SPECIAL SECTION

REPORTING CHARITY CARE

Hospitals Must Prepare to Comply With New AICPA Accounting Rules

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In July 1990 the American Institute of Certified Public Accountants (AICPA) issued a new audit and accounting guide, *Audits of Providers of Health Care Services*, which established rules that are having a notable impact on the way hospitals and other providers report charity care in their financial statements. The new rules are a response to the heightened awareness—on the part of Congress, the Internal Revenue Service and other governmental agencies, and the general public—of the level of charity care provided by hospitals.

In the past, many hospital financial statements made no reference to charity care. Those hospitals which did report charity care information usually lumped it together with bad debts under a caption such as "uncompensated services" in the revenue deductions section of the income statement, or they disclosed a specific amount of charity provided for compliance with Hill-Burton or other governmental programs.

Bad Debts and Charity Care

One major reason hospitals failed to report charity care is that the information seemed to be of little interest to anyone other than governmental programs. Another is that it is notoriously difficult to differentiate between bad debts and charity care (see **Box**). All this will change in financial statements prepared for fiscal years ending in mid-July 1991 and thereafter. From now on, providers' financial statements must:

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Summary To comply with new accounting rules issued by the American Institute of Certified Public Accountants (AICPA), hospitals will have to change the way they report charity care in the financial statements they prepare for fiscal years ending mid-July 1991 and later.

In the past, those hospitals which did report charity care information usually lumped it with bad debts under a caption such as "uncompensated services" or disclosed a specific amount of charity care to comply with Hill-Burton or other governmental programs. From now on, however, providers' financial statements must distinguish bad debt from charity care, not report gross patient revenues in the income statement, not imply that charity services generate revenue or receivables, make specific disclosures about the level of charity care provided, and report bad debts as an expense, rather than as a deduction from revenue.

Distinguishing bad debts from charity care will be difficult. The AICPA defines bad debts as actual or expected uncollectibles resulting from an extension of credit, and charity care as services for which the provider does not expect payment. The AICPA believes that facilities which establish a definitive management policy on charity care should be able to distinguish between the two.

To collect the data necessary to meet the AICPA requirements, hospitals need to establish a method to catalog the charity services they provide. Facilities should also ensure that patients and staff are familiar with their charity care policies.

- Distinguish bad debts from charity care
- Not report gross patient revenues in the income statement
- Not imply that charity services generate revenue or receivables
- Make specific disclosures about the level of charity care provided
- Report bad debts as an expense, rather than as a deduction from revenue

Despite the difficulties discussed above, the AICPA believes that distinguishing charity care from bad debts is essential to the process of quantifying charity care levels. To help make this distinction, the new audit guide offers the following definitions:

- *Bad debts* represent actual or expected uncollectibles resulting from extension of credit.
- *Charity care* represents healthcare services provided with no expectation of payment.

The distinction between the two comes down to whether a facility anticipates payment for the healthcare services it provides. When a hospital renders services for which it expects payment, it extends credit to the patient. In this type of a transaction, the facility incurs bad debts if the patient (or third-party payer) does not pay the account. In this situation the patient is unwilling (as opposed to unable) to pay the account.

Conversely, if the provider knows that the patient is unable to pay some or all of a bill, it renders services (or at least a portion of them) with no expectation of payment. In this case, no credit is extended; the charges incurred are simply written off and considered charity care. The new guide explicitly states that a facility does not have to determine that a patient is unable to pay at the time of admission. Therefore a patient who is originally classified as a self-pay or insurance account may subsequently be transferred to a charity classification.

The Healthcare Financial Management Association's (HFMA's) Principles and Practices Board (P&PB) has issued a statement, titled *Defining Charity Service as Contrasted to Bad Debts* (1978), which provides additional insights in this area. The P&PB is also working on another project, *Valuation, Recording, and Presentation of Charity Care*, which addresses these issues in light of the new audit guide. An exposure draft of this advisory statement was expected to be released by the end of 1991.

