

Community Benefit Reporting Guidelines and Standard Definitions "
.....FY 2039"

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Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Acknowledgements

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Complete the Community Benefit Collection Tool provided by the HSCRC using the following guidelines;

Financial Accounting

In terms of financial accounting practices, hospitals should use audited financial statements as the source. Hospitals with a fiscal year that coincides or closely coincides with the HSCRC's required Community Benefit reporting period of July 1 to June 30 should report Community Benefit data using the most recent audited financial statements as the source.

Hospitals whose fiscal year is calendar-year based should also collect community benefit information for the reporting period of July 1 through June 30. Since a calendar year hospital's audited financial statements will not be completed by January 1 of the following year, however, the Commission understands that all information contained within the Community Benefit Report may not directly correlate to final audited figures. A hospital should make clear in its Community Benefit Report submission, therefore, the types of financial data used and time periods covered. Every effort should be made to have these reported figures directly tie to the hospital's financial statements.

The data included in this report should be limited to Hospital Services that are reported on the IRS 990 schedule H, and should not include unregulated entities that are not reported on the IRS 990 Schedule H.

Offsetting Revenue

Finally, for completion of the statewide Community Benefit Report for distribution to the public, the HSCRC will include hospital-specific information regarding the amount of revenue provided to the hospital in rates for the appropriate fiscal year for Graduate Medical Education, Nurse Support Programs, and Uncompensated Care. Therefore, offsetting revenue provided in the form of HSCRC – approved rates to the hospital should not be reported in the “offsetting revenue” column. Additionally, for the purposes of this report, offsetting revenue shall be considered as revenue from the activity during the year that offsets the total community benefit expense of that activity, it includes any revenue generated by the activity or program, such as payment or reimbursement for services provided to program patients. Offsetting revenue includes restricted grants or contributions¹ used to provide a community benefit, but does not include unrestricted grants or contributions that the organization uses to provide community benefit

For more information please contact Katie Wunderlich, Principal Deputy Director at Katie.Wunderlich@Maryland.gov, or Amanda Vaughan, Center for Clinical and Financial Information at Amanda.Vaughan@Maryland.gov, or at the Commission's offices at (410) 764-2605.

I. ACCOUNTING PRACTICES

A. Staff Hours & Number of Encounters

Hospitals should report the number of staff hours associated with and the number of encounters served by the reported community benefit activity (please note that a number of encounters is different than number of people served – one person could have several encounters).

¹ The IRS has issued 2013 instructions for the Schedule H which include a change to how direct offsetting revenue is reported. “Restricted grants and contributions” used to provide a community benefit must be included in direct offsetting revenue. Unrestricted grants are still not to be included. See instructions at: <http://www.irs.gov/pub/irs-pdf/i990sh.pdf> Page 3 instructions for column D

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 and that would not exist if the service or effort did not exist.

C. 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, salaries for human resources and finance departments, insurance, and overhead expenses.

Hospitals can currently calculate an indirect cost ratio from their HSCRC Annual Cost Report data. This can be calculated using Schedule M from the hospital's Annual Cost Report. To calculate:

1. Determine Indirect Expenses: Add the total of columns #3 (Patient Care Overhead), #4 (Other Overhead), #9 (Building and General Equipment CFA), and #10 (Departmental CFA).
2. Determine Direct Expenses: Add the total of columns #2 (Direct Expenses), #6 (Physician Support Expenses), and #7 (Resident Intern Expenses).
3. Divide Indirect Expenses by Direct Expenses. Please enter this number into Item I1. Please enter this number as a whole number, not as a percentage. The spreadsheet will convert the number into a percentage.

Rather than calculating a separate indirect cost per activity, the HSCRC inventory spreadsheet permits hospitals to calculate an indirect cost ratio calculated by the hospital and entered into Item I10 Indirect Cost Ratio, which can then be used to allocate indirect costs to the following community benefit categories: (A) Community Health Services; (F) Community Building Activities; and (G) Community Benefit Operations.

