CHA
Catholic Health Association of the United States

Community Benefit Categories & Definitions

The Catholic Health Association of the United States

For over 35 years, CHA has been the leading source of information and tools for planning and reporting hospital community benefit. In 2008, CHA's accounting system for reporting community benefit was used in the development of the IRS Form 990 Schedule H.

CHA represents more than 650 hospitals and 1,600 long-term care and other health facilities in all fifty states. Our hospitals were established to address health needs in their communities and that tradition continues today. Catholic hospitals are a critical source of care and services in their communities, including community based services that address significant health and health-related needs reported as community benefit.

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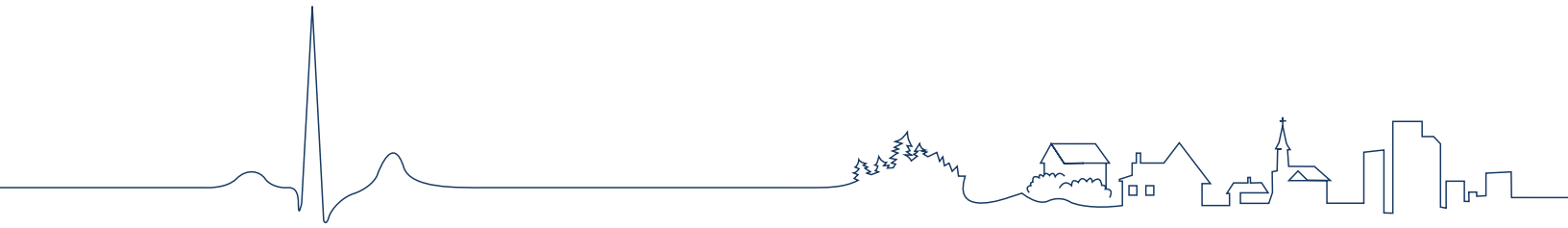
Community Benefit Categories & Definitions

The community benefit categories and definitions developed by CHA and its partners were used by the IRS to develop the Form 990 Schedule H. CHA's *Guide* and the IRS Form 990 Schedule H instructions continue to align today.

DISCLAIMER: This resource provides recommendations for what counts as community benefit. It is provided for educational purposes and is not intended as tax or legal advice. Health care organizations should consult the most recent instructions to IRS Form 990, Schedule H, and similar guidelines published by states regarding how to report community benefit information.



Community Benefit Categories & Definitions | At A Glance

Category 1: Financial Assistance

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Category 3: Other Community Benefit Programs and Activities

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- F8. Workforce Development

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- G3. Other Resources

General Reporting Criteria

To be reported as a community benefit, a community health need for the activity or program must be established.

Community benefit activities or programs also seek to achieve a community benefit objective, including:

- Improving access to health services.
- Enhancing public health.
- Advancing increased general knowledge.
- Relieving the government burden to improve health.

This includes activities or programs that:

- Are available broadly to the public and serve people with low incomes.
- Reduce geographic, financial or cultural barriers to accessing health services and that, if ceased, would result in access problems (e.g., longer wait times or increased travel distances).
- Address federal, state or local public health priorities, such as addressing differences in health status and well-being 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.
- Would otherwise become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage; required for licensure or accreditation, except when responding to a community health need, enhancing public health, or relieving the burden of government to improve health; or restricted to individuals affiliated with the organization (employees and physicians of the organization).

CATEGORY 1

Financial Assistance

Financial assistance is free or discounted health care services provided to persons who cannot afford to pay and who meet the eligibility criteria in the organization's financial assistance policy (FAP). Financial assistance is sometimes referred to as charity care. For community benefit purposes, financial assistance is reported in terms of costs, not charges. Financial assistance does not include bad debt and discounts not described by the FAP (e.g., discounts provided to self-pay patients and/or services ineligible for financial assistance).

Benefits to Communities: The consequences of being uninsured/under-insured are significant. Many people delay seeking health care due to cost, especially the uninsured and under-insured. Delaying care can have a significant impact on how well and how long an individual lives. Providing financial assistance improves access to health care, improving an individual's opportunity for better health.

Reporting Considerations: The amount reported is based on cost, not gross patient charges, less direct offsetting revenue. Hospitals convert charges using either a cost-to-charge ratio (as adjusted to avoid double-counting) or another more accurate cost accounting method.

Do Count:

- The cost of free and partially discounted care provided, based on the financial assistance policy.
- Provider taxes, assessments or fees if Medicaid Disproportionate Share Hospital (DSH) funds in your state are used in whole or in part to offset the cost of financial assistance.
- The cost of care associated with out-of-pocket liabilities (copayments and deductibles) for Medicaid and other low-income patients, if the organization's financial assistance policy grants financial assistance to these types of underinsured patients.

Do Not Count:

- Bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay.
- Medicaid or Medicare losses (reported elsewhere).
- Self-pay or prompt-pay discounts.
- Contractual adjustments with any third-party payers.

