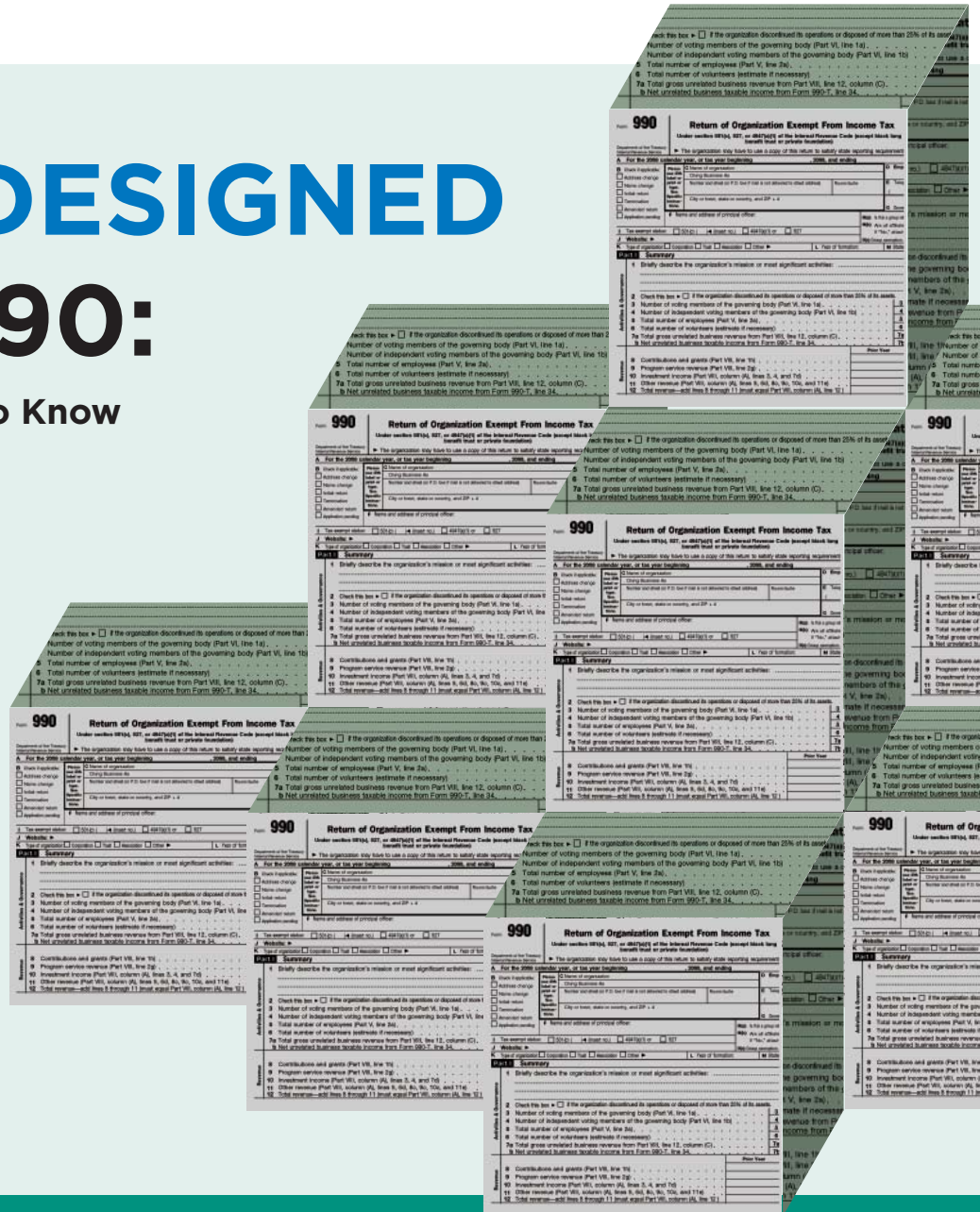


HEALTHCARE SERVICES

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THE REDESIGNED FORM 990:

What Hospitals Need To Know



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By Scott J. Mariani, JD, Tax Partner

