



**hfma**

healthcare financial management association

## **Principles and Practices Board Statement 15**

# **Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers**

December 2012

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## I. Introduction

**1.1** As the magnitude of unreimbursed care grows, so does the urgency to report uncompensated care—and to distinguish between charity care and bad debt—clearly and comparably. However, current reporting practices are inconsistent and contribute to confusion about the amount of charity care healthcare facilities provide and the amount of bad debt facilities have. Statement 15 seeks to provide clarity on this important topic.

**1.2** Appropriate classification of charity care and bad debts is often difficult. The urgency of some treatments, as well as certain federal regulations, often requires the provision of service without consideration of the ability to pay. Some patients have complex medical conditions with unpredictable treatment needs. Also, the complex billing and payment arrangements for healthcare services, including the involvement of government agencies and third-party payers, often result in processing and payment delays. All of these factors must be considered when evaluating the amount of collections, the cost of bad debts, the time required to collect accounts, and management's control over receivables.

**1.3** Bad debts result when a patient who has been determined to have the financial capacity to pay for healthcare services is unwilling to settle the claim, whereas charity care is provided to a patient with demonstrated inability to pay. Determining each patient's ability to pay and the amount of service eligible for charity support is complex, requires judgment, and is the topic of this statement.

**1.4** While hospitals are the most high-profile providers of charity care, these guidelines are applicable to all taxable and tax-exempt institutional healthcare providers, including skilled nursing facilities, subacute care facilities, multispecialty clinics, freestanding ambulatory centers, and continuing care retirement communities. This guidance does not apply to facilities under GASB.

## History of Statement 15

In 1978, HFMA's Principles and Practices (P&P) Board first issued Statement No. 2, which provided a basis for differentiating between charity care and bad debts. The statement reflected the generally accepted accounting principles (GAAP) of the time, and noted that while the differentiation was helpful, the financial accounting and reporting of charity care and bad debts were the same.

In 1990, the American Institute of Certified Public Accountants (AICPA) published (after review and approval by the Financial Accounting Standards Board) an extensive revision of *Audits of Providers of Health Care Services*. This audit guide substantially changed the reporting of bad debts and eliminated charity care from revenue. The revised guide also required disclosure of the entity's policy for providing charity care and the level of charity provided. In 1996 the guide was again revised extensively (and renamed the *AICPA Audit and Accounting Guide, Health Care Organizations*) but the 1990 guide's provisions relating to bad debts and charity care were not changed.

The P&P Board revised its Statement No. 2 to conform to the revised 1990 guide and to provide direction on implementation of the revised 1990 guide's requirements. In 1993, the Board replaced Statement No. 2 with Statement No. 15. In January 1997, Statement No. 15 was reviewed for conformity with the 1996 guide and technical references were updated.

In 2006, Statement No. 15 was again updated to improve clarity and address congressional and legal questions about the charity reporting practices of tax-exempt hospitals. In 2012, Statement No. 15 was reviewed and updated to conform with the 2011 guide and technical references. While there are a wide range of policy and business processes involved in the reporting of charity care and bad debt, the scope of this statement is specifically to recommend best accounting and financial reporting practices for these types of uncompensated care.

## II. The Importance of Properly Reporting Charity Care and Bad Debt

**2.1** The 2011 AICPA audit guide and the current guidance, in accordance with Accounting Standards Codification (ASC) 954-310: *Health Care Entities-Receivables* and ASC 954-605: *Health Care Entities-Revenue Recognition*, generally require the following with respect to reporting bad debts and charity care:

- Classify bad debts as a deduction from patient service revenue,
- Eliminate charity care from both revenue and receivables, and
- Disclose the charity care policy and the amount of charity care provided.

**2.2** In addition to audit requirements, it is necessary to differentiate charity care from bad debts because:

- Charity care represents the consumption of valuable uncompensated resources that must be managed wisely.
- Charity care is an important indicator of the fulfillment of an organization's charitable purposes and, therefore, should be clearly identified and disclosed.
- Rigorous separating of charity care from bad debt is critical to the disclosure of charity care and community benefit reports.
- Bad debt expense is one key measure of the organization's revenue cycle effectiveness. This is particularly important because additional credit risk is being placed on providers as patient copayments increase.
- Distinguishing between charity and bad debt is important for compliance purposes and for extending discounts based on a demonstrable financial need.

**2.3** All types of healthcare providers, including tax-exempt, governmental, and investor-owned, need to differentiate bad debts from charity care. The extent of disclosure about charity care will be influenced by the organization's mission and the amount of these services provided.

