CHA
Catholic Health Association of the United States

# Community Benefit Reporting: *Subsidized Health Services*

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

# COMMUNITY BENEFIT REPORTING: SUBSIDIZED HEALTH SERVICES

For many years, the Catholic Health Association of the United States and Vizient (CHA/Vizient) have published guidelines to help hospitals plan and report community benefits. CHA and Vizient are pleased to provide this additional resource which contains information designed to help hospital organizations identify and report Subsidized Health Services.

At a high level, Subsidized Health Services are clinical programs (inpatient or outpatient product lines) that hospitals provide at a financial loss and that are needed by communities they serve. To avoid double counting community benefits (in Part I of IRS Form 990, Schedule H), the loss is calculated after excluding losses for Medicaid, Other Means-tested Government Programs and Financial Assistance (referred to herein as "adjusted loss"). Bad debt also is excluded because those losses are reported in full in Part III of Schedule H.

Identifying and reporting these services presents certain challenges. As a result, this important category of community benefits is under-reported by many organizations.

This document is designed to help and is organized into the following sections:

- Subsidized Health Services Defined,
- Why Reporting Subsidized Health Services is Important,
- Why Reporting Subsidized Health Services is Challenging, and
- Steps Recommended to Identify and Report Subsidized Health Services.

### What you need to know

- Tax-exempt hospitals provide Subsidized Health Services at a loss because communities need access to the care.
- This category of community benefit frequently is under-reported.
- Hospitals can follow recommended steps to identify and report clinical product lines that are subsidized and that are needed by communities.
- Steps include:
  - Excluding Financial Assistance, Medicaid and bad debt losses to avoid double counting, and
  - Documenting community need for the services.

## SUBSIDIZED HEALTH SERVICES DEFINED

Community benefit reporting on IRS Form 990, Schedule H largely is based on CHA/Vizient guidelines that first were published in 1989.[1] The Subsidized Health Services category has been included since then in recognition that tax-exempt hospital organizations are more likely than for-profit hospitals to provide relatively unprofitable clinical services.[2]

1. See: Social Accountability Budget for Not-For-Profit Healthcare Organizations, 1989.
2. See: "Making Profits and Providing Care: Comparing Nonprofit, For-Profit and Government Hospitals" by Jill R. Horowitz, May/June 2005, accessed at: https://www.healthaffairs.org/doi/10.1377/hlthaff.24.3.790.

The CHA/Vizient definition of *Subsidized Health Services* has remained essentially unchanged over the years and was carried into instructions for Schedule H. See below:

**Definition of Subsidized Health Services in IRS Form 990, Schedule H Instructions (2019)[3]**

"Subsidized Health Services" means 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 … In addition, in order to qualify as a subsidized health service, the organization must provide the service because it meets an identified community need.

A service meets an identified community need if it is reasonable to conclude that if the organization no longer offered the service:

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

Subsidized Health Services can include qualifying inpatient programs (for example, neonatal intensive care, addiction recovery and inpatient psychiatric units) and outpatient programs (emergency and trauma services, satellite clinics designed to serve low-income communities, and home health programs). Subsidized Health Services generally exclude ancillary services that support inpatient and ambulatory programs such as anesthesiology, radiology, and laboratory departments.

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 …, must describe that it has done so and report in Part VI such costs …"

**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.

The intent for this category has been that hospitals would report qualifying clinical inpatient and/or outpatient product lines in their entirety (e.g., psychiatric services, emergency services, home health programs) and not narrowly defined subsets or components of these services.

For example, CHA/Vizient guidelines discourage reporting on-call payments to physicians to assure emergency room coverage as a Subsidized Health Service. The guidelines advise hospitals to include these costs when determining whether their entire emergency rooms qualify to be reported as Subsidized Health Services. If the entire emergency room qualifies to be reported as a Subsidized Health Service, then expenses for on-call payments would be deemed expenses of providing that overall service.

3. See: https://www.irs.gov/pub/irs-pdf/i990sh.pdf.

The guidelines also discourage separately reporting payments to hospitalists and other physicians to serve low-income or uninsured inpatients. Instead, these payments are included when assessing whether various product lines in their entirety are reportable as Subsidized Health Services.

Similarly, when identifying and reporting Subsidized Health Services, costs for ancillary services such as laboratory, radiology and pharmacy are to be allocated to the clinical product lines they support. For example, any laboratory charges, reimbursements and expenses generated by inpatient psychiatry patients (during their hospital episode of care) would be included as part of the inpatient psychiatry service when assessing whether it is reportable as a Subsidized Health Service.

Due to how *Subsidized Health Services* is defined, these services:

- Always generate patient care charges and patient bills.

  Activities and programs that don't generate patient care charges and bills may be reportable as community benefits (e.g., community health improvement services), but not as Subsidized Health Services.

- Tend to be "Medicare heavy."

  Two payer categories generally remain after a hospital removes "losses associated with bad debt, financial assistance, Medicaid, and other means-tested government programs;" namely, commercial and Medicare. For many hospitals, Medicare reimbursement is below cost. A product line with large numbers of Medicare patients thus is more likely to qualify as a Subsidized Health Service.

- Tend to be programs with comparatively low commercial reimbursement rates and/or restrictive health insurance benefits.

  For these reasons, mental health, addiction recovery, dental, and other services often meet the financial tests required to be reported as Subsidized Health Services.

- Sometimes are reported intermittently (i.e., reported in 2016 and in 2018 but not in 2017).

  Some years, a Subsidized Health Service that has been reported in the past may not qualify because it generates a financial gain (after the required adjustments). This phenomenon suggests the need to analyze all candidate inpatient and outpatient product lines each year and that the list of qualifying services is dynamic.

  As stated in the Schedule H instructions, to be reported as a Subsidized Health Service, a clinical product line or service also must meet an identified community need. Services meet community needs if access problems would result "if the organization no longer offered the service." CHA/Vizient guidelines provide examples where services generally don't meet such needs and should not be reported, for example:

- If the hospital loses money on an inpatient addiction recovery program due to low occupancy and because there are several other units nearby with excess capacity.

- If losses are occurring primarily due to inefficiency rather than program, patient, or other needs-related characteristics.

Note that a change regarding reporting physician clinics was made to the Schedule H instructions as of tax year 2013. Physician clinics can be reported as a Subsidized Health Service only if the organization operated both the clinic and any associated hospital services at a financial loss during the year. If a physician clinic requires subsidy (professional services) but the hospital makes money on services provided to clinic patients (technical or facility services), then the physician clinic is not to be reported as a Subsidized Health Service.

## WHY REPORTING SUBSIDIZED HEALTH SERVICES IS IMPORTANT

A review of Schedule H filings indicated that over 900 hospital facilities did not report any Subsidized Health Services for tax year 2016.[4] Hospitals that haven't been reporting Subsidized Health Services may have under-reported their community benefits.

Reporting Subsidized Health Services accurately and completely is important, because:

- Providing Subsidized Health Services differentiates tax-exempt from for-profit hospital organizations,
- Subsidized Health Services represent significant ways that tax-exempt hospitals benefit their communities by providing access to needed health care services,
- Not reporting Subsidized Health Services is inconsistent with Schedule H instructions (unless no qualifying services in fact are being provided), and
- The Subsidized Health Services category provides an opportunity to report Medicare-funded activities as community benefit.

## WHY REPORTING SUBSIDIZED HEALTH SERVICES IS CHALLENGING

Subsidized Health Services is perhaps the most frequently under-reported category of community benefits for several reasons:

- Recurring questions are asked about the types of clinical services that can be considered eligible for reporting as Subsidized Health Services.

  The Schedule H instructions include examples: "Subsidized health services can include qualifying inpatient programs (for example, neonatal intensive care, addiction recovery, and inpatient psychiatric units) and outpatient programs (emergency and trauma services, satellite clinics designed to serve low-income communities, and home health programs)."

  As previously stated, the intent has been that hospitals would report qualifying clinical inpatient and/or outpatient product lines in their entirety (such as inpatient cardiology) and not narrowly defined subsets or components of these services (such as payments to cardiologists for low-income or uninsured inpatients).

- Calculating reportable losses is somewhat complex and requires dedicated support by staff in Finance, Decision Support, Reimbursement, and/or similar departments.

  As stated above, net community benefits for Subsidized Health Services are to be calculated excluding losses for Financial Assistance, Medicaid, Other Means Tested Government Programs, and Bad Debt. The adjustments are needed to prevent double counting amounts that have been reported in full either in Part I of Schedule H (as community benefits) or in Part III (as bad debt). These complexities suggest that Finance or Decision Support staff trained in finance and accounting should play a meaningful role in reporting Subsidized Health Services.

- Subsidized Health Services should be assessed each year.

  Answers to the following two primary questions regarding whether various product lines are reportable can change from one year to the next. Each year, hospital organizations should ask these questions:

  - Which clinical (inpatient and/or outpatient) product lines generate losses after the required adjustments?
  - For those clinical services that generate losses, can community need be established?

Accurate reporting of Subsidized Health Services requires substantial collaboration between Finance/Tax and Community Benefit/Community Health staff. Finance staff identify clinical programs that have been subsidized by the hospital (because they lose money even after subtracting losses for Financial

4. Analysis of data from http://www.communitybenefitinsight.org/.

Assistance, Medicaid, Bad Debt, and Other Means-tested Government Programs have been excluded) and community benefit staff establish whether or not community need for the program(s) is present.

## STEPS RECOMMENDED TO IDENTIFY AND REPORT SUBSIDIZED HEALTH SERVICES

To report Subsidized Health Services, hospital organizations can consider the following steps. These steps can be implemented on a quarterly and/or annual basis.

### Subsidized Health Services Reporting Steps

1. Develop list of candidate health services (product lines).
2. Assure Finance/Tax and Community Benefit/Community Health staff understand the availability and applicability of available cost accounting systems.
3. Ask Finance (or Decision Support) for an analysis that estimates profits and losses for each unique health service (product line).
4. Take clinical services that yield losses based on the Step 3 analysis and subtract revenues and expenses (and thus any losses) for:
   - Financial assistance (charity care),
   - Medicaid,
   - Other Means Tested Government Programs, and
   - Bad debt.
5. If after Step 4 there are stand-alone physician clinics that appear to have losses, then assess the financial performance of associated hospital services (technical or facility services), if any.
6. Establish and document community need for the health services (product lines) that satisfy Steps 1-5.
7. Add all values together for services found to be operating at an adjusted loss (and meeting a community need) after performing Steps 1-6 and enter data onto Schedule H (Part I, Line 7g).

A discussion regarding each of these steps is presented below.

**1. Develop list of candidate health services (product lines)**

The first step is to develop a list of candidate health services or product lines for assessment. As described in the Schedule H instructions, these include inpatient and outpatient services or product lines. Stand-alone physician clinics also can be assessed to see if they qualify for reporting.

One approach to defining inpatient product lines is to rely on Major Diagnostic Categories or "MDCs" (currently 25 mutually exclusive diagnosis areas, as specified by the Centers for Medicare & Medicaid Services). MDC 19, for example, represents discharges for "Mental Diseases and Disorders." Outpatient procedures and services also can be organized into similar types of product lines.

Ancillary services (e.g., laboratory, radiology, pharmacy, physical therapy) generally are not to be considered candidates for Subsidized Health Services. Rather, costs and revenues for these services are to be allocated to candidate product lines. An assessment of an inpatient psychiatric program, for example, should include the costs and revenues for ancillary services associated with psychiatric patients during their episodes of care.

If certain ancillary services are not being provided as part of an overall episode of care, e.g. outpatient pharmacy or physical therapy, then they can be considered for reporting as *Subsidized Health Services.*

Because Subsidized Health Services always generate patient charges and patient bills, services that don't (e.g., physician on-call payments) are not candidates for this type of community benefit. Even though these represent "subsidies" of certain "health services," they don't align with the definition of Subsidized Health Services as originally intended or as stated in Schedule H instructions.

**2. Assure Finance/Tax and Community Benefit/ Community Health staff understand the availability and applicability of available cost accounting systems**

Many hospital organizations have cost accounting systems that can estimate profits and losses for each inpatient and outpatient product line. These systems produce data comparable to the following:

**Table 1: Example Cost Accounting Report**

| Impatient Service Line | Charges | Net Revenue | Direct Cost | Indirect Cost | Operating Margin | Margin % |
|---|---|---|---|---|---|---|
| **Cancer** | $ 50,000,000 | $ 15,000,000 | $ 9,000,000 | $ 4,500,000 | $ 1,500,000 | 10% |
| **Orthopedics** | $ 60,000,000 | $ 20,000,000 | $ 12,000,000 | $ 4,800,000 | $ 3,200,000 | 16% |
| **General Surgery** | $ 50,000,000 | $ 6,900,000 | $ 4,500,000 | $ 2,250,000 | $ 150,000 | 2% |
| **Nephrology** | $ 5,000,000 | $ 1,300,000 | $ 850,000 | $ 270,000 | $ 180,000 | 14% |
| **Psychiatry** | **$ 10,000,000** | **$ 2,400,000** | **$ 2,500,000** | **$ 1,000,000** | **$ (1,100,000)** | **- 46%** |
| **Other** | — | — | — | — | — | — |
| | | | | | | |
| **Total** | $ 750,000,000 | $ 215,000,000 | $ 130,000,000 | $ 75,000,000 | $ 10,000,000 | 5% |

In **Table 1** (based on an actual cost accounting system), the hospital's inpatient psychiatry program stands out as a candidate for assessment as a Subsidized Health Service.

- Patients of the example inpatient psychiatry program were billed a total of $10 million for services they received, including inpatient routine and ancillary services.
- Net patient revenue of $2.4 million also was recorded based on reimbursements expected or received from commercial, Medicare, Medicaid, and other payers.
- The inpatient psychiatric program generated a loss of $1.1 million, because direct and indirect costs exceed this product line's net revenue by that amount.

Other inpatient product lines in the table show financial gains and thus do not meet the definition of Subsidized Health Services.

All staff involved in the community benefit reporting process should understand the availability and applicability of these types of cost accounting systems.

**3. Ask Finance (or Decision Support) for an analysis that estimates profits and losses for each unique health service (product line)**

The next step is to conduct a financial analysis of each hospital clinical service or product line. The analysis should be conducted annually, because financial performance is subject to change.

If a cost accounting system is not available, the analysis can be conducted using:

- The hospital's overall patient care cost-to-charge ratio (preferably based on Worksheet 2 of the Schedule H instructions),
- Gross charges by payer (for each product line), and
- Overall reimbursement rates for each payer.

The Schedule H instructions indicate that hospitals are to use their "most accurate costing methodology" across all categories of community benefit and that such methodology should be consistent with the methodology used in the Schedule H worksheets for calculating each type of community benefit.

Cost accounting systems are a preferred ("most accurate") source for the Step 3 financial analysis, because reimbursement rates, direct and indirect costs are estimated in ways that are specific to each product line. In the absence of a cost accounting system, it's preferable (and "most accurate") to prepare an analysis using hospital-wide metrics rather than not to report any Subsidized Health Services at all.

If the financial analysis prepared in Step 3 indicates that no clinical product lines generate financial losses, then there is no need to undertake further steps. The hospital has no Subsidized Health Services for the year and can leave Part I, Line 7g of Schedule H blank.

**4. Take clinical services that yield losses based on the Step 3 analysis and subtract revenues and expenses (and thus any losses) for Financial Assistance (charity care), Medicaid, Other Means Tested Government Programs and Bad Debt**

In Step 3, clinical services or product lines with financial losses are identified as candidates to be reported as Subsidized Health Services.

The example inpatient psychiatric program, which (per **Table 1**) generated $1.1 million in losses, is one such candidate. Importantly, though, some of the $1.1 million loss was due to patients with Financial Assistance, Medicaid, or coverage from Other Means Tested Government Programs. Some of the losses also were due to bad debt.

In Step 4, revenues, expenses and losses for these patients and for bad debt are excluded (subtracted) from the program's total financial performance. As previously discussed, this step is needed to prevent double counting community benefits and bad debt that are reported elsewhere on Schedule H in full.[5]

5. Refer to Worksheet 6 in the Schedule H instructions, which portrays the need to subtract Medicaid, financial assistance and bad debt from revenues and expenses for subsidized health services.

The two tables that follow show example calculations for the inpatient psychiatric program. The first table begins with the Total Program Financial Performance. The Total Program Financial Performance column comes directly from the cost accounting system data shown in **Table 1**.

A "Double Counting and Bad Debt Adjustment" then is made. The adjustment (derived from values presented in **Table 3**) is comprised of gross charges, net patient revenue and expense associated with Financial Assistance, Medicaid, Other Means Tested Government Programs, and bad debt. Subtracting the amounts in the "Adjustment" column from the total program amounts in the first column yields "Net Program Financial Performance."

See Table 2 below.

**Table 2: Analysis of Candidate Subsidized Health Service - Inpatient Psychiatric Program**

| Impatient Psychiatric Line | Total Program Finacial Performance | Minus: Double Counting and Bad Debt Adjustment | Net Program Finacial Performance |
|---|---|---|---|
| **Gross Charges** | $ 10,000,000 | $ 2,050,000 | $ 7,950,000 |
| **Net patient revenue** | $ 60,000,000 | $ 20,000,000 | $ 2,150,000 |
| **Other revenue** | $ — | $ — | $ — |
| **Direct offsetting revenue** | $ 5,000,000 | $ 1,300,000 | **$ 2,150,000** |
| **Total community benefit expense** | $ 10,000,000 | $ 2,400,000 | **$ 2,817,500** |
| **Net community benefit expense** | $ 1,100,000 | $ 432,500 | **$ 667,500** |

Assuming that community need for the inpatient psychiatric program has been established, amounts in the "Net Program Financial Performance" column are reportable as community benefits — because the program still shows $667,500 in losses after the adjustment is made.

The above example shows that while the inpatient psychiatric program lost $1.1 million on an overall basis for the year, $432,500 of the loss was due to care provided to Financial Assistance, Medicaid, and Other Means-Tested Government Program patients. Bad debt also played a role in the program's overall losses.

The three values in bold font ($2,150,000 million in Direct Offsetting Revenue, $2,817,500 in Total Community Benefit Expense, and $667,500 in Net Community Benefit Expense) are included in Part I, Line 7g of Schedule H — so long as community need for the example program has been established.

Details regarding the example "Double Counting and Bad Debt Adjustment" are presented in **Table 3**. The amounts are derived from the hospital's cost accounting system and from other hospital accounting records regarding Financial Assistance and Bad Debt write-offs.

**Table 3: Analysis of Candidate Subsidized Health Service - Inpatient Psychiatric Program Double Counting and Bad Debt Adjustment**

| Impatient Psychiatric Line | Medicaid | Other Means Tested Government Programs | Financial Assistance | Bad Debt | Double Counting and Bad Debt Adjustment |
|---|---|---|---|---|---|
| **Gross Charges** | $ 1,500,000 | $ 200,000 | $ 250,000 | $ 100,000 | $ 2,050,000 |
| **Net patient revenue** | $ 300,000 | $ 50,000 | | $ (100,000) | $ 250,000 |
| **Other revenue** | | | | | $ — |
| **Direct offsetting revenue** | $ 300,000 | $ 50,000 | $ — | $ (100,000) | $ 250,000 |
| **Total Expense** | $ 525,000 | $ 70,000 | $ 87,500 | $ — | $ 682,500 |
| **Net Expense (Loss)** | $ 225,000 | $ 20,000 | $ 87,500 | $ 100,000 | $ 432,500 |

- The hospital's cost accounting system allows breaking out the inpatient psychiatric program's financial performance by payer. In this example, Medicaid losses were $225,000 and losses for Other Means Tested Government Programs were another $20,000.
- The hospital also has records regarding write-offs for Financial Assistance and for bad debt generated by inpatient psychiatric program patients.
    - By reviewing patient accounting data, the hospital determined that $250,000 (2.5 percent) of the program's overall $10 million in gross charges were written off to Financial Assistance. The $250,000 in charges were converted to "Total Expense" using the hospital's patient care ratio of cost to charges.
    - In this example, the hospital was able to determine that program patients generated $100,000 in bad debt expense. This is the amount that the hospital actually recorded as revenue and thus also represents the true financial loss for the year. In the table, bad debt expense is not "converted" to expense.

In Step 4, a similar analysis is prepared for each of the clinical services (product lines) that appear to have losses based on the assessment described in Step 3.

If no clinical services show losses after the Step 4 analysis, then the hospital has no Subsidized Health Services as defined by Schedule H instructions and can leave Part I, Line 7g of Schedule H blank.

The example calculations above are based on product line-specific reimbursement rates, ratios of patient care cost to charges and Financial Assistance and Bad Debt write-offs. In the absence of product-line specific values, it certainly is possible to base calculations on hospital-wide metrics, such as the hospital's overall Medicaid reimbursement rate (in relation to charges), the overall percentage of charges written off to Financial Assistance and Bad Debt and the overall ratio of patient care costs to charges.

Applying overall hospital metrics to calculate Subsidized Health Services is "more accurate" than reporting no such services at all.

**5. If after Step 4 there are stand-alone physician clinics that appear to have losses, then assess the financial performance of associated hospital services (technical or facility services), if any**

Step 5 is required by the Schedule H instructions. A stand-alone physician clinic only is reportable as a Subsidized Health Service if (a) it meets the definition of Subsidized Health Services and (b) the hospital loses money on the clinic and any associated facility/technical work of these physicians.

For example, losses at a stand-alone cardiology practice operated by the hospital organization would not be reportable if overall financial gains are generated by the organization for cardiology services.

**6. Establish and document community need for the health services (product lines) that satisfy Steps 1-5**

To be reported as Subsidized Health Services, community need must be established for services (product lines) that satisfy Steps 1 through 5. The hospital should be able to establish that the community needs these services and that without them, access would be problematic. As stated in the Schedule H instructions: "A service meets an identified community need if it is reasonable to conclude that if the organization no longer offered the service:

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

Community need can be established based on community health needs assessments and/or information demonstrating barriers (e.g., excessive travel time) to accessing alternative, comparable services.

**7. Add all values together for services found to be operating at an adjusted loss (and meeting a community need) after performing Steps 1-5 and enter data onto Schedule H (Part I, Line 7g)**

The final step is to add Direct Offsetting Revenue, Total Community Benefit Expense, and Net Community Benefit expense for all of the services that qualify to be reported as Subsidized Health Services. Resulting values then are entered on Part I, Line 7g of Schedule H.

Schedule H instructions also indicate that:

- If Subsidized Health Services include one or more stand-alone physician clinics, then the physician clinic(s) and the amount of the losses must be disclosed in Part VI.
- Any Medicare revenues and expenses reported within Subsidized Health Services are to be subtracted from Medicare revenues and expenses otherwise reportable in Part III of Schedule H. This also is required and is meant to assure that no double counting exists across the filing.

Hospital organizations that undertake Steps 1 through 7 each year can assure that Subsidized Health Services are reported accurately and can avoid under-reporting this important category of community benefit.

## ABOUT THE CATHOLIC HEALTH ASSOCIATION

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

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

## ABOUT VIZIENT

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

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

## ABOUT THE AUTHOR

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

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

**www.veriteconsulting.com**

COMMUNITY BENEFIT

# 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*

CHA
Catholic Health Association of the United States

**Washington Office**
1875 Eye Street, NW, Suite 1000
Washington, DC 20006
(202) 296-3993

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

**chausa.org**