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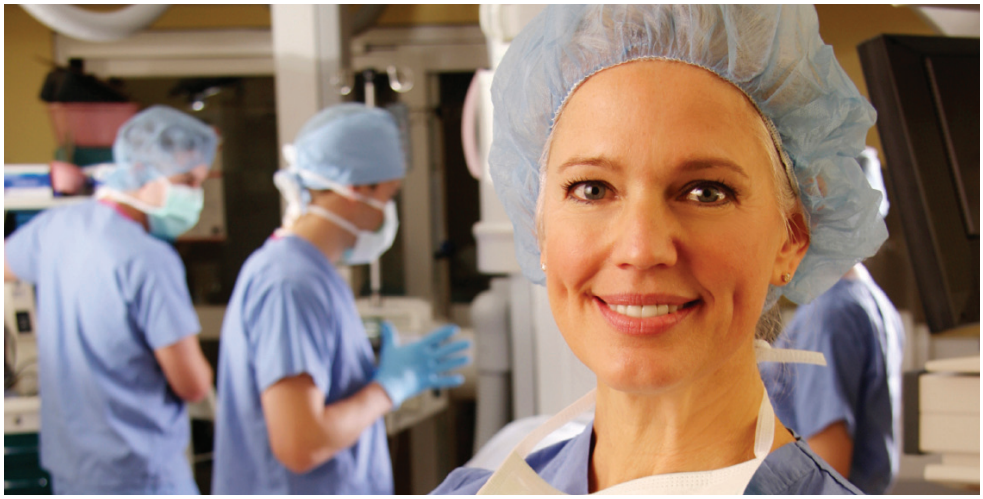
THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

BDO KNOWS HEALTHCARE



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NEW ASUs AFFECTING HEALTH CARE ENTITIES

By Karen Fitzsimmons, Assurance Partner with BDO

In August 2010, the Financial Accounting Standards Board issued Accounting Standards Update (ASU) 2010-23, *Health Care Entities (Topic 954): Measuring Charity Care for Disclosure – a consensus of the FASB Emerging Issues Task Force.* The purpose of this ASU is to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care by healthcare entities. In practice, entities currently either compile the disclosure information using a basis of cost measurement or a revenue measurement since no existing guidance existed.

The ASU requires that cost be used as the measurement basis for charity care disclosure purposes and that cost be identified as the direct and indirect costs of providing the charity care. In order to accumulate this information, healthcare entities will most likely use various techniques to identify the direct and indirect costs associated with providing the charity care. Some entities may obtain the information directly from a costing system while others may utilize reasonable estimation techniques. Since there will be a disparity in how this information is accumulated, the entity will be required to disclose the method used to identify and determine the charity costs.

The amendments in ASU 2010-23 are effective for fiscal years beginning after December 15, 2010 and should be applied retrospectively to all prior periods presented. Early adoption is permitted.

The second ASU the FASB issued was the FASB issued ASU 2010-24, *Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries – a consensus*

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NEW ASUs AFFECTING HEALTH CARE ENTITIES

of the FASB Emerging Issues Task Force. This ASU addresses the diversity in practice related to accounting for medical malpractice claims and similar liabilities and their related insurance recoveries by healthcare entities. Most healthcare entities net anticipated insurance recoveries against the related claims liability while the remainder have presented the anticipated insurance recovery and related claims liability on a gross basis. The amendments in this ASU clarify that a healthcare entity should not net insurance recoveries against a related claim liability. The ASU also requires that the calculation of the claim liability should be determined without considering the possible insurance recoveries.

The amendments in ASU 2010-24 are effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. A cumulative-effect adjustment should be recognized in beginning retained earnings in the period of adoption if a difference exists between any liabilities and insurance receivables recorded as a result of applying the amendments in this update. Retrospective application and early adoption are both permitted.

