

THE NEWSLETTER FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

# BDO KNOWS HEALTHCARE



## BACK TO BASICS: WHY ADHERING TO CENTRAL REAL ESTATE AND FACILITIES MANAGEMENT PRINCIPLES IS CRITICAL FOR HOSPITALS IN TIME OF ACA UNCERTAINTY

by Ross Forman

**President Trump and the Republican leadership's plan to repeal the Affordable Care Act (ACA) has created a climate of uncertainty across the healthcare industry, with direct impact on real estate and facilities healthcare operations.**

It is difficult for a hospital to make capital commitments, expansion and hiring decisions, and investments in research without knowing what its long-term revenue stream potential may be.

Given the current climate, it is more critical than ever that hospitals implement and adhere to basic real estate and facilities management fundamental principles. Proactively managing healthcare assets is independent from what may or may not occur in changes to the ACA. The goal of optimizing the performance of the portfolio as defined by the individual healthcare organization remains.

With that, healthcare providers should focus on known variables:

- ▶ Data from the Organisation for Economic Co-operation and

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**BACK TO BASICS**

Development (OECD) has consistently shown the average unit costs for U.S. physicians, hospitals, facilities and drugs are the highest in the world.

- ▶ Real estate represents an average 40 percent of a hospital system's assets on the balance sheet.
- ▶ Cost of operations (utilities, maintenance, environmental services) average \$5,000 per full-time equivalent (FTE) for a medical center.
- ▶ The retail [real estate strategy](#) of placing primary and urgent care clinics in more strategic locations than traditional medical facilities is gaining momentum.

These costs, financial indicators and trends are material. They will remain constant regardless of changes in healthcare coverage. Most likely, facility cost ratios will increase as the task of doing more with less has become the norm.

The question then becomes: What does "back to the basics" mean and how does a healthcare facilities department protect itself from the unknown outcomes of an ACA repeal? The answer: start from the beginning:

- ▶ **Ensure real estate/facility management goals are aligned with the overall objectives of the healthcare network.**
  - The organization as a whole drives the mission, vision, priorities and objectives, with real estate and facilities implementing strategies that support those goals.
- ▶ **Establish a clear understanding of the current state of the network's portfolio performance.**
  - Aggressively manage and benchmark insight, visibility and transparency into all costs, utilization and productivity.
  - Establish goals, with consistent reporting to track progress distributed to key stakeholders.
- ▶ **Develop an appropriate operating model and strategy for world-class service delivery.**
  - Define the right internal and external capabilities.
  - Leverage a sourcing strategy and maximize economies of scale.
  - Ensure ongoing contract management and frequently completed compliance audits.
  - Develop and regularly update required ongoing training programs.
- ▶ **Establish processes, procedures and governance.**
  - Adhere to Standard Operating Procedures (SOPs) in all decisions and commitments.

- Standardize business case requirements.
  - Minimize costs and maximize value-add through beneficial impacts on cash flow, and apply the right analysis to present the value of capital projects, revenues and the balance sheet.
  - Prioritize flexibility and agility in all real estate/facility decisions.
- ▶ **Enable an increased investment in technology and work toward a cloud-computing workforce**, which has higher levels of productivity and employee satisfaction and is a key factor in attracting and retaining top talent.
    - Customize space that enables mobility from room to room and remote work from anywhere and anytime to deliver patient services.
    - Establish a single source of information for planning and management.
    - Create and regularly update an [information governance](#) framework to provide guidance to your network around governance, data quality, security, availability, management, and the alignment of data and information across the enterprise.
    - Establish and regularly test basic cyber defenses and a coordinated response plan in the event of a breach incident.

Implementing fundamental real estate and facility leading practices is critical to mitigating potential risks of an unknown healthcare environment. This may require new ways of thinking, and a restructuring of internal capabilities and priorities. Without following these fundamental portfolio optimization recommendations, though, healthcare networks leave themselves exposed to poor-performing asset management results.



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# HOW HOSPITALS CAN IMPROVE CYBER-RESPONSE BY FORGING A STRONGER RELATIONSHIP BETWEEN COUNSEL & IT

by George Socha and Ian Lewis

Fostering a better working relationship between corporate counsel and information technology staff can be a tricky dance, but it's one that's essential in today's digital world—where a cyber incident can put a major dent in a hospital's reputation and assets with a single keystroke.