CATEGORY 2

Government-Sponsored Means-Tested Health Care

This category includes losses incurred in providing access to health care for Medicaid recipients and for low-income individuals participating in other government-sponsored means-tested insurance programs. Losses (net community benefits) are reported as the difference between net patient revenue recorded by the organization and the cost of providing health care services. Medicaid costs include Medicaid provider taxes, fees and assessments paid by the organization, as these amounts generate Medicaid revenue. These community benefits are not valued in the same way as contractual allowances (the difference between gross charges and net patient revenue).

Benefits to Communities: Medicaid and other means-tested programs continue to be vital in filling the gap in health care coverage, so all may receive the care they need. Providing care to community members, regardless of ability to pay or insurance type, increases access and improves community health. Most hospitals' reimbursements from means-tested programs do not cover the cost of providing services.

Reporting Considerations: The amount reported is based on cost, not gross patient charges, less direct off-setting revenue, which is reported in accordance with generally accepted accounting principles (GAAP). Hospitals convert charges using either a cost-to-charge ratio (as adjusted to avoid double-counting) or another more accurate cost accounting method. Offsetting revenue for Medicaid includes fee-for-service and managed care from all states and Medicaid DSH, Delivery System Reform Incentive Payment (DSRIP), and Indirect Medical Education (IME) reimbursement.

Do Count:

Net patient revenues and costs related to:

- Medicaid (fee-for-service and managed care, from all states).
- Other means-tested government programs, including:
  - Children's Health Insurance Programs (CHIP).
  - State and local indigent care medical programs for low-income or medically indigent persons ineligible for Medicaid.

Do Not Count:

- Medicare shortfalls. Note, however, that some Medicare-related losses are reportable under subsidized health services and Health Professions Education (Graduate Medical Education).
- Government health care programs that are not means-tested, such as the Department of Veterans Affairs and the Indian Health Service.

CATEGORY 3

Other Community Benefit Programs & Activities

Other community benefit programs and activities include the following:

A. Community health improvement services
B. Health professions education
C. Subsidized health services
D. Research
E. Cash and in-kind contributions for community benefit
F. Community-building activities
G. Community benefit operations

Do Count:

- Programs that respond to an identified community health need and are designed to accomplish one or more community benefit objectives (see the General Reporting Criteria section).
- Programs and activities directed to or including at-risk persons, such as underinsured and uninsured persons.
- Programs offered to the broad community (including at-risk persons) designed to improve community health.

Do Not Count:

- Programs intended primarily for marketing or promotion purposes.
- Activities that don't generate an expense to the hospital, such as time spent by volunteers and employees on their own time.
- Routine or required care and services.
- Activities or programs required for licensure or accreditation, except when the activity is responding to a community health need, enhancing public health, or relieving the burden of government to improve health (e.g., injury prevention programs which address a community need and are implemented in part with your organization's trauma accreditation).

A. Community Health Improvement Services

These activities are carried out to improve community health, extend beyond patient care activities and are subsidized by the health care organization. Such services do not generate patient care bills, although they may involve a nominal fee.

Specific community health programs and activities that may qualify (if they satisfy the General Reporting Criteria) include:

- Community health education
- Support groups
- Community-based clinical services, such as health services and screenings for underinsured and uninsured persons
- 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
- Community-based chaplaincy programs and spiritual care, including pastoral outreach programs
- Programs that focus on addressing social and environmental determinants of health (with evidence of community health improvement effects)
- Community health initiatives addressing specific health needs and goals

Benefits to Communities: Community health improvement services extend beyond patient care activities, increasing access, enhancing care, and providing needed supports. These activities improve community health across the continuum from direct health improvement to addressing the social determinants of health.

Reporting Considerations: The amount reported is the total expense for each activity incurred, less any offsetting revenue. Total expense includes both direct and indirect costs for each program. Direct offsetting revenue includes any fees paid by program participants and restricted grant funds used for qualifying programs during the year.

A1. Community Health Education

Community health education includes lectures, presentations, other group programs and activities, and the development and dissemination of materials that focus on prevention and health behaviors. Education activities can be provided in multiple formats, including resources made available to communities through support groups and through initiatives with a self-help emphasis.

Such programs are not focused on marketing and are conducted apart from the delivery of clinical services. Direct and indirect costs for staff time, travel, materials and staff preparation are reportable.

Do Count, *if the program addresses a community health need and meets a community benefit objective:*

- Caregiver training for persons caring for family members at home.
- Education on specific diseases or conditions, such as diabetes or heart disease.
- Health fairs, when not performed as goodwill and that respond to community health needs.
- Consumer health libraries.
- Faith-based health–related programs.
- Community health promotion and wellness programs, including newsletters primarily intended to educate the community about health issues and available health and social services, and health education lectures and workshops provided to community groups.
- Information provided through news releases and other modes to the media to educate the public about health issues (such as wearing bike helmets, treatment news, health resources in the community, etc.).
- School health education programs. (School-based health services are reportable in category A2, Community-based clinical services.)
- Work site health education programs when, not performed as goodwill and provided in response to community health need.

