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THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

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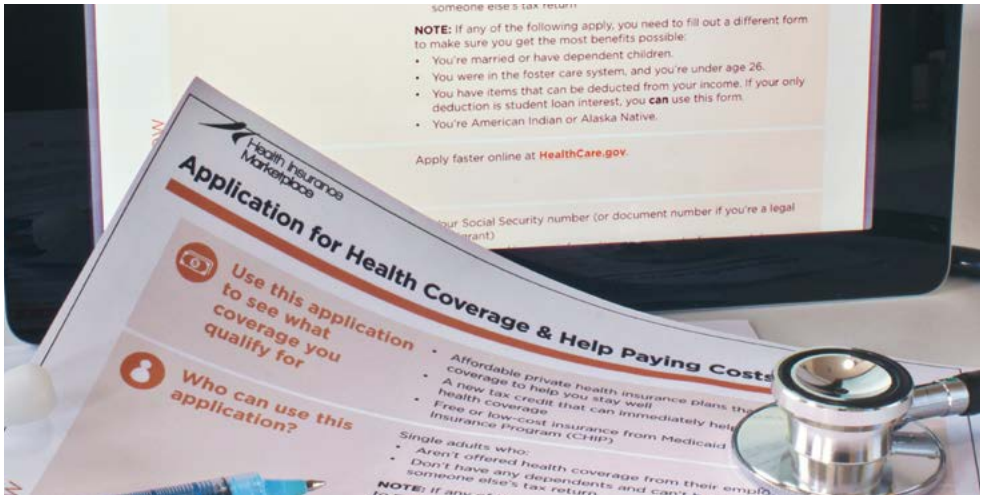

HEALTHCARE TRANSFORMATION IS ACCELERATING, DESPITE POLITICAL RHETORIC

By Dr. David Friend, MBA and Patrick Pilch, BDO Consulting

IT'S HARD NOT TO GET CAUGHT UP IN THE CONVERSATION GOING ON IN WASHINGTON.

In recent months, our elected representatives have proved just how explosive the debate over our country's healthcare system has become. This vigorous battle at the federal level over national policy has created uncertainty for healthcare organizations as they try to predict the ultimate effect the new system will have on their business.

Major economic forces are driving the debate. As the baby boomer generation enters retirement, the total number of Medicare recipients in the United State is set to dramatically increase. While Medicare has steadily expanded in scope since its inception in 1966, the number of participants is expected to boom from the current levels, just under 50 million, to more than 60 million in just the next eight years. In short, more people are growing older. The number of Americans over the age of 85 stood at 5.8 million in 2010. By 2050, this number is expected to reach 19 million, representing an almost

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THE HEALTHCARE INDUSTRY IS CHANGING

230 percent increase in this demographic and a significant growth in costs to provide them with adequate care. As a result of these economic changes, the healthcare system is experiencing significant shifts in the way patients receive their care, and it is happening regardless of the often distracting political discourse.

The Changing Model of Healthcare Coverage: From Defined Benefits to Defined Contribution

The traditional model for healthcare coverage provides patients with a predetermined healthcare plan, set by the employer and provided to the employee. This is also referred to as defined benefits. Under the defined benefits model, businesses are able to control their costs by providing a fixed contribution each year. The process is similar to pension systems, which provide employees with a fixed retirement plan that is guaranteed to the employee. Today, many employers have moved away from pension plans to 401(k) investments. While employers still provide employees with funding for retirement, the responsibility of how to invest that money is determined by the employee.

A similar shift is occurring in healthcare. We're now transitioning to a defined contribution model in which employees are provided with a set dollar amount and control the way that money is spent. This model empowers patients to be more active in choosing the way they receive care – a complete paradigm shift. Under the Patient Protection and Affordable Care Act, popularly known as Obamacare, public exchanges have been established to help consumers find the best coverage to fit their individual needs. Similar exchanges have already been established by private companies, showing that these trends are happening regardless of regulation.

