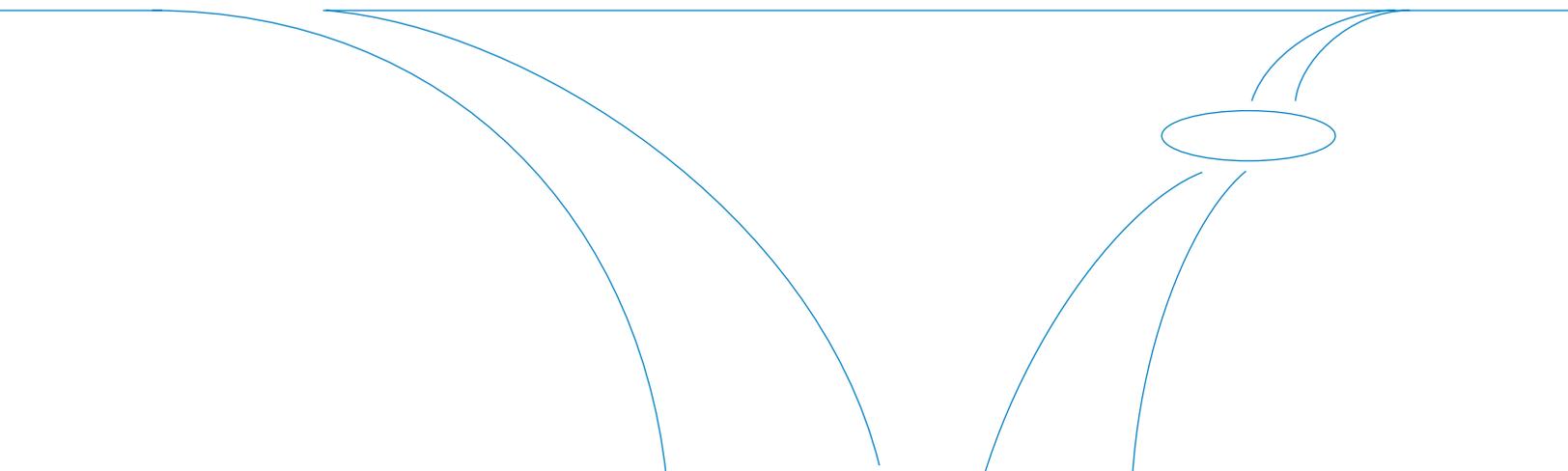




Community Benefit and Finance/Tax Staff: *Cultivating Relationships for Accurate Reporting*

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



INTRODUCTION

For many years, the Catholic Health Association of the United States (CHA) and Vizient have published guidelines to help hospitals plan and report community benefit. CHA and Vizient are pleased to provide this resource, which contains information designed to help staff in community benefit and in finance (and in some health systems, also the tax departments) cultivate effective relationships important to assuring accurate community benefit reporting. The resource is organized into the following sections:

- + Strategies for Effective Finance/Tax and Community Benefit Staff Relationships
- + An Accounting Primer on Community Benefit¹
- + Tips to Avoid Under- and Over-Reporting

CHA and Vizient intend to include additional sections in upcoming editions of this resource.

¹ An Appendix includes information on the Ratio of Patient Care Cost to Charges.

STRATEGIES FOR EFFECTIVE FINANCE/TAX AND COMMUNITY BENEFIT STAFF RELATIONSHIPS

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

- + Manifests commitments by hospitals and health systems to their missions
- + Increasingly is recognized as vital to improving population health and achieving strategic objectives
- + Responds to federal expectations that tax-exempt hospitals focus on improving community health by (among other activities): providing access to care for low-income patients, enhancing public health, advancing knowledge through health professions education and research and making contributions for community benefit
- + Responds to requirements in many states that hospitals provide community benefits to qualify for sales, property and/or corporate income tax exemptions or to satisfy conditions placed on mergers and acquisitions

Hospitals and health systems also recognize that tax-exemptions provide important organizational benefits, including the ability to receive charitable donations, issue tax-exempt debt and remain exempt from paying federal, state, and local taxes.

Whatever the reasons, it's important for hospitals to report community benefit accurately – both to avoid potential under-reporting and to avoid possible over-reporting.