Do Not Count:

- Community calendars and newsletters, if a prudent layperson would conclude that they focus primarily on marketing.
- Patient education that is part of comprehensive patient care (e.g., diabetes education provided only for patients).
- Health education sessions that are offered for a fee and that result in a profit.
- Advertisements with health messages when the primary purpose is marketing.
- Childbirth and parenting education classes that are reimbursed or designed to attract paying or insured patients.

Support Groups

Support groups typically are established to address social, psychological or emotional issues related to specific diagnoses or occurrences.

Do Count, *if the program addresses a community health need and meets a community benefit objective:*

- Support groups related to community need, such as for the prevention of child abuse or managing chronic disease
- Costs to run support groups

Do Not Count:

- Services routinely given to patients and families in the course of their inpatient or outpatient encounters.

Self-help Programs

These include wellness and health-promotion programs and classes for the community, such as those for smoking cessation, exercise and weight loss.

Do Count, *if the program addresses a community health need and meets a community benefit objective:*

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

Do Not Count:

- Employee wellness and health promotion provided by the organization as an employee benefit
- The use of facility space to hold meetings for community groups (reportable in category E3. In-Kind Donations)

A2. Community-Based Clinical Services

These are clinical services provided on a periodic basis or as special events in the community. They include screenings, one-time or occasionally held clinics, clinics for underinsured and uninsured persons, and mobile units.

They do not include permanent subsidized hospital outpatient services, which are reportable as Hospital Outpatient Services in category C3. As with other categories of community benefit, these programs and activities should be counted only if they are designed to meet identified community health needs and meet a community benefit objective.

Screenings

Screenings are health tests conducted in the community as a public 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. Referrals to any community health or social services providers should be available if necessary. To be considered community benefit, screenings should provide follow-up care as indicated and should provide access to services for all, including individuals who are uninsured and underinsured.

Do Count, *if the program addresses a community health need and meets a community benefit objective:*

- General screening programs and health-risk assessments
- Behavioral health screenings
- Screenings for high blood pressure, lipid profiles, cholesterol levels and stroke risks
- Eye examinations and hearing screenings
- Mammography screenings
- Prostate screenings
- Osteoporosis screenings
- School and sports physical examinations (only if there is a demonstrated need for vulnerable populations)
- Skin cancer screenings
- Colon cancer screenings

Do Not Count:

- Health screenings associated with conducting a health fair (reportable in category A1, Community Health Education)
- Screenings for which a profit is realized
- Screenings when the primary purpose is to generate referrals to the organization or its physicians
- Screenings provided primarily for public relations or marketing purposes

One-Time or Occasionally Held Clinics

Do Count, *if the program addresses a community health need and meets a community benefit objective:*

- Blood pressure and/or lipid profile/cholesterol screening clinics
- Cardiology risk factor screening clinics
- Dental care clinics
- Immunization clinics
- One-time or occasionally held primary care clinics
- School physical clinics to increase access to health care for vulnerable populations

Do Not Count:

- Free school team physicals, unless there is a demonstrated need for this service.
- Flu shots or physical exams for the organization's employees.
- Clinics for which a fee is charged and/or patient bills are generated and for which a profit is realized.
- Subsidized, permanent, ongoing programs and outpatient services (reportable in category C3, Hospital Outpatient Services).

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 may donate their time.

Do Count, *if the program addresses a community health need and meets a community benefit objective:*

- Clinic operating costs
- Facilities and overhead costs
- Lab and medication costs

Do Not Count:

- Grants to an unrelated free clinic or Federally Qualified Health Centers (reportable in category E1. Cash Contribution for Community Benefit).

Mobile units

Do Count, *if the program addresses a community health need and meets a community benefit objective:*

- Mobile units that deliver primary care, dental care and related services to underserved populations on an occasional or one-time basis.
- Vans and other vehicles used to deliver primary care services.

Do Not Count:

- Subsidized, mobile specialty care services that are an extension of the organization's outpatient department, such as mammography, radiology or lithotripsy (reportable in category C3. Hospital Outpatient Services).
- Costs for marketing associated with the mobile unit. For example, if 30 percent of the mobile unit's time is spent on marketing or goodwill efforts and the remainder of the time is spent addressing community health needs, then 30 percent of the cost of the mobile unit would not be reported as a community benefit expense.

A3. Health Care Support Services

Health care and social support services are provided by the hospital to enhance access to and the quality of health care services for vulnerable populations, especially persons living in poverty.

