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INTRODUCTION

It is the policy of Catholic Health Initiatives, its tax-exempt Direct Affiliates1 and tax-exempt Subsidiaries2 (hereafter collectively referred to as “CHI”) to provide medically necessary health care to all patients, without regard to the patient’s financial ability to pay, at each facility (whether operated directly or through a joint venture) that is required by a state to be licensed, registered or similarly recognized as a hospital.

A CHI-sponsored facility under a joint operating agreement (JOA) shall adopt the CHI charity care policy unless adoption is not permitted by language contained in the applicable JOA. Facilities shall consider charity care obligations in agreeing upon the terms and conditions of JOAs and joint ventures.

As Catholic health care providers and tax-exempt organizations, CHI is called to meet the needs of patients and others who seek care, regardless of their financial abilities to pay for services provided.

In addition, most CHI entities are designated as charitable (i.e. tax-exempt) organizations under Internal Revenue Code (IRC) Section 501(c)(3). Pursuant to IRC Section 501(r), in order to remain tax-exempt, each tax-exempt hospital is required to adopt and widely publicize its financial assistance policy.

The purpose of this document is to establish CHI standard procedures for identifying and recording charity care services and other discounts and to address how CHI calculates amounts charged to patients. Other discounts include self-pay for uninsured patients with the ability to pay and third-part discounts for non-contracted payers. The terms charity care and financial assistance are used interchangeably throughout this document.

Facility revenue cycle teams along with facility leadership are responsible for the implementation of this policy in accordance with these procedures.

The provision of charity care and other discounts may now or in the future be subject to federal, state or local law. Such law governs to the extent it imposes more stringent requirements than this policy.

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1 A Direct Affiliate is any corporation of which CHI is the sole corporate member or sole shareholder.
2 A Subsidiary refers to either an organization, whether nonprofit or for-profit, in which a Direct Affiliate holds the power to appoint a majority of the voting members of the governing body of such organization or any organization in which a Subsidiary holds such power.
DEFINITIONS

Financial Assistance – Financial Assistance is defined as care provided to patients without expectation of payment for services as a result of a patient’s financial inability to pay. The terms charity care and financial assistance are used interchangeably throughout this document.

Hospital Facility or Facility – A CHI facility that is required by a State to be licensed, registered or similarly recognized as a hospital.

Medical Necessity - Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or avert the worsening of conditions that endanger life; cause suffering or pain; result in illness or infirmity; threaten to cause or aggravate a handicap; or cause physical deformity or malfunction; if there is no other equally effective, more conservative or less costly course of treatment available.

Medically Indigent Patients - Those patients whose health insurance, if any, does not provide full coverage for all of their medical expenses, in relationship to their income, [and] would make them indigent if they were forced to pay full charges for their medical expenses.

Self-pay Discounts for Uninsured Patients – The discount extended to those patients/guarantors that provide evidence that no health insurance coverage exists either through an employer-provided program or a governmental program such as Medicare, Medicaid or other state and local program to pay for health care services rendered to the patient.

Third Party Discounts – Those discounts offered to those third-party payors who do not have an existing contract in effect with the hospital. The discount is offered for various reasons including for example, expediting payments (payment in a specified number of days) or in lieu of an audit.

Uninsured Patients – Those patients without coverage for their medical expenses.
PROCEDURES

SECTION I – Financial Assistance

After an assessment of financial ability, CHI may provide free or discounted care to patients who qualify for financial assistance under this financial assistance policy. CHI will follow standard procedures in determining eligibility for financial assistance and in collecting on delinquent patient accounts as follows:

1. Eligibility Criteria – Medical Necessity

   a. EMTALA

   Consistent with the principles of a Catholic faith-based healthcare ministry, any patient seeking urgent or emergent care (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) at a CHI hospital shall be treated without discrimination, and without regard to a patient’s ability to pay for care. CHI hospitals shall operate in accordance with all federal and state requirements for the provision of health care services, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). CHI hospitals should consult and be guided by their emergency services policy, EMTALA regulations and applicable Medicare / Medicaid Conditions of Participation in determining what constitutes an urgent or emergent condition and the processes to be followed with respect to each.

