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THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

BDO KNOWS HEALTHCARE

CONTENTS

COMPENSATION SURVEY – HEALTHCARE INDUSTRY

By Anita Samuelson, Executive Compensation Consultant

The results of a survey recently performed by BDO of 75 publicly traded healthcare companies with between $25 million – $1 billion in revenue was published. All data was extracted from proxy statements that were filed between May 15, 2010 and May 15, 2011. Increases in annual average compensation for board members and C-level management ranged from 13% to 20% year over year.

▶DIRECTOR COMPENSATION CLIMBS TO $137,601

BDO surveyed 75 publicly traded companies in the healthcare industry with between $25 million and $1 billion in revenue. We found that average annual compensation paid to board members for fiscal year 2010 service at these companies was $137,601. This value is more than $25,000 more than compensation paid to directors in the general industry ($110,155) for FY 2010 service.

Director compensation at healthcare companies increased by 13% in the past year, which is the largest increase of the eight industries we surveyed.

The $137,601 value is comprised of board retainers and fees ($38,149), committee retainers and fees ($8,660), full-value stock awards ($48,514) and stock options ($42,278). Therefore, the resulting pay mix is as follows: 28% board retainers and fees, 6% committee retainers and fees, 35% full-value stock awards and 31% stock options. Healthcare companies use the highest percentage of equity and the smallest percentage of cash in their compensation plans compared to other industries.

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HEALTHCARE COMPENSATION

▶CEO COMPENSATION REACHES $2,028,241 AND CFO COMPENSATION RISES TO $944,861

At the same companies, average annual compensation paid to CEOs for FY 2010 service was $2,028,241 and to CFOs was $944,861. Compensation paid to healthcare CEOs is less than compensation paid to CEOs in the general industry ($2,338,874) but compensation for healthcare CFOs is slightly higher than compensation paid to CFOs in the general industry ($927,743).

Pay for healthcare CEOs is comprised of salary ($524,674), bonus and annual incentives (AI) ($421,947), stock options ($554,610), full-value stock awards ($518,714), and other long-term incentives (LTI) ($8,296). CEO compensation in the healthcare industry increased by an average of 13% over FY 2009.

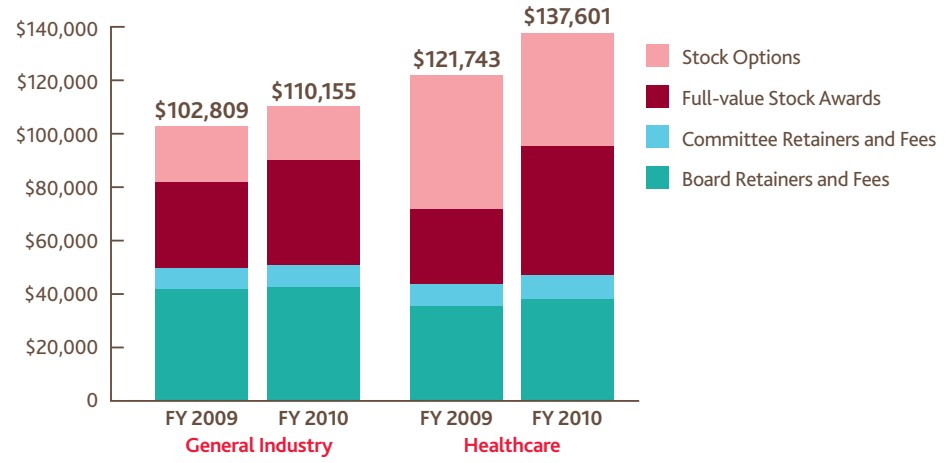
Pay for healthcare CFOs is comprised of salary ($311,689), bonus and annual incentives ($182,789), stock options ($178,743), full-value stock awards ($268,717), and other LTI ($2,923). CFO compensation in the healthcare industry increased by an average of 20% over FY 2009.

