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A Guide for Planning & Reporting Community Benefit

2022 Edition

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Chapter Two: Understanding What Counts and Does Not Count as Community Benefit

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Chapter Two: Understanding What Counts and Does Not Count as Community Benefit

The guiding principle in determining a community benefit is that the activity or program responds to an identified community health need and is not provided primarily for organizational benefit.

Over the last 25 years, CHA and others in the field of community benefit have worked to create standard definitions and categories for community benefit programs and activities. Parts I and II of the IRS Form 990, Schedule H, are based on the community benefit definitions and categories developed by CHA and its partners.

The use of standard definitions and categories has many benefits:

- Helps organizations identify what activities and programs are and are not considered community benefit.
- Allows organizations and oversight agencies to reliably assess activities over time.
- Improves comparability across organizations.
- Allows health care systems to consolidate and report on community benefit amounts reliably.
- Improves the integrity of reported numbers, both internally and externally.

In this chapter, you will learn how to do the following:

Guideline 1: Determine if a program or activity is a true community benefit.
Guideline 2: Determine the programs that should not be counted and reported as community benefit.
Guideline 3: Distinguish programs and services for persons living in poverty from those for the broader community.
Guideline 4: Categorize community benefit programs and activities.

The guidelines in this chapter are recommendations only. They are not legal advice. Be sure to check the most recent requirements from your state and the IRS regarding the reporting of community benefit information.

Guideline 1
Determine if a program or activity is a true community benefit

Community benefits are programs or activities that provide treatment or promote health and healing in response to identified community health needs and meet at least one of these community benefit objectives:

- Improve access to health services.
- Enhance public health.
- Advance increased general knowledge.
- Relieve the burden on government to improve health.

This includes activities or programs that do the following.

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial or cultural barriers to accessing health services.
- Address federal, state or local public health priorities, such as eliminating disparities in access to health care services or disparities in health status among different populations.
- Leverage or enhance public health department activities, such as childhood immunization efforts.
- Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.
- Become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

The following section provides guidance on how to determine whether a program or activity is addressing a community health need and meets one or more community benefit objectives.

Community Need

The instructions for IRS Form 990, Schedule H, state that community health needs can be demonstrated through one of the following:

- A CHNA developed or accessed by the organization.
- Documentation that demonstrates community need or a request from a public agency or community group as the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

KEEP RECORDS ON THE NEEDS THAT DRIVE PROGRAMS

Records should document the community health need that the program seeks to address. This information can help to identify whether programs offer true community benefit and help tell the community benefit story. Check with your organization's tax, legal or finance departments for policies regarding maintaining and retaining records.

Community Benefit Objectives

In addition to addressing a community health need, a community benefit program or activity must meet at least one community benefit **objective.**

Improve access to health care services — demonstrated when at least one of these criteria is met:

- The participants include underserved persons.
- The program reduces or eliminates a barrier to access.
- The program is available broadly to the public and not only to insured persons and patients.
- The community would lose access to a needed service if the program ceased to exist.

Enhance public health — demonstrated when at least one of these criteria is met:

- The program is designed around public health goals or initiatives, such as eliminating health disparities or achieving goals described in *Healthy People 2030, The National Prevention Strategy* or similar publications.
- The program yields measurable improvements in health status.
- The community's health status would decline if the program ceased to exist.
- A public health agency provides comparable services. (However, a community benefit program should not unnecessarily duplicate or compete with a public program.)
- The program is operated in collaboration with public health partners.

Advance increased medical knowledge — demonstrated when these criteria are met:

- The program results in a degree, certificate or training that is needed to practice as a health professional.
- The organization does not require trainees to work for the organization after completing training.
- Health professional continuing education programs are open to professionals in the community, not exclusively for the organization's employees and physicians.
- The program involves health-related research that is funded by a tax-exempt source (e.g., the National Institutes of Health, a foundation or the organization itself) and that is intended to be made publicly available and to be useful to other providers.

