

**A COMMUNITY BENEFIT REPORTING TOOLKIT
FOR
CRITICAL ACCESS HOSPITALS**

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A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

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Monitoring
Team** | **University of Minnesota
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The Flex Monitoring Team is a consortium of the Rural Health Research Centers located at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. Under a cooperative agreement with the federal Office of Rural Health Policy (PHS Grant No. U27RH01080), the Flex Monitoring Team is cooperatively conducting a performance monitoring project for the Medicare Rural Hospital Flexibility Program (Flex Program). The monitoring project is assessing the impact of the Flex Program on rural hospitals and communities and the role of states in achieving overall program objectives, including improving access to and the quality of health care services; improving the financial performance of Critical Access Hospitals; and engaging rural communities in health care system development.

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The Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospitals (CAHs) and offers grants to States to help implement initiatives to strengthen the rural health care infrastructure. To participate in the Flex Grant Program, States are required to develop a rural health care plan that provides for the creation of one or more rural health networks; promotes regionalization of rural health services in the State; and improves the quality of and access to hospital and other health services for rural residents of the State. Consistent with their rural health care plans, states may designate eligible rural hospitals as CAHs.

CAHs must be located in a rural area (or an area treated as rural); be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads available) from another hospital or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient and swing bed services).

The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820, available at http://www.ssa.gov/OP_Home/ssact/title18/1800.htm

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This document draws heavily on work of the Catholic Health Association of the United States, VHA, Inc., and the Public Health Institute in creating standardized community benefit categories, definitions, and reporting guidelines in an effort to achieve a national standardized approach for not-for-profit health care organizations. The Flex Monitoring Team would like to express its appreciation to these organizations for their work in developing what has become the *de facto* standard in community benefit reporting. We would also like to thank Julie Trocchio, Senior Director of Community Benefit and Continuing Care for Catholic Health Association of the United States for her review of this document and her insightful comments.

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OVERVIEW OF THIS DOCUMENT

This document is designed to provide guidance to the staffs of Critical Access Hospitals (CAHs) in collecting and reporting community benefit data to comply with federal and/or state community benefit reporting requirements or to prepare community benefit reports for internal and external audiences. The introduction provides an overview of the Flex Monitoring Team's (FMT) Community Impact reporting project, presents the three-tiered community impact framework developed by the FMT (of which community benefit is an integral part), and a review of the organizations and issues driving the interest in community impact and community benefit reporting. Following an overview of the community benefit reporting requirements for not-for-profit hospitals implemented by the Internal Revenue Service in its revisions to Form 990 Return of Organization Exempt from Income Tax and the related Schedule H, Hospitals, the document is divided into sections which describe these data collection requirements. Sections I–III review the categories of community benefits arising from the delivery of patient care services (e.g., charity care and shortfalls from the delivery of services to patients covered by government-sponsored health care programs) and related categories of activity such as bad debt. Section IV reviews the reporting of community benefit activity for community health improvement services, health professions education, subsidized health services, research, financial and in-kind contributions, community-building activities, and community benefit operations. Section V reviews accounting issues and cost calculations in the reporting of community benefit activities. Section VI discusses issues related to community benefits provided and funded by hospital foundations. Appendix A provides a glossary of definitions for the community impact and benefit terms used in this report. Appendix B provides a community benefit inventory event/activity tracking form for hospitals to use to capture community benefit data.

This document is meant to be an overview to the community benefit reporting requirements implemented by the Internal Revenue Service under its Revisions to Form 990 and Schedule H. It should not be considered either legal or accounting advice for community benefit reporting. CAHs and other hospitals using this manual should consult appropriate legal and/or financial advisors prior to implementing or changing their community benefit reporting process and strategies. They should also consult the most recent guidance from the Internal Revenue Service and, in states with mandatory community benefit reporting requirements, the responsible state agencies prior to making decisions regarding the reporting of community benefits.

Further information on the Catholic Health Association of the United States' community benefit framework can be found in *A Guide for Planning & Reporting Community Benefit, 2008 Edition*.¹ This is a valuable and extensive resource to the community benefit framework upon which the IRS based its community benefit reporting requirements for its revised Form 990 and Schedule H. Specific guidance on filing Form 990 and Schedule H can be found in the Revenue Service's *Instructions for Form 990, Return of Organization Exempt from Income Tax*.²

¹ Catholic Health Association. *A Guide for Planning & Reporting Community Benefit*. Washington, DC: Catholic Health Association of the United States; 2008.

² Internal Revenue Service. (2008). *Instructions for Form 990, Return of Organization Exempt from Income Tax*. [Online.] Available: <http://www.irs.gov/pub/irs-pdf/i990.pdf>. Accessed June 16, 2009.

Introduction to the Flex Monitoring Team's Community Impact Reporting Project

The Flex Monitoring Team has a cooperative agreement with the Federal Office of Rural Health Policy (ORHP) to monitor the implementation and impact of the Medicare Rural Hospital Flexibility Program. As part of that work, the Muskie School of Public Service at the University of Southern Maine is leading the development of community impact indicators for Critical Access Hospitals (CAHs) to complement the emerging financial and clinical benchmarking data sets developed by the Flex Monitoring Team. These indicators will support the efforts of the Flex Program and ORHP to encourage CAHs to serve as the hub of community-focused systems of care by:

- Developing a reporting system to document the valuable community impact and benefit work underway in CAHs;
- Organizing community benefit data to simplify completion of Internal Revenue Service Form 990, Return of Organization Exempt from Income Tax and the related Schedule H for Hospitals as well as relevant state community benefit reporting requirements;
- Embedding community impact indicators in hospital reporting and strategy;
- Improving board engagement on community impact activities; and
- Facilitating the development of an annual community impact and/or benefit report for distribution to key constituents.

The community impact indicator set developed for this project is designed to measure the direct care services, activities, economic contribution, and charitable and subsidized activities of this important group of rural providers. The goal is to develop a set of rural-relevant community impact indicators for CAHs to quantify the ways in which they impact their communities. Data collected through this project will be used to:

- Document the community impact of CAHs;
- Monitor the progress of CAHs in addressing community needs;
- Provide the Federal Office of Rural Health Policy (ORHP) with community performance indicators to document the Medicare Rural Hospital Flexibility Program's (Flex Program) performance for its Government Performance and Results Act of 1993 and Office of Management and Budget's Program Assessment Rating Tool reporting requirements; and
- Provide tools for CAHs to strategically manage, monitor, and report their community impact activities.

Hospitals, including CAHs, operate in an environment of growing public scrutiny of the ways in which they serve and improve the health of their communities. The Balanced Budget Act of 1997, the legislation establishing the Flex Program, anticipated the community role of CAHs by requiring eligible hospitals to engage their communities as part of the conversion process. In addition, ORHP has created clear expectations and incentives for CAHs to engage with their communities; develop collaborative delivery systems in their communities with CAHs as the hub of those systems of care; and undertake collaborative efforts to address unmet community health and health system needs.

Coinciding with the Flex Program's community focus has been the emerging interest in the "community benefits" provided by not-for-profit hospitals. The development of community benefit reporting standards has been led by the Catholic Health Association of the United States (CHA), VHA, Inc.,³ and the Public Health Institute. Twenty-six states have implemented mandatory or voluntary community benefit reporting requirements. The goals of these reporting initiatives are to quantify the community benefits provided by not-for-profit hospitals to justify their tax benefits.

Nationally, the Internal Revenue Service (IRS) has revised Form 990, Return of Organization Exempt from Income Tax. As part of these revisions, it added Schedule H to collect community benefit data from not-for-profit hospitals. The revisions and additions to Form 990, which are consistent with the CHA's community benefit standards, will be fully implemented in tax year 2009 (for returns filed in 2010). As part of this process, not-for-profit hospitals will be required to submit comprehensive data on their community benefit activities.

Although there is a great deal of state and national attention paid to the community benefits provided by not-for-profit hospitals, they are only one measure of the impact of hospitals on their communities. CAHs, and all hospitals, provide a wide range of self-supporting patient care services to the general public including inpatient, outpatient, ambulatory, and diagnostic care. Others provide more specialized services that may include behavioral health, long-term care, and other specialty services. The services provided by a hospital are not generally captured by community benefit reporting systems unless the services are specifically subsidized by the hospital and offered at a loss. Another important element of the impact of CAHs on their communities is the economic contribution they make to the local economy. CAHs are often among the major employers in a rural community as well as a significant consumer of goods and services from local merchants. As with the service offerings of CAHs, the economic impact of these facilities is not captured in traditional community benefit reporting systems. We have developed a three-tiered definition of community impact to capture data on the full range of activities undertaken by CAHs that benefit their communities.

Defining Community Impact

The following is the three-tiered definition of community impact that we have developed for this project. It identifies the full range of hospital activities and programs that positively impact the health and well-being of communities, including those that:

1. Expand access to health care services and programs for members of the community including those services and programs that are unsubsidized, have a source for reimbursement to the CAH, and/or are expected to be self-sustaining;
2. Document the economic benefits of CAHs as an employer and consumer of goods and services in the community; and
3. Fall into the more tightly defined category of community benefit activities as developed and refined by CHA, VHA, Inc, and the Public Health Institute and adopted by the IRS and numerous state community benefit reporting initiatives.

³ VHA, Inc. was formerly known as Voluntary Hospitals of America. The company formally changed its name to VHA, Inc. in 1994. Scott, L. (1994). VN Posts Profit, and Shortens Name. *Modern Healthcare* April 25, 24(17):8.

This document is designed to assist CAHs in capturing and reporting data related specifically to community benefit activities (those activities covered in tier # 3 as described above) to comply with the community benefit reporting requirements established by the IRS for not-for-profit hospitals and relevant state reporting requirements.

Community Benefit Categories and Reporting Guidelines

CHA⁴, VHA, Inc, and the Public Health Institute have been the leaders in developing a uniform definition of community benefit and a standardized framework (hereafter referred to as the CHA community benefit framework) to assist hospitals in quantifying and reporting their community benefit activities. As described above, the Flex Monitoring Team’s community impact project expands upon the widely accepted CHA community benefit framework to provide CAHs with a set of tools to document the many ways in which they positively affect the health of their communities, including those that do not meet the more tightly defined standards of “community benefit”. The Flex Monitoring Team’s community impact framework retains a focus on the subset of community benefit activities articulated in the CHA community benefit framework (tier # 3) as these activities are an important part of the charitable and community missions of many hospitals.

Community benefit activities are programs or services that provide treatment and/or promote health and healing in response to identified community needs. They are not provided for marketing and/or business development purposes. They are activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status including:

- Health services provided to vulnerable or underserved populations;
- Financial or in-kind support of public health programs;
- Donations of funds, property, or other resources that contribute to a community priority;
- Health care cost containment activities;
- Health education, screening, and prevention services;
- Clinical and community health research;
- Health professions education; and
- Subsidized health services.

What is a community benefit?

According to the CHA community benefit framework, a community benefit is a planned, managed, organized, and measured approach to a health care organization’s participation in meeting identified community health needs. It implies collaboration with a “community” to “benefit” its residents, particularly the poor; racial, cultural, or ethnic minorities; and other underserved groups, by improving health status and quality of life. Policymakers are interested in understanding the value of community benefit activities undertaken by not-for-profit hospitals

⁴ Catholic Health Association. *A Guide for Planning & Reporting Community Benefit*. Washington, DC: Catholic Health Association of the United States; 2008.

within the context of their tax exempt status. As a result, data on community benefit activities are typically expressed as dollar values for each of the activities and programs.

A community benefit must respond to an identified community need and meet at least one of the following criteria:

- Generates a low or negative margin;
- Responds to the needs of special populations, such as people living in poverty; the uninsured; racial, cultural, or ethnic minorities; frail elderly; persons with disabilities; persons with chronic mental illness; and persons with AIDS;
- Supplies a service or program that would likely be discontinued if the decision were made on a purely financial basis;
- Responds to public health needs; and/or
- Involves education or research that improves overall community health.