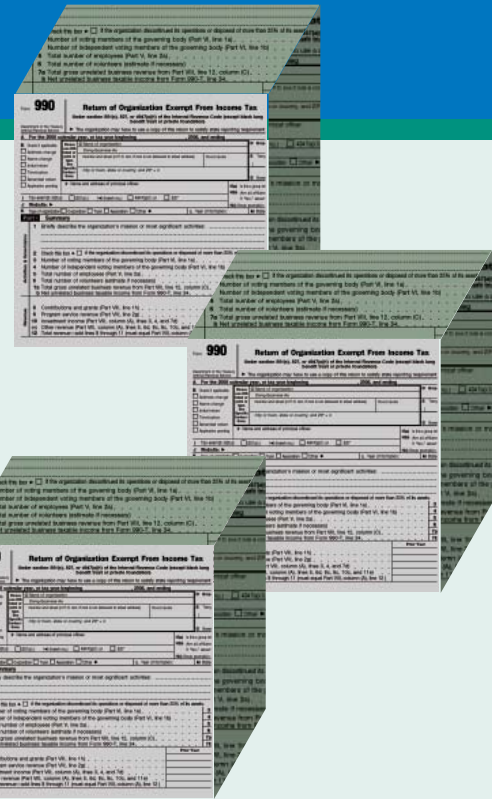
The Form 990 is the tax return filed annually by an organization recognized by the IRS as a tax-exempt organization. These organizations typically include charities, hospitals, foundations, nursing homes, colleges and universities. The official name of the Form 990 is "Return of Organization Exempt From Income Tax".

The last time the IRS significantly revised the Form 990 was in 1979; 29 years ago. The IRS felt that the prior Form 990 failed to keep pace with changes in the laws, rules and regulations of the tax-exempt industry and the increasing size, diversity and complexity of the tax-exempt industry. As a result, the Form 990 in its format prior to this major revision failed to meet the IRS' tax compliance interests or the transparency and accountability needs of the state taxing authorities and the general public.

Organizations are required to use the redesigned Form 990 for the year ending December 31, 2008, to be filed in 2009. Organizations will file the old format Form 990 for the year ending December 31, 2007.

SCHEDULE CHANGES AFFECTING HOSPITAL FILINGS

The redesigned Form 990 consists of an 11-page main part, or "core form," as the IRS refers to it, containing 10 different parts. In addition, the IRS also created supplemental schedules which may also have to be completed as part of the Form 990 annually. These schedules begin with the letter A and continue through the letter R (except no Schedule P). Part IV of the main part of the redesigned Form 990 is called Checklist of Required Schedules and is comprised of 37 questions. These 37 questions will determine which Schedules A through R an organization must also complete annually. It is important to note that hospitals will be required to complete many of these supplemental schedules.



In recent years the IRS has implemented various compliance and enforcement initiatives with respect to the tax-exempt sector, particularly with hospitals. Several of these initiatives and the results and findings are incorporated into the redesigned Form 990.

Both Part VII of the main part of the redesigned Form 990 and Schedule J, Compensation Information, relate to compensation of officers, directors, trustees, key employees, highest compensated employees and independent contractors and ask for more detailed information than the prior Form 990. For example, Schedule J requires compensation of certain individuals to be disclosed by specific elements such as base compensation, bonus/incentive compensation, other compensation, deferred compensation and nontaxable benefits. These schedules reflect certain results and findings of the May 2006 IRS Form 13790, Compliance Check Questionnaire for Tax Exempt Hospitals and the 2004 IRS executive compensation and benefits initiative.

In addition, Schedule H, Hospitals, is applicable specifically to hospitals and asks for information relating to community benefit provided by the hospital. This schedule also reflects certain results and findings of the May 2006 IRS Form 13790, Compliance Check Questionnaire for Tax Exempt Hospitals.

Schedule K, Supplemental Information on Tax-Exempt Bonds, also incorporates certain portions of the recent IRS tax-exempt bond initiative and related IRS Form 13907, Tax-Exempt Bond Financings Compliance Check Questionnaire.

However, there is some good news with respect to both Schedules H and K. The IRS granted some transitional relief for organizations in order to allow them to prepare and implement

the procedures to accurately accumulate and report the requested information. For the 2008 redesigned Form 990, certain sections of both schedules are optional. Of course, organizations may still fully complete both Schedules H and K with their 2008 Form 990 (filed in 2009) if they desire. Both Schedules H and K must be fully completed with the 2009 Form 990 (filed in 2010).