**2.4** The extent of disclosure also is affected by state requirements, since reporting requirements for charity care vary widely by state and locality. Description of these ever-changing reporting requirements is beyond the scope of this statement and should be monitored through appropriate government information services and state health associations.

**2.5** It is worthwhile to note that charity care is only one type of community benefit provided by healthcare organizations. There is a wide range of other community benefits, such as education, research, and essential or unprofitable services that can be important evidence of fulfillment of mission and can help identify the reasons an organization qualifies for tax exemption. These services are normally addressed in the community benefit disclosure footnote, but are not addressed in this statement, with the exception of Section XI, which addresses the P&P Board's views on the classification and disclosure of government program payment shortfalls. Additional resources on the reporting of community benefits are listed in Appendix A.

## III. Criteria for Charity Care

**3.1** No single set of criteria for charity care policies is universally applicable. Each institutional provider of healthcare services must establish its own policies that are consistent with the organization's mission and financial ability, as well as with state laws. Examples of the wide range of influences on an organization's charity care policy include:

- Some providers have financial resources dedicated to the provision of charity care, such as philanthropy, state or local tax revenues, or designated federal resources.
- Some providers serve wealthy communities, while others are located in areas with many low-income residents.
- Some communities support public hospitals with a special mission to serve indigent patients.
- Some institutions provide specialized services that influence their charity care policies.

- 3.2** Charity care and bad debt policies should be clearly documented and approved by the provider's governing body. The existence and basic eligibility criteria of these policies should be communicated to patients and the community.
- 3.3** Eligibility criteria for charity care or discounts are often based on a percentage of the federal poverty guidelines (which are set by the Department of Health and Human Services to determine financial eligibility for certain federal programs) or the eligibility guidelines used for Housing and Urban Development programs. States may also have charity care criteria for specific purposes. Providers must be able to identify patients who fulfill these criteria for relevant government programs (see paragraph 3.7 for discussion of cases where insufficient information for charity care determinations is available). Where state regulations exist, they represent minimum standards, but individual organizations' policies may be broader.
- 3.4** When determining eligibility for a provider's financial assistance program, a number of factors must be considered, all of which require judgment. Thus, the expectation that criteria can be applied rigidly is unrealistic. By allowing for some flexibility in charity care eligibility standards, providers can avoid rigid or complex programs that are difficult for staff to carry out and for patients to understand. Similarly, criteria may be more detailed and call for more specific evidence of eligibility for large amounts of charity care than for small amounts.
- 3.5** Eligibility criteria for charity care could include many factors. The following list provides examples, but is not definitive:
- 3.5(a)** *Individual or family income*, which may take into account family size, geographic area, and other pertinent factors. Individual or family income generally is not the exclusive criterion for determining the appropriate amount of charity care.
  - 3.5(b)** *Individual or family net worth*, which considers liquid and nonliquid assets owned, less liabilities and claims against assets. It should be noted that when gathering this information from the patient, it is useful to clarify whether this information will be used solely to determine eligibility or whether the assets would be considered as a possible source of payment.
  - 3.5(c)** *Employment status*, criteria for which should consider the likelihood of future earnings sufficient to meet the healthcare-related obligation within a reasonable period of time.
  - 3.5(d)** *Other financial obligations*, for example, living expenses and other items of a reasonable and necessary nature.
  - 3.5(e)** *Amount and frequency of healthcare bills*, or the potential for medical indigence (sometimes referred to as medical hardship), must be considered in relation to all the other factors outlined above. The history of service and the need for future service by the institution or other providers may be considered. In these cases, a separate determination of the amount of charity care for which a patient is eligible is made on each occasion of service, or regular confirmation of eligibility is made during extended programs of service.
  - 3.5(f)** *Other financial resources available to the patient*, such as Medicaid and other public assistance programs, will affect the determination of the appropriate amount of charity care.
- 3.6** Different providers may apply similar criteria differently. For example, a patient with catastrophic healthcare costs but with substantial net worth may be eligible for charity care by one provider, but another provider may require that net worth in excess of a threshold be used to pay for healthcare services before the patient is eligible for charity care. Some providers may be able to establish automatic criteria for certain classes of patients (such as for noncovered services to Medicaid patients), and other providers may require case-by-case determination.
- 3.7** Determining the amount of charity care for which a patient is eligible is based in large part on information supplied by the patient or someone acting on the patient's behalf. The charity care policy should address eligibility for charity care when there is insufficient information provided by the patient to fully evaluate all the criteria and the ability to pay cannot be reliably determined. Policies may refer to external sources such as credit reports or Medicaid enrollment to help support such determinations.

