hfma Eastern Michigan Chapter
healthcare financial management association

HealthCents

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MAKING IT Count

President's Message

By: Elyse Berry, FHFMA

Greetings!
This being my first President's message, I want to begin by thanking past President Steve Collard for his tremendous leadership this past year. Other than one member short of our goal (and that was only missed by a day or two), the chapter had a great year achieving all of its other national requirements. We had many challenges, primarily a result of the economic struggles in our industry & our state, but our officers, board, committee chairpersons, committee members, and staff worked extra hard to achieve our results and keep the chapter vibrant.

As we move into the new HFMA year, chapter leadership has been extremely busy training and planning for another exciting year. Several of us attended the national Leadership Training Conference (LTC) to interact with other chapters across the country, finding best practices to bring back to the Eastern Michigan Chapter. Additionally, we recently held our local "mini" Leadership Training Conference at which all of our committees presented their plans for this year. Many thanks to all who participated and committed their time and talents for the coming year.

The national HFMA theme for 2009-2010 is "Making It Count" as selected by recently elected national HFMA President, Cathy Jacobson. In her speech at the Leadership Training Conference, she said "Making It Count depends on leadership, on individuals…who are willing to take an extra step, take a chance, speak up, or make a difficult choice because they believe that their actions will help a loved one, better their community, improve an organization, or bring about a needed change."

I ask you to join us as we put this theme into practice. One of our major initiatives this year is to be a resource to the community for health related needs. We will be identifying volunteer opportunities where chapter members can use their talents and skills to make a difference in our communities.

Speakers at the national LTC spent a lot of time focusing on the communication and education differences among the senior, baby boomer, gen x, and millennial "generations." We will devote time to make sure we are meeting the needs of all of our membership. Look for some new social networking to begin addressing this challenge. The Eastern Michigan Chapter is already "Linked In," with investigation for Facebook and Twitter.

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Who knows? – We may all learn to "tweet" soon.
Lastly, we will work to diversify the institutions participating in our chapter, involve new organizations, and strengthen leadership participation of current hospital organizations.

In closing, I want to thank you for the opportunity to serve as chapter president. I am excited about all the great ideas our board and committees have for the upcoming year. You will be receiving an invitation soon to join a committee if you do not already belong. You may also be asked to share your talents in building our social networks, speak at a meeting, teach a course, or volunteer on a community project.

When asked, please say YES. It's only through a strong collaborative effort that we can truly achieve our goal of "Making It Count."

Let's share our talents and "Make It Count."

Chapter leaders enjoyed the Florida sunshine during a planning meeting at LTC in Ft. Lauderdale, April 19 -21. Pictured left to right; Rhonda Main, Mark McIntosh, Elyse Berry, Sue Dimic, Diane Justewicz, Jo Ann Roberts, Maria Abrahamsen, Mike Berryman, Cheryl Comeau, and Christina Wong

Committee chairs and officers gather for mini-LTC planning session held May 14, 2009 in Troy. Pictured left to right. Carl St. Amour, Kim Hauschild, Sherrie White, Jo Ann Roberts, Maryanne VanHaitsma, Ryan O'Roark, Debbie Sieradzki, Shelley Lake, Maria Miller

Up Front – Editor's Letter

By: Jo Ann Roberts
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Why Not Volunteer and Make a Difference?

As Elyse summarized in her President's message, the HFMA National theme for this coming year is "Making it Count." I cannot think of a better way to make it count than to volunteer one's time and energy to benefit others. My family and I volunteered to participate in the American Heart Association Heart Walk in Southfield on May 16, 2009. It always amazes me how many people wake up early on a Saturday morning, put on their tennis shoes, drive miles from their home, many times in rainy weather to participate in an organized walk. It is wonderful to see the joy on their faces knowing that in some small way they are making a difference. I have included some photos from the Southfield Heart Walk. As you will see there are no age boundaries, all are welcome to participate.

Of course, we as HFMA members know the meaning of volunteering one's time. Volunteers represent our largest resource. The efforts of volunteers keep our chapter moving forward. When people give of their time, energy and talents, everyone benefits. The newsletter committee would like to keep you informed of volunteering opportunities within HFMA and local community events. Please keep us informed of volunteer opportunities for health care professionals so that we can include in future newsletter publications.

Heart Walk Photos by Mark Nuytten, William Beaumont Hospital

Please submit articles to Maryanne VanHaitsma mvanhait@dmc.org or Jo Ann Roberts JRoberts@beaumonthospitals.com . Next HealthCents deadline is July 17, 2009.

Physician Fees Now Payable to ASCs

By: Maria B. Abrahamsen
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On May 1, CMS acknowledged that previous upgrades to its contractors' systems did not include the provisions necessary to process Medicare claims filed by ambulatory surgery centers for the professional services of physicians and non-physician practitioners. CMS has directed its contractors to modify their systems to accept and process these reassignment claims properly by October 1, 2009.