To determine whether a program or cost is a community benefit, as opposed to a routine service or a marketing initiative, CAHs should attempt to answer the following questions:

- Does the activity address an identified community need?
- Does the activity support the organization's community-based mission?
- Is the activity designed to improve health?
- Does the activity produce a measurable community benefit?
- Can the activity be credibly described as a community benefit (meaning it is not of a questionable nature that could jeopardize the credibility of the hospital's community benefit report)?
- Does the activity require subsidization (meaning it results in a net financial loss after deducting revenue generated by the activity)?

These reporting guidelines can be used to assist CAHs in quantifying services for persons who are economically poor as well as services to the broader community. Services provided to either group can be reported as a community benefit if they meet the above guidelines.

Persons who are poor or are medically indigent cannot afford health care because they have inadequate resources and/or are uninsured or underinsured. Criteria used to identify community benefit programs for this target population include:

- Most program users are economically poor;
- Most program users cannot afford to pay for needed health care services;
- Most program users are beneficiaries of Medicaid or state or local programs for the medically indigent;
- The program is designed to reduce morbidity and mortality rates caused by or related to poverty (e.g., prevention of low birth weight); and/or
- The program is physically located in and apparently attracts most of its participants from a site identified as poor or medically underserved via demographic data showing a

higher-than-average poverty rate than the state as a whole and/or designation as a “medically underserved area” or a “health professional shortage area”.

The term “broader community” refers to persons other than members of a “target population” who benefit from a hospital’s community services and programs.

The IRS instructions for completing Schedule H specify that community need for a program or activity must be established for it to be reported as a community benefit. This can be done through:

- A community needs assessment developed or accessed by the organization;
- Documentation that demonstrated community need and/or a request from a public agency or community group was the basis for initiating or continuing the program or activity; or
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the program or activity.

Community benefit programs or activities seek to achieve objectives, including: improving access health services; enhancing public health; advancing generalizable knowledge; and relief of government burden. This includes programs or activities that:

- Are available broadly to the public and serve low-income consumers;
- Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist, would result in access problems (e.g., longer wait times or increased travel distances);
- Address federal, state, or local public health priorities (such as eliminating disparities in health among different populations)
- Leverage or enhance public health department activities (such as childhood immunization efforts);
- Otherwise would become the responsibility of government or other tax-exempt organizations; or
- Advance generalizable knowledge through education or research that benefits the public.

Activities or programs may not be reported if they are provided primarily for marketing purposes and the program or activities are more beneficial to the organization than the community; for instance, if the program or activity is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization.⁵

With one exception, the IRS initially adhered to the community benefit classification categories of the CHA community benefit framework in its initial revisions to the Form 990. That exception involved the category of community benefit activities related to community building. The CHA framework allows community building activities to be classified as community benefits while the IRS originally excluded them. The IRS released the initial draft of the revised Form 990 in June

⁵ Internal Revenue Service. (2008). *Instructions for Schedule H (Form 990)*. [Online.] Available: <http://www.irs.gov/pub/irs-pdf/i990sh.pdf>. p. 10. Accessed June 16, 2009.

2007 for public review and comment. The IRS received almost 700 comment letters from hospitals and hospital advocates and a bi-partisan Congressional letter signed by over 300 U.S. House of Representative members.⁶ Many of the comments letters requested that the IRS allow Medicare shortfalls, bad debt, and community building activities to be counted as community benefits.^{7,8}

On December 20, 2007, the IRS released the final version of Form 990 and its accompanying schedules. The final version of Form 990 differs from the CHA community benefit framework in that it requests data on the Medicare shortfalls, bad debt, and community building activities of not-for-profit hospitals.⁹ These activities are not reported as community benefits on Part I of Schedule H, rather they are reported in Sections II and VI (community building activities) and Part III and VI (Medicare shortfalls and bad debt). The IRS has not taken a position on whether expenses in these three areas should be classified as a community benefit. Rather, it will collect data on hospital activity in these three areas to inform its decision-making regarding these issues. The final version of Form 990 requires hospitals to report their:

- Medicare shortfalls, if any, should be reported in Part III of Schedule H. Hospitals should provide an explanation as to what percentage of the shortfalls should be counted as a community benefit and why in Part VI of Schedule H;
- Bad debt levels with an estimate of the portion of the bad debt that should be counted as a community benefit, and whether the hospital reports bad debt expense in accordance with the Health Care Financial Management Association's Statement No. 15 should be reported in Part III of Schedule H with further explanation and information provided in Part VI; and
- Total expenses related to community-building activities, with offsetting revenues, net expenses related to community building activities, and the percentage of total expenses represented by net community building expenses. Optionally, hospitals may report the number of activities or programs and the number of individuals served. These data should be reported in Part II of Schedule H). In Part VI, hospitals will be asked to describe how the activities reported in Part II promote the health of the communities the hospital serves.

The IRS will review the data and explanations provided by hospitals on Form 990 and make a determination as to whether Medicare shortfalls, bad debt, and community building activities represent a community benefit and, if they are to be counted, how much of the costs in these

⁶ Illinois Hospital Association. (2008, January 10). *Final Revised Draft of IRS Form 990*. [Online]. Available: <http://www.ihatoday.org/issues/payment/charity/irsform990final.html>. Accessed June 16, 2009.

⁷ The CHA community benefit framework excludes Medicare shortfalls and bad debt from classification as community benefits. As mentioned above, the CHA framework includes community building activities as a community benefit.

⁸ Hospital advocates argued that a significant portion of the bad debt carried by hospitals represented charity care delivered to individuals who would qualify for charity care under hospital charity care policies if the individuals had completed the form. The IRS acknowledged the difficulty many hospitals experience in classifying charity care versus bad debt.

⁹ Internal Revenue Service. (2007, December 20). *Form 990 Redesign for Tax Year 2008 Schedule H, Hospitals – Highlights*. [Online]. Available: http://www.irs.gov/pub/irs-tege/highlights_schedule_h.pdf. Accessed June 16, 2009.

three categories should be counted. This manual reflects the IRS's current reporting requirements.

How to identify and quantify community benefit activities

As the standards for determining and reporting community benefits are very specific, this document focuses on assisting CAHs in understanding the concept of community benefit and provides them with the tools and guidelines to identify and quantify community benefit activities and costs. To be included in a quantifiable inventory of community benefit activities, services generally must:

- Result in a financial loss to the organization, requiring subsidization of some sort;
- Be quantified in terms of dollars spent, number of encounters, or number of people served;
- Not be of a questionable nature that jeopardizes the credibility of the inventory; and
- Have an explicit budget.

Implementing a Community Benefit Reporting Process

Identifying, quantifying, and reporting a hospital's community benefit activity is a significant undertaking. Given the importance of this activity, hospitals should not wait until year end to begin collecting the data to complete Form 990 and Schedule H. CAHs are likely to have varying levels of experience with community benefit reporting. Although most, if not all CAHs, are providing some level of community benefit, many may not have approached this process in a systematic manner. Some hospitals will have no community benefit tracking process in place, will be unclear on what to count, will not have conducted a needs assessment, and have minimal coordination of community benefit activities. Others may have a well developed community benefit tracking process in place and approach the delivery and reporting of community benefit activities in a strategic manner. Most will fall somewhere between these two extremes. Regardless of where your hospital falls on this continuum of readiness to report community benefits, it is important to begin now to implement or refine a process to undertake this important activity. This section of the toolkit will provide advice on developing a process to identify and report community benefits.

Prerequisites to Establishing a Community Benefit Reporting Process: There are a number of important prerequisites to establishing an effective community benefit reporting process. These include the commitment of the hospital's senior management and board, the identification of an internal champion who will be responsible for managing the process, and the development of a hospital-wide community benefit committee to strategically address the reporting requirements of Form 990 and Schedule H. The committee should include a broad range of hospital staff including representatives from senior management, finance, the business office, the legal department, clinical departments, physicians, marketing and public relations, and, if appropriate, community partners.

Conducting a Community Benefit Inventory: A hospital that has not previously reported its community benefit, should begin the process by conducting an inventory of its community

benefit activities. Prior to beginning the inventory, members of the community benefit committee should review the framework described in this toolkit. The framework is based on the Catholic Health Association's community benefit framework and is consistent with the IRS's latest instructions for completing Schedule H (2008). Additional information on the framework and related accounting advice is provided in CHA's *A Guide for Planning & Reporting Community Benefit* (2008).¹⁰ The 2008 Guide is a comprehensive resource on community benefit reporting and management. Other resources on community benefit reporting are available from the American Hospital Association, the Association for Community Health Improvement, the Healthcare Financial Management Association, the Catholic Health Association of the United States, the Public Health Institute, and state hospital associations.

As part of the inventory process, we recommend that hospitals review all identified programs and activities to ensure that they meet IRS standards as community benefits. Ideally, data on community benefit should be collected throughout the year, rather than at year end. Hospitals should also consider the use of information technology to facilitate data collection and reporting. We also recommend that the hospital educate staff on the importance of community benefit activities using the community benefit framework contained in this toolkit along with CHA's "What Counts" guidelines from the 2008 *Guide for Planning and Reporting Community Benefit*.

Following the education of staff, the hospital should undertake a systematic inventory of its current community benefit activities using an appropriate tracking form such as the sample form provided in Appendix B. Prior to its use, the form should be reviewed with representatives from the finance department and modified as necessary to meet your hospital's needs. The tracking form should be widely distributed within the hospital with the request that staff use the form to identify and report all relevant activities to the community benefit committee. While it is unlikely that all activities identified through this process will meet the standards of a community benefit, it is important to examine these various activities to ensure that nothing is missed. The completed forms should be submitted to the community benefit committee for review.

The inventory should also include an examination of the hospital's clinical programs to determine if any may be counted as "subsidized health services" (e.g., programs that require subsidization and for which community need has been established).

Evaluating Current Community Benefit Activities: As members of the committee review the program and activities identified through the inventory, they should ask the following questions about each activity:

- Why are we offering this service/program? (e.g., What need does it address?)
- What evidence exists to verify the need for this program?¹¹

¹⁰ Catholic Health Association. *A Guide for Planning & Reporting Community Benefit*. Washington, DC: Catholic Health Association of the United States; 2008.

¹¹ Need can be demonstrated by showing that the service or program was developed: as a result of a needs assessment conducted by or accessed by the hospital; in response to a request from a community group, in collaboration with a government agency such as a local public health department or an unrelated tax-exempt healthcare organizations; that the health problems it addresses are generally accepted as significant health problems and/or well documented in the literature.

- How and when was the need for the service/program identified?
- Who is being served by the service/program? (Be specific about the populations served.)
- What are the costs of the service/program? (Engage the finance department in answering this question.)
- How well is the service/program serving its target population?
- What are the sources of data to monitor this service/program?
- Does the service/program meet the IRS standards as a community benefit?
- Should this program be continued, modified, or eliminated?

This process of inventorying and assessing the hospital's current community benefit activity is important foundational work. The committee should establish a schedule to meet regularly and a timeline in which to accomplish the inventory and evaluation of community benefit activities. Only after this inventory is complete can the hospital understand its full range of community benefit activities and consider ways to automate and manage these them. It would be also helpful to establish a process to regularly report the committee's progress to senior management.

Once the inventory is complete, the hospital finance and accounting staff will need to review the activities and develop a process to account for their costs. Particular attention should be paid the ways in which charity care, bad debt, and shortfalls from government programs are reported by the hospital to ensure that the process is consistent with the IRS instructions for Schedule H. This toolkit provides preliminary guidance on accounting for community benefits. Additional accounting advice is provided in the CHA 2008 Guide. As mentioned in the overview to this document, the information provided in this toolkit should not be considered legal or accounting advice for community benefit reporting. CAHs and other hospitals using this manual should consult appropriate legal and/or financial advisors prior to implementing or changing their community benefit reporting process and strategies. They should also consult the most recent guidance from the Internal Revenue Service and, in states with mandatory community benefit reporting requirements, the responsible state agency prior to making decisions regarding the reporting of community benefits.