By altering the way patients receive coverage, defined contribution plans will greatly impact the way organizations are expected to provide care. Patients now have a vested interest in finding the right care for the right price or, put another way, the best value. The result will be a healthcare industry that is much more consumer-driven, a change that will force providers to rethink their traditional models. An example of this can be seen in skilled nursing facilities (SNFs). The Centers for Medicare and Medicaid Services (CMS) have created a Five Star Quality Rating System for SNFs, allowing patients, their families and caregivers to easily compare nursing facilities. The system gives each facility a quality rating between one and five stars, with five being the highest, based on specific quality measures including staffing patterns. This represents a clear shift toward a model that recognizes that more consumers are beginning to shop for the best value.

Evolving to a Successful Future State

To be successful in this environment, providers will need to develop new, innovative strategies that ensure value by focusing on the patient. Technology, for example, can be used to create a more interactive experience capable of detecting gaps in care, correcting cost inefficiencies and providing unprecedented access to healthcare information. Social and mobile technology will also be important for healthcare organizations and even individual physicians and practices as patients begin to rate, critique and comparison shop through these channels. As a result, price and outcomes are critical. The individuals and companies that are unable to provide quality care for a reasonable cost will be eliminated from the market due to these consumer forces.

The best organizations will look to the public to correct their operating model. While critical changes are being discussed in D.C., it's the patients who will ultimately shape price, quality measurement and overall value proposition for the healthcare industry.

Dr. David Friend and Patrick Pilch are both Managing Directors with BDO Consulting and lead BDO's Healthcare Consulting Practice. For more information, please contact David at dfriend@bdo.com or Patrick at ppilch@bdo.com.

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SEAL THE DEAL:
The CFO's Role in Minimizing Post-Acquisition Disputes in the Healthcare Industry

By Jeffrey M. Katz, BDO Consulting

According to Healthcare M&A Watch, *Modern Healthcare's* quarterly report on healthcare M&A activity, healthcare providers announced 93 transactions in the third quarter of 2013, about 35 percent more than they did during the same period last year. As new reimbursement models, an aging population and changes mandated under healthcare reform continue to reshape the industry, this trend is likely to continue. Healthcare providers looking to cut costs and elevate the quality of care are turning to consolidation as a way to gain leverage by combining assets, staff and other critical resources.

For CFOs involved in such transactions, it's important to understand the post-acquisition dispute issues that often arise after closing. CFOs who proactively consider common post-acquisition dispute issues before an agreement is reached can minimize the chances of being distracted with such post-closing disputes and can instead focus on integrating the newly acquired business, driving operational efficiency and setting the company on a path for growth.

M&A agreements often contain adjustments to the purchase price that occur post-closing. These adjustments are predicated on changes in the balance sheet of the company being sold between the date a deal is negotiated and the date the transaction closes. While the metrics for adjustment vary from one agreement to the next, a common adjustment is based on the change in a business's net working capital. Disputes often arise because the buyer and seller have different opinions regarding the amounts that should be included on the closing date balance sheet. These disputes often focus on generally accepted accounting principles (GAAP) and their application within the context of the terms of the M&A agreement.

For example, M&A agreements may contain language that requires the closing date balance sheet to be prepared in accordance with GAAP and consistent with a company's past policies, practices and procedures. Post-closing purchase price adjustment disputes often arise when a company's past practice was not in accordance with GAAP and the M&A agreement is silent on which should prevail—past practice or GAAP. CFOs can play an important role in minimizing transaction disputes by suggesting clarifying language in the agreement that specifies which prevails. Alternatively, if the parties' intent is to be consistent with past policies, practices and procedures, then the parties might consider not even mentioning GAAP in the M&A agreement provision on preparing the closing date balance sheet.

When drafting an M&A agreement, parties often believe that the phrase "GAAP consistent with a company's past policies, practices and procedures" provides sufficient instructions for preparing the closing date balance sheet. As CFOs are aware, GAAP

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SEAL THE DEAL

requires management to make judgments and estimates in preparing financial statements. However, the buyer's and seller's respective management teams may have differing estimates for the same balance sheet item, though both estimates are in accordance with GAAP. In transactions involving healthcare companies, an often-disputed item when determining the post-closing purchase price adjustment is whether the contractual allowances applied to the revenues were sufficient such that the net accounts receivable are collectible. CFOs involved in healthcare M&A transactions might consider performing a detailed review of the target company's provision for contractual allowances in order to assess the historical accuracy of the company's net accounts receivable.