Also in August 2010, the FASB issued a proposed ASU, *Health Care Entities (Topic 954): Accounting for Legal Costs Associated with Medical Malpractice and Similar Claims – a consensus of the FASB Emerging Issues Task Force*. This proposed ASU would eliminate the industry-specific requirement that healthcare entities accrue legal costs related to litigating medical malpractice claims or similar claims before these costs are incurred. The amendments in this ASU would allow healthcare entities to make a policy election to expense legal fees as incurred or accrue estimated legal fees when the associated claim is incurred. The policy election should be disclosed. This revised guidance would align the accounting treatment that is currently utilized for these types of liabilities in other industries to the healthcare industry.

The ASU would affect healthcare entities within the scope of ASC 954, *Health Care Entities*. An entity within the scope of ASC 944, *Financial Services – Insurance*, would apply the amendments in the proposed ASU only to its healthcare activities and would continue to follow ASC 944-40 for claims related to insurance activities.

The effective date of the proposed ASU will be decided upon the final issuance of this ASU, which was projected for the fourth quarter of 2010. However, in a subsequent meeting, the staff decided that it was not appropriate to allow the election for healthcare entities and therefore they removed the item from their agenda.

The amendments in the ASU would be applied retrospectively to all prior periods presented.

For more information, contact Karen Fitzsimmons, Assurance Partner, Healthcare Practice, at kfitzsimmons@bdo.com.

THE 10 TOP-GROSSING PUBLIC HOSPITALS IN THE UNITED STATES LISTED BY TOTAL PATIENT REVENUE, ACCORDING TO CMS COST REPORT DATA ANALYZED BY THE AMERICAN HOSPITAL DIRECTORY.

These facilities include hospitals operated by a hospital district, a city, a county, or a city-county partnership:

1. Jackson Memorial Hospital, Miami . . . . . $4.15 billion
2. Carolinas Medical Center, Charlotte, N.C. . . . . $2.94 billion
3. Memorial Regional Hospital, Hollywood, Fla. . . . . $2.74 billion
4. Parkland Memorial Hospital, Dallas . . . . . $2.39 billion
5. VCU Medical Center, Richmond, Va. . . . . $2.29 billion
6. Westchester Medical Center, Valhalla, N.Y. . . . . $2.08 billion
7. Ben Taub General Hospital, Houston . . . . . $2.04 billion
8. Sharp Grossmont Hospital, La Mesa, Calif. . . . . $2.04 billion
9. Santa Clara Valley Medical Center, San Jose, Calif. . . . . $1.93 billion
10. University Medical Center, Las Vegas. . . . . $1.92 billion

Note: The hospital total patient revenues reported here are reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include patient revenue from other facilities that share a provider number with the main hospital.

Source: Becker's Hospital Review. September 15, 2010.

ACCORDING TO FINDINGS PUBLISHED BY THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE NUMBER OF UNINSURED ROSE SHARPLY IN 2009, REACHING 50 MILLION PEOPLE.*

Basic facts explaining why so many people lack coverage and the effects of being uninsured include:

1. Most of the nation's 50 million uninsured are low or moderate income.
2. More than three-quarters of the uninsured are in a working family.
3. Medicaid fills a key gap by preventing more people from becoming uninsured.
4. About one-quarter of uninsured adults go without needed care due to cost.
5. Medical bills are a burden for the uninsured and frequently leave them with debt.

* This analysis focuses on people under age 65 because almost all of the elderly are covered by Medicare. However, 676,000 of those aged 65 and over are uninsured, bringing the total uninsured to 50.7 million.

Source: Kaiser Family Foundation

IRS FOCUS ON POST-ISSUANCE BOND COMPLIANCE

By Laura Kalick, Assurance Director with BDO

IN ORDER FOR BONDHOLDERS' INTEREST ON TAX-EXEMPT BONDS TO BE EXEMPT FROM INCOME TAXATION, THE BONDS MUST BE IN COMPLIANCE WITH A MYRIAD OF RULES.