The HSCRC asks that hospitals examine its calculated indirect costs carefully, and to override the calculated indirect costs where the hospital believes the direct costs may, in part, reflect the total costs of the community benefit initiative. For the remaining categories, the indirect cost calculation will default to zero, and may be overridden if the hospital believes there are indirect costs involved with the initiative, but are not accurately represented in the direct costs.

D. Offsetting Revenue

Hospitals should report offsetting revenue as revenue from the activity during the year that offsets the total community benefit expense of that activity, it includes any revenue generated by the activity or program, such as payment or reimbursement for services provided to program patients. This does include restricted grants. It does not include unrestricted grants or contributions that the organization uses to provide the community benefit.

E. Net Community Benefit

The Net Community Benefit column is a formula-driven cell that subtracts the sum of the hospital's reported direct and indirect costs from any reported offsetting revenue for each individual community benefit. Therefore, no number needs to be entered by the hospital in this column.

F. Accounting Practices and Calculating Costs

The hospital's financial statements most accurately reflect internal accounting practices for tracking community benefit programs and services, and negative margin departments are more easily identified and tracked. Verifying the calculations of a hospital's community benefit should also be done in conjunction with an organization's audited financial statements. Further, the HSCRC plans to subject certain elements of the Community Benefit Report to future special audit and compliance checks.

II. COMMUNITY BENEFIT CATEGORIES AND REPORTING GUIDELINES

For the purpose of these reporting requirements, Maryland hospitals are the non-profit health care organization planning the community benefit.

A community benefit is a planned, organized, and measured approach, by a non-profit healthcare organization, to meeting identified community health needs within its service area. It most often requires collaboration with other non-profit and public organizations within the community in determining the health needs of its residents. Such planning relies on the use of objective data and information to determine community needs, and the impact of the organization's participation on those needs.

Community benefits respond to an identified community need, and meet the following criteria:

- Ultimately improve the health status and well being of specific populations in the organization's service area who are known to have difficulty accessing care and/or who have chronic needs;
- The program is designed to impact measurable and documented health disparities and poor health outcomes
- Generate a low or negative margin;
- Are not provided for marketing purposes; and/or
- The service or programs would likely be discontinued if the decision were made on a purely financial basis

Maryland hospitals have raised many individual questions on whether a specific activity should be counted in the community benefits inventory. As a result, the Commission has looked to other organizations with expertise in community benefits that offer additional guidance on what may be considered an initiative or program appropriate for inclusion in a hospital's community benefits inventory.

The information provided below may be used as a reference guide in determining whether your organization's program fits the definition of a "Community Benefit."

The VHA, CHA, and Lyon Software collaborative document "Community Benefit Reporting Guidelines and Standard Definitions," states 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, 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 a service 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 hospitals in quantifying 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. 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 it’s 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, or has
 - Designation as a “medically underserved area” (MUA) or a “health manpower shortage area” (HMSA); or
 - Designation as a Health Enterprise Zone by the Community Health Resources Commission.

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 number of encounters
- Not be of a questionable nature that jeopardizes the credibility of the inventory
- Have an explicit budget
- Reduce health and healthcare disparities in the community that the hospital serves

In all categories, count negative contribution margin departments or services. Do not include bad debt.

T00. MEDICAID COSTS

In FY 2013, Maryland hospitals are required to provide a Deficit Assessment Fee to the Maryland Medicaid Program. A spreadsheet will be provided on the HSCRC website along with these instructions which will provide the total amount of the Deficit Assessment Fee, broken down between payer and hospital portions. The total assessment amount, (see column labeled, “Total Payments July 1, 2012 thru June 30, 2013”), for your hospital, should be reported in ‘Direct Cost’. The payer portion, (see column labeled “Payer Portion”) for your hospital, should be reported in ‘Offsetting Revenues’. The resulting ‘Net Community Benefit’ will equal the hospital’s portion of the assessment, (see column labeled “Hospital Portion” to verify the calculation).