We expect director and executive compensation in the healthcare industry to continue to increase as systemic and regulatory changes necessitate attracting only the most highly qualified leaders to successfully run these companies.

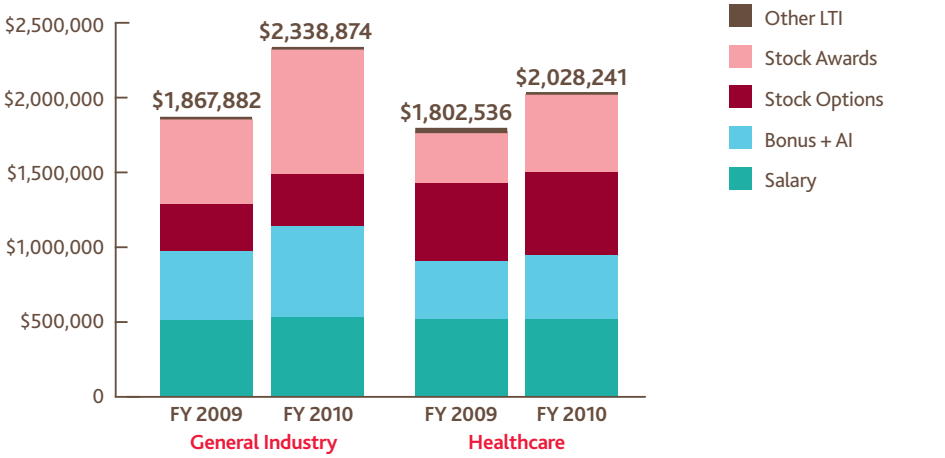
Further detail can be found in *The 2011 BDO 600 Survey: Board of Directors Pay Study* and *2011 Survey of CEO and CFO Compensation Practices of 600 Mid-Market Public Companies.*

For more information, contact Andy Gibson, Partner and Compensation and Benefits Practice Leader, at agibson@bdo.com.

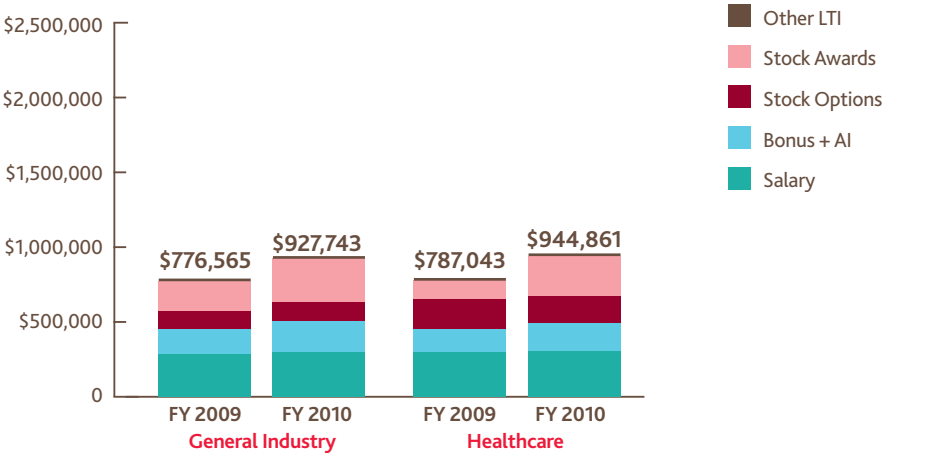
Director Compensation



CEO Compensation



CFO Compensation



DOES YOUR FACILITY QUALIFY FOR ADDITIONAL MEDICARE REIMBURSEMENT?

By Ronald K. Rybar, CEO and Michele Causley, Director of Provider Reimbursement – The Rybar Group, Inc.

BACKGROUND

Recognizing that rural hospitals were more financially vulnerable under the constraints of the Prospective Payment System (PPS), effective April 1, 1990, the Medicare program established special payment provisions to provide financial assistance to hospitals classified as Sole Community (SCH) or Medicare Dependent (MDH) Hospitals. Both types of hospitals are paid the higher of the PPS rate or a hospital-specific rate based on costs per discharge for a certain base year determined by Medicare regulations. In addition to the hospital-specific rate, a provision for a special payment adjustment has also been created and is often referred to as a Low Volume Adjustment (LVA).

PAYMENT ADJUSTMENT

There are two basic criteria that qualify an SCH or MDH for the LVA payment. First, the hospital must experience a decline in discharges greater than 5% as compared to the immediately preceding cost reporting period. The number of discharges should include only adult and pediatric inpatients; newborn, swing bed, and distinct unit discharges should be excluded. Second, the decrease in volume must be due to circumstances beyond the hospital's control. This could include unusual situations or occurrences such as strikes, inability to recruit essential physician staff, floods, unusual prolonged severe weather conditions, or other similar occurrences.

To qualify for the payment, a written request must be filed with the Fiscal Intermediary (FI)/ Medicare Audit Contractor (MAC) within 180 days following the Notice of Program Reimbursement (NPR) date. A request may also be filed for a cost report that has not received an NPR date, allowing the request to be incorporated into the audit cycle. Extensive documentation must be submitted with the request and should include a detailed description of the circumstances that resulted in the volume decline and efforts made by the facility to control costs.

The LVA is designed to fully compensate a hospital for the fixed costs it incurs and may not be able to reduce during the period in which a decline in volume occurred. This includes the reasonable cost of maintaining necessary core staff and services. Many costs in a hospital are neither specifically fixed nor variable, but are semi-fixed; that is, there are costs that are necessary to maintain operations but also may vary somewhat with volume.

Per the LVA regulations, when experiencing a decline in discharges, a cost-effective hospital would take measures to decrease unnecessary operating costs. It is for this reason that the allowable costs the LVA payment is based upon are limited to the prior period costs updated for inflation. When making an LVA determination the FI/MAC is required to review semi-fixed costs; particularly whether the level of core nursing staff was adjusted appropriately for the decline in census. To do this, the hospital's actual Full Time Equivalent (FTE) nursing staff is compared to the staffing levels of peer hospitals. The comparison data is obtained from the Occupational Mix Survey (OMS) results. If the nursing FTEs for the year in which the volume decline occurred are greater than the comparable nursing staff level, an adjustment will be made to reduce total acceptable costs for the excess staff and therefore reduce the LVA payment.

PAYMENT ADJUSTMENT STRATEGIES

No hospital wants to experience a significant decline in volume but it does happen. The fact that these occurrences are unanticipated means they cannot be planned for. However, there are several strategies a hospital should employ in order to be prepared for a potential low volume opportunity.

- Review the cost report structure and allocation methodologies each year. Since the LVA payment is limited to the prior year's updated costs, each cost report should be viewed as a possible base year for setting the next year's LVA cap in the event a qualifying volume decline occurs. Certain cost report elections and allocations can be made, consistent with Medicare regulations, to optimize a potential LVA payment. The Rybar Group routinely counsels its SCH and MDH clients regarding the importance of these reviews as part of a long-term strategy to take full advantage of all available Medicare reimbursement opportunities.
- Track discharges monthly in order to identify as early as possible a 5% or greater decline in discharges. Requests for many cost report elections and changes in allocations must be submitted to the FI/MAC prior to the end of the fiscal year; early detection of an LVA opportunity will allow time to analyze and request changes to optimize the potential payment amount.
- The response to the OMS data should be carefully reviewed to ensure that core nursing staff is reported accurately and within the proper categories. The OMS data is used for comparisons for a period of three years. The LVA payment may be significantly reduced for excess nursing staff and the OMS report is often referred to when determining a hospital's core nursing FTEs.

Sole Community and Medicare Dependent hospitals face many significant challenges, specifically financially. The low volume adjustment payment is designed to assist rural providers that have lost discharge volume and significant Medicare revenue due to unanticipated circumstances. It is essential for SCHs and MDHs to put into place policies and procedures aimed towards the successful completion and optimization of a potential low volume opportunity.

