PHYSICIAN PRACTICES

POSSIBILITIES

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Measuring Patient Satisfaction

OVERVIEW

In today's competitive health care environment, physicians must make excellent customer service a priority in order to protect their patient base and generate new patients. This article explains how to measure and improve patient satisfaction.

Most physicians believe "customer service" simply means they deliver quality medical care, but in reality, it means much more. As a physician, you know that caring for the patient is very important to promote successful healing. However, caring encompasses much more than what happens while in the exam room.

There's a misconception that the patient will accept poor service from a practice's staff because they "like" their physician. This is not the case. Patients not only do not accept poor service as a standard within the health care community; they are demanding more—and better—from their physicians. In today's highly competitive health care environment, you must learn how to protect the patient base and how to generate new patients—and that means ensuring customer service and patient satisfaction are priorities in your practice.

Once you decide to make patient satisfaction a priority, you must communicate your expectations to staff. Be prepared if some staff members do not share your views or desires; in fact, many may feel they are already doing the best they can. Reiterate how each person in the practice contributes to the overall patient experience, and therefore plays an important role in the success of the practice.

Next, get the facts. Survey your patients and your referral sources and find out how they rate their experiences at your practice. Having this data will provide you with the benchmark information needed to begin the improvement process, and a way to measure improvement as you move along. Don't forget: customer service affects not only your referral sources, co-workers and your patients, but also their family members.

For a higher response rate and best results, the survey must be clear, concise and easy to complete. Use a rating scale, much like a movie critic. For your practice, five stars would indicate the individual received excellent service or care and had a great overall experience, with little room for improvement. On the other hand, one star would indicate customer service left much to be desired; this person would not refer his or her family and friends to the practice. Using this rating scale makes it much easier to compile the data and to compare from year to year.

Patient Satisfaction—continued on page 8

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CPAs & BUSINESS ADVISORS

Preventing the Top 10 Fraud Schemes in Your Practice

OVERVIEW

Fraud is becoming more prevalent—even in medical practices. This article explains the most common fraud schemes and what you can do to prevent them in your practice.

Fraud is a word that frightens even the most seasoned business person. Fraud is becoming more prevalent, even in medical practices, due to the economic downturn. The *Association of Certified Fraud Examiners* now estimates 7 percent of a business' annual revenue is lost to fraud. Unfortunately, practices with less than 100 employees are most vulnerable. Fraud is present in nearly all businesses; the question is—to what degree is it affecting your practice? Following is an explanation of the top fraud schemes and recommendations to help deter them.

Skimming of Cash or Checks 1

The top fraud scheme affecting businesses is known as "skimming." Skimming involves taking assets before the assets are recorded on the books. This includes removing cash from the cash register, not recording cash payments made by patients or removing checks from the mail before the checks reach the accounts payable department. Most skimming schemes are frauds of convenience; if given the opportunity to take cash, many employees will. Keep in mind that it is just as easy to remove cash from the daily deposit as it is from the cash register.

Recommendation: Practices should implement internal controls to verify the accuracy of the cash collected at the end of the day. A daily reconciliation of patients' payments to the daily deposit should be done. Also, consider having patients' payments sent to a PO Box rather than your office.

Unauthorized Payments 2

There are only a few ways to remove cash from the practice; the most common is by check. A common scheme is to write a duplicate check for the same invoice. A fraudster will then take the duplicate and either attempt to cash it or use it for a personal expense. For example, a duplicate check written to a utility company can then be sent in as payment for the fraudster's utilities. This is also true for credit card payments. The fund will be applied to the account listed on the remit slip sent with the check.

Recommendation: Practices should review cancelled checks for any duplicate checks, or checks endorsed by their employees. Also, all invoices should be stamped "paid" when approved for payment so the invoices cannot be used as backup for additional checks.

Billing Schemes 3

Billing schemes include anything from a fictitious vendor scheme, pay and return scheme, or overpayment of invoice. A classic billing scheme is the "fictitious vendor" scheme. An accounts payable clerk sets up a fictitious vendor in the system. The fraudster then submits invoices for services never rendered to the practice. The practice pays the invoices and the fraudster is able to cash the checks and pocket the money.