   Eligibility for free or discounted care, if any, for urgent or emergent services is outlined in “Eligibility Criteria– Financial Ability” below.

   b. Other Medically Necessary Services

   CHI will extend free or discounted care to eligible individuals for all medically necessary services. While patients visiting from out of country and requiring emergency services are eligible for financial assistance, patients visiting the U.S. with an intent of receiving non-emergent care in the United States are not eligible for financial assistance. The patient/guarantor must make arrangements and pay for care prospectively.

2. Eligibility Criteria – Financial Ability

   a. Basic Financial Ability

   Financial assistance for medically necessary services is available on a sliding scale of up to 100% of charges, and up to a full waiver of co-payments after third-party insurance proceeds based on indigence. A discount up to 100% will be extended to those uninsured or underinsured patients whose family income is equal to or less than 130% of the HUD
Geographic Very-Low Income Guidelines. Lesser discounts are available, based on individual facility guidelines, to those patients with incomes that exceed 130% of the HUD Geographic Very-Low Income Guidelines.

b. Medical Indigence - Financial Ability

Patients may also be extended a discount based upon medical indigency. A determination as to a patient’s medical indigency takes into consideration significant and/or catastrophic medical bills not covered by insurance in addition to the patient’s income level and liquid assets.

For example, a patient suffering a catastrophic illness may have a reasonable level of income, but a low level of liquid assets such that the payment of medical bills would be seriously detrimental to the patient’s basic financial (and ultimately physical) well-being and survival. Such a patient may be extended discounted or free care based upon the facts and circumstances.

CHI facilities’ charity care committees have discretion as to whether to extend a discount related to patient accounts that do not clearly qualify under the basic financial ability criteria (i.e. those to be considered for financial assistance on the basis of medical indigency). Extension of financial assistance based on medical indigency will be based upon the committee’s review of documents in addition to documents evidencing income.

Those documents may include but are not limited to:
- Letter from physician confirming medical necessity of services provided
- Copies of unpaid patient / guarantor medical bills
- Information related to patient / guarantor drug costs
- Evidence of multiple instances of high-dollar patient / guarantor co-pays, deductibles, etc.
- Other evidence of high-dollar amounts related to health care costs.
- Information concerning available insurance coverage
- Information concerning available liquid assets
3. Applying for Financial Assistance

a. Registration and Presentation of Financial Assistance Information

Upon registration, and after all EMTALA requirements are met, patients without Medicare / Medicaid, other local health care financial assistance, and adequate health insurance shall receive either (1) a packet of information that addresses the financial assistance policy and procedures or (2) immediate financial counseling assistance from staff, including the presentation of the application for financial assistance (if requested).

1) Emergent Patients - Patients receiving emergent services shall be treated in accordance with the hospital’s emergency services policy, developed in accordance with EMTALA and other requirements. The emergency department will have a reasonable registration process. A reasonable registration process shall include asking whether an individual is insured and, if so, the name of the insurance program utilized, if such inquiry does not delay screening or treatment, or unduly discourage patients from remaining for further evaluation.

2) Non-Emergent / Elective Patients - Non emergent / elective patients without Medicare / Medicaid, other local health care financial assistance, and adequate health insurance shall receive either (1) a packet of information that addresses the financial assistance policy and procedures or (2) immediate financial counseling assistance from staff, including the presentation of the application for financial assistance (if requested).

b. Completion of Application / Presumptive Eligibility

In general, patients requesting financial assistance will be required to complete the CHI Financial Assistance Application Form (as adapted) in order to establish eligibility. In certain situations the financial assistance application process may be instituted by the facility as presumptive charity care.

Some patients are presumed to be eligible for charity care discounts on the basis of individual life circumstances (e.g. homelessness, patients who have no income, patients who have qualified for other financial assistance programs, etc.) Facilities shall grant only 100% charity care discounts to patients determined to have presumptive charity care eligibility.