Relieve the burden on government to improve health — demonstrated when at least one of these criteria is met:

- The program or activity relieves a government financial or programmatic burden for improving community health or for providing access to care for vulnerable or medically underserved persons.
- The government provides the same or a similar service (e.g., immunizations or Medicaid enrollment services).
- The government provides financial support of the activity (e.g., funding from the CDC).
- The health-related cost to government or another tax-exempt organization would increase if the program ceased to exist.

Guideline 2
Determine what programs should not be counted and reported as community benefit

Reporting programs that are clearly not community benefit or are questionable can jeopardize the credibility of the health care organization's community benefit report and undermine its community benefit efforts and the organization's tax-exempt status.

Do not report programs and services as community benefit under the following circumstances:

- The program is provided primarily for marketing purposes (e.g., a seminar on hip replacements to motivate patients needing surgery to choose the hospital for the procedure).
- The program benefits the organization more than the community (e.g., a flu clinic available only to the hospital's employees designed to reduce absenteeism).
- An objective, "prudent layperson" would question whether the program truly benefits the community (e.g., a health fair located in or proximate to an upscale shopping mall).
- The program or contribution is unrelated to health or the organization's mission (e.g., donating a scoreboard to a local high school).
- The program represents a community benefit provided by another entity or individual (e.g., activities performed by employees on their own time).
- The program only serves the hospital's patients post-discharge and has return on investment to the hospital as its primary purpose (e.g., targeted case management available exclusively to recently discharged patients and designed to reduce readmissions penalties).
- The program is targeted only to the organization's "covered lives," or individuals for whom the organization bears financial risk (e.g., a community health worker who visits only individuals who represent covered lives in an Accountable Care Organization (ACO) affiliated with the organization).
- Access to the program is restricted to hospital employees or physicians (e.g., education program available only to your medical staff or emergency funds for employees and their families).

- The activity represents a normal "cost of doing business," is associated with the current standard of care, or is required for licensure or accreditation (e.g., staff development activities, such as training and facility licensure, or accreditation requirements, such as routine discharge planning or translation services, provided at levels designed to meet minimum regulatory requirements).

Additional questions that may help determine whether a program is a community benefit or primarily represents organizational benefit include:

- Is there a cost to the organization, and can the expense for the activity be found in the organization's financial statements (e.g., the Statement of Functional Expenses on IRS Form 990, Part IX)?
- Is the activity designed to address an identified community health need?
- Will the activity produce a measurable health outcome?
- Is the activity accessible to uninsured and low-income persons?

A RESOURCE FOR DETERMINING WHAT COUNTS AS COMMUNITY BENEFIT

Visit CHA's website at https://www.chausa.org/whatcounts for questions that have been raised and recommendations for whether and how to report community benefit.

See Appendix B for examples of activities or programs that should and should not be reported as community benefit.

IRS

IRS NOTE

The instructions for Schedule H give guidance as to what cannot be reported as community benefit:

"Activities or programs cannot be reported if they are provided primarily for marketing purposes and the program is more beneficial to the organization than to the community. For example, if the activity or program is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization)."

Guideline 3
Distinguish programs and services for persons living in poverty from those for the broader community

When planning and reporting community benefit, some organizations separate programs and activities that assist low-income persons from those directed to the broader community. This is especially important for organizations that have a mission to serve low-income and other vulnerable persons so that the organizations can demonstrate they are living that mission.

Programs for Persons Living in Poverty

To determine who is considered a low-income or medically indigent person, a commonly used income benchmark is 200 percent of the federal poverty level (https://www.aspe.hhs.gov/poverty-guidelines).

Community benefit programs designed to reach persons living in poverty may include one or more of the following characteristics:

- Most program users are in households that would qualify for financial assistance under your organization's financial assistance policy or other means-tested public programs.
- Most program users cannot afford needed health care services.

- Most program users are uninsured or underinsured persons, or experience barriers accessing health care.
- Most program users are beneficiaries of Medicaid or state or local programs for medically indigent persons.
- The program is intended to reduce health problems caused by or related to poverty.
- The program is physically located in and draws most of its participants from an area known as low income or identified as a medically underserved area (MUA) or a health professional shortage area (HPSA). Visit https://www.muafind.hrsa.gov/ to find information on MUAs, HPSAs and medically underserved populations.