An area also related to contractual allowances that is often disputed in healthcare M&A is the allowance for doubtful accounts. CFOs involved in an M&A transaction may want to suggest the inclusion of language in the agreement that removes the subjective nature of this estimate. For example, the parties can agree on a formula based on the accounts receivable aging to determine the amount of the allowance for doubtful accounts to be recorded on the closing date balance sheet.

Another area that is predicated on management's judgments and estimates and often the subject of post-acquisition disputes is contingent liabilities. In order for a liability to be recorded on the closing date balance sheet, it must meet the requirements of FASB Accounting Standards Codification Topic 450 (ASC 450) (formerly Financial Accounting Standards No. 5). In general, ASC 450 provides that an accrual for a liability is necessary if (a) it is probable a liability has been incurred and (b) the amount of the liability can be reasonably estimated. Oftentimes the buyer and seller of a business have differing views of whether the requirements of ASC 450 have been satisfied resulting in a dispute over whether a contingent liability should be recorded on the closing date balance sheet. Once again CFOs can provide additional value to the deal team by making those individuals aware of contingent liabilities that might become an issue post-closing. This will allow the parties to address such issues in the drafting of the M&A agreement.

In addition to net working capital adjustment provisions, many M&A agreements contain earn-out provisions intended to bridge the differing views on the value of a business between the buyer and the seller. Because these provisions frequently have a financial-related metric that needs to be achieved in order for the additional purchase price to be paid, there are often differing views between the buyer and seller regarding whether the targets have been met or could have been met had the business been operated differently. Because the healthcare industry is experiencing significant changes, CFOs can assist the deal team negotiating the earn-out targets by helping to set targets that take into consideration these anticipated changes.

Understanding that M&A agreements are often subject to interpretation and disagreement between the buyer and seller, CFOs can serve as a valuable resource to attorneys throughout the drafting process of the M&A agreement, often helping to minimize post-acquisition disputes and allowing CFOs to focus on their businesses.

Jeffrey Katz is a Partner and Practice Leader for Post-Acquisition Disputes and Economic Damages with BDO Consulting. For more information, please contact Jeffrey at jkatz@bdo.com.

POINT-OF-SERVICE COLLECTIONS – READY, SET, COLLECT!

By Claudia Birkenshaw Garabelli, MSA, The Rybar Group

IN 2014, PATIENTS' FINANCIAL RESPONSIBILITY FOR HEALTHCARE CLAIMS IS PROJECTED TO BE 30-40 PERCENT.

Although coverage is expanding through the insurance marketplace, also known as the exchange, many policies will have deductibles of $5,000 to $6,000 along with coinsurance and copays. In 2013, about 58 percent of employers offered high-deductible plans but the future estimates are 80 to 85 percent.

In 2014, the Kaiser Family Foundation Survey reported that 22 percent of large employers will only offer plans with high deductibles. Some patients who had traditional coverage, now will have high deductibles before the payer is involved.

During November 2013, almost 5 million people received notices that their health plans were being cancelled – some of those plans may be reinstated but, as of this writing, it's unclear which state insurance commissioners will allow the last-minute change. Due to the higher cost of policies on the exchange, some people plan to pay the federal penalty. These individuals will have no health insurance if they are in need of care.

These financial challenges are compounded by the fact that many people entering our providers' doors do not understand their coverage and countless others still have no insurance and do not understand how to enroll.

As we look forward to a post-Affordable Care Act (ACA) implementation environment, many questions arise.