Do Count, *if the program addresses a community health need and meets a community benefit objective:*

- Costs to screen and refer low-income persons for needs associated with social determinants of health when a community health need has been established (e.g., housing and food insecurity issues are present in the community) and the activities are above and beyond the standard practice of patient registration or discharge planning.
- The cost of screening and referral tools (e.g., incremental costs to add screening and referral capabilities to electronic health records systems or the cost of stand-alone screening and referral platforms).
- Chronic disease management and case management of underinsured and uninsured persons that goes beyond routine chronic disease management and routine discharge planning.
- Telephone information services, such as Ask a Nurse, medical and mental health service hotlines, and poison control centers, which are not provided for marketing purposes.
- Physician referral programs for Medicaid and uninsured persons.
- Transportation programs for patients and families to enhance patient access to care (include cab vouchers provided to low-income patients and families, but not to increase the use of the facility's services).
- Assistance to enroll patients in governmental health insurance programs for low-income persons, such as CHIP and Medicaid.
- Assistance to enroll patients in health insurance marketplace programs.
- Costs associated with financial assistance **only if,** 1. The primary purpose is to increase access to care; 2. The hospital has identified the need to provide low-income patients greater access to health care as a community need; **and** 3. Enrollment assistance, presumptive eligibility screening and decision support tools for financial assistance 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).
- Costs of navigator services.
- Personal response systems, such as Lifeline.
- Assistance for patients experiencing homelessness following discharge, such as meals, transportation and clothing.

Do Not Count:

- A physician referral program intended primarily for marketing purposes or only for hospital-affiliated physicians (unless for Medicaid or uninsured persons).
- Routine discharge planning.
- Translation and interpreter services otherwise required of all providers.
- Costs of developing, maintaining, and/or translating your financial assistance policy, plain language summary, and application as a community health improvement service expense

A4. Social and Environmental Improvement Activities

These are programs and activities that improve the health of persons in the community by addressing social and environmental determinants that impact health. They include programs that address social and community factors, poverty and economic stability, education, and neighborhood and the built environment.

Report in this category initiatives that address social and environmental determinants if they are provided in response to an identified community health need and meet a community benefit objective. It would strengthen the case that an initiative satisfies the Schedule H definition of a community health improvement service if evidence exists that the initiative improves community health.

Community-building activities (see Category F) that are provided in response to an identified community health need and that meet the definition of community health improvement services also should be reported here. Note: If a community-building activity meets the definition of and is reported as a community benefit, do not also report it as a community-building activity. Activities should only be reported once.

Below are examples of efforts that can be reported as community benefit. They are organized by the social determinants of health categories used by the Centers for Disease Control and Prevention Healthy People 2030, which can be found here: https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

Do Count, *if the program addresses a community health need and meets a community benefit objective:*

- Social and community context:
  - Support for at-risk youth activities
  - Reentry programs for persons who have been incarcerated
  - Activities related to community resiliency and disaster preparedness (beyond requirements expected of all organizations)
  - Advocacy related to health care access

- Education access and quality:
  - Support of local schools when education-related community needs have been identified
  - Support or provision of early childhood education and development programs
  - Efforts to reduce truancy and improve graduation rates
  - Efforts to improve literacy and health literacy
- Neighborhood and the built environment:
  - Neighborhood improvements in low-income areas (e.g., sidewalks to encourage walking and lighting for safety)
  - Removal of harmful materials (such as lead and asthma triggers) in low-income housing
  - Violence and crime prevention
  - Development of bike lanes, playgrounds and walking trails in response to needs related to obesity and lack of exercise
- Economic stability and financial opportunity:
  - Job creation and training programs for people experiencing poverty and vulnerable populations
  - Participation in an economic development council to revitalize a depressed community
  - Activities to address food insecurities
  - Expenses and losses incurred for initiatives that expand access to affordable housing

Do Not Count:

- Activities unrelated to community health needs
- Neighborhood events (parties, festivals) not related to a community health need
- Sponsorship of teams and clubs unrelated to community health needs; contributions that can't be restricted to a community benefit purpose
- Neighborhood improvements designed to make the health care organization's facilities more attractive
- Contributions to the arts (unless part of a comprehensive plan for economic development in an at-risk community)
- Participation in economic development not explicitly related to poverty or the needs of low-income people
- Activities for employees
- Development of housing and investments made for community development when a return is expected
- Advocacy specific to a health care organization's operations and financing

B. Health Professions Education

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 to retain state licensure or certification by a board in the individual's health profession specialty.

Benefits to Communities: These programs address current and future shortages of health professionals, both locally and nationally and to ensure that communities preserve and enhance access to care, addressing well-established workforce needs. As an important component of their missions, hospitals provide clinical and educational experiences for many more students than are needed for their own medical and hospital staffs.

Reporting Considerations: The amount reported includes the direct and indirect expenses for graduate medical education (GME) and other health professions education (e.g., nursing students) necessary for the trainees to be licensed or certified in their field. Hospitals follow Medicare Cost Reporting principles in accounting for GME costs. Direct offsetting revenue includes Direct GME revenue from Medicare, Medicaid (if any) and Children's Hospital Graduate Medical Education (CHGME).

