## Section 1: Costs

**Hospital Name:** St. Alphonsus Medical Center - Baker City, Inc.

**Reporting Period:** July 1, 2011 - June 30, 2012

| Please indicate what type of cost accounting system is being used for this reporting. (Check all that apply and explain.) | Cost accounting system | Cost to Charge Ratio | Other (explain) |
|---|---|---|---|
| | | X | We use the cost to charge ratio from our filed Medicare Cost report. |

| | Community Benefit Categories | Column A | Column B | Column C | Column D | Column E |
|---|---|---|---|---|---|---|
| | **Charity Care and Public Programs** | **Patient Visits** | **Total community benefit expense** | **Direct offsetting revenue** | **Net community benefit expense (B-C)** | |
| 1 | Charity care at cost | 599 | $816,289 | | $816,289 | |
| | Unreimbursed costs of public programs: | | | | | |
| 2 | Medicaid/Managed Medicaid Plans | | | | $0 | |
| 3 | Medicare/Managed Medicare Plans | | | | $0 | |
| 4 | Other public programs | | | | $0 | |
| 5 | Charity Care and Public Programs Total (sum of lines 1 through 4) | 599 | $816,289 | $0 | $816,289 | |
| 6 | What percentage of Charity Care dollars granted represented a discount of 100% of charges? | 78.0% | | | | |
| | **Other Benefits** | **Encounters** | **Total community benefit expense** | **Direct offsetting revenue** | **Net community benefit expense (B-C)** | **Description of Activities** |
| 7 | Community health improvement services | 3,752 | $19,601 | | $19,601 | Community-based education, clinical services and support services |
| 8 | Research | n/a | | | $0 | |
| 9 | Health professions education | n/a | $21,056 | | $21,056 | Nursing students |
| 10 | Subsidized health services | n/a | $842,255 | $443,685 | $398,570 | 24 hour Emergency Room |
| 11 | Cash and in-kind contributions to other community groups | n/a | $39,269 | $0 | $39,269 | Donations of excess inventory and othe local group donations |
| 12 | Community building activities | n/a | $49,915 | | $49,915 | Community Support and Coalition Building |
| 13 | Community benefit operations | n/a | $0 | | $0 | |
| 14 | Other Benefits Totals (sum of lines 7 through 13) | 3,752 | $972,096 | $443,685 | $528,411 | |
| 15 | **Community Benefits Totals** (line 5 plus line 14) | **4,351** | **$1,788,385** | **$443,685** | **$1,344,700** | |

# Filing Instructions

## Section 1: Costs (required)

Section 1 of this form is a **requirement** pursuant to OAR___-OAR___. The form should be completed using expenses and revenues associated with each category during the hospitals fiscal year. Reporting guidelines are detailed in Community Benefit Reporting Guidelines (CBR-2), found at the Office website.

## Section 2: Supplemental Information (optional)

Section 2 of this form is **optional** pursuant to OAR___-OAR___. The section should be completed using additional written documents answering the questions provided or referencing specific community benefit categories from Section 1. Submission of this section should be in conjunction with Section 1. Any submission should clearly identify the hospital name and fiscal year in which the documentation is intended to provide additional clarity.

## Instructions for electronic submission (preferred method)

Save the CBR-1 to your computer and complete electronically. After completion of Section 1, submit CBR-1 via electronic mail to ohpr.datasubs@state.or.us. *Please use email for data submissions only and not inquiries* . Any supplemental information submitted in response to Section 2 on this form or in general, should be submitted using Adobe PDF format and should be submitted in conjunction with the electronic submission of CBR-1.

## Instructions for printed submission

Save the CBR-1 to your computer and complete electronically. After completion of Section 1, print and mail to the Research & Data Unit at Office for Oregon Health Policy & Research, 1225 Ferry Street SE 1st Floor, Salem, OR 97301. Or save and e-mail to ohpr.datasubs@state.or.us. Any supplemental information submitted in response to Section 2 on this form or in general, should be submitted in conjunction with the electronic submission of CBR-1.