A00. 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 Charity Care).

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
- Other areas

As a reminder, Maryland law defines a community benefit as an activity that is “intended to address community needs and priorities primarily through disease prevention and improvement of health status.”

A10. 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
- Writing an article on specific disease conditions or health issue as long as the purpose is not marketing
- Only the staff time used to write the article may be counted, the circulation number does not equal the number of encounters.
- This does not include scholarly publications such as journal articles or peer reviews.
- 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, workshops, or hospital tours by staff to community groups
- Pastoral outreach education programs
- Parish congregational programs
- Prenatal/childbirth classes serving at-risk populations
- Providing 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 is 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

A11. 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:

- Support groups related to community need, such as for prevention of child abuse.
- 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 and parenting education classes that are reimbursed or designed to attract paying or insured patients.

A12. Self-help

Wellness and health promotion programs offered to the community, such as smoking-cessation, exercise, and weight-loss programs.

Count:

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

Do not count:

- Health care organization employee wellness and health promotion provided as an employee benefit.

A20. 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 C Mission Driven Health Services).

A21. 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
- Screenings where referrals are made only to the health care organization or its physicians
- Screenings provided primarily for public relations or marketing purposes
- Free school team physicals provided for public relations purposes

A22. One-Time or occasionally held clinics

Count:

- Blood pressure and/or lipid profile/cholesterol screening clinics
- Cardiology risk factor screening clinics (take care not to include if screening is really marketing or case-finding)
- 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:

- Free school team physicals, unless there is a demonstrated need for this service
- Flu shots or physical exams for employees
- Clinics for which a fee is charged and a profit is realized (do report if there is a negative margin)
- Subsidized, permanent, ongoing, hospital-sponsored programs (these should be counted in subsidized health services C, Mission Driven Health Services)

A23. Clinics for underinsured and uninsured persons

These programs, which in the past may have been called “free clinics,” provide free or low-cost health care to medically underinsured and 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

A24. Mobile Units

Count:

- Vans and other mobile units used to deliver primary care services

Do not count:

- Subsidized, mobile specialty care services that are an extension of the organization’s outpatient department, e.g., mammography, radiology, lithotripsy, etc. (report in C, Mission Driven Health Services)

A30. Health Care Support Services

Health care support services are provided by the hospital to increase access and quality of care in health services to individuals, especially persons living in poverty and those in other vulnerable populations.

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 hot-lines, poison control centers)
- Transportation programs for patients and families to enhance patient access to care (include cab vouchers provided to low-income 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
- Routine discharge planning

A40-A44 Other

Other areas include community benefit initiatives and programs where the recipient is not billed. Please list each program separately and include only those programs that were not reported elsewhere in a different community benefit reporting category.

Count:

- Free Medications or medication subsidies/vouchers (if provided as part of a non-healthcare organization sponsored free health care clinic, such as a FQHC, report under A20 Community Based Clinical Services)

B00. HEALTH PROFESSIONS EDUCATION

As a reminder, Maryland law defines a community benefit as an activity that is “intended to address community needs and priorities primarily through disease prevention and improvement of health status.”

Additionally, please remember that offsetting revenue provided in the form of HSCRC-approved rates should not be reported in the “Offsetting Revenue” column.

B10. Physicians/Medical Students

Count:

- A clinical setting for undergraduate/vocational training
- Internships/clerkships/residencies
- Residency education
- Fellows that are paid for by the hospital
- Continuing medical education (CME) offered to physicians outside the medical staff on subjects for which the organization has special expertise

Do not count:

- Expenses for physician and medical student in-service training

- Joint appointments with educational institutions, medical schools
- Orientation programs
- Continuing medical education (CME) costs to members of the medical staff

B20. Nurses/Nursing Students

Count:

- 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)
- Internships/externships when on-site training of nurses (e.g., LVN, LPN) is subsidized by the health care organization
- Costs associated with underwriting faculty positions in schools of nursing in response to shortages of nurses and nursing faculty

Do not count:

- Education required by 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
- Programs where nurses are required to work for the organization
- Staff costs associated with joint appointments with educational institutions, nursing schools

B30. Other Health Professionals

Count:

- A clinical setting for undergraduate training and internships for dietary professionals, technicians, chaplaincy/pastoral care, physical therapists, social workers, pharmacists, and other health professionals – when there is no work requirement tied to training
- Training of health professionals in special settings, such as occupational health or outpatient facilities
- Unpaid costs of medical translator training beyond what is mandated
- Medical libraries open to the general public

Do not count expenses associated with:

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

B40. Scholarships/Funding for Professional Education

Count:

- Funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and community health improvement

- Scholarships or tuition payments for nursing and health professional education to non-employees with no requirement to work for the organization as a condition of the scholarship
- Specialty in-service and videoconferencing programs made available to professionals in the community

Do not count expenses associated with:

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

C00. MISSION DRIVEN HEALTH SERVICES

C10-C91 Mission driven health services are services provided to the community that were never expected to result in cash inflows but: 1) which the hospital undertakes as a direct result of its community or mission driven initiatives; or 2) would otherwise not be provided in the community if the hospital did not perform these services.

VHA and CHA provide further guidance in the Community Benefit Reporting guidelines that 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 ascertain whether the negative contribution is truly a community benefit. The Commission would reiterate that those initiatives geared towards increasing a hospital’s market share or are a part of the hospital’s routine cost of doing business should not be included in a hospital’s community benefit report.

As a reminder, Maryland law defines a community benefit as an activity that is “intended to address community needs and priorities primarily through disease prevention and improvement of health status.” Please also refer to pages 6 & 7 of these guidelines to the checklist of questions developed by VHA and CHA to answer possible questions of whether an activity is appropriately considered a community benefit.

For hospitals that are considering reporting physician subsidies, remember to include only those costs that are not part of the hospital’s routine cost of doing business but are, rather, community benefit activities that arise as a result of the hospital’s tax exempt status. Remember to specifically designate those costs attributable in a separate line distinct from other mission driven health services within Section C.

Whenever possible, classify physician subsidies into the following categories:

- Hospital-based physicians with whom the hospital has an exclusive contract and/or subsidy in order to retain services that represent a community benefit;
- Non-Resident house staff and hospitalists;
- Coverage of Emergency Department call;
- Physician provision of financial assistance to encourage alignment with hospital financial assistance policies; and
- Recruitment of physicians to meet community need as shown by a hospital’s medical staff development plan

Other costs as appropriate can be included so long as supplemental documentation describing the service and community need being met is provided. Also to the degree possible, categorize physician staffing of community-based clinics that serve underserved populations or otherwise meet unmet community need under section A20. Community Clinics.

TO THE EXTENT POSSIBLE, PLEASE NOTE FOR CATEGORIES 1, 2, AND 3 WHETHER THE SUBSIDIES ARE DIRECTED TOWARDS OBSTETRICS, MENTAL HEALTH (PSYCHIATRIC CARE), PRIMARY CARE, OR SPECIALTY CARE.

To the extent possible, please note for categories

Remember to include only items that generate a negative margin and that have not been otherwise accounted for in a separate Community Benefit reporting section. Report costs using financial statements for initiatives such as:

- Organizationally owned health care clinics or urgent care centers
- Hospice services
- Outpatient mental health services

Do not report:

- Bad debt
- Hospital based Charity care

D00. 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). As a reminder, Maryland law defines a community benefit as an activity that is “intended to address community needs and priorities primarily through disease prevention and improvement of health status.”

D10. Clinical Research

Count:

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

D20. Community Health Research

Count:

- Studies on health issues for vulnerable persons
- Studies on health issues for racial and ethnic minority groups
- Studies on community health, incidence rates of conditions for special populations
- Research papers prepared by staff for professional journals or presentation
- Other

D30-D32 Other

Count:

- Research studies on innovative health care delivery models

E00. Cash and In-Kind Contributions

This category includes funds and in-kind services donated to individuals and/or the community at large. This category was formerly called donations. 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. **This category is restricted to funds allocated to Community Benefits, as is reported on the IRS 990 Schedule H.**

E10. Cash Donations

Count:

- Contributions and/or matching funds provided to not-for-profit community organizations
- Contributions and/or matching funds provided to local governments
- 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.

E20. Grants

Count:

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

E30. In-Kind Donations

Count:

- Meeting room overhead/space for not-for-profit organizations and community (e.g. coalitions, neighborhood associations, social service networks)
- 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
- Blood Drive at your facility (cost of the employees' time, food/canteen expense)
- Supplies provided in aid to community outside of your service area in answer to public call for assistance.

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. These expenses are considered employee benefit
- Salary expenses paid to employees deployed on military services or jury duty. These expenses are considered employee benefit.

E40. Cost of Fund-Raising for Community Programs

This category is meant to capture the costs of raising funds for community benefit programs, and not to capture all fundraising costs of the hospital.

Count:

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

F00. 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.

Please keep in mind that you must be able to tie these activities back to an assessed need within the community and the action plan developed to address those needs.

Remember to subtract any subsidies or grant amounts from total expenses incurred in this category.

F10. Physical Improvements and 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
- Other

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
- Health facility construction and improvements, such as a meditation garden or parking lot.

F20. Economic Development

Count:

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

Do not count:

- Routine financial investments

F30. Community Support

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
- Other

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

F40. 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)
- 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
- Other

Do not count:

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

F60. 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

F70. Advocacy for Community Health Improvements

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

F80. Workforce Development

Count:

- Recruitment of physicians and other health professionals for federally medical 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 to community members not specific to health care professions (count in E1, Cash)
- Employee workforce mentoring, development, and support programs

F90-F92. Other

Please list each program separately and include only those programs that were not reported elsewhere in a different community benefit reporting category.

G00. 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.

G10. Assigned Staff

Count:

- Staff costs of management/oversight of community benefit program activities that are not included in other community services categories
- Staff costs for internal tracking and reporting community benefit
- 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

G20. 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

G30-G32. Other

Count:

- Cost of evaluation efforts of community benefits initiatives or programs
- 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
- Dues to an organization that specifically support the community benefit program, such as the Association for Community Health Improvement
- Software that supports the community benefit program
- Costs associated with attending educational programs to enhance community benefit program planning and reporting

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
- Dues to hospital and professional organizations not specifically and directly related to community benefit
- Software not specifically and directly purchased to support the community benefit program
- Costs associated with attending education programs that are not specifically and directly related to community benefit

H99. 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.

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.

Do not count:

- Bad debt
- Costs already included in the Mission Driven Health Care Services category

III. OTHER GUIDELINES

I00. FINANCIAL DATA

In terms of financial accounting practices, hospitals should use audited financial statements as the source. Hospitals with a fiscal year that coincides or closely coincides with the HSCRC's required Community Benefit reporting period of July 1 to June 30 should report Community Benefit data using the most recent audited financial statements as the source.

Hospitals whose fiscal year is calendar-year based may collect community benefit information for the reporting period of January 1 through December 31. A hospital should make clear in its Community Benefit Report submission, therefore, the types of financial data used and time periods covered. Every effort should be made to have these reported figures directly tie to the hospital's financial statements.

I10. INDIRECT COSTS

Hospitals can currently calculate an indirect cost ratio from their HSCRC Annual Cost Report data. This can be calculated using Schedule M from the hospital's Annual Cost Report. Hospitals should calculate an indirect cost ratio from their HSCRC Annual Cost Report data (please see pages 4 & 5 for instructions on how to calculate an indirect cost ratio). Please enter this calculated number into Item I10. Please enter this calculated number as a whole number, not as a percentage. The spreadsheet will convert the number into a percentage.