1) Each facility shall utilize the applicable CHI Financial Assistance Application Form(s), adapting them by adding any additional requirements necessary to accommodate local programs and circumstances.

See attached Exhibit 4: CHI Financial Assistance Application Form – Presumptive Eligibility (1 page, Word document)

To allow the facility to properly evaluate financial assistance eligibility, documents provided by patients to the facility shall be written in English.

2) Each facility shall utilize the CHI Financial Assistance Determination Checklist, adapting it by adding any additional requirements necessary to accommodate local programs and circumstances.


4. Review and Processing Financial Assistance Applications

An established financial assistance assessment methodology, applied consistently, shall be adopted by each facility. The methodology shall consider income, family size, available resources and the likelihood of future earnings (net of living expenses) sufficient to pay for health care services.

a. Evaluation of Resources

All available financial resources shall be evaluated before determining financial assistance eligibility. That evaluation may include eligibility for benefits provided by governmental agencies and other third parties. Facilities shall consider financial resources not only of the patient, but also of other persons having legal responsibility to provide for the patient (e.g. the parent of a minor child or patient’s spouse). The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers’ compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs.

• Note: The term “patient/guarantor” sometimes is used subsequently in this document to refer collectively to the patient as well as any such other person(s) having legal responsibility for the patient. Persons who have a legal responsibility for the patient may include a parent or parents for a minor child, an executor of the estate for a deceased patient, a person holding a valid financial power of attorney for a patient, and a court-appointed guardian for a patient (usually incompetent) when the court order grants financial powers to the guardian. Some powers of attorney and guardianship orders are limited to healthcare decision-making only, so it is important to check the scope of the powers granted before pursuing payment from someone who is assumed to be legally responsible for a patient.
In evaluating the financial ability of a patient/guarantor to pay for health care services, questions may arise as to the patient/guarantor’s legal responsibility for purported dependents. While legal responsibility for another person is a question of state law (and may be subject to Medicaid restrictions), the patient/guarantor’s most recently-filed federal income tax form shall be reviewed to determine whether an individual should be considered a dependent. The patient/guarantor shall provide employment information for the patient/guarantor, as well as for any other individuals to whom the guarantor is legally obligated. Such information shall identify the length of service with the current employer, contact information to verify employment and the individual’s job title.

b. Eligibility for Assistance from Third Party Organizations

Information provided in the financial assistance application may indicate that a patient is eligible for financial assistance, insurance coverage, and other benefits through governmental agencies or third party organizations. Financial counseling staff shall assist patients in applying for available coverage.

Facilities that contract with organizations to assist patients in applying for federal, state or other assistance shall ensure that such agreements are in writing and contain provisions requiring compliance with CHI Standards of Conduct, maintain patient confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, and delineate compliance with all applicable laws and regulations including the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

c. Documentation

All information obtained from patients, family members, and external resources, shall be treated as confidential. Assurances about confidentiality of patient information shall be provided to patients in both written and oral communications. Application forms shall provide documentation of all income sources on a monthly and annual basis (taking into consideration seasonal employment and temporary increases and/or decreases in income) for the patient/guarantor, including the following evidence of:

- Income from wages
- Income from self-employment
- Alimony
- Child support
- Military family-allotments
- Public assistance
- Pension
- Social Security
- Strike benefits
• Unemployment compensation
• Workers’ compensation
• Veterans’ benefits
• Other sources, such as income from dividends, interest or rental property

Copies of documents to substantiate income levels shall be obtained (e.g., pay check stubs, alimony and child-support documents).

