



Community Benefit Reporting: *Accounting Primer*

DEVELOPED BY THE CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES IN COLLABORATION WITH VIZIENT



AN ACCOUNTING PRIMER ON COMMUNITY BENEFIT

For many years, the Catholic Health Association of the United States and Vizient (CHA/Vizient) have published guidelines to help hospitals plan and report community benefits. CHA and Vizient are pleased to provide this new resource, which contains an accounting primer on community benefit.

Each year, the IRS publishes instructions to IRS Form 990, Schedule H. CHA and Vizient have for years published community benefit accounting worksheets and guidelines. While effort has been made to assure those publications are user-friendly, they can be daunting for Community Benefit and Finance staff alike. This short accounting primer is designed to help.

The primer begins with a review of relevant accounting principles, then summarizes accounting methods for each category of reportable activities and programs, and then identifies issues that sometimes contribute to under-reporting and over-reporting community benefits. An Appendix reviews how the Ratio of Patient Care Cost to Charges (the Cost to Charge Ratio used to convert charges for Financial Assistance, Medicaid and Subsidized Health Services to cost) should be calculated.

WHY ACCURATE AND COMPREHENSIVE COMMUNITY BENEFIT REPORTING IS IMPORTANT

Tax-exempt hospitals provide community benefits for many reasons. Providing community benefits:

- + Manifests commitments by hospitals and health systems to their missions;
- + Increasingly is recognized as vital to improving population health and achieving strategic objectives;

- + Responds to federal expectations that tax-exempt hospitals focus on improving community health by providing access to care for low-income patients, enhancing public health, advancing knowledge through health professions education and research that benefits the public, making contributions for community benefit; and
- + Responds to requirements in many states that hospitals provide community benefits to qualify for sales, property and/or corporate income tax exemptions or to satisfy conditions placed on mergers and acquisitions.

What you need to know

- + Accurate community benefit reporting is important.
- + This short accounting primer:
 - Is designed for Finance/Tax and Community Benefit/Community Health staff alike.
 - Summarizes accounting principles and calculation methods for each community benefit category.
 - Identifies common under-reporting and over-reporting issues.

Hospitals and health systems also provide community benefits in recognition that tax-exemptions are valuable and provide the ability to receive charitable donations, issue tax-exempt debt and remain exempt from paying federal, state and local taxes.

Hospital organizations exempt under 501(c)(3) have been required to file community benefit information on IRS Form 990, Schedule H since tax year 2009.¹ About one-half of U.S. states also mandate some form of community benefit reporting.² Hospitals thus have been gathering and reporting community benefit information for over a decade.

Whatever the reasons, it's important for hospitals to report their community benefit accurately (to avoid potential under-reporting and possible over-reporting) and to assure alignment with instructions for IRS Form 990, Schedule H and with CHA/Vizient guidelines.

ACCOUNTING PRINCIPLES

Community benefits are accounted for by quantifying the actual total expense, the direct offsetting revenue and the resultant net expense borne by the hospital organization for:

- + Financial Assistance³,
- + Medicaid,
- + Other Means-tested Government Programs (*e.g.*, county indigent care programs for which individuals qualify based on their household income and assets),
- + Community Health Improvement Services,
- + Community Benefit Operations,
- + Health Professions Education,
- + Subsidized Health Services,
- + Research Funded by Government and Other Tax-exempt Sources, and
- + Cash and In-kind Contributions for Community Benefit.

On Schedule H, hospitals also account for Community Building Activities (in Part II), Medicare (amounts not elsewhere reported as community benefits) and Bad Debt (in Part III).

Community benefit accounting is grounded in a number of accounting principles, the most significant of which are as follows.⁴ These principles were reviewed with IRS staff as Schedule H instructions were being developed.

Principle: Only report actual expense for community benefits, not “opportunity costs” or capital expenditures.

Community benefits are valued on the basis of actual expense. For hospital organizations that file IRS Form 990, this means any amounts reported as expense on Schedule H should also be included as expense on IRS Form 990 in Part IX, the Statement of Functional Expenses⁵.