A Charity Care Policy

The AICPA acknowledges that distinguishing between bad debts and charity care is difficult; however, the organization believes that establishing a definitive management policy regarding charity care would produce reasonable results in distinguishing between the two. In theory, if management's policy is to provide care without expectation of payment in certain situations, management should be able to establish a formal policy concerning the situations in which patient care will be classified as charity, as well as any financial criteria employed in determining a sliding scale or full write-off, and so forth. Therefore the guide requires that providers establish a formal policy indicating the criteria they will use to determine who qualifies for charity care. Patients who do not meet the criteria for classification as charity cases will be extended credit.

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The new guide provides latitude in developing the financial statement charity care policy. Individual providers are responsible for developing their own charity care policies for purposes of external financial reporting. This allows hospitals to establish criteria consistent with their unique missions and financial capabilities. The policy developed must be disclosed each year in the notes to the financial statements (see **Table 1**, on p. 60).

The HFMA P&PB documents mentioned above may be helpful to providers in establishing their charity care policies. The Catholic Health Association (CHA) is also working with other hospital associations and relevant agencies to develop guidelines in this area.

Charity Care Not Revenue

One of the new guide's most controversial aspects is the disappearance of charity care from

WHY BAD DEBTS AND CHARITY CARE ARE HARD TO DIFFERENTIATE

- Admission and discharge procedures often are not designed to systematically identify charity care patients.
- Emergency room and outpatient services, the two primary admission sources for charity care patients, seldom have an admitting process for identifying them, and prospective determination is often impractical in these situations.
- Many of the uninsured poor try to pay their bills in small installments, which results in classification of any write-offs as bad debts.
- Some patients mistakenly or intentionally claim to have insurance coverage when they do not, which throws them into a bad-debt classification if the account goes unpaid.
- With regard to insured patients, unpaid catastrophic care (i.e., unusually high expenses that the family is not able to meet) often is written off as bad debts when the family may have been impoverished by the medical expenses.
- Similarly, many insured patients may have significant copayments and deductibles they are unable to pay, which are often classified as bad debts.

the revenue section of the income statement. Hospitals can no longer report charity care as a deduction from revenue either on the face of the income statement, in the notes to the financial statements, or in supplemental schedules. As discussed earlier, the AICPA believes that rendering services for which no payment is anticipated does not result in the generation of revenue or a receivable; therefore, for financial reporting purposes, "charity revenue" or "charity receivables" do not exist.

TABLE 1: CHANGE IN CHARITY REPORTING REQUIREMENTS–INCOME STATEMENT

Old Presentation Format

Patient service revenue	$101,000
Deductions from revenue (includes $8,000 in charity care and bad debts)	20,000
Net patient service revenue	$ 81,000
Other revenue	5,000
TOTAL REVENUE	$ 86,000
Expenses (details omitted)	84,000
EXCESS OF REVENUE OVER EXPENSES	$2,000

New Presentation Format

Net patient service revenue (notes 1 and 2)	$82,000
Other revenue	5,000
TOTAL REVENUE	$87,000
Expenses (details omitted–includes bad debt expense of $1,000)	85,000
EXCESS OF REVENUE OVER EXPENSES	$2,000

FOOTNOTE DISCLOSURES

NOTE 1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

[Along with other accounting policies, the following charity care policy note would appear.]

Charity care. The hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

NOTE 2. CHARITY CARE

The hospital maintains records to identify and monitor the level of charity care provided. These records include the amount of charges forgone for services and supplies furnished under its charity care policy, the estimated cost of these services and supplies, and equivalent service statistics. The following information measures the level of charity care provided during the year ended March 31, 1992:

Charges forgone, based on established rates	$7,000
Estimated costs and expenses incurred to provide charity care	$5,600
Equivalent percentage of charity care patients to all patients served	5.7%

The AICPA's requirement to exclude charity care charges from revenue will not have an impact on the bottom line because in the past all charity care transactions "canceled out" (i.e., charges attributable to charity care reported in "patient service revenue" were completely offset by the provision for charity care reported in "deductions from revenue" [see **Table 2**]). The change may, however, have a significant impact on supplemental disclosures. Some providers may continue to furnish information concerning gross patient service revenue and deductions from revenue in either the notes to the financial statements or in a supplemental schedule. They can do so as long as they meet the following stipulations:

- Gross patient service revenue should not include charges pertaining to charity care patients. A provider that wishes to include these charges in the amount it discloses should use a caption such as "gross charges" in lieu of "patient service revenue."
- Deductions from revenue may not reflect the provision for bad debts or write-offs pertaining to charity care.