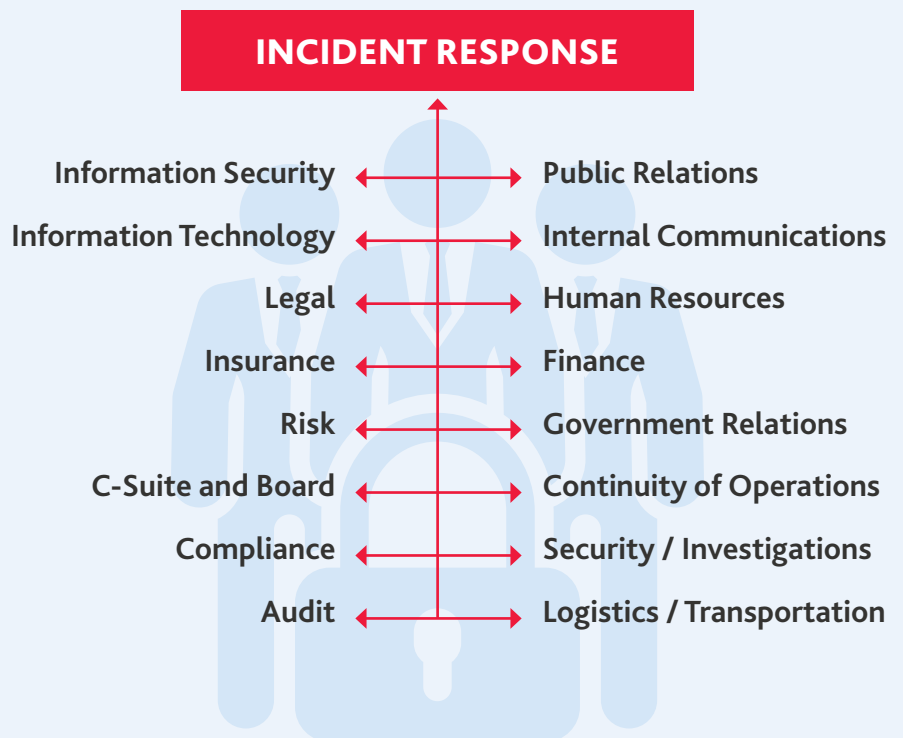
Hospitals should keep several key components in mind.

## There are three "must haves" for hospitals before an incident occurs.

Too often, hospitals may have basic cyber defenses in place but don't prepare a coordinated response plan until after an incident occurs, leaving their assets—and their patients—at risk. Prior to an attack, hospitals should review internal controls, and legal and insurance considerations. They should also instate a comprehensive cyber risk management strategy that outlines the response structure, governance, policies and procedures, and training, as well as:

- ▶ **A crisis communications plan** that includes both internal and external communications and is aligned with an existing enterprise risk management (ERM) framework;
- ▶ **A comprehensive coordinated incident response plan** that is regularly tested and takes into consideration hospital network processes and responsibilities of individuals; and
- ▶ **Post-breach digital forensics and cyber investigations** to identify the cause of the breach and implement remediation measures for affected areas

## A CYBER INCIDENT RESPONSE: A MULTIDISCIPLINARY CORPORATE RESPONSE WILL BE REQUIRED



of the hospital's system. Other post-breach activities should include system repair and data recovery.

To execute these components successfully, responsible team members should be designated for each, ensuring lateral communication and coordinated action. Tabletop exercises should also be conducted with all key stakeholders so everyone knows their individual role in the event of an incident.

Communication between all enterprise stakeholders is key both in advance of and in response to a cyber-attack. And a multidisciplinary corporate response is

crucial to best avoid and quickly recover from a cyber-attack. To effectively respond to a potential incident, relevant stakeholders should have a defined process in place to act swiftly. In most cases, stakeholders should include those responsible for information technology, legal, risk, insurance, compliance, audit, communications, human resources, finance and government relations, along with the C-suite and the board of directors.

While timely data breach notification is critical to preserving relationships with patients and network partners, hospitals should be cautious about launching external communications too



quickly after a breach to avoid spreading misinformation. Response teams should first work with their IT and security professionals to pinpoint the source of the incident so vulnerabilities can be patched, internal controls strengthened and messages aligned.