Practitioners may reassign their professional fees to an ASC (or other organization) by filing Form 855R with the Medicare Part B contractor. Such reassignments are permitted by Medicare policy, for example, if the practitioner is employed by or under contract with the ASC to provide patient care. Contractors have been directed by CMS to accept and process valid reassigned claims for dates of service on or after January 1, 2008, if the claim is brought to the contractor's attention and has not already been paid to the ASC or the practitioner. In other words, the contractors do not have an affirmative obligation to search for claims that were previously filed by ASCs and inappropriately rejected.

Important – Action Required
Please Verify & Update Your Information for the Membership Directory

We are preparing the documents for the membership directory for 2009-10. We would like to have this member resource as accurate as possible. Please take a few moments and verify your member information on HFMA National's website. Please click on the following link below (you will be asked for your username and password.)

https://www.hfma.org/msc/MSC_ProfileUpdate/MSC_ProfileUpdate.aspx .

Under the Update Profile heading; click on view and change profile. A listing of your information will appear on the screen. Please edit any information that is not correct. This is the information that will appear in the membership directory, which you will receive in November.

Please review and edit your information by July 31, 2009. If you are having trouble making changes please send an email to Susan Stokes at susan-stokes@comcast.net to have your information updated.

Membership Committee News

By: Christina Wong and Michael Berryman

New Members of the Eastern Michigan Chapter are an important part of the chapter's continued success. Please take a moment to contact our new members and share your experiences about our chapter. We value their membership and encourage them to become active on chapter committees.

Rachel Nosowsky, Senior Counsel
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Deborah S. Solem, Accounting Manager
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Kim Balfour, Senior Financial Analyst
St. John Health
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Michael J. Felczak, Jr., Senior Financial Analyst-Reimbursement
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Fran Jurcak, Manager
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Ralph P. Binggeser, CFO
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Naeem Rabbani, Assistant Administrator/Controller
bnaeemrabbani@yahoo.com

Ron Cash, Director
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Christopher Angi
Image Soft Inc.
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Antonio Simbeni, Finance Specialist
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Caston Thomas
Intelligent Insites
Caston.thomas@intelligentinsites.com

Dave Reese, Sales Executive
David_reese@ibi.com

Steven P. McCarty, Partner
UHY Advisors
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Members who transferred from other chapters:

John J. Liston, Chief Financial Officer
Port Huron Hospital
jliston@porthuronhospital.org

Leonard Zeck, Revenue Mgt. Consultant
Trinity Health
Len.zeck@gmail.com

W. Karl Bailey, CHFP, Corp. V.P. – Financial Planning
Trinity Health
lailekarl@trinity-health.org

Talitha H. Vanke, Audit Manager
CHAN LLC
TalithaHannah@yahoo.com

Recovery Audit Contractor Program Begins First, Second Wave Rollout

By: Kevin M. Feldman
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kfeldman@bkd.com

The Recovery Audit Contractor (RAC) program should now be rolling out in the first ("yellow") and second ("green") wave states (see map next page). After the March 1, 2009 effective date, the RACs began educating providers, analyzing data and requesting records.

In other states—those not part of the first or second wave—providers are watching eagerly to see what happens. The program should rollout in these states August 1, 2009 or later.

The permanent RAC program was originally scheduled to rollout in March 2008. However, the program has faced significant delays in becoming active nationwide.

As the rollout continues, health care providers (especially hospitals) should be doing as much as they can to determine their RAC vulnerability. RACs will be able to review cases back to October 1, 2007. Hospitals with flawed coding and case management practices may encounter issues that will be subject to review and repayment.

What follows is an update on the RAC rollout, including details on some of the program's finer points.

Background

The implementation date for the first wave of states subject to the RAC was pushed back to October 2008. Contractors were announced October 6, 2008, six days after the official effective date of the program. The four RACs corresponding to the regions shown on the map, are: A - Diversified Collection Services, Inc.; B - CGI Technologies and Solutions, Inc.; C - Connolly Consulting, Inc.; D - Health Data Insights, Inc. RACs around the country began planning and scheduling provider educational sessions at that time.

However, two vendors who bid but did not win the contract filed protests with the Government Accountability Office (GAO). CMS imposed a stay on RAC activities until GAO could make a determination. On February 4, 2009, the parties involved in the protest came to a settlement agreement. The four previously announced RACs will strike contracts with the protesting organizations so the protesting organizations can serve as subcontractors and supplement the RAC efforts. According to Centers for Medicare & Medicaid Services (CMS), each subcontractor has negotiated its own regional responsibilities, including some claims review.