Assessment forms may provide for a recap of average monthly expenses including:

• Rental or mortgage payments
• Utilities
• Car payments
• Food
• Medical bills

For situations in which patients have other assets, liquid assets shall be defined as investments that could be converted into cash within one year; these assets shall be evaluated as cash available to meet essential living expenses. Assets that shall not be considered as available to meet living expenses include: a patient’s primary place of residence; adequate transportation; adequate life insurance; and sufficient financial reserves to provide normal living expenses if the wage earners are unemployed or disabled. Listings of other assets shall be provided, including copies of the following documents:

• Savings, certificates of deposit, money-market or credit union accounts
• Descriptions of owned property

The patient/guarantor shall provide demographic information for the patient/guarantor. The patient/guarantor shall provide information about family members and/or dependents residing with the patient/guarantor, including the following information:

• Name, address, phone number (both work and home)
• Age
• Relationship

Copies of rent receipts, utility receipts or monthly bank statements may be requested

d. Establishing Amount of Charity Care Discount

Eligibility for charity care discounts shall be determined based on 130% of the annually updated HUD Geographic Very-Low Income Guidelines, available assets, and any circumstances. Thus the standards of eligibility for the application of charity discounts must consider assets as well as income. Any patient whose income is equal to or less than 130% of
HUD Geographic Very-Low Income Guidelines is eligible for a full charity care write-off, provided that the individual does not have significant assets. The facility may not require the individual to have a lower income such as 120% of the HUD Guidelines in order to qualify for a full charity care write-off. These HUD guidelines take into consideration family incomes that do not exceed 50% of the median family income for the geographic area and using a sliding scale approach based on income and family size. The guidelines are available at the office of HUD Guideline of Policy Development and Research website at http://www.huduser.org/datasets/il/html. Datasets may be downloaded in PDF, Word or Excel formats.

See attached Exhibit 3: 130% of the annually updated HUD Very-Low Income Guidelines as the base (Updated January 28, 2010), including Instructions and Application Example: Little Rock AR (8 pages, Excel document).

- The need for future services requiring financial assistance shall be assessed.
- Separate determinations of eligibility for charity care discounts shall be made for each date of service for all medically necessary services.
- Confirmation of continued eligibility shall be updated every 90 days for patients who require ongoing health care services i.e.; therapeutic services or repeated laboratory work.
- If the patient has received charity within the past 90-days, facilities shall revalidate the patient’s financial condition, before charity is granted.
- Determination of eligibility for charity care discounts shall occur as closely as possible to the time of the provision of service to enable the facilities to properly record the related revenues, net of charity care allowances. The objective is to provide financial relief for those people who are truly in need. When charity assistance is not identified at the time of service CHI will generally allow applications within 18 months of the date of service.

e. Waiver of Co-payments and Deductibles

- Medicare and Medicaid - Facilities shall not routinely waive co-payments and deductibles for Medicare or Medicaid patients. Medicare and Medicaid patients are eligible for charity care on those co-payments if they qualify as underinsured. Facilities may consider patients with Medicare primary and Medicaid secondary as eligible for presumptive charity assistance if no application or payment in full is made after the 120 day statement cycle prior to sending to collections.

- Third-Party Insurance - Facilities shall not routinely waive co-payment and deductibles for third party insurance. There may be a requirement within a managed care agreement to pursue patients for their portion of the payment amount (i.e. co-payments). Patients with third party insurance are eligible for charity care on co-payments and deductibles if they qualify as underinsured. Patients with health spending accounts
(HSAs) are considered to have insurance if the HSA is used only for deductibles and co-payments (i.e. the patient has insurance to cover the remainder of the patient’s bill). Deductibles and co-payments are not eligible for any discount.

f. Authorization – The authorization of charity care discounts shall be provided pursuant to either Level 1 or Level 2 authority as noted below. Facilities will determine authority level based upon size and will inform the Finance and Audit Committee. The Finance and Audit Committee will be kept apprised of charity activities. It shall be the facility’s responsibility to train and ensure that the financial counselor/representative level receives education on this policy.

