

THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

# BDO KNOWS HEALTHCARE



## NEW YEAR BRINGS NEW CHANGES, CHALLENGES TO HEALTHCARE INDUSTRY

By Steven Shill and Chris Orella, Partners and Healthcare Practice Co-Leaders, BDO USA, LLP

**D**uring much of 2012, implementation of the Patient Protection and Affordable Care Act (ACA) was quietly underway from a regulatory perspective. The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services started to define Accountable Care Organizations, establish value-based purchasing for Medicare and reduce payments to hospitals for readmissions.

But while the federal government was moving forward, many healthcare organizations held off making major changes as they awaited the final decision on the ACA from the U.S. Supreme Court challenge, followed by the outcome of the presidential election.

With these decisions behind the nation, implementation of the ACA has rapidly moved forward. Just 10 days after the election, states had to submit paperwork to the HHS indicating that they planned to operate state-based health insurance exchanges or a partnership exchange. And as the year came to a close, efforts by the medical device industry to delay the implementation of the 2.3 percent excise tax on the sale of any taxable medical device was rejected by President Obama. As a result, the entire healthcare industry must take swift and decisive action to keep pace with the rate of change being set by the federal government.

Not all of the changes will come easily.

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## NEW YEAR BRINGS NEW CHANGES

Already, many are focused on the potential cost of health reform as the nation grapples with its own fiscal well-being in the midst of the ongoing global economic crisis. One of the main concerns both healthcare organizations and employers have is the number of regulations that may be required to implement the ACA. Initial estimates indicate that the government has developed thousands of pages of ACA-related regulations, which could require extensive investment to comply.

Even the interpretation of the regulations could be costly. There are already several interpretations of the 50-employee rule, which requires employers with more than 50 employees to offer health insurance or face a penalty. Without clear resolution on this issue, it will likely lead to litigation.

Another area that could impact implementation of the ACA is the increasing shortage of healthcare professionals. Between the additional 50 million people expected to be added to the health insurance rolls by 2015 and the aging population, even more healthcare providers will be needed in the next several years. However, a survey by Merritt Hawkins & Associates, a national physician search and consulting firm, indicates half of all physicians between 50 and 65 years of age plan to sharply cut back or abandon patient care within the next three years, with many driven out by a perceived lack of control over how they practice and the fees they charge. Compounding the problem is that almost half of physicians in the U.S. are over the age of 50. The Council on Graduate Medical Education, a panel of healthcare authorities, has endorsed a study predicting a shortage of 96,000 physicians by 2020.

While the number of physicians is decreasing, the need to improve the quality of care is increasing. Under the ACA, providers will be penalized for medical errors and readmission rates, which could lead to even further litigation, as well as added financial pressure and stress on organizations that are already trying to figure out how to do more with less.

These issues may result in monumental change driven by the healthcare industry as it tries to comply with the requirements of the ACA. Among the biggest changes expected:

**Cradle-to-grave care** – Vertical consolidation has been underway for several years in the healthcare industry as organizations have tried to realize business efficiencies. This consolidation will continue and even begin to accelerate as it becomes clear that small healthcare operations, such as community hospitals, small physician groups and independently owned assisted-living centers, are no longer cost effective to maintain. The resulting monolithic organizations will be able to provide an entire continuum of care, from birth through the end of life.

Physicians will also benefit from this type of consolidation. Many physicians in smaller practices end up burdened with administrative issues, which can infringe on the amount of time they can spend with patients. Many small practices will not survive as the margins get thinner and the administrative work increases. An exception to this will be elite, independent physicians who provide specialized care and can demand a premium for their services. Increasingly, these physicians will move to select concierge-style medical practices.

**Combining forces to offer care** – While consolidation is happening among providers, other parts of the industry will also begin to coordinate care. Health plans, which have significant power and resources within the industry, will align with pharmaceutical and medical device companies in the development of formularies. Under these alliances, payors will only cover products from suppliers with which they are aligned, providing them even greater control over pricing and products used.