In addition, CMS posted a revised rollout map (but did not reference it in the announcement) that the RAC program will be effective in the first wave, or "yellow" states as of March 1, 2009, instead of October 1, 2008. The "green" or second wave states are still on schedule to go live March 1, 2009, as previously announced.

Now that the bid process is finalized, the RACs have started educating the provider community, conducting data analytics and preparing record requests and demand letters.

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Provisions for error extrapolation

While most providers understand the claim-specific RAC review process, they may not know about the provisions for error extrapolation in the RAC scope of work (SOW). The RAC SOW says the RAC cannot review records based on high reimbursement without cause and it must conduct targeted reviews based on data analytic results. The SOW also states the RAC can follow the extrapolation methodology outlined in the Program Integrity Manual (PIM), and the RAC will receive its full contingency fee for extrapolated claims. *Do you know what trends are revealed in your claims data?*

CMS released the record request limits for RACs in October 2008. Essentially, limits are established by provider type, by national provider identifier (NPI) and, in some cases, by volume of Medicare claims. For example, inpatient hospitals, inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and hospices are subject to a record request limit of 10 percent of their average monthly Medicare claims (up to a maximum of 200 requests) per 45 days.

Other Part A providers, such as hospital outpatient and home health agencies, are limited to 1 percent of the average monthly Medicare services (maximum of 200 services) per 45 days. For demonstration purposes, consider a fictitious 120 acute bed rural Medicare prospective payment system (PPS) facility. The provider reports 2,100 Medicare discharges a year and 19,800 outpatient visits per year. A RAC record request might look like the following:

Example: PPS rural facility, claim/service volume	Potential record request volume every 45 days
Inpatient records, average of 175 discharges a month	17 Records
Outpatient visits, average of 1,650 claims per month, 3 reimbursed services per visit, for a total of 4,950 services per month	50 records (one service per record)

Providers should review each record prior to release, log it in the tracking system, photocopy it and send it to the RAC via registered mail. If the claim is denied and the hospital disagrees with the determination, it should initiate an appeal no later than 40 days after the denial to prevent an automatic recoupment of payment. Each step in the five-level appeal process (fiscal intermediary or Medicare administrative contractor (MAC); then qualified independent contractor; then administrative law judge; then Medicare appeals counsel and finally federal district court) has different due dates and different time frames for decision by the determining body. Providers will need a robust tracking mechanism to keep up with each appealed claim. Over the course of a year, hundreds of claims could be in different stages of RAC review and appeal.

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Appeals process

CMS released updated appeal results for the RAC demonstration project in January. For all Part A and B claims combined, as of August 31, 2008, approximately 23 percent of denied claims have been appealed. Of those, 33 percent of the appeals were decided in favor of the provider, for an average of 7.6 percent of all claims overturned on appeal. It appears appealing denials could be beneficial.

Have you determined which types of claims you'll appeal or will you appeal every denial? Now is the time to establish policies and processes, determine who in your organization is responsible for those policies and processes, set up tracking mechanisms and decide on the appeals process to make sure you use resources wisely and appropriately exercise your rights.

MACs could affect RAC in some states

In January 2009, CMS announced the names of the remaining MACs. How does this pertain to RACs? Section 302 of the *Tax Relief and Health Care Act of 2006* specified there would be a blackout period, during which claims would not be available for review, for states transitioning to MACs three months before and three months after the new MAC begins processing claims. So Vermont, New Hampshire, Maine, Massachusetts and Rhode Island, all "yellow" states, won't experience RAC activity until August 2009.

The MACs are required to be fully operational by March 2010. With implementation of both the permanent RAC program and the regional MAC occurring between now and 2010, confusion could be common in many states.

What should you do now? BKD CPA's and Advisors strongly recommend you determine your areas of vulnerability to the RAC through mock audits or other means, and implement corrective action moving forward. If you identify significant trends, work with your compliance officer as well as your hospital counsel and determine appropriate next steps. Ensure the hospital has an appropriate infrastructure to manage the operational impact of the RAC and implement robust tracking tools, policies and procedures.

Make sure you designate an RAC point person within your hospital. This person will monitor the status of claims requests, initiate the appeals process and keep management updated, and be certain the hospital is paid appropriately for the services it provides. Do everything you can to offset potential revenue recoupment—implement or reinforce internal documentation and case management programs and be sure charge capture processes are comprehensive.

