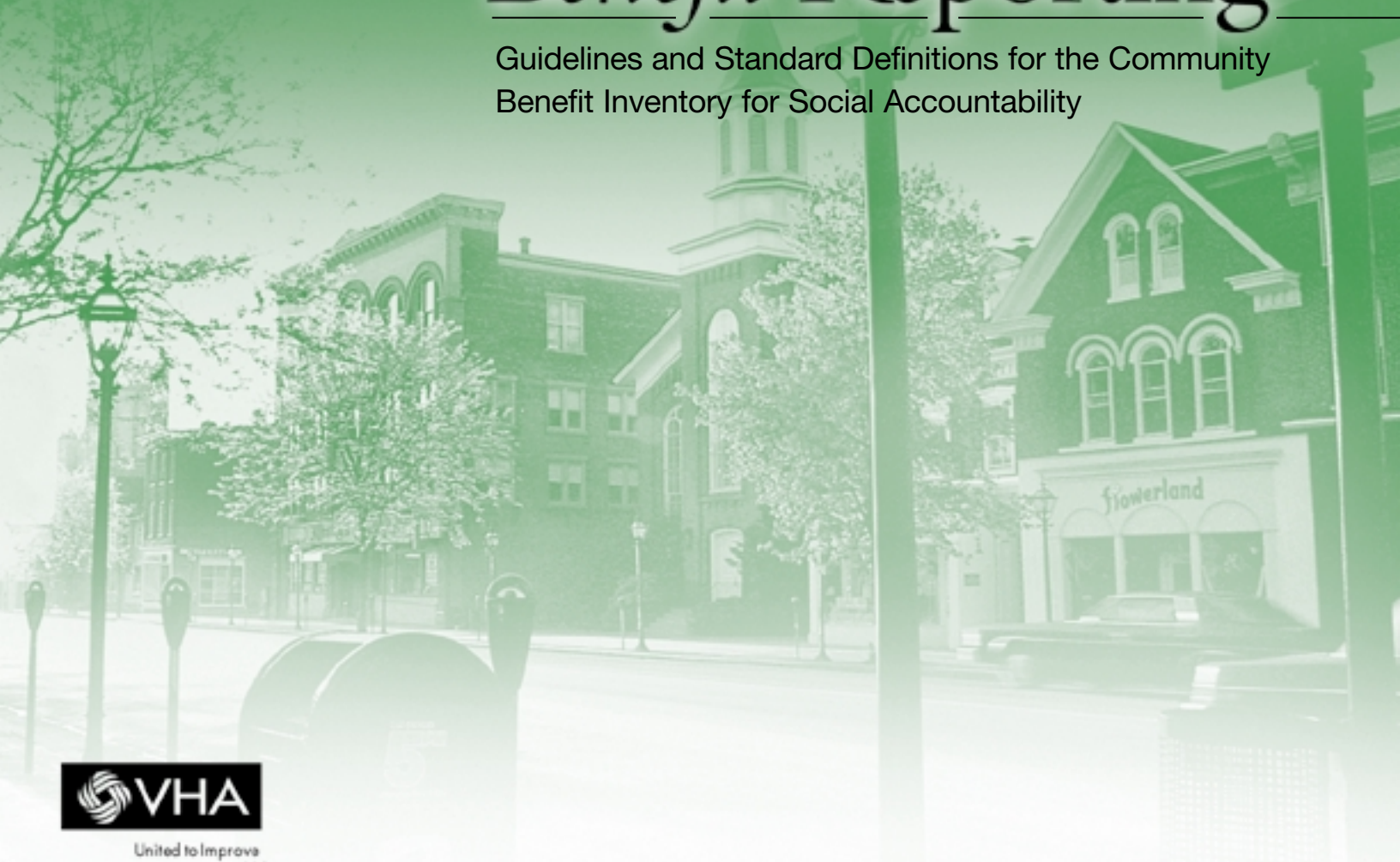




Community *Benefit Reporting*

Guidelines and Standard Definitions for the Community
Benefit Inventory for Social Accountability



United to Improve
America's Health®



THE CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES



Lyon Software

The St. Louis-based Catholic Health Association of the United States (CHA) is the national membership association of the Catholic health ministry. By pursuing the strategic directions of mission, ethics, and advocacy, CHA is engaged in strengthening the health ministry for the future and creating health care that works for all. CHA represents more than 2,000 sponsors, systems, facilities, and related organizations that form the nation's largest group of not-for-profit health care. Founded in 1915, CHA unites the ministry engaged to advance selected strategic issues that are best addressed together rather than as individual organizations.

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VHA Inc. is a national cooperative of leading not-for-profit health care organizations that work together to improve the health of the communities they serve. VHA leverages the collective strength of the membership to improve clinical, operational and financial performance. Through the VHA cooperative, members benefit from resources that assess critical needs and identify best practices to create customized solutions that lower costs and improve clinical quality. As a cooperative, VHA distributes income annually to members based on their participation. VHA is based in Irving, Texas, with 18 offices across the U.S. For more information, go to www.vha.com.

Lyon Software is a leading provider of community benefits/social accountability/corporate citizenship software for hospitals and healthcare systems, long term care organizations, universities, cities, other nonprofits and businesses. Its community benefits tracking and reporting software—CBISA—is currently used by over 800 hospitals, health systems and long term cares in all states. Lyon Software's leadership has worked for nearly fifteen years with CHA and VHA in continuously revising and improving its CBISA software to coincide with the evolving definitions and requirements of community benefits reporting.

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This document is the result of collaboration among VHA Inc., the Catholic Health Association of the United States, and Lyon Software to create standardized community benefit categories, definitions, and reporting guidelines in an effort to achieve a national standardized approach for not-for-profit health care organizations. We would like to express our appreciation to, and acknowledge the hard work and dedication of, the following community benefit leaders who have contributed to this work over many years:

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Background

Not-for-profit health care organizations have a rich tradition of providing benefit to their communities. Our organizations were established not because of economic opportunity, but rather because there was a need for health services in their communities. They were born out of community need and continue that tradition today.

