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2020 Edition

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Printed in the United States of America.

Community Benefit Categories and Definitions

Community Benefit Categories

Category 1: Financial Assistance

Category 2: Government-Sponsored Means-Tested Health Care

Category 3: Other Community Benefit Programs and Activities

This reference can be downloaded from the Catholic Health Association (CHA) website at www.chausa.org/guideresources.

This section provides recommendations for what counts as community benefit. It is not 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.

General Reporting Criteria

To be reported as a community benefit, 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, or
- Relief of a government burden to improve health.

This includes activities or programs that:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to health care services or disparities in health status among different populations.

- Leverage or enhance public health department activities such as childhood immunization efforts.
- Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.
- Otherwise would 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, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

Following are recommendations for how programs and activities should be categorized and examples of what should and should not be reported as community benefit. Health care organizations should document the rationale for why they have reported a program or activity as a community benefit. What community health need is it addressing? Does the need continue? What community benefit objective is being met?

FINANCIAL ASSISTANCE

CATEGORY 1

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). 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 (for example, discounts provided to self-pay patients and/or services ineligible for financial assistance).

Count:

- The cost of free and partially discounted care provided based on the financial assistance policy.
- Provider taxes, assessments or fees if Medicaid 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).

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 Veterans Administration and Indian Health Service.

OTHER COMMUNITY BENEFIT PROGRAMS AND ACTIVITIES

CATEGORY 3

Other community benefit programs and activities include the following:

- Community Health Improvement Services
- Health Professions Education
- Subsidized Health Services
- Research
- Cash and In-kind Contributions for Community Benefit
- Community Building Activities
- Community Benefit Operations

Across these programs and activities:

Count:

- Programs that respond to an identified community health need and are designed to accomplish one or more community benefit objectives (see General Reporting Criteria).
- 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 expense to the hospital, for example time spent by volunteers and employees on their own time.
- Routine or required care and services.
- Activities or programs required for licensure or accreditation (e.g. cancer or trauma registries).

Also see General Reporting Criteria at the beginning of this Reference.

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 to quantify (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.

A1. Community Health Education

Community health education includes lectures, presentations, other group programs and activities, and 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 clinical services delivery. Direct and indirect costs for staff time, travel, materials, and staff preparation are reportable.

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 that respond to community health needs.
- Consumer health libraries.
- Parish and congregational 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 (Note: Report school-based health services for students in community-based clinical services, A2.).
- Worksite health education programs when not performed as "good will" 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 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, including: diseases and disabilities, grief, infertility, support for patient families, and the community.

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

- Support groups related to community need, such as for 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 encounter.

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.

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 (report as In-kind Donations, E3).

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, 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.

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, not only to the organization's services. 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.

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 (report in Community Health Education, A1).
- 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

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 a profit is realized.
- Subsidized, permanent, ongoing programs and outpatient services (report in Hospital Outpatient Services, C3).

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.

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 Cash Donations, E1).

Mobile units

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, and lithotripsy (report in Hospital Outpatient Services, C3).
- Costs for marketing associated with the mobile unit. For example, if 30% 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% of the cost of the mobile unit would not be reported as community benefit expense.

A3. Health Care Support Services

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

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 community health need has been established (for example, housing and food insecurity issues are present in community) and the activities are above and beyond the standard practice of patient registration or discharge planning.
- Include 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 discharge planning.
- Telephone information services, such as Ask a Nurse, medical and mental health service hotlines, and poison control centers, 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 of navigator services.
- Personal response systems, such as Lifeline.
- Assistance for homeless patients 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 required of all providers.

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) provided in response to an identified community health need and that meet the definition of community health improvement services also should be reported here.

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 2020 - https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Count:

1. Social and Community Factors
   - 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 healthcare access.

2. Education

   - 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.

3. 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.
   - Developing bike lanes, playgrounds, and walking trails in response to needs related to obesity and lack of exercise.

4. Poverty and Economic Stability

   - Job creation and training programs for economically poor and vulnerable populations.
   - Participation in economic development council to revitalize 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 healthcare organization's facilities more attractive.
- Contributions to the arts (unless part of a comprehensive plan for economic development in at-risk community).

- Participating in economic development not specifically related to poverty or the needs of low-income people.
- Activities for employees.
- Development of housing and investments made for community development where a return is expected.
- Advocacy specific to 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 license or certification by a board in the individual's health profession specialty.

B1. Graduate and Undergraduate Medical Education and Continuing Medical Education for Physicians

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.
- Continuing medical education (CME) required for state licensure or certification if CME programs are made available to practitioners on a community-wide basis.

Do not count:

- Expenses for the organization's physician and medical student in-service training.
- CME programs limited to members of the organization's medical staff only.

B2. Nurses/Nursing Students

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 and other allied health professions 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.
- 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 (but report in Cash Contributions, E1).

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.

B3. Other Health Professions Education

Count:

- Expenses borne by the organization to train other allied health professionals where such training is necessary for them to retain state license or certification by a board in the professional's health profession specialty. These professions may include physical therapy, occupational therapy, respiratory therapy, public health, emergency medical technician, lab tech, clinical pastoral education (chaplain), registered dietician, pharmacy. 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 for example:
  - 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 where trainees are required to work for the organization after training.
- Training for non-health related professions such as accounting.

B4. Scholarships/Funding for Health Professions Education

Count:

- Scholarships or tuition payments for nursing and other health professions education to nonemployees with no requirement to work for the organization as a condition of the scholarship.
- Specialty in-service and video conferencing programs required for certification or licensure made available to professionals in the community.

Do not count:

- Costs for staff conferences and travel other than those listed above.
- Financial assistance for employees who are advancing their own educational credentials.
- Staff tuition reimbursement costs provided as an employee benefit.
- Financial assistance where students/trainees are required to work for the organization.

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. In order to qualify as a subsidized health service, the organization must provide the service because it meets an identified community health 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 generally exclude ancillary services that support inpatient and ambulatory programs such as anesthesiology, radiology, and laboratory departments.

In general:

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 generally include entire product lines (e.g., inpatient psychiatry, trauma program), rather than narrowly defined sub-components (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 catch-all 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

Count:

- Air Ambulance/helicopter.
- Trauma center.
- Emergency department.

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

Count:

- Safety net clinics where patients are not billed.
- 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

Count:

- Hospice.
- Adult day programs.
- Skilled nursing facilities.*

C8. Behavioral Health Services

Count:

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

C9. Palliative Care

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 the goal of which is to generate increased generalizable knowledge made available to the public (for example, knowledge about underlying biological mechanisms of health and disease, natural processes, or principles affecting health or illness; evaluation of 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 internally funded research it conducts, as well as the cost of research it conducts funded by a tax-exempt or government entity.

D1. Basic and Applied Clinical Research

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

D2. Community-based Research

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 economically poor 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 presentation.
- Studies on innovative health care delivery models.
- Creation of partnerships for community-based research projects.

Do not count:

- Costs to prepare Community Health Needs Assessments, which are reported in Category G (Community Benefit Operations).
- Market research.
- Research where findings 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 are restricted, in writing, so the amounts are used by recipients 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. (Note: contributions to provide support services to individuals should be reported in category A3. Health Care Support Services.)

E1. Cash Contributions for Community Benefit

Count:

Contributions restricted to be used by another entity to one or more of the following community benefit activities and programs, as defined in 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; for example, payments made in lieu of taxes that the organization makes to prevent or forestall local or state property tax assessments, and 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

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 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

Count:

- Non-cash donations of goods, services, and resources for community benefit purposes. Examples include:
    - Cost of staff hours donated by the organization to the community while on the organization's payroll.

- Cost of space donated to tax-exempt community groups (such as for meetings based on space per square foot and not market value).
- The financial value (generally measured at cost) 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.
- Costs of coordinating community events for a community benefit purpose not sponsored by the health care organization
- Employee costs on work time associated with community health-related boards and other community involvement.
- 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/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. 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 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 Schedule H, Part II.

Categories of community-building activities as defined in the IRS Schedule H, Part II include:

F1. Physical Improvements And Housing

- May include, but is not limited to, 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, but is not limited to, 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, but is not limited to, child care 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, but are not limited to, 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 provided to improve community health, addresses environmental issues known to affect community health and must be subsidized.

F5. Leadership Development And Training

- For community members may include, but is not limited to, training in conflict resolutions, civic, cultural or language skills, and medical interpreter skills for community residents.

F6. Coalition Building

- May include, but is not limited to, participation in community coalitions and other collaborative efforts with the community to address health and safety issues.

F7. Community Health Improvement Advocacy

- May include, but is not limited to, 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, but is not limited to, 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 Part I of the Form 990 Schedule H).

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.

G1. Assigned Staff

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 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/Implementation Strategy

Count:

- Costs related to the organization's community health needs assessment.
- Contribution for conducting a collaborative assessment with other organizations.
- Costs related to developing the implementation strategy.
- Costs of producing reports that describe progress of implementation strategy.

Do not count:

- Costs of a market share analysis.
- Marketing surveys.

G3. Other Resources

Count:

- Costs associated with community benefit evaluation.
- Cost 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 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 by Lyon Software.
- Costs associated with attending educational programs to enhance community benefit program planning and reporting.
    - Portion of system assessments or fees that supports 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 (counted under In-kind Donations, E3).