**A good in-house lawyer should bridge the divide between the IT and business worlds.**

Many people look to the general counsel or legal team to be the voice of reason. However, to be that voice in the wake of a cyber incident, an in-house lawyer must know enough about the technology involved to not only understand industry language, but also to communicate about it to the relevant stakeholders. One emerging practice is to add an IT professional to a hospital's legal department to serve as a dedicated liaison between the two. However, the best way to bridge the divide between IT and legal is to be the lawyer who already knows and is trusted by the IT security team.

**The cost of a cyber incident is two-fold.**

In the immediate aftermath of an incident, hospitals suffer from reputational and financial fallout due to the loss of intellectual property or records fundamental to viability, interruption costs and a loss of revenue. Additionally, several sustained opportunity costs come into play, including: higher cyber insurance premiums, IT infrastructure restoration costs, cybersecurity costs related to securing the network and its data, and regulatory scrutiny or litigation.

**Lagging data governance is sometimes the greatest threat to cybersecurity.**

One of the greatest risks to a hospital's cybersecurity is poor data management hygiene. Often it is enterprise insiders with permissions to access key information who steal from their employers. It's important to clearly delineate who has permissions to what information—and to regularly update those permissions as the hospital and its employees change, applying the principle of least privilege.

**There are two types of hospitals—those who have been hacked and those who are going to be hacked.**

This reality underscores the importance of cybersecurity controls.

While IT security professionals help to thwart would-be attackers, potential red flags can quickly multiply, and potential breaches can be missed. A hospital's legal team should approach cybersecurity knowing there are vulnerabilities that will fall through the cracks. Even with the best preventive measures in place, social engineering alone can take down an entire firewall. It is for this reason, among others, that early detection and a well-planned, rapid response may ultimately prove most valuable when it comes to a hospital's cybersecurity.



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# WHY UNDERSTANDING VALUATION METHODS IS PARAMOUNT TO SUCCESS OF EARLY-STAGE HEALTH TECH COMPANIES

by Josh Lefcowitz

The healthcare industry is facing significant changes, not only in the practice of medicine, but also in the tools by which providers practice.

**Significant changes** are also underway to the methods by which healthcare is paid for vis-a-vis value-based payment models. Technological advancements have opened the door to an era of digital medicine, an expanded environment for telemedicine and the increased use of robotics in patient care.

Value-based payment models are intended to align provider motivations to a common goal: patient wellness. As a result, a renewed focus on preventive healthcare measures is starting to take place and will expand in the coming years.

Companies that are creating new technologies to assist in the advancement of these industry changes are seeing significant investments. Understanding proper valuation methods around these types of investments is paramount to a successful outcome for the investors.

Early-stage companies have traditionally determined value through a market-centric basis. This occurs by asking two questions: 1) What are market multiples for companies with similar products that are more advanced in their business lifecycle? and 2) What will an investor pay to get into the company? Market multiples are a great indicator if you can obtain relevant information. This approach is and always will be a “garbage in, garbage out” technique: Without a sound benchmarking analysis to determine whether the “comparables” are actually comparable, the investor is in a more



vulnerable position. Often, with early-stage companies, value is simply determined based on what the market will bear. If an investor is hungry enough, current economic principles may take a backseat to hope for the future.

Once an enterprise valuation is determined, the rights and preferences associated with the equity class being acquired need to be assessed. This includes the ability to convert to common stock, participation rights and dividend rates.

## **OPTION-PRICING METHOD: WHEN FUTURE POSSIBLE LIQUIDITY EVENTS ARE SPECULATIVE**

The option-pricing method (OPM) treats the various classes of equity securities

outstanding in an entity's capital structure as a series of call options on the entity's overall equity value. OPM considers the potential upside from the distribution of possible future equity values over the remaining term to a liquidity event.

The OPM is most appropriate to use when future possible liquidity events are speculative. It is generally appropriate in situations in which the entity's equity value depends on how well the entity navigates through various possible business opportunities and changes in the economic environment over the term to an exit event. The major drawbacks to the OPM are its complexity and the difficulty of formulating appropriate assumptions.