With respect to Schedule H and tax-exempt hospitals, the determination of what constitutes community benefit and how it is quantified has been highly publicized; the final version of the Schedule H does help clarify the issue.

The draft version of the redesigned Form 990 reflected the Catholic Health Association interpretation of community benefit which does not recognize Medicare shortfalls and bad debt as part of its quantification of community benefit costs. The final version of the redesigned Form 990, Schedule H now includes a separate section which allows a hospital to show its Medicare shortfalls and bad debt costs which is a position supported by the American Hospital Association and many tax-exempt hospitals. Although not included in the section relating to charity care and community benefit costs on Schedule H, at least Schedule H now allows a hospital to fully disclose costs associated with Medicare shortfalls and bad debt.

In addition to the sections mentioned above, a hospital must review in depth Part VI of the main part of the redesigned Form 990 entitled Governance, Management and Disclosure. Part VI is very important and relates to the organization's governance practices. It is important to note that certain questions in this part of the redesigned Form 990 require written explanations and not just yes/no responses.

It is recommended that a hospital closely examine the following supplemental schedules to ensure adequate preparation and full and proper disclosure:

Schedule C	Political Campaign and Lobbying Activities
Schedule D	Supplemental Financial Statements
Schedule L	Transactions with Interested Persons ("Conflicts")
Schedule R	Related Organizations and Unrelated Partnerships

It is also recommended that an organization start planning for the redesigned Form 990 immediately. An organization should form an internal working group to review the redesigned Form 990 and assign duties and responsibilities as appropriate. The working group should include finance personnel; in-house counsel; patient account personnel; corporate compliance and human resources. An organization's CEO and COO should also be involved on high level issues. An organization may also want to present the redesigned Form 990 to its Board of Trustees for review and their consideration. An organization should also seek assistance

externally from its advisors, including its attorneys and accountants. Starting the process now allows an organization to implement certain changes due to the redesigned Form 990 and the new disclosures.

The redesigned Form 990 and supplemental schedules constitutes the largest and most significant revision to anything we've seen in the last 20 years in the tax-exempt sector from a tax perspective. The redesigned Form 990 and supplemental schedules are exhaustive and will require a significant amount of additional time and effort not previously associated with the old format Form 990.

FUTURE AFFECTS ON QUALIFICATION FOR TAX-EXEMPTION

It is conceivable that the IRS will likely attempt to change the basis for tax-exemption for hospitals. The current community benefit standard as the basis for tax-exemption was outlined in IRS Revenue Ruling 69-545; almost 40 years ago. Under this Ruling the criteria for tax-exemption includes a requirement to provide health care services to all individual's regardless of ability to pay, including charity care, self-pay, Medicare and Medicaid patients; operating an active emergency room for all persons; which is open 24 hours a day, 7 days a week, 365 days per year; maintaining an open medical staff, with privileges available to all qualified physicians; and ensuring control rests with its Board of Directors; which is comprised of independent civic leaders and other prominent members of the community.

Many, including the IRS, feel the criteria in this Ruling is outdated like the prior Form 990 and needs to be updated to reflect the changes in the laws, rules and regulations of the tax-exempt industry. To that end, I believe that sometime in the near future the IRS will attempt to enact some criteria whereby a hospital will need to meet a certain minimum dollar amount of community benefit costs annually in order to maintain classification as an Internal Revenue Code Section 501(c)(3) tax-exempt organization. The redesigned Form 990 is a significant first step in this direction as the IRS will be receiving community benefit costs information annually on each hospital's Schedule H.

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Scott is a Tax Partner in our Firm's Tax Department, based in the Morristown, NJ, office. He specializes in providing tax advice to integrated health care delivery systems, hospitals, long-term care facilities, physician groups and other not-for-profit organizations.



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Don't Be a RAC Ostrich

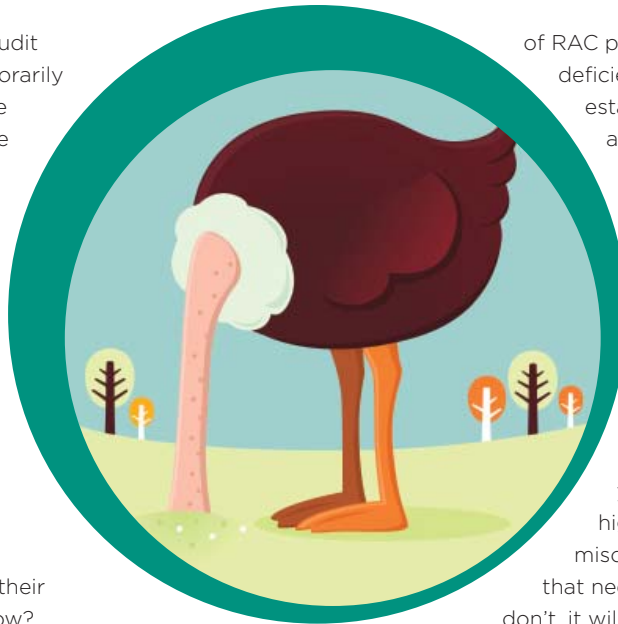
The Top 3 Best Practices for RAC Program Preparedness **By Leo Paul D'Orazio, MBA, FACHE**

The national rollout of the recovery audit contractor (RAC) program was temporarily put on hold this past November, while the Government Accountability Office (GAO) reviewed protests about the RAC contractor selection process filed by two vendors, Viant, Inc. and PRG Schultz, USA, Inc. that were not awarded permanent contractor status. Well, it's now official... the stay is over!

On February 4th, it was announced that the parties involved in the appeal withdrew their appeals, thus lifting the stay on the RAC program. The RAC program floodgates have opened, with many states beginning their reviews on March 1. So what to do now?

Don't Be an Ostrich!

That is, you cannot bury your head in the sand about the RAC program and think it will go away on its own. Members of your hospital board and management team have a fiduciary responsibility to deal with this major Medicare billing take-back issue, and to ensure the financial viability of your facility. Everyone, including those hospitals that have until August 1 of this year or later, should prepare or continue on the course



of RAC preparedness. That includes assessing deficiencies, quantifying the take-back risk and establishing a tracking mechanism. Here are three recommended best practices to follow:

1. Identify systemic coding and clinical documentation problems within your organization.

By conducting your own internal audit of patient record documentation and billing coding practices, you should have a good sense of the level of accuracy within your system. If there is indeed a high level of inaccuracies or consistent miscoding of documents, this is an issue that needs to be addressed immediately! If you don't, it will ultimately lead to regular RAC take-backs year after year, if the RAC program does not end in 2009! Moreover, you will have a huge compliance issue to address and control. Education is the key component here, and it is incumbent on the hospital to put together a permanent multi-disciplinary RAC committee to deal with the RAC issues on an ongoing basis.

With limited resources already fighting the daily fight of documenting good quality care and getting paid appropriately

Investing in Electronic Medical Records

While many of President Barack Obama's proposals to reform healthcare are not yet vetted, his decision to invest in health information technology as part of an economic recovery plan seems to be broadly supported by an industry that has been challenged by narrow operating margins.

As part of the proposed economic stimulus package, \$20 billion is earmarked to assist hospitals and physicians to develop electronic medical records (EMR). The President is committed that this initiative will eliminate redundancies in claims processing, reduce ordering of unnecessary tests, prevent medical mistakes, increase the efficiency of

for it, outsourcing your internal audit function is an option many facilities are exploring. With the current high demand for accountants and internal auditors, it can be more efficient and cost effective to draw upon resources from outside the facility. The hospital can, in effect, “borrow” high cost and scarce resources that would not otherwise be available. Even if you have a strong in-house internal audit department, hiring an outside internal auditor to provide an objective opinion, as well as lend additional experience, can prove to be extremely beneficial in these circumstances.

2. Clearly state your financial position.

In addition to assessing coding accuracy levels, your internal audit should also identify the risk level of potential take-backs your facility may endure. It is important to understand that you need to project your cash flow based on the potential RAC take-back, as not doing so could affect your financial position, including meeting your bond covenants. For example, lending institutions and bonding authorities are well aware of the potential RAC take-back issue and will want to know what actions the hospital has taken to ensure the accuracy of their cash flow position and remain compliant with existing covenants.