Next Steps: Completing the interview and preparing to complete Schedule S is just the first step in reporting and managing hospital community benefit. As part of its work, the committee should develop recommendations on an organizational infrastructure (including staff responsibilities) to support the hospital's community benefit activities, policies/procedures to govern the community benefit reporting process, internal and external communication plans, and a hospital community benefit policy. It should also consider a the development of a process to periodically review and evaluate each community benefit service/program to ensure that each service/program continues to meet an identified need and appropriately services its target population. This review should include the hospital's charity care, bad debt, and patient billing policies; subsidized services; and all individual community benefit services and programs provided by the hospital. A hospital's portfolio of community benefit activities should evolve with the needs of the community. The establishment of a process to systematically review and strategically manage the hospital's activities in this area will help to ensure that the hospital's community benefit program continues to address community needs and maximize the value of its efforts.

OVERVIEW OF IRS FORM 990 AND SCHEDULE H

For tax year 2008 (with returns filed in 2009), the IRS requires all not-for-profit hospitals to file Form 990, Return of Organization Exempt from Income Tax along with Part V of Schedule H for Hospitals. Parts I, II, III, IV, and VI are optional in tax year 2008. For tax year 2009 (with returns filed in 2010), the IRS requires all not-for-profit hospitals to file Form 990, Return of Organization Exempt from Income Tax along with all parts of Schedule H for Hospitals. The forms and instructions for completing the forms are available on the IRS website (<http://www.irs.gov/charities/article/0,,id=185561,00.html>). Not-for-profit hospitals (e.g., those that are exempt from income tax under section 501(a)) are required to complete and file Form 990 and appropriate schedules.¹² Public, proprietary, and other select hospitals are not required to complete Form 990 and Schedule H. Although these hospitals are not required to file the IRS Form 990, 34 states have implemented either mandatory or voluntary community benefit and/or charity care reporting standards, many of which are based on the CHA community benefit framework.¹³ We recommend that you check with your financial and legal advisors to determine if your hospital is required to file Form 990 or participate in state community benefit reporting systems. We further recommend that you review Form 990 and related schedules and instructions with appropriate financial and legal advisors to ensure appropriate compliance.

Schedule H for Hospitals requests a wide range of information on hospital community benefit activities.¹⁴ **Part 1** of Schedule H, *Charity care and Certain Other Community Benefits at Cost* collects data on the hospital's charity care policies, the use of Federal Poverty Guidelines to determine eligibility for free and/or discounted care, and data on the costs related to charity care, other means-tested government programs, community health improvement services, community benefit operations, health professions education, subsidized health services, research, and cash/in-kind contributions. **Part II**, *Community Building Activities* collects data on community-building activities by category of activity. **Part III**, *Bad Debt, Medicare, & Collection Practices* collects data on bad debt, Medicare, and collection practices. **Part IV**, *Management Companies and Joint Ventures* collects data on any management companies owned by hospitals or joint ventures in which they participate. **Part V**, *Facility Information* collects basic data on the facility. **Part VI**, *Supplemental Information* collects supplemental data including information on how the hospital assesses the health care needs of the community it serves; how the organization educates and informs patients about the availability of financial assistance and charity care; the hospital's targeted service area and populations; community-building activities; and information on the hospital's other activities and initiatives that further its exempt purpose by promoting the health of the community.

¹² Internal Revenue Service. (2008). *Instructions for Form 990, Return of Organization Exempt from Income Tax*. [Online.] Available: <http://www.irs.gov/pub/irs-pdf/i990.pdf>. Accessed June 16, 2009.

¹³ Association for Community Health Improvement (2009). *State Government Requirements and Reports on Community Benefit and Charity Care*. [Online.] Available: <http://www.communityhlth.org/communityhlth/resources/cbmap.html>. Accessed June 16, 2009.

Association for Community Health Improvement (2009). *State Hospital Association Reports and Resources on Community Benefit*. [Online.] Available: <http://www.communityhlth.org/communityhlth/resources/cbmap2.html>. Accessed June 16, 2009.

¹⁴ Internal Revenue Service. (2008). *Instructions for Schedule H (Form 990)*. [Online.] Available: <http://www.irs.gov/pub/irs-pdf/i990sh.pdf>. Accessed June 16, 2009.

I. CHARITY CARE

Charity care is free or discounted health and health-related services provided to persons who cannot afford to pay and who meet the CAH's criteria for financial assistance. Charity care results from a CAH's policy to provide free or discounted health care services to individuals who meet certain financial criteria. Typically, a bill must be generated supported by a patient record documenting the encounter. In addition, the patient must demonstrate an inability to pay and meet the CAH's criteria for financial assistance. Charity care is reported in terms of costs, not charges and does not include bad debt. Charity care includes:

- Care provided to uninsured, low-income patients who are not expected to pay all or part of a bill, or who are able to pay only a portion using an income-related fee schedule;
- Health care services that were never expected to result in cash inflows;
- The unreimbursed cost to the health system for providing free or discounted care to persons who cannot afford to pay and who are not eligible for public programs.

In determining total charity care expenses, count:

- Free and discounted care;
- Expenses incurred in the provision of charity care;
- Indirect cost not already included in calculating costs; and
- Provider taxes, assessments, or fees if Medicaid Disproportionate Share Hospital (DSH) funds in your state are using whole or part to offset the cost of charity care.

Do not count:

- Bad debt;
- Contractual allowances or quick-pay discounts;
- Discounts provided to self-pay (uninsured) patients who do not qualify for financial assistance; and
- Any portion of charity care costs already included in the subsidized health care services category.

Charity care activity along with certain other community benefit costs are reported in Part I, *Charity care and Certain Other Community Benefits at Cost* of Schedule H of Form 990.¹⁵ Hospitals will be asked to report the total community benefit expense for charity care, certain direct offsetting revenue, the net community benefit expense for charity care, and the percent of total hospital expenses represented by charity care. Optionally, hospitals will also be asked to report the number of activities or programs as well as the number of persons served. In addition, hospitals will be asked to report whether or not they have a charity care policy and, if they do, whether or not it is written. Hospitals will also be asked to describe how it determines eligibility for the provision of free and discounted care (e.g., whether or not it uses a percentage of Federal Poverty Guidelines (FPG) to determine eligibility), the specific percentage of FPG used to

¹⁵ Internal Revenue Service. (2008). *Instructions for Form 990, Return of Organization Exempt from Income Tax*. [Online.] Available: <http://www.irs.gov/pub/irs-pdf/i990.pdf>. Accessed June 16, 2009.

determine eligibility for free and discounted care, and the process used to determine eligibility if FPG is not used (to be reported in Part VI, *Supplemental Information* of Schedule H). Hospitals will also be asked to report if they provide free and discounted care to the “medically indigent”.¹⁶ The hospital will also be asked to report whether or not the organization budgets for free or discounted care and, if it does, whether the charity care expenses for the organization exceeded the established budget. Finally, it will be asked to report whether or not the organization was unable to provide free or discounted care due to budget considerations (IRS 2008). Optional Worksheets 1 through 8 can be used to assist the hospital in completing Schedule H, Part 1, lines 7a - 7k.

Under Part I of Schedule H, hospitals will also be asked to report whether or not it prepares an annual community benefit report. For those hospitals that do, they will be asked to report whether or not the report is made available to the public.

II. MEANS-TESTED AND OTHER GOVERNMENT HEALTH CARE PROGRAMS

The unpaid costs for the provision of care to individuals covered by means-tested for low income individuals and other government health care programs may be captured and counted as a community benefit. The unpaid costs of care provided to individuals enrolled in these programs are known as “shortfalls” and are created when a facility receives payments that are less than the costs of caring for program beneficiaries. This “payment shortfall” is not the same as a contractual allowance, which is the difference between charges and government program payments. It does not include any shortfall that results from inefficiency or poor management. All shortfalls must be based on costs, not charges. It is appropriate to count shortfalls/losses related to:

- Medicaid;
- State Children’s Health Insurance Programs (CHIP);
- Public and/or indigent care, including local or state government medical programs for low-income or medically indigent persons;
- Days, visits, or services not covered by Medicaid or other indigent care programs; and
- Medicare (if appropriate based on the description below).

Do not count:

- Other government programs that are not mean-tested such as the Veteran’s Administration, CHAMPUS, and Indian Health Service.

¹⁶ According to the IRS (2008), “Medically indigent” means persons whom the organization has determined are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income or assets (for example, due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the generally applicable eligibility requirements for free or discounted care under the organization’s charity care policy.

There has been no clear consensus as to whether Medicare shortfalls should be included as a community benefit. Arguments against counting Medicare shortfalls as a community benefit include the following:

- Hospitals offering programs with large numbers of vulnerable Medicare patients that are losing money may report the costs for the programs in the category of “subsidized health services”.
- Medicare losses for some hospitals may be associated with inefficiency and poor operating practices, not underpayment. For others, they may be associated with low patient volume. (Cost-based Medicare reimbursement for CAHs is designed to be a more appropriate reimbursement method given the lower patient volume experienced by these facilities.)
- Medicare may be one of the best payers in many communities. Per-diem and per-case payments can be higher for Medicare than for managed care payers.
- Serving Medicare patients is not a differentiating feature of not-for-profit hospitals compared to for-profit hospitals. Most hospitals typically compete to attract Medicare patients while the same cannot be said of Medicaid and charity care patients.¹⁷

Shortfalls related to the delivery of services for beneficiaries enrolled in means-tested government health care programs are reported in Part I of Schedule H.¹⁸ Hospitals will be asked to report the total community benefit expense for services rendered to patients enrolled in Medicaid and other means-tested government programs, any direct offsetting revenue received from these programs, the net community benefit expense for these shortfalls, and the percent of total hospital expenses represented by these shortfalls. Optionally, hospitals will also be asked to report the number of activities or programs as well as the number of persons served.

The IRS, in its revisions to Schedule 990, does not automatically allow the reporting of Medicare shortfalls as a community benefit. Instead, it directs hospitals to report this information in Section B, Part III, Bad Debt, Medicare, & Collection Practices of Schedule H with further explanation provided in Part VI. Part III requires reporting of total revenue received from Medicare (including Disproportionate Share Hospital [DSH] and Indirect Medical Education [IME], but not Graduate Medical Education [GME]), and the total cost to deliver care reimbursed by Medicare, in order to report total Medicare surpluses or shortfalls. In addition, a hospital will be asked to describe what portion, if any, of its Medicare shortfalls it believes should be counted as a community benefit and explain the rationale for its position in Part VI of Schedule H. This approach will collect important information regarding Medicare revenues and costs, shortfalls or surpluses, and costing methodologies; provide for uniform Medicare reporting by all hospitals; and permit a hospital to explain what portion of its Medicare shortfalls should be treated as a community benefit.

¹⁷ CHA (2007). *Topic: Medicare Losses (What Counts Q&A)*. [Online.] Available: <http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/whatcounts/countsfqa/governmentprograms/Medicarelosses.htm>. Accessed June 16, 2009.

¹⁸ Internal Revenue Service. (2008). *Instructions for Form 990, Return of Organization Exempt from Income Tax*. [Online.] Available: <http://www.irs.gov/pub/irs-pdf/i990.pdf>. Accessed June 16, 2009.

In the event that your hospital reports a Medicare shortfall, the following guideline should be used to determine whether or not some portion of that shortfall should be treated as a community benefit:

- The hospital has a clear mission commitment to serving elderly patients and can demonstrate that commitment through the provision of specific subsidized programs designed not for marketing reasons but to improve the health status of the elderly.

The following information related to Medicare should be reported:

- Total revenue received from Medicare (including DSH and IME);
- Medicare allowable costs related to the above payments;
- The calculated surplus/shortfall (total Medicare revenues – Medicare allowable costs); and
- The costing methodology used in determining the above figures and the rationale for treating part or all of the CAH's Medicare shortfalls, if any, as a community benefit.