Effective relationships between staff directing community benefit/community health activities and staff in finance (and in other departments such as tax, government relations and communications) are critically important to accurate community benefit reporting. Such relationships also facilitate:

- + Developing and maintaining Financial Assistance Policies that balance community access to care and hospital financial performance needs
- + Analyzing the budget implications of new community health improvement programs
- + Establishing community benefit spending budgets and targets
- + Generating meaningful benchmarking information to guide strategy and policy
- + Effectively telling the organization's "community benefit story"

Several steps as described on the pages that follow can be taken to assure effective relationships with finance and tax departments.

ASSURE FINANCE/TAX AND COMMUNITY BENEFIT STAFF ROLES ARE CLEAR

As shown in the following table, staff in finance and tax departments and staff in community benefit each have important roles to play in the community benefit reporting process. Assuring that roles and responsibilities are clear is the first step for achieving effective relationships.

Community Benefit Financial Reporting *Primary Roles*

Finance and Tax Staff

Identify and compile values for:

- + Ratio of Patient Care Cost to Charges
- + Financial Assistance at cost
- + Medicaid shortfalls (or gains, reported at \$0)
- + Health professions education and associated reimbursement
- + Subsidized health services (net of financial assistance, Medicaid, other means-tested government programs and bad debts)
- + Accounting value of in-kind contributions (e.g., conference room space and donated equipment)
- + Medicare and bad debt (assuring no double counting)

Allocate community benefit amounts to hospital organizations from:

- + System offices
- + Physician practices
- + Other affiliates²
- + Joint ventures
- + Foundations

Assure that the community benefits generates expense to the hospital (with the expense in financial statements and the IRS Form 990 Statement of Functional Expenses) and its value is based on actual expenses and not on “opportunity costs.”

Provide community benefit staff with statistics:

- + Hourly wage values to apply to staff time while working on community benefit activities and programs
- + Percentage(s) applied to salaries and wages to account for employee benefits
- + Indirect cost factors to apply to direct expenses for community benefit programs

Assure that cash donations for community benefit are restricted, as required by Schedule H instructions.

Assure that community benefit amounts reported on Schedule H accurately reflect the health system’s EIN structure.

Assess year-over-year changes in community benefit values to assure rational explanations are available.

Assure regular reporting to management and board regarding community benefit.

² In many cases, community benefits incurred by hospital affiliates and joint ventures can be included in hospital community benefit reports. Examples of methodologies for allocating such amounts may be the subject of future publications.

Community Benefit Financial Reporting *Primary Roles, continued*

<p>Community Benefit Staff</p>	<p>Assure that criteria for “what counts as community benefit” are met for all reported programs and activities; document that reported programs address community health needs.</p> <p>Track and report data (staff hours and compensation expense, supplies expense, total expense, offsetting revenue and statistical information) for:</p> <ul style="list-style-type: none"> + Community health improvement services + Community building activities and programs + Community benefit operations expenses + Contributions for community benefit <p>Help identify reportable health professions education and research activities.</p> <p>Draft narrative to respond to Schedule H questions (Part V, Section C and Part VI).</p>
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Accurate reporting of subsidized health services, in particular, requires substantial collaboration between finance/tax and community benefit staff. Finance staff identify clinical programs that have been subsidized by the hospital (because they lose money) and community benefit staff establish whether or not community need for the program(s) is present.

Hospital organizations sometimes receive inquiries from the press, government officials and the public about their community benefit. Responding effectively and consistently to these inquiries also requires collaboration between finance/tax, community benefit, government relations and marketing/communications staff. Establishing in advance how inquiries will be handled (and by whom) is helpful.

Responses to Schedule H questions (Part V, Section C and Part VI) are most effective when they are prepared collaboratively, with community benefit, finance, tax and communications staff involved.

UNDERSTAND THE IMPORTANCE OF EFFECTIVE COMMUNICATIONS

Effective communication by finance/tax and community benefit staff is important due to the important roles played by each. Without such communication, the probability of errors (either underreporting or overreporting) increases. Chief financial officers and governing boards need confidence that information reported on Schedule H and otherwise to the public is accurate. In many health systems, increasingly the finance/tax function is being regionalized or centralized, making communication between local community benefit staff even more challenging.

Other reasons why effective communication is important:

- + Instructions for completing Schedule H have changed over the years, and some changes have affected community benefit accounting methods. Finance/tax and community benefit staff need to share information about such changes when they occur, or reports are likely to be inaccurate.