B1. Graduate and Undergraduate Medical Education

Do Count:

Be sure to subtract direct graduate medical education revenue received from Medicare (and possibly Medicaid) from these costs before counting. You may count:

- Total expenses for graduate medical education considered allowable by the Medicare program (salaries for interns and residents, costs associated with faculty supervision, and other allowable program expenses).
- Expenses attributable to training and precepting medical students.

Do Not Count:

- Expenses for the organization's physician and medical student in-service training.

B2. Nurses/Nursing Students

Do Count:

- Costs to operate a nursing school, if any.
- Costs associated with clinical staff hours when staff are unavailable to perform clinical duties because they are devoting time solely to instructing, training or precepting students.
- Additional compensation, if any, paid to nurses and other staff members to serve as preceptors for nursing students.
- Costs to train staff nurses to serve as preceptors.
- Costs of time spent by instructors when they interact with students in classroom settings and simulation labs.
- Administrative costs associated with having nursing and other allied health professions students and faculty in the facility.

Do Not Count:

Expenses associated with:

- Education required by the organization rather than by state or third-party accrediting organizations, such as staff orientation, in-service programs (e.g., regarding how to use electronic health records systems) and similar training.
- Expenses for standard in-service training and in-house mentoring programs.
- In-house nursing and nurse's aide training programs.
- Costs if nursing students are required to work for the organization.
- Restricted cash contributions made to schools of nursing to underwrite faculty positions in schools of nursing in response to shortages of nurses and nursing faculty (reportable in category E1. Cash Contributions).

B3. Other Health Professions Education

Do Count:

- Expenses borne by the organization to train other allied health professionals when such training is necessary for them to obtain state licensure or certification by a board in the professional's health profession specialty. These professions may include physical therapist, occupational therapist, respiratory therapist, emergency medical technician, clinical lab technologist, clinical pastoral educator (chaplain), social worker, or pharmacist. Also see guidance above regarding reliably estimated costs or impacts on productivity.

Do Not Count:

- Expenses not required for state licensure or board certification, including:
  - Education required by both licensed and non-licensed staff, such as orientation and standard in-service programs.
  - On-the-job training, such as pharmacy technician and nurse's assistant programs.
- Programs that require trainees to work for the organization after training.
- Training for non-health-related professions, such as accounting.

B4. Scholarships/Funding for Health Professions Education

Do Count:

- Scholarships or tuition payments for nursing and other health professions education to non-employees with no requirement to work for the organization as a condition of the scholarship.

Do Not Count:

- Financial assistance for employees who are advancing their own educational credentials.
- Staff tuition reimbursement costs provided as an employee benefit.
- Financial assistance for which students/trainees are required to work for the organization.

B5. Continuing Health Professions Education

Do Count:

- Expenses borne by the organization for continuing health professions education when such training is necessary for the health professional to retain state licensure or certification by a board in the professional's health profession specialty AND when the continuing health professions education programs are made available to professionals on a community-wide basis. Continuing health professions education includes, but is not limited to,
  - CME (continuing medical education) – MD or DO
  - CHES® and MCHES® - Health Education
  - CNE - Nursing
  - CPH - Certified in Public Health
- Specialty in-service and videoconferencing programs required for certification or licensure made available to professionals in the community.

Do Not Count:

- Health professions education programs limited to members of the organization's medical and clinical staff only.
- Annual competency trainings and in-service trainings on new equipment or protocols.

C. Subsidized Health Services

Subsidized health services are clinical services provided despite a financial loss to the organization. The financial loss is measured after removing losses associated with bad debt, financial assistance, Medicaid and other means-tested government programs. To qualify as a subsidized health service, the organization must provide the service because it meets an identified community health need.

If it is reasonable to conclude that one of the following would happen if the organization no longer offered the service, then it meets an identified community need:

- The service would be unavailable in the community.
- The community's capacity to provide the service would be below the community's need.
- The service would become the responsibility of government or another tax-exempt organization.

Subsidized health services generally exclude ancillary services that support inpatient and ambulatory programs, such as anesthesiology, radiology and laboratory services.

Benefits to Communities: Access to care impacts how well and how long we live. Without access to critical services, i.e., behavioral health, neonatal intensive care, emergency and clinical care, the health outcomes of community members would be negatively impacted. Providing critical services that are unprofitable and that meet a community need is community benefit. Tax-exempt hospitals provide subsidized health services at a loss because communities need access to the care.

The subsidized health services category is included in Schedule H in recognition that tax-exempt hospital organizations are more likely than for-profit hospitals to provide relatively unprofitable clinical services (Health Affairs, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01115).

Reporting Considerations: Amount reported is based on cost, not gross patient charges, less direct offsetting revenue, excluding losses associated with financial assistance, bad debt, and Medicaid and other means-tested government programs — all four of which are reported elsewhere on Form 990 Schedule H. Subsidized health services include qualifying inpatient programs (for example, addiction recovery and inpatient psychiatric units) and outpatient programs (for example, satellite clinics designed to serve low-income communities). Subsidized health services exclude ancillary services such as anesthesiology, radiology, and laboratory departments.