The following general steps comprise the OPM analysis:

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## VALUATION METHODS

- ▶ Analyze the rights, privileges and preferences associated with each class of equity outstanding.
- ▶ Derive the amount of proceeds that would be paid out to each class of equity based on its liquidation preferences (if any) in the event of the sale of the business. Use the equity breakpoints and the relative priority of the claims to define the total amount of proceeds required for each equity class to receive funds exceeding the liquidation preference, in the event the business is sold.
- ▶ Derive the value at which securities receive additional preferences by determining the value at which each security holder would receive the same amount in conversion as in liquidation.

These values (as calculated in steps b and c) reflect the value of the economic rights and preferences of the various classes of securities in a company's capital structure. Collectively, the values at which the liquidation preferences begin to be satisfied if the company were sold, or the values at which conversions are economically justified, are the breakpoints, used in the OPM.

- ▶ Apply the Black-Scholes model, based on appropriate inputs and assumptions.
- ▶ Identify the percentage claim on each tier value attributable to each class of security based on each security's relative right to the proceeds, and multiply each tier value by the percentage attributable to each class of security.
- ▶ The final step involves the aggregation of the tier values to calculate the value of each class of equity.

### MONTE CARLO SIMULATION: WHEN A SINGLE-SCENARIO MODEL IS NOT ENOUGH

In certain instances, a static single-scenario model is not sufficient to properly assess the potential outcomes. In those cases,

a Monte Carlo simulation model is a useful tool. A Monte Carlo simulation is a method for iteratively evaluating a deterministic model based on one or more random numbers as inputs. Using multi-variate statistical analysis and appropriate modeling, healthcare organizations can go beyond binary analysis to show all the possible outcomes of clinical treatment, insurance premium pricing, business valuations and even personalized medicine in near-real time.

Due to their ability to assess risks, probabilities and varying scenarios, [Monte Carlo simulations](#) are used by practitioners of many industries to model highly sophisticated and complex issues. In addition, Monte Carlo simulations are often adopted to value complex investments, portfolios, derivatives and hard-to-value assets.

Healthcare organizations can also use Monte Carlo to decide whether to pursue certain business opportunities such as real estate acquisitions, partnerships or research initiatives—and perhaps more importantly, when to abandon them because the risks outweigh the reward.

With a thorough understanding of valuation for early-stage companies revolutionizing the industry, healthcare companies looking to invest will be well positioned to make smart decisions regarding the tools and innovations that will propel the industry into the next era centered on value-based care.



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## DID YOU KNOW...



The market for big data analytics in healthcare is forecast to grow more than \$34.27 billion by the end of 2022, according to the [Big Data in Healthcare Market Research Report](#).

A recent AICPA [survey](#) of CFOs and other healthcare leaders found that, regardless of healthcare reform outcomes in Washington, respondents predict a rise in healthcare costs this year and next.

Most physicians (82 percent) would like patients to type visit agendas into electronic health record systems before their appointment, and most patients (73 percent) would like to continue the practice, according to a [study](#) published in the *Annals of Family Medicine*.

According to a NEJM Catalyst [survey](#), when asked about the biggest opportunities to use data in healthcare, 81 percent of respondents said care coordination, 79 percent said decision support, 68 percent said predictive analytics and 45 percent said precision medicine.

Mortality rates for patients admitted during hospital inspection weeks were lower than patients admitted during other weeks by .18 percentage points, with the biggest difference occurring at large teaching hospitals, according to a [study](#) published in *JAMA Internal Medicine*.

# NEW ACCOUNTING STANDARD PRESENTS UNIQUE CHALLENGES FOR PAC PROVIDERS

by Steven Shill



**By 2018, publicly traded companies will be required to comply with a new way of reporting revenues, with all other companies following suit in 2019. Healthcare companies, particularly post-acute care providers, may feel the pain more than others, and they—along with their investors—should prepare sooner rather than later.**

Under this new standard, [ASC Topic 606 Revenue from Contracts with Customers](#), the timing and pattern of revenue recognition will likely change for many entities. In short, the standard will require companies to determine revenue recognition based on five steps: identifying the contract; identifying separate

performance obligations; determining the transaction price; allocating the transaction price to separate performance obligations; and recognizing revenue when the entity fulfills performance obligations.

The main goal of the standard “is for companies to recognize revenue to depict the transfer of goods or services to customers in amounts that reflect the consideration (that is, payment) to which the company expects to be entitled in exchange for those goods or services,” wrote the International Accounting Standards Board (IASB) and the U.S.’ Financial Accounting Standards Board (FASB) when they announced the changes in 2014. The idea is to eliminate industry-specific revenue recognition accounting to give investors a more streamlined picture of revenues—and one that’s comparable across countries.