**Health plans partnering with physicians** – As noted, the number of healthcare providers is expected to drop precipitously in the coming years as the need for quality increases. The ACA contains provisions to encourage students to select a medical career, such as the ability to cap student loan repayments and loan forgiveness for opting to practice in a public service job, but the real solution to the physician shortfall may come from health plans that subsidize medical school costs for students who agree to join their staff upon successful completion of their education. Given the number of retiring physicians and the rise in the aging population, payors must be part of the solution or the quality of care

will continue to deteriorate as the physician-to-patient ratio dwindles.

### Patients taking control of their own health

– Consumer-directed healthcare has been discussed for many years. Now, consumers are taking greater responsibility for understanding healthcare and the cost of care, but they are still lagging behind in an essential area: taking responsibility for their health. The health of the country has continued to erode over the last couple of decades, leading to the point where children are expected to live shorter lives than their parents. Obesity is a major part of the problem, leading to increases in costly chronic diseases, such as diabetes, heart disease and cancer. In fact, a December 2012 report in *The Lancet* notes that the health burden from high body mass indexes found around the world now exceeds that caused by hunger.

To combat this, many health plans have started implementing wellness programs and encouraging the adoption of incentive-based models, in which people are rewarded for becoming healthier and hitting health milestones. Physicians, in particular, are interested in seeing incentive-based models implemented because it requires patients to be more engaged in their own care, and healthier patients are less expensive patients to treat, which is important under the value-based payment paradigm.

These changes will not occur overnight, but they are coming. And they will require leadership to execute on a local and regional level. Historically, the C-suite at provider organizations has spent the majority of its time on community relations. Now, they must increasingly shift their focus to the business of healthcare and how to meet the new realities created by the ACA. This will require executives to work on mergers and acquisitions, infrastructure improvements, the implementation of information technology solutions and – where necessary – identify organizations that can help them navigate these coming changes.

For more information, please contact Steven Shill, Assurance Partner, at [sshill@bdo.com](mailto:sshill@bdo.com), or Chris Orella, Assurance Partner, at [corella@bdo.com](mailto:corella@bdo.com).

# 2013 CHALLENGES: CAPTURING CHARGES THROUGH THE CHARGE DESCRIPTION MASTER

By Herbert Bruss, RT(R), RCC, MA, Data Quality and Compliance Consultant, The Rybar Group, Inc.

As this article is being prepared, one of the greatest challenges facing the nation is our economy and how it will impact our healthcare system. If there were a big stethoscope placed over America's healthcare system, what would its prognosis be? Is the health of our healthcare system thriving or surviving? Can hospitals continue to sustain decreasing reimbursement while increasing the load of patients who are getting older?

This article will not address all the conundrums facing our healthcare woes, but it will highlight an important tool that will help hospitals continue to thrive and fulfill their mission of serving their patients. This tool is the Charge Description Master (CDM). It is the hospital's data warehouse that contains procedure code numbers used for billing supplies and services. The CDM can be likened to an engine of a car. When the engine is well tuned, the driver can expect high performance from his or her car, but if the engine isn't maintained, the driver will run into problems. That is what happens when the CDM isn't maintained or updated. Problems that are unnoticed in the CDM can spiral out of control, especially if charges are going to payors without the correct information. The results can be challenging because claims are rejected and the facility doesn't receive the reimbursement it needs to sustain its services.

So what can a hospital do to tune up its CDM engine and get the most bang for their buck? There are three steps or three "Rs" to consider when capturing charges from your CDM: 1) *Remove* the outdated/invalid codes, 2) *Reflect* the new/revised codes involving services and supplies and 3) *Review* the code changes through a quality audit while evaluating the CDM process.