In their early days, not-for-profit health care organizations were known without question as community benefit organizations. Responding to community needs was once fairly straightforward: a need was voiced, funds were raised, and services were provided. In the days before health care insurance, not-for-profit health care organizations were known for taking care of all persons regardless of ability to pay. Members of local communities saw the good works being provided because they were involved with our organizations on a regular basis as volunteers, board members, and patrons.

Not-for-profit health care organizations continue their tradition as community benefit organizations by conducting often sophisticated community needs assessments and by paying attention to the needs of low income and other vulnerable persons and the community at large. They partner with community groups to identify needs, strengthen existing community programs, and plan new needed services. They provide, alone and in collaboration, a wide-ranging array of community benefit services designed to improve community health and the health of individuals and to increase access to health care. They provide free and discounted services to people who are uninsured and underinsured.

Today, however, in contrast to years past, the community benefit role of not-for-profit health care organizations is not well understood, even by persons within our institutions. Across the nation, local and state government, consumer advocacy groups, and other constituents have challenged whether not-for-profit health care organizations deserve tax exemption. Internally, persons and groups who serve in, sponsor, and govern not-for-profit health care organizations have asked if our organizations are still the community benefit organizations they started out to be. Increasingly, we are being asked to demonstrate value and benefit to the communities we serve.

Providing community benefits is also increasingly challenging. Complex organizational structures and financial constraints have demanded that a proactive community benefit strategy replace the spontaneous community benefit programs carried out by our predecessors. Community benefit strategies are a planned, managed, and measured organizational approach to meeting and reporting identified community health needs and improving community health. They involve the planning, design, implementation, evaluation, and reporting of community benefit, and they help leaders of our organizations align community benefit initiatives with strategic, operational, and clinical objectives.

This process is described in “Community Benefit Planning: A Resource for Not-for-Profit Social Accountability,” published by the Catholic Health Association (CHA) and the Coalition for Not-for-Profit Health Care with assistance from VHA Inc., Premier Inc., and the Alliance of Community Health Plans in 2002. Through a companion software program, community benefit can be tracked and reported using the “Community Benefit Inventory for Social Accountability” (CBISA) developed by Lyon Software, in collaboration with VHA Inc. and CHA. It is also detailed in the VHA Inc. document, “Community Benefit Planning: Strengthening Commitment to Mission,” published in 2001.

As not-for-profit health care organizations have used these tools and carried out their community benefit strategies, they have expressed a desire for a more standardized approach to reporting community benefits. This has been especially important for users of the CBISA community benefit tracking software, many of whom want to compare performance from year to year and among health care organizations. They have found that different organizations and people within these organizations use different definitions of community benefits and have a different understanding of “what counts.”

Over the course of 2003, a group of CHA and VHA Inc. members worked together to review and revise existing community benefit definitions, categories, and reporting guidelines. They reviewed successful practices and guidelines used by several health care systems in order to create a common national framework for all not-for-profit health care organizations. This document is the result of their efforts. It is designed to provide guidance on quantification and reporting community benefit, emphasizing “what to count” and “what not to count.” While primarily prepared for CBISA users, it also should be helpful to others wanting to report community benefit in a manner more consistent with not-for-profit colleagues in the field.

It is recognized at this time that a uniform methodology for calculating community benefit cannot be achieved because some facilities are utilizing a cost accounting method while others utilize a cost-to-charge ratio. It is generally accepted that health care organizations that have cost accounting systems in place can use this system to more accurately determine costs. But because the adoption of these systems is inconsistent in the field, each hospital/health system needs to continue to strive for the most accurate accounting practices possible, whether it is through cost accounting or calculating cost-to-charge ratio, and strive to improve reporting accuracy from year to year, rather than assume consistent methodology for comparative purposes.

What Is a 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, minorities, and other underserved groups—by improving health status and quality of life.

Community benefits respond to an identified community need and meet at least one of the following criteria:

- Generate a low or negative margin
- Respond to needs of special populations, such as minorities, frail elderly, poor persons with disabilities, the chronically mentally ill, and persons with AIDS
- Supply services or programs that would likely be discontinued if the decision were made on a purely financial basis

To determine whether a program or cost is a community benefit, as opposed to a routine service or a marketing initiative, not-for-profit health care organizations can attempt to answer the following questions:

- Does the activity address an identified community need?
- Does the activity support an organization’s community-based mission?
- Is the activity designed to improve health?
- Does the activity produce a measurable community benefit?

- Does the activity survive the “laugh” test (meaning it is not of a questionable nature that could jeopardize the credibility of the inventory)?
- Does an activity require subsidization (meaning it results in a net financial loss after applying grants and other supplemental revenue)?

These reporting guidelines can be used to assist you to quantify services for persons who are economically poor as well as services to the broader community. Community benefits are provided for both groups.

Persons who are economically poor or are medically indigent cannot afford health care because they have inadequate resources and/or are uninsured or underinsured. The income benchmark is typically considered to be 150 percent of the federal poverty level, but some organizations choose a higher level. Criteria used to evaluate 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 (e.g., low birth weight baby prevention) caused by or related to poverty
 - 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
 - Designation as a “medically underserved area” (MUA) or a “health manpower shortage area” (HMSA)

The term “broader community” refers to persons other than a “target population” who benefit from a health care organization’s community services and programs.