This is where we run into challenges for the healthcare industry.

Under the existing U.S. GAAP reporting requirements, the industry has already struggled to use comparable revenue measures because of the diversity of its constituents. For investors to compare the revenues of a hospital versus those of a skilled nursing facility would be like comparing apples to oranges. And if one healthcare company’s structure includes a variety of provider types—hospitals, accountable care networks, post-acute care and pharmacies, for example—bundling such a diverse group of revenue streams within the same financial report could provide some difficulties. It could even be misleading without significant supplemental disclosures and discussions.

But healthcare has yet another unique variable: the recently implemented value-

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## NEW ACCOUNTING STANDARD

based reimbursement demonstration initiatives under [Medicare](#). These models (having bipartisan support and hence potential political staying power irrespective of what happens to the Affordable Care Act under the Trump administration), potentially make the new Rev Rec standard even more challenging for an industry already struggling to accurately report revenues. Furthermore, commercial payers too have jumped on the bandwagon and are following suit with their own form of bundled reimbursement.

One of the first mandatory bundled payment initiatives, the Comprehensive Care for Joint Replacement rolled out in 67 Metropolitan Services Areas (MSAs) in April 2016. CJR holds participant hospitals financially responsible for the quality and cost of treatment during a 90-day episode of care after a hip or knee replacement, incentivizing the coordination of care between hospitals, doctors and post-acute care providers. CJR financially incentivizes providers to administer the best quality of care the first time around and to partner with providers, especially in post-acute care, who have proven to do the same. The model, which Medicare has now expanded to certain cardiac cases in 98 MSAs and will expand to hip and femur fractures in July 2017, creates multiple partner contracts and multiple payer arrangements. Whereas under the old paradigm each provider (hospitals through post-acute) operated and billed independently of one another, now the value-based “supply chain,” is held responsible for the convalescing patient over a 90-day period.

In this environment, the third step to the Rev Rec standard—determining the transaction price—presents significant challenges.

Healthcare revenues under value-based arrangements are considered a variable consideration because these reimbursements may be subject to retroactive adjustment after the fact. Under current GAAP, allowances against revenue are generally recorded based on

payments or settlements due to or from the payer using the “best estimate” basis. Under ASC 606, revenue to be recognized is limited to the amount of variable consideration where it is probable that a significant adjustment will not occur when the uncertainties are resolved (i.e. revenue not reverse out).

This step is likely to be difficult in the value-based reimbursement world, as it would require providers to have visibility into the costs and quality of other providers within their own supply chain to make a reasonable assessment.

But it would not stop there.

The reimbursement model would likely also require providers to have visibility into the costs and quality of other competing supply chains within their MSA relative to their own metrics. This data is unlikely to be readily available on a timely basis. Each new reporting year will present a fresh set of challenges in determining where providers and their supply chains are relative to the arithmetic mean of bundled costs established by the payers.

Furthermore, loss and gain sharing arrangements within the value-based supply chain are likely to further complicate matters. They will require an evaluation of the impact of the settlements and even the financial viability of the other participants to settle their end of the bargain when the piper comes piping.

When preparing for the new Rev Rec standard, healthcare organizations should first conduct a comprehensive inventory of their contracts, reviewing their revenue cycle management in the process. During this process, they should develop a good understanding of their exposure to value-based retroactive reimbursement.

Secondly, providers should carefully choose an appropriate estimation methodology as required under ASC 606. Their choices will be either the Expected Value Method, which is based on a probability weighted range of possible outcomes suited for

multiple contracts, or the Most Likely Amount Method, which is based on the single most likely amount from a range of possible outcomes.

Thirdly, it will be imperative for providers to open channels of communications between their business partners in their supply chains and establish the ability to share data. This process may be new and daunting for many post-acute providers and could create legal, regulatory and technological challenges.

Finally, providers are highly recommended to either individually, or jointly with their network partners, identify vendors that can provide reliable regional or MSA data not only for critical operational and clinical decisions, but also to support estimation methodologies under the new Rev Rec standard.

For some, implementing a robust contract management system to help evaluate, negotiate and efficiently manage payer contracts, may also be a good first step in boosting cost savings and safeguarding revenues.