The first step in a CDM review is to remove the outdated and invalid codes. In other words, remove the clutter or charges that do not reflect the most current medical billing Healthcare Common Procedure Coding System (HCPCS) codes and find the codes

relevant for the new year. For example, a medical service for patients seven years and older involves an injection for tetanus and diphtheria toxoids. This injection had an associated billing HCPCS code 90718 and it may have been in your CDM for calendar year 2011 or 2012. If you bill this service in 2013, you will not receive payment for the service. The Tetanus billing code and many other codes have been deleted because they are not recognized as a payable service. In other words, the changes in medicine (new method or technology of drugs, supplies and services) have rendered these services non-reimbursable and/or obsolete. Whatever the reason for the deletion, the department overseeing the CDM must remove the outdated and invalid codes.

The second step to a CDM review is to reflect the revised and/or new codes in the CDM. Let's look at the revision of procedure codes. Some of the revisions may be rather insignificant because changes have redefined the procedure description to best describe the exam. Unfortunately, some description revisions have resulted in bundling of several procedures, thus reducing the components that were separately reportable. For example, over the last several years, fluoroscopy (the ability to X-ray real-time) has been added to the description of many surgical exams and radiology is unable to charge separately for these services. The task for the CDM team is to be careful in bundling charges for fluoroscopy exams when they are included in the revised code.

The team must also be careful with new codes because these codes are generated from a multiple of other procedures. Keeping up with the revised codes and the new codes is challenging but also rewarding, especially if the hospital performs services that involve new technology and improve patient care. Take, for example, a bronchoscopy exam. HCPCS code 31647 was created this year to describe a bronchoscopy exam that has the ability to deliver a value that improves a patient's breathing. This updated technique

provides an opportunity to improve patient care and provides hospitals the ability to bill for new services and add to its bottom line. But again, it's important to mention that if the hospital hasn't cleaned up its CDM and mistakenly reports a deleted HCPCS code (31656 for a normal bronchoscopy), the opportunity for reimbursement is lost.

That brings us to the third step: a quality audit. A hospital can make the necessary changes to the CDM but if there is a hiccup in the process (incorrect revenue code, incorrect modifier, improper code pairs), the new or revised exam will not get paid. That is why it's important to pull a sampling of electronic claims and records to validate the procedure codes that have been deleted, added or revised. Auditing the claims and supporting documentation will assure the hospital is using the proper code with the correct components. In the end, the hospital will increase the opportunity for reimbursement, but if the CDM team doesn't audit the end product, the hospital may be leaving money on the table. It takes a team approach to ensure the correct codes are put into the CDM and it takes the same team to validate those changes.

The process of reviewing the CDM is a huge undertaking and most facilities use a sophisticated electronic tool to help with the CDM review. But the analytical tool is not enough because it takes the knowledge of the financial and clinical team to have the right information in the CDM. Your hospital's bottom line and reputation can be compromised if the information in the CDM is not correct and compliant. Medical facilities that have a balanced approach to their charging process will be rewarded. In the end, they will thrive in our struggling economy and continue to provide good healthcare in the 21st century.

*To learn more about charge capture, revenue cycle or reimbursement services, please contact The Rybar Group, Inc., a healthcare financial consulting firm and an independent member of the BDO Seidman Alliance.*

# CONTINUING CARE RETIREMENT COMMUNITIES: FINANCIAL RATIOS AND BENCHMARKING

By Randall Severson, CPA, Assurance Director, BDO USA, LLP



**A**lthough a financial statement audit can be seen as a commodity to management and the board of directors of many healthcare organizations, there are other financial metrics continuing care retirement community (CCRC) organizations can benefit from. In particular, CCRCs can gain valuable information from financial ratios and benchmarking, which provide management and the board insights into performance trends within the industry they can use to help make informed decisions about the future of an organization.

There are several sources of financial ratios available for the CCRC industry. One such source is Fitch. Fitch provides an annual report on “Median Ratios for Not-for-Profit Continuing Care Retirement Communities.” The 2012 report was released on Sept. 10, 2012, and includes data based on fiscal year 2011 financial statements for a total of 65 Fitch-rated credits. Medians are calculated for a variety of liquidity, profitability and capital and cash flow ratios. These medians

are further detailed by credit category (“A” and “BBB” credits), contract type (types A, B and C) and “stand-alone” facilities vs. “system” credits.