Recommendation: Practices should require approval to add vendors to the system and an employee supervising the accounts payable position should approve payment of all invoices.

Expense Scheme 4

Fraud can be perpetrated by employees overstating expenses, submitting false expenses, claiming other individuals' expenses and buying unauthorized purchases with company funds. The most common scheme is submitting expenses that an employee did not incur. For example, two business acquaintances go to dinner and at the end of the meal, one of the individuals pays the tab using the company's credit card. However, the other individual takes the itemized receipt from the restaurant and expenses it to his company claiming he paid the tab in cash.

Recommendation: Practices should require adequate documentation and itemized receipts from employees listing purchases and reasons for the purchases.

Payroll Schemes 5

Payroll schemes include theft of time, exaggerating overtime and the most costly scheme—a ghost employee. A ghost employee may not be a fictitious individual, just an individual that does not work for the practice. An example is a supervisor who keeps an employee on the payroll after the employee has quit or has been terminated. The supervisor submits and signs-off on false timecards, then receives and cashes the checks for the ghost employee.

Recommendation: Direct deposit of paychecks helps remove the possibility of an employee collecting paychecks on behalf of others. Also, complete a periodic review of the practice's employee list to look for any past employees or unrecognizable names.

Commission Schemes 6

Commission schemes involve inflating sales, altering the price of sales or claiming others' sales as one's own. If an employee inflates sales to receive a larger commission, a by-product of the fraud is the overstatement of the practice's overall financials. This could result in higher tax liability and potential fines for the business.

Recommendation: Businesses should elect an individual who does not receive commission to verify the accuracy of all sales and commissions.

Kickback Schemes 7

A kickback occurs when an employee uses a specific company or vendor because he or she has received cash, gifts or other benefits from the vendor. It is important to remember that kickback schemes can be based on more than money. For example, a kickback scheme could involve a contractor buying all materials from a certain lumber yard because the owner of the lumber yard hired his son-in-law as a favor.

Recommendation: Practices set procedures for selecting vendors and verify that employees are not receiving benefits from those vendors. Conduct annual reviews of vendors to determine if they are the best fit for the practice.

Forgery 8

Forgery includes more than signing another person's name; it can also involve an unauthorized person signing a check for the company, endorsing a check not written to him or her, altering the amount of a check or check washing. One easy scheme is endorsing a check written to another individual. Since most banks will not cash a check for an individual unless that person has an account with them, the fraudster will dual endorse the check, meaning the fraudster will forge the signature of the payee and then sign his or her name below.

Recommendation: Practices should review all cancelled checks received against their bank statements to look for dual endorsements.

Voids 9

You have likely seen the signs at various stores, "If you don't receive a receipt, your next purchase is free." This is the store's attempt to prevent false voids. In order to process a void, the employee needs an original receipt. This is the same case in practices. Charges can be voided out of the system in order for the fraudster to keep the cash payment from patients. Appointments can also be marked as "no-show" or "no procedures done."

Recommendation: Reconcile the daily payment log to the daily sign-in log. Verify there is an entry and payment for each patient who walked in the door that day.

Misuse of Company Credit Cards 10

Company credit cards are convenient, but often misused. Fraudsters will charge personal expenses such as dining, clothes or car repairs on the company's credit cards. Many times these charges are not discovered for months, and by then, thousands of dollars in expenses have been incurred by the practice.

Recommendation: Practices should limit the amount of business credit cards issued to employees and require receipts and adequate documentation from employees to verify business-related expenses. Credit card statements should be reconciled monthly to the receipts.

Medical practices fall victim to fraud everyday. Fortunately, schemes are easy to recognize if you know what to watch for. By implementing these recommendations, you will increase the perception of detection in your practice and may reduce your fraud risk. ∎

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The Association of Certified Fraud Examiners now estimates that 7 percent of a business' annual revenue is lost to fraud. Unfortunately, practices with less than 100 employees are most vulnerable.

