately, the cash flow projections relied upon by management did not reflect the problems embedded in the billing cycle. Although the cash flow projection assumptions may have been technically correct, the billing "apparatus" was deficient and not reflective of those assumptions, thereby causing the two processes to be "disconnected." Not surprisingly, payment promises were made to vendors that could not be kept and vendor payments fell further behind. Once discovered, the billing issues were remedied and the company's cash flows and payment performance improved. Equally important, the CFO began regular verification of inputs to both the billing system and cash flow projections to ensure the two were in sync.

This example illustrates how analyzing just one aspect of a business – the Billing and Collection Cycle – "stopped the bleeding" in one of the company's operating systems and yielded additional cash flow. This type of exercise, though somewhat tedious, may be repeated in other areas of an organization with similar results. It bears repeating, now more than ever, "Cash is King!"

For more information contact Rich Davis, Director, Business Restructuring Services, at rdavis@bdo.com.

ACCOUNTING CONSIDERATIONS IN MERGERS AND ACQUISITION TRANSACTIONS FOR NOT-FOR-PROFIT HEALTHCARE ORGANIZATIONS

By Art Nemiroff

It is highly likely that we will see a new round of healthcare mergers and acquisitions in the near future due to growing pressure on bottom lines, combined with added pressure to meet national, regional and local mandates for quality, together with the increasing difficulty for organizations to successfully access the capital markets.

Not-for-profit healthcare organizations are now coming under the requirements of ASC 958-805 (previously known as FASB 164 Not-for-Profit Entities: Mergers and Acquisitions) which requires prospective application as follows:

- Mergers (as defined) where the date of merger is on or after the beginning of an initial reporting period beginning on or after December 15, 2009
- Acquisitions (as defined) for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2009

It may not be applied to mergers or acquisitions taking place before those dates.

Additionally, the following items that were not previously applicable to not-for-profit entities now apply with the same effective dates as above:

- ASC 350's (formerly FASB 142) requirements on subsequent accounting for goodwill and other intangible assets acquired in an acquisition
- ASC 810 (formerly FASB 160 amendments to *Noncontrolling Interests in Consolidated Financial Statements* made to ARB No. 51, *Consolidated Financial Statements)*
- ASC 805 (formerly FASB 141R, *Business Combinations, as revised)*

Firstly, lets understand what this pronouncement **doesn't** apply to as follows:

- The formation of a joint venture
- The acquisition of an asset or a group of assets that does not constitute either a business or a nonprofit activity
- A combination between not-for-profit entities, businesses, or nonprofit activities already under common control
- A transaction or other event in which a not-for-profit entity obtains control of another entity but does not consolidate that entity, as permitted or required by ASC 958-805 (AICPA Statement of Position 94-3, *Reporting of Related Entities by Not-for-Profit Organizations)*, or ASC 954 (AICPA Audit and Accounting Guide, *Health Care Organizations)*

So now that we've identified what the new accounting pronouncement doesn't apply to, let's discuss in general terms how to determine whether you're dealing with a merger or an acquisition. Firstly, something you might have already guessed – it's complicated. The new pronouncement is 45 pages long, and to make it crystal clear, the FASB decided they needed to publish *Appendix A: Implementation Guidance* which also contains 45 pages wherein the first 28 paragraphs "clearly" define the terms needed to distinguish between a merger and an acquisition. The following definitions are taken directly from the Appendix:

Merger – is a transaction or other event in which the governing bodies of two or more not-for-profit entities cede control of those entities to create a new not-for-profit entity. If the participating entities retain shared control of the new entity, they have not ceded control. To qualify as a new entity, the combined entity must have a newly formed governing body; a new entity often is, but need not be, a new legal entity. Control of a not-for-profit entity is the direct or

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ACCOUNTING CONSIDERATIONS

indirect ability to determine the direction of management and policies through ownership, contract, or otherwise.

Acquisition – is a combination in which a not-for-profit acquirer obtains control of one or more nonprofit activities or businesses. The formation of a new entity is not a significant factor in assessing whether one entity has obtained control over another.

The Appendix provides many illustrative examples which I commend to your reading.

Now that we have a good grasp of the two definitions, let's describe the differences in the accounting treatment for each approach.

As a result of determining that the transaction is a merger, the new not-for-profit entity must use the *Carryover* method requiring the combining of the assets and liabilities recognized in the separate financial statements of the merging entities as of the merger date; the new entity does not recognize additional assets or liabilities, such as internally developed intangible assets, that GAAP did not require or permit previously. There are a couple of relatively minor exceptions that one needs to read about further in the literature. The new entity's initial reporting period begins with the merger date so that the statement of activities and statement of cash flows for its initial reporting period begin with the combined amounts of the merging entities' assets, liabilities, and net assets as of the merger date. Operations and cash flows are only reported from the date of merger. There are significant disclosures that need to be made in the footnotes, including *supplemental pro forma information* if the new entity is deemed to be a "public" entity as a result of having issued *Pass Thru Obligor Bonds(FSP 126-1)*.

If a determination is made that the transaction is to be treated as an acquisition, then generally the provisions of ASC 958-805 (formerly FASB 141R, previously issued) and applicable to for profit entities, will apply to not-for-profit healthcare entities. One of the biggest changes of note is the fact that acquired goodwill will no longer be amortized, but will be subject to at least annual evaluation of impairment. There are, however, some unusual provisions that differ, specifically those applying to step transactions involving increasing or decreasing ownership of the acquiree. These computations are too involved to explore in this article, so once again, we recommend for your reading enjoyment paragraphs 59-60 of FASB 164.

In summary, as always, the business considerations of a potential merger or acquisition should govern the decision, BUT one should understand the accounting requirements and implications before consummating the transaction.

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BDO HEALTHCARE INDUSTRY PRACTICE

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- Integrated Delivery Systems
- Acute Care
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- Senior Housing
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- International Health Research Organizations

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