- + Community benefit staff frequently have more exposure to community benefit-related webinars, trainings and information. Including finance/tax staff in training, or sharing that information with finance/tax staff can contribute to accurate and complete reporting, as well as serve to develop a deeper appreciation of the “people being helped” behind the numbers.
- + If finance/tax staff actively are involved, some types of community benefit can be reported more accurately. For example, with proper documentation, community benefit operations costs incurred at the system office typically can be allocated to system hospitals as a component of management fees or other expense allocations. Communication also helps ensure that costs are not double-counted.
- + Community benefit staff need help with several important accounting variables, such as indirect cost factors that apply to all categories of community benefit.³ Without effective communications with finance/tax, those variables are unlikely to be accurate or to align with cost reports and other accounting records.
- + Finance/tax and community benefit staff need to work together to assure that what counts criteria are met. Sometimes “what counts” is determined by finance (i.e., the program needs to generate actual expense to the hospital). Finance staff can help with judgments regarding whether programs were established primarily to benefit the community or primarily to benefit the hospital (e.g., by providing a return on investment or to maintain licensure or accreditation). Assuring

that the primary purpose of specific programs is community benefit rather than organizational benefit is key.

UNDERSTAND BARRIERS TO EFFECTIVE COMMUNICATIONS

There are reasons why effective communication may not be occurring.

- + Within finance/tax, responsibility for community benefit accounting may not have been assigned to a dedicated, consistent staff member. Community benefit reporting guidelines and instructions take time to understand fully; an investment of time in studying Schedule H instructions and other available materials is helpful. Turnover happens, requiring ongoing assurances that individuals in finance/tax are well versed in community benefit accounting.
- + With growing centralization of finance/tax functions in multi-hospital systems, sometimes local community benefit staff don't know whom to call.
- + Community benefit staff sometimes have limited training in accounting and finance. Their exposure to finance terms like “indirect cost,” “IME” and “restricted contributions” can be limited – complicating clear communication with and requests of finance.
- + Conversely, finance/tax staff sometimes have limited training on community benefit. Their exposure to criteria for what counts as community benefit and reasons why providing community benefit is important also can be limited – making it challenging to communicate clearly with community benefit staff and provide them with the support they need.

³ See CHA's *A Guide for Planning and Reporting Community Benefit*, in Appendix D, Part 2.

- + The IRS has published instructions to Schedule H, and the Catholic Health Association of the United States and Vizient (CHA/Vizient), for years, have published community benefit accounting guidelines. While effort has been made to assure these publications are user-friendly, they can be daunting for community benefit and finance/tax staff alike.
- + Have finance/tax mentor community benefit staff to help them better understand how community benefit accounting fits into the overall financial picture and financial reporting processes.
- + Create opportunities for finance/tax staff to see community benefit work in action so they can see the community members impacted by the community benefit efforts – this can be very impactful in working with finance leadership in budgeting for community benefit.

IMPLEMENT STRATEGIES TO ENHANCE RELATIONSHIPS

Several strategies have been used for enhancing relationships between finance/tax and community benefit staff including:

- + Schedule regular meetings between finance/tax and community benefit staff to share reporting updates, important timelines, learning opportunities and other issues impacting these two critical function areas.
- + Strive to assure that consistent, dedicated staff are devoted by finance/tax to community benefit accounting and to supporting community benefit staff.
- + Assure finance/tax staff are trained in community benefit accounting and that this responsibility is documented in job descriptions.
- + Include finance/tax staff as part of an organization's community benefit/ community health improvement councils/ committees.
- + Have representatives from finance/tax and community benefit attend training opportunities together (e.g., CHA's Community Benefit 101 class and webinars).
- + Assure that community benefit staff are involved in the development or refinement of Financial Assistance (and Billing and Collections) policies.
- + Annually evaluate the effectiveness of communication between finance, tax and community benefit staff.

AN ACCOUNTING PRIMER ON COMMUNITY BENEFIT

The IRS publishes instructions to Schedule H, and CHA/Vizient, for years, have published community benefit accounting guidelines. While effort has been made to assure those publications are user-friendly, they can be daunting for community benefit and finance staff alike. This short accounting primer is designed to help.

Community benefit reports are filed with the Internal Revenue Service (IRS Form 990, Schedule H), are required by about one-half of state governments, and are published voluntarily by most tax-exempt hospitals and health systems.

Community benefit is accounted for by quantifying the total expense, the direct offsetting revenue and the resultant net expense borne by the hospital organization for:

- + Financial assistance⁴
- + Medicaid
- + Other means-tested government programs (e.g., county indigent care programs for which individuals qualify based on their household income and assets)
- + Community health improvement services
- + Community benefit operations
- + Health professions education
- + Subsidized health services
- + Research funded by government and other tax-exempt sources
- + Cash and in-kind contributions for community benefit

On Schedule H, hospitals also account for community building activities (in Part II), Medicare (amounts not elsewhere reported as community benefit) and bad debts (in Part III).

