This resource is an excerpt from CHA's *Community Benefit and Finance/Tax Staff: Cultivating Relationships for Accurate Reporting*, available at chausa.org/communitybenefit

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 EINs[7] 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 over-stated 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.

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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