**3.8** Data used to determine eligibility for charity care should be verified to the extent practical in relation to the amount involved and the significance of an element of information in the overall determination. Similarly, a single element of information may be sufficient to make a reasonable determination, and additional investigation may not be cost-effective. The procedures implementing the charity care policy should address the extent of verification necessary and any modification of a determination already made if subsequent findings indicate the information relied upon was in error.

**3.9** In gathering information about charity care eligibility, providers should ensure their financial communications and counseling are clear, concise, correct, and considerate of the needs of patients and family members, in accordance with the principles of the PATIENT FRIENDLY BILLING® project. (The Patient Friendly Billing project is a nationwide initiative to improve financial communications with patients. For more information, visit <http://www.hfma.org/pfb>.)

## IV. Timing of Charity Care Eligibility Determinations

**4.1** The P&P Board recommends providers make every practical effort to make charity care eligibility determinations before or at the time of service (in compliance with state agency reimbursement requirements regarding determinations). However, determinations can be made at any time during the revenue cycle, and there should be no rigid time limit for when determinations are made, because in some cases, eligibility is readily apparent, while in other cases, investigation is required to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information.

**4.2** For clarity of financial reporting, it is desirable (and is customary in other industries) to determine eligibility for discounts or free care based on whether the individual fulfills the provider's charity care criteria at the time service is rendered. However, the special circumstances surrounding healthcare services (notably, EMTALA regulations requiring the provision of emergency care before discussing patient financial information), combined with the potential for medical indigence that develops after the time of service, make it more appropriate for the provider to define a window of eligibility for their charity care policy, based on community needs and the facility's available resources. Therefore, in addition to qualifications regarding capacity to pay, policies should address the time frame within which patients are eligible if the provider wishes to accommodate unexpected changes in a patient's ability to pay that occur after the time that service is provided.

**4.2(a)** For example, if a patient agreed to a payment plan that was reasonable in relation to his or her circumstances at the time, but the patient subsequently lost his or her job and became unable to pay under the plan, the provider may cover that subsequent change under its charity care policy.

**4.2(b)** Alternatively, if a patient who was eligible for charity care when service was rendered subsequently experiences a positive change in his or her ability to pay for the services provided, the provider may bill the patient for services rendered.

**4.3** Collection efforts can yield essential information about the amount of charity care for which a patient is eligible. Commencement of collection efforts does not alter the patient's financial status. A provider's collection efforts, including the use of outside collection agencies, are part of the information collection process and can appropriately result in identification of eligibility for charity care.

**4.3(a)** Collection agencies should demonstrate consistency with the provider's customer service and Patient Friendly Billing policies.

**4.4** For a service to be considered charity care, the provider must make reasonable attempts to notify the patient of the determination and make no further attempt to collect anything (except in cases where sliding-scale payments are part of a charity care policy).

## V. Recordkeeping for Charity Care

**5.1** According to the AICPA audit guide, charity care is not to be reported in revenue or receivables. However, it is often not known whether services will meet charity care criteria at the time the services are rendered, so there is no alternative to keeping records for charity care in the same manner as for any other service. Similar to the recordkeeping for bad debts (Section VIII), the use of separate accounts for a charity care provision and the related allowance is usually necessary.

**5.2** The appropriate recordkeeping steps for charity care related to charges are:

**5.2(a)** Record services at the full-established charges amount in revenue and receivables as services are rendered, as consistent with all other services.

**5.2(b)** Adjust revenue and receivables to the amount that a payer (or payers) has an obligation to pay. If it is possible to determine that an amount qualifies as charity care, it is written off immediately as described in step 5.2(d). If collection efforts are needed to identify patients who qualify for charity care, it is generally necessary to make an estimate, as described in step 5.2(c).

**5.2(c)** Estimate the amount of the remaining receivables that will eventually be written off as charity care. This amount is recorded as a provision for charity care (a revenue contra account) and an allowance for charity care (a receivable contra account). The supporting documentation for the estimation of charity care should be retained.

**5.2(d)** Write off receivables as they are subsequently determined to meet charity care criteria against the allowance for charity care. Documentation concerning the eligibility for charity care should be retained.

**5.2(e)** Regularly evaluate the adequacy of the allowance for charity care, with adjustments to increase or decrease the allowance offset by adjustments in the provision for charity care. The frequency of evaluation should be based on the healthcare provider's charity care policy.