Rather than calculating a separate indirect cost per activity, the HSCRC inventory spreadsheet permits hospitals to calculate an indirect cost ratio calculated by the hospital and entered into Item I1, which can then be used to allocate indirect costs to the following community benefit categories: (A) Community Health Services; (F) Community Building Activities; and (G) Community Benefit Operations.

The HSCRC asks that hospitals examine its calculated indirect costs carefully, and to override the calculated indirect costs where the hospital believes the direct costs may, in part, reflect the total costs of the community benefit initiative. For the remaining categories, the indirect cost calculation will default to zero, and may be overridden if the hospital believes there are indirect costs involved with the initiative, but are not accurately represented in the direct costs.

J00. 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.

J10. 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
- Other

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

J20. 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

J30-J32. Other

Count:

- Community Benefit operations cost
- Any other community benefit programs or services that do not fit within sections J10 or J20

K00. Total Hospital Community Benefit

For this section, the worksheet cells are formula driven utilizing hospital-specific data provided. Therefore, no numbers will need to be entered by the hospital in this section.

IV. DO NOT COUNT!

The following are frequently posed scenarios that the Community Benefit Report Guidelines developed by the VHA, CHA, and Lyon software 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 payers 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. 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
- Token of sympathy to staff or patients at times of crisis or bereavements (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, with 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 (this is considered an employee benefit)
- Staff presenting to professional organizations
- Tuition reimbursement costs provided as an employee benefit
- Nurses teaching/delivering papers at professional meetings

V. COMMUNITY BENEFIT DEFINITIONS ²

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

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:

- 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

"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

² These definitions are drawn directly from the collaboration among VHA Inc., the Catholic Health Association of the United States, and Lyon Software, which worked 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.

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.

Community Benefit

A community benefit is a planned, organized, and measured approach, by a non-profit healthcare organization, to meeting identified community health needs within its service area. It most often requires collaboration with other non-profit and public organizations within the community in determining the health needs of its residents. Such planning relies on the use of objective data and information to determine community needs, and the impact of the organization's participation on those needs.

Community benefits respond to an identified community need, and meet the following criteria:

Ultimately improve the health status and well being of specific populations in the organization's service area who are known to have difficulty accessing care and/or who have chronic needs;

Generate a low or negative margin;

Are not provided for marketing purposes; and/or

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
- Mission Driven Health Services
- Research
- Financial Contributions
- Community Building Activities
- Community Benefit Operations
- Charity care
- Foundation Funded Community Benefit

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

Community Benefit Operations

Community benefit operations are costs associated with dedicated staff, community health needs and/or assets assessments, 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

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 partnership areas of attention.

Community Building

Community building activities include 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

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.

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.

Continuing Care Services

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

Counseling

Counseling is 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

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.

Disparity

All differences among populations in measures of health and healthcare.

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 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 foundation is 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

Government-sponsored health care describes 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 is given on a one-on-one basis to assist community members.

Health Disparity

A higher burden of illness, injury, disability, or mortality experienced by one population group in relation to a reference group.

Healthcare Disparity

Racial or ethnic differences in the quality of healthcare that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention.

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. (for calculation and detailed explanation, please see Section I).

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 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, etc.

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.

Mission Driven Health Services

Mission driven health services are services provided to the community that were never expected to result in cash inflows but: 1) which the hospital undertakes as a direct result of its community or mission driven initiative; and 2) would otherwise not be provided in the community if the hospital did not perform these services.

Mobile Unit

Vans and other mobile units 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.

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 can be designed to be 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.

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.

Self-help

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

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 on a regular or intermittent basis.

Target Group

A target group is the primary audience for which a program is intended such as infants, children, adolescents, adults, seniors, the disabled, or racial and ethnic populations.