Table 3 on p. 62 provides an example of a supplemental disclosure that meets these guidelines.

A Charity Care Yardstick

The above change does not mean that the AICPA intends for all mention of charity care to disappear from providers' financial statements. The AICPA now requires hospitals to disclose the level of charity care they provided during the years covered by the financial statements in the notes to the financial statements.

The new guide allows hospitals to select the measuring stick (or sticks) they believe most clearly convey the level of charity care they provide. The flexibility inherent in this requirement allows hospitals to show that more is involved in providing charity care than just writing off a certain dollar level of charges, as has been the usual extent of disclosure in the past.

According to the guide, providers may use established rates, estimated costs, relevant statistics, or any combination of these to measure the level of charity care they contribute. **Table 1** shows an example adapted from the guide of such a disclosure that used all three. Each of these measurement bases has merits and drawbacks.

Charges Reporting "charges forgone" is the easiest measurement of charity care to make, but it is

also one of the least accurate. As discussed in CHA's *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint* (1989), measuring on the basis of uncollected charges overstates the actual cost of providing the care. More important, this deduction can distort comparisons between healthcare facilities because of differences in the markup of charges over costs at each facility. Thus, for example, one hospital may appear to provide more charity care than another facility only because the hospital has higher charges. If other hospitals in a provider's area continue to report charity care in the form of charges, that provider should do likewise when comparisons are being made; however, the provider should probably consider using the cost measurement method for planning and supplemental reporting purposes.

Costs Cost may be the most useful gauge of charity care levels, and it allows for the most accurate comparisons between facilities. However, it is not as easy to derive measurement based on costs as to derive measurement based on charges. A cost-accounting system produces the best estimate of costs. If such a system is not available, providers can apply a cost-to-charge ratio to their charity care charges as an approximation.

Some hospitals may be capturing charity care information on a departmental basis. In such cases, facilities will also have to allocate indirect costs to ensure they do not understate the total cost of providing services to charity care patients. Some providers may find it useful to develop inpatient and outpatient charity care logs, similar to Medicare and Medicaid logs. These logs can provide valuable information pertaining to charges (by area of service), amounts of any payments received, and amounts written off.

Some providers that have quantified costs in an auditable manner have chosen to disclose this information on the face of the income statement, as shown in **Table 2**. Doing so solves the perceived problem of charity care "vanishing" from the face of the income statement. However, providers also could call attention to their footnote disclosures by using notations in the body of the income statement (see **Table 1**).

Unit-of-Service Statistics A hospital can also use unit-of-service statistics such as patient days and percentage of total patients, if it believes them to be appropriate and informative.

The new guide's disclosure requirements allow a hospital to show that more is involved in providing charity care than just writing off a certain dollar value of charges. Under the new requirements, a facility can more thoroughly describe the ways in which it provides charity care and other community benefits. The hospital may also want to consider other disclosures describing the broad range of community services it performs. It is important that the financial statement not imply that the facility's tax-exempt status is linked solely to the provision of a certain level of hospital charity services.

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The HFMA P&PB's new exposure draft on charity care is expected to contain additional discussion and recommendations with regard to disclosure of the level of charity services provided.

Bad Debts

As stated above, the new guide requires facilities to report bad debts as an expense, rather than as a deduction from revenue. Within the expense section of the income statement, a hospital may report bad debts as a separate line item or include them with other expenses in a summary caption, just as would be the case for any other business enterprise.