## VI. Valuation of Charity Care

**6.1** Although charges are the basis for charity care recordkeeping purposes, costs, not charges, should be the primary reporting unit for valuing charity care. Accounting Standards Update (ASU) – Health Care Entities (Topic 654): *Measuring Charity Care for Disclosure*, was issued to reduce the diversity of practice regarding the measurement basis used. The ASU requires that cost be used as the measurement basis for charity care. By contrast, there is great variance among providers' charges, and consequently very little comparability. Also, measures on charges provide little and potentially misleading information about the resources consumed in providing charity care.

**6.2** In accordance with ASC paragraph 954-605-50-3, costs of charity care should be measured based on the provider's direct and indirect costs. If costs cannot be specifically attributed to services provided to charity care patients (for example, based on a cost accounting system), management may estimate the costs of those services using reasonable techniques. The method used to identify or estimate such costs should be clearly disclosed in the footnote.

**6.3** In addition to care provided at no charge, providers' charity care policies usually include sliding-scale discounts for low-income, uninsured patients who have the ability to pay a small portion of their bills. Discounts offered under these policies are accounted for as a reduction of revenue.

**6.3(a)** Once a patient is determined to be eligible for a discount under the facility's charity care policy, the whole account is classified as charity care. As payments are received, revenue is recognized as receipts relating to charity care.

**6.3(b)** If a patient is not eligible for discounts under the facility's charity care policy, then any subsequent discounts, such as reduction to the standard managed care rate or a prompt pay discount, should not be accounted for as charity care. This is an important distinction, because only the charity care provided is included in disclosure footnotes.

## VII. Disclosure of Charity Care

7.1 The goal of charity care disclosure is to identify the net cost related to charity care, as determined by the total cost of charity care services less any patient-related revenue due to sliding-scale payments or other patient-specific sources. Financial statement presentation requirements result in an absence of information about the provision of charity care from the face of the statement of operations (also called the statement of revenues and expenses).

7.2 A provider's mission or volume of charity care may make it important to include information about the provision of charity care on the face of the statement of operations. The P&P Board concludes such disclosure should generally be limited to a reference to the note that discusses the provision of charity care. In that note, the quantity of charity care should be expressed in relation to costs, with disclosure of how the costs are calculated. The quantity of charity care expressed in relation to cost may be included with the references to operating expense or the total expense notes. More than one reference is appropriate if more than one method of quantification is used.

7.3 The P&P Board recommends footnoted disclosure that patients go into the charity care category if their accounts include a discounted patient-pay portion under the facility's charity care policy (as discussed in section 6.3). Calculations should include all accounts, including sliding scale adjustments. The reimbursement calculation needs to include all accounts if any portion of an account that qualifies for charity care includes amounts received or expected.

7.4 In presenting financial statement footnotes for charity care, financial managers should be careful to disclose information that is objective, auditable, and not misleading. Although the current authoritative guidance on charity care provides alternatives, the P&P Board concludes that a single footnote with all information about the provision of charity care will best meet the needs of financial statement users. This footnote should include:

- A clear description of the organization's charity care policy (see paragraph 7.5),
- The cost of charity care provided (see paragraph 7.6),
- The volume (also sometimes referred to as the units, amount, value, quantity, or level) of charity care provided (see paragraphs 7.7, 7.7(a), and 7.7(b)), and
- Receipts relating to charity care, (see paragraph 10.1).

7.5 **Charity care policy.** Detailed disclosure of the organization's charity care policy is required, including discounted rates for uninsured or underinsured patients. The note about this policy may include information such as the following:

The XYZ Hospital provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. The criteria for charity care consider (describe criteria, such as family income, net worth, extent of financial obligations for healthcare services, etc.).

Discounts are provided on a sliding scale based on (describe discount criteria).

7.6 **Financial value of charity care.** Footnote disclosure of cost information should describe the cost estimation method used. The note on charity care might provide the following disclosure based on cost:

The net cost of charity care provided was approximately \$xx,xxx in 20x1 and \$xx,xxx in 20x2. The total cost estimate is based on (describe the cost estimation method). The net cost of charity care is determined by the total charity care cost less any payments for patient service revenue due to sliding-scale payments or other patient-specific sources, which were \$x,xxx in 20x1 and \$x,xxx in 20x2.