Programs for the Broader Community

Programs for the broader community are not focused on specific, low-income population groups and are aimed at improving the health and welfare of everyone living in the community.

Programs offered to the broader community should always be accessible to and involve outreach for low-income and other vulnerable persons.

Guideline 4
Categorize community benefit programs and activities

Standardized categories enable uniform reporting so that community benefit can be reliably reported internally and externally. This allows health systems to consolidate community benefit amounts and improves comparability among organizations.

See Community Benefit Categories and Definitions in the appendix for a comprehensive list of community benefit services.

ACCOUNTING FOR COMMUNITY BENEFIT

Refer to Chapter 4, Accounting for Community Benefit, for guidelines on how to account for and report expenses in each category of community benefit.

Categories of Community Benefit

Refer to the instructions for Schedule H for IRS definitions of these categories. The instructions can be accessed at https://www.irs.gov and on the CHA website at https://www.chausa.org/form990.

Financial Assistance

Financial assistance (charity care) is free or discounted health services provided to persons who cannot afford to pay all or portions of their medical bills and who meet the criteria specified in the organization's financial assistance policy.

Financial assistance is to be reported in terms of costs, not charges. Financial assistance does not include bad debt, which may be reported in Part III of Schedule H but not as community benefit. Financial assistance also does not include prompt-payment discounts or self-pay discounts made available to all uninsured patients regardless of income.

Unpaid co-pays for Medicaid and other low-income patients (e.g., those covered by health insurance purchased on https://www.healthcare.gov) can be reported as financial assistance if so specified in the organization's financial assistance policy. Patients in these circumstances are referred to as "underinsured."

REVIEW FINANCIAL ASSISTANCE POLICIES

Be sure your organization's policies are consistently applied, comply with federal and state requirements (including relevant provisions in 501(r) of the Internal Revenue Code), and allow sufficient flexibility to grant assistance for all persons unable to pay, even in the absence of complete information about their household means.

See Chapter 4 for additional recommendations.

Medicaid and Other Means-Tested Public Programs

Government-sponsored (public) means-tested programs have eligibility requirements tied to the recipient's income and assets.

Means-tested public programs may include:

- Medicaid.
- Other means-tested government programs, including:
  - State Children's Health Insurance Programs (SCHIP).
  - Local and state government programs for low-income persons not eligible for Medicaid.

Means-tested public program revenues and costs are reported in terms of total and net expense (with "net community benefit expense" determined by subtracting net patient revenue from total expense).

MEDICARE SHOULD NOT BE REPORTED AS COMMUNITY BENEFIT

Medicare is not a means-tested program and thus is not included in this category of community benefit. Medicare-funded programs are reportable as subsidized health services and in the health professions education and research categories. Other Medicare revenues and costs may be reported on Parts III and VI of Schedule H but not as community benefit.

Community Health Improvement Services

These activities are carried out to improve community health. Community health improvement activities do not generate inpatient or outpatient bills, although they may involve a nominal fee (e.g., $5 payment for flu shots provided in a community setting).

Community health improvement activities may not be counted as community benefit if they are available only to individuals affiliated with the organization (e.g., employees and members of the medical staff).

Examples of community health improvement services include:

- Community health education outreach, such as:
  - Classes or lectures on disease conditions.
  - Support groups that go beyond the current standard of care.
  - Self-help programs for persons and families facing health problems.
- Community-based clinical services for which there is no patient bill, including:
  - Screenings.
  - One-time or occasionally held clinics.
- Health care support services, such as:
  - Enrollment assistance for health insurance through the health insurance marketplace, Medicaid and other means-tested government-funded health programs.
  - The cost of software tools that support decision-making for granting financial assistance, if these tools are applied at the beginning of the patient experience

or revenue cycle rather than at the end of the revenue cycle (e.g., as a means of reclassifying bad debt write-offs into financial assistance).

- Information and referral, but not exclusively to the organization or its affiliated physicians.
- Transportation to improve access for low-income persons to health care in the community and not for the purpose of increasing referrals to the organization or its affiliated physicians.