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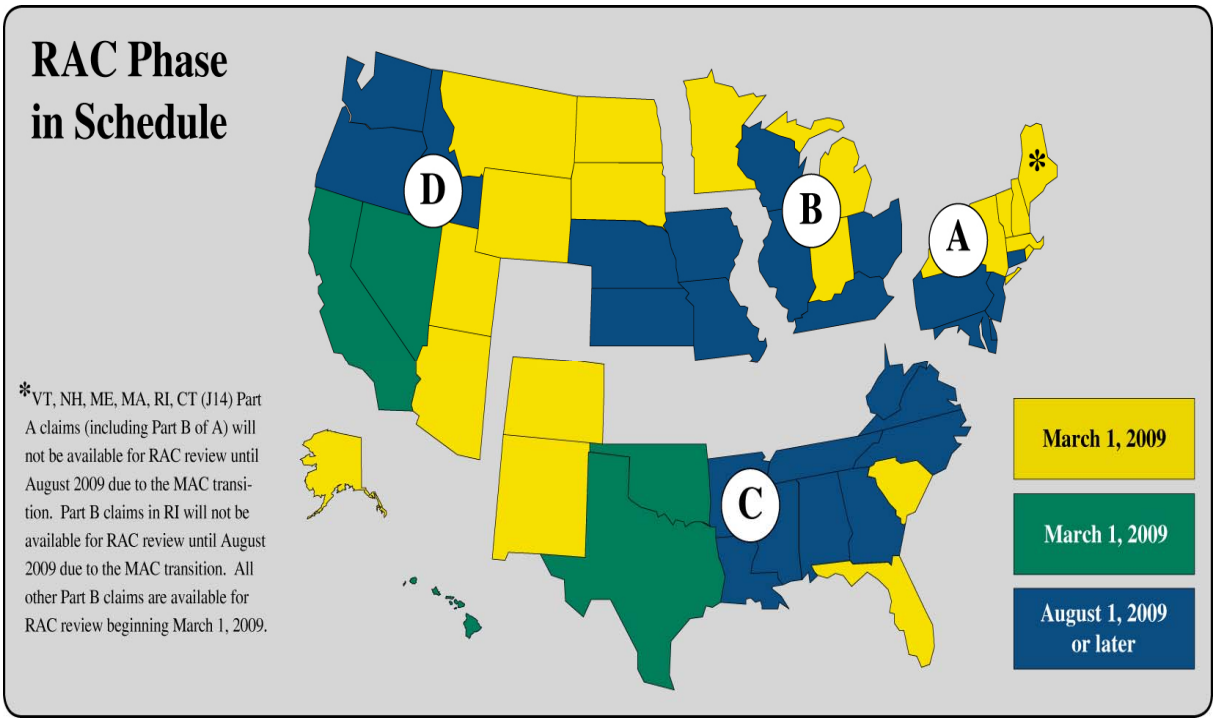

Conclusion

More information about the RAC program should come to light as it rolls out. You are likely to need specific guidance for your particular situation. Contact Kevin Feldman at 260-460-4009 for help and for more information on RAC and related issues.

Save these Dates!

HFMA Golf Outing

June 25, 2009

Tanglewood Golf Course
South Lyon, MI
Shotgun Start: 10:30AM

Click on link below for brochure

http://www.hfmaemc.org/Documents/2009OutingFlyer.doc

Mail your registration today!

HFMA – Tiger Baseball game

Tuesday, July 21, 2009
Tigers vs. Seattle
Game Start: 7:05PM

HFMA Revenue Cycle – Fall Conference

"Bridging the Gap"

Location: DoubleTree Hotel
Bay City, MI

Date: September 16, 17 & 18

HFMA – Fall Conference

September 24 & 25, 2009

Location: The Inn at St. John
44045 Five Mile Road
Plymouth, MI 48170

Retiree Luncheon

Wednesday, November 4, 2009

Time: 12PM

Location: Meriwether's
25485 Telegraph Rd
Southfield, MI 48033

Any retiree who has not received an invitation in past years should contact Susan Stokes
susan-stokes@comcast.net
or Jon Haber jhaber8201@aol.com

Why Does the Auditor…?

By: Gloria Siemiesz
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And Avec O'Brien
Deloitte & Touche LLP

Avec O'Brien, Audit Manager at Deloitte & Touche LLP, gave an informative presentation regarding the audit process on May 22, 2009 at the HFMA Financial Accounting and Reporting Committee meeting. Avec has more than 12 years of public accounting experience, serving clients in healthcare, not-for-profit, and manufacturing industries. She has extensive experience in compliance audits for Circular OMB A-133. Many of her current clients are hospitals in Southeast Michigan. As a graduate student, her coursework specifically focused on not-for-profit management. Avec currently serves as the President of the Association of Latino Professionals in Finance and Accounting for the Michigan Chapter.

Avec stressed the fact that the presentation was based upon her education and experience. However, the content did not necessarily represent the positions of the Financial Accounting Standards Board, AICPA, or Deloitte & Touche LLP.