Opportunity costs are estimated or theoretical amounts that don't represent an actual, auditable expense and thus can't be found in the Statement of Functional Expenses. Opportunity costs thus are not a valid way to report community benefits.

One example is the cost of space provided by a hospital to a community group so it can hold a meeting. This in-kind donation by the hospital should be valued based on the actual cost of the space (building depreciation, utilities, security) while in use by the group — not on the market rate that the group might have had to pay at a hotel.

Capital “expenditures” are not reportable as “expense” all in one year. Capital expenditures (*e.g.*, amounts spent to construct or renovate a building that houses a community benefit program) are not expensed all at once in the year the expenditure is made. Rather, a capital expenditure is expensed (reported as depreciation expense) over the years that the asset

1. Schedule H first was published for fiscal years that begin in 2008 but reporting community benefits was optional for that first year. Certain governmental hospitals that are described by 501(c)(3) are exempt from filing IRS Form 990.

2. State requirements frequently (but not always) align with Schedule H and CHA/Vizient guidelines.

3. Before the Affordable Care Act this generally was known as “charity care.”

4. These accounting principles are discussed in more detail in in CHA's *Guide to Planning and Reporting Community Benefit*, Chapter 4.

5. Schedule H calculates the percentage of expenses reported by the organization in Form 990, Part IX (after certain offsetting revenues are subtracted) that are for community benefits. In other words, if amounts are not reported as expense in Part IX of Form 990, they should not be reported as community benefit on Schedule H.

resulting from the expenditure has a useful life (e.g., over five, seven, or 30 years depending on the asset).

Principle: Use “most accurate” cost accounting methods.

Community benefit accounting largely is an exercise in cost accounting. Longstanding CHA/Vizient guidelines encourage organizations to rely on their most accurate cost accounting methods, such as the Ratio of Patient Care Cost to Charges, cost accounting systems, Medicare or Medicaid cost reports and others — whichever is considered most accurate. Schedule H instructions incorporate this principle.

Principle: Include indirect (overhead) costs for every category.

Schedule H instructions state the following:

“Total community benefit expense” includes both “direct costs” and “indirect costs.” “Direct costs” means salaries and benefits, supplies and other expenses directly related to the actual conduct of each activity or program. “Indirect costs” means costs that are shared by multiple activities or programs, such as facilities and administration costs related to the organization’s infrastructure (space, utilities, custodial services, security, information systems, administration, materials management and others).

Principle: Avoid double-counting.

Without care, double counting some community benefits is possible. For example, hospitals report total and net expenses for Financial Assistance, Medicaid and Bad Debts in full. Hospitals also separately report Subsidized Health Services (clinical services provided by the hospital that lose money but are provided because the community needs them). Expenses and revenues for Subsidized Health Services should exclude amounts for Financial Assistance, Bad Debt and Medicaid or double counting would occur.

Principle: Include direct offsetting revenue generated by each category of community benefit.

Several types of community benefit generate and/or are funded by revenues. Examples include Medicaid reimbursement, direct graduate medical education (DGME) reimbursement provided by Medicare and the Children’s Hospital Graduate Medical Education program, nominal fees paid by individuals participating in community health improvement programs and grants restricted by third parties to be used for specific community benefits.

Schedule H instructions state the following:

“Direct offsetting revenue” includes any revenue generated by the activity or program, such as reimbursement for services provided to program patients. “Direct offsetting revenue” also includes restricted grants or contributions that the organization uses to provide a community benefit, such as a restricted grant to provide financial assistance or fund research. “Direct offsetting revenue” does not include unrestricted grants or contributions that the organization uses to provide a community benefit.

Principle: If in doubt, follow generally-accepted accounting principles (GAAP) and align with financial statements.

Questions sometimes arise regarding how certain expenses or revenues should be valued. One example is the amount of Medicaid net patient revenue. Hospitals are encouraged to use the same accounting principles that apply to their audited financial statements and to IRS Form 990, so that community benefit accounting aligns as much as possible with those principles.