- Social and environmental improvement activities, such as:
  - Removing materials, such as asbestos and lead, that harm residents in public housing.
  - Working to improve the availability of fresh fruits and vegetables in areas known as "food deserts."
  - Preventing violence.

See community-building category definition later in this chapter for more guidance on what types of community-building activities may count as community health improvement.

POST-DISCHARGE CARE AND COMMUNITY BENEFIT

Do not report routine discharge planning and most chronic disease and care management services (such as home visits or calls) for persons who have been hospitalized when those services are in follow-up to the hospitalization. Do not report services when the primary purpose of the service is to benefit the hospital organization, such as cost reduction or penalty avoidance.

However, in the following circumstances, chronic disease and care management services (such as screening for social needs, referrals to community programs, and health coaching and educational programs) should be reported as community benefit if they include all of these characteristics:

- Respond to an identified community need.
- Include outreach to persons who are vulnerable, disadvantaged or face barriers to accessing such health care services.
- Go beyond routine discharge planning and standards of care.

Health Professions Education

Educating future and current health care professionals is a distinguishing characteristic of not-for-profit health care and constitutes a community benefit recognized by IRS Revenue Ruling 69-545 that is reportable on Schedule H. This category includes educational programs for physicians, interns and residents; medical students, nurses and nursing students; pastoral care trainees and other health professionals when that education is necessary for a degree; and a certificate or training that is required by state law, an accrediting body or a health profession specialty.

Do not include programs provided exclusively for the organization's employees or medical staff, such as orientation programs or routine professional development. Include continuing medical and nursing education and education for other professionals only if such programs are open to other professionals in the community and the program is deemed eligible for continuing education credit by an accrediting or health care professional society (or other appropriate standard-setting or accrediting body).

Report activities designed to interest students in health professions as "workforce development" in the community-building category. This would include mentoring high school and other students.

IRS NOTE

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From the Schedule H instructions:

"Health professions education" means educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law, or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education or training programs available only to the organization's employees and medical staff or scholarships provided to those individuals. However, it does include education programs if the primary purpose of such programs is to educate health professionals in the broader community. Costs for medical residents and interns can be included, even if they are considered "employees" for purposes of Form W-2, Wage and Tax Statement.

Subsidized Health Services

Subsidized health services are patient care programs provided despite a financial loss so significant that losses remain after removing the effects of financial assistance, Medicaid

shortfalls and bad debt. The services are provided because they meet identified community health needs, and if these services were no longer offered, they would be unavailable in the area, the community's capacity to provide the services would be below the community's need, or provision of the services would become the responsibility of government or another not-for-profit organization.

Subsidized health services can, if they meet the above qualifying criteria, include:

- Inpatient programs (such as addiction recovery and psychiatric units).
- Outpatient programs (emergency and trauma services, satellite clinics designed to serve low-income communities, and home health programs).
- Services or care provided by physician clinics and skilled nursing facilities if such clinics or facilities satisfy the criteria for subsidized health services. Physician clinics should not be reported as subsidized health services if the hospital earns positive income (technical fees) from the work of those clinicians.

IRS

IRS NOTE

The Schedule H instructions state that if stand-alone physician clinics are included as subsidized services in Part I of Schedule H, the hospital must report the amount of those costs in Part VI.

Subsidized health services exclude ancillary services that support inpatient and ambulatory programs, such as anesthesiology, radiology and laboratory departments. Also, when reporting the service, be sure to report the whole service, not a subset of the service. For example, the emergency department might be reported as a subsidized health service, but the costs of retaining on-call physicians within the department should not be reported separately if the emergency department as a whole does not qualify as a subsidized health service.

Do not report a program as a subsidized health service if it:

- Is not meeting an identified community health need.
- Experiences loss due to inefficiency or volatile reimbursement.
- Has many competitors or excess capacity in the market and is not accessed by patients in need.

Research

Engaging in medical and health care research indicates the organization is concerned about the long-term welfare of the community at large and wants to generate and share knowledge that enhances the future of health care.