The Rybar Group, Inc., established in 1989 in Fenton, Michigan, is an independently owned and operated member of the BDO Seidman Alliance. The firm provides specialist reimbursement consulting and other services to the healthcare industry.

For more information, contact Claudine Hildreth, Director of Client Relations and Business Development – The Rybar Group, Inc., at claudineh@therybargroup.com.

IRS CHANGES POSITION ON WHO MUST APPROVE GOVERNANCE POLICIES

By Laura Kalick, JD, LLM in Tax

AS YOU KNOW, THE FORM 990 REQUESTS INFORMATION ABOUT WHETHER AN ORGANIZATION HAS ADOPTED VARIOUS POLICIES, INCLUDING CONFLICT OF INTEREST, COMPENSATION REVIEW, DOCUMENT RETENTION, ETC.

These questions were introduced for the first time when the Form 990 was revised. At the time, the addition of the questions was very controversial and some still take the position that the IRS does not have the statutory authority to ask the questions. On the other hand, the IRS believes that it does have the authority to ask the questions because it is the IRS's responsibility to see that the tax laws are properly administered.

Instructions to the 2008 and 2009 Forms 990 allowed an organization to state affirmatively that it had adopted the various policies if as of the last day of the organization's tax year the policy was in place. Then the IRS changed the instructions for the 2010 Form 990 to provide that an organization could answer the question "Yes" but "only if the organization's governing board (not a department or committee) adopted the policy by the end of its tax year." Now the IRS has announced that full board approval will not be required, but rather, the IRS will instead allow a committee of the full board to adopt the policy if it is done by the end of its tax year. The IRS indicated that this change would be effective for tax years 2010 and beyond, and that the instructions will be revised for the 2011 Form 990.

How did we get to this point and what effect do these questions and instructions have on exempt organizations? Does the fact that an organization has policies necessarily mean that the organization is well governed or are there other factors that are more important? Why would it be necessary for the full board to approve adoption of a policy if a committee with delegated authority had approved the policy? Does the fact that an organization has a conflict of interest policy mean that all conflicts are disclosed and the policy is enforced?

The IRS takes the position that a well-governed organization is more likely to be tax compliant. In an attempt to prove their hypothesis, the IRS has trained its agents on governance issues and provided a check sheet [for 501(c)(3) entities] with questions in order to show that there is a correlation between a poorly governed organization and numerous infractions of the tax laws. The check sheet[1] contains various questions, including whether the organization has a written mission statement that articulates its current §501(c)(3) purpose(s); how often the full board met during the year under examination and whether the number of meetings met or exceeded the number of meeting requirements set forth in the organization's bylaws, etc.

Although the basic premise that a well-governed organization is more likely to be more tax compliant may have some merit, as was pointed out by the Advisory Committee on Tax Exempt and Government Entities (ACT)[2], it is the practices of an organization, not necessarily the policies of an organization, that will show whether an organization is

[1] http://www.irs.gov/pub/irs-tege/governance_check_sheet.pdf (Form 14114 (12-2009) Catalog Number 54282M)

[2] The Internal Revenue Service's Advisory Committee on Tax Exempt and Government Entities (ACT) is a group of outside professionals and practitioners who advise the IRS on various matters in order to improve the IRS. See http://www.irs.gov/pub/irs-tege/executive_summary_actgovernancerept.pdf (June 11, 2008) THE APPROPRIATE ROLE OF THE INTERNAL REVENUE SERVICE WITH RESPECT TO TAX-EXEMPT ORGANIZATION GOOD GOVERNANCE ISSUES

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GOVERNANCE POLICIES

well governed. The executive summary of the report states:

> *Effective governance practices among these organizations will vary depending on numerous factors, including size, sophistication, location, available resources, and activities. Moreover, while we may all agree that governance matters, it is not at all clear that requiring specific governance practices results in greater compliance with the tax laws. In fact, superior board governance may have much more to do with the values, active engagement, and accountability of those in charge than with the adoption of procedures and policies.*