The presentation started with a simple definition of an audit. Wikipedia defines an audit as "an evaluation of a person, organization, system, process, project or product." There are many types of audits. Avec identified internal and external audits. Internal audits are those that are performed by auditors who are generally employed by the organization and are insuring that policies and internal controls are being followed and can be compliance or operational in nature. External audits can be due to regulatory requirements, such as the SEC, or at the request of shareholders or other interested parties, such as creditors and government agencies.

The objective of an external audit of the financial statements is to express an opinion as to whether, in all material respects, the financial position and results of the operations are presented fairly in conformity with Generally Accepted Accounting Principles (GAAP). External audits of the financial statements are performed by independent auditors. An independent auditor is responsible for rendering an opinion on an organization's financial statements in accordance with Generally Accepted Auditing Standards (GAAS). By relying on GAAS, the auditor can minimize the probability of missing material information. GAAS professional standards are divided into three main sections:

- General Standards – including training, independence and performance requirements.
- Standards of Fieldwork – defines supervision and planning, internal control, and evidence.
- Standards of Reporting – use of GAAP, consistency, disclosure, expressing an opinion.

Factors for a successful audit include:

- Auditor independence – the auditor is not an employee of the client. They represent neither management nor the end user of the financial statements.
- Understanding the entity and its environment – the auditor must understand the client's business and the current issues impacting that client.

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- Risk-based approach – those items that have the highest risk of being materially misstated, such as accounts that require a large degree of judgment, receive a higher degree of attention during an audit. An example of such accounts is bad debt and contractual allowance.
- Professional skepticism – must see evidence of internal controls and GAAP adhered to. The auditor is not going to rely on verbal statements. An example of professional skepticism is the confirm letters that are sent to banks. Although the client provides copies of the bank statement with the account reconciliation, the auditor confirms the balance with the financial institution. The direct mailing of the confirm back to the audit firm ensures that the client cannot change the contents of the letter.

Audit Process Steps

- Plan audit – involves obtaining knowledge and understanding of the industry, transactions, engagement letter, etc.
- Review internal control.
- Evaluate internal control.
- Evidence.
- Determine final assessed level of control risk – helps determine nature, extent and timing of substantive tests.
- Substantive tests – performed by the auditors in the field through random sampling. Scope and size of the sample depends largely on GAAS and the risk associated with the account being tested.
- Audit report – issued at the end of the engagement. An unqualified opinion states that the financial statements present a fair and accurate picture of the company and comply with GAAP. A qualified opinion contains exceptions, which may include the scope of the audit.

Avec then responded to the most common questions clients ask themselves “why does the auditor…” and emphasized that auditors need to comply with the professional standards defined above.

In her closing remarks, Avec’s main suggestion for both client and auditor was to communicate with each other. She stressed that good communication by both parties makes the audit process flow much more smoothly. The auditor needs to remember that the client still has its normal workflow, along with the additional work required for the audit. The client needs to communicate its availability for discussions to the auditor.

Presentation Summary from Financial Accounting & Reporting Committee Meeting - March 20, 2009
Current Issues in Healthcare Accounting & Reporting

By: Julie Case
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Director Finance
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The Financial Accounting and Reporting Committee invited Cline Comer and Dan Frein, both principals with LarsonAllen LLP, to give a presentation on current issues affecting healthcare providers. There were 46 attendees and those present came away with relevant information relating to changes specific to the health care industry.

Cline Comer is a member of the AICPA Healthcare Expert Panel assigned to overhaul the Healthcare Audit and Accounting Guide. The Guide has not been updated since 1996. Issues under discussion include:

- Self-pay Revenue Recognition
- Third-party Disclosures
- Charity Care
- Investments
- Managed Care
- Tax-Exempt Financing
- Self-insurance Arrangements
- Joint Ventures
- Net Assets/Restricted donations
- Separate Reporting Arrangements
- Business Combinations
- Intangibles
- Derivatives

Cline indicated that an estimated date for issuance of the final approved Guide has not been set. The process has been delayed by the FASB Codification project, the FASB's attention to Fair Value/Mark to Market issues, and the country's economic crisis. Hopefully, more information should be coming out later in the year.

Recent updates of selected FASB Pronouncements affecting Health Care Providers were also reviewed. Topics included SFAS 157 and 159 relating to Fair Value Accounting. This was followed by a discussion of recent FASB Exposure Drafts outstanding, including: Mergers and Acquisitions by Not-for-Profit Organizations, Goodwill, and Other Intangible Assets.

Other current topics in Healthcare Accounting and Reporting covered include:

- Bond Market
- FSP 126-1 Public Disclosures
- UPMIFA/FSP 117-1
- Investment Classification
- Alternative Investments
- 403(b) Plans
- Leases

The Committee would like to thank Cline and Dan for their informative presentation and we are looking forward to our series of speakers in the coming year.