The instructions for Schedule H provide many examples of research activities that may be reported as community benefit, including activities to increase general knowledge about the underlying biological mechanisms of health and disease; natural processes or principles affecting health or illness; epidemiology, health outcomes and effectiveness; and studies related to changes in the health care delivery system.

The IRS asks hospitals to report only research that produces increased general knowledge and that is funded by government or tax-exempt sources, such as the National Institutes of Health, foundations or the organization itself. Information about industry-sponsored research that provides public benefit (e.g., for which protocols call for broad publication of results) can be included in Part VI.

Cash and In-Kind Contributions for Community Benefit

This category includes the value of cash and in-kind services donated by the health care organization to support community benefits provided by others. Examples of in-kind services include hours spent by staff members as part of their work assignment while on the organization's work time, the cost of meeting space provided to community groups, and donations of food, equipment and supplies.

Cash and in-kind contributions may include:

- Cash donations to tax-exempt entities and other organizations that provide community benefits.
- In-kind donations, such as meeting rooms, supplies, equipment and parking vouchers.

For a cash contribution to be reportable as community benefit expense on Schedule H, the organization granting the funds must restrict in writing that the contribution is to be used for an activity or program that meets the criteria for a community benefit. Community organizations that receive these restricted cash contributions can use them for community-benefit-related expenses (e.g., supporting medical education) or capital expenditures (e.g., renovating free clinic space). Cash and in-kind contributions that support community-building activities are to be reported in the community-building category.

RESTRICTING CONTRIBUTIONS

Contributions from health care organizations to community organizations should be accompanied by a letter or comparable written communication restricting the funds to be used to carry out a community benefit activity, as defined in Schedule H instructions.

Contributions should not be reported as community benefit if they:

- Are unrestricted and thus may be used by the recipient for activities other than community benefit.
- Involve a *quid pro quo*, such as a Payment in Lieu of Taxes (PILT), that benefits the organization that provides the contribution. Providing loans or funds that represent an investment in another organization ("contributions to the capital of another organization") are other examples of *quid pro quo* arrangements that are not reportable as community benefit.

As with all community benefit programs, contributions must be intended to address community health needs. For example, the hospital should ensure that any donated equipment and supplies are needed by the receiving organization or the community served by that organization before sending the contribution.

See Guideline 1 in this chapter for more information about how the organization can demonstrate community need for a program or activity.

Contributions that themselves are funded by a restricted grant received by the organization may be reported as community benefit expense. For example, if an affiliated foundation provides a restricted grant to a hospital for a diabetes health education program, and the hospital shares a portion of that grant with a community partner, the contribution to the partner is reportable as community benefit, and the amount of the grant used for that purpose is reported as "direct offsetting revenue."

Do not report as community benefit time spent by volunteers and staff members engaged in an activity on their own time.

DO NOT REPORT VOLUNTEER EFFORTS

Volunteer efforts not on paid time are not an expense to the organization and, therefore, cannot be counted.

Example: A camp for children who have cancer is supported by the hospital. Each year the hospital sends a team of nurses to work at the camp and pays the nurses their regular salaries.

Other staff members use vacation days to volunteer at the camp. The nurses' time, which is an expense to the organization, can be reported as an in-kind community benefit expense but not the time of the other staff members who are working as volunteers during their vacations.

CONTRIBUTIONS TO THE CAPITAL NEEDS OF OTHER ENTITIES

Questions frequently arise regarding whether contributions made by tax-exempt hospital organizations to help other entities (e.g., community health centers or free clinics) with their capital needs are reportable as community benefit. Such contributions can be in the form of cash grants that are used by the other entities for new buildings or equipment or in the form of capital assets, such as land or buildings donated by hospitals to others.