Tax Saving Opportunities for Health Care Facilities

OVERVIEW

A tax tool known as cost segregation can create tax savings for health care facilities by reclassifying part of the building as equipment. This article explain how cost segregation works, and how it may benefit you.

After years of stagnation during the 1990s, the health care construction industry is making a comeback. There has been a surge in hospital construction and accompanying ambulatory and primary care clinics in response to changing demographics and population growth. The aging population and retirees are impacting the success of planned and existing communities. In certain geographic areas, this growing, retired population is fueling the demand for expanded hospital beds, geriatric facilities and specialists in geriatrics, cardiology and internal medicine.

With the surge in construction and renovation of health care facilities, a tax tool known as cost segregation can create a huge cash flow advantage for owners by identifying, accumulating, separating and reclassifying part of the building as equipment. This accelerates the depreciation over five, seven or fifteen years, which is the standard for personal property, rather than the standard 39 years for buildings.

Cost segregation for health care facilities is not a new idea, yet real estate owners are often confused about what a cost segregation study really is and how they can receive maximum benefits from the procedure. Cost segregation identifies those costs hidden in a building that actually represent non-building assets.

A cost segregation engineer will typically review construction invoices and building plans to determine which assets can be allocated to five, seven or fifteen-year assets. An on-site inspection follows to collect additional information, and the exterior and interior of the building are photographed. The engineer will allocate material components, direct labor and indirect costs using industry-standard construction cost data, and calculate often-ignored items such as wire, nails, screws and a portion of the contractor's overhead which can also be depreciated over a much shorter life. The engineer then creates a written report detailing the findings and cost allocations, with appropriate references and rulings to support positions. The engineer helps the owner file the report with the annual tax return and will represent the owner in the event that any cost segregation decisions result in an audit.

Cost segregation can create a huge cash flow advantage for owners by identifying, accumulating, separating and reclassifying part of the building as equipment.

Examples of assets within a project that can qualify include equipment, office furniture and fixtures, landscaping, land improvements, floor coverings and specialty electrical and HVAC equipment. Decisions as to what can be segregated are based on sound engineering principles that are supported by IRS regulations, rulings and case law. For example, medical and dental offices have specialized wiring, built-in improvements for treatment rooms and possibly special shielding for X-ray rooms. The building may have internal wiring and cabling for data transmission.

In addition to new construction projects and building acquisition, this methodology applies to owners who have either constructed or acquired buildings in prior years. An owner is allowed to reclassify these types of assets by making an accounting method change and recognizing the entire "catch-up" amount in the year of the change. It is never too late to correct the books, even if an owner has overlooked cost segregation in the past (unless the building is fully depreciated).

For-profit hospitals, medical and dental offices, nursing homes, skilled nursing homes and assisted-living facilities are ideal subjects for a cost segregation study. Under certain circumstances, and in certain states, non-profit facilities are allowed a gross receipts tax exemption for personal property.

A cost segregation study may be beneficial if the cost of a structure (land excluded) is at least $500,000, the purchase, construction or renovation has taken place in the past seven years and the owner plans to retain the property for several years and currently has taxable net income.

The following health care facility examples illustrate the potential benefits of a cost segregation study:

- A $3.2 million medical clinic located in a renovated grocery store had a first year increase in cash flow of $48,600 with net present value (NPV) of accelerated cash flow of $149,000.

- A $2.1 million newly constructed ambulatory facility achieved a first-year increase in cash flow of $26,000 with NPV of accelerated cash flow of $72,400.

- A $6.3 million newly-constructed retirement facility with on-site health care facilities had a first-year increase in cash flow of $100,300 with NPV of accelerated cash flow of $261,800.

Each building is unique, and the amount of reclassification varies, so it is best to consult a professional. The IRS recently issued guidance for tax auditors to use in reviewing cost segregation studies. While no specific credentials are required, the IRS states that a study by a construction engineer is more reliable than one conducted by an individual with no engineering or construction background. In addition, experience in cost estimating, allocation, and knowledge of the applicable law is also important. Real estate owners of health care facilities owe it to themselves to look into this proven, value-added benefit. ▮

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For-profit hospitals, medical and dental offices, nursing homes, skilled nursing homes and assisted-living facilities are ideal subjects for a cost segregation study.