Read more

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POINT OF SERVICE COLLECTIONS

Self Check – Ask Yourself:

Will the uninsured disappear with healthcare reform?	*No.*
Will people who have insurance for the first time in their life understand what is covered, what is not covered, copays, deductibles and coinsurance?	*No.*
Will every uninsured family purchase insurance through the exchange?	*No.*
Is it expected that providers' bad debt will decrease with the Affordable Care Act?	*Highly unlikely – in fact, it will increase if providers do not develop effective education, communication and point-of-service collection strategies.* *Where similar state plans were implemented years ago, bad debt remained about the same if the provider implemented effective collection and education efforts at the front of the revenue cycle.*
Do consumers understand their health insurance coverage?	*No, many do not.*
Will your provider, hospital, physician, etc., be covered by every exchange offered in your state?	*This varies by state. Many plans have "narrow" networks in order to reduce their expenses. For example, only one plan is offered on the exchange in New Hampshire and 10 of the 26 hospitals are excluded. In New York, Memorial Sloan-Kettering Cancer Center is not listed in any exchange. In Illinois, Rush University Medical Center had been covered by all plans but, in the exchange, it is only covered by 38 of the 71 plans.* [1]
Do your scheduling, reception and patient access staff understand the increasingly complex benefit plans offered through the exchange in your state, and are they able to explain it to customers?	*Many do not. You must develop an educational program and tools to equip the staff.*
Does your organization currently collect at point of service (POS)?	*No.* *Yes – but we could do a better job.*
Have you examined the percentage of your bad debt that is due to uncollected copays and deductibles?	*This is eye-opening and may give you the impetus to embark on this necessary campaign. Many providers' bad debt percentages related to uncollected copays and deductibles range from 30 to 50 percent! Bad debt amounts are certain to skyrocket without immediate change to the entire front-end processes of the revenue cycle.*

The best performing providers collect more than 40 percent of patient responsibility at point of service,[2] and all of them say that it's a journey, not a one-time event, procedure and process. One small provider that we worked with recently implemented POS collections and brought in more than $4,000 on average the first two months – that's $208,000 for the year.

The cornerstones driving change include:

- Shift of the financial burden from employers to payers to patients
- Transparency, HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) and additional reporting agencies
- Healthcare reform through the Affordable Care Act and hundreds of other initiatives
- Pay for performance, quality and value

It is imperative to become more efficient and to collect more effectively – do not grow faint of heart. Now is the time to rally and support our customers, patients and our organizations so we can remain fiscally strong.

The providers' to-do list includes:

1) Create a positive culture for collections
2) Share data about changes in healthcare, reduced reimbursement, financial indicators, bad debt numbers and amounts
3) Educate scheduling, reception, patient access and the front-line staff
   a. Empower staff to resolve patient issues while treating them with dignity and respect
   b. Offer scripting tools, reviewing them with your staff one-on-one to ensure good outcomes
4) Educate the physicians, management and the entire staff. Everyone is connected to the payment process one way or the other, or they may hear a complaint from a neighbor. Equip them with the necessary knowledge.
5) Educate patients about their healthcare coverage (a patchwork of options are available in the healthcare marketplace).
6) Identify key points where initial patient interactions occur, such as:
   a. Scheduling
   b. Reception, patient access

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POINT-OF-SERVICE COLLECTIONS

   c. Emergency departments
   d. Obstetric departments
   e. Outpatient laboratory and other outpatient arenas, such as rehabilitative therapy

7) Set point-of-service goals, measure and monitor

8) Create tools or purchase software to assist with the task of estimating charges as well as determining amounts owed by patients (deductible, copays and coinsurance). Develop workflow, procedures and policies.
   a. Insurance eligibility system
   b. Determine if the patient qualifies for financial assistance (ideally, complete this while the patient is onsite)
   c. Categorize patients into propensity-to-pay segments
   d. Consider working with Medicaid eligibility vendors to help patients and assist with Medicaid enrollment
   e. Technology – consider:
      i. Where are you able to accept credit card payments, what is the number of systems you currently have; review current technology and implement improvements
      ii. Are patients able to make payments online? Invest in a portal

9) Communicate across your organization

This may be challenging to all of us. Now is the time to:

- Evolve
- Educate our patients
- Educate our front-line patient access staff and others involved
- Be an advocate for our patients

1 Avalere Health Market Analysis, *Star Tribune Health*, November 20, 2013
2 *HFMA Map Award* winners 2012; equation: POS payments divided by total patient cash collected

Claudia Birkenshaw Garabelli is the Director of Revenue Cycle Services with The Rybar Group, a healthcare financial consulting firm and independent member of the BDO Seidman Alliance. Claudia can be reached at cgarabelli@therybargroup.com.