How to Count

This document provides guidelines on how to count and quantify community benefits. To be included in a *quantifiable inventory*, services generally will:

- Result in a financial loss to the organization, requiring subsidization of some sort
- Best be quantified in terms of dollars spent or numbers of persons served
- Not be of a questionable nature that jeopardizes the credibility of the inventory
- Have an explicit budget

Some community benefit services are not easily counted or are inadequately portrayed quantitatively. These items are better reported through a *narrative summary* and include services that:

- Are of significant community benefit, but break even or involve minimal cost
- Are better appreciated by a reader when described in terms of benefit provided or numbers served rather than dollars spent
- Are provided entirely by volunteers or involve staff donating their own time to the program
- Are somewhat controversial as to whether they represent a “true” community benefit

For those services that can and should be quantified, the CHA and VHA workgroup hopes the following guidelines will be helpful. As you use this document, please keep two things in mind. First, these are offered as guidelines. It is perfectly acceptable for organizations to develop their own criteria for community benefit. In fact, it was not possible to reach consensus among all advisory group members on every item that follows. Second, these guidelines are fluid. They will be revised as a result of ongoing discussion and experience. If you have suggestions for additions or changes, please contact Patsy Matheny, VHA Inc., pmatheny@vha.com; Natalie Dean, Trinity Health, DeanN@trinity-health.org; or Julie Trocchio, Catholic Health Association of the United States, jtrocchio@chausa.org.

I. Accounting Guidelines and Calculating Costs

A. 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.

B. 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 resource and finance departments, insurance, support departments, and overhead expenses. An indirect cost factor is determined by dividing total indirect costs by total direct costs.

C. Indirect Cost Factor

Rather than calculating a separate, indirect cost per activity, we recommend computing an indirect cost factor and using this factor to allocate indirect costs to each category as indicated. Apply this formula to arrive at total indirect costs:

Example

Total Operating Expenses (less Bad Debts)	\$ 80,000,000
- Total Direct Expenses	- 60,000,000 (B)
<hr/>	
Total Indirect Expense	\$ 20,000,000 (A)

To calculate the indirect cost factor, divide (A) by (B)

Total Indirect Costs (A)	<u>\$ 20,000,000 (A)</u>
Total Direct Costs (B)	\$ 60,000,000 (B)

Answer: 33.3%

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

Example

Community Education Costs = \$ 20,000

Indirect Cost Factor = 33.3%

Indirect Costs = \$20,000 x 33.3% = \$6,660

Total Costs = \$20,000 (Direct Costs) + \$6,660 (Indirect Costs) = \$26,660

An indirect cost factor may be added to any community benefit categories A, F, and G as applicable. In the Lyon software, CBISA 6, you can set the default for indirect costs on the default page making manual entry for each activity unnecessary.

D. Calculating Community Benefit Costs

It is recognized that a uniform methodology for calculating community benefit cannot be achieved at this time because some facilities are utilizing a cost accounting method while others utilize a cost-to-charge ratio. It is suggested that a footnote to your community benefit report explain the method used to determine the expense reported.

Two sources of financial information are available to calculate costs in this area: an organization's financial statement and the Medicare Cost Report. It is generally accepted that health care organizations that have cost accounting systems in place can use this system to more accurately determine costs. But because the adoption of these systems is inconsistent in the field, each hospital/health system needs to continue to strive for the most accurate accounting practices possible, whether through cost accounting or calculating cost-to-charge ratio, and strive to improve reporting accuracy from year to year, rather than assume consistent methodology for comparative purposes.

Detailed calculation of costs is in several key areas:

D1. 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, because they are needed in the community and other providers are unwilling to provide the services, or the services would otherwise not be available to meet patient demand.

Care should be taken not to double-count information. Services in this category should be separated from charity care and Medicaid/Medicare shortfalls. For example, assume a scenario in which a hospital emergency department operates at an annual loss of \$200,000. Medicare and Medicaid shortfalls, together with charity care, 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.

In addition, the category of subsidized services is not a "catch-all" category for any services that operate at a loss. Care needs to be taken to ascertain whether the negative contribution margin is truly community benefit.

In all categories, count negative contribution margin departments or services. Do not include bad debt. Calculate the "payment shortfall," not the contractual allowance, by extracting data from your audited financial statements.

Count:

- Amount the health care organization subsidizes to maintain these services, but not what it subsidizes for individual patients

Do not count:

- Charity care
- Bad debt
- Medicare and Medicaid shortfalls

D2. Charity care

Charity care is:

- Free or discounted health and health-related services provided to persons who cannot afford to pay
- 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
- Billed 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

Charity care results from a provider's policy to provide health care services free of charge, or on a discounted fee schedule, 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. There is general consensus that traditional charity care should be reported in terms of costs, not charges.

Charity care does not include bad debt. Bad debt is uncollectible charges excluding contractual adjustments, arising from the failure to pay by patients whose health care has not been classified as charity care.

Count:

- Expenses incurred by the provision of charity care, preferably using financial statements as the source of data
- Report indirect costs only if they have not already been included in calculating costs

Do not count:

- Bad debt
- The portion of charity care costs already included in the subsidized health care services category (double counting)

D3. 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.

Unpaid costs of public programs include losses related to:

- Medicaid
- Medicare in some circumstances (see below)
- 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.

There is no clear consensus whether to include Medicare losses as community benefit. Over the years, arguments both favoring the inclusion of Medicare shortfalls, especially in certain circumstances, and against inclusion have been voiced.

Arguments in favor of including Medicare losses:

- One element of the theory behind granting tax-exempt status to not-for-profit hospitals (and other not-for-profits) is that, unless services were provided by the not-for-profit organization, they would become the obligation of government, since the federal government would need to fulfill this responsibility. Under this argument, Medicare losses should be included as a community benefit because the losses are incurred in performing an important public service.
- Under the Balanced Budget Act of 1997 (and the subsequent BBRA refinements), it is highly likely that Medicare gains are to be reduced in the next few years (or that losses will grow). If Medicare is not included in the inventory of community benefits, it will be difficult to capture this important development for advocacy and/or other purposes.
- Some not-for-profit facilities extend services to elderly patients and adults with disabilities as a major mission commitment. Many may serve particularly difficult or chronic patients who need special services beyond direct hospital patient care (e.g., Meals on Wheels, transportation, etc.) In providing these mission-driven services, facilities incur higher losses (or generate lower earnings) than they would otherwise.