Another source of financial ratios is available through a joint project of the Commission on Accreditation of Rehabilitation Facilities – Continuing Care Accreditation Commission (CARF-CCAC), ParenteBeard, LLC and Ziegler. “Financial Ratios & Trend Analysis of CARF-CCAC Accredited Organizations” is published annually. The 2012 report includes data based on fiscal year 2011 financial statements for approximately 150 single-site and 30 multi-site organizations that are accredited by CARF-CCAC. The report includes a total of 17 profitability, liquidity and capital structure ratios. Ratios are presented from “worst” to “best” with quartiles at the 25th, 50th and 75th percentile. Medians are also presented by contract type (types A, B and C) for single-site and multi-site organizations. Comparisons with Fitch and Standard and Poor’s ratios are also provided.

Ratios provided in the CARF-CCAC publication include the following:

## Margin (Profitability) Ratios

- Net operating margin
- Net operating margin – adjusted
- Operating
- Operating margin
- Total excess margin

## Liquidity

- Days in accounts receivable
- Days cash on hand
- Cushion

## Capital Structure

- Debt service coverage – revenue basis
- Debt service coverage
- Debt service as a percentage of total operating revenues and net non-operating gains and losses
- Unrestricted cash and investments to long-term debt
- Long-term debt as a percentage of total capital
- Long-term debt as a percentage of total capital – adjusted
- Long-term debt to total assets
- Average age of facility
- Capital expenditures as a percentage of depreciation

An approach BDO uses in presenting such ratios includes trending of the past three years’ financial ratios based on audited financial statements with the most recent year’s ratios benchmarked with those of the CARF-CCAC. As a result, trends in performance are revealed in conjunction with benchmarking with the CARF-CCAC data. Many clients have adopted this presentation and have incorporated financial ratios and benchmarking as an ongoing component of their monthly reporting package to management and the board of directors.

Financial ratios provide a valuable tool in identifying trends, analyzing strengths and weaknesses, identifying unusual results, illustrating best practices and providing

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## CONTINUING CARE RETIREMENT COMMUNITIES

Continuing Care Retirement Community, Inc.				Financial Ratios and Trend Analysis 2012 Ratio Quartiles Single-Facility Providers - All Contract Types					
	Previous Audit Year 6/30/10	Previous Audit Year 6/30/11	Current Audit Year 6/30/12		25%		50%		75%
<b>Operating Performance</b>									
Net Operating Margin	11.84%	5.52%	4.00%		1.40%	x	7.03%		12.32%
Net Operating Margin - Adjusted	13.03%	8.94%	6.41%	x	13.53%		20.65%		29.43%
Operating Ratio	92.41%	98.99%	99.80%		103.18%	x	98.51%		94.08%
Operating Margin Ratio	1.19%	-5.54%	-5.54%	x	-3.41%		1.62%		5.15%
Total Excess Margin Ratio	-0.96%	-3.72%	2.06%		-1.63%	x	3.60%		7.42%
<b>Liquidity</b>									
Days in Accounts Receivable	21.45	18.76	26.29		27.00	x	19.00		11.00
Days Cash on Hand Ratio	272.22	271.00	269.64		181.00	x	290.00		517.00
Cushion Ratio	7.66	7.91	8.85		2.63		6.17	x	11.11
<b>Capital Structure</b>									
Debt Service Coverage Ratio	1.43	1.37	2.00		1.26		1.91	x	3.32
Debt Service Coverage Ratio-Rev Basis	1.29	0.97	1.69		0.37		0.90		1.39
Debt Service % of Tot. Oper & Net Nonoper Gains	8.89%	8.78%	7.38%		18.85%		11.93%	x	6.92%
Unrestricted Cash & Investments to L/T Debt	69.02%	72.27%	75.59%		25.97%		52.12%	x	88.76%
Long-term Debt as a Percentage of Total Capital Ratio	61.30%	61.69%	61.99%		116.12%		83.98%	x	53.29%
Long-term Debt as a Percentage of Total Capital Ratio-Adjusted	61.30%	61.69%	61.99%		85.51%	x	56.80%		38.08%
Long-term Debt to Total Assets Ratio	46.72%	40.78%	46.40%		52.29%	x	42.23%		28.67%
Average Age of Facility	14.19	14.36	14.98	x	13.70		11.51		9.10
Capital Expenditures as a Percentage of Depreciation Ratio	66.82%	53.83%	29.41%	x	50.00%		76.00%		136.00%