Bond counsel and a host of other advisors make sure that there is compliance with the rules when the bonds are issued. Now the IRS is focusing on whether there is post-issuance compliance. The IRS has some specific post-issuance compliance programs, such as the one the IRS Tax Exempt Bonds function (TEB) initiated regarding Build America Bonds (BABs) issued in 2009 and 2010. In such a compliance program the IRS examines a sample of cases and sends information document requests to garner the information that they need.

In addition to specifically targeted types of bonds, broadly speaking, the Form 990 with the new Schedule K will provide the IRS with the information that it needs in order to determine if the rules are being followed or further review is necessary.

One of the areas of focus of Schedule K is whether the bond proceeds are being used for qualified uses or whether the proceeds are being used for nonqualified uses, such as private business use or unrelated trade or business use. In general, at least 95% of the proceeds of a tax-exempt bond must be used by either a state or local governmental unit or a section 501(c)(3) organization in activities which do not constitute unrelated trade or business activities.

Private business use can arise when property financed with tax-exempt bonds allows a private individual or entity a special legal entitlement to the use of the property. For example, the lease of bond financed property to a taxable corporation is private business use even if the taxable corporation is a wholly owned subsidiary of the tax-exempt organization or even if it is exempt under 501(c)(4), (5), or (6). Also, a lease of bond financed property to a joint venture in which the 501(c)(3) organization is a partner may also constitute private use if the other partners are taxable entities.

A management contract with a private entity to manage a bond-financed facility may constitute private business use. If a management contract meets the IRS safe harbors found in Rev. Proc 97-13, which include limitations on the length of the contract, manager compensation and control, among others, the contract will not be tantamount to private business use. If the safe harbors are not met, a finding of private business use will be based upon the facts and circumstances. A management or service contract for the financed property generally results in private business use if the contract provides that the manager of the property is compensated by receiving a net profits interest in the property.

Use of a facility for privately sponsored research may also constitute private business use. IRS has published safe harbors as to when such research agreements will not result in private business use. In general, if the private sponsor is the lessee or owner of the property, then there will be private business use.

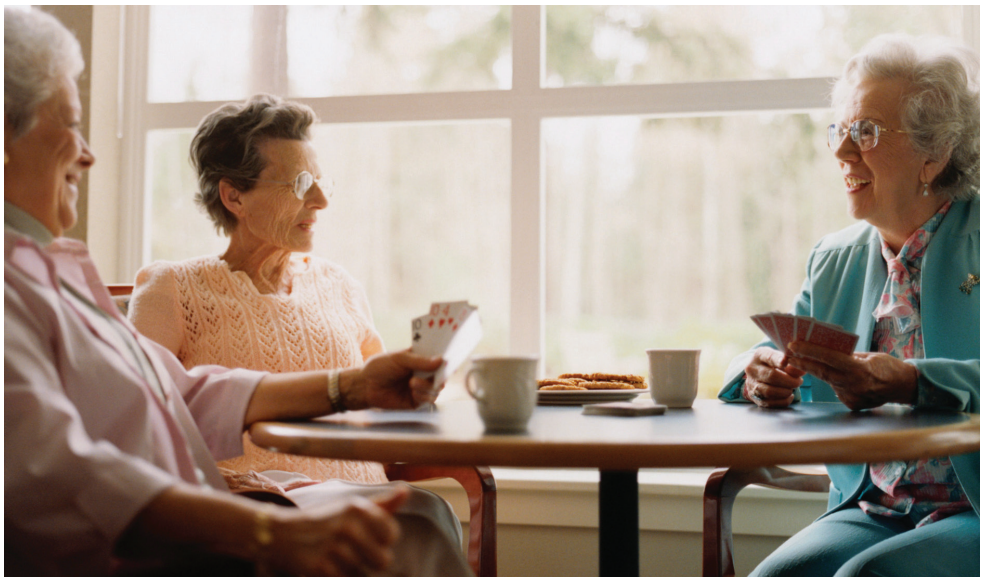
Finally, unrelated trade or business use is not qualified use and must be counted along with the private business use in order to determine whether or not the bond proceeds are being used appropriately. Therefore, it is important for organizations to consistently allocate costs such as depreciation expense for purposes of calculating unrelated business income and bond reporting as the IRS can and will compare.