Editorial - by State Representative Marc Corriveau (D-Northville) (Speaker at HFMA/MACPA Conference in April 2009)

As our state and nation continue to address our global economic crisis, the rising costs of health care place an even greater burden on our hard-working residents. Through no fault of their own, they have become victims of a health care system that is broken and in need of serious reform. As chair of the House Health Policy Committee I have spent the last year alongside my colleagues from both sides of the aisle, carefully evaluating the problems and potential solutions for our health care system. Using what we have learned, we have crafted a comprehensive plan that will guarantee access, bring affordability to the system, and hold insurance companies accountable to *every* Michigan resident.

As health care costs continue to skyrocket families have been burdened by the daunting task of trying to afford even the most basic levels of care. What's more, many employers are scaling back or altogether cutting health care coverage for their employees. As a result our neighbors who have lost their paychecks and benefits are forced to choose between purchasing expensive individual coverage or go without.

This trend forces far too many of our residents to gamble with their health, and it's a risk that no one should have to take – especially our children. More than 1.1 million of Michigan's 10 million residents are uninsured, and more than 100,000 children in Michigan don't have the health coverage they need, according to the Michigan Department of Community Health.

While lawmakers in Washington, D.C., have expressed an interest in tackling the issue, Michigan's health care system is failing us today, and we cannot wait for the federal government to act. That is why we recently introduced an aggressive reform plan in the Michigan House of Representatives that will guarantee access to health care for all Michigan citizens. Michigan can lead the way and position ourselves to benefit from any reform accomplished at the national level.

The House Health Care Reform Package will prohibit insurance companies from "cherry picking" healthy residents over individuals with pre-existing conditions like diabetes, asthma or heart disease. Further, the package ensures that insurance companies can't cancel or jack up prices on people when they become sick.

To help reign in skyrocketing costs, we will establish the Michigan Catastrophic Protection Plan (MICAPP), funded entirely by the insurance system. MICAPP distributes the cost of providing care for the most expensive medical conditions to all insurance companies. This will help everyone, including Michigan businesses, who are often asked to make up for losses. By helping to maintain employer provided health care, Michigan residents will continue to have quality coverage without the burden of having to choose between health care and other life essentials.

Additionally, the plan will reduce health care costs by creating incentives for healthy behavior, integrating technology, and implementing measures that industry experts recommended time after time.

Finally, the plan establishes the Michigan Health Affordability Fund, which puts the tax exempt value of our non-profit insurance companies to work for Michigan residents. The Fund will expand the eligibility of the state's MIChild program to cover every child across the state, and assist the uninsured in purchasing

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health coverage, avoiding costly emergency room visits.

There is no question that the issue of how to approach reforming our health care system is complex. But it should not be political. I welcome input from all who would like to contribute to our process. Whether you're a health care professional or a consumer, I encourage you to share your thoughts and experiences with my colleagues and me, as we continue to improve on our Heath Care reform package.

State Representative Marc Corriveau, who represents Michigan's 20th House District, which includes Northville, Plymouth, Plymouth Township, Wayne, and parts of Northville and Canton Township, and also recently spoke at the HFMA/MACPA Healthcare Conference. Contact Representative Corriveau at (877) 208-4737 or MarcCorriveau@house.mi.gov

Evaluating Capital Equipment Financing in Today's Market: The Value of the Sale-Leaseback Transaction

By: Mike Parris
Relational Technology Solutions (RTS)
Account Manager
Mparris@rts.com.

It is no secret we are stuck in a precarious moment in time. The healthcare industry has felt the economic "sting" as much as anyone, especially in terms of securing capital dollars. As credit continues to get tighter and traditional financing sources dry up, hospitals must begin to evaluate different strategies to preserve capital and ensure financial stability.

Depending on size, location, patient volume, and current balance sheet, hospitals are cutting budgetary spending, delaying capital-intensive projects, or all but eliminating acquisitions of equipment and technology.

Those who have the ability to implement new technologies in the medical equipment or IT space for providing optimal patient care are asking themselves, "what are my funding options?"

Organizations which have not previously explored leasing are now beginning to do so. Many of those who have purchased medical and IT equipment in the past have begun to evaluate lease options as a means to preserve cash.

Why?

In many cases leasing provides multiple benefits. It reduces up-front capital outlay, improves cash flow, offers tax advantages, and provides greater end-of-life flexibility and avoidance of technology obsolescence.

What many people fail to realize is that there are flexible and innovative ways to structure leases in order to fit the needs of a particular hospital, clinic, or organization. While most decision makers understand the basic principles of operating leases and capital leases, they must also become familiar with more specialized lease structures that can be applied to address the specific challenges presented by today's credit market.