ACCOUNTING OVERVIEW

The table that follows summarizes accounting methods for each category of community benefit and also for community building. The table describes how to approach valuing total expense and direct offsetting revenue; net community benefit expense is the difference between these two values⁶. However, if direct offsetting revenue is greater than total expense, net community benefit expense is zero.

6. The primer is not meant to substitute for instructions to IRS Form 990, Schedule H or for chapters in CHA’s Guide to Planning and Reporting Community Benefit. Those publications include more in-depth guidelines regarding what counts as community benefit, accounting for joint ventures, how transactions between related and unrelated organizations are to be handled and other important topics.

In the CHA/Vizient guidelines and Schedule H instructions, hospitals are allowed to use their “most accurate” cost accounting methods. Many use the

Ratio of Patient Care Cost to Charges (Cost to Charge Ratio) formula presented in Worksheet 2 of the Schedule H instructions.

Category	Summary of Accounting Methods
<p>Financial Assistance (charity care)</p>	<p>Total Expense. Take charges for amounts written off pursuant to the Financial Assistance Policy and convert the charges to cost using either the Cost to Charge Ratio (as adjusted to avoid double-counting) or another more accurate cost accounting method.</p> <p>Direct Offsetting Revenue. Typically, direct offsetting revenue is zero unless the hospital has received grants restricted to be used for financial assistance or if payments received from an uncompensated care pool or Medicaid Disproportionate Share Hospital (Medicaid DSH) program are intended primarily to offset the cost of financial assistance.</p>
<p>Medicaid</p>	<p>Total Expense. Take charges generated in serving Medicaid patients (from all states and for both fee-for-service/direct Medicaid and for managed care) and convert the charges to cost using either the Cost to Charge Ratio or another more accurate cost accounting method (e.g., a Medicaid cost report). Also include in total expense any provider taxes, assessments, or fees paid by the hospital to participate in the Medicaid program.</p> <p>Direct Offsetting Revenue. Add up all Medicaid net patient revenue, including fee-for-service and managed care from all states and also including any Medicaid DSH, Delivery System Reform Incentive Payment (DSRIP), and Indirect Medical Education (IME) reimbursement. Include payments received from an uncompensated care pool or Medicaid DSH program if such payments are intended primarily for Medicaid services. Exclude from this category any Medicaid Direct Graduate Medical Education (DGME) revenue, which instead is included in direct offsetting revenue for health professions education.</p>
<p>Other Means-tested Government Programs</p>	<p>Use the same methodology as Medicaid to account for the Total Expense and Direct Offsetting Revenue associated with SCHIP, county indigent care programs and other government health insurance programs under which patients are eligible based on their household means. Note that Medicare, VA Health Benefits and TriCare are not provided on a means-tested basis so are not reported.</p>
<p>Community Health Improvement Services</p>	<p>Total Expense. Determine the expense incurred by the hospital for each program that qualifies as a Community Health Improvement Service. This generally is done by including compensation expense for hospital staff while working on qualifying programs (hours x hourly rates plus a factor for employee benefits), supplies expenses, any other direct expenses and also a factor for indirect (overhead) costs. The indirect cost factor can be derived from the Medicare Cost Report, cost accounting system or other sources⁷. Direct Offsetting Revenue. Include any fees paid by program participants and restricted grant funds used for qualifying programs during the year.</p>