3. Implement the right software to assist in the clean client documentation.

There are many established companies and consultants who offer software solutions that can manage your clinical

documentation for Medicare compliance, your coding accuracy, as well as financial assessments, potential RAC exposure, and RAC response and appeals management. Having these tools in place can greatly enhance your staff’s ability to be more responsive when it comes to preparation and fighting the inevitable fights that will come along with the RAC program. So, don’t be an ostrich! Being aware and proactive with regard to the RAC program will put you in a much stronger position, so when the RAC audit contractors descend upon your facility with first wave of RAC Demand Letters, surprises are minimized.

ABOUT THE AUTHOR

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Director of Healthcare Services Group**

Leo Paul. D’Orazio has directed many consulting engagements for hospitals and physicians, home healthcare, mental health and addictive disease and outpatient treatment facilities, and is a Fellow in the American College of Healthcare Executives.



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all providers through better workflow and result in better outcomes for all patients.

It is unclear who would be eligible to receive assistance or how it would be distributed if the package passes. When President Bush first proposed a similar initiative in 2004 the amount of money devoted to demonstration projects was \$100 million. Current estimates to establish an interoperable system of health records across all providers of health care is in excess of \$150 billion. While President Obama’s plan is clearly a step in the right direction, it appears that it toO may be also be another severely underfunded program.

Insurers and providers both view EMR for its potential to streamline their operations. Consumers still remain concerned about the security of their personal health information (PHI) and how it would be protected during this initiative. In a letter to Congress, Consumer Watchdog was highly critical of the current proposed legislation and has cited holes in that would allow the sale of PHI to commercial entities; they are also calling for consumers to be able to audit releases of information from database owners so that accountability and safeguards are assured, similar to checking your credit report.

A Hospital CFOs Top 10

Resolutions for a Positive 2009 By Lewis D. Bivona, JR., CPA, AFE

A recent article published in The Washington Post reported on how hospitals across the nation, which employ 5 million+ people, are “reporting that donations and investment returns are down, patient visits are flat and profitable diagnostic procedures and elective surgeries are declining as people with inadequate insurance delay care.” Okay, this is all very doom & gloom, but take heart and stay optimistic. As a hospital CFO, there are many things you can be thinking about and doing as you progress deeper into 2009. The following is a list of Top 10 Resolutions every hospital CFO should be making in order to move forward on a positive note this year.

01 Make all decisions in concert with an eye on the bottom line, remembering the axiom, “With no money, there is no mission!” Don’t contract if it does not make sense and do make sure you get paid for everything the hospital is legitimately entitled to.

02 “I’m going to lose the fat from our budget.” Just like individuals, hospitals are often in denial that there is a problem that needs to be addressed. Remember, cut fat but don’t make your organization anorexic.

03 Teach someone how to read... their benefits, that is. Focusing on helping your patients understand their insurance programs creates good will for the hospital and also reduces collection problems. One hospital in the mid-west educated their patients about deductibles and experienced a spike in year-end spending. Once people realized that fact, year-end elective procedures surged!

04 Don’t try to do everything yourself! Most CEOs and CFOs are “Type A’s” who are reluctant to ask for help or share their burdens. You would be surprised how much the rank and file will support you if they are engaged as part of the solution. Also, don’t be afraid to ask a trusted advisor (your CPA or go to consultant) for assistance in tasks or projects that you could not reasonably complete with internal resources.

05 “Compliance and internal controls will be a key driver in everything I do.” Increased focus on regulatory audits from DSH, RAC and IRS, to name a few, requires that financial transactions and reporting are done at the highest level of integrity.

06 Bad times don’t last forever, so prepare for the future. Sure the economy will be off in 2009, self pays will increase and charity care funding will not keep up, but that is no reason not to review and refocus your strategic plan for emerging from this crisis, ready to take on and beat your competition.

07 Be accepting of the kindness of strangers. One NJ hospital was literally rescued from bankruptcy by taking their plight to the community which rallied financially to prop up the organization. If you have been good to the community, your community will be good to you.

08 Give unto others without reservation. By being active charitable corporate citizens, you not only protect yourself from losing your 501(c)(3) status, but you add to the hospitals resume of community benefit which can be handsomely rewarded (also see 7 above).

09 Mend fences. Reconcile with your admitting and referring physician base, if needed. Physicians are having tough times, too. Helping your physicians and their office staff to thrive builds loyalty and trust that you can depend on.

10 Do make investments for the future. Like most financial advisors preach, the best time to invest, if you can, is when prices are low. IT infrastructure and other projects can be a better purchase in a down economy. Remember that information and new assets that are leveraged effectively results in better utilization of resources and the production of infrastructure to propel the organization forward in 2010!

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Hospital Finances

During Difficult Economic Times **By Joseph J. Perez, CPA, Partner**

New Jersey hospitals are facing a tremendous financial crisis. Healthcare in general is inherently expensive. Hospitals must pay exorbitant amounts of money in order to upgrade their equipment and construct new facilities. These upgrades result in better patient care and an ability to serve larger numbers of patients. However, in light of volatile economic times, hospitals are faced with unpredictable cash flow and are finding it difficult to keep plans for growth and upgrades on the table.

In this economic climate, banks are lending less. With as many as two thirds of patients either uninsured or covered by Medicare/Medicaid, which offer delayed payments or rates that can be well below the hospital's actual costs, banks are even more reluctant to provide financial assistance.

A rising unemployment rate translates to more people now without insurance. As a result, there are not only increased instances of nonpayment, but there has also been a reduction on discretionary health care. Many consumers have opted to delay medical procedures until the economy improves. These precautions have expectedly hurt sales and profit growth at hospitals.

Public and private hospitals are suffering an additional loss, as taxpayer philanthropic support fails to keep up with the increasing cost of caring for the uninsured and underinsured. Some hospitals are finding it very hard to even keep their doors open. Within the last 18 months, eight NJ hospitals have closed and five have filed for bankruptcy. And 15 years ago, NJ had 112 acute care hospitals; today there are only 74, with half of those losing money last year.

Variable rate demand bonds that were a good deal for the healthcare industry for much of the past decade because their rates were significantly below fixed-rate bonds are now being affected. The interest rates hospitals are paying, which can change on a weekly basis making them highly volatile and unpredictable, have now shot up significantly. While they were previously in the range of just 3 or 4 percent, they may be as high as 10 percent.

Of course, these financial constraints have had a considerable impact on patients as well. With a limited budget, many hospitals have found themselves short staffed and unable to repair or replace damaged equipment, which has resulted in overcrowding. This has led to lengthy delays in the waiting room and pharmacy, and patients possibly waiting 24 hours before they are moved to intensive care. Hospitals have been forced to discontinued some services altogether in order to

survive, and there are long-lasting waits for appointments due to the staff shortage.

To add to all of this, New Jersey hospitals are in the shadows of impending RAC program reviews in the fall of 2009, which could add more stress to the bottom line when the Centers for Medicare and Medicaid Services (CMS) look to recoup Medicare overpayments.

What can a hospital do in these difficult economic times?

First and foremost from an accountant's perspective, wasteful spending must be identified and minimized. According to recent studies, wasteful spending in the health system has been calculated at up to \$1.2 trillion of the \$2.2 trillion spent in the United States, with unnecessary or inappropriate tests and procedures being the biggest problem. These common inefficiencies can add up. CFO's and Directors of Finance, with possible assistance of outside professional guidance such as an external auditor, must work to identify areas of excess in order to reduce these expenditures.

According to another national study, approximately 65% of all bad debt is the result of insured patients, not uninsured patients. This is due to the frequent non-collection of upfront payments such as co-pays, co-insurance, deductibles and other out-of-pocket costs. The average outstanding insured patient portion ranges from \$700-\$1,100, depending on geography. Implementing the right software to track and alert staff to proper payment is crucial, as is training of staff on the execution of this software.

The RAC program being implemented in New Jersey hospitals is inevitable. In preparation of this review, and for the benefit of your facility in general, it would be wise to conduct your own internal audit of documentation practices to ensure accuracy and minimize risk of RAC recoveries. A hospital may want to organize a RAC committee that would be responsible for reviewing samples of data on claims, admissions, documentation and coding, in order to identify repeated errors. All findings should be shared with your compliance officers, legal counsel and external auditor/accountant in order to address these issues and assess and mitigate risk.

Finally, the healthcare industry collectively must support legislators and policymakers who support efforts to expand health insurance opportunities in New Jersey in order to reduce the number of uninsured.



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