Effects on Policies, Procedures, and Systems

To collect the data necessary to effect these requirements, hospitals need to establish a method to catalog charity services provided. A provider should review its accounting system to ensure that it can separately track bad debts and charity care in a manner consistent with its charity care policy and that it can easily summarize the information for the monthly financial statements and the year-end audit. In conducting this review, facilities should check with both external

TABLE 2: ALTERNATIVE DISCLOSURE OF CHARITY INFORMATION—INCOME STATEMENT

Net patient service revenue	$82,000
Other revenue	5,000
TOTAL REVENUE	$87,000
Expenses (including estimated costs of providing charity care of $5,600)	
Professional care of patients	$55,000
General services	11,000
Administrative services	10,000
Medical malpractice costs	1,000
Depreciation	5,000
Interest	2,000
Bad debts	1,000
TOTAL EXPENSES	$85,000
Excess of revenue over expenses	$2,000

TABLE 3: ALTERNATIVE DISCLOSURE OF CHARITY AND OTHER DEDUCTIONS—SUPPLEMENTAL SCHEDULE

Gross charges	$101,000
Deductions from gross charges	
Medicare contractual allowances	$8,000
Medicaid contractual allowances	3,000
Charity services provided	7,000
Courtesy discounts and other	1,000
TOTAL DEDUCTIONS	$ 19,000
Net patient service revenue	$ 82,000

and internal auditors about the record-keeping requirements needed to test the procedures for distinguishing bad debts from charity care. Clarifying these requirements up front can save a lot of headaches, frustration, and time during the internal and external audits.

Setting up a separate payer class (or classes) for charity care may make this process easier. Facilities can set up an allowance for charity care, similar to the bad debt allowance, in the receivables section of the general ledger. Unlike the allowance for bad debts, the allowance for charity care would not be disclosed in the financial statements by netting it against accounts receivable.

In the first year that the new guide's rules are adopted, facilities that present comparative financial statements will need both current and prior year data for charity care and bad debts. Actual data are best, if available. However, many facilities have not kept track of this information, and capturing it can be an arduous task. As an alternative, providers can scrutinize a sample of uncollected accounts to determine how much is bad debt and how much is charity and use these percentages to develop the estimates necessary for the financial statements.

Implementing these system changes goes hand in hand with a review of charity care policies and procedures. As discussed at the beginning of this article, it is often hard to tell what is bad debt and what is charity care, and the amount shown in financial statements as "charity care" often understates the amount of care provided to the poor because many bills for low-income persons are, in the end, written off to bad-debt expense. What policies and procedures can a facility put in place to give itself the best chances of recording charity care correctly? The *Social Accountability Budget* has the following suggestions.

Facilities should ensure that staff are aware of their charity policies and are encouraged to inform patients who may need assistance.

Notification Facilities should ensure that their charity policies include a uniform and regularly applied process (for both inpatients and outpatients) at the time of admission or discharge during which qualifying patients are notified that they do not have to pay all or part of their bill. Hospital personnel should discuss the charity policy with patients when they receive their bill and at other key times in the hospitalization process, such as during consultation with a community services worker. Finally, facilities should ensure that staff (including nurses and physicians) are aware of their charity policies and are encouraged to inform patients who may need assistance.

Prospective Determination Facilities should flag charity care accounts as early as possible in the admission-treatment-discharge process. To do this effectively, hospitals should have clear, uniform procedures for determining charity eligibility *prospectively*. The approach adopted by one hospital in the Western United States is presented in the **Box**. Facilities should also ensure that their means tests are reasonable given periodic changes in government guidelines.

Retroactive Determination Even with the best procedures in place, in many cases hospitals cannot determine instances of charity care prospectively. Prospective determinations are often impractical in emergency or outpatient settings. Therefore procedures should also include mechanisms to identify patients who are unable to pay but who somehow fell through the cracks during the prospective determination process.

One such mechanism might involve reexamining patients who have been referred to collection agencies, but from whom payment has not been received after a specified time. For example, after a specified period of collection efforts, the collection agency could be authorized to offer the patient charity care and begin collecting the required income information. Another idea is to send readily understandable notices of the availability of financial assistance with overdue and referral notices. This may encourage some patients who are currently being counted as bad debt to come forward and qualify for charity care. Facilities should also identify persons who *become* medically indigent as a result of the cost of their current medical treatment.