III. BAD DEBT

As discussed earlier, the IRS breaks from the CHA community benefit framework by providing hospitals with an opportunity to explain why some or all of their bad debt expenses should be counted as a community benefit. Many hospitals have a difficult time determining whether certain expenses are properly classified as charity care or bad debt, because they are unable to obtain the information required to classify charity care expenses properly and in a timely fashion for financial reporting purposes. The CHA community benefit framework does not classify bad debt as a community benefit because it regards bad debt as a cost of doing business incurred by both not-for-profit and for-profit hospitals and because hospitals should implement and promote policies to identify patients who may qualify for charity care based on financial need. Because of the substantial divergence of practices and views in this area, Schedule H of Form 990 directs hospitals to report bad debt expense information in Section A, Part III of Schedule H.¹⁹

Part III requires a hospital to report aggregate bad debt expense at cost, provide an estimate of how much is attributable to persons who would normally qualify for financial assistance under the hospital's charity care policies, and provide a rationale for what portion of bad debt it believes should constitute a community benefit. In addition, the hospital must report whether it has adopted Healthcare Financial Management Association Statement No. 15. In Part VI of Schedule H, hospitals will be asked to provide the text of footnotes from the organization's financial statement that describe bad debt expense, describe the costing methodology used in reporting the data provided, and the rationale, if any, for why some portion of the hospital's bad debt should be considered a community benefit. This approach collects important and uniform bad debt expense information and permits an organization to explain why certain portions of bad debt should be counted as a community benefit.

¹⁹ Internal Revenue Service. (2008). *Instructions for Form 990, Return of Organization Exempt from Income Tax*. [Online.] Available: <http://www.irs.gov/pub/irs-pdf/i990.pdf>. Accessed June 16, 2009.

In addition to the information requested in Section A and B of Part III, Schedule H, hospitals will be asked to report if they have a written debt collection policy and, if the answer is yes, whether or not the collection policy specifies the collection practices to be followed for patients known to qualify for charity care or financial assistance. Further, hospitals will be asked to describe these provisions in Part VI of Schedule H.

IV. COMMUNITY BENEFIT SERVICES

The challenge of identifying and reporting community benefit information hinges on the ability of the CAH to identify, capture, and record data on its community benefit activities as they occur, rather than waiting until the end of its fiscal year. Appendix B provides a Community Benefit Inventory Event/Activity Form to assist CAHs in capturing and recording information on these activities as they occur throughout the year. To maintain consistency with the CHA framework adopted by the IRS, this form was modeled substantially on the tools developed by CHA in an early version of its community benefit Guidelines.

Community benefits are reported in terms of the dollar value of the direct and indirect costs of developing and offering these services and programs. This focus on the cost of activities/initiatives tells only part of the CAH's community benefit story as it does not account for the effect of these programs on individuals and populations served by the CAH. Data on the outputs (e.g., numbers of persons served, meeting or classes held, meals served, etc.) and outcomes (e.g., improvements in health, improved access to services, reductions in smoking, and other outcomes of these activities) are needed to fully describe how CAH's benefit their communities. These data are also critical to enabling CAHs to strategically manage, target, and evaluate their community benefit activities to achieve maximum effect. The Community Benefit Inventory Event/Activity Form (Appendix B) can be used to capture this important output and outcome data to assess the effectiveness of the hospital's community benefit activities. For those that would like additional information and/or training on collecting and reporting output and outcome data, the Flex Monitoring Team has produced a Flex Program Logic Modeling Toolkit that provides an orientation to the use of logic models to identify, monitor, and report the outcomes of program activities. This document is available on the Flex Monitoring Team's website at the following URL: <http://www.flexmonitoring.org/documents/PLMToolkit.pdf>.

Within the following sections, data on community health improvement services and community benefit operations; health professions education; subsidized health services; research; cash and in-kind contributions to community groups, and other community benefits will be reported under questions 7e through 7j, Part I, Schedule H.²⁰ Community building activities will be reported in Section II, Schedule H by type of community building activity (e.g., physical improvements and housing, economic development, etc.). A description of how these community building activities promote the health of the communities the hospital serves is to be provided in Part VI, Schedule H. Hospitals will be asked to report the total community benefit expense for each of these categories, any direct offsetting revenue, the net community benefit expense, and the percent of total hospital expenses represented by these activities. Optionally, hospitals will also be asked to report the number of activities or programs as well as the number of persons served.

²⁰ Internal Revenue Service. (2008). *Instructions for Form 990, Return of Organization Exempt from Income Tax*. [Online.] Available: <http://www.irs.gov/pub/irs-pdf/i990.pdf>. Accessed June 16, 2009.

Within Part VI of Schedule H, hospitals will also be asked to describe how the organization assesses the health care needs of the communities it serves. They will also be asked to provide any other information important to describing how the hospital and any of its related organizations further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.). Further, they will be asked to describe whether or not they are part of an affiliated health care system and to describe the roles of the organization and its affiliates in promoting the health of the communities served. Finally, if appropriate, they will be asked to identify all states with which they, or related organizations, file a community benefit report.

As a general rule of thumb, the following may be counted as community benefits:

- Programs that respond to an identified community need and are designed to accomplish one or more community benefit objectives;
- Programs or services directed to or including at-risk persons, such as underinsured or uninsured persons; and
- Programs offered to the broad community (including at-risk persons) designed to improved community health.

The following may not be counted:

- Programs primarily designed for marketing or promotional purposes;
- Time spent by volunteers, including employees, on their own time; and
- Routine or required care and services.

A. Community Health Improvement Services²¹

Community health services include activities carried out to improve community health. They extend beyond routine patient care activities and are usually subsidized by the health care organization. Community services do not generate inpatient or outpatient bills, although there may be a nominal patient fee and/or sliding scale fee. Report inpatient and outpatient care bills that are forgiven for low-income persons that qualify for such forgiveness under the hospital's charity care policies separately as charity care (see Section I, Charity Care).

Specific community health services to quantify include:

- Community health education;
- Community-based clinical services, such as free clinics and screenings;
- Support groups;

²¹ Catholic Health Association of the United States. *A Guide for Planning & Reporting Community Benefit*. Washington, DC: Catholic Health Association of the United States; 2008, p.101.

- Health care support services, such as enrollment assistance in public programs, and transportation efforts;
- Self-help programs, such as smoking cessation and weight loss programs;
- Pastoral outreach programs;
- Community-based chaplaincy programs and spiritual care;
- Social services programs for vulnerable populations in the community; and
- Community health initiatives addressing specific health targets and goals.

A1. Community Health Education

Community health education includes lectures, presentations, and other programs and activities provided without clinical or diagnostic services to groups. Community benefits in this area can include staff time, travel, materials, and indirect costs. The following may be counted as community health education activities:

- Caregiver training for persons caring for family members at home;
- Community newsletters if the primary purpose is to educate the community about health issues and free community health programs;
- Consumer health libraries;
- Education on specific diseases or conditions (diabetes, heart disease, etc.);
- Health fairs (if not primarily intended for marketing purposes);²²
- Health law topics for consumers;
- Health promotion and wellness programs;
- Health education lectures and workshops by staff to community groups;
- Parish and congregational programs;

²²

Health fairs, health advertisements, health education programs and classes, and other hospital activities can serve dual purposes as both marketing and community benefit activities. Distinguishing between the two can be difficult, particularly since the IRS instructions for completing Schedule H do not provide guidance at this level of detail. The burden falls to the staff of the hospital to honestly assess the primary purpose of a given activity and to report it accordingly. The advice provided by CHA involves the consideration of a number of factors including the target population to be served, the location of the event, the message of the educational program, the extent of the screening and diagnostic tests provided during health fairs, the extent to which participants in health fairs are connected to needed services, and the linkage of the activity to hospital services. Health fairs, for example, that are offered in venues where the target participants are most likely to be affluent and insured and are designed to yield referrals to the hospital or its programs should not be counted as a community benefit while a similar program offered in a venue where the participants are more likely to be low income and uninsured can be counted as a community benefit. Health fairs that provide only basic screening services or do not include a mechanism to connect at-risk participants to providers or services for follow-up should be assessed honestly to determine if it truly meets the standard of a community benefit. Health advertisements that have a marketing focus and are designed primarily developed to attract patients to a specific service offered by the hospital, even if they contain some educational materials, should not be counted as a community benefit. Prenatal, childbirth, and other classes that primarily target insured persons as a way of increasing the hospital's market share for this population should not be counted. Similar classes that target uninsured or low income persons as a way of improving access to care for underserved persons can be counted.

- Information provided through press releases and other modes to the media (radio, television, newspaper) to educate the public about health issues (wearing bike helmets, treatments news, health resources in the community, etc.);
- Radio call-in programs with health professionals to address community health need;
- School health education programs (school-based programs on health care careers and workforce enhancement efforts may be reported in Section IV.F8; school-based health services for students may be reported in Section IV.A2);
- Web-based consumer health information; and
- Work site health education programs.

The following may not be counted as community health education activities:

- Health education classes designed to increase market share (such as prenatal and childbirth programs for insured patients);
- Community calendars and newsletters if the primary purpose is marketing;
- Patient educational services that are part of comprehensive patient care (e.g., diabetes education for patients);
- Health education sessions offered for a fee in which a profit is realized;
- Volunteer time for parish and congregation-based and other services; and
- Advertisements with health messages when the purpose is marketing.

Support Groups

Support groups are typically established to address social, psychological or emotional issues related to specific diagnoses or occurrences (e.g., for diseases and disabilities, grief, infertility, patients' families, other). These groups may meet regularly or intermittently. They may be counted as a community benefit if they are related to community need and meet a community benefit objective. If they meet these conditions, it is appropriate to count the costs to run support groups. It is not appropriate to count support given to patients and families in the course of their inpatient or outpatient encounters and/or childbirth education classes that are reimbursed or designed to attract paying or insured patients.

Self-Help Programs

Self-help programs include wellness and health promotion programs offered to the community, such as smoking cessation, exercise, and weight loss programs. Examples include:

- Anger management programs;
- Exercise classes;
- Mediation programs;
- Smoking cessation programs;
- Stress management classes; and/or
- Weight loss and nutrition programs.

It is not appropriate to count employee wellness and health promotion services provided by the CAH as an employee benefit or the use of facility space by community groups to hold meetings (as this will be reported in Section IV.E3).

A2. Community-Based Clinical Services²³

Community-based clinical services are clinical services provided to the community (e.g., free clinics, screenings, or one-time events). This category does NOT include permanent subsidized hospital outpatient services as these will be reported in Section IV.C3. As with other categories of community benefits, these services and programs should be counted only if they are designed to meet identified community needs or to improve community health. Please note that there may be some overlap between the categories listed below as taken from the CHA community benefit framework. In determining where one or more of the listed activities can be counted as a community benefit, it is important that the activity addresses a community need and meets a community benefit objective.

Screenings

Screenings are health tests that are conducted in the community as a public clinical service, such as blood pressure measurements, cholesterol checks, school physicals and other events. They are a secondary prevention activity designed to detect the early onset of illness and disease and can result in a referral to any community medical resource. To be considered community benefits, screenings should provide follow-up care as needed, including assistance for persons who are uninsured and underinsured. The following services may be counted in this category:

- Behavioral health screenings;
- Blood pressure screenings;
- Lipid profile and/or cholesterol screenings;
- Eye examinations;
- General screening programs;
- Health risk appraisals;
- Hearing screenings;
- Mammography screenings (if these are done at a freestanding breast diagnostic center, report in Section IV.C5);
- Osteoporosis screenings;
- School physical examinations;
- Skin cancer screening; and/or
- Stroke risk screening.

The following may not be counted:

- Health screenings associated with conducting a health fair (report in Section IV.A1);
- Screenings for which a fee is charged, unless there is a negative margin;

²³ Catholic Health Association of the United States. *A Guide for Planning & Reporting Community Benefit*. Washington, DC: Catholic Health Association of the United States; 2008, p.203.

- Screenings where referrals are made only to the CAH or its physicians;
- Screenings provided primarily for public relations or marketing purposes; and
- Free school team physicals provided for public relations purposes.

One-time or Occasional Clinics

One-time or occasional clinics offering screening services differ from the screening programs described above in that they are typically a more structured program and suggest a more comprehensive package of services than a community-based screening program. They may be facility or clinic based.

The following may be counted under this category:

- Blood pressure and/or lipid profile/cholesterol screening clinics;
- Cardiology risk factor screening clinics (only if the clinics are not being held for marketing or case finding purposes);
- Colon cancer screening clinics;
- Dental care clinics;
- Immunization clinics;
- Mobile units that deliver primary care to underserved populations on an occasional or one-time basis;
- One-time or occasionally held primary care clinics;
- School physical clinics; and/or
- Stroke screening clinics.