In particular, sale-leasebacks are becoming more prevalent as a simple way to preserve working capital, though it has historically been an under-utilized tool.

What is a sale-leaseback? Quite simply, a sale-leaseback is an agreement in which an organization – in

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this case a hospital – sells fixed assets, currently owned, for cash to a lessor and leases the assets back.

The sale-leaseback is a tremendous tool when cash is tight such as in today's economic environment. Not only will it free up capital, but when done effectively a hospital can realize immediate financial advantages without compromising the long term economic objectives. From an operational perspective, this approach can better position a hospital to keep pace with the ever changing healthcare landscape and more specifically the dynamic expectations of patients and physicians.

The proceeds from the sale-leaseback can be used for working capital, debt restructuring, additional equipment acquisitions, and paying off other miscellaneous debt.

The value of the equipment you acquire– whether it is IT infrastructure, imaging assets, or related diagnostic equipment – comes from using it, not owning it. A general rule of thumb is that it makes good business sense to own equipment that appreciates in value and lease equipment that depreciates in value.

With technology lifecycles moving at a rapid rate, as well as the added pressures of maintaining competitive advantage by offering the latest innovations, hospitals cannot afford to be left with aging assets that are now obsolete and hold little value.

Financial executives and IT professionals working in unison can use the sale-leaseback to establish a regular equipment refresh cycle. With an operating lease in place on the previously purchased assets, the sale-leaseback allows for back-end flexibility, providing organizations with several end-of-term options:

- Renew the lease at fair market value (FMV)
- Return the equipment
- Purchase the assets at fair market value (FMV)

Each leasing company has stipulations on what types of assets are eligible for sale-leaseback and how long ago they were purchased, but in general any "tier 1" medical equipment (CT, MRI, Digital Mammography) or IT infrastructure (PCs, servers, routers) acquired within 12 to 18 months is a viable candidate. An independent lessor is likely to offer the most flexibility, as it will perform the transaction on any equipment, regardless of vendor. A captive lessor will rarely execute a sale-leaseback outside of its own equipment.

Let's take a look at a hypothetical sample sale-leaseback transaction.

A 150-bed short-term acute-care hospital acquired a 64-slice CT scanner in February 2008 after realizing it was losing patient volume to a larger, more technologically-advanced hospital in the same region. The hospital purchased the asset outright at the time, as it weren't experienced with leasing and estimated that it was going to hold onto the asset for five or more years.

When the economy faltered later in the year and patient volume remained flat, the hospital realized the need to tighten its belt. It began to evaluate options to free up capital and learned that a sale-leaseback of the CT, which was purchased for $1.5 million, could be a means to that goal.

The CFO began working with an independent lessor who proposed a 60-month FMV sale-leaseback in

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which the lessor would purchase the asset from the hospital for original equipment cost ($1,500,000). Following a credit review and providing proof of payment, the lessor figured an 8-percent debt rate and put 15 percent of equity ($225,000) into the deal.

After calculation, the hospital (lessee) would assume a monthly payment of $25,685. In this operating lease format, the lessee does not assume the risk of ownership and the lease payment is treated as an operating expense in financial statement and does not affect the balance sheet. As a result, the hospital has freed up a significant amount of working capital.

In conclusion, the sale-leaseback may be an option worth exploring if significant capital-intensive assets have been purchased in the past 12-18 months. Cash is king in this market, and freeing some additional resources to help improve the hospital's bottom line may only be a pain-free transaction away.

HFMA National Founders Merit Program

The Founders Merit Program is a personal incentive program designed to encourage, monitor, and recognize individual volunteer involvement in HFMA.

How can I earn points?

Members can earn points by volunteering in a chapter or national committee; writing an article for HealthCents; mentoring a new member; proctoring a certification exam; speaking at an event; participating on a panel and participating in a chapter or with National HFMA in a volunteer role such as Committee Chair, Board of Director or Officer of the Chapter. All points earned by members are reported to National HFMA by the Founders contact (mailto:susan-stokes@comcast.net) by August 1 each year. In July a letter will be sent to check your Founders points, please take the time to do this when you receive the emai.

The Awards

Four awards can be obtained based on the point system.

The Follmer Bronze Award is award to individuals who earn 25 points.
The Reeves Silver Award is awarded to individuals who earn 50 points
The Muncie Gold Awards is awarded to individuals who earn 75 points
The Medal of Honor is awarded to recognize individuals who have been involved in the association for at least three years after earning the Muncie Gold Award, have provided significant service at the chapter level in at least two of those years, and remain members in good standing.

