SHARON HOSPITAL POLICY AND PROCEDURE	REFERENCE # 007 PAGE 1 of 4
POLICY: Charity Care	**DATE ISSUED: 4/12/2002** **DATE REVISED: 2/04, 2/06, 2/08, 5/10, 2/11** **DATE REVIEWED: 2/06, 2/08, 5/10, 2/11, 6/14**
MANUAL: Financial Services	
SECTION: Billing	
ATTACHMENTS:	

Purpose: To provide services to residents of the community who are uninsured or underinsured and do not have adequate financial resources to pay for necessary healthcare services provided by the hospital.

Policy: It is the policy of the Hospital to provide a reasonable amount of its services without charge to eligible patients who cannot afford to pay for care.

All services of this facility will be available as uncompensated services. The determination should be made at admission, or as soon as possible, thereafter. Charity is defined as the demonstrated **inability of a patient to pay**, versus bad debt as the unwillingness of the patient to pay. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity and bad debt.

Charity care includes services provided to:

- Uninsured patients who do not have the ability to pay based on criteria set.
- Insured patients whose coverage is inadequate to cover a catastrophic situation.
- Emergency patients, because of the hospital's inability to assess a patient's financial situation prior to rendering services.
- Persons whose income is sufficient to pay for basic living costs but not medical care, and also those persons with generally adequate incomes who are suddenly faced with catastrophically large medical bills.
- Patients who demonstrate ability to pay part but not all of their liability.

Determination of eligibility for uncompensated care will remain valid for 6 months for all necessary hospital services. If there is a change in financial circumstances, an updated or new application must be completed.

The charity care budget will be established once a year during the annual budget process.

Write-offs $0-2,000 will be approved by the PFS Director. Write-offs over $2,000 will be approved by the CFO.

PROCEDURE:

1 Consider the following factors when determining the amount of charity service for which a patient is eligible at the time of service:

1.1 Patient must reside in the hospital's primary/secondary service area. Out of area applications will be reviewed upon the request of a physician or collection supervisor.

1.2 Gross income generally should fall within Hospital Charity Care Income Guidelines based on federal standards for determination of poverty level with consideration to family size, geographic area, and other pertinent factors.

1.3 Evaluate financial need by reviewing the completed Financial Statement Form.

1.4 Consider the amount(s) and frequency of hospital and other healthcare/medication related bill(s) in relation to all of the factors outlined above.

1.5 **All other applicable resources must be applied first, including third-party payers, Victims of Crime programs and Medicaid.**

1.6 If a patient does not have Medicaid but would qualify, he/she must cooperate with the application process. If the application is denied, consider for uncompensated care.

1.7 If the patient has Medicare but no secondary coverage and income is within the Federal Poverty Guidelines contained in this policy, and updated each April in the Federal Register, ask the patient to apply for Medicaid.

2 Determine the appropriate amount of charity service in relation to the amounts due after applying all other resources. A patient who can afford to pay for a portion of the services will be expected to do so. *If the patient does not pay the amount deemed to be his/her responsibility, the uncollectible remainder would become bad debt.*

2.1 If the charity care applicant is the guarantor on immediate family member's accounts and the family members reside in the guarantor's household, those accounts should be included in the charity care application.

3 **VERIFICATION** of Income must be provided with the application. Applicants are encouraged to provide multiple forms of income verification. Acceptable verification includes:

- Prior Year Tax Returns,

(or recent bank statement if tax information not available),

- Current Pay Stubs
- Written verification of wages from Employer
- Unemployment Letter

Credit reports may be utilized to evaluate eligibility as well.

-- If patient requesting charity does not have a tax return, a signed statement detailing the reason why they don't will be required.

4. Patients within the Federal Poverty Guidelines will automatically be approved on a semi-annual basis. Charity care provisions will be reevaluated for a patient's eligibility when the following occur:
   - Subsequent rendering of services
   - Income change
   - Family size change
   - When any part of the patient's account is written off as a bad debt or is in collections.
   - When six months has passed since the last application or when circumstances change, whichever comes first.

4.1 If patient has Medicaid, they are considered at the federal poverty level and would qualify for 100% charity for current and all past tax years. Upon submission of 1 (one) additional prior year tax return, the patient could be eligible for further consideration of charity.

5. Determine eligibility for charity service at the time of admission/registration, or as soon as possible thereafter.

6. Any hospital employee can inform patients about the charity program. Financial counselors or Business Office staff will initiate charity considerations.

7. Applications for charity care will be reviewed and approved within 15 business days after receipt of complete packet from the applicant.

8. PFS will retain all records relating to charity care for ten years.

10. Notify patients in writing, regarding approval, denial or pending of uncompensated/charity care.

11. Denials may be appealed with supporting documents that prove inability to pay that were not part of the initial consideration.

HOSPITAL CHARITY CARE INCOME GUIDELINES

Methodology: "Sliding Scale Method" with income guidelines as published in the Federal Register each April to determine the dollar amount to be considered as charity care for eligible patients utilizing the following procedure:

Procedure:

Family Size	2014 FPL	Maximum Income
1	$ 11,670.00	$ 29,175.00
2	$ 15,730.00	$ 39,325.00
3	$ 19,790.00	$ 49,475.00
4	$ 23,850.00	$ 59,625.00
5	$ 27,910.00	$ 69,775.00
6	$ 31,970.00	$ 79,925.00
7	$ 36,030.00	$ 90,075.00
8	$ 40,090.00	$ 100,225.00
9	$ 44,150.00	$ 110,375.00
10	$ 48,210.00	$ 120,525.00
11	$ 52,270.00	$ 130,675.00
12	$ 56,330.00	$ 140,825.00

If the patient's annual family income is below or equal to 100% of the Federal Poverty Limits then the patient responsibility is 0%.

If a patient's annual family income is below 250% of the Federal Poverty Limit but above 100% of the Federal Poverty Limit, use the following formula to calculate the percentage of charity write off to which the patient is entitled.

- Determine the annual household income.
- Use the Federal Poverty Limits Guidelines as established annually to determine the eligibility of medically needy individuals.
- Express the annual household income as a percentage of the Federal Poverty Limits.
- Divide the amount derived above by 150 percent. The resulting percentage is the amount the patient is responsibility percentage.
- Multiply the patient responsibility percentage times the unpaid balance to determine the amount owed.
- If the patient responsibility amount determined above is greater than 60% of the annual income amount, then the maximum patient responsibility is 60% of the annual income.
- Subtract the maximum patient responsibility determined above from the unpaid balance on the account. The resulting amount is the charity care write off amount.

Payment arrangements may be established when the patient has out of pocket. If the patient does not honor the payment arrangement or pay his/her share, the amount that did not qualify for charity will be considered bad debt.

Approved: 01.25.2012

Director, PFS – Ginger Betti

Accounting Policy Guide

Policy Description:	Allowance for Doubtful Accounts
Policy No:	104
Replaces Policy Dated:	March 1, 2012
Effective Date:	October 1, 2014

SCOPE:

All facilities affiliated with Regional Care Hospital Partners.

PURPOSE:

To provide guidance in accounting for allowances for doubtful accounts on patient receivables.

POLICY:

It is our policy to record all patient receivables at net realizable value each month end. Net realizable value is defined as the expected payment amount for each patient account. Patient accounts receivable are reported net of estimated allowances (i.e. contractual allowances, allowance for doubtful accounts, etc.).

PROCEDURES:

Each facility's allowance for doubtful accounts methodology is established by Corporate Operations and Corporate Finance based on historical collection information and hindsight analyses. Any changes to the facility's methodology must be reviewed and approved by the RCHP CFO, SVP of Financial Operations and the Corporate Controller.

Corporate management is responsible for establishing appropriate routine processes to review the adequacy of each facility's allowance methodology as well as the adequacy of the consolidated allowances. These processes will include a comparison of certain financial metrics such as cash collections to net revenue less bad debt expense, accounts receivable aging trends, Days Sales Outstanding (DSO), etc.

In general, our allowance policy is to reserve 100% of all net patient accounts receivable (net of contractual adjustments and excluding credit balance accounts) aged greater than 180 days after discharge plus a percentage of uninsured self pay receivables aged 180 days or less as determined by the Corporate Office based upon hindsight analyses and key receivables metrics. In certain circumstances an individual facility's allowance policy may be adjusted to more accurately reflect collections experience. See **Exhibits A and B – AFDA Calculation**.

Regardless of each facility's allowance methodology, any receivables aged greater than 180 days after discharge that are to be excluded from the facility's total allowance for doubtful accounts must be approved by the RCHP CFO, SVP of Financial Operations and the Corporate Controller. Each month, approval of the exception must be obtained and documented on the Approval of Exceptions to **Allowance for Doubtful Accounts Policy (Exhibit C).**

All facilities must utilize the worksheet established by the Corporate office to calculate the necessary allowance for doubtful accounts each month end. This worksheet should be used as supporting documentation for the monthly provision journal entry and for the allowance for doubtful accounts balance sheet account reconciliation. The allowance worksheets are due to the corporate offices in accordance with the **Monthly Financial Close Calendar.**

- **Net A/R Aging**
- **A/R Progression**
- **Cash Collections Trend**
- **DSO Computation**

RegionalCare HOSPITAL PARTNERS

Accounting Policy Guide

Policy Description:	Allowance for Doubtful Accounts
Policy No:	104
Replaces Policy Dated:	March 1, 2012
Effective Date:	October 1, 2014

Bad Debt Write-Offs

A patient account is considered to be a bad debt of the facility when there is no likelihood of collection within a reasonable period of time using normal and customary collection procedures and resources, including outside collection agencies. These collection efforts should be consistent between all payors and must be documented in the patient's account.

An account sent to the primary collection agency is not considered uncollectible until all collection efforts have been exhausted by the primary collection agency and the account is no longer an active claim at the collection agency. Accounts should be written off as a bad debt when it is returned from the primary collection agency. This applies to all payors. See **Reimbursement Policy** for Medicare bad debt write off recoveries.

Documentation should be maintained to evidence the date the account is placed with the primary collection agency and the date that it is returned to the facility (i.e. collection agency reports or communications indicating active and returned accounts).

All bad debt write-offs should be recorded as a debit to the allowance for doubtful accounts and a credit to accounts receivable on the balance sheet.

Proper documentation of the amount written off and the approvals obtained should be maintained by month. Any accounts receivable bad debt write-offs (net amount due) must be approved as follows:

- Billing Manager – All write-offs
- Business Office Director - $10,000 and over
- Facility CFO - $20,000 and over

EXHIBITS:

Exhibit A – AFDA Calculation for Hospitals and Hospital Based Clinics
Exhibit B – AFDA Calculation for Non-Hospital Based Clinics
Exhibit C – Approval of Exceptions to Allowance for Doubtful Accounts Policy

Approvals:

Michael Browder, EVP and CFO — Date: 10/20/14

Steve Wilson, VP and Corporate Controller — Date: 10/20/14

Exhibit A - AFDA Calculation for Hospitals and Hospital Based Clinics (i.e. ED, Anesthesia)

Facility or Clinic Name:

RegionalCare Hospital Partners | AFDA Exhibit | Monthend: 12/31/2013

Instructions: Complete the highlighted cells and record the calculated entry.

AR	Unbilled	Under 180	Over 180	Total
Total AR (debit balances)	$ 1,000	$ 1,000,000	$ 100,000	$ 1,101,000
Selfpay AR (debit balances)	$ 100	$ 100,000	$ 10,000	$ 110,100
Total Non Selfpay AR	$ 900	$ 900,000	$ 90,000	$ 990,900
RAC/MAC A/R Outstanding	$ -	$ 150,000	$ 50,000	$ 200,000
Non Selfpay A/R Excluding RAC/MAC	$ 900	$ 750,000	$ 40,000	$ 790,900
Client/Industrial AR	$ 10	$ 100	$ 1,000	$ 1,110

AFDA % Policy	Unbilled	Under 180	Over 180
Selfpay AR	77%	77%	100%
Non Selfpay	0%	0%	100%
Client/Industrial AR	0%	0%	100%

AFDA Calculation

Selfpay AFDA Calc	$ 77	$ 77,000	$ 10,000	$ 87,077
Non Selfpay AFDA Calc	$ -	$ -	$ 40,000	$ 40,000
Client/Industrial AR	$ -	$ -	$ 1,000	$ 1,000
	$ 77	$ 77,000	$ 51,000	$ 128,077

AFDA/CA Reclass %		
		$ 40,000
Historical Blended Contractual Allowance % per C/A Package		60.0%
	CA Reclass	$ 54,000

Total Allowance Required on AR	$ 128,077
Estimated Contractual Allowance on AR	$ 54,000
AFDA at Month End Required	$ 74,077
Balance Sheet AFDA prior to entry	$ 70,000
Adjustment Required to AFDA	$ 4,077

Estimated Contractual Allowance on AR	$ 54,000
Balance Sheet CA over 180 prior to entry	$ 60,000
Adjustment Required to CA over 180	$ (6,000)

ENTRY - GJ	Debit	Credit
AFDA Allowance	-	4,077
Bad Debt Expense	4,077	-
Contractual Allowance over 180	6,000	-
Contractual Expense over 180	-	6,000

Exhibit B - AFDA Calculation for Non Hospital Based Clinics

Clinic Name:

RegionalCare Hospital Partners | AFDA Exhibit | Monthend: 12/31/2013

Instructions: Complete the highlighted cells and record the calculated entry.

AR	Unbilled	Under 180	Over 180	Total
Total AR (debit balances)	$ 1,000	$ 1,000,000	$ 100,000	$ 1,101,000
Selfpay AR (debit balances)	$ 100	$ 100,000	$ 10,000	$ 110,100
Total Non Selfpay AR	$ 900	$ 900,000	$ 90,000	$ 990,900
Client/Industrial AR	$ 10	$ 100	$ 1,000	$ 1,110

AFDA % Policy	Unbilled	Under 180	Over 180
Selfpay AR	25%	25%	100%
Non Selfpay	0%	0%	100%
Client/Industrial AR	0%	0%	100%

AFDA Calculation

Selfpay AFDA Calc	$ 25	$ 25,000	$ 10,000	$ 35,025
Non Selfpay AFDA Calc	$ -	$ -	$ 90,000	$ 90,000
Client/Industrial AR	$ -	$ -	$ 1,000	$ 1,000
	$ 25	$ 25,000	$ 101,000	$ 126,025

AFDA/CA Reclass %		
		$ 90,000
Historical Blended Contractual Allowance % per C/A Package		60.0%
	CA Reclass	$ 54,000

Total Allowance Required on AR	$ 126,025
Estimated Contractual Allowance on AR	$ 54,000
AFDA at Month End Required	$ 72,025
Balance Sheet AFDA prior to entry	$ 120,000
Adjustment Required to AFDA	$ (47,975)

Estimated Contractual Allowance on AR	$ 54,000
Balance Sheet CA over 180 prior to entry	$ 60,000
Adjustment Required to CA over 180	$ (6,000)

ENTRY - GJ	Debit	Credit
AFDA Allowance	47,975	-
Bad Debt Expense	-	47,975
Contractual Allowance over 180	6,000	-
Contractual Expense over 180	-	6,000

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Exhibit C

Approval of Exceptions to Allowance for Doubtful Accounts Policy

Hospital Name: _____

Month: _____

Amount: _____

Description of Exception Requested:

Facility Level Approval _____ Hospital CFO	_____ Hospital CEO
Corporate Approval _____ SVP of Operations Finance _____ EVP and CFO	_____ VP and Corporate Controller