Could a Cash Balance Retirement Plan Benefit You?

OVERVIEW

As a practice becomes more profitable, a physician may desire to contribute more to a retirement plan than a traditional 401(k) allows. This article explains how a cash balance defined benefit retirement plan may allow for significantly higher retirement contributions.

Cash balance plans generally allow for larger contributions and tax deductions than 401(k) plans and other defined contribution plans. The larger deductions may provide significant tax benefits to the employer—in this case, the physician or physician's group—as contributions to a cash balance plan are not included in the employee's current taxable income.*

Physicians and other highly compensated professionals are constantly on the lookout for effective ways to limit their current taxable income, reduce their current tax liability and better position their assets for retirement.* Yet, many such professionals rely entirely on a 401(k) defined contribution plan to help them meet these goals—a strategy that may fall far short of the intended mark.

The problem for physicians and other highly compensated professionals is that their income, and frequently the cost of their daily lifestyle, dwarfs the percentage of their compensation they are allowed to save in a 401(k); for 2009, the maximum employee contribution is limited to $16,500 for those under age 50 and $22,000 for those 50 and older. Yet, with annual paychecks that often range from $250,000 to well into the millions of dollars, many of these professionals would like a way to save 10, 15, even 20 percent of their income—a level that would allow them the opportunity to maintain their lifestyle during their golden years. Perhaps you are one of them.

For starters, you may want to consider adding a profit-sharing component to your 401(k) plan. The profit-sharing provision allows the employer (the physician or physician's group) to make additional discretionary contributions to the 401(k)/profit-sharing plan. The profit-sharing contributions are calculated based on the age and salary of the employee. Generally, the physician/employer will receive the largest percentage of the profit-sharing contribution because he or she has the highest income and is generally several years older than most of the employees. The combination of both the 401(k) salary deferral and profit-sharing contributions cannot exceed an aggregate limit of $49,000 for those younger than 50, or $54,500 for those older than 50 (2009). This is a big improvement, but still may not accommodate those who are really interested in tax-deferred savings.

A physician's practice generally becomes more efficient and profitable as he or she moves beyond age 50. This may afford the physician both the desire and the cash flow to contribute more than $54,500 per year to his or her retirement plan—much more in some cases. For those individuals, the addition of a cash balance defined benefit retirement plan may allow for significantly higher contributions.

Essentially, a cash balance defined benefit retirement plan has some features that resemble a defined contribution plan, or 401(k). It is often referred to as a "hybrid" of a traditional defined benefit plan and a defined contribution plan. Like a traditional defined benefit plan, cash balance plans pay a specified benefit amount at retirement. However, like a defined contribution plan, participants have individual (albeit hypothetical) accounts, allowing for easy tracking of accrued benefits.

The value of a cash balance defined benefit plan can grow in two ways. First, the account accrues employer contribution credits. Second, the account value can increase with an interest credit, which is guaranteed (and not dependent on the plan's investment performance).

The following is an overview of some of the key features of a cash balance plan.

- **The saving potential is greater than with other plans.** Cash balance plans generally allow for larger contributions and tax deductions than 401(k) plans and other defined contribution plans. The larger deductions may provide significant tax benefits to the employer*—in this case, the physician or physician's group—as contributions to a cash balance plan are not included in the employee's current taxable income. Of course, when a participant begins to receive benefits from the plan, those benefits are taxable. But, beyond the issue of required minimum distributions, you control how much and how quickly you withdraw money from your account during retirement.

- **Each participant has an individual (hypothetical) account.** Each participant's account tracks his or her contribution credits and interest credits. Because it is a defined benefit plan, the interest credit is guaranteed to the participant and is not dependent on the plan's investment performance. Participants in a cash balance plan have no say over the

underlying investments selected. Plan assets are held in a pension trust that the employer establishes, contributes to and uses to pay benefits when participants retire or terminate their employment.