The table that follows summarizes accounting methods for each category of community benefit and also for community building. The table describes how to approach valuing total expense and direct offsetting revenue; net community benefit expense is the difference between these two values.⁵ However, if direct offsetting revenue is greater than total expense, net community benefit expense is zero.

In the CHA/Vizient guidelines and Schedule H instructions, hospitals are allowed to use their “most accurate” cost accounting methods. Many use the Ratio of Patient Care Cost to Charges (Cost to Charge Ratio) formula presented in Worksheet 2 of the Schedule H instructions.

⁴ Before the Affordable Care Act this generally was known as “charity care.”

⁵ The primer is not meant to substitute for instructions to IRS Form 990, Schedule H or for chapters in CHA's *A Guide for Planning and Reporting Community Benefit*. Those publications include more in-depth guidelines regarding what counts as community benefit, accounting for joint ventures, how transactions between related and unrelated organizations are to be handled and other important topics.

Category	Summary of Accounting Methods
Financial assistance (charity care)	<p>Total Expense. Take charges for amounts written off pursuant to the Financial Assistance Policy and convert the charges to cost using either the Cost to Charge Ratio (as adjusted to avoid double-counting) or another more accurate cost accounting method.</p> <p>Direct Offsetting Revenue. Typically, direct offsetting revenue is zero unless the hospital has received grants restricted to be used for financial assistance.</p>
Medicaid	<p>Total Expense. Take charges generated in serving Medicaid patients (from all states and for both fee-for-service/direct Medicaid and for managed care) and convert the charges to cost using either the Cost to Charge Ratio or another more accurate cost accounting method (e.g., a Medicaid cost report). Also include in total expense any provider taxes, assessments or fees paid by the hospital to participate in the Medicaid program.</p> <p>Direct Offsetting Revenue. Add up all Medicaid net patient revenue, including fee-for-service and managed care from all states, and also including any Medicaid DSH, DSRIP and IME reimbursement. Exclude from this category any Medicaid direct GME revenue, which instead is included in direct offsetting revenue for health professions education.</p>
Other means-tested government programs	<p>Use the same methodology as Medicaid to account for the Total Expense and Direct Offsetting Revenue associated with SCHIP, county indigent care programs and other government health insurance programs under which patients are eligible based on their household means. Note that Medicare, VA Health Benefits and TRICARE are not provided on a means-tested basis so are not reported</p>
Community health improvement services	<p>Total Expense. Determine the expense incurred by the hospital for each program that qualifies as a community health improvement service. This generally is done by including compensation expense for hospital staff while working on qualifying programs (hours x hourly rates plus a factor for employee benefits), supplies expenses, any other direct expenses, and also a factor for indirect (overhead) costs. The indirect cost factor can be derived from the Medicare Cost Report, cost accounting system or other sources.⁶</p> <p>Direct Offsetting Revenue. Include any fees paid by program participants and restricted grant funds used for qualifying programs during the year.</p>

⁶ In many cases, community benefit incurred by hospital affiliates and joint ventures can be included in hospital community benefit reports. Examples of methodologies for allocating such amounts may be the subject of future publications.

Category	Summary of Accounting Methods, <i>continued</i>
Community benefit operations	<p>Total Expense. Add up the direct and indirect (overhead) expense incurred by the hospital for community benefit administrative staff, community health needs assessments (CHNAs), conferences and related administrative activities. Note that if the hospital is part of a multi-hospital system and the system office includes community benefit staff or activities, a reasonably determined portion of those system office costs can be included by each system hospital.</p> <p>Direct Offsetting Revenue. Typically zero for this category unless restricted grants are received to pay for CHNAs and other operations costs.</p>
Health professions education	<p>Total Expense. Add up the direct and indirect (overhead) expense for graduate medical education (GME) and for other health professions education (e.g., nursing students) necessary for the trainees to be licensed or certified in their field. The Medicare Cost Report frequently is used to value GME expense. Use care not to overstate the cost associated with nurses precepting nursing students; the incremental cost borne by the hospital to provide these students with clinical experience and didactic training may not be substantial. In-service staff education is not reportable.</p> <p>Direct Offsetting Revenue. Include direct GME (DGME) revenue for Medicare and for Medicaid, and CHGME. Any GME reimbursement provided by Medicaid and CHGME may need to be split into direct and indirect components (using proportions derived from Medicare DGME/IME amounts).</p>