For more information, contact Laura Kalick, Assurance Director, Healthcare Practice, at lkalick@bdo.com.

CONTINUING CARE RETIREMENT COMMUNITIES: DO THE REWARDS OUTWEIGH THE RISKS?

By Randy Severson, Assurance Director with BDO

Continuing Care Retirement Communities (CCRC) are one of a number of living options available to seniors today. In fact, industry sources say that the CCRC model has been in existence for more than 100 years. CCRCs generally provide services ranging from independent living to skilled nursing care in a campus-like setting. Fees charged to residents typically include both a fee upon entrance and monthly fees. Entrance fees, which oftentimes exceed six figures, may be refundable, nonrefundable or some combination thereof. Refundable fees are commonly refunded only upon the CCRC's receipt of an entrance fee from a new resident.



As a result of several bankruptcy filings over the past year, two studies have been conducted which have examined the risks associated with CCRCs. The United States Government Accountability Office (GAO) issued its report, "Continuing Care Retirement Communities Can Provide Benefits, but Not Without Some Risk" in June 2010 while the United States Special Committee on Aging (SCA) issued its report, "Continuing Care Retirement Communities: Risks to Seniors" in July 2010.

The GAO was asked to (1) describe how CCRCs operate and the risks they face, (2) describe how state laws address these risks, (3) describe risks that CCRC residents face, and (4) describe how state laws address these risks. To that end, the GAO analyzed state statutory provisions pertaining to CCRCs with respect to financial oversight and consumer protection, met with state regulators and interviewed CCRC providers, resident's associations and consumer groups. The GAO found that CCRC residents can benefit from their ability to "age in place" as a result of the variety of services provided within the CCRC. In addition, as a result of the range of contract types and fee arrangements, contracts provide a level of long term care and transfer varying degrees of risk of future cost increases from the resident to the CCRC. However, although CCRCs are generally regulated by the states and subject to financing requirements, residents still face considerable risk. For example, CCRC financial difficulties can lead to unexpected increases in monthly fees which may be beyond the residents' ability to pay. Furthermore, although rare, should a CCRC fail, residents could lose all or part of their entrance fee. Residents may also become dissatisfied if CCRC policies or operations fall short of expectations or there is a change in arrangements not contractually guaranteed. While the GAO did not recommend specific action at this time, the potential risks to residents highlight the importance of states' vigilance in their oversight efforts.

The SCA initiated an investigation into the composition and business practices of CCRC providers by requesting information from five CCRC companies. The companies included a mix of publicly traded and privately held entities. Across the companies, there were also variations in operating profile, financial profile and contract types. Similar to the benefits identified in the GAO report, the SCA found that CCRC residents can benefit from a convenient range of housing, supportive services, healthcare options and the ability to age in place. Once again, however, these arrangements are not without risk. Residents need to be aware of a community's ownership and fee structures; financial performance and security measures; entrance fee refund policies; and protections against involuntary transfers.

The GAO and SCA reports acknowledge that CCRCs provide many benefits to an estimated 745,000+ residents of over 1,800 communities across the United States. However, the CCRC model is particularly vulnerable during economic downturns as stagnant real estate markets drive down occupancy levels and tight credit markets limit access to capital. As a result of these turbulent economic times, it is now more important than ever for residents to conduct a thorough "due diligence" of a prospective community…a community expected to be "home" for years to come.

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BDO HEALTHCARE INDUSTRY PRACTICE

BDO's national team of professionals offers the hands-on experience and technical skill to address the distinctive business needs of our healthcare clients. We supplement our technical approach by analyzing and advising our clients on the many elements of running a successful healthcare organization.

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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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