Subsidized health services do not include service lines or programs that report a net gain after expenses related to Medicaid, financial assistance, and bad debt are factored out.

Do Count:

- Clinical programs or service lines that the organization provides at a financial loss after any losses for financial assistance, bad debt, Medicaid and other means-tested government programs have been removed.
- Subsidized health services that generally include entire product lines (e.g., inpatient psychiatry, trauma program) rather than narrowly defined subcomponents (e.g., psychiatric emergency room service).

Do Not Count:

- Ancillary services (such as lab, radiology and pharmacy).
- Services that:
  - Are not needed by the community
  - Experience losses due to inefficiency
  - Have many competitors in the market and are not accessed by patients in need

Carefully Examine Subsidized Services

The category of subsidized services is not a catchall category for services that operate at a loss. Care needs to be taken to ascertain whether the service satisfies all criteria for being included as a subsidized health service that provides community benefit.

Examples of Services That Frequently Qualify as Subsidized Health Services:

C1. Emergency and Trauma Services

Do Count:

- Air ambulances/helicopters
- Trauma centers
- Emergency departments

Do Not Count:

- Ancillaries that support these services, such as imaging
- Subsets of the service, such as geriatric, pediatric or psychiatric emergency rooms, if the overall emergency department does not need to be subsidized

C2. Neonatal Intensive Care

C3. Hospital Outpatient Services

Do Count:

- Safety-net clinics that do not bill patients
- School-based clinics
- Satellite and ambulatory services designed to serve low-income persons
- Physician clinics*

C4. Burn Units

C5. Women's and Children's Health Services

C6. Renal Dialysis

C7. Subsidized Continuing Care

Do Count:

- Hospice
- Adult day programs
- Skilled nursing facilities*

C8. Behavioral Health Services

Do Count:

- Addiction recovery
- Other substance abuse programs
- Inpatient psychiatric services

C9. Palliative Care

Do Count:

- Outpatient and community-based palliative care

Do Not Count:

- The organization's inpatient palliative care program

***FROM IRS INSTRUCTIONS FOR FORM 990, SCHEDULE H:** "Subsidized health services include services or care provided at physician clinics and skilled nursing facilities if such clinics or facilities satisfy the general criteria for subsidized health services. An organization that includes any costs associated with stand-alone physician clinics (not other facilities at which physicians provide services) as subsidized health services in Part I, line 7g, must describe that it has done so and report in Part VI such costs included in Part I, line 7g. Note: The organization can report a physician clinic as a subsidized health service only if the organization operated the clinic and associated hospital services at a financial loss to the organization during the year."

D. Research

Research means any study or investigation for which the goal is to generate increased generalizable knowledge made available to the public (e.g., knowledge about underlying biological mechanisms of health and disease, natural processes, or principles affecting health or illness; evaluation of the safety and efficacy of interventions for disease, such as clinical trials and studies of therapeutic protocols; laboratory-based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care or prevention; studies related to changes in the health care delivery system; and communication of findings and observations, including publication in a medical journal).

The organization can include the cost of its internally funded research, as well as the cost of research funded by a tax-exempt or government entity.

Benefits to Communities: Engaging in medical and health-related research generates knowledge that is made available to and benefits the public, enhancing the future of health care and improving the long-term welfare of the community at large.

Reporting Considerations: The amount reported is total expenses for each activity incurred, less any offsetting revenue (e.g., grants to the hospital restricted in writing for charitable research). Total expense includes both direct and indirect costs for qualifying research, including the proportional share of the cost of the Institutional Review Board (IRB). Direct off-setting revenue includes any restricted grant funds and any license fees or royalties received by the hospital for research reported as community benefit currently or in past periods.

D1. Basic and Applied Clinical Research

Do Count:

Direct and indirect costs for studies funded by a tax-exempt or government entity and intended to be made available to the public, including:

- Basic research
- Translational research
- Clinical trials
- Other types of clinical research (e.g., studies regarding nutrition, quality improvement or information technology)
- Costs borne by the organization to conduct research, including an appropriate portion of costs associated with research administration — unless those costs already have been included in indirect costs

Do Not Count:

- Research findings that are used only internally
- Research that is funded by a for-profit entity or source
- Research that yields knowledge used for proprietary purposes

D2. Community-Based Research

Do Count:

Direct and indirect costs for studies funded by a tax-exempt or government entity and intended to be made available to the public, including:

- Studies on health issues for people experiencing poverty and vulnerable persons
- Studies on community health, such as incidence rates of conditions for special populations (e.g., children, older adults or persons with a disability)
- Research papers prepared by staff for professional journals or presentations
- Studies on innovative health care delivery models
- Creation of partnerships for community-based research projects

Do Not Count:

- Costs to prepare CHNAs (reportable in category G2. Community Benefit Operations)
- Market research
- Research findings that are only used internally or by the funder

E. Cash and In-Kind Contributions for Community Benefit

This category includes cash contributions or grants and the cost of in-kind contributions that support financial assistance, health professions education and other community benefit activities described in the other community benefit categories.