Category	Summary of Accounting Methods, <i>continued</i>
<p>Subsidized health services</p>	<p>Identify clinical services provided by the hospital that lose money but are provided because the community needs them. For each clinical service reported, determine total expense (including expenses for ancillary services) and offsetting revenue excluding losses associated with financial assistance, bad debt, Medicaid, and other means-tested government programs – all four of which are reported elsewhere in full and should not be double-counted.</p> <p>Total Expense. Estimate total expense for each clinical service by taking total charges and applying the Cost to Charge Ratio, or by using another more accurate cost accounting method. Then, compute an adjusted total expense by subtracting from the service’s total expense the cost for financial assistance, bad debt and Medicaid.</p> <p>Direct Offsetting Revenue. Add up all net patient revenue, other operating revenue and restricted grant revenue for the clinical service, and then compute an adjusted direct offsetting revenue amount by subtracting net revenue for Medicaid and financial assistance (if any), and adding back revenue deductions for bad debt.</p> <p>A clinical service may lose money when all payers and revenues are included, but make money when Medicaid, other means-tested government program, bad debt and financial assistance losses are excluded. If so, then the service doesn’t qualify to be reported as a subsidized health service.</p>
<p>Research</p>	<p>Total Expense. Add up the direct expense and the indirect expense borne by the hospital for research studies that qualify to be reported as community benefit because they seek to advance public knowledge and primarily are funded by grants or resources from a tax-exempt or government source (e.g., NIH, a foundation or the hospital itself). Indirect cost factors based on NIH guidelines or from other sources may be used in determining total expense.</p> <p>Direct Offsetting Revenue. Include in revenue any grants provided and restricted by a third party (e.g., NIH or a foundation) to fund the research expenses reported as community benefit. Also, include any license fees or royalties received by the hospital for research reported as community benefit either in the current or prior periods.</p>

Category	Summary of Accounting Methods, <i>continued</i>
<p>Cash and in-kind contributions for community benefit</p>	<p>Total Expense. Add up the dollar value of cash donations the hospital made and restricted (in writing) to be used by the recipient for a specific community benefit purpose. Exclude an indirect cost add-on for restricted cash donations.</p> <p>In-kind donations (for donated supplies, meeting room space, depreciated computers and other resources) should be valued based on book value and/or reasonable, cost-based estimates. If a community group uses a conference room for an hour, for example, that in-kind donation should be valued based on an average hourly cost per square foot for depreciation, utilities, security, supplies and related expenses – not the fair market amount the group would have paid commercially.</p> <p>Direct Offsetting Revenues. Generally zero, unless the hospital has received a restricted grant from another organization and is re-granting or sharing the resource with another entity.</p>
<p>Community building</p>	<p>Total Expense. Determine the expense incurred by the hospital for each program that qualifies as community building. This generally is done using the same accounting methods that apply to community health improvement services. If a program meets the definition of community building and the definition of community health improvement services, it should be reported as community health improvement.</p> <p>Direct Offsetting Revenue. Include any fees paid by program participants and restricted grant funds used for qualifying programs during the year.</p>

TIPS TO AVOID UNDER-REPORTING AND OVER-REPORTING

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

UNDER-REPORTING ISSUES

Hospitals under-report community benefit if they:

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

Indirect expenses include overhead (such as facilities, administrative and support costs) shared by multiple activities or programs and that therefore must be allocated.
- + Don't include portions of system office community benefit expenses in their reports, even though those system office expenses are recovered from (allocated to) the hospitals through management fees or expense allocations.
- + Don't reclassify bad debt expense into Financial Assistance, using generally accepted methods of identifying patients eligible for Financial Assistance on a presumptive basis.
- + Don't systematically reclassify self-pay discounts provided to patients found eligible for Financial Assistance to charity care.
- + Don't include Medicaid provider taxes, fees or assessments in the total expense incurred to serve Medicaid patients.

Medicaid losses are miscalculated unless these taxes are included – in particular if Medicaid revenues funded in part by the taxes are included in direct offsetting revenue.
- + Don't shift expenses for community building programs to community health improvement services (if there is evidence that the community building programs improve community health).