Contributions of this nature may be counted as community benefit under certain circumstances, as follows:

- Any cash contributions for capital needs are restricted *in writing* to a community benefit purpose. For example, if a hospital contributes $500,000 to a community clinic that will be used for a new building, the clinic is required to use the new building in a manner that enhances access to care for uninsured or Medicaid patient, offers subsidized health services, facilitates health professional education or other purposes that are defined as a community benefit.
- The hospital is able to document its intent that in-kind contributions (e.g., donating a building or land) also are to be used by the recipient entity for a community benefit purpose.
- The accounting for the cash or asset contributions yields an expense borne by the hospital organization that is reported in Part XI of the core Form 990 (Statement of Functional Expenses). For example, if the hospital donates a building with a remaining “book value” of $500,000, the loss associated with donating this asset is reported in Part XI of the core Form 990.
- Any asset (land, buildings) contributions are valued for community benefit purposes based on the accounting value placed on the asset when donated. For example, the value of a donated building is based on its “book value” (original cost minus accumulated depreciation) rather than a fair market value or appraisal estimate.
- The hospital organization does not retain a financial interest in the contributed assets but instead has provided them out of a sense of “disinterested generosity.” Said another way, these cash or in-kind contributions may not be reported if they represent loans or advances or, as stated in, Schedule H instructions, are “contributions" to the capital of another organization that are reportable in Part X of the core Form 990.” Part X of the core Form 990 is the organization’s balance sheet. Thus, contributions that result in a balance reported as an asset or investment on the organization’s balance sheet are not reportable as contributions for community benefit on Schedule H.

CONTRIBUTIONS TO THE CAPITAL NEEDS OF OTHER ENTITIES *(continued)*

Some organizations are finding it straightforward to lease buildings to other entities rather than to donate them outright. Leases can incorporate terms that help ensure the lessee provides community benefit in the leased space. Instead of providing leases with nominal (e.g., $1 per year) lease payments — a structure that requires estimating and reporting as community benefit the expense borne by the hospital in maintaining the property — some organizations are providing leases based on fair market value and then are making a separate community benefit grant to the lessee organization.

For example, a hospital leases a building to a free clinic for $100,000 per year. It then makes an annual community benefit grant to the clinic of $100,000 (or more) that is restricted to a community benefit purpose. On a net basis, the free clinic is able to occupy the building in a budget-neutral fashion. The hospital is able to report the $100,000 community benefit grant on Schedule H as a cash contribution — rather than valuing the arrangement solely as an in-kind transaction.

Contributions may be made outside of the community, for example, in response to global poverty or a natural disaster. However, contributions outside the community should not constitute a substantial proportion of the organization's community benefit. Also, be aware that many taxing authorities do not consider funds used outside of the community as community benefit. Additionally, to be reported on Schedule H, the contributions must be restricted to a community benefit purpose.

Community Building

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IRS NOTE

The Schedule H instructions require hospitals to report community-building activities in Part II of the form rather than in the Part I community benefit table. Part VI requires hospitals to describe how these activities protect or improve the health of the communities served. The instructions also state that some community-building activities may also meet the definition of community benefit and instruct that organizations may report those activities under Part I, line 7(e) as community health improvement and not in Part II.

See callout on page 62 titled "Community building or community health improvement?" for more guidance.

Community-building activities are programs that address the underlying causes of health problems and thus improve health status and quality of life. They focus on the root causes of health problems, such as poverty, homelessness and environmental hazards. These activities enhance community assets by offering the expertise and resources of the health care organization.

Examples of community-building activities include:

- Physical improvements and housing.
- Economic development.
- Community support.
- Environmental improvements.
- Leadership development and training for community members.
- Coalition building.
- Community health improvement advocacy.
- Workforce development.

The Schedule H instructions say that the organization should not report as environmental improvement "expenditures it made to reduce the environmental hazards caused by, or the environmental impact of, its own activities" **unless the activity (i) is provided for the primary purpose of improving community health; (ii) addresses an environmental issue that is known to affect community health; and (iii) is subsidized by the organization at a net loss, and so long as the organization does not "engage in the activity primarily for marketing purposes."**

Visit https://www.chausa.org/whatcounts for more detailed guidance on environmental activities that can be reported as community benefit.

COMMUNITY BUILDING OR COMMUNITY HEALTH IMPROVEMENT?

An activity that might otherwise fit into one of the categories of community building is reportable as community health improvement when the activity meets all IRS criteria for community health improvement.