PErspective in Healthcare

In anticipation of healthcare reform, private equity investment in the healthcare sector fell 65 percent in the first part of 2013, according to The New York Times. Yet, despite this early uncertainty, private equity investors regained confidence in Q3 with a flurry of activity, culminating in approximately $11 billion of capital invested across 74 healthcare companies, according to Pitchbook.

Capitalizing on the evolving state of the healthcare industry is not a new private equity strategy. In a recent report published by Pitchbook, more than 454 private equity investors have backed U.S.-based healthcare companies since 2009. Lately, a number of GPs have focused their attention on the post-acute care continuum. Consisting of skilled nursing facilities (SNFs), long-term care facilities (LTCFs), inpatient rehabilitation facilities, and home health and hospice care providers, many of these smaller providers are undergoing a paradigm shift as they face tremendous pressure to compete in a new environment that incentivizes quality of care over quantity of patients.

Bringing much-needed capital and financially experienced leadership, private equity's involvement in the post-acute care sector has been seen as the saving grace for many healthcare providers. Private equity firms now own several of the largest chains of senior care facilities in the United States.

On the other end of the spectrum, there also lies the potential for increased scrutiny of post-acute care facilities that are backed by private equity – leading some GPs to steer clear from these types of investments. Critics' concerns about private equity's short-term focus and bottom-line approach could lead to accusations of neglect or myopic intentions. Unfortunately, no matter how well these organizations are run there is always a risk of something going wrong, leading to negative attention and reputation risk.

Yet, despite these concerns from some, private equity funding in the healthcare industry is poised to grow as dedicated and informed investors continue to see opportunities arise in the midst of sea change.

PErspective in Healthcare is a feature examining the role of private equity in the healthcare industry.

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THE FUTURE OF SKILLED NURSING

By Randall Severson, BDO USA

SKILLED NURSING FACILITIES JUST KEEP CHUGGING ALONG.

Despite oftentimes being maligned for poor quality care and certainly the target of reimbursement reductions, skilled nursing facility valuations have been remarkably consistent for years. According to The Senior Care Acquisition Report (2013), the median cap rate has ranged between 12.0 percent and 14.4 percent over the past 15 years with the most recent year reported at 12.6 percent (2012). Such resilience is hard to believe given the reimbursement changes and the challenges that have occurred during the period. With no end to payment challenges in sight, what does the future hold for today's skilled nursing facility, especially those facilities with tired physical plants, no capital for improvements and a census dominated by Medicaid residents?

Many years ago, the long-term care consulting practice at BDO prepared for the onslaught of managed care. For the most part, we are still waiting. However, with the enactment of the Affordable Care Act and the development of Accountable Care Organizations (ACOs), the onslaught may be just around the corner. Even now, managed care companies are squeezing reimbursement and lengths of stay while raising the bar on outcomes and readmissions.

Even though MedPAC has recommended rate reductions for years due to double-digit Medicare profit margins, lawmakers have continued to support market basket increases, knowing well that they are subsidizing Medicaid shortfalls. In fact, the most recent report on Shortfalls in Medicaid Funding for Nursing Center Care prepared by Eljay, LLC for the American Health Care Association, estimated Medicaid shortfalls at 12.5 percent. Despite an estimated Medicare margin of 14.6 percent, the combined Medicare/Medicaid margin (deficit) was 2.8 percent. As managed care populations become more prevalent and fee-for-service populations decline, federally subsidized Medicaid price supports will diminish in value. With managed care, shorter lengths of stay and lower rates will become the norm as managed care companies look for even lower cost settings as care progresses. The primary goals of ACOs will be no different.

So as length of stays are reduced, how do you increase admissions to maintain inpatient volumes? It may mean that you either form or join an integrated network. One just needs to take a look at what Kindred Healthcare (Kindred) is doing to gain an appreciation of the changes that are on the way and how at least one company is repositioning itself for success with future post-acute care delivery and payment models. It appears that Kindred is significantly reducing its capacity and focusing on markets where it will offer the full post-acute care arsenal.

According to The Advisory Board Company, the hallmarks of successful adaptation to the evolving post-acute care marketplace may include the following:

Clinical Enhancement and Specialization

- Top-tier clinicians
- Extensive clinical capabilities
- Far-reaching specialty programs
- Patient-centered care

Comprehensive, Efficient Delivery System

- Efficient care delivery
- Supportive care access
- Full portfolio alignment for patients' needs
- Cross-continuum care management

Health Care System Integration

- Shared clinical resources
- IT integration
- Community-based resource networks
- Primary care linkages
- System navigation
- Long-term care management

While it always seems that change is slower to take place than initially anticipated (at least in the post-acute care marketplace) and 2014 may be too early for industry-altering changes to materialize, future success may soon be bestowed not on those who can talk the talk, but those who can walk the walk. That walk may no longer be alone, but hand in hand with other members of an integrated network.

Randall Severson is a Director in the Healthcare Practice for BDO USA, LLP. For more information, please contact Randall at rseverson@bdo.com.

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WHAT TAX-EXEMPT HOSPITALS SHOULD KNOW ABOUT UBIT

By Laura Kalick, JD, LLM in Tax, BDO USA

The IRS is reviewing tax-exempt hospitals every three years to see the level of compliance with IRC 501(r) and since they will be looking at documents available to the public, such as the Forms 990 and 990-T, they will also look at unrelated business income (UBI) and the allocation of expenses. Congress is breathing down the necks of the IRS since they found so many UBI errors and issues with colleges and universities. And since IRS is looking, it makes sense for tax-exempt hospitals to make sure that UBI issues are in order and well-documented.

Last April the IRS issued the final report on its Colleges and Universities Compliance Project (CUCP). The Project started in 2008 when the IRS sent a 33-page questionnaire to 400 colleges and universities resulting in the examination of 34 schools. Upon completion of the exams, the IRS issued its final report that focuses on two main areas: underreporting of unrelated business taxable income (UBTI) and compensation practices of the selected organizations. Although the focus of the project was colleges and universities, the conclusions of the report are clearly not limited to these institutions. In fact, the IRS Workplan also contains projects to review the compensation practices and the unrelated business income of organizations where a large amount of gross unrelated business income has been reported on the Form 990, but no unrelated business income tax is due.

The IRS' CUCP Final Report found underreporting of UBTI that resulted in an increase in UBTI for the schools totaling approximately $90 million in the aggregate and disallowance of more than $170 million in losses and net operating losses (NOLs) due to:

- Disallowing expenses that were not connected to unrelated business activities because consistent losses from the activities pointed to a lack of profit motive, which is a fundamental requirement for an activity to constitute a trade or business. If there is no trade or business, then the activity does not rise to the level of being an unrelated trade or business.
- Improper expense allocations, including where expenses for related activities were used to offset unrelated income or where an allocation of overhead to unrelated activities was unreasonable.
- Errors in computations or substantiation of NOLs.
- Misclassification of an activity as exempt when it was really unrelated.

At a Congressional hearing held May 8, 2013, congressional representatives suggested they could not believe that noncompliance with tax laws—a key finding in the IRS report—could be so widespread and wondered aloud whether legislation was needed to address the problem. So here are some areas that hospitals should take a look at regarding unrelated trade or business income:

- Laboratories and pharmacies: Where there are non-patient sales, are expenses being properly allocated?
- Rent, interest or royalties from a controlled subsidiary: If the tax-exempt hospital or parent receives rent, interest or royalties from a taxable subsidiary, is it being included in UBI or does the arrangement meet an exception to the rule? 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 gross 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 the 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.
- Joint ventures: Does the venture further tax-exempt purposes or meet other requirements to allow the revenue stream to be considered related?
- Alternative investments: If the hospital has any alternative investments which report income on Forms K-1, are all items of UBIT included in the hospital's UBIT calculations? There can also be multistate filings and taxation from K-1's.

These are just a few of the key areas. So make sure that your documentation is in order.