Arguments against including Medicare losses:

- In many communities, Medicare is one of the best payers. Per-diem and per-case payments are higher in many localities for Medicare than they are for managed care payers.
- Serving Medicare patients is not a true, differentiating feature of not-for-profit health care organizations, compared to for-profit health care organizations. Hospitals of all kinds compete aggressively to attract Medicare patients to their facilities. This is not generally true of Medicaid and uncompensated or undercompensated care patients.
- Medicare losses may be highly associated with inefficiency, not underpayment. If facilities are losing money, one could argue that those losses are the result of poor operating practices, not inadequate reimbursement.

In deciding whether your organization should include this shortfall in its community benefit report, the following guidelines could be applied:

Count Medicare shortfalls when:

- You have a clear mission commitment to serving elderly patients and can demonstrate that through the provision of specific subsidized programs developed not for marketing reasons, but to help improve the health status of the elderly.
- You can make a credible argument that losses are not due primarily to operational inefficiency, or
- Losses are material, meaning that negative margins under Medicare are greater than five percent or some threshold of that nature.
- In reporting community benefits for a hospital system, Medicare gains at one facility should be offset by Medicare losses at other hospitals, so that a net, system wide perspective can be reported.

Report unpaid costs, or “shortfalls” of public programs for:

- Medicaid
- Medicare (if you so choose)
- Consider adding in disallowed costs that do not qualify for Medicare reimbursement, but do reflect community benefit
- Public and/or indigent care
- Other public programs

E. Other Financial Reporting Guidelines

In order 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 an institution to be consistent from year to year; (2) it could be important for an institution, in comparing itself with other institutions, to be consistent in terms of which components of revenue and expense are included here. Standard recommended financial data include:

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

When you calculate 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 you calculate community benefit as a percent of operating expenses, use only the total operating expenses figure.

Financial Statement

Financial statements are the preferred source for calculating cost-to-charge ratio.

- 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.
- Calculating community benefit can be done in conjunction with an organization’s annual financial audit.

Medicare Cost Report

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

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

Use the Medicare Cost Report:

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).

- Determine the value of room space on a square foot basis by using 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 against the square footage of the room(s) used.

Cost-to-Charge Ratios: Take Care Not to Double Count

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. Double counting can occur.

Indirect Costs: Take Care Not to Double Count

Report indirect costs 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.

Grants and Supplemental Revenue

Subtract any revenue or grants to determine costs.

Capital Items/Depreciation Expenses

Report depreciation expenses, not initial costs or net book values, for capital equipment items that are used to provide community benefit, for example:

- Call center telecommunications equipment
- Vans and other automobiles used for transportation programs and/or clinics
- Lab screening equipment

- Laptops used for community assessment programs
- Computers and IT systems for mobile outreach programs and clinics

F. Guidelines Into Practice: The Community Benefit and Finance Team

It is recommended that the Community Benefit Coordinator and team meet with the Chief Financial Officer and finance department a minimum of twice annually to review definitions, guidelines, internal inventory status and plans for reporting to maximize the accuracy and integrity of your data. In addition, we recommend that the CFO or CEO of your health care organization formally sign off on your organization's annual community benefit plan and report.

II. Community Benefit Categories and Reporting Guidelines

The following are recommendations for community benefit reporting according to standard reporting categories. These categories follow the Lyon Software Community Benefit Inventory for Social Accountability (CBISA 6) format. Key community benefit definitions and terminology are defined beginning on page 37.

To quantify community benefit:

Report the negative margin

(the difference between operating costs and external subsidies)

- Include programs for the poor and the broader community.

Include both direct and indirect costs

- Include staff time and staff benefits to operate program.
- Include materials costs to deliver program.

A. Community Health Services

Community health services include activities carried out 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 separately as charity care. See section H.

Specific community health services to quantify include:

- Community health education
- Community-based clinical services, such as free clinics and screenings
- Support groups
- 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
- Community spiritual care
- Social services programs for vulnerable populations in the community

A1. Community Health Education

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

Count:

- Baby-sitting courses
- Caregiver training for persons caring for family members at home
- Community calendars and newsletters if the primary purpose is to educate the community about community health programs and free community events
- Consumer health library
- Education on specific disease conditions (diabetes, heart disease, etc.)
- Health fairs, career days
- Health promotion and wellness programs
- Health education lectures and workshops by staff to community groups
- Pastoral outreach education programs
- Parish congregational programs
- Prenatal/childbirth classes serving at-risk populations
- Information through press releases and other modes to the media (radio, television, newspaper) to educate the public about health issues (wearing bike helmets, new treatments now available, health resources in the community, etc.)
- Public service announcements with health messages
- Radio call-in programs with health professionals
- School health education programs (report school-based programs on health care careers and workforce enhancement efforts in F8; report school-based health services for students in A2)
- Web-based consumer health information
- Work site health education programs

Do not count:

- Health education classes designed to increase market share (such as prenatal and childbirth programs for private patients)
- Community calendars and newsletters if the purpose is primarily a marketing tool
- Patient educational services understood as necessary for comprehensive patient care (e.g., diabetes education for patients)
- Prenatal and other educational programs for low income population that are reimbursed
- Health education sessions offered for a fee in which a profit is realized
- In-house pastoral education programs
- Volunteer time for parish and congregation-based and other services

Support Groups

Support groups typically are established to address social, psychological, or emotional issues related to specific diagnoses or occurrences. These groups may meet on either a regular or an intermittent basis.

Count:

Costs to run various support groups (e.g., diseases and disabilities, grief, infertility, patients' families, other)

Do not count:

- Support given to patients and families in the course of their inpatient or outpatient encounter
- Childbirth education classes that are reimbursed

Self-Help

Wellness and health promotion programs, such as smoking-cessation, exercise, and weight-loss programs.

Count:

- Anger management
- Exercise
- Mediation programs
- Smoking cessation
- Stress management
- Weight loss and nutrition

Do not count:

- Employee wellness and health promotion provided by your organization as an employee benefit.

A2. Community-Based Clinical Services

These clinical services are clinical services provided (e.g., free clinics, screenings, or one-time events) to the community. This category does NOT include permanent subsidized hospital outpatient services (report this in category C3).

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.

Count:

- Behavioral health screenings
- Blood pressure screening
- Lipid profile and/or cholesterol screening
- Eye examinations
- General screening programs
- Health risk appraisals
- Hearing screenings

- Mammography screenings, if not a separate free-standing breast diagnostic center (then report in section C5)
- Osteoporosis screenings
- School physical examinations
- Skin cancer screening
- Stroke risk screening
- Other screenings

Do not count:

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

One-Time or Occasionally Held Clinics

Count:

- Blood pressure and/or lipid profile/cholesterol screening clinics
- Cardiology risk factor screening clinics
- 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
- Stroke screening clinics
- Other clinics

Do not count:

- Screenings in which a fee is charged and a profit is realized (do report if there is a negative margin)
- Permanent, ongoing programs and outpatient services (these should be counted in subsidized health services C3, Hospital Outpatient Services)

Free Clinics

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

Count:

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

Do not count:

- Volunteers' time and contributions by other community partners

Mobile Units

Count:

- Vans and other vehicles used to deliver primary care services

Do not count:

- Mobile specialty care services that are an extension of the organization's outpatient department, e.g., mammography, radiology, lithotripsy, etc. (report in C3, hospital outpatient clinics)

A3. Health Care Support Services

Health care support services are given on a one-on-one basis to assist community members.

Count:

- Enrollment assistance in public programs, including state, indigent, and Medicaid and Medicare programs
- Information and referral to community services
- Telephone information services (Ask a Nurse, medical and mental health service hotlines, poison control centers)
- Transportation programs for patients and families to enhance patient access to care (include cab vouchers provided to patients and families)

Do not count:

- Physician referral if it is primarily an internal marketing effort (include 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 inpatient or outpatient encounter
- Discharge planning

B. Health Professions Education

B1. Physicians/Medical Students

Count:

- A clinical setting for undergraduate/vocational training
- Internships/clerkships/residencies
- Residency education

Do not count:

- Items above without subtracting governmental subsidies from costs
- Expenses for physician and medical student in-service training
- Joint appointments with educational institutions, medical schools
- Orientation programs
- Continuing medical education (CME) costs

B2. Scholarships/Funding for Professional Education

Count:

- Funding, including registrations, fees, travel, and incidental expenses for staff education, that is linked to community services and health improvement
- Nursing scholarships or tuition payments for professional education to non-employees and volunteers

Do not count:

- Costs for staff conferences and travel other than above
- Financial assistance for employees who are advancing their own educational credentials
- Tuition reimbursement costs provided as an employee benefit

B3. Nurses/Nursing Students

Count:

- The provision of a clinical setting for undergraduate/vocational training to students enrolled in an outside organization
- Internships/externships when on-site training of nurses (e.g., LVN, LPN) is subsidized by the health care organization

Do not count expenses associated with:

- Education required by staff, such as orientation, in-service programs, new grad training
- Expenses for standard in-service training and in-house mentoring programs
- In-house nursing and nurse's aide training programs
- Staff costs associated with joint appointments with educational institutions, nursing schools

B4. Technicians

Count:

- A clinical setting for undergraduate training for lab and other technicians

Do not count expenses associated with:

- Education required by staff such as orientation, in-service programs
- Expenses for standard in-service programs
- Joint appointments with educational institutions, schools of medical technology, etc.

B5. Other Health Professional Education

Count:

- A clinical setting for undergraduate training for dietitians, physical therapists, pharmacists, and other health professionals
- Training of health professionals in special settings (occupational health, outpatient facilities, etc.)

Do not count expenses associated with:

- Education required by staff, such as orientation, in-service programs
- Expenses for standard in-service training
- Joint appointments with educational institutions, schools of physical therapy, etc.

B6. Other

Count:

- Internships for pastoral education, social service, dietary, and other professional/instructional internships
- Medical translator training
- Program costs associated with high school student “job shadowing” and mentoring projects
- Recruitment/retention of underrepresented minorities
- Scholarships to community members (not employees)
- Specialty in-service and videoconferencing programs made available to professionals in the community

Do not count:

- On-the-job training such as pharmacy technician and nurse’s assistant programs
- Orientation programs
- Staff time delivering care concurrent with “job shadowing” and mentoring projects
- Staff tuition reimbursement
- Standard in-service education

C. 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 because they are needed in the community and other providers are unwilling to provide the services, or the services would otherwise not be available to meet patient demand.

Care should be taken not to double-count information. Services in this category should be separated from charity care and Medicaid/Medicare shortfalls. For example, assume a scenario in which a hospital emergency department operates at an annual loss of \$200,000. Medicare and Medicaid shortfalls, together with charity care, 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.

In addition, the category of subsidized services is not a “catch-all” category for any services that operate at a loss. Care needs to be taken to ascertain whether the negative contribution margin is truly community benefit.

In all categories, count negative contribution margin departments or services. Do not include bad debt. Calculate the “payment shortfall,” not the contractual allowance, by extracting data from your audited financial statements.