Cash contributions are made by the organization to health care organizations and other community groups and must be restricted, in writing, so recipients use the amounts for one or more community benefits. If the contribution is used for a community-building activity or program, it should be reported as community building.

In-kind donations include hours contributed by staff to the community while on health care organization work time, the cost of meeting space provided to community groups, and the book value of donations of food, equipment and supplies. (Report contributions to provide support services to individuals in category A3. Health Care Support Services).

Benefits to Communities: Cash and in-kind contributions provide needed support and increase the capacity of other non-profit organizations, which provide added benefit to the community and/or improve related social
determinants of health.

Reporting Considerations: The amount reported is the cash contribution or total expenses for each in-kind activity incurred, less grants to the hospital restricted in writing for making such cash contributions. Report only contributions for activities that would qualify as community benefit in Schedule H. Include a written restriction that funds will be used for a community benefit activity that does not include funds contributed by employees or emergency or other funds provided to employees.

E1. Cash Contributions for Community Benefit

Do Count:

Contributions made by the organization to another entity, a health care organization or other community group restricted, in writing, to be used for one or more of the following community benefit activities and programs, as defined in the Schedule H instructions:

- Financial assistance
- Medicaid
- Other means-tested government programs

- Community health improvement services
- Health professions education
- Subsidized health services
- Research
- Community benefit operations

Do Not Count:

- Payments that the organization makes in exchange for a service, facility or product or that the organization makes primarily to obtain a benefit, such as payments made in lieu of taxes that the organization makes to prevent or forestall local or state property tax assessments or a teaching hospital's payments to its affiliated medical school for intern or resident supervision services by the school's faculty members.
- Unrestricted sponsorships
- Other donations that have not been restricted, in writing, to a community benefit purpose
- Employee-donated funds
- Emergency funds provided to employees
- Fees for sporting event tickets

E2. Grants for Community Benefit

Do Count:

- Grants made by the organization to health care organizations and other community groups restricted, in writing (e.g., by letter, contract or grant agreement), to one or more of the community benefit activities, as defined in the Schedule H instructions.

Do Not Count:

- Unrestricted grants
- Other grants that have not been restricted, in writing, to a community benefit purpose

E3. In-Kind Donations

Do Count:

- Noncash donations of goods, services and resources for community benefit purposes. Examples include:
  - The cost of staff hours donated by the organization to the community while on the organization's payroll.
  - The cost of space donated to tax-exempt community groups for a community benefit purpose, such as for meetings (based on space per square foot and not market value).
  - The financial value (generally measured at cost or book value) of donated food, equipment and supplies.
  - Equipment and medical supplies (includes national and international donations, with the greatest proportion of donations being local) for health-related programs.
  - Emergency medical care at a health-related community event.
  - The costs of coordinating community events for a community benefit purpose not sponsored by the health care organization.
  - Employee costs associated with board and other community involvement while on work time and on behalf of the organization.
  - Food donations to organizations such as Meals on Wheels and homeless shelters.
  - Laundry services for community organizations.
  - Ancillary services, such as lab, radiology and pharmacy services, provided at low or no cost to other providers in the community, such as clinics or shelters.
  - Technical assistance to community organizations, such as information technology, grant writing, accounting, human resource support, planning and marketing.

Do Not Count:

- Employee costs associated with board and community involvement when these occur on an employee's own time, not on behalf of the organization, or not related to a community benefit objective.
- Volunteer hours provided by hospital employees on their own time for community events.
- Salary expenses paid to employees deployed on military services or jury duty (considered employee benefits).
- Time spent at golf outings or other primarily recreational events.

F. Community-Building Activities

Community-building activities are activities the organization engages in to protect or improve the health and safety of its residents. Categories of community-building activities are reported and defined in IRS Form 990, Schedule H, Part II. If a community-building activity is undertaken in response to an identified community health need and meets a community benefit objective, it is reportable as a community health improvement service in IRS Form 990, Schedule H, Part I. If reported as a community health improvement service in Part I, it should not be reported as a community-building activity in IRS Form 990, Schedule H, Part II; therefore, this section does not include specific "do count" and "do not count" recommendations.

IRS NOTE

From the IRS Schedule H instructions, "An organization that enters information in this Part II must describe in Part VI how its community building activities promote the health of the communities it serves."

Benefits to Communities: The World Health Organization defines the social determinants of health as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." Community building activities address the social determinants of life, impacting how long and how well people live.

Reporting Considerations: Reported in Part II of 990, Schedule H. The amount reported is the total expenses for each activity incurred, less any offsetting revenue. Total expense includes both direct and indirect costs for each program. Direct offsetting revenue includes any restricted grant funds.