**7.7 Volume of service.** Units of service, statistical information about the number of patients receiving charity care, or the proportion of service provided on a charity basis should also be included in the note on charity care. Disclosure of statistical information or the proportion of services related to charity by itself does not give a clear picture of the financial value of these services, but can help describe the breadth of service and the values that are not fully described in financial terms. The following wording could be included in the note to describe the proportion of services provided on a charity basis:

In 20x1, xx% of all services (as defined by [measurement]) was provided on a charity basis. In 20x2, xx% of services (similarly measured) was charity.

**7.7(a)** Units of service or statistical disclosure should include information that describes the relative significance of charity care. For example, a more detailed breakdown of charity patients or services compared to all patients or services may be provided, such as:

In 20x1, xxx inpatients out of xxx total and xxx outpatients out of xxx total received charity care. In 20x2, xxx inpatients out of xxx total and xxx outpatients out of xxx total received charity care.

**7.7(b)** Details about the types of services may be included with wording such as:

The largest proportion of services provided on a charity basis was for (describe service, such as cancer, emergency services, etc.).

**7.8** To further describe the relative significance of charity care provided, alternative or additional statistical disclosure such as the following may be included:

In 20x1, of a total of xxx inpatients, xxx received their entire episode of service on a charity basis and xxx received a partial subsidy. In 20x2, of a total of xxx inpatients, xxx received full charity and xxx received partial subsidy.

## VIII. Recordkeeping for Bad Debts

**8.1** Consistent with the discussion of charity care in Section V, bad debts are recorded as follows:

**8.1(a)** Services are recorded at the full-established charges amount in revenue, and receivables are recorded as services are rendered. However, revenue should be recognized only when it meets GAAP's revenue recognition criteria. The P&P Board believes that the core principles of GAAP (see FASB Concept Statement No. 6, *Elements of Financial Statements*, and FASB Statement No. 117, *Financial Statements of Not-for-Profit Organizations*) require the following criteria:

- Pervasive evidence exists of a payment agreement between the provider and the patient,
- Services have been rendered,
- The price is fixed or determinable, and
- Collectibility is reasonably assured.

Many patients who are uninsured or have high-deductible plans may not meet the collectibility criteria, and thus, those amounts should not be recognized as revenue at the time of service. In these instances, revenue should be recognized only when collections are reasonably assured and for an amount that is determinable.

**8.1(b)** If a self-pay patient account does not meet the collectibility criteria, charged amounts may not be recognized as revenue at the time of service. In these instances, no determination of bad debt should be made until sufficient financial information is gathered to reach a payment agreement or a determination of charity care. Revenue should be recognized only when collections are reasonably assured and for an amount that is determinable. The provider's charity care policy should address instances in which patients do not provide sufficient information to make a determination. In situations not addressed in the policy, amounts expected to be collected are classified as bad debt. The facility's policy should define the criteria for a collection to be reasonably assured.

**8.1(c)** The receivable amount is adjusted to the expected payment amount, with an offsetting amount recorded in a revenue contra account.

**8.1(d)** As expected payments are determined to be uncollectible, they are written off against the allowance for bad debts. Documentation concerning the collection effort and result should be retained.

**8.1(e)** The adequacy of the allowance for bad debts is evaluated regularly, with adjustments to increase or decrease the allowance offset by adjustments in the provision for bad debts. The frequency of evaluation should be based on the healthcare provider's policy.

**8.2** Ideally, bad debt determinations, like charity care determinations, should be made as close to the time of service as practical. No determination should be made, however, until there is sufficient evidence to support the determination, based on the patient's financial or other qualifying status, as determined by the facility's revenue cycle policies.

**8.3** Estimates are necessary to record patient accounts receivable and recognize revenue. Historical collection results by payer are often used for initial revenue estimation with updates made as additional information becomes available. Accounts such as "pending Medicaid" or "pending charity" are commonly used. Any changes in estimates are accounted for in the most recent reporting period.

**8.4** Expected medical indigence as a criterion for charity care is discussed in Paragraph 3.5(e). In the absence of such provisions, healthcare providers should have policies to recognize situations of unexpected financial hardship after service is rendered and allow the write-off of such adjustments promptly, before any significant collection efforts are undertaken. These policies should be consistent with Patient Friendly Billing principles.

**8.5** If new information is discovered during the collections process that reveals a patient was eligible for charity care, then reclassification of the bad debt to charity care is appropriate.

## IX. Recognition and Disclosure of Bad Debts

**9.1** FASB ASU – Health Care Entities (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*, was issued to provide greater transparency about net patient service revenue and the related allowance for doubtful accounts. 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 healthcare entity expects to collect that amount.