Level 1 Authority:
- Up to $1,000 – financial counselor/representative level
- Up to $5,000 – Director level
- Up to $25,000 – CFO/Vice President of Finance
- Charity Committee: $25,000 and above

Level 2 Authority:
- Up to $2,500 – financial counselor/representative level
- Up to $25,000 – Director level
- Up to $100,000 – CFO/Vice President of Finance
- Charity Committee – $100,000 and above

g. Approved Financial Assistance – Patients / guarantors shall be notified when the facility determines the amount of financial assistance discount eligibility related to services provided by the facility. Patients/ guarantors shall be advised that such eligibility does not include services provided by non-facility employees or other independent contractors (i.e. independent physicians, physician practices, anesthesiologists, radiologists, pathologists, etc. depending on the circumstances). The patient/guarantor shall be informed that periodic verification of financial status shall be required in the event of future services.

h. Denied Financial Assistance – Patients / guarantors shall be informed in writing if financial assistance is denied and a brief explanation shall be given for the determination provided. All denials must be credible and done with the highest integrity; the facilities need to be comfortable with their reasons for determining that the patient is not eligible for financial assistance.

i. Record Retention – Records maintained by the facility to substantiate eligibility for charity care shall be completed in English. Facilities shall retain a central file by each patient/guarantor containing financial assistance applications. Copies of written approval and denial letters for charity care, including denial reasons, shall be retained in a
confidential central file. Such documentation may include the patient’s application and other supporting materials. Files will be maintained for seven years from the date of approval or denial.

5. Charity Care Review Committee

Each facility shall establish a Charity Care Review Committee to assist in the evaluation of information related to patient accounts that do not clearly qualify under basic charity care discount eligibility criteria.

a. The types of patient accounts to be reviewed by the Committee shall include, but not be limited to, the following:

- Patients with extenuating circumstances (e.g., patients who may be medically indigent, patients who may have presumptive eligibility for a charity care discount, etc.).
- Patients who appear to have excessive discretionary spending such as payments for tanning salon services, expensive accessories for their vehicle, vacations, electronic equipment etc.
- Patients who have significant non-liquid assets
- Patients whose eligibility exceeds -130% of the HUD Very Low Income Guidelines and thus are not eligible for charity care discounts on the sliding scale, but whose medical bills are so large that they are unable to pay.
- Any questionable situations.

b. The Committee shall be comprised of hospital employees and chaired by a senior management representative. At a minimum, membership shall include a social worker and staff from mission/ministry, general accounting and patient financial services. Other members may be appointed to the Committee as deemed appropriate by the facility.

c. The Committee shall meet as needed, depending on facility size, nature of patient population and frequency and types of charity care discounts provided. For large facilities, meetings will be required on at least a monthly basis and at times more often. For small facilities, meetings may be required only once every one to three months.

d. The agenda for each meeting shall be comprised of patient cases requiring additional review and input by the Committee prior to the determination of charity care discount eligibility. For each patient case, the agenda will include a summary of the case, the financial situation of the patient and other pertinent information as necessary.

e. Documentation of the Committee’s meetings shall be recorded. Actions related to specific patients shall be included in the central file as discussed in Section 4. i. above (“Record Retention”).
6. **Limit on Charges**

Charges for medical care provided to uninsured patients will be limited to not more than the amounts generally billed to those individuals who have insurance.

7. **Publicizing Availability of Financial Assistance**

Each facility shall clearly post signage in English to advise patients of the availability of financial assistance. Signs shall be posted in other languages in instances where 10% or more of the local population speaks a foreign language. Every effort will be made to ensure that, for patients speaking languages other than those for which the charity guidelines are printed, the policies are clearly communicated.

Each facility is required to maintain packets of information explaining that the facility provides care, without regard to ability to pay, to individuals with limited financial resources, and shall explain how patients can apply for financial assistance. In instances in which there are a significant number of patients not proficient in reading and writing, additional assistance shall be made available to complete necessary forms. In addition, facilities with 10% or more non-English speaking populations shall prepare informational notices in each of the languages that account for 10% or more of the population.

Each facility will publish the CHI Hospital Financial Assistance policy No. 15 to its hospital website, along with a link to the *CHI Financial Assistance Application Form*. Each facility is responsible for ensuring that this policy and associated application are available on the facility’s website at all times that the website is operational (or “up”). The policy must be published in English, but may be published in other languages after appropriate review of the translated document has been performed.