The 2008-09 winners for the Eastern MI Chapter are as follows:

Follmer Bronze
Michael T. Klett

Reeves Silver
Robert M. Carlesimo, CPA
Suzanna Dimic
Barbra A. Kootsillas, JD
Amy L. Vandecar, FHFMA, CPA

Muncie Gold
Elyse A, Berry, FHFMA
Cheryl L. Comeau
Michael A. Tomkovich, CPA
Michelle A. Whittaker-McCracken, CPC, SPHR

Medal of Honor
Maria B. Abrahamsen, JD

Job Search Survival 2009

By: Deborah Walker
Career Coach
Alpha Advantage
Deb@AlphaAdvantage.com

Undoubtedly, this is the toughest year on record to land a new job. Reaching your career goal will take courage and nerves of steel. Are you up to the challenge? Here are four tips for job-search endurance that will keep you on the right track toward your employment goal.

1. **Keep your career goal realistic.**

This is not the time to strike out in a risky career direction. Following your heart toward a career in which you have little qualifications could yield months of frustration as you find yourself competing against legions of candidates who are far more qualified. Unless you are in the position to hold out for a very long job search, concentrate on positions where you are best qualified.

2. **Realize it will take longer to land your next position.**

If you've never experienced a lengthy job search, set your expectations out several months and practice patience. You will apply for many positions as the perfect candidate, and get no response. Expect that. You will conduct perfect interviews and hear nothing back. Expect that as well. Just remember that eventually the right company with the right job at the right time will come your way if you stay calm and focused and don't let discouragement keep you from moving forward. Just keep with it.

3. **Write a better resume than your competition.**

Less jobs and more applicants equals extremely high competition. The quality of your resume has never been more important. For the best possible resume keep these guidelines in mind:

- Focus your resume. Avoid a one-size-fits-all resume.
- Showcase your best information in the top half of page one.
- Include accomplishments that illustrate your ability to solve today's business challenges.

4. **Sharpen your interview skills.**

With employers interviewing only the best of the best, when you are chosen to interview be sure you are your competitive best. You CANNOT “just wing” an interview and expect to be called back for a second. Today it takes solid interview strategy to earn a second round of interviews. Interview books are helpful, but they usually fall short of teaching you how to read the interviewer's mind to understand his/her hiring motivations. A study in the art of selling is more effective to achieve great interview performance. A few basic selling strategies include:

- Asking the right questions to understand the interviewer's “hot button” motivations.
- Formulate answers around the interviewer's motivations.
- Know your accomplishments well enough to weave them effectively through your interview to achieve top candidate status.

Throughout 2009, the best jobs will go to those who persevere and stay focused. Keeping your expectations and goals realistic will help prevent the emotional ups and downs. Prepare for your job search as if you were competing in a marathon. With patience, endurance and skill you will win your next job.

Presentation Summary from Insurance & Reimbursement Committee Meeting - April 23, 2009
Fiscal Intermediary

By: Carl St. Amour
Beaumont Hospital
Senior Reimbursement Specialist
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Sue Liu from National Government Services, Inc. (NGS) presented an update of the Fiscal Intermediary (FI) in Michigan, and gave an update of recent audit issue.
The presentation focused on the **three** main areas: ***the PS&R Redesign, CMS Cost Report data, and recent important audit issues.***

PS&R Redesign: NGS has established a new "web-based" Provider Statistical & Reimbursement form (PS&R) that will need to be used for all cost reporting periods on or after 1/31/09. The re-designed PS&R will be rolled out in the near future, and fazed into the provider community based on their fiscal year end. The re-designed PSR for these future cost reports will contain a full fiscal years data, and there will not be a need to blend legacy PSR with the redesigned PSR.

Cost Report Data: CMS wanted to stress and emphasize that cost reports are still very important, and that ALL schedules are still very important regardless of their impact on reimbursement.

The last part of the presentation focused on ***important audit issues***. The first audit issue involved Medicare bad debt. A Medicare bad debt that is a Medicaid cross over account needs to have proper rejection code appear on the Medicaid remittance advice. A large discussion ensued on this area, and it was discovered that the State of Michigan is developing new vouchers, and those vouchers will have new codes. The allowable (those that NGS will accept) bad debt codes are not set yet. The current 107 and 840 rejection codes are good for now, and line item review might be performed by the FI, on future audits to assure that the proper codes are in place. Unpaid Medicare Advantage plan deductible and coinsurance are not allowable as a Medicare bad debt on the Medicare cost report. The Medicare HMO rate from the private Medicare HMO Company should already include this amount. Collection agency accounts need to be brought back before they can be claimed. The FI would like to see this activity come back on the AR before they are claimed

The second audit issue involved the Medicare Wage Index. Pension expense was discussed. The FI will only allow the amount of funding up to normal cost plus an amortization of the unfunded liabilities over a ten-year period. Contract labor support must have support with actual hours reported.

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