Groups/Healthcare/Consulting/Misc/Fin Ratio Trend - Single

comparisons among providers, regardless of size. In addition, they are easy to use. The CARF-CCAC publication provides a definition for computation of each ratio and insight into the interpretation of each. However, financial ratios have limitations as the interpretation of a set of ratios may vary based on different financial reporting practices across providers and, of course, no two providers are alike. As a result, financial ratios should not be used in isolation.

In its 2012 report, Fitch concludes that the 2011 ratios demonstrate stability across the industry. Median ratios were stable when compared with prior year levels as management teams continued to focus on maintaining solid financial performance in the face of a sluggish economic recovery

and a soft housing market. Fitch also noted the decline in capital spending to a five-year low as management teams continue to be cautious in moving forward with capital plans. The economy and housing market continue to weigh on industry performance as Fitch has seen a flattening of independent living occupancy at lower levels than historically seen. Despite the continued challenges of high unemployment, weak job growth and decreased home values, Fitch believes the fundamental characteristics of the senior living industry to be robust over the long term with the growth in the elderly population fueling solid demand.

If you have not included financial ratio analysis and benchmarking as part of your organization's financial reporting culture, it's

time to start. Much more than a value-add to your financial statement audit, such analysis will help to focus management and the board of directors on issues that may be key to your organization's future success.

For more information, contact Randall Severson, Assurance Director, at [rseverson@bdo.com](mailto:rseverson@bdo.com).

# SELF-INSURANCE

By Steven Glicksman, FCAS, MAAA, President, Glicksman Consulting, LLC - Actuarial Services



## THERE COMES A TIME IN THE PROGRESSION OF ALMOST EVERY SUCCESSFUL BUSINESS WHEN SELF-INSURANCE BECOMES ATTRACTIVE.

"Self-insurance" can include gradually increasing deductibles, as well as captives and insurance fronting arrangements. That is, self-insurance is a financing plan in which money is accrued to pay for potential future claims rather than buying traditional insurance.

The first step is to decide whether self-insurance is right for your business. It is tempting and deceptively easy to compare your insurance premiums with your claims and conclude that your insurance company has been making money on you all these years, and that self-insurance is the answer.

*"Everybody said it would happen one day. That was the day."*

– Bob Harris

For example, most of us purchase coverage for catastrophic events (earthquake, hurricane and so on). The premiums are often hefty. We hope to never make a claim. But, catastrophic events are not self-insured as they are too unpredictable in frequency and high in loss severity. You should never self-insure a risk that threatens the vitality of your business.

The best coverages to self-insure are those that can be estimated according to the

mathematical law of large numbers (stable long-term results for random events) where the probability of that event occurring in the future can be quantified. They occur with regularity and can be reasonably estimated over the course of a few years. For example, automobile physical damage (collisions) for a fleet of taxis is an ideal starter. Automobile physical damage claims occur all too often. The typical cost is a few thousand dollars, and even in the event of a total loss, many businesses can afford it. One way to begin may be to increase your deductible from \$1,000 to \$10,000.