These are just some of the variables healthcare entities should consider when deciding how to best prepare for the Rev Rec standard.

Regardless of the specific steps companies take to prepare, one thing is for certain: they should outline their path to compliance well ahead of the 2018 implementation date.

*This column was [originally published](#) in the Jan. 27 edition of McKnight's.*

## McKnight's



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# PErspective in HEALTHCARE

A FEATURE EXAMINING THE ROLE OF PRIVATE EQUITY IN THE HEALTHCARE SPACE.

## MEDICARE & MEDICAID SPENDING DRIVING PE ACTIVITY IN HEALTH IT



**The health IT space continues to heat up as the healthcare**

**industry drives toward technology-enabled efficiencies, improved delivery of care and treatment innovations.**

And with federal agencies—Medicare, Medicaid, and the Departments of Veterans Affairs and Defense—remaining among the leading global consumers of healthcare, according to *Washington Technology*, government contractors providing the latest in analytics, cloud computing and other key health innovations could become ripe targets for PE investment. In 2015, the Centers for Medicare & Medicaid Services (CMS) reported that Medicare and Medicaid spending reached nearly \$1.2 trillion, representing more than a third of all national health expenditures and exceeding private health insurance spending by roughly \$2 billion. And according to Deltek, a government contractor information solutions provider, federal spending on health IT spending is on track to reach \$6.4 billion by 2021, up from \$6 billion in fiscal year 2016.

Deal activity in the health IT space has already started to accelerate in response to this burgeoning market. In January, the Merck Global Health Innovation Fund, GE Ventures, Peloton Equity, Zaffre Investments and Morgan Stanley Alternative Investment Partners announced a \$30 million joint investment in Arcadia Healthcare Solutions, while

TPG finalized its acquisition of Mediware Information Systems from private equity firm Thoma Bravo in February. Terms of the deal were not disclosed.

Meanwhile, *Washington Technology* reports that IT solutions provider ManTech International acquired Edaptive Systems, a company providing software, business intelligence and data services to the Department of Health and Human Services, for an undisclosed sum in December 2016. Primus Capital also announced in January that it had acquired healthcare payment automation company Payspan, also for an undisclosed sum.

While the mid- to long-term picture suggests robust growth for government spending on health IT, the near-term picture is not quite so rosy. In fact, *Nextgov* reports that federal health IT spending is facing a \$700 million decrease in fiscal year 2017. However, a number of recent fundraising announcements suggest that the PE industry is already beginning to position itself to reap the benefits that a steady, long-term increase in public and private sector demand will yield for investors.

In December, Wildcat Venture Partners announced that it had raised \$52.2 million toward its debut fund, which will focus on startups leveraging artificial intelligence, virtual reality, machine learning and other technologies in the digital health space, according to *PitchBook*. *PitchBook* also reports that NewGen Capital and Pitango Venture Capital—both of which invest in the digital health space—have announced new flagship funds that will target

technological innovation in the health industry. NewGen is seeking \$75 million, according to SEC filings, while Pitango's \$175 million fund has already made its first investment.

Of course, much remains to be seen about how federal spending priorities may shift under a new presidential administration. The longer-term outlook, however, remains bright as the government's need for increasingly sophisticated healthcare technology—particularly for veterans and military members—continues to grow.

*This article has been adapted from BDO's Winter 2017 Perspective in Government Contracting.*

*Sources: Bloomberg, Business Insider, Buyouts, Deltek, Nextgov, PitchBook, The Wall Street Journal, Washington Technology*

## MARK YOUR CALENDAR...

### APRIL

April 30-May 3

#### World Health Care Congress

The Marriott Wardman Park Hotel  
Washington, D.C.

### MAY

May 4

#### HFMA Virtual Conference

Online sessions

May 8-10

#### HFMA Spring Seminars

Motif Seattle  
Seattle

May 15-17

#### National Healthcare CXO Summit

JW Marriott Orlando  
Grande Lakes, Fla.

May 22

#### Crain's New York Heritage Healthcare Innovation Awards 2017

New York

### JUNE

June 6

#### 2017 Healthcare Leaders of New York Annual Gala and Awards Presentation

Glen Island Harbour Club  
New Rochelle, N.Y.

June 25-28

#### HFMA ANI 2017

Orange County Convention Center  
Orlando, Fla.

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