Unintentional Intimidation Although healthcare facilities usually have a written policy of providing care to all acutely ill persons, regardless of insurance status or ability to pay, practices (intentional or unintentional) may discourage use of the facility by uninsured or underinsured patients. Facilities should be alert for practices such as formal or

informal encouragement that the uninsured patient go elsewhere for care, redirection or transfer of emergency patients for financial reasons, burdensome or intimidating application procedures for charity care, or other practices that may systematically discourage use of the facility.

Mixed Messages As financial pressures increase, billing and admissions staff often receive mixed messages. They may be aware of the facility's charity policies but also attuned to cost-cutting drives. In this environment, hospital administrators should ensure that charity policies are being consistently and fairly applied. Ideas include:

- Questionnaires to gauge staff perceptions of charity policies, the results of which can be used for staff discussion or training
- Discussion groups that allow staff to describe their perceptions of charity procedures and to identify possible conflicting practices
- Monitoring of staff practices on an ongoing basis to ensure that practice is following policy
- Questionnaires, telephone surveys, discharge interviews, or focus groups to obtain input from patients

Governmental Indigent Care Programs Some states and localities limit the number of days, visits, or services reimbursable through Medicaid or other programs for indigent persons. A hospital should not count services to public program recipients that fall outside the scope of the contractual agreements as bad debts or contractual allowances; it is more correct to count them as charity care. (Do not include expenses disallowed through utilization review procedures or other case-by-case denials, or the contractual portion related to payments that are actually received from such programs.)

Some providers believe it is important to discuss their mission in the financial statement footnote on the entity's significant policies.

Remembering the Mission Statement

The new audit guide requires providers to clearly define their central mission. This obligates them to review their mission statements and revise them if necessary in light of the guide's requirements with regard to charity care policies and definition of central mission. Although it is not required, some providers believe it is important to discuss their mission in the financial statement footnote on the entity's significant policies.

According to the *Social Accountability Budget*, effective mission statements make explicit reference to community benefits, including those concerning the poor and populations with special needs. They should be written so that they can serve as a set of criteria for helping with strategic planning decisions and evaluating benefits to the community. This does not mean the mission statement has to be lengthy. The mission statement should be short, uncomplicated, and straightforward to best be understood. Such a document will help hospitals show their publics the value of the community service they provide. □

CHARITY CARE PROCEDURES

A hospital located in the Western United States is reorganizing its admitting and patient accounting functions because of concerns about two fundamental problems:

- The hospital has not been able to collect the income and/or asset information it needs to determine the need to waive bills up front or before the patients are discharged.
- As a result, the anxiety levels of patients who are truly unable to pay their bills are unproductively increased by the hospital's account managers, who are encouraged to press for payment.

The processes to be implemented are designed to promote the sharing of information in a nonthreatening manner, for the mutual benefits of both the patient and the hospital, so that the patient can focus on medical (versus financial) recovery and the hospital does not spend valuable resources on low-yield collection efforts. Significantly, this is a hospital facing serious financial constraints. The hospital plans to implement the following procedures:

- Referring physicians' office staffs will be supplied with preadmission forms and trained in the hospital's financial policies. The staff will begin communication with the hospital as soon as hospitalization is recommended for the patient. The communication and documentation will include disclosure of the patient's expected source of payment.
- If the office staffs or the preadmission forms indicate payment problems, the patient will be referred immediately to a hospital financial counselor, who will not be motivated, as are the account managers for other patients, on the basis of successful collection. The financial counselor will be authorized to supply the hospital's sliding-fee scale or to waive the bill entirely for patients who demonstrate need.
- Patients who qualify for charity will thus be separated from the normal hospital billing process and will be treated as patients with insurance. Also, they will not have to revisit the accounting office before discharge.

The hospital staff believes that this process will help maintain the dignity of the patient and improve the decision-making process for granting charity for a significant number of its patients.

From *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint*, Catholic Health Association, St. Louis, 1989.