In practice, total or exclusive self-insurance is rare. Most businesses operate with combination of self-insurance and commercial insurance. Usually the predictable losses of the risk are retained and self-insured, forming a first or "working" layer of coverage. Then, insurance or reinsurance is purchased from a traditional commercial insurer. The commercial insurer pays for losses above the specified self-insurance limit per loss. In essence, the losses paid for by the insured before the commercial insurance policy pays becomes the deductible layer. Depending on the deductible, commercial insurance coverage should become less and less

expensive the further away the commercial insurer moves from the working layer of paying claims each year.

Selecting the optimal deductible or self-insured retention for your business is a mixture of actuarial science and art. Of course, the cost of the insurance premiums matter. But so does your ability and willingness to retain risk. It is also important to appreciate that insurance is a strangely cyclical business. In some years, insurance companies are competitive and may offer coverage that appears less than the actuarial projection of losses. In other years, premiums seem to rise precipitously for no apparent reason. So, you cannot simply choose to be self-insured and let it rest there. It is a process of regular monitoring and adjustment.

*"It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change."*

– Charles Darwin

You must also consider the secondary costs of self-insurance in terms of money and your time. There will still be the cost to manage claims and engage legal expertise when needed. As a stakeholder, minimizing the frequency of claims and the cost of claims becomes more important. Risk management and loss control can help, and may require you to invest in training programs. However, there are cost savings to the self-insured business that are usually realized through the elimination of the carrying costs that commercial insurers pass on to their insurance consumers.

Finally, there are accounting and tax issues that go beyond the scope of this primer. For your specific situation, contact your BDO professional.

*To learn more about self-insurance or actuarial services, please contact Glicksman Consulting, LLC, an actuarial consulting firm and an independent member of the BDO Seidman Alliance.*

# TAX UPDATE FOR TAX EXEMPT HOSPITALS

By Laura Kalick, JD, Director, BDO USA, LLP



## THERE ARE A NUMBER OF RECENT EVENTS THAT COULD IMPACT TAX EXEMPT HOSPITALS AND WE WANTED TO SHARE A FEW:

### Charitable Deduction

The American Taxpayer Relief Act of 2012 reinstates a limitation on itemized deductions for individuals with incomes over \$250,000 and married couples filing joint returns with incomes over \$300,000. Under the new law, most itemized deductions, including the charitable deduction, are reduced by the lesser of 3 percent of adjusted gross income (AGI) over the threshold or 80 percent of itemized deductions. These limitations on the charitable deduction are less drastic than some of the other proposals that were being considered. In fact, there are estimates that the new tax law, with its increased rates on the wealthy will increase charitable giving. <http://www.urban.org/publications/412732.html>.

### Extension of the Exception from UBIT for Payments from Controlled Organizations

The American Taxpayer Relief Act of 2012 also contains a provision that had expired and provided an exception to the rule that payments from controlled organizations

constitute unrelated business income (UBI). In general, section 512(b)(13) of the Internal Revenue Code provides that if a controlled entity, such as a taxable subsidiary, pays rent, royalties, interest or an annuity to a controlling exempt entity that the payment will constitute UBI. There is an exception to this rule if the payments are not in excess of fair market value and are made pursuant to a binding contract that was in effect on Aug. 17, 2006, or an extension of such contract. This is an important provision for many organizations with taxable subsidiaries. If your organization is using this exception, make sure all the elements of the exception are documented and in your files.

### IRS Review of Hospitals

The Affordable Care Act (ACA) enacted March 23, 2010, added new requirements that hospital organizations must satisfy to be described in section 501(c)(3), as well as new reporting and excise taxes. Also, under the ACA the IRS is required to review tax exempt hospitals every three years to determine if they are in compliance with Community Health Needs Assessment (CHNA) requirements. Over 3,000 hospitals will be reviewed this year by IRS and hospitals will not be notified they are being reviewed. The IRS will look at Form 990 and other publicly available resources such as the financial statements attached to Form 990, Form 990-T and the organization's website.

In particular, the IRS will focus on the answers to Form 990, Schedule H. Community Health Needs Assessment questions are now in Schedule H, Part V, Section B, but these questions are optional for tax years 2010 and 2011 because the CHNA requirements of section 501(r) are only effective for tax years beginning after March 23, 2012. However, note that all other questions in Part V, Section B are not optional for the 2011 tax year and must be completed (they were optional for the 2010 tax year).