The following may not be counted:

- Free school team physicals unless there is a demonstrated need for the services;
- Flu shots or physical exams for employees
- Screenings for which a fee is charged and a profit is realized;
- Permanent, ongoing, hospital-sponsored programs (as these should be counted in Section IV.C3).

Clinics for Underinsured and Uninsured Persons (often called Free Clinics)

These programs provide free or low-cost health care to medically underinsured and uninsured persons through the use of volunteer providers, including physicians and other health care professionals who donate their time. This category does not include CAH-sponsored practices and clinics such as Federally Qualified Health Centers or Rural Health Clinics.

The following activities may be counted:

- Hospital subsidies such as grants;
- Costs for staff time, equipment, and overhead costs; and
- Lab and medication costs.

Volunteers' time and contributions by other community partners may not be counted. Grants to an unrelated free clinic should not be counted in this category as these may be reported under Section C3.

Mobile Units

The costs of vans and other mobile units used to deliver primary care services may be counted.

Mobile specialty care services that are an extension of the organization's outpatient department, e.g., mammography, radiology, lithotripsy, etc., may not be counted as these should be reported in Section IV.C3.

A3. Health Care Support Services

Health care support services are provided by the CAH to increase access and quality of care in health services to individuals, particularly persons living in poverty or those in other vulnerable populations. The following activities may be counted:

- Enrollment assistance in public programs, such as state, indigent, state children's health insurance programs (SCHIP), and/or Medicaid programs;
- Information and referral to community services for community members (but does not include routine discharge planning);
- Case management of underinsured or uninsured that goes beyond routine discharge planning;
- Telephone information services (medical and mental health service hotlines, poison control centers);
- Physician referral programs for Medicaid and uninsured programs;
- Transportation programs for patients and families meeting the organization's financial assistance guidelines to enhance patient access to care (such as van services and/or cab vouchers provided to patients and families);
- Personal assistance programs such as LifeLine; and
- Translation/interpreter services that go beyond the requirements of the law or for accreditation.

The following activities may not be counted:

- A physician referral service if primarily an internal marketing effort which refers only to the hospital's physicians (include only if the call center refers to other community organizations or to physicians from across an area without regard to admitting practices);
- Health care support given to patients and families in the course of their encounter with a provider;
- Routine discharge planning; Enrollment assistance programs designed to increase facility revenue; and
- Translation/interpreter services required of all providers.

A4. Other Areas

- Include initiatives and programs for which the recipient is not billed. Each program should be listed separately and include only those programs that were not reported elsewhere in a different community benefit reporting category. An example of such an activity might be free medications or medication subsidies/vouchers.

B. Health Professions Education²⁴

Activities related to the training of health care providers and/or the provision of scholarships or funding for professional education should be reported in this category. Any funding or subsidies, government or otherwise, should be subtracted from these costs before counting.

B1. Physicians/Medical Students

The following activities may be counted:

- Providing a clinical setting for undergraduate/vocational training;
- Internships/clerkships/residencies;
- Residency education; and
- Continuing medical education (CME) offered to physicians outside of the medical staff on subjects in which the hospital has special expertise.

The following may not be counted:

- Expenses for physician and medical student in-service training;
- Joint appointments with educational institutions and medical schools (unless for a specialty where there is a documented shortage);
- Orientation programs; and
- Continuing medical education (CME) restricted to hospital clinicians and staff.

B2. Nurses/Nursing Students

The following should be counted:

- The provision of a clinical setting for undergraduate/vocational training to students enrolled in an outside organization (count time that staff nurses are taken away from their routine duties); and
- Costs associated with underwriting faculty positions in schools of nursing in response to shortages of nurses and nursing faculty.

²⁴ Ibid., 287-289.

Expenses for the following activities may not be counted:

- Education required for nursing staff, such as orientation, in-service programs, and new graduate training;
- Expenses for standard in-service training and in-house mentoring programs;
- In-house nursing and nurse's aide training programs; and
- Programs where nurses are required to work for the organization.

B3. Other Health Professional Education

The following activities may be counted:

- Providing a clinical setting for undergraduate training for dietitians, physical therapists, technicians, chaplaincy/pastoral care, social workers, pharmacists, and other health professionals (when there is no work requirement tied to training);
- Training of health professionals in special settings (occupational health, outpatient facilities, etc.);
- Unpaid costs of medical translator training (beyond what is mandated); and
- Medical libraries open to the general public.

Expenses associated with the following activities may not be counted:

- Education required for staff, such as orientation and in-service programs;
- Expenses for standard in-service training;
- On-the-job training, such as pharmacy technician and nursing assistance programs; and
- Programs where trainees are required to work for the organization.

B4. Scholarships/Funding for Professional Education

The following may be counted:

- Funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and health improvement;
- Nursing and health profession scholarships or tuition payments for professional education to non-employees and volunteers with no requirement to work for the organization as a condition of the scholarship; and
- Specialty in-service and videoconferencing programs made available to professionals in the community.

The following may not be counted:

- Costs for staff conferences and travel other than above;
- Financial assistance for employees who are advancing their own educational credentials;
- Staff tuition reimbursement costs provided as an employee benefit; and
- Financial assistance where students/trainees are required to work for the organization.

*C. Subsidized Health Services*²⁵

Subsidized health services (also known as negative margin services) are those services provided to the community that are not expected to be self-sustaining but: 1) which the CAH undertakes as a direct result of an identified community need; 2) would otherwise not be provided in the community if the CAH did not provide these services; or 3) responsibility for which would fall to government or another not-for-profit agency if the CAH did not provide these services. These services are provided despite a financial loss to the CAH and the negative margin remains after removing losses, measured by cost associated with charity care, bad debt, Medicaid shortfalls, and other means-tested government program shortfalls related to the delivery of these services. These subsidized health services include costs for billed services that are subsidized by the CAH because the facility incurs costs that are not reimbursed by third-party payers.

Subsidized services do not include ancillary services that support services lines, such as lab and radiology (if these services are provided to low-income patients, they should be reported as charity care/financial assistance).

This category should not be viewed as a “catch-all” category for any service that operates at a loss. Care needs to be taken to verify whether the subsidy is truly a community benefit and is being provided because of community need. Those initiatives geared towards increasing a hospital’s market share or that are a part of the hospital’s routine cost of doing business may not be included in a hospital’s community benefit report. (For CAHs that are considering reporting physician subsidies, only those costs that are not part of the hospital’s routine cost of doing business but are community benefit activities that arise as a result of the CAH’s mission should be included. CAHs should include the necessary detail to explain the nature and details of the physician subsidy.)

Remember to include only services that generate a negative margin and that have not been otherwise accounted for in a separate community benefit reporting section (including bad debt, charity care, Medicaid shortfalls, and other means-tested government program shortfalls).²⁶ The amount that the CAH subsidizes to maintain these services, but not what it subsidizes for individual patients, should be counted. Within this category, the CAH may count programs or service lines being subsidized and the amount that it subsidizes to provide these services. Examples of services that often qualify subsidized health services are described below.

The following activities/information may not be reported in this category:

- Ancillary services such as lab or radiology;
- Bad debt;
- Charity care;

²⁵ Ibid., 289-292.

²⁶ Care should be taken not to double-count information. Charity care, Medicaid shortfalls, and, if appropriate, Medicare shortfalls, related to the provision of these services should be separated from the subsidy provided for these services and reported under the appropriate category. Only the remaining loss (after separating charity care, Medicaid shortfalls and other means-tested government program shortfalls), as subsidized by the CAH, should be reported in this category.

- Medicaid shortfalls; and
- Medicare shortfalls (if appropriate).

The IRS Instructions for Form 990, Schedule H requires exclusions of shortfalls from bad debt.

C1. Emergency and Trauma Care Services

The following may be counted (if they meet the conditions described above):

- Air ambulance services;
- Emergency department;
- Local community emergency medical technician training (when there is a negative margin);
- Trauma center; and
- Fees to physicians to see Medicaid and uninsured patients.

Payment for routine on-call physician services may not be counted.

C2. Hospital Outpatient Services

The following may be counted (if they meet the conditions described above):

- Subsidized permanent outpatient services and primary/ambulatory care centers, whether they are located within the hospital facility or are freestanding facilities (e.g. urgent care center); and
- Mobile units including mammography and radiology units.

(IRS instructions require reporting/describing subsidies to physician clinics.)

C3. Women's and Children's Services

As with all community benefits in this category, count only those services for which an identified community need exists and for which the CAH's failure to provide the service would result in a shortage within the community. The following are examples of activities that may be counted (if they meet these conditions and those described above):

- Freestanding breast diagnostic centers;
- Newborn care (neonatal care, if provided, should be reported separately);
- Obstetrical services;
- Pediatrics; and
- Women's services.

Do not count services that are provided in order to attract physicians or health plans.

C4. Renal Dialysis Services (if subsidized and meets the conditions described above)

C5. Subsidized Continuing Care (if subsidized and meets the conditions described above)

The following are examples of subsidized continuing care services that may be counted:

- Hospice care;
- Home care services;
- Skilled nursing care or nursing home services;
- Senior day health programs; and
- Durable medical equipment.

Step-down or post-acute services provided in order to discharge outlier patients, to the financial advantage of the facility, may not be counted.

C6. Behavioral Health Services

The following services may be counted (if they meet the conditions described above):

- Inpatient mental health;
- Inpatient substance abuse (including detoxification);
- Outpatient mental health; and
- Outpatient substance abuse (including detoxification).

C7. Palliative Care

Outpatient and outreach palliative care programs may be counted (if they meet the conditions described above). Routine pain control programs may not be counted nor should the organization's inpatient palliative care program.

D. Research²⁷

Research includes any study or investigation with the goal of generating generalizable knowledge made available to the general public and/or other providers. The assumption is that the information generated has value to and is shared with others outside the organization. Research activities may include clinical and community health research, as well as studies on health care delivery. (Research activities where the findings are only used internally and not useful to a wider audience may not be counted as a community benefit.) In this category, count the total cost of qualifying research programs including direct and indirect costs. Grant funding does not need to be accounted for as offsetting revenue but should be tracked for budgeting and planning purposes.

²⁷ *A Guide for Planning & Reporting Community Benefit*, 292-293.

D1. Clinical Research

The following clinical research activities may be counted if the above described conditions are met:

- Research development costs, using formal research protocols;
- Studies on therapeutic protocols;
- Evaluation of innovative treatments; and
- Research papers prepared by staff for professional journals.

Research where findings are used only internally or yields knowledge for proprietary purposes may not be counted.

D2. Community Health Research

The following community health research activities may be counted if the above described conditions are met:

- Studies on health issues for vulnerable persons;
- Studies on community health and incidence rates of conditions for populations;
- Research papers prepared by staff for professional journals; and
- Research studies on innovative health care delivery models.

Market research and research where findings are only used internally or by the funder may not be counted.

E. Financial and In-Kind Contributions²⁸

This category includes funds and in-kind services donated to individuals not affiliated with the hospital and/or to community groups and other not-for-profit organizations. In-kind services include hours donated by staff members to the community during normally scheduled health care organization work time, overhead expenses of space donated to not-for-profit community groups for meetings, etc., and donation of food, equipment, and supplies.

The IRS requires that donations in this category be restricted to services or activities that would qualify as community benefits if provided by the organization itself. If the contribution is provided for a community building activity or program, it should be reported as part of community building.

²⁸ Ibid., 293-295.

E1. Cash Donations

As a general rule, CAHs should only count donations to organizations and programs that are for the same type of activities and programs that would count as community benefits provided by the hospital. The following may be counted:

- Contributions provided to not-for-profit community organizations;
- Contributions for providing technical assistance or evaluation of community coalition efforts;
- Contributions to charity events of not-for-profit organizations, after subtracting the market value of participation by employees or organization; and
- Financial assistance given outside the local community in response to natural disasters or poverty.

The following may not be counted:

- Employee-donated funds;
- Emergency funds provided to employees;
- Fees for sporting event tickets; and
- Time spent at golf outings or other primarily recreational events.

E2. Grants

These include grants made by the organization to community and other not-for-profit entities, projects, and initiatives. The following grants may be counted:

- Program, operating, and education grants;
- Matching grants;
- Event sponsorship; and
- General contributions to not-for-profit organizations/community groups.

Do not count grants passed through from an affiliated organization if already reported as a community benefit.