F1. Physical Improvements and Housing

- May include the provision or rehabilitation of housing for vulnerable populations, such as removing building materials that harm the health of residents; neighborhood improvement or revitalization projects; provision of housing for vulnerable patients upon discharge from an inpatient facility; housing for low-income seniors; and the development or maintenance of parks and playgrounds to promote physical activity.

F2. Economic Development

- May include assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness.

F3. Community Support

- May include childcare and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.

F4. Environmental Improvements

- May include activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards.
- Do not report expenditures made to reduce the environmental hazards caused by the organization unless they are provided to improve community health or to address environmental issues known to affect community health and are subsidized.

F5. Leadership Development and Training

- May include training in conflict resolution; civic, cultural or language skills; and medical interpreter skills for community residents.

F6. Coalition Building

- May include participation in community coalitions and other collaborative efforts with the community to address health and safety issues.

F7. Community Health Improvement Advocacy

- May include efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment and transportation.

F8. Workforce Development

- May include recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved and collaboration with educational institutions to train and recruit health professionals needed in the community (other than the health professions education activities reported in IRS Form 990, Schedule H, Part 1).

G. Community Benefit Operations

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

Benefits to Communities: Community benefit operations coordinate efforts across the hospital and work with the community to address priority health needs. Coordination and collaboration increase efficiency and effectiveness in efforts to improve community health.

Reporting Considerations: The amount reported is the total expenses, direct and indirect (overhead), incurred by the hospital for community benefit administrative staff, community health needs assessments (CHNAs), conferences, and related administrative activities.

G1. Assigned Staff

Do Count:

- Staff costs for managing or overseeing community benefit program activities that are not included in other categories of community benefit
- Staff costs for internal tracking and reporting of community benefit

Do Not Count:

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

G2. Community Health Needs Assessment/Implementation Strategy

Do Count:

- Costs related to the organization's CHNA
- Contributions for conducting a collaborative assessment with other organizations
- Costs related to developing the implementation strategy
- Costs of producing reports that describe the progress of the implementation strategy

Do Not Count:

- Costs of a market share analysis
- Marketing surveys

G3. Other Resources

Do Count:

- Costs associated with community benefit evaluation
- Costs of fundraising for hospital-sponsored health improvement programs
- Grant writing and other fundraising costs related to equipment used for hospital-sponsored community benefit services and activities
- Costs associated with developing a community benefit strategic plan, conducting community forums and reporting community benefit
- Overhead and office expenses associated with community benefit operations
- Dues to and participation in an organization that specifically supports the community benefit program, such as the Association for Community Health Improvement
- Software that supports the community benefit program, such as CBISA™ (Community Benefit Inventory for Social Accountability) by Lyon Software
- Costs associated with attending educational programs to enhance community benefit program planning and reporting, such as the portion of system assessments or fees that support community benefit activities performed by the system office

Do Not Count:

- Grant writing and other fundraising costs of hospital capital projects (such as funding of buildings and equipment) that are not hospital community benefit programs
- Dues or employee time contributed to hospital and professional organizations not specifically and directly related to community benefit
- Grant writing for community organizations (reportable in category E3. In-Kind Donations)

A Mission to Care: A Commitment to Community

COMMUNITY BENEFIT

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.

We are concerned with the health and well-being of our entire community and in doing so, as Community Benefit Leaders:

We are committed to the dignity of each and all persons.

We are compelled to improve health care access, health and well-being for all persons at every stage of life regardless of race, gender, culture or economic status and to eliminate differences in treatment and outcomes.

We promote the common good.

We acknowledge the impact of social conditions on individual and community health, and we partner with our communities to address the social factors of health, including access to care, economic stability, housing, belonging, and the natural and built environment.

We have special concern for vulnerable persons.

We prioritize programs that address the health needs of our communities' most vulnerable and ensure that programs reach out to those most in need.

We responsibly and effectively steward resources.

We exercise prudence in developing programs and using limited resources, employing resources where they are most needed and most likely to be effective.

We are called to justice.

We advocate for access to health care and community conditions that support health and well-being and where every person can reach their fullest potential and flourish.

We care for the whole person.

We acknowledge the health needs of individuals and communities are not singular, but complex, so we design community benefit programs that improve health through prevention, health promotion, education, health care services, research and more.

We do our work in solidarity with the community.

We walk alongside our communities with humility and patience - listening first, building relationships and trust, and sharing in decision-making. We recognize our lives are interconnected and we commit to working with our communities in ways that honor our shared humanity and promote the common good.

CHA
Catholic Health Association of the United States

For more information about community benefit and Catholic health care, visit **chausa.org/cb**

Washington Office
1625 Eye Street NW, Suite 550
Washington, DC 20006
(202) 296-3993

St. Louis Office
4455 Woodson Road
St. Louis, MO 63134
(314) 427-2500

chausa.org