- **Contributions are paid by the employer.** The hypothetical account is funded by employer contributions, which are determined by the benefit formula in the plan document. The contribution is typically a percentage of the participant's salary. It tends to favor more highly compensated employees. Generally, $245,000 (2009) is the maximum amount of salary that can be considered in the calculations.

- **Benefits may be portable.** Many such plans allow an employee who is leaving the organization to take benefits with him or her—as a lump sum or a rollover into to an IRA. This feature is similar to other more familiar retirement plans. Meanwhile, for those considering actual retirement, cash balance plans typically offer the choice of an annuity benefit or a lump sum benefit.

- **A word to the wise: Cash balance plans obligate the employer to make annual contributions to the plan.** So, your practice should have predictable cash flows that will enable you to fund the plan for at least five years or more. Discontinuing a cash balance plan within the first five years could have significant negative implications.

HERE'S HOW A CASH BALANCE PLAN LOOKS IN ACTION

The Need

A group of physicians (who are over age 40 and are partners in the practice) are interested in setting aside more money each year than the defined contribution 401(k)/profit sharing limit of $49,000 each. They are also interested in protecting more of their income from current taxation.

The Solution

In addition to their firm's existing 401(k)/profit sharing plan, they adopted a cash balance plan.

The Results:

- Average tax-deferred contributions for each partner within the practice increased from $37,500 to $72,600 per year—basically doubling the annual additions to their tax-deferred retirement savings.
- Annual tax-deferred contributions are now approaching $125,000 for several physicians who are older than 50.
- Meanwhile, contributions for staff increased from 4 percent to 6 percent of salary in order for the firm to pass the IRS non-discrimination testing—a small price to pay for the benefits reaped by the physicians/business owners.

This is a hypothetical illustration only, and is not a statement of actual results. Please contact a qualified tax advisor for advice relating to your specific situation.

So, could you benefit from a cash balance retirement plan? A cash balance plan can offer substantial value to both the organization's professionals/business owners and the other employees. Remember, however, to work with a qualified retirement plan consultant and your tax advisor to determine whether a cash balance plan would be appropriate for your practice.

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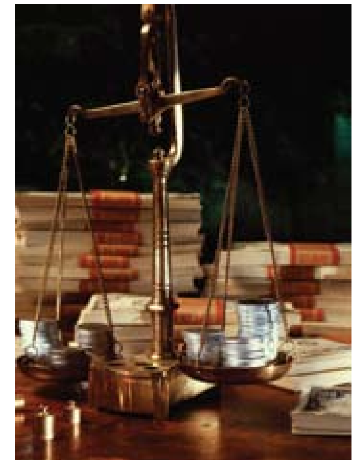

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FORWARDING SERVICE REQUESTED

Patient Satisfaction—from page 1

On the survey, you will want to ask a variety of questions addressing all aspects of the individual's experience, from the ease of making an appointment and checking in at the front desk, to the cleanliness of all areas (not just the exam rooms). Be sure to ask about wait times in the reception area and in the exam room. Ask about the physician care as well—how did you do? Did you listen? Did you answer their questions? Did you explain everything thoroughly?

At the end of the survey, leave space for the patient to provide additional information through open-ended questions. For example, "What could we have done better?"

Whether you administer the survey to the patient at their appointment or by mail, make sure you include a postage-paid self-addressed envelope for the return. Ideally, use an outside mailing address for the return, as this will limit any internal manipulation of the document. Consider using your accounting firm as the recipient of the survey and to assist with the preparation of the report.

Do not forget to survey your referral sources. This is especially important if you are a specialist and depend on referrals for your new patients. You should plan to include past referral sources in addition to the current sources. Use your practice management system to provide a report showing your referrals from the past 24 months.

For any physician, measuring your patient satisfaction is critical to understanding how well you and your staff perform. If your survey results indicate patient satisfaction is not at the level you expect or desire, use this as your incentive for improvement. By working toward continuous improvement, you will increasingly protect your patient base and generate new patients.

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