**SECTION II – Other Discounts (Other than Financial Assistance / Charity Care)**

Facilities shall not offer patient discounts in a manner prohibited by law (e.g., discounts used in connection with marketing healthcare services to potential patients or discounts that may influence patients to select a facility or related entity) or prohibited by contract (e.g., prohibitions contained in managed care organization [MCO] contracts).

Consistency shall be essential in the definition, communication, distribution and implementation of self-pay and third-party discounts standards among all facilities, and within functional areas of facilities (e.g., patient access, patient accounting, collection agents, satellite clinics, outpatient diagnostic, therapeutic and surgical centers, etc.).

1. **Self-Pay Discounts** – Self-pay discounts shall be given to all (a) patients with accounts that are 100% self-pay and who meet the definition of uninsured patients without the ability to pay or (b)
patients with accounts that are 100% self-pay and who are uninsured patients with the ability to pay or (c) patients who have insurance but whose services are 100% non-covered by that insurance. Those patients with an HSA without third-party coverage shall qualify for self-pay discounts.

2. **Prompt-Pay Discounts** – CHI does not offer prompt pay discounts.

3. **Third-Party Discounts** – Third-party discounts, for accounts in which there are no contracts between the insurers and the facilities, shall be permitted *only* under certain circumstances.

   - Third-party discounts shall be permitted under certain circumstances to non-contracted primary payors.

   - Third-party discounts to non-contracted secondary payors (e.g., Medigap, etc.) shall not be permitted.

   - Discounts to non-contracted primary payors may be made available only if the balance is paid in full within 30 days of the initial billing date or agreed upon date with the facility, and the payor does not dispute the charges and services rendered. If charges are found by the facility to be in error, the payer will be allowed 30 days from receipt of a corrected claim to pay; payments past the agreed upon time frame may not be eligible for the third-party discount.

   - Discounts applied to payments received within the applicable time frame shall be allowed *up to the self-pay* discount rate. This discount will be made in conjunction with the managed care department. As part of the prompt pay discount with a non-contracted provider the patient will only be responsible for in network benefits. The facility will work with the patient to ensure the patient gets the maximum discount.

*Most* states have a *clean claim* statute that requires payment within 45 days of receipt by the payor of a clean claim. These state statutes shall mitigate the need to discount billed charges for non-contracted payors.

A facility in a state with a clean claim statute may offer third-party discounts to *non-contracted* payors, if it is deemed necessary and sufficient documentation is maintained (i.e., the average payment period for these payors consistently exceeds the payment period identified in the *clean claim* statute).

Cases in litigation shall be considered settlements and amounts due to CHI as a result of that litigation shall not qualify for third party discounts.

4. **Package Programs** – Hospital services, procedures and programs for which (a) third-party payors in general do not cover the services/procedures (e.g., cosmetic surgery, clinical research trials,
bariatric surgery, etc.) and (b) the patient is self pay, the patient shall not be extended a self pay discounts on the package procedures.

Any package offer shall be provided to all patients who receive the service, irrespective of payor category, subject to the limitations noted above.

To the extent that a patient receiving services under a package program is uninsured / underinsured and the procedure has been determined to be medically necessary, the patient should be considered for a financial assistance discount pursuant to Section I.

Members of CHI Participating Congregations - Discounts to members of CHI participating congregations shall be covered by separate guidance. Guidance is contained in Governance Policy #3 – “Relationship CHI Sponsoring Congregations” which can be found on Inside CHI at the following location:

- National / About CHI / National Policies & Procedures / Governance

SECTION III – Accounting

1. Recording Charity Care – Each facility shall properly distinguish write-offs of patient accounts between charity care and bad debt expenses. Such amounts shall be recorded in accordance with generally accepted accounting principles and properly disclosed in financial statements and other reports.

