



hfma[™]

healthcare financial management association

By Electronic Filing June 1, 2008

Internal Revenue Service
Draft 2008 Form 990 Instructions, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

RE: COMMENTS ON DRAFT FORM 990, SCHEDULE H, AND SELECTED OTHER INSTRUCTIONS

The Healthcare Financial Management Association's (HFMA's) Principles and Practices Board appreciates the opportunity to formally comment on the draft Form 990 and Schedule H instructions, and we especially applaud the ongoing efforts the IRS has made to get input from the healthcare community. Throughout the IRS's informal deliberations and discussions with HFMA and provider associations, we have been able to share extensive recommendations and observations. Therefore in these formal comments we will concentrate instead on selected specific points that we believe are of paramount importance.

Minimizing administrative burden

We appreciate the interest and objectives of Congress and others to ensure that tax-exempt status is granted appropriately. However, we have learned from past governmental approaches to oversight that overly burdensome reporting discourages the creation of, and impedes the functioning of, nongovernmental entities, many of which fill important societal needs that government will not or cannot meet. Minimizing burden and providing flexibility in reporting is paramount to the continuation of the critical services provided by many charitable, tax-exempt organizations.

Although much effort has gone into assessing the additional reporting burden that will result from the proposed revisions, those efforts cannot provide the insight that comes from actually completing the forms with real data from live records. There is much to be learned from the hospitals that will be performing "dry runs" of applying the Revised Form 990 reporting requirements to 2008 returns. Therefore, we repeat HFMA's recommendation from its September 2007 comment letter that because of the magnitude of the substantial new requirements, the IRS should permit hospitals to submit comments to the IRS into 2009 to share what they learn from applying the new requirements, and allow you the opportunity to respond with supplemental or updated instructions before

making the first official use of the new forms effective for the 2009 reporting year (to be submitted in 2010).

Reference to HFMA Statement 15

The clarification is appropriate in the draft instructions for Schedule H, Part III, Section A, that hospitals are not required to adopt or rely on the HFMA's Principles & Practices Board Statement No. 15 (*Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Providers*), as is the assurance that a "no" response to the related question at Line 1 in Part III, Section A will not reflect poorly on an organization or otherwise be used to target an organization for an audit.

Statement 15 is intended to provide guidance in areas where additional guidance or interpretation is needed regarding the documentation and disclosure requirements of the Financial Accounting Standards Board and the American Institute of Certified Public Accountants' *Audit and Accounting Guide, Health Care Organizations*. We believe IRS interest in the reporting practices recommended by Statement 15 will serve to promote positive change in the healthcare industry.

Cost vs. net recognized revenue

We strongly recommend that the Schedule H instructions stress the clear and crucial distinction between the *cost* of care (which is the basis for measuring charity care) and the *net, recognized amount* of revenue (which is the basis for measuring bad debt).

Charity care is an indicator of the degree to which low-income, usually uninsured individuals require subsidized care because they are unable to pay for the services they need. In the current health policy debate, accurate charity data are important for understanding and evaluating efforts to ensure indigent populations have adequate health coverage and access to care. Cost-based reporting is an appropriate method to evaluate the financial consequences of such policies and, by extension, an important category of charitable service.

Bad debt is fundamentally different. It is the amount of revenue that a hospital expects to receive for a service, but that the payer does not pay. When reporting revenue for patient services that is foregone because of bad debt, such revenue should be recognized only when it meets the following GAAP 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

Cost-based reporting of bad debt is inappropriate, because these revenue amounts have a varying relationship to cost, ranging from cost-plus-margin to cost-minus-discount, depending on the hospital's policies and the individual's income level.

Bad debt is both an indicator of operational efficiency for hospitals and a measure of the degree to which payers honor an agreement to pay their debt. In the current health policy debate, accurate bad debt data are especially important for understanding consumers' behavior as insurance benefit designs shift more financial obligations to individuals. If this distinction is not crystal clear to both reporters and users of this data, the opportunity to understand these very different categories of uncompensated care is largely lost.

Bad debt footnotes

Line 4 requires an organization to provide the text of the footnote to the organization's financial statements that describes bad debt expense. The draft instructions further provide that footnotes related to "accounts receivable," "allowance for doubtful accounts," or similar designations may satisfy this reporting requirement. We concur with the American Hospital Association's concern that many healthcare organizations' financial statements may not contain footnotes relating to bad debt expense or any similar footnotes or designations. The instructions to this question should clarify that organizations are not required to create footnotes in financial statements regarding bad debt expense or to satisfy this question.

Worksheets

We commend the IRS for the clarification provided in the Highlights to Schedule H regarding the completion of the Worksheets or alternative, equivalent documentation. We recommend that similar language be used to maintain that clarity within the Schedule H Instructions.

We concur with the American Hospital Association's suggestion of the following regarding the language for Worksheet 1 changes related to Medicaid:

Line 4: Enter the amount of Medicaid provider taxes paid by the organization, if payments received from an uncompensated care pool or Medicaid Disproportionate Share Hospital (DSH) program in the organization's home state are intended primarily to offset the cost of charity care. If such payments are primarily intended to offset the cost of Medicaid services, then report this amount in Worksheet 3, Line 4(A).

"Medicaid provider taxes," sometimes termed a "fee" or "assessment," or "health care related tax," means amounts paid or transferred by the organization to one or more states as a mechanism to generate federal Medicaid funds.

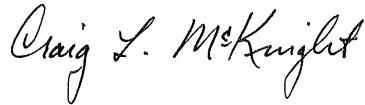
Conclusion

The revised Form 990, Schedule H, and instructions offer tremendous potential to bring the role of tax-exempt hospitals in our healthcare system into sharper focus than ever before, which in turn provides unprecedented opportunity to evaluate health policy decisions, as well as regulatory compliance, on a factual, quantifiable level. However,

achieving this potential is a profoundly complex undertaking that will require continuous learning and dialogue.

HFMA's Principles and Practices Board again applauds the IRS for its efforts to work with the healthcare community. As always, we are at your service to help ensure the final reporting rules strike an appropriate balance between oversight and reporting. If we can provide additional background material or perspective on this complex issue, please contact Richard Gundling, Vice President of HFMA's Washington, DC, office at (202) 296-2920.

Sincerely,

A handwritten signature in black ink that reads "Craig L. McKnight". The signature is written in a cursive, flowing style.

Craig L. McKnight, CPA
P&P Board Chair

About HFMA

HFMA is the nation's leading membership organization for more than 35,000 healthcare financial management professionals. Our members are widely diverse, employed by a variety of healthcare providers, accounting and consulting firms, and insurance companies. Members' positions range from chief executive officer and chief financial officer to patient accounts manager and accountant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve health care by identifying and bridging gaps in knowledge, best practices, and standards.

About HFMA's Principles & Practices Board

HFMA established the Principles and Practices Board in 1975 to reevaluate, clarify, and establish accounting principles and financial reporting practices to meet the unique characteristics of health service organizations.

The P&P Board consists of twelve members who have demonstrated technical competence in the industry and possess outstanding personal and professional qualities. At least six members must be employees of provider organizations; six or fewer members must work in organizations that serve the industry.