Count:

- Amount the health care organization subsidizes to maintain these services, but not what it subsidizes for individual patients

Do not count:

- Charity care
- Bad debt
- Medicare and Medicaid shortfalls

C1. Emergency and Trauma Services

Count:

- Air ambulance
- Emergency department
- Local community EMS (emergency medical technician) training when there is a negative margin
- Trauma center

C2. Neonatal Intensive Care

C3. Hospital Outpatient Services

Count:

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

C4. Burn Unit

C5. Women’s and Children’s Services

Count:

- Freestanding breast diagnostic centers
- Newborn care (NICU in section C2)
- Obstetrical
- Pediatrics
- Women’s services

C6. Renal Dialysis Services

C7. Hospice/Home Care/Adult Day Care

Count:

- Assisted living
- Geriatric services
- Hospice and home care services
- Personal response systems for seniors
- Nursing home
- Senior day treatment programs
- Medical equipment costs to provide hospice/home care/adult care

C8. Behavioral Health Services

Count:

- Inpatient behavioral health services
- Outpatient behavioral health services

C9. Other

Count:

- Pain management
- Negative contribution margin departments, services, and payment shortfalls not categorized above

D. Research

Research includes clinical and community health research, as well as studies on health care delivery. In this category, count the difference between operating costs and external subsidies such as grants (negative margin).

D1. Clinical Research

Count:

- Unreimbursed studies on therapeutic protocols
- Evaluation of innovative treatments
- Research papers prepared by staff for professional journals

D2. Community Health Research

Count:

- Studies on health issues for vulnerable persons
- Studies on community health, incidence rates of conditions for populations
- Research papers prepared by staff for professional journals

D3. Other

Count:

- Research studies on innovative health care delivery models

E. Financial Contributions

This category includes funds and in-kind services donated to individuals and/or the community at large. In-kind services include hours donated by staff to the community while on 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.

E1. Cash Donations

Count:

- Contributions and/or matching funds provided to not-for-profit community organizations
- Contributions for not-for-profit event sponsorship
- Contribution/fees paid for golf tournaments, concerts, galas, dinners and other charity events to not-for-profit organizations after subtracting value of participation by employees/organization
- Contributions provided to individuals for emergency assistance
- Scholarships to community members not specific to health care professions

Do not count:

- Employee-donated funds
- Emergency funds provided to employees
- Fees for sporting event tickets, such football, basketball, etc.

E2. Grants

Count:

- Contributions and/or matching funds provided as a community grant to not-for-profit community organizations, projects, and initiatives. These include:
 - Program grants
 - Operating grants
 - Education and training grants
 - Matching grants
 - Event sponsorship
 - General contributions to nonprofit organizations/community groups

E3. In-Kind Donations

Count:

- Meeting room overhead/space for not-for-profit organizations and community (e.g., coalitions, neighborhood associations, social service networks). Use the Medicare Cost Report as the source of this cost.

- Equipment and medical supplies
- 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 (Report health care organization-sponsored community events under G1, Community Benefit Operations)
- Provision of parking vouchers for patients and families in need
- Employee costs associated with board and community involvement on work time
- Food donations, including Meals on Wheels and donations to food shelters
- Gifts to community organizations and community members (not employees)
- Laundry services for community organizations
- Technical assistance, such as information technology, accounting, human resource process support, planning, and marketing

Do not count:

- 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 (belongs to volunteer, not the health care organization)
- Health care organization laundry expenses
- Promotional and marketing costs concerning the health care organization's services and programs (considered employee benefit)
- Salary expenses paid to employees deployed on military services or jury duty. These expenses are considered employee benefit.

E4. Cost of Fund-Raising for Community Programs

Count:

- Grant writing and other fund-raising costs specific to community programs and resource development assistance not captured under category G, Community Benefit Operations

F. Community-Building Activities

Community-building activities include cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships. When funds or donations are given directly to another organization, count in E, Donations. Remember to subtract any subsidies or grant amounts from total expenses incurred in this category. Include indirect costs in all categories.

F1. Physical Improvements/Housing

Count:

- Community gardens
- Neighborhood improvement and revitalization projects
- Public works, lighting, tree planting, graffiti removal
- Housing rehabilitation, contributions to community-based assisted living, senior and low income housing projects
- Habitat for Humanity
- Smoke detector installation programs

Do not count:

- Housing costs for employees
- Projects having their own community benefit reporting process: e.g., a senior housing program that issues a community benefit report

F2. Economic Development

Count:

- Small business development
- Participation in economic development council, chamber of commerce

Do not count:

- Routine financial investments

F3. Support System Enhancements

Count:

- Adopt-a-school efforts
- Child care for community residents with qualified need
- Mentoring programs
- Neighborhood systems, watch groups
- Youth Asset Development initiatives, including categories of caring adults, safe places, healthy start, marketable skills, and opportunities to serve (America's Promise)
- Disaster readiness
 - Costs as they relate to changes made to accommodate prospective disasters, including costs associated with lockdown capability, enhanced security measures, package handling, air machines and filters, water purification equipment, expanded mortuary facilities, facilities for personnel quarantine, expanded patient isolation facilities, shower facilities, and storage space for stockpiles
 - Costs of creating new or refurbishing existing decontamination facilities, such as water supply communications facility and equipment costs, equipment changes to ensure interoperability of communications systems; and additional disaster-related purchase of pagers, cell phones, mobile data terminals, and laptop computers specific to the communications component of the disaster plan. Include depreciation expenses

- Community disease surveillance and reporting infrastructure, updating laboratory diagnostic capability and associated training for laboratory personnel, informatics updating and patient tracking systems, detection instruments/monitors to detect radiation, and tests/assays for detection of chemical agents and toxic industrial materials, as well as tests for identification of biologic agents
- Purchase of personal protective equipment (PPE) for stockpiles, including gloves, masks, gowns, and other items
- Facility areas, waste water containment systems, decontamination tables, storage, shower systems, tents, soap, dispensers, and linen
- Costs of stockpiling medical, surgical, and pharmaceutical supplies, including barriers, respirators, clothing, IV pumps and poles, IV fluids, suction machines, stretchers, wheelchairs, linens, bandages, and dressings
- Costs associated with new or expanded training, task force participation, and drills
- Mental health resource costs associated with training, community partnerships, and outreach planning

Do not count:

- Costs associated with subsidizing salaries of employees deployed in military action (this is considered employee benefit)
- Costs associated with routine disaster preparedness

F4. Environmental Improvements

Count:

- Efforts to reduce environmental hazards in the air, water, and ground
- Residential improvements (lead, radon programs)
- Neighborhood, community (air pollution, toxin removal in parks)
- Community waste reduction and sharps disposal programs
- Health care facility (waste and mercury reduction, green purchasing, other)

F5. Leadership Development/Training for Community Members

Count:

- Conflict resolution
- Community leadership development
- Cultural skills training
- Language skills/development
- Life/civic skills training programs
- Medical interpreter training for community members

Do not count:

- Interpreter training programs for hospital staff, as required by law

F6. Coalition Building

Count:

- Hospital representation to community coalitions
- Collaborative partnerships with community groups to improve community health
- Community coalition meeting costs, visioning sessions, task force meetings
- Costs for task force–specific projects and initiatives

F7. Community Health Improvement Advocacy

Count:

- Local, state, and/or national advocacy for community members and groups relative to policies and funding to improve:
 - Access to health care
 - Public health
 - Transportation
 - Housing
 - Other

Do not count:

- Advocacy specific to hospital operations/financing

F8. Workforce Enhancement

Count:

- Recruitment of physicians and other health professionals for federally medically underserved areas
- Recruitment of underrepresented minorities
- Job creation and training programs
- Participation in community workforce boards, workforce partnerships, and welfare-to-work initiatives
- Partnerships with community colleges and universities to address the health care workforce shortage
- Workforce development programs that benefit the community, such as English as a Second Language (ESL)
- School-based programs on health care careers
- Community programs that drive entry into health careers and nursing practice
- Community-based career mentoring and development support

Do not count:

- Routine staff recruitment and retention initiatives
- In-service education and tuition reimbursement programs for current employees
- Scholarships for nurses and other health professionals (count in B, Health Professions Education)

- Scholarships for community members not specific to health care professions (count in E1, Cash)
- Employee workforce mentoring, development, and support programs

G. Community Benefit Operations

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

G1. Dedicated Staff

Count:

- Staff costs of management/oversight of community benefit program activities that are not included in other community services categories
- Staff costs to coordinate community benefit volunteer programs

Do not count:

- Staff time to coordinate in-house volunteer programs, including outpatient volunteer programs
- Volunteer time of individuals for community benefit volunteer programs

G2. Community Health Needs/Health Assets Assessment

Count:

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

Do not count:

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

G3. Other Resources

Count:

- Cost of fund-raising for hospital-sponsored community benefit programs, including grant writing and other fund-raising costs
- Cost of grant writing and other fund-raising costs of 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

- Overhead and office expenses associated with community benefit operations exclusive of fundraising

Do not count:

- Recognition/awards for volunteer staff
- 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

III. Other Guidelines

A. Financial Data

In order 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 an institution to be consistent from year to year; (2) it could be important for an institution, in comparing itself with other institutions, to be consistent in terms of which components of revenue and expense are included here. Standard financial data include:

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

When you calculate 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 you calculate community benefit as a percent of operating expenses, use only the total operating expenses figure.

B. Reporting Community Benefit on IRS Form 990

Documenting community benefit underlies tax exemption. Fully reporting community benefit on your organization's IRS Form 990 is important because IRS Form 990 disclosure regulations, adopted in 1999, require tax-exempt organizations to make available their IRS Form 990s to anyone requesting them. This regulation heightens the emphasis on not-for-profit accountability to communities, government, and consumers.

In October 1999, the Urban Institute teamed up with Philanthropic Research, Inc., to launch a free Internet website at www.guidestar.org. This website provides instant access to IRS Form 990 of hundreds of thousands of not-for-profit organizations, including most health care organizations. Easy access to information from the IRS Form 990 increases public scrutiny of financial statements of all types of not-for-profit organizations, including hospitals and health care organizations.

We recommend attaching a copy of your community benefit report to your organization's annual IRS Form 990. With Internet availability of the IRS Form 990 in Portable Document Format (PDF), full text community benefit reporting that includes narrative reporting, as well as financial benchmarks, as an attachment to Part III or IV of the form is recommended. Care should be taken to emphasize content, rather than graphical layout, as the format will be scanned and uploaded in PDF.

For the IRS Form 990 Community Benefit Report attachment:

- Use a simple, laser-printed format that translates to PDF through the scanning and posting process.
- Highlight your health care organization’s mission, vision, and community benefit plan, priority areas, and impact. Provide both narrative descriptions (stories) and quantitative information (financials) in a clear format.
- Utilize the standardized reporting categories outlined in this document, providing clear titles that describe activities and programs.

C. Foundation-Funded Community Benefit

A foundation is a separate not-for-profit organization affiliated with the health care organization that conducts fund-raising. A foundation can support health care organization operations and/or may fund community health improvement programs, activities, and research. Alignment of foundation (philanthropy) and community health improvement demonstrates commitment to mission and advances business goals while improving community health. Foundation-funded community benefit is 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 operations should record community benefit activity in the health care organization sections. Include indirect costs in all categories.

1. Community Services

Community health services include activities carried out 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:

- Community health education
- Community-based clinical services
- Support groups
- Health care support services
- Self-help

More detail regarding community health services to quantify can be found in sections A1 to A6 of this document.

2. Community Building

Community building activities include cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships. Remember to subtract any subsidies or grant amounts from total expenses incurred in this category.