Public health resources should be used to provide evidence that a community-building activity meets a community benefit objective and can be reported as community health improvement. These resources include, among others:

- *Healthy People,* Office of Disease Prevention and Health Promotion
- *The Guide to Community Preventive Services,* Centers for Disease Control and Prevention.
- *Aims of Public Health Quality,* U.S. Department of Health and Human Services (HHS).
- *National Prevention Strategy,* National Prevention Council, HHS.
- *Consensus Statement on Quality in the Public Health System and Priority Areas for Improvement of Public Health Quality,* HHS.

Links to these resources can be found on the CHA website at https://www.chausa.org/guideresources.

These and other public health resources contain examples of activities that improve the health of people in the community by addressing the social and physical determinants of health. They can be referenced in hospitals' community benefit records to document why the activity is being reported as community health improvement.

Visit https://www.chausa.org/whatcounts for examples of activities that are reportable as community health improvement (as long as the activity or program is carried out for purpose of improving community health and meets other criteria for community health improvement) and that are reportable as community building.

Community Benefit Operations

Community benefit operations include costs associated with planning and operating community benefit programs.

Examples of community benefit operations include:

- Costs of assigned staff and other community benefit administration costs.
- CHNAs.
- Evaluation of individual programs and activities.
- Software that supports the community benefit program, such as the Community Benefit Inventory for Social Accountability.
- The organization's costs incurred in writing grants or raising funds specifically for community benefit activities and programs.
- Dues and program expenses for organizations that specifically support the community benefit program, such as the Association for Community Health Improvement and the American Public Health Association.

IS IT COMMUNITY BENEFIT?

The following questions can help determine whether a program or activity should be reported as a community benefit in the following categories: community health improvement, health professions education, subsidized health services, research, or cash and in-kind contributions.

STEP ONE:

Does the program or activity:

- Address a demonstrated community health need?
- Seek to address at least one of the following community benefit objectives?
  - Improve access.
  - Enhance public health.
  - Advance generalizable knowledge.
  - Relieve the government burden to improve health.

Does the program or activity:

- Primarily benefit the community rather than the organization?
- Result in measurable expense to the organization?

IF "NO" TO ANY OF THE QUESTIONS IN STEP I, IT IS NOT A COMMUNITY BENEFIT.

IF "YES" TO ALL QUESTIONS IN STEP I, PROCEED TO STEP TWO.