Category	Summary of Accounting Methods
<p>Community Benefit Operations</p>	<p>Total Expense. Add up the direct and indirect (overhead) expense incurred by the hospital for community benefit administrative staff, community health needs assessments (CHNAs), conferences and related administrative activities. Note that if the hospital is part of a multi-hospital system and the system office includes community benefit staff or activities, a reasonably determined portion of those system office costs can be included by each system hospital.</p> <p>Direct Offsetting Revenue. Typically, zero for this category unless restricted grants are received to pay for CHNAs and other operations costs.</p>
<p>Health Professions Education</p>	<p>Total Expense. Add up the direct and indirect (overhead) expense for graduate medical education (GME) and for other health professions education (e.g., nursing students) necessary for the trainees to be licensed or certified in their field. The Medicare Cost Report frequently is used to value GME expense. Use care not to overstate the cost associated with nurses precepting nursing students; the incremental cost borne by the hospital to provide these students with clinical experience and didactic training may not be substantial. In-service staff education is not reportable.</p> <p>Direct Offsetting Revenue. Include DGME revenue from Medicare, Medicaid (if any) and Children’s Hospital Graduate Medical Education (CHGME). Any CHGME and Medicaid GME reimbursement provided on a lump sum basis should be split into direct and indirect components. Exclude IME GME revenue from these sources.</p>
<p>Subsidized Health Services</p>	<p>Identify clinical services provided by the hospital that lose money but are provided because the community needs them. For each clinical service reported, determine total expense (including expenses for ancillary services) and offsetting revenue excluding losses associated with financial assistance, bad debt, Medicaid and other means-tested government programs — all four of which are reported elsewhere in full and should not be double-counted.</p> <p>Total Expense. Estimate total expense for each clinical service by taking total charges and applying the Cost to Charge Ratio, or by using another more accurate cost accounting method. Then, compute an adjusted total expense by subtracting from the service’s total expense the cost for financial assistance, bad debt and Medicaid.</p> <p>Direct Offsetting Revenue. Add up all net patient revenue, other operating revenue and restricted grant revenue for the clinical service, and then compute an adjusted direct offsetting revenue amount by subtracting net revenue for Medicaid and financial assistance (if any) and adding back revenue deductions for bad debt.</p> <p>A clinical service may lose money when all payers and revenues are included, but make money when Medicaid, other means-tested government program, bad debt and financial assistance losses are excluded. If so, then the service doesn’t qualify to be reported as a subsidized health service.</p>

Category	Summary of Accounting Methods
<p>Research</p>	<p>Total Expense. Add up the direct expense and the indirect expense borne by the hospital for research studies that qualify to be reported as community benefit, because they seek to advance public knowledge and primarily are funded by grants or resources from a tax-exempt or government source (e.g., National Institutes of Health (NIH), a foundation, or the hospital itself). Indirect cost factors based on NIH guidelines or from other sources may be used in determining total expense.</p> <p>Direct Offsetting Revenue. Include in revenue any grants provided and restricted by a third party (e.g., NIH or a foundation) to fund the research expenses reported as community benefit. Also, include any license fees or royalties received by the hospital for research reported as community benefit either in the current or prior periods.</p>
<p>Cash and In-kind Contributions for Community Benefit</p>	<p>Total Expense. Add up the dollar value of cash donations the hospital made and restricted (in writing) to be used by the recipient for a specific community benefit purpose. Exclude an indirect cost add-on for restricted cash donations.</p> <p>In-kind donations (for donated supplies, meeting room space, depreciated computers and other resources) should be valued based on book value and/or reasonable, cost-based estimates. If a community group uses a conference room for an hour, for example, that in-kind donation should be valued based on an average hourly cost per square foot for depreciation, utilities, security, supplies and related expenses — not the fair market amount the group would have paid commercially.</p> <p>Direct Offsetting Revenues. Generally zero, unless the hospital has received a restricted grant from another organization and is re-granting or sharing the resource with another entity.</p>
<p>Community Building</p>	<p>Total Expense. Determine the expense incurred by the hospital for each program that qualifies as community building. This generally is done using the same accounting methods that apply to community health improvement services. If a program meets the definition of community building and the definition of community health improvement services, it should be reported as community health improvement.</p> <p>Direct Offsetting Revenue. Include any fees paid by program participants and restricted grant funds used for qualifying programs during the year.</p>

TIPS TO AVOID UNDER-REPORTING AND OVER-REPORTING

This section identifies and discusses issues that can contribute to under-reporting and over-reporting community benefits. Community benefit reports are more accurate if these issues are avoided.