CONCLUSION

With the exception of document retention and whistleblower policies that Sarbanes-Oxley mandates for nonprofit corporations as well as taxable corporations, none of these other policies are required by the Federal tax laws. In fact, the IRS cannot deny an organization exemption if it does not have a conflict of interest policy or a broad based independent board in the absence of a showing of private inurement. However, IRS will make it difficult to obtain the exemption and if an organization appears to be at risk for the possibility of providing insiders unreasonable compensation or other private inurement, agents are told to mark the case for future referral.[3] Likewise, although the IRS may request information regarding whether an organization has a conflict of interest policy or various other policies, the fact that the organization does not have the policies cannot be the basis for revocation of exemption. However, the presence of the policies does provide a framework for an organization in which to operate. One size does not fit all and organizations should adopt the policies that are appropriate for them and should use the policies as guidance in operating an effective, ethical organization.

[3] See Internal Revenue Manual 7.20.4.6 (11-01-2004) Board Expansion

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FY 2012 MEDICARE RATES FOR SNFs ON THE CHOPPING BLOCK

By Randy Severson, Assurance Director

The Centers for Medicare & Medicaid Services (CMS) have proposed two rate options for skilled nursing facilities (SNFs) effective October 1, 2011 ... and the end results are vastly different.

THE OPTIONS ARE AS FOLLOWS:

Option 1: Market Basket Adjustment	Option 2: Market Basket Adjustment plus Parity Adjustment
• 2012 market basket increase (2.7%) • Productivity adjustment (1.2%) • Net increase of 1.5% ($530 million)	• Net increase of 1.5% (per Option 1) • Parity adjustment (12.8%) • Net decrease of 11.3% ($3.94 billion)

As you may recall, the FY 2011 payment rates included the transition from MDS 2.0 to MDS 3.0 in conjunction with a move from the RUGS III to the RUGs IV payment system (see *BDO Knows Healthcare Summer 2010*). Although there was a budgeted market basket increase of approximately 1.7% effective October 1, 2010, the transition to RUGs IV was to be budget neutral. Based on limited data available on provider payment rates since October 1, 2010, the transition was anything but budget neutral. For a variety of reasons, many providers saw double-digit average rate increases. The CMS has not been blind to that fact. Needless to say, the industry believes such a dramatic decrease as proposed in Option 2 would seriously harm access to the quality services required by people with complex clinical conditions as cared for in today's nursing homes.

The CMS acknowledges that it has limited data from which to base the dramatic decrease in rates and that its data may be exaggerating its view of the current payment situation. Both the American Health Care Association (AHCA) and LeadingAge (formerly the American Association of Homes and Services for the Aging or AAHSA) are advocating for Option 1 effective October 1, 2011 with the opportunity for CMS to make changes to future rates based on more extensive data analysis as that data becomes available.

In addition to the rate options noted above, the CMS's proposed rule also includes a number of changes related to the resident assessment process primarily related to the provision of therapy services.

As has been well documented in previous articles on the "state" of Medicaid reimbursement (see *BDO Knows Healthcare Spring 2011*), long-term care financing is precarious at best as providers rely on Medicare margins to offset losses on Medicaid. As lawmakers deal with deficit reduction proposals, the CMS's proposed rule for FY 2012 payment rates for nursing facilities will certainly play a part. As always, stay tuned.

Author's note: On July 29, 2011, the CMS published its final rule which adopts the provisions of Option 2 as described above. The CMS's final rule implements a net reduction in payment rates of $3.87 billion, or an average rate decrease of 11.1% (approximately $60 per resident day).

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BDO HEALTHCARE INDUSTRY PRACTICE

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- Home Care and Hospice
- Hospitals
- Integrated Delivery Systems
- International Health Research Organizations
- Long-term Care
- Physician Practices
- Preferred Provider Organizations (PPOs)
- Senior Housing, including CCRCs

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