Presentation and Disclosure of Patient Service Revenue *Continued from Page 4...*

of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), Entity A records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Entity A's allowance for doubtful accounts for self-pay patients increased from 90 percent of self-pay accounts receivable at December 31, 20X1, to 95 percent of self-pay accounts receivable at December 31, 20X2. In addition, Entity A's self-pay writeoffs increased $1,000,000 from $8,000,000 for fiscal year 20X1 to $9,000,000 for fiscal year 20X2. Both increases were the result of negative trends experienced in the collection of amounts from self-pay patients in fiscal year 20X2. Entity A has not changed its charity care or uninsured discount policies during fiscal years 20X1 or 20X2. Entity A does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant writeoffs from third-party payors.

Recognition—Revenue

In general, gross service revenue is recorded in the accounting records on an accrual basis at the provider's established rates, regardless of whether the health care entity expects to collect that amount.

The provision for contractual adjustments (the difference between established rates and expected third-party payor payments) and discounts (the difference between established rates and the amount billable) are recognized on an accrual basis. These amounts are deducted from gross service revenue to determine net service revenue.

Other Presentation Matters

Some health care entities may perform services for patients for which the ultimate collection of all or a portion of the amounts billed or billable cannot be determined at the time services are rendered. For example, some health care entities have a policy of providing services to patients and recording patient service revenue regardless of their ability to pay and, in some cases (hospital emergency departments), are required by law to treat emergency conditions regardless of a patient's ability to pay. As a result, those health care entities might record revenue along with a relatively high bad-debt provision in the period of service.

A health care entity that recognizes significant amounts of patient service revenue at the time the services are rendered even though it does not assess the patient's ability to pay shall present all of the following as separate line items on the face of the statement of operations:

a. Patient service revenue (net of contractual allowances and discounts)
b. The provision for bad debts (the amount related to patient service revenue and included as a deduction from patient service revenue)
c. The resulting net patient service revenue less the provision for bad debts.

Bad debts that shall continue to be presented as an operating expense in the statement of operations are the following:

a. Bad debts related to receivables from revenue other than patient service revenue
b. Bad debts related to receivables from patient service revenue if the entity only recognizes revenue to the extent it expects to collect that amount.

Disclosure—Sources of Revenue

A health care entity that recognizes significant amounts of patient service revenue at the time the services are rendered even though it does not assess the patient's ability to pay shall disclose both of the following by major payor source of revenue for interim and annual periods:

a. Its policy for assessing collectability in determining the timing and amount of patient service revenue (net of contractual allowances and discounts) to be recognized
b. Its patient service revenue (net of contractual allowances and discounts) before the provision for bad debts.

Major payor sources of revenue shall be identified by the entity and be consistent with how the entity manages its business (i.e. how it assesses credit risk).

Source: ThomsonReuters/PPC

Article written by Patrick P. Rohrkaste, CPA, Health Care Partner

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Providing Value to the Health Care Industry

Today's health care industry is a fast-paced environment where regulatory issues, competition and rapidly changing consumer expectations converge. Managing risks and realizing opportunities become a more important focus as providers decide how they will adapt and evolve their business models for long-term survival. UHY LLP recognizes the importance of adding value to our delivery of professional services to health care organizations. Our National Health Care Group has significant experience serving health care clients and we bring this understanding of your industry together with innovative solutions that have a positive impact on the bottom line.

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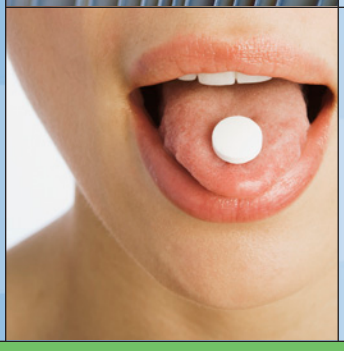

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In This Issue

Form 990 Schedule H Updates

The Patient Protection and Affordable Care Act added additional requirements that a hospital organization must meet to qualify for tax exemption under IRC section 501(c)(3) for tax years beginning after March 23, 2010. These additional requirements cover a hospital organization's financial assistance (charity care) policy, policies related to emergency medical care, billing and collections, and charges for medical care. In addition, hospital organizations must conduct community health needs assessments for tax years beginning after March 23, 2012.

Part V, Facility Information has been expanded to include a Section A in which a hospital organization must list its hospital facilities (facilities that were required to be licensed under state law at any time during the tax year). Section B, Facility Policies and Practices, also has been added to report the information on policies and practices noted above. A separate Section B must be completed for each hospital facility listed in Section A.

Financial Assistance and Certain Other Community Benefits

This section requires the reporting of the hospital's financial assistance policies, the availability of community benefit reports and the cost of financial assistance and other community benefit programs. Financial assistance includes free or discounted care provided to people who meet the hospital's criteria for financial assistance.

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It does not include bad debts or uncollectible charges where the hospital originally recorded the revenue but wrote it off due to the patient's failure to pay. Also excluded from this computation is the difference between the cost of providing care to Medicaid and Medicare patients and the revenue derived from such care, and contractual adjustments with any third-party payers.

In the instructions to Schedule H, the IRS has included optional worksheets to assist in completing the information. Regardless of whether these worksheets or alternative documentation are used, the organization is required to retain such information to substantiate the information reported. The information should be completed using the organization's most accurate costing methodology (cost accounting system, cost-to-charges ratio, a combination, or some other method).

Information required to be reported includes whether the hospital had a written policy that explains the eligibility for financial assistance, whether such policy included free or discounted care, what criteria was used (Federal Poverty Guidelines or other guidelines), how the amounts charged to patients was calculated and measures taken to publicize the policy to the community served.