Count:

- Physical improvements
- Economic development
- Support system enhancements
- Environmental improvements
- Leadership development and skills training
- Coalition building
- Community health improvement advocacy
- Workforce enhancement
- Other

3. Other Areas**Count:**

- Community benefit operations costs
- Any other community benefit programs or services that do not fit within sections K1 or K2 categories
- Indirect costs

D. Additional Areas Not to Count

Throughout this document, we have made numerous references to what to count, and what not to count, when quantifying community benefit. The following are frequently posed scenarios that we recommend NOT COUNTING:

- Activities specifically geared 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 payors or physicians
- Providing copies of medical records, x-rays
- Providing continuing medical education (CME), orientation, and in-service education
- Discharge planning
- Salary expenses paid to employees deployed for military services or jury duty (employee benefit)
- 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 unless subsidized by the organization
- Token of sympathy to staff or patients at times of crisis or bereavement (e.g., flowers, cards, meals)
- Free or discounted immunizations and other health services to staff (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, volunteers
- Medical library (include percentage of costs only if there is a significant consumer health library focus)
- Staff donations to assist other staff
- Pharmacy discounts for employees and volunteers
- Reimbursed home health care services
- Staff volunteering (report only volunteer efforts done on work time)
- Volunteer time by community volunteers for either in-house OR community efforts (it is their time, not the health care organization's)
- Professional education such as in-services and cost for professional conferences
- Economic impact of employee payroll and purchasing dollars
- Employee contributions such as United Way or Adopt a Family at Christmas
- Physician referral, if it is more of an internal marketing effort (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 incurred for inpatient health education
- Costs associated with provision of day care services for employees
- Employee costs associated with board and community involvement when it is the employee's own time for personal or civic interests
- Costs associated with subsidizing salaries of employees deployed in military action (employee benefit)
- Staff presenting to professional organizations
- Tuition reimbursement costs provided as an employee benefit
- Nurses teaching/delivering papers at professional meetings

IV. Community Benefit Definitions

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 community benefit.

Bioterrorism

The intentional use or threatened use of viruses, bacteria, fungi, toxins from living organisms, or chemicals to produce death and/or disease in humans and living systems.

Broader Community

Persons other than a “target population” who benefit from a health care organization’s community services and programs.

Charity Care

Charity care is:

- Free or discounted health and health-related services provided to persons who cannot afford to pay
- 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
- 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

Charity care results from a provider’s policy to provide health care services free of charge or discounted 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

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

Clinical services are clinical services provided (e.g., free clinics, screenings, or one-time events) to the community. This category does NOT include permanent subsidized hospital outpatient services.

Community Benefit

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, minorities, and other underserved groups—by improving health status and quality of life.

Community benefit responds to an identified community need and meet at least one of the following criteria:

- Generate a low or negative margin
- Respond to needs of special populations, such as minorities, frail elderly, poor persons with disabilities, the chronically mentally ill, and persons with AIDS
- The service 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. These categories are:

- Community health services
- Health professions education
- Subsidized health services
- Research
- Financial contributions
- Community building activities
- Community benefit operations
- Charity care
- Government-sponsored health care

Community benefit can be quantified for the hospital, other health care organizations, health system, and/or dependent foundation.

Community Benefit Operations

Costs associated with dedicated 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 and Services

Projects and services identified by health care organizations in response to the findings of a community health assessment, strategic and/or clinical priorities, and partnership areas of attention.

Community Building

Activities including cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships. Enhancements 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

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

Community Health Services

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.

Continuing Care Services

Hospice, home care services, nursing home care, geriatric services, senior day centers, and assisted living.

Counseling

Support given on a one-on-one basis to assist a community member in various areas, including referral to community services, public assistance, and crisis intervention.

Direct Costs

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

Funds and in-kind services donated to individuals and/or the community at large. In-kind services include hours donated by staff to the community while on 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.

Foundation

A separate not-for-profit organization affiliated with the health care organization that conducts fund-raising. A foundation can support core health care organization operations and/or may fund community health improvement programs, activities, and research. Alignment of foundation (philanthropy) and community health improvement is an emerging strategic alliance that demonstrates commitment to mission and advances business goals while improving community health. Foundation-funded community benefit is 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 operations should record community benefit activity in the health care organization sections.

Free Clinics

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

Government-Sponsored Health Care

Services that are reimbursed or partially reimbursed through federal, state, and local programs such as Medicaid, Medicare, and public indigent and health care programs.

Health Care Support Services

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

Immunizations

Personnel, equipment, and supplies necessary to provide immunizations to community members and groups.

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 resource and finance departments, insurance, support departments, and overhead expenses. An indirect cost factor is determined by dividing total indirect costs by total direct costs. (See section I)

In-Kind Services

Hours donated by staff to the community while on health care organization work time, as well as overhead expenses of space donated to not-for-profit community groups for meetings.

Medical Education

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

Vans and other vehicles used to deliver primary care services.

Negative Margin

The negative difference between what it costs to offer programs, health care, or services, and any cash or reimbursements received.

Non-billed Services

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 can be designed to be offered as a public benefit with charitable or community service intent.

Patient Education

Health education provided to inpatients and outpatients. Texas law identifies this as a community benefit. For the purposes of standardized reporting, we recommend that you consider patient education a standard component of health care and not a community benefit.

Poor

Persons who cannot afford health care because they have inadequate resources and/or are uninsured or underinsured. The income benchmark is typically considered to be 150 percent of the federal poverty level. Community benefit programs for the poor are geared to reducing 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

Studies on health care delivery, unreimbursed studies on therapeutic protocols, evaluation of innovative treatments, and research papers prepared by staff for professional journals.

Screenings

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

Wellness and health promotion programs such as exercise classes, smoking cessation and nutrition education.

Subsidized Health Services

Costs for billed services that are subsidized by the health care organization. They include clinical patient care services that are provided despite a negative margin because, although they are needed in the community, other providers are unwilling to provide the services and the services would otherwise not be available to meet patient demand. Negative contribution margin departments and/or services can be categorized in the subsidized health services area.

Support Groups

Groups typically established to address social, psychological, or emotional issues related to specific diagnoses or occurrences. These groups may meet on a regular or intermittent basis.

Target Group

The primary audience for which a program is intended such as infants, children, adolescents, adults, seniors, or the disabled.

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