# 2012 CBR-1 Form Instructions

| CBR-1 Line Item; Column | Field/Community Benefit Category | Instructions | Office for Oregon Health Policy & Research CBR-2 Version July 2008<br>Community Benefit Reporting Categories<br>(Adapted from CHA/VHA Community Benefit Categories) | |
|---|---|---|---|---|
| All | Reporting entity/Hospital Name | To ensure consistent reporting, it is important to first define the reporting entity for completion of the CBR-1 Form. For purposes of community benefit reporting, the reporting entity defined as "Hospital," should be the individual hospital located within Oregon, and include all activities within Oregon that are under the governance of the hospital whether physically in the same location as the hospital or not. If the hospital is part of a System that has governance responsibility over the hospital then the costs of the community benefit activities provided by the System in Oregon should be allocated to the System's individual hospitals based on an allocation methodology attempting to match where the community benefit is provided. | | |
| 1–4; A | Patient visits | For lines 1 through 4, report the number of patient visits associated with the reported costs. A visit includes an outpatient encounter, a hospital admission, or other patient encounter. Include only outpatient lab encounters, not tests. An inpatient admission and the episode of care should be counted as only one visit. Provider/physician visits to inpatients may be counted separately if unable to remove them from visit counts. This is intended to be a duplicated patient count and reasonable estimates may be used if necessary. | | |
| 1-4 & 7-13; B | Total Community Benefit Expense | In quantifying Total Community Benefit Expense (column B), care should be taken not to count the same costs in more than one community benefit category. This principle also applies to quantifying the cost of charity care, Medicaid, Medicare, and other public programs whether using an RCC (ratio of cost to charges) or a cost accounting system.<br><br>For instance, if an RCC method is being used to calculate the cost of charity care, Medicaid, and/or Medicare, the cost of other community benefits on lines 7-13 (except for line 10 if the RCC is being used to quantify subsidized health services) should be removed from the total operating expenses included in calculating the RCC so as not to double count costs.<br><br>The RCC Worksheet provided with these instructions may be used as a guide to calculate the hospital's ratio of cost to charge percentage. | | |
| 1-4 & 7-13; C | Direct offsetting revenue | Organizations should enter as direct offsetting revenue in column C any reimbursement received associated with the total community benefit costs. For example, the Medicare reimbursement received for services provided to Medicare patients should be entered as direct offsetting revenue associated with the costs to provide Medicare services. Or if your organization received a grant for research, that grant reimbursement should be entered as direct offsetting revenue related to the cost of the research reported as total community benefit cost. | | |

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| CBR-1 Line Item; Column | Field/Community Benefit Category | Instructions | Office for Oregon Health Policy & Research CBR-2 Version July 2008<br>Community Benefit Reporting Categories<br>(Adapted from CHA/VHA Community Benefit Categories) | |
|---|---|---|---|---|
| 1; B, C, D | Charity Care at cost | Hospitals have flexibility to use the method they determine appropriate to establish their costs to provide charity care. A cost accounting system may be the best source for establishing cost. If this is not available or is not complete, the RCC (ratio of cost to charges) is a standard method that can be used to estimate costs (see the RCC Worksheet, discussed earlier).<br><br>The Charity Care Worksheet provided with these instructions can be used as a guide to calculate charity care at cost. | Charity care- "Charity care" means free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. 'Charity care' does not include bad debt, contractual allowances or discounts for quick payment. Eligibility determinations by hospitals can be made at any point during the revenue cycle but all efforts should be made to determine eligibility as early in the revenue cycle as possible.<br>**Count**: Free and discounted care, expenses incurred by the provision of charity care, indirect costs not already included in calculating costs.<br>**Do not count**: Bad debt, contractual allowances or quick-pay discounts, Any portion of charity care costs already included in the subsidized health care services category (see CBR-1 worksheets). | |
| 2-4; B, C, D | Unreimbursed costs for public programs: Medicare, Medicaid, and other public programs | Instructions on specific issues:<br>• Include managed Medicaid and managed Medicare in Medicaid and Medicare totals, respectively.<br>• Include Tricare, Champus, Veterans Health Administration, Indian Health Service, and other federal, state, or local programs reported in "other" public programs totals. Do not duplicate amounts already included in Medicare or Medicaid totals.<br>• Include all patient accounts within a payor type or category, thus netting those patient accounts with both gains and losses.<br>• Direct offsetting revenue reported should be equal to aggregate Medicare, Medicaid, or other public program reimbursements related to the reported costs. This should include, but is not limited to, patient payments, cost report settlements, lump sum adjustments, capitated payments, indirect medical education payments (IME), and disproportionate share hospital revenue (DSH). Only report the DSH revenue that has not already been reported in the Charity Care offsetting revenue.<br>• If the aggregate NET revenue exceeds the total cost (expense) to operate the public program, exclude it from the report. In other words, if the result in column D is NEGATIVE, remove the amounts in columns B and C to report nothing for that public program.<br><br>The Medicaid Worksheet and Medicare Worksheet provided with these instructions may be used as a guide to quantify the unreimbursed costs of these public programs. | Government-Sponsored