### Unrelated Business Income

When the IRS reviews a hospital's Forms 990 and 990-T they may also look a little closer at UBI. The IRS is looking more closely at UBI in general, especially at organizations

that report gross UBI on Form 990 but do not file a Form 990-T or have large net operating losses reported on Form 990-T. The IRS will implement an unrelated business income tax (UBIT) study in the next year on these issues.

The new Form 990 has put the UBIT issue front and center. A snapshot is provided on page 1 of Form 990 by requiring information on gross UBI and net UBI reported on Form 990-T. Further back on page 9 of the form, revenue is broken down into columns that show whether the income is being characterized as related, unrelated or not reported as UBI because it meets an exception or modification to UBI. Page 9 can be very revealing, especially where the same activity generates both related and unrelated income; for example, a hospital laboratory that serves both patients (related) and non-patients (unrelated). Where the unrelated income is offset by large expenses, this may call into question whether some of the expenses used to offset the unrelated business income are really expenses of the related activity.

How to prepare? If your organization has UBI and reports negative or no taxable income on Form 990-T, you should review the basis of the losses that have been used to offset the unrelated business income and the reasonableness of the allocation and document their validity. Organizations that have UBI over \$1,000 and do not file Form 990-T should consult their tax advisers.

### Governance Update

Finally, the IRS is still looking at governance and compensation practices of exempt organizations. We had previously reported to you (Summer 2011) that IRS agents were preparing checklists at the completion of examinations of 501(c)(3) organizations to determine if there is some correlation between a well-governed organization and one that is tax compliant (measured by the IRS as to whether there were significant issues found upon audit). The results of the project were reported by the IRS and they found there was a statistically significant correlation between certain practices as follows (see [http://www.irs.gov/pub/irs-tege/georgetown\\_04192011.pdf](http://www.irs.gov/pub/irs-tege/georgetown_04192011.pdf)):

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## TAX UPDATE FOR TAX EXEMPT HOSPITALS

- Organizations with a written mission statement are more likely to be compliant;
- Organizations that always use comparability data when making compensation decisions are more likely to be compliant;
- Organizations with procedures in place for the proper use of charitable assets are more likely to be compliant; and
- Organizations where Form 990 was reviewed by the entire board of directors are more likely to be compliant.

Interestingly, the IRS found no statistically significant correlation with tax compliance if the organization had a conflict of interest policy, if the organization never or only occasionally used comparability data to set compensation or if voting board members had a family relationship and/or outside business

relationship with other board members, officers or key employees.

### Compensation

If your organization is relying upon comparable data when making compensation decisions, this practice should be consistently applied. The way to show that the practice has been consistently applied is to have written documentation of the comparability data. Also note that contemporaneously documenting the independence of the decision-making body and the comparables may allow an organization to establish the “rebuttable presumption of reasonableness” that shifts the burden of proof to the IRS to show whether there is an excess benefit transaction that could be subject to intermediate sanctions (see IRC 4958). The rebuttable presumption of reasonableness can also be established

with regard to transactions with “disqualified persons,” those who can substantially influence an organization. These rules could come to light especially where a hospital is buying the practice of a physician who has the ability to exercise substantial influence over the hospital.

### Conclusion

Since there will be increased scrutiny of tax exempt hospitals by the IRS, documentation of tax positions is more key than ever. Let us know if we can assist.

*For more information, contact Laura Kalick, National Director of Non-profit Tax Consulting, at [lkalick@bdo.com](mailto:lkalick@bdo.com) and visit our Nonprofit Standard Blog at <http://nonprofitblog.bdo.com>.*

### 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.

The BDO Healthcare practice provides services in the following areas:

- Acute Care
- Ancillary Service Providers
- Health Maintenance Organizations (HMOs)
- 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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