2. Generally Accepted Accounting Principles – The AICPA Audit and Accounting Guide for Health Care Organizations [AAG-HCO] is the current guidance for reporting charity care and bad debt expense in an entity’s financial statements.

   a. Section 10.03 of the AAG-HCO states the following, with regard to distinguishing bad debt expense from charity care:

   Distinguishing bad-debt expense from charity care requires judgment. Only the portion of a patient's account that meets the entity's charity care criteria should be recognized as charity. FASB ASC 954-605-25-11 states that although it is not necessary for the entity to make this determination on admission or registration of an individual, at some point the entity must determine that the individual meets the established criteria for charity care. Charity care represents health care services that were provided but were never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements.

   b. Each facility shall write off patient accounts in one of the following two categories:

      • Charity care – consisting of:
Patients with no third-party payment source and for whom there is no expectation of payment
Patients with a third party payment source however they are underinsured and they do not have sufficient assets for payment

… Or …

Medicare (and Medicaid if applicable in the particular state) patients who are determined to be financially unable to pay applicable co-payment obligations, in which case the unpaid co-payment qualifies as charity care for the facility and can be claimed on any filing for reimbursement as a Medicare (Medicaid) bad debt.

- Bad debts – consisting of patients who have the ability to pay for health care services (including those with private insurance), where the patient or insurer does not pay the applicable obligation.

3. **Self-pay Discounts** – unless otherwise mandated by local law which would require a more specific discount, an average managed care contractual allowances rate shall be developed annually. Annual calculation of the average managed care discount shall be made in January / February of each year in order to allow for incorporation into the annual budget. Implementation of the new rate will be applied to patient accounts with service or discharge dates beginning on July 1 of the fiscal year. The discount shall be calculated by each facility by dividing the total amount of managed care contractual allowances, (excluding managed care Medicare and managed care Medicaid plans) for the most recent fiscal year, by the total gross charges for those managed care plans to determine a discount rate that shall be used for the upcoming fiscal year, as follows:

\[
\text{Discount Percentage} = \frac{\text{Total managed care contractual allowances}}{\text{Total managed care gross charges}}
\]

Federal, state, local and county entitlement programs shall be excluded from the above calculation (i.e., disregard the discounts and charges from such plans).

The self-pay discount rate shall be based on the average managed care contractual allowances rate at the specific facility, applied to final gross charges. The facility shall include appropriate documentation to support the percentage used and shall be approved by the facility finance committee or board on an annual basis.

The self-pay discount will be taken at time of billing. If a patient is later determined to qualify for a charity discount, the self pay discount should be reversed and the total charge amount would qualify for the appropriate charity care discount. If there is a balance remaining on the account after the charity discount has been applied, that balance would qualify for the self pay only discount.

4. **Third-party Discounts** – shall be mapped to a revenues deduction account in the facility general ledger and shall be recorded as a revenues deduction item in the financial statements in the same period the discount is earned.
Third-party discounts shall be posted to patient accounts only when payment is received in full to satisfy the entire payor financial obligation. When interim payments are made, these payments shall be posted to the patient account as received; however, the discount shall be posted to the account only if the final interim payment is received and occurs within the stated discount period.

A tracking mechanism shall be developed and maintained in the facility patient accounting system to quantify the number of accounts and associated amounts related to third-party discounts. This tracking mechanism/code shall be called third party discounts and shall measure only third-party discounts. This code shall be unique to third-party prompt-pay discounts and shall not be used for any other type of adjustment posted to a patient account.

5. Members of CHI Participating Congregations

Discounts for members of CHI participating congregations shall be recorded on a standardized basis in all facility patient accounting systems.

Guidance concerning benefits provided to CHI Participating Congregations is contained in Governance Policy #3 – “Relationship CHI Sponsoring Congregations” which can be found on Inside CHI at the following location:

- National / About CHI / National Policies & Procedures / Governance

Discounts for members of CHI participating congregations shall be posted to patient accounts as soon as the discount has been determined.

A tracking mechanism shall be developed and maintained in the facility patient accounting system to quantify the number of accounts and associated amounts related to participating congregation discounts. This tracking mechanism/code shall be called participating congregation discounts and shall measure only participating congregation discounts. This code shall be unique and shall not be used for any other type of adjustment posted to a patient account.