**9.2** The provision for contractual adjustments (that is, the difference between established rates and expected third-party payer payments) and discounts (that is, 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.

**9.3** A healthcare 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:

**9.3 (a)** Its policy for assessing the timing and amount of uncollectible patient service revenue recognized as bad debts by major payer source of revenue. Major payer sources of revenue shall be identified by the entity and be consistent with how the entity manages its business (for example, 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.

**9.3 (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 write-offs, the amount of third-party payer write-offs, and other unusual transactions impacting the allowance for doubtful accounts.

## X. Classification of Receipts Relating to Charity Care

**10.1** Healthcare providers may receive funds (other than Medicaid or Medicare disproportionate share adjustments and Medicaid provider-specific tax programs) to offset the general cost of charity care without relation to specific cases or services. This type of support can be provided by foundations, local tax support, or other sources. These payments (or accrued revenue related to firm commitments of such support) are generally recorded as other revenue. If these amounts are of a sufficient size to be separately disclosed in the operating statement, captions such as the following might be used: "Local tax support received," or "XYZ Foundation support received." Whether or not this revenue is separately disclosed on the operating statement, the charity care note should disclose this type of support with wording such as:

Funds for the support of charity care were received from (name or describe the source). The amount received was \$xx,xxx in 20x1 and \$xx,xxx in 20x2. These amounts are included in other revenue.

## XI. Classification and Disclosure of Payment Shortfalls

**11.1** If Medicaid or similar government programs pay less than the provider's cost of rendering the services, the difference (shortfall) between the payment amount and cost should be disclosed as a community benefit, but should not be identified as charity care. Wording such as the following might be used:

In addition to charity care, ABC hospital provided services under the XYZ program for financially needy patients, for which the payments received were less than the cost of providing the services. The unpaid costs attributable to providing services under this program, which are considered a community benefit, were estimated to be \$xx,xxx in 20x1 and \$xx,xxx in 20x2.

**11.2** Medicare shortfalls, if disclosed, should be treated separately, because the program serves all elderly and disabled beneficiaries, regardless of income. This difference has resulted in a wide diversity of practice regarding the inclusion of Medicare shortfalls as community benefit. The P&P Board acknowledges that Medicare shortfalls can be an important issue for many providers, and that such losses can be material to the facility's financial status. The P&P Board concludes that each hospital should decide, based on its circumstances, whether Medicare shortfalls should be part of its community benefit disclosure. In all cases where Medicare shortfalls are disclosed, the disclosure should be separate from charity care and accompanied by sufficient detail and context to help readers understand each reported cost calculation.

## XII. APPENDIX A: RESOURCES

### Charity and Bad Debt Valuation and Reporting

1. *Audit and Accounting Guide, Health Care Organizations*, The American Institute of Certified Public Accountants, 2011.
2. FASB ASU—Health Care Entities (Topic 954): *Measuring Charity Care for Disclosure*.  
<http://www.fasb.org/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobkey=id&blobwhere=1175821172671&blobheader=application%2Fpdf>
3. FASB ASU—Health Care Entities (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*.  
<http://www.fasb.org/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobkey=id&blobwhere=1175822797036&blobheader=application%2Fpdf>
4. Kovener, Ronald, *Chart of Accounts for Hospitals: An Accounting and Reporting Reference Guide*, McGraw Hill, 1999.

### Community Benefit Reporting

5. HFMA Principles & Practices Board, *Issue Analysis 05-01, The Relationship of Community Benefit to Hospital Tax-Exempt Status*, Healthcare Financial Management Association, 2005.  
<http://www.hfma.org/PandPBoardStatements>
6. *Hospitals Share Insights to Improve Financial Policies for Uninsured and Underinsured Patients: A Report from the PATIENT FRIENDLY BILLING® Project and the Patient Friendly Billing Project Worksheet for Reviewing Financial Assistance Policies*.  
<http://www.hfma.org/pfb>
7. Internal Revenue Service, Section 501(r), added to the Code by the Affordable Care Act, new requirements on 501(c)(3) organizations.  
[http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501\(c\)\(3\)-Hospitals-Under-the-Affordable-Care-Act](http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act)

### Patient Communications

8. The Patient Friendly Billing Project.  
<http://www.hfma.org/pfb>

### **XIII. PRINCIPLES AND PRACTICES BOARD MEMBERS, 2006-07 and 2012-13**

#### **2006-07 PRINCIPLES AND PRACTICES BOARD MEMBERS**

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