Under-reporting Issues

Hospitals under-report community benefits if they:

- + Have not identified all of their reportable programs, including:
 - Community Health Improvement Services, such as helping patients enroll in Medicaid or the ACA Health Insurance Marketplace and other programs whose primary purpose is to improve public health.
 - Subsidized Health Services — either because no clinical services qualify or because this category takes significant work to (a) find services that lose money after adjusting out financial assistance, Medicaid, other means-tested government program and bad debt losses and (b) to establish that community need for each exists.
 - Health Professions Education costs for medical students, nurses, pharmacy technicians and other allied health professionals — in addition to net GME expenses (for interns, residents and supervising faculty).
- + Only report direct expenses for some types of community benefits (e.g., Community Health Improvement Services), even though Schedule H instructions indicate that both direct and indirect expenses are to be included.

Indirect expenses include overhead (such as facilities, administrative and support costs) shared by multiple activities or programs and that therefore must be allocated.

- + Don't include portions of system office community benefit expenses in their reports, even though those system office expenses are recovered from (allocated to) the hospitals through expense allocations and thus are included in the Statement of Functional Expenses (Part IX) of Form 990.
- + Don't reclassify Bad Debt expenses or certain implicit price concessions into Financial Assistance, using generally accepted methods of identifying patients eligible for Financial Assistance on a presumptive basis.
- + Don't systematically reclassify self-pay discounts provided to patients found eligible for Financial Assistance to charity care.
- + Don't include Medicaid provider taxes, fees, or assessments in the total expense incurred to serve Medicaid patients.

Medicaid losses are miscalculated unless these taxes are included — in particular if Medicaid revenues funded in part by the taxes are included in direct offsetting revenue.

- + Don't shift expenses for Community Building programs to Community Health Improvement Services (if there is evidence that the Community Building programs improve community health).
- + Subsidize physician practices or medical groups that operate in separate EINs⁷ or for-profit corporations and that incur financial assistance, Medicaid and other community benefit losses, but have not recognized that these subsidies can be structured as restricted contributions by the hospital for community benefits⁸.

7. "EINs" are Employer Identification Numbers — or unique entities that file returns with the IRS. With a few exceptions, each not-for-profit "organization" that is exempt under 501(c)(3) of the Internal Revenue Code files IRS Form 990 each year. Each organization frequently is referred to as an "EIN." EINs (and thus IRS Form 990 filings) may contain multiple hospitals and other entities that filed for tax-exempt status as a group. In most cases, hospital organizations operate in one EIN and affiliated physician groups/practices operate in their own, separate EINs and file their own, separate returns.

8. Examples of methodologies for restructuring physician practice subsidies as contributions for community benefit may be the subject of future publications.

- + Don't include community benefits provided by joint ventures owned in part by the hospital (and that don't file their own returns with the IRS), even though a portion of the expenses generated by those joint ventures has been included in the Statement of Functional Expenses (Part IX) of Form 990.

Over-reporting Issues

Hospitals over-report community benefits if they:

- + Report programs that don't satisfy generally accepted definitions of community benefit or that would be questioned by a prudent layperson because the primary purpose appears to be benefiting the organization itself⁹.
- + Include costs associated with providing interpreter services, which as of 2016 must be provided by all hospitals to all patients based on federal regulations¹⁰.
- + Fail to adjust the Ratio of Patient Care Cost to Charges as indicated by the instructions to Schedule H (see Appendix).
- + Only report net community benefit expense, rather than total community benefit expense, direct offsetting revenue and net community benefit expense — because this yields an overstated Ratio of Patient Care Cost to Charges.
- + Include certain amounts that haven't generated an expense actually included in Part IX of Form 990 for the EIN that operates the hospital (e.g., because they were performed by employees on their own time or were incurred by an affiliate that files its own, separate return with the IRS).
- + Don't use care when consolidating community benefit information across entities, particularly when one or more entities have generated Medicaid gains (see Appendix).
- + Report "opportunity costs" rather than actual cost reported by the hospital in its financial statements.
- + Report as community benefit cash contributions that have not been restricted, in writing, to be used for one or more community benefit purposes (e.g., Financial Assistance or Community Health Improvement Services), with community benefit defined based on instructions to Schedule H.
- + Fail to subtract the net effects of Medicaid, Other Means-tested Government Programs, Financial Assistance and/or Bad Debt to calculate the loss from Subsidized Health Services.
- + Define Subsidized Health Services too narrowly, for example including payments to physicians so they are available (on-call) to cover the emergency room (rather than assessing the entire emergency room with these payments included in expenses).
- + Over-report indirect costs¹¹.
- + Report a high proportion of the hours spent by nurses to precept nursing students as community benefit, even though precepting the students doesn't materially affect productivity.
- + Report capital expenditures rather than the annual carrying cost (depreciation and amortization) associated with those expenditures over their useful lives.