Participating congregation discounts shall be mapped to a revenues deduction account in the facility general ledger and shall be recorded as a revenues deduction item in the financial statements in the same period the discount is earned.

6. Financial Statement Disclosures – Each facility shall provide charity care information as requested by the National Financial Reporting department via the audit template so information about the amount of charity care will be included in the consolidated year-end CHI community benefit disclosure. FASB issued ASU No. 2011-07. Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, provision for Bad Debts and Allowance for Doubtful Accounts for Certain Health Care Entities which provides guidance on the
presentation of bad debt expense and disclosures of patient service revenue (net of contractual services), as well as qualitative information about changes in the allowance for doubtful accounts. Please direct specific questions related to the implementation of this ASU and disclosures to the National Financial Reporting department.

7. **IRS Reporting** – Each facility shall include the cost of charity care, along with other community benefit data in the IRS Form 990, Schedule H. Facilities are encouraged to publicize this information in notices to the local community.

8. **Charity Care Write-Offs** – Charity care is netted against gross revenues and, therefore, does not appear in the facility statements of operations as a separate line item. As a practical matter, this essentially meets the accounting requirement that charity care revenue not be recorded since it is immediately written off or allowed for in the allowance calculation described below. The amounts written-off should be tracked for comparison with both the amounts budgeted for charity care and prior-period charity care. The cost of providing charity care to patients is comingled with the expense in the facility statements of operations.

Where scholarships are provided for community health education programs, the waived tuition or fee amounts should be tracked and reported as part of the community benefit reporting process.

9. **Allowance for Charity Care** – There may be a lag between the time services are provided to patients and when the determination is made about the eligibility for charity care or financial assistance. As a result, facilities are required to establish an allowance methodology for estimating charity care. The following are the journal entries required to record the allowance for charity care. Facilities shall apply these accounting standards for all entities. These entries assume the facility is using the *indirect method* of recording charity care write-offs, whereby charity care write-offs are recorded against the allowance for charity care on the balance sheet.
a. To record monthly allowance for charity care:

<table>
<thead>
<tr>
<th>Journal Entry</th>
<th>Dr</th>
<th>Cr</th>
<th>Description of Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity care write-offs</td>
<td>X</td>
<td></td>
<td>Contra revenues account (statement of operations)</td>
</tr>
<tr>
<td>Allowance for charity care</td>
<td></td>
<td>X</td>
<td>Contra gross accounts receivable (balance sheet)</td>
</tr>
</tbody>
</table>

i. Monthly journal entries should be established for estimated charity care.

ii. The amount recorded will be the difference (debit or credit) between the allowance for charity care and the calculation of the required reserve performed by the facility on a monthly basis.

b. To record charity care write-offs:

<table>
<thead>
<tr>
<th>Journal Entry</th>
<th>Dr</th>
<th>Cr</th>
<th>Description of Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowance for charity care</td>
<td>X</td>
<td></td>
<td>Contra gross accounts receivable account (balance sheet)</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td></td>
<td>X</td>
<td>Accounts Receivable (Balance sheet account)</td>
</tr>
</tbody>
</table>

i. This transaction should be recorded in the patient billing system as accounts are processed and will be posted to the general ledger through the billing system interfaces.

c. To change the status of accounts receivable from bad debts to charity care discounts:

<table>
<thead>
<tr>
<th>Journal Entry</th>
<th>Dr</th>
<th>Cr</th>
<th>Description of Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reserve for bad debt</td>
<td>X</td>
<td></td>
<td>Contra gross accounts receivable (balance sheet)</td>
</tr>
<tr>
<td>Allowance for charity care</td>
<td></td>
<td>X</td>
<td>Contra gross accounts receivable account (balance sheet)</td>
</tr>
</tbody>
</table>

i. This transaction occurs when an account that was written off as a bad debt expense is subsequently determined to be a charity care patient account. Specific posting process to the general ledger dependant on billing application utilized within the market.