Facility Information

All of the organization's hospital facilities must be listed in order of size from largest to smallest. The list must include licensed facilities (licensed by the state as a hospital), general medical and surgical facilities (those primarily engaged in diagnostic and medical treatment), children's hospitals, teaching hospitals, critical access hospitals, research facilities, facilities that operate emergency rooms and any other hospital facility that is not described above.

Community Health Needs Assessment

A community health needs assessment must take into account input from people who represent the broad interests of the community served by the hospital including those with expertise in public health. Health needs assessments must be conducted at least once every three years beginning with the tax year beginning after March 23, 2012. The health needs assessment may include a definition of the community served, demographics of the community, existing health care facilities that are available to respond to the health needs of the community, how the data was obtained, the health needs of the community, primary and chronic disease needs of the community's uninsured and low income persons, the process for identifying and prioritizing the community health needs, the process for consulting with people representing the community's interests, etc. This needs assessment generally should be made available to the public.

Billing and Collections Policy

This section requires the hospital to report whether it had a separate written billing and collections policy or written financial assistance policy that explains actions the hospital may take against individuals upon non-payment, including reporting to a credit agency, lawsuits, liens on residences, etc. IRC section 501(r) requires a hospital to forgo extraordinary collection actions before the facility has made reasonable efforts to determine eligibility under its financial assistance plan. If the hospital took the actions noted above before determining eligibility, then those actions must be reported. The hospital must also indicate what efforts it made before initiating these actions, such as notifying patients of the financial assistance policy upon admission, prior to discharge, in communications with the patients regarding the patient's bills, and/or documented its determination of whether the patient was eligible for financial assistance under its policy.

Policies Related to Emergency Medical Care

The hospital must report whether it has a written policy regarding emergency medical care that required the hospital to provide, without discrimination, care for emergency medical conditions to individuals without regard to their eligibility under the hospital's financial assistance policy. If not, the hospital is required to report why it does not have such a policy.

Charges for Medical Care

The hospital must report how it determined the maximum amounts that can be charged to patients for emergency or other medically necessary care for patients who are eligible for financial assistance. The hospital must also disclose whether they charged patients who were eligible for assistance under its policies amounts that were greater than amounts billed to individuals who were covered by insurance and amounts that were equal to its gross charges.

Article written by Richard M. Lipman, CPA, Health Care Partner

Presentation and Disclosure of Patient Service Revenue

Update Summary

Some health care entities recognize patient service revenue at the time the services are rendered—regardless of whether the entity expects to collect that amount. Interested parties have raised concerns that such accounting practices result in a gross-up of patient service revenue and the related provision for bad debts. In addition, because health care entities make their own judgments regarding adjustments to revenue and bad debts, those judgments are different from one health care entity to another and comparability is impaired, making analysis difficult for financial statement users.

The objective of this Update is to provide financial statement users with greater transparency about a health care entity's ***net patient service revenue*** *and the related* ***allowance for doubtful accounts*** *(ASU) No. 2011-07.* This FASB Update provides information to assist financial statement users in assessing an entity's sources of net patient service revenue and related changes in its allowance for doubtful accounts. The amendments require health care entities that recognize significant amounts of patient service revenue at the time the services are rendered even though they do not assess the patient's ability to pay to present the provision for bad debts related to patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) on their statement of operations.

Who's Affected?

The amendments in this Update affect entities that recognize significant amounts of patient service revenue at the time services are rendered even though the entities do not assess a patient's ability to pay. All other entities would continue to present the provision for bad debts (including bad debts associated with patient service revenue) as an operating expense.

Main Provisions

The amendments in this Update require certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts.

Changes in U.S. GAAP

The amendments in this Update change the presentation of the statement of operations and add new disclosures that are not required under current Generally Accepted Accounting Principles (GAAP) for entities within the scope of this Update. The provision for bad debts associated with patient service revenue for certain entities is required to be presented on a separate line as a deduction from patient service revenue (net of contractual allowances and discounts) in the statement of operations. This change in the presentation of the statement of operations will be an improvement from current GAAP because it will result in the presentation of an amount of net patient service revenue (after any provision for bad debts) that is closer to the amount that the health care entity expects to collect. The new disclosures will assist users of financial statements to better understand how health care entities recognize patient service revenue and assess bad debts.

Effective Dates

For public entities, the amendments in this Update are effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2011, with early adoption permitted. ***For nonpublic entities, the amendments are effective for the first annual period ending after December 15, 2012***, and interim and annual periods thereafter, with early adoption permitted. The amendments to the presentation of the provision for bad debts related to patient service revenue in the statement of operations should be applied retrospectively to all prior periods presented. The disclosures required by the amendments in this Update should be provided for the period of adoption and subsequent reporting periods.

Disclosure—Receivables

A health care entity that recognizes significant amounts of patient service revenue at the time the services are rendered even though it does not assess the patient's ability to pay shall disclose both of the following for interim and annual periods:

a. Its policy for assessing the timing and amount of uncollectible patient service revenue recognized as bad debts by major payor source of revenue. Major payor sources of revenue shall be identified by the entity and be consistent with how the entity manages its business (i.e. how it assesses credit risk). For example, one entity's accounting system may classify patient accounts receivables arising from deductibles and coinsurance as part of third-party receivables, another may classify deductibles and coinsurance as self-pay receivables, and another may classify deductibles and coinsurance as either third-party or self-pay receivables on the basis of which party has the primary remaining financial responsibility.

b. Qualitative and quantitative information about significant changes in the allowance for doubtful accounts related to patient accounts receivable. This may include information such as significant changes in estimates and underlying assumptions, the amount of self-pay writeoffs, the amount of third-party payor writeoffs, and other unusual transactions impacting the allowance for doubtful accounts.

Implementation Guidance and Illustrations

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, Entity A analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

For receivables associated with services provided to patients who have third-party coverage, Entity A analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization

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