9. Please refer to "what counts" resources available on the CHAUSA website for up-to-date recommendations regarding programs that do and don't count as community benefit.

10. See Final Rule published by the U.S. Department of Health and Human Services entitled Nondiscrimination in Health Programs and Activities.

11. Many of these issues are discussed in more detail in the CHA Guide to Planning and Reporting Community Benefit, e.g. example maximum values for indirect cost factors.

APPENDIX TO ACCOUNTING PRIMER: CONSOLIDATING COMMUNITY BENEFIT AMOUNTS ACROSS ENTITIES

Part I, Line 7 of IRS Form 990, Schedule H is copied below. This part of Schedule H commonly is referred to as the “community benefit table.”

7 Financial Assistance and Certain Other Community Benefits at Cost						
Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits						
k Total. Add lines 7d and 7j						

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat. No. 50192T **Schedule H (Form 990) 2018**

As of Tax Year 2015, filers were instructed as follows regarding the last two columns of the table:

Columns (e) and (f). Do not report negative numbers. If the net community benefit expense is less than \$0, enter “0.” Similarly, do not report a negative percent in column (f), but enter “0.”

No further instructions were provided regarding the implications of this change for the totals to be reported in rows d, j, or k. The implications for some organizations with Medicaid gains (direct offsetting revenue greater than total community benefit expense) can be significant.

Say, for example, a hospital has:

- + Medicaid direct offsetting revenue of \$11 million,
- + Medicaid total community benefit expense of \$9 million, and

- + A resultant Medicaid gain (or negative net community benefit expense) of \$2 million.

Say this hospital also has total and net Financial Assistance expense of \$2 million. Should the “net community benefit expense” reported in line 7d (and included in line 7k) be:

- + Zero (which would net the \$2 million Medicaid gain against the \$2 million Financial Assistance loss), or
- + \$2 million (which would ignore the Medicaid gain because it is entered as “0” in column (e)?)

Because Schedule H instructions were silent on this question, in 2017 the CHA/Vizient guidelines were updated. The CHA Guide to Planning and Reporting Community Benefit currently states:

CHA recommends continuing to prepare community benefit reports based on the guidelines throughout [the *CHA/Vizient Guide to Planning and Reporting Community Benefit*]. However, when reporting to the IRS, any negative numbers for net community benefit expense (and net community benefit expense as a percent of total expense) should be set at zero. **Any gains still would be included in overall totals (the last line of the community benefit table).**

If gains result from extraordinary events such as the receipt of substantial prior year revenue (e.g., from a Medicaid Cost Report settlement), these circumstances should be footnoted so readers understand the basis for reported community benefit amounts.

The CHA/Vizient guidelines thus suggest that the example hospital’s net community benefit expense for Financial Assistance and Medicaid together should be reported at zero.

However, because the Schedule H instructions remain silent, hospital organizations have discretion to treat the negative numbers or zero values either way.

The treatment of negative net community benefits (including Medicaid gains) also affects how community benefit reports across entities are consolidated.

Say, for example, a hospital organization with three hospital facilities files a group IRS Form 990 return, and:

- + Hospital 1 generated a Medicaid gain of \$5 million,
- + Hospital 2 incurred a Medicaid loss of \$5 million, and
- + Hospital 3 incurred a Medicaid loss of \$10 million.

There are two options for how hospital organizations may decide to aggregate these results and report them on Schedule H. See below:

Medicaid	Total Expense (Column C)	Offsetting Revenue (Column D)	Net Expense (Column E)
Hospital 1	40,000,000	45,000,000	—
Hospital 2	25,000,000	20,000,000	5,000,000
Hospital 3	50,000,000	40,000,000	10,000,000
Total (Option 1)	115,000,000	105,000,000	15,000,000
Total (Option 2)	115,000,000	105,000,000	10,000,000

Under Option 1, only the losses incurred at Hospitals 2 and 3 are reported, for an overall net community benefit expense of \$15 million for the organization as a whole. Under Option 2, net expense is based on subtracting direct offsetting revenue for all three hospitals combined from total expense also for the three hospitals combined. Under Option 2, the \$5 million gain thus reduces the reported Medicaid net community benefit expense for the organization as a whole.

CHA/Vizient guidelines suggest that consolidated community benefit reports be prepared under Option 2 — meaning that when values are totaled across entities the consolidated amounts should report Medicaid losses incurred by the organization as a whole and not the losses incurred only by entities that lose money. These guidelines apply to preparing Schedule H and also to other documents that report community benefits on a system-wide or regional basis.

APPENDIX TO ACCOUNTING PRIMER: THE RATIO OF PATIENT CARE COST TO CHARGES

The Ratio of Patient Care Cost to Charges (the Cost to Charge Ratio) generally is used to

convert charges for Financial Assistance, Medicaid and Subsidized Health Services to cost (unless the hospital has a more accurate cost accounting method). A worksheet designed to help hospitals calculate the Cost to Charge Ratio is included in Schedule H instructions (Worksheet 2) and in the *CHA Guide to Planning and Reporting Community Benefit*.

Several adjustments are made to the Cost to Charge Ratio primarily to avoid double counting. For example, a hospital may have \$10 million in total Health Professions Education expense reported in full as community benefit. If that \$10 million remains in the numerator of the Cost to Charge Ratio, then a portion of Health Professions Education expense is reported again wherever the ratio is applied. The table below demonstrates and explains the adjustments.

Because double-counting is possible, it's important first to determine community benefit expenses for categories not valued based on the Cost to Charge Ratio (including Health Professions Education, Community Health Improvement Services, Research and others). Total expenses for these categories then should be subtracted from the numerator of the Cost to Charge Ratio before it's used.

Worksheet 2 Variable	Example Value	Explanation
Total operating expense	\$100,000,000	The numerator of the Cost to Charge Ratio starts with total operating expense, derived from audited financial statements and excluding bad debt expense.
Less: adjustments		Then, adjustments are made to minimize double-counting and to assure the Cost to Charge Ratio (which is applied to patient care charges) excludes nonpatient care activities.
+ Nonpatient care activities	\$5,000,000	+ Hospitals may use Other Operating Revenue as a proxy for the cost of nonpatient care activities (assuming they have corresponding break-even expenses); however, it's preferable to include in this adjustment the actual cost of those activities (e.g., cafeteria). It's also important to exclude grant revenue that funds community benefits from this adjustment (because the expenses funded by the grants already are one of the adjustments) — and to exclude any other operating revenue that doesn't have a corresponding expense (e.g., joint venture income).
+ Medicaid provider taxes, fees and assessments	\$10,000,000	+ Another adjustment is to reduce the numerator of the Cost to Charge Ratio for Medicaid provider taxes/fees — if that amount is included in total operating expense rather than deducted from net patient revenue. This adjustment is needed because this amount is reported as expense in full already in the Medicaid category.
+ Medicaid provider taxes, fees and assessments	\$4,000,000	+ Then, adjust the numerator for other community benefit expenses to which the Cost to Charge Ratio has not been applied (e.g., community health improvement services and health professions education), because those expenses are reported in full and should not be included again (double-counted) in financial assistance, Medicaid and other community benefits.
+ Total community building expense	\$300,000	+ Community building expenses are to be adjusted out of the numerator for the same reasons.

Worksheet 2 Variable	Example Value	Explanation
Total adjustments	\$19,300,000	Adjustments to the numerator can be substantial, particularly for hospitals with health professions education programs.
Adjusted operating expense	\$80,700,000	Equals total operating expense minus the above adjustments.
Gross patient charges Less adjustments: + Gross charges for community benefit programs Adjusted patient care charges	\$300,000,000 \$0 \$300,000,000	Gross patient charges also may need adjustment, if hospitals use a cost accounting system or cost report for Subsidized Health Services or other community benefits. Generally, a subtraction from the denominator only occurs if hospitals use their cost accounting systems or cost reports for Subsidized Health Services, Medicaid and/or Other Means-tested Government Programs. Equals gross patient charges minus the above adjustments to charges.
Ratio of patient care cost to charges	0.269	Note that without the above adjustments, the example Ratio would have been 0.333 and would have included nonpatient care expense and double counted community benefit and community building expenses.

ABOUT THE CATHOLIC HEALTH ASSOCIATION

The Catholic Health Association of the United States (CHA), founded in 1915, supports the Catholic health ministry's commitment to improve the health of communities and provide quality and compassionate health care.

CHA is recognized nationally as a leader in community benefit planning and reporting. In collaboration with member hospitals, health systems and others, CHA developed the first uniform standards for community benefit reported by not-for-profit health care organizations. These standards were used by the Internal Revenue Service to develop the Form 990, Schedule H for Hospitals.

ABOUT VIZIENT

Vizient is a member-driven, health care performance improvement company committed to optimizing every interaction along the continuum of care. Vizient was founded in 2015 as the combination of VHA Inc., a national health care network of not-for-profit hospitals; University HealthSystem Consortium, an alliance of the nation's leading academic medical centers; and Novation, the care contracting company they jointly owned. In February 2016, Vizient acquired MedAssets' Spend and Clinical Resource Management (SCM) segment, which included Sg2 health care intelligence.

Vizient has a long track-record of working to ensure that community-based, not-for-profit health care is supported. Congress, the White House and federal regulatory agencies, such as the Internal Revenue Service, regularly examine the merits of tax-exemption for not-for-profit hospitals and look to ensure that exemption is justified by activities that provide meaningful benefits to their communities. Vizient continues to work with policymakers to ensure that our members are represented in those policy discussions and are able to fully tell the full story of the essential care that they provide to the communities they serve.

ABOUT THE AUTHOR

Keith Hearle, MBA, is President of Verité Healthcare Consulting. Prior to establishing Verité in 2006, Keith led the Hospitals and Health Systems practice for The Lewin Group, Inc., served as CFO of the San Francisco Department of Public Health (Public Health Division), as a Manager at KPMG Peat Marwick and as a Senior Equity Analyst (Healthcare) for a California-based money manager.

In 1989, he developed for CHA/Vizient the first accounting framework for hospital community benefit and co-authored the CHA/Vizient Social Accountability Budget. He also authored the accounting chapters (and worksheets and other materials) in the May 2006 and December 2008 CHA/Vizient Guide to Planning and Reporting Community Benefit and in all subsequent editions. He developed a framework for determining "What Counts as Community Benefit," adopted by CHA/Vizient in 2007. In 2008, he was asked by IRS officials to draft major sections of the Instructions to IRS Form 990, Schedule H. He worked with IRS staff thereafter on refinements to the Instructions.

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A Mission to Care: A Commitment to Community

From the very beginning, civic leaders and congregations of religious women and men courageously responded to the needs of the communities they were called to serve.

Today, that same call to provide health and hope is being answered in unique and creative ways through community benefit programs.

AS COMMUNITY BENEFIT LEADERS:

We are concerned with the dignity of persons.

We are committed to improving health care access for all persons at every stage of life regardless of race, culture or economic status and to eliminating disparities in treatment and outcome.

We are concerned about the common good.

We design community benefit programs to improve health through prevention, health promotion, education and research.

We have special concern for vulnerable persons.

We put a priority on programs that address the most vulnerable in our communities and ensure that all programs reach out to persons most in need.

We are concerned about stewardship of resources.

We use resources where they are most needed and most likely to be effective.

We are called to justice.

We advocate health care for all and work to improve social conditions that lead to improved health and well-being.

We care for the whole person.

We engage partners in our communities so that together we improve health and quality of life through better jobs, housing and the natural environment.

For more information about community benefit and Catholic health care, go to www.chausa.org/communitybenefit



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