E3. In-Kind Donations

These include the costs associated with non-cash contributions of space, services, and supplies by the CAH to community organizations, projects, and initiatives. The following may be counted if the above described conditions are met:

- Meeting room overhead/space for not-for-profit organizations and community groups (e.g. coalitions, neighborhood associations, social service networks);
- Equipment and medical supplies (includes national and international donations with the greatest proportion of donations being local);
- Emergency medical care at a community event;

- Costs of coordinating community events not sponsored by the health care organization, e.g., March of Dimes Walk America;
- Employee costs associated with community health-related boards and other community involvement during work time;
- Food donations, including Meals on Wheels and donations to food shelters;
- Donations to community organizations and community members (not employees);
- Laundry services for community organizations;
- Other free ancillary services such as lab, radiology, and pharmacy services to other providers in the community, such as clinics or shelters; and
- Technical assistance, such as information technology, grant writing, accounting, human resource support and planning, and marketing.

The following may not be counted:

- Employee costs associated with board and community involvement when it is the employee's own time and he or she is not engaged on behalf of his or her organization;
- Volunteer hours provided by hospital employees on their own time for community events;
- Salary expenses paid for employees deployed on military services or jury duty, as these expenses are considered employee benefits; and
- Provision of facility parking vouchers for patients and families in need unless space would otherwise be filled by a paying customer.

F. Community-Building Activities²⁹

Community-building activities expenses include cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships or to address the root causes of health problems such as poverty, homelessness, and environmental problems and are not reportable under other sections of Schedule H.³⁰ These activities support community assets by offering expertise and resources of the health care organization. Information on community building activities should be reported in Part II of Schedule H. If the hospital makes a grant, donation or an in-kind contribution to an organization to be used to accomplish one of the community building activities listed below, then the hospital should include the amount of the grant, donation or in-kind contribution on the appropriate line in Part II. Hospitals will be expected to describe how activities recorded in this section contribute to or promote the health of the communities served by the hospital. Do not include any contribution made by the hospital that was funded in whole or in part by a restricted grant, to the extent that such grant was funded by a related organization. A review of the CHA Guide for Planning and Reporting Community Benefit and the IRS instructions for Form 990, Schedule H suggests that the IRS is taking a somewhat narrower view of this area of community benefit activity than the CHA framework by specifically focusing on the extent to which community building activities contribute to the health of the communities served by the hospital.

²⁹ Ibid., 296-301.

³⁰ Internal Revenue Service. (2008). *Instructions for Form 990, Return of Organization Exempt from Income Tax*. [Online.] Available: <http://www.irs.gov/pub/irs-pdf/i990.pdf>. Accessed June 16, 2009.

F1. Physical Improvements/Housing (Reported on Line 1, Part II)

The following activities may be counted:

- Provision or rehabilitation of housing for vulnerable populations (such as removing building materials that harms the health of residents);
- Neighborhood improvement and revitalization projects;
- Provision of housing for vulnerable populations upon discharge from an inpatient facility;
- Housing for low income seniors; and
- Development or maintenance of parks and playgrounds to promote physical activity.

F2. Economic Development (Reported on Line 2, Part II)

The following may be counted:

- Assisting small business development in neighborhoods with vulnerable populations; and
- Creating new employment opportunities in areas with high rates of joblessness.

F3. Community Support (Reported on Line 3, Part II)

This includes efforts to establish or enhance the operational structures of the community and community networks. Activities include both community-based and facility-based initiatives. The following may be counted:

- Child care and mentoring programs for vulnerable populations or neighborhoods;
- Neighborhood support groups;
- Violence prevention programs; and
- Disaster readiness and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.

F4. Environmental Improvements (Reported on Line 4, Part II)

The following may be counted:

- Efforts to reduce environmental hazards that affect community health such as alleviation of water or air pollution;
- Safe removal or treatment of garbage and other waste products;
- Neighborhood and community improvements such as toxin removal in parks; and
- Residential improvements, such as lead and radon programs.

The following may not be counted:

- Expenditures made to comply with environmental laws and regulations that apply to activities of itself, its disregarded entity or entities, a joint venture in which it has an ownership interest, or a member of a group exemption included in a group return of which the organization is a member; and
- Expenditures related to environmental hazards caused by, or the environmental impact of, its own activities, or those of its disregarded entities, joint ventures, or group exemption members.

F5. Leadership Development/Training for Community Members (Reported on Line 5, Part II)

The following may be counted:

- Training in conflict resolution;
- Training for civic, cultural, or language skills; and
- Medical interpreter training for community members.

F6. Coalition Building (Reported on Line 6, Part II)

The following may be counted:

- Hospital representation to community coalitions and other collaborative efforts with the community to address health and safety issues.

F7. Community Health Improvement Advocacy (Reported on Line 7, Part II)

The following may be counted:

- Efforts to support policies and programs to safeguard or improve:
 - Access to health care services;
 - Public health;
 - Transportation; and
 - Housing.

F8. Workforce Enhancement (Reported on Line 8, Part II)

These programs address community-wide workforce issues, not the workforce needs of the health care organizations, which should be considered human resources rather than community benefit activities. The following activities may be counted:

- Recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved; and

- Collaboration with educational institutions to train and recruit health professionals needed in the community (other than the health profession activities reported in Section B).

The following may not be counted:

- Routine staff recruitment and retention initiatives;
- Programs designed primarily to address workforce issues of the CAH;
- In-service education and tuition reimbursement programs for current employees;
- Scholarships for nurses and other health professionals (count in Category IV.B, Health Professions Education);
- Scholarships to community members not specific to health care professions (count in Section IV.E1); and
- Employee workforce mentoring, development, and support programs.

F9. Other (Reported on Line 9, Part II)

The following may be counted:

- Community building activities that protect or improve the community's health or safety that are not described in categories 1-8 described above.

G. Community Benefit Operations³¹

Community benefit operations include costs associated with assigned staff, community health needs and/or assets assessment, and other costs associated with community benefit strategy and operations.

G1. Assigned Staff

The following may be counted:

- Costs of staff management/oversight of community benefit program activities that are not included in other community services categories;
- Staff costs for internal tracking and reporting community benefits; and
- Costs of staff coordination of community benefit volunteer programs.

The following may not be counted:

- Costs of staff coordination of in-house volunteer programs; and
- Volunteer time of individuals for community benefit volunteer programs.

³¹ Ibid., 301-302.

G2. Community Health Needs/Health Assets Assessment

The following may be counted:

- Community health needs assessment; and
- Community assessments, such as a youth asset survey.

The following may not be counted:

- Costs of a market-share assessment and marketing survey process; and
- Economic impact survey costs or results.

G3. Other Resources

The following may be counted:

- Cost of evaluation efforts of community benefits initiatives or programs;
- Cost of raising funds for hospital-sponsored community benefit programs, including grant writing and other fund-raising costs;
- Cost of grant writing and other fund-raising costs for equipment used for hospital-sponsored community benefit services and activities;
- Costs associated with developing a community benefit plan, conducting community forums, and reporting community benefit; and
- Overhead and office expenses associated with community benefit operations exclusive of fund-raising costs;
- Dues to an organization that specifically support the community benefit program;
- Software that supports the community benefit program; and
- Cost associated with attending educational programs to enhance community benefit planning and reporting.

The following may not be counted:

- Grant writing and other fund-raising costs of hospital projects (such as capital funding of buildings and equipment) that are not hospital community benefit programs; and
- Dues to hospital and professional organizations not specifically and directly related to community benefit.

V. ACCOUNTING GUIDELINES AND COST CALCULATIONS³²

This section contains accounting guidelines and recommendations on the use of financial reports, Medicare Cost Reports, and the use of cost-to-charge ratios in collecting and reporting

³² Catholic Health Association of the United States, VHA Inc. & Lyon Software. *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability*. St. Louis, MO: Catholic Health Association of the United States; 2005.

community benefit data. These guidelines and recommendations are intended to provide general advice for CAH managers and staff members charged with collecting their hospital's community benefit data. They are not intended to supplant the advice of the hospital's financial staff and/or accountants. We strongly encourage CAHs to consult their financial staff and/or accountants prior to undertaking this process. Additional accounting advice is provided in the Catholic Health Association of the United States' *Guide for Planning and Reporting Community Benefit*, 2008 Edition.

A. Financial Data

To express community benefit categories as a percentage of annual expenses or revenue, it is important to include final audited amounts, when available, for the fiscal year being reported. There are two consistency issues here: (1) it is important for a hospital to be consistent from year to year; (2) it could be important for a hospital, in comparing itself with other hospitals, to be consistent in terms of which components of revenue and expense are included. Standard financial data include:

- Operating revenue
 - Net patient service revenue
 - Other revenue
- Operating expenses
 - Total operating expenses
- Net revenue (loss) from operations
- Non-operating gains
 - Interest income and other non-operating gains
- Net revenue (loss)

When calculating community benefit as a percent of revenue and/or operating expenses, use total operating revenue, which includes net patient service revenue and other revenue. When calculating community benefit as a percent of operating expenses, use only the total operating expenses figure.

B. Direct Costs

Direct costs include salaries, employee benefits, supplies, interest on financing, travel, and other costs that are directly attributable to the specific service or program and that would not exist if the service or program did not exist.

C. Indirect Costs

Indirect costs are costs not attributed to services or programs that are included in the calculation of costs for community benefit. These could include but are not limited to human resources and finance departments, insurance, support departments and overhead expenses. An indirect cost factor is determined by dividing total indirect costs by total direct costs.

D. Indirect Cost Factor

Typically, cost accounting systems allow for the allocation of indirect (e.g., overhead) costs to programs based on sophisticated allocation techniques. This is the preferred approach if the hospital's accounting system has this capacity. In the absence of a cost accounting system, community benefit experts recommend computing an indirect cost factor and using this factor to allocate indirect costs to each category of community benefit activities using data from the Medicare Cost Report or from studies conducted by the finance department. Indirect costs are the costs for support or administrative services that cannot be directly associated with a program or service line and would include such hospital departments as administrative and general services, maintenance, finance, the business office, housekeeping, personnel, etc. The indirect cost factor may be added to any community benefit in categories A, F, and G as applicable. The following formula can be used to calculate total indirect costs:

$$\text{(Total Indirect + Direct Costs)/Direct Costs} - 1 = \text{Indirect Cost Factor}$$

Example

$$\text{Indirect (A) + Direct (B) / Direct (B) - 1 = Indirect Cost Factor}$$
$$(\$2,000,000 + \$6,000,000) / \$6,000,000 - 1 = .333$$

Total Hospital Indirect Costs (A)	\$2,000,000 (A)
Total Hospital Direct Costs (B)	\$6,000,000 (B)

To calculate total cost for community benefit in the community services area, multiply total direct costs for the activity/project by this indirect cost factor, and then add this sum to direct costs.

Example

$$\begin{aligned} \text{Direct Costs for Community Education Activities} &= \$20,000 \\ \text{Indirect Cost Factor} &= .333 \\ \text{Indirect Costs} &= \$20,000 \times .333 = \$6,660 \\ \text{Total Costs for Community Education Activities} &= \$20,000 \text{ (Direct)} + \$6,660 \text{ (Indirect)} = \\ &= \$26,660 \end{aligned}$$

CHA (2008) recommends calculating at least two indirect cost rates to be used in assigning indirect costs to community benefit activities— one rate for hospital-based programs and a second rate for community-based programs. CHA's rationale is that hospital-based programs should absorb the higher costs of utilities, maintenance, and other indirect costs associated with a program housed in the hospital. As programs housed in community settings outside of the hospital rely less on the hospital for support and administrative services, it is appropriate to develop a lower "community-based" indirect cost rate that reflects the actual overhead resources used by the program.

*E. Calculating Community Benefit Costs*³³

In calculating community benefit costs, the IRS allows hospitals to use data from their cost accounting systems or to estimate costs using a cost-to-charge ratio. The method used should be explained in a footnote to your CAH's community benefit report.

Either the CAH's financial statements or its Medicare Cost Report may be used to calculate community benefit costs. CAHs that have a cost accounting system in place can use this system to more accurately determine costs. As the adoption of cost accounting systems is inconsistent across hospitals, each CAH/health system should strive for the most accurate accounting practices possible, whether through cost accounting or calculating a cost-to-charge ratio, and work to improve reporting accuracy from year to year, rather than assume consistent methodology solely for comparative purposes.