- + Subsidize physician practices or medical groups that operate in separate EINs⁷ or for-profit corporations and that incur financial assistance, Medicaid, and other community benefit losses, but have not recognized that these subsidies can be restructured into restricted contributions by the hospital for community benefits.⁸

OVER-REPORTING ISSUES

Hospitals over-report community benefit if they:

- + Report programs that don't satisfy generally accepted definitions of *community benefit* or that would be questioned by a prudent layperson because the primary purpose appears to be benefiting the organization itself.
- + Fail to adjust the Ratio of Patient Care Cost to Charges as indicated by the instructions to Schedule H (see next section).
- + Only report net community benefit expense, rather than total community benefit expense, direct offsetting revenue, and net community benefit expense – because this yields an overstated Ratio of Patient Care Cost to Charges.
- + Include certain amounts that haven't generated an expense actually incurred by the EIN that operates the hospital (e.g., because they were performed by employees on their own time or were incurred by an affiliate that files its own, separate return with the IRS).
- + Report “opportunity costs” rather than actual cost reported by the hospital in its financial statements.

Opportunity costs, based on value or revenue forgone, are theoretical and not treated as

actual cost in financial statements. If, for example, the hospital makes conference room space available to a community group, the cost should be reported based on the actual cost borne by the hospital to make the space available (i.e., a reasonably estimated amount for depreciation expense, interest expense, utilities, food incurred while the group uses the space) and should not be based on what the group would have needed to pay at an area hotel.

- + Report as community benefit cash contributions that have not been restricted, *in writing*, to be used for one or more community benefit purposes (e.g., financial assistance or community health improvement), with *community benefit* defined based on instructions to Schedule H.
- + Fail to subtract the net effects of Medicaid, other means-tested government programs, financial assistance and bad debt to calculate the loss from subsidized health services.
- + Define subsidized health services too narrowly, for example, including physician clinics as subsidized health services without assessing whether the hospital is generating gains from the physicians' work.
- + Over-report indirect costs.⁹
- + Report the entire staffing costs of nurses supervising nursing students rather than the time taken away from regular duties.
- + Report capital expenditures rather than the annual carrying cost (depreciation and amortization) associated with those expenditures over their useful lives.

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

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

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

APPENDIX

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

Worksheet 2: Ratio of Patient Care Cost to Charges	
PATIENT CARE COST	
1. Total operating expense (including bad debt expense)	
LESS ADJUSTMENTS	
2. Non-patient-care activities	
3. Bad debt expense	
4. Medicaid or provider taxes, fees, and assessments (if in operating expense)	
5. Total community benefit expense	
6. Total community building expense	
Adjustments (add lines 2 through 7)	
Cost (subtract line 7 from line 1)	

The Ratio of Patient Care Cost to Charges (the Cost to Charge Ratio) generally is used to convert charges for Financial Assistance, Medicaid and subsidized health services to cost (unless the hospital has a more accurate cost accounting method). A worksheet designed to help hospitals calculate the Cost to Charge Ratio is included in Schedule H instructions (Worksheet 2) and in CHA's *A Guide to Planning and Reporting Community Benefit*.

Several adjustments are made to the Cost to Charge Ratio primarily to avoid double counting. For example, a hospital may have \$10 million in total Health Professions Education expense reported in full as community benefit. If that \$10 million remains in the numerator

of the Cost to Charge Ratio, then a portion of Health Professions Education expense is reported again wherever the ratio is applied. The table on the pages that follow demonstrates and explains the adjustments.

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

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

continued ▶

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

ABOUT THE CATHOLIC HEALTH ASSOCIATION

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

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

chausa.org/communitybenefit

ABOUT VIZIENT

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

Vizient has a long track-record of working to ensure that community-based, not-for-profit health care is supported. Congress, the White House and federal regulatory agencies, such as the Internal Revenue Service, regularly examine the merits of tax-exemption for not-for-profit hospitals, and look to ensure that exemption is justified by activities that provide meaningful

benefits to their communities. Vizient continues to work with policymakers to ensure that our members are represented in those policy discussions and are able to fully tell the full story of the essential care that they provide to the communities they serve.

vizientinc.com

ABOUT THE AUTHOR

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

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

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“We need to communicate with each other, to discover the gifts of each person, to promote that which unites us, and to regard our differences as an opportunity to grow in mutual respect.”

POPE FRANCIS, JUNE 2016





A Mission to Care: A Commitment to Community

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

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

AS COMMUNITY BENEFIT LEADERS:

We are concerned with the dignity of persons.

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

We are concerned about the common good.

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

We have special concern for vulnerable persons.

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

We are concerned about stewardship of resources.

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

We are called to justice.

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

We care for the whole person.

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

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



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