Laura is the National Nonprofit Tax Consulting Director for BDO USA. For more information, Laura can be reached at lkalick@bdo.com

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THE SECOND COMING OF HEALTHCARE

By Reese Bacon, BDO USA

Sales and business development functions are either non-existent or relatively new for healthcare systems and providers. But with a carefully thought out approach and process, success can be achieved.

As healthcare systems prepare for the coming onslaught of changes in their industry as a result of the Affordable Care Act, there are a number of questions that will need to be addressed for those establishing sales or business development organizations.

Customer segmentation:

- Do you have a clear picture of where your best opportunities exist?
- Is there a well thought out plan for attracting and acquiring particular employers or consumers?
- Do you know their buying habits and preferences for purchasing?

Distribution channels:

- How will you gain access to employers and consumers?
- Direct contact or via some third party partner or intermediary?
- Are you clear on how your targeted customers wish to engage and purchase?

Value proposition:

- Do you have offerings that are unique from your competition or just "me too", and that are specifically designed for the targeted customers you wish to acquire?
- Are your marketing messages aligned with the sales and business development efforts?

Sales or business development strategies:

- Do you have a plan for how you will manage ongoing relationships with newly acquired customers to ensure long term retention and value creation?
- Have you envisioned a long term plan for how strategies need to evolve over time as you gain more and more market penetration?

Sales or business development roles:

- How many unique and different roles are required to acquire growth, retain and service your customer base?
- What skills and competencies will be required for success, including leadership?

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SECOND COMING

Organization design:

- What is the ideal organizational design for the short term and how do you envision it evolving as you grow?
- Should you organize by customer segment or by channel partner or some other consideration?
- How many resources do you need and located where to capitalize on your greatest opportunities?

Performance metrics:

- Which key indicators will you monitor and measure and how often to determine your degree of success?
- What portion of revenue should be allocated to customer facing activities versus other expenses of running the business?

Sales enablers:

- What's the appropriate mix between salary, short- and long-term incentives and recognition programs to drive desired behavior and results?
- How will we acquire, manage, develop and retain talent?
- What particular leadership and sales culture will we foster consistent with our organizational values?
- What tools and technology will support the sales effort?
- How will we embrace and manage continuous change to secure our future?

Each of these components of an effective sales effort, while important individually, are all interrelated and must all be continuously fine-tuned, like the precise mechanisms of a watch. If any become out of alignment, swift action is necessary in restoring equilibrium.

Reese Bacon is a Senior Director in BDO's Compensation and Benefits Practice. For more information, Reese can be reached at rbacon@bdo.com.

MARK YOUR CALENDAR...

JANUARY 2014

January 23-26
ACPE 2014 Winter Institute
Loews Don CeSar Hotel
St. Pete Beach, Fla.

January 28-29
World Congress 8th Annual Leadership Summit on Health Care Supply
Chain; Strategies for Balancing Clinical Outcomes with Financial Objectives
Monte Carlo Resort & Casino
Las Vegas, Nev.

January 30-31
World Congress 5th Annual Leadership Summit on Hospital Readmissions
Doubletree by Hilton Orlando at SeaWorld
Orlando, Fla.

January 30-February 1
iHealth 2014
Hilton Orlando Lake Buena Vista
Orlando, Fla.

FEBRUARY 2014

February 11
State-of-Science Stroke Nursing Symposium (AHA)
ISC Pre-Conference Symposium (AHA)
International Stroke Conference (AHA)
San Diego Convention Center
San Diego, Calif.

MARCH 2014

March 9-11
15th Annual International Summit on Improving Patient Care
in the Office Practice and the Community
Gaylord National Resort and Convention Center
Washington, D.C.

March 10-12
NCAL Spring Conference
Caesars Palace
Las Vegas, Nev.

March 16-18
NIC Regional
Boca Raton Resort and Club
Boca Raton, Fla.

March 18-21
Epidemiology and Prevention & Nutrition, Physical Activity and Metabolism 2014 Scientific Sessions (AHA)
Hilton San Francisco Union Square
San Francisco, Calif.

March 24-27
Congress on Healthcare Leadership
Hyatt Regency Chicago
Chicago, Ill.

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BDO HEALTHCARE 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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