The following sections will provide additional detail on the calculation of costs in several key areas.

E1. Subsidized Health Services

Subsidized health services include costs for billed services that are subsidized by the health care organization. These services generate a bill for reimbursement, and include clinical patient care services that are provided despite a negative margin. Take care not to double-count information. Charity care, bad debt, Medicaid shortfalls, and other means-tested government program shortfalls should be subtracted from the costs of providing these services to determine the level of subsidy provided by the hospital, if any.

For example, assume a situation in which a hospital emergency department operates at an annual loss of \$200,000. Medicaid shortfalls, other means-tested government program shortfalls, charity care, and bad debt account for one half of the total loss, and are reported elsewhere. Thus, only one half, or \$100,000 of the emergency department loss would be counted as a community benefit in the subsidized health services area.

The category of subsidized services is not a "catch-all" category for any services that operate at a loss. Ascertain whether the negative contribution margin is truly a community benefit based on the criteria described above. Do not count all negative margin departments, programs, or services that contribute to the delivery of the overall subsidized service. Do not include bad debt.

E2. Charity Care

There is general consensus among community benefit experts that traditional charity care should be reported in terms of costs, not charges. As mentioned earlier, charity care does not include bad debt. CAHs may use their accounting system to determine the costs of charity care or use the ratio of costs to charges to estimate costs.

³³ Ibid.

E3. Bad Debt

Bad debt represents uncollectible charges excluding contractual adjustments, arising from the failure to pay by patients whose health care has not been classified as charity care. Bad debt should be reported in terms of costs, rather than charges, using data from the CAH's cost accounting system or estimated through the use of the ratio of costs to charges. Although Schedule H of Form 990 requires hospitals to report bad debt, it is not automatically considered a community benefit. CAHs should prepare a justification, if appropriate, for why their bad debt, or some portion thereof, should be considered a community benefit.

E4. Government-sponsored Health Care

Government-sponsored health care community benefit includes unpaid costs of public programs, the "shortfall" created when a facility receives payments that are less than costs for caring for public program beneficiaries. This "payment shortfall" is not the same as a contractual allowance, which is the full difference between charges and government payments.

The unpaid costs of the following public programs may be counted as a community benefit:

- Medicaid;
- Medicare in some circumstances (as described earlier in this document); and
- Public and/or indigent care: medical programs for the indigent, medically indigent, or local and state programs that provide payments to health care providers to persons not eligible for Medicaid.

All shortfalls must be based on costs, not charges, and may be calculated using the CAH's cost accounting system or estimated through the use of the ratio of costs to charges. Total costs of providing care to patients covered by these programs should be calculated. All payments received from these sources should then be subtracted from the total costs. The resulting shortfall, if any, for Medicaid or public/indigent care programs may be counted as a community benefit.

As explained above, Medicare shortfalls may be, but are not automatically, considered a community benefit. The IRS provides an opportunity for hospitals to describe why their Medicare shortfalls, or some portion thereof, should be considered a community benefit in Part IV of Schedule H, Form 990.

E5. Financial Statements

Financial statements are the preferred source for calculating cost-to-charge ratios for the following reasons:

- Financial statements most accurately reflect internal accounting practices for tracking community benefit programs and services;
- Negative margin departments (subsidized health services) are easily identified and tracked; and

- Community benefit can be calculated in conjunction with an organization’s annual financial audit.

E6. Medicare Cost Report

The Medicare Cost Report is not the preferred source for calculating cost-to-charge ratio for the following reasons:

- The Medicare Cost Report is based upon certain “allowable” expenses for reimbursement; and
- Certain expenses are “disallowed” and cost centers can be “non-reimbursable.”

While these expenses may not be included in an organization’s cost report and/or internal accounting practices for grouping costs, they can qualify as community benefit. Therefore, total community benefit may not be captured if the cost-to-charge ratio is calculated using Medicare cost reporting criteria.

Because of the cycle associated with completing cost reports and finalizing cost reports, estimates are often used. Estimates do not always accurately capture total community benefit.

The Medicare Cost Report may be used to calculate the in-kind community benefit expense of providing hospital space for regular meetings or special events to nonprofit community-based organizations or informal community groups (e.g. coalitions, neighborhood associations, social service networks). The value of room space on a square foot basis may be determined by using the unit cost multiplier from Worksheet B-1, line 104 of the Medicare Cost Report. The multiplier includes depreciation costs, maintenance and repairs, operation of plant, and housekeeping. These will be multiplied by the square footage of the room(s) used.

E7. Unreimbursed Cost of Care

When considering the total unreimbursed costs of care in the health care service areas, be sure to think through what is included before applying a cost-to-charge ratio. Avoid double counting.

E8. Indirect Costs

Indirect costs should only be reported only if they have not already been included in calculating direct costs or if they have not been included in other community benefit categories, such as medical education or community health services. Avoid double counting.

E9. Grants & Supplemental Revenue

The IRS does not require restricted or unrestricted grants or contributions received by the hospital and used to provide a community benefit to be subtracted from total costs to determine community benefit.

E10. Capital Items/Depreciation Expenses

Depreciation expenses, not initial costs or net book values, should be reported for capital equipment items that are used to provide community benefits. Examples include the following:

- Call center telecommunications equipment;
- Vans and other automobiles used for transportation programs and/or clinics;
- Lab screening equipment;
- Laptops used for community assessment programs; or
- Computers and IT systems for mobile outreach programs and clinics.

E11. Guidelines into Practice: Coordination with the CAH's Finance Team

The Community Benefit Coordinator and/or Team should meet with the Chief Financial Officer and members of the finance staff regularly to review definitions, guidelines, internal inventory status, and plans for reporting to maximize the accuracy and integrity of the CAH's data. In addition, community benefit experts recommend that the CFO or CEO of the hospital formally sign off on its annual community report.

VI. FOUNDATION-FUNDED COMMUNITY BENEFIT³⁴

A foundation is a separate not-for-profit organization affiliated with the CAH that conducts fund-raising activities. A foundation can support health care organization operations and/or may fund community health improvement programs, activities, and research. Alignment of the foundation's philanthropic and fund raising activities and local community health improvement needs demonstrate a commitment to mission and advances the hospital's business goals while improving community health. The same standards used to determine community benefit activities for hospitals apply to determining foundation-funded community benefit activities. Foundation-funded community benefits are defined as significant community benefit activities, including community health improvement initiatives, school-based clinics, community partnership development, and other areas that are funded by the foundation. Foundation departments that are part of the health care organization's operations should record community benefit activity in the health care organization sections. Include indirect costs in all categories.

A. Community Services

Community health services include activities designed to improve community health. They extend beyond patient care activities and are usually subsidized by the health care organization. Community services do not generate inpatient or outpatient bills, although there may be a nominal patient fee and/or sliding scale fee. Forgiving inpatient and outpatient care bills to low-income persons should be reported as charity care. Count the following foundation-funded community services activities:

³⁴ Ibid.

- Community health education;
- Community-based clinical services;
- Support groups;
- Health care support services;
- Self help; and
- Other.

More detail regarding the counting of community services to quantify can be found in sections IV.A1 through IV.A6 of this document.

B. Community Building

Community-building activities include cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships. The following foundation-funded community-building activities should be counted:

- Physical improvements/Housing;
- Economic development;
- Support system;
- Environmental improvements;
- Leadership development/Training for community members;
- Coalition building;
- Community health improvement advocacy; and
- Workforce enhancement.

C. Other Areas

Count the following additional foundation-funded community benefits:

- Community benefit operations costs;
- Other community benefit programs or services that do not fit within the two sections above; and
- Indirect costs.

The following are commonly occurring activities that, according to the CHA community benefit framework, may not be counted:

- Activities specifically intended to increase market share;
- Facility anniversary celebrations;
- Grand opening events, dedications, and related activities for new services and facilities;
- Nurse call lines paid for by payers or physicians;
- Providing copies of medical records and x-rays;
- Providing continuing medical education (CME), orientation, and in-service education;
- Discharge planning;

- Salary expenses for employees deployed for military services or jury duty, as these expenses are considered employee benefits;
- Promotional and marketing information about health care organization services and programs;
- Social services for patients;
- Problem resolution and referral of issues related to health system services;
- Cardiac rehabilitation services;
- Tokens of sympathy to staff or patients at times of crisis or bereavement (e.g., flowers or cards);
- Free or discounted immunizations and other health services to staff members (employee benefit);
- Providing information on services provided by the health system at a health fair or mall;
- Decorating facilities for the holidays;
- In-house pastoral care;
- Free meals and meal discounts for volunteers and/or employees;
- Free parking for clergy and volunteers;
- Medical library (include percentage of costs only if there is a significant consumer health focus);
- Staff donations to assist other staff members;
- Pharmacy discounts for employees and volunteers;
- Reimbursed home health care services;
- Staff volunteering (report only volunteer efforts during work time);
- Volunteer time by community volunteers for either in-house or community efforts;
- Professional education such as in-services and costs for professional conferences;
- Economic impact of employee payroll and purchasing expenditures;
- Employee contributions to organizations such as the United Way;
- Physician referral for internal marketing (include if it refers to many community organizations or to physicians from across an area, without regard to admitting practices);
- Hospital tours;
- Amenities for visitors such as coffee in the waiting rooms, etc.;
- Costs of inpatient health education;
- Costs associated with provision of day care services for employees;
- Employee costs associated with community involvement when it is the employee's own time for personal or civic interests;
- Presentations to professional organizations by staff members;
- Costs of tuition reimbursement provided as an employee benefit; and
- Nurses teaching/delivering papers at professional meetings where the focus is on the nurse's professional development.

**APPENDIX A:
COMMUNITY BENEFIT DEFINITIONS** ³⁵

- Bad Debt:** Uncollectible charges, excluding contractual adjustments, arising from the failure to pay by patients whose health care has not been classified as charity care. Bad debt is not a community benefit.
- Broader Community:** “Broader community” means persons other than a “target population” who benefit from a health care organization’s community services and programs.
- Charity Care:** Charity care is: 1) free or discounted health services provided to persons who cannot afford to pay; 2) care to uninsured, low-income patients who are not expected to pay all or part of a bill, or who are able to pay only a portion using an income-related fee schedule; 3) health care services that were never expected to result in cash inflows; and/or 4) the unreimbursed cost to the health system for providing free or discounted care to persons who cannot afford to pay and who are not eligible for public programs. Charity care results from a provider’s policy to provide free or discounted health care services to individuals who meet certain financial criteria. Generally, a bill must be generated and recorded and the patient must meet the organization’s criteria for charity care and demonstrate an inability to pay. Charity care does not include bad debt.
- Community:** "Community" describes all persons and organizations within a circumscribed geographic area in which there is a sense of interdependence and belonging. The term “broader community” refers to persons other than a “target population” who benefit from a health care organization’s community services and programs.
- Community-Based Clinical Services:** These are clinical services provided to the community (e.g., free clinics, screenings, or one-time events). This category does NOT include permanent subsidized hospital outpatient services.
- Community Benefit:** Community benefit is a planned, managed, organized, and measured approach to a health care organization’s participation in meeting identified community health needs. It implies collaboration with a “community” to “benefit” its residents—particularly the poor; racial, ethnic, or cultural minorities; and other underserved groups—by improving health status and quality of life. Community benefits respond to identified community needs and meet at least one of the following criteria: 1) generate a negative margin; 2) respond to needs of special populations, such as racial, ethnic, or cultural minorities; frail elderly; persons living in poverty; persons with

³⁵ Based on Catholic Health Association’s community benefit reporting guides, 2005 and 2008 editions., op. cit.

disabilities; persons with chronic mental illness; and persons with AIDS; or 3) the services or programs would likely be discontinued if the decision were made on a purely financial basis.