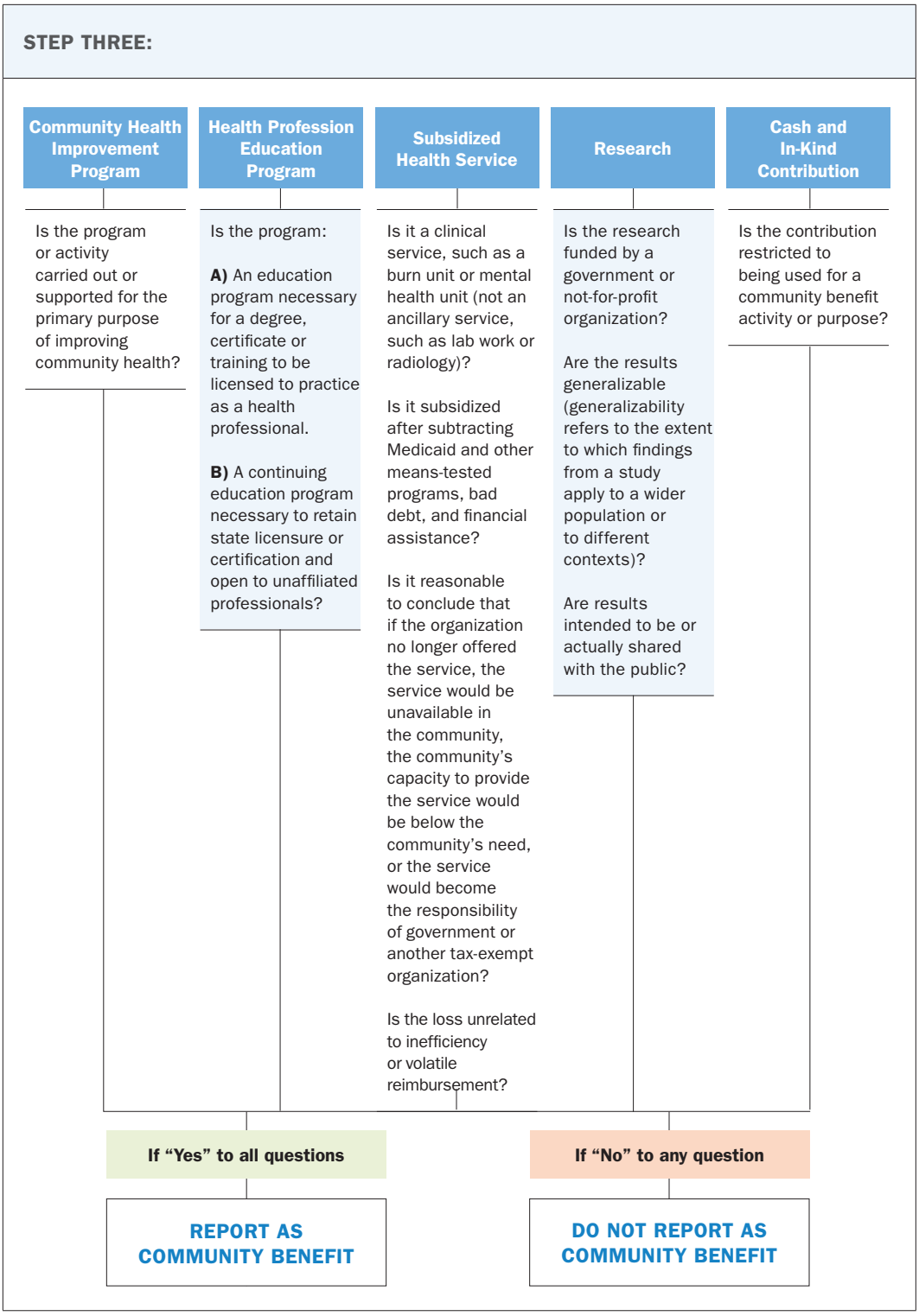
STEP TWO:

Is the program or activity:

- Provided primarily for marketing purposes?
- Standard practice, expected of all hospitals (such as activities required for accreditation, licensure or participation in Medicare)?
- Provided primarily for the organization's "covered lives"?
- Provided primarily for employees (not including interns, residents and fellows) or affiliated physicians?

IF "YES" TO ANY OF THE QUESTIONS IN STEP II, IT IS NOT A COMMUNITY BENEFIT.

IF "NO" TO ALL QUESTIONS IN STEP II, PROCEED TO STEP THREE.


STEP THREE:
Community Health Improvement Program
Is the program or activity carried out or supported for the primary purpose of improving community health?
Health Profession Education Program
Is the program:
A) An education program necessary for a degree, certificate or training to be licensed to practice as a health professional.
B) A continuing education program necessary to retain state licensure or certification and open to unaffiliated professionals?
Subsidized Health Service
Is it a clinical service, such as a burn unit or mental health unit (not an ancillary service, such as lab work or radiology)?
Is it subsidized after subtracting Medicaid and other means-tested programs, bad debt, and financial assistance?
Is it reasonable to conclude that if the organization no longer offered the service, the service would be unavailable in the community, the community's capacity to provide the service would be below the community's need, or the service would become the responsibility of government or another tax-exempt organization?
Is the loss unrelated to inefficiency or volatile reimbursement?
Research
Is the research funded by a government or not-for-profit organization?
Are the results generalizable (generalizability refers to the extent to which findings from a study apply to a wider population or to different contexts)?
Are results intended to be or actually shared with the public?
Cash and In-Kind Contribution
Is the contribution restricted to being used for a community benefit activity or purpose?
If "Yes" to all questions
REPORT AS COMMUNITY BENEFIT
If "No" to any question
DO NOT REPORT AS COMMUNITY BENEFIT

Notes: