

8 Eight Financial Reporting Issues every CFO should know



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By Robert A. Wright, CPA

There is one certainty in the accounting world – standards will change. It is also certain that such change is very slow – much more of an evolution than a revolution. Five years ago, the American Institute of Certified Public Accountants (AICPA) formed the Health Care Organizations Audit and Accounting Guide Revision Task Force (Guide Task Force), initiating the process of completely overhauling the current guide.

During that time, new general standards have been issued and senior technical board, committee and staff members at the Financial Accounting Standards Board (FASB) and AICPA have changed. Add to that, new health care accounting issues have been identified as financial matters and transaction types in the industry have evolved. Originally, rewriting the guide was estimated to take about three years, but is now more likely to take twice as long. Currently, the Guide Task Force is presenting eight accounting recommendations and issues to the FASB for their consideration which will affect the final issuance of the new guide. Following is a review of each of these issues and their potential impact on health care providers.

Revenue Recognition for Self-Pay Patients

A basic revenue recognition principle for most industries is that revenue should not be recognized in the financial statements until collection is reasonably assured. This is not the case for most health care providers where revenue is recognized when services are provided (with a few exceptions such as charity care and other allowances) to self-pay patients. Hospitals typically record an allowance for bad debts to recognize the collection risk inherent in this class of payors. Services to self-pay (uninsured or underinsured) patients generally have low collection rates, so collection is not assured. The FASB has been asked to reexamine the revenue recognition principle for health care organizations for services to patients where collection is not reasonably assured. The Guide Task

Force recommends that the FASB move to recognize patient revenue in the health care industry when collection can be reasonably assured, as is the case in other industries. Once approved by the FASB, this change would significantly reduce bad debt expense for most health systems and hospitals. Revenue related to services performed for self-pay patients would essentially be recognized on a cash basis.

Measuring Charity Care

Financial statements of health care providers must present a measure of charity care in the notes to their financial statements. Currently, a provider may present this measurement using the provider's rates (charges foregone) for those services, cost of the charity services provided or some other statistical measure. In practice, most health care organizations use charges foregone as the measure of charity care provided. Years ago, the profession stopped requiring health care providers to disclose gross charge information in their financial statements. As a result, use of a charge-based measure for charity care disclosure is not very useful. Use of a cost measurement is viewed as more relevant because financial statements can relate a cost-based disclosure to the total costs of operations displayed in financial statements. The Guide Task Force is recommending to the FASB that a change to cost as the basis for measuring charity care would be an improved reporting standard. This is also consistent with guidance recently recommended by the HFMA Principles and Practices Board.

Managed Care Loss Contracts

Presently, the determination and measurement of managed care contract losses differs in the health care industry from that of the insurance industry. The Guide Task Force recommends to FASB that managed care contracts consider only costs that vary with, and are primarily related to, a contract (or group of contracts) in determining losses on such contracts. This change would bring health care contract accounting in line with insurance accounting principles.

Contributions of Long-Lived Assets

Contributions of long-lived assets such as fixed assets – or contributions to be used for the purpose of long-lived assets – are presently classified in a not-for-profit health care organization's statement of operations below the performance indicator (akin to net income in the for-profit world). Since long-lived assets are generally acquired or contributed for operational purposes, and in view of the fact that other contributions are classified as part of the performance indicator, the current practice appears to no longer seem appropriate. The Guide Task Force is recommending to the FASB that all contributions be included in the determination of the performance indicator.

Gross vs. Net Presentation of Insurance Claims and Related Insurance Reserves

There are inconsistencies in accounting literature as to whether accrued malpractice claims should display the total estimated liability as an accrual net of expected insurance recoveries or if the expected recoveries should be reported as a receivable in a health care provider's financial statements. The Guide Task Force has asked the FASB to resolve the inconsistencies in its literature. This issue has implications for other self-insured liabilities and other industries.

Discounting of Medical Malpractice Claims

Discounting accrued medical malpractice claims is permitted by current literature and is practiced widely by providers. Some believe that discounting may not be appropriate because the payment of claims, given their nature, generally is not fixed or readily determinable – criteria required for use of discounting. The Guide Task Force has asked the FASB to determine if discounting should be permitted for medical professional malpractice, and, if so, to clarify under what circumstances discounting should be permitted.

Further, the FASB has been asked to address the determination of the interest rate that should be used for discounting.

Medical Malpractice Confidence Level

Accrued medical malpractice claims are generally measured by actuaries for health care organizations. Some claim that the liability should be measured using an actuary's 50 percent confidence level as the best estimate of the liability under current requirements. Others believe that a higher confidence level produces a better estimate of the liability. There are differences in application between the health care industry and the insurance industry. The FASB has been asked to improve guidance to resolve these inconsistencies and address disclosure requirements around use of factors in these estimates.

Accounting for Transfers Between Unrelated Not-For-Profit Health Care Organizations

There appears to be diversity in practice in accounting for transfers, particularly of fixed assets, between unrelated not-for-profit organizations (i.e., from one hospital to another unrelated hospital). Some believe that such transfers may be recorded at book value. Others believe that these transfers must be recorded at fair value at the time of the transfer. The Guide Task Force has asked the FASB to clearly state the standard here to reduce diversity in practice. The Guide Task Force believes such transfers should be treated as contributions at fair value.

The FASB's response to these issues is unknown at this time. However, momentum to move forward with some of them is building in the industry and with interested organizations, such as the HFMA. The IRS is developing its new 990 Form embracing some of the revenue recognition and charity concepts. Also, HFMA's Principles and Practices Board has issued its own statement embracing these concepts.

The process of change is moving, but moving *very slowly!*



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