Community Benefit Categories:

Community benefit programs and initiatives are quantified in broad categories. Community benefit can be quantified for the hospital, health system, and/or dependent foundation. These categories are:

- Charity Care
- Government-sponsored Health Care
- Community Health Services
- Health Professions Education
- Subsidized Health Services
- Research
- Financial Contributions
- Community-Building Activities
- Community Benefit Operations

Community Benefit Operations:

Community benefit operations are costs associated with assigned staff, community health needs and/or assets assessment, and other costs associated with community benefit strategy and operations.

Community Benefit Plan:

A community benefit plan is a document, often produced in conjunction with the health care organization's annual strategic plan that explicitly details how an organization intends to fulfill both its mission of community service and its charitable, tax-exempt purpose. It includes a description of community benefit priorities, programs, staffing and resources, and anticipated outcomes.

Community Benefit Programs/Services:

Community benefit programs and services are projects and services identified by health care organizations in response to the findings of a community health assessment, strategic and/or clinical priorities, and priorities identified by the CAH's collaborative community partners.

Community Building:

Community-building activities include cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships. Activities include physical improvements, economic development, healthy community initiatives, partnerships, environmental improvements, and community leadership skills training.

Community Health Assessment:

Usually conducted in collaboration with other community groups and organizations, a community health assessment is a structured process for determining the health status and needs of community members, as well as identifying target community health improvement programs and services.

Community Health Education:

Community health education includes lectures, presentations, and other programs and activities provided to groups, without providing clinical or diagnostic services. Community benefits in this area can include staff time, travel, materials, and indirect costs.

Community Health Services:

Community health services include activities carried out for the express purpose of improving community health. They extend beyond patient care activities and are usually subsidized by the hospital. Community services do not generate inpatient or outpatient bills, although there may be a nominal patient fee and/or sliding scale fee. Forgiving inpatient and outpatient care bills to low-income persons should be reported as charity care.

Community Impact: Community impact is a concept that builds upon and incorporates the concept of “community benefit” to provide a more comprehensive approach to measuring the impact of CAHs on their communities. “Community impact” is consistent with the definition of “community benefit” except that it does not impose the criterion that programs or activities must be provided at a low or negative margin. The Flex Monitoring Team’s three-tiered community impact framework identifies the full range of hospital activities and programs that positively impact the health and well-being of communities including those that:

1. Expand access to health care services and programs for members of the community including those services and programs that are unsubsidized, have a source for reimbursement to the CAH, and/or are expected to be self-sustaining;
2. Document the economic benefits of CAHs as an employer and consumer of goods and services in the community; and/or
3. Fall into the more tightly defined category of community benefit activities as developed by CHA, VHA, and PHI and adopted by the IRS and some state community benefit reporting initiatives.

Continuing Care Services:

Continuing care services include hospice home care services, nursing home care, geriatric services, senior day centers, and assisted living.

Direct Costs: Direct costs include salaries, employee benefits, supplies, interest on financing, travel, and other costs that are directly attributable to the specific service/department that would not exist if the service or effort did not exist.

Donations: This category includes funds and in-kind services donated to individuals and/or the community-at-large. In-kind services include hours donated by health care organization staff members to the community during work time; overhead expenses of space donated to not-for-profit community groups for meetings, etc.; and donation of food, equipment and supplies.

Foundation: A foundation is a separate not-for-profit organization affiliated with the health care organization that conducts fund-raising activities. A foundation can support core health care organization operations and/or fund community health improvement programs, activities, and research. Alignment of a foundation's philanthropic and fund-raising activities and local community health improvement needs is an emerging strategic alliance that demonstrates commitment to mission and advances the hospital's business goals while improving community health. Foundation-funded community benefits are defined as significant community benefit activities, including community health improvement initiatives, school-based clinics, community partnership development, and other areas that are funded by the foundation. Foundation departments that are part of the health care organization's operations should record community benefit activities in the health care organization sections.

Free Clinics: A free clinic provides free or low-cost health care to medically uninsured or underinsured persons through the use of volunteers, including physicians and health care professionals who donate their time.

Government-Sponsored

Health Care: Government-Sponsored Health Care describes services that are reimbursed or partially reimbursed through government-sponsored programs such as Medicare.

Health Care Support

Services: Support given on a one-on-one basis to assist community members.

Indigent: A financially indigent individual is an uninsured or underinsured person who is accepted for care with no obligation (or a discounted obligation) to pay for the services rendered, based on the health care organization's eligibility system.

Indirect Costs: Indirect costs are costs not attributed to products and/or services that are included in the calculation of costs for community benefit. These could

include but are not limited to human resources and finance departments, insurance, support departments and overhead expenses.

Immunizations: Immunization services include personnel, equipment, and supplies necessary to provide immunizations to community members and groups.

In-kind Services: In-kind services include hours donated by health care organization staff members to the community during work time, as well as overhead expenses of space donated to not-for-profit community groups for meetings, etc.

Means-Tested Government

Health Care: Means-Tested Government Health Care describes services that are reimbursed or partially reimbursed through means-tested government programs for low income persons such as Medicaid, and public indigent and health care programs.

Medical Education: Medical education includes the negative margin (the difference between cost and reimbursements) incurred in providing clinical settings, including clinic costs, internships, and programs for physicians, nurses, and health professionals. It also refers to scholarships for health profession education related to providing community health improvement and services and specialty in-service programs to professionals in the community.

Mobile Unit: A van or other mobile unit used to deliver primary care services.

Negative Margin: Negative margin is the negative difference between what it costs to offer programs, health care, or services, and any cash or reimbursements received (e.g., the cost of the program or service exceeds its revenues).

Non-billed Services: Non-billed services are activities and services for which no individual patient bills exist. These services are not expected to be financially self-supporting, although some may be supported by outside grants or funding. They are offered as a public benefit with charitable or community service intent.

Patient Education: Patient education is health education provided to inpatients and outpatients. For the purposes of standardized reporting, it is recommended that hospitals consider patient education a standard component of health care and not a community benefit.

Poor: The poor are persons who cannot afford health care because they have inadequate resources and/or are uninsured or underinsured. Community benefit programs for the poor are geared to reduce morbidity and mortality in beneficiaries of Medicaid or state or local indigent programs. They draw most of their users from a site demonstrated to be poor or medically

underserved through demographic data and/or the designations of medically underserved or health manpower shortage areas.

- Research:** Research includes studies on health care delivery, unreimbursed studies on therapeutic protocols, evaluation of innovative treatments, and research papers prepared by staff for professional journals.
- Screenings:** Screenings are health tests that are conducted in the community as a public clinical service, such as blood pressure measurements, cholesterol checks, and school physicals. They are a secondary prevention activity designed to detect the early onset of illness and disease and can result in a referral to a community medical resource.
- Self-Help:** Self-help refers to wellness and health promotion programs such as exercise classes, smoking cessation and nutrition education.
- Support Groups:** Support groups typically are established to address social, psychological, or emotional issues related to specific diagnoses or occurrences. These groups may meet regularly or intermittently.
- Target Group:** A target group is the primary audience for which a program is intended, such as children, adolescents, seniors, uninsured persons, low-income persons, or persons with disabilities.

**APPENDIX B:
COMMUNITY BENEFIT INVENTORY
Event/Activity Form**

Title of event/activity: _____

Category of event/activity (Choose the ONE BEST FIT/PRIMARY FOCUS):

- | | |
|---|---|
| <p>A. COMMUNITY HEALTH IMPROVEMENT SERVICES</p> <ul style="list-style-type: none"><input type="checkbox"/> A1. Community Health Education<input type="checkbox"/> A2. Community-Based Clinical Services<input type="checkbox"/> A3. Health Care Support Services <p>B. HEALTH PROFESSIONS EDUCATION</p> <ul style="list-style-type: none"><input type="checkbox"/> B1. Physicians/Medical Students<input type="checkbox"/> B2. Nurses/Nursing Students<input type="checkbox"/> B3. Other Health Professional Education<input type="checkbox"/> B4. Scholarships/Funding for Professional Education <p>C. SUBSIDIZED HEALTH SERVICES</p> <ul style="list-style-type: none"><input type="checkbox"/> C1. Emergency and Trauma Services<input type="checkbox"/> C2. Neonatal Intensive Care<input type="checkbox"/> C3. Hospital Outpatient Services<input type="checkbox"/> C4. Burn Unit<input type="checkbox"/> C5. Women's and Children's Services<input type="checkbox"/> C6. Renal Dialysis Services<input type="checkbox"/> C7. Subsidized Continuing Care<input type="checkbox"/> C8. Behavioral Health Services<input type="checkbox"/> C9. Palliative Care <p>D. RESEARCH</p> <ul style="list-style-type: none"><input type="checkbox"/> D1. Clinical Research<input type="checkbox"/> D2. Community Health Research<input type="checkbox"/> D3. Other Research | <p>E. FINANCIAL AND IN-KIND CONTRIBUTIONS</p> <ul style="list-style-type: none"><input type="checkbox"/> E1. Cash Donations<input type="checkbox"/> E2. Grants<input type="checkbox"/> E3. In-Kind Donations<input type="checkbox"/> E4. Cost of Raising Funds for CB Programs <p>F. COMMUNITY-BUILDING ACTIVITIES</p> <ul style="list-style-type: none"><input type="checkbox"/> F1. Physical Improvements/Housing<input type="checkbox"/> F2. Economic Development<input type="checkbox"/> F3. Community Support<input type="checkbox"/> F4. Environmental Improvements<input type="checkbox"/> F5. Leadership Development/Training
for Community Members<input type="checkbox"/> F6. Coalition Building<input type="checkbox"/> F7. Comm. Health Improvement Advocacy<input type="checkbox"/> F8. Workforce Development <p>G. COMMUNITY BENEFIT OPERATIONS</p> <ul style="list-style-type: none"><input type="checkbox"/> G1. Assigned Staff<input type="checkbox"/> G2. Community Health Needs/Assets Assessment<input type="checkbox"/> G3. Other Resources |
|---|---|

Category: Persons living in poverty (under 300% of FPL) Broader Community

Description: _____

Contact person: _____ **Phone:** _____

If this is a collaborative effort, who are your partners and what are their respective roles? _____

How does this activity address an unmet community need? _____

Intended Outcomes/Baseline/Strategies: _____

Outputs: Persons served _____ **Meetings/classes held** _____ **Other outputs** _____

Outcome indicators: _____

Outcome time frame (indicate time frame for expected outcomes):

Short term (< 1 year) ____ Intermediate Term (1–5 years) ____ Long Term (>5 years) ____

Anecdotal results/outcomes: _____

HOURS: Staff _____ **Volunteer** _____

EXPENSES

Salaries and benefits expenses (complete for each staff person involved; add more staff numbers if necessary.)

Staff #1 Job class/type _____

\$ _____ X (1+ multiplier) X _____ = \$ _____
(Average hourly wage) (benefits) (hours worked) Salary and benefit expense – Staff 1

Staff #2 Job class/type _____

\$ _____ X (1+ multiplier) X _____ = \$ _____
(Average hourly wage) (benefits) (hours worked) Salary and benefit expense – Staff 2

Total Salaries and Benefits \$ _____

Purchased Services \$ _____

Supplies \$ _____

Other Direct Expenses \$ _____

Indirect Expenses \$ _____

Total salaries and expenses \$ _____

FUNDING & OFFSETTING REVENUE

Foundation/funds raised \$ _____

Grants/support Source of grant: _____ \$ _____

Fees collected \$ _____

Other (voluntary contributions, etc.) \$ _____

Total funding and offsetting revenue \$ _____

Setting/location (select all that apply):

- Community (mall, community center, etc.)
- School
- Workplace
- Home
- In facility (not within a clinical setting)
- Inpatient
- Outpatient
- Speakers Bureau

Format (select all that apply):

- Clinic
- Events/Meetings
- Health Fairs/Screenings
- Newsletter
- Seminars
- TV/Radio

Target audiences:

Special needs populations (select all that apply):

- Persons with disabilities
- Uninsured/underinsured
- Racial, cultural and ethnic minorities
 - American Indian/Alaska Native
 - Asian
 - Black or African American
 - Native Hawaiian or Other Pacific Islander
 - White
 - Hispanic or Latino
 - Women

Ages of targeted audience (select all that apply):

- Infants
- Children
- Teens
- Adults
- Seniors
- All Ages

Genders:

- Male
- Female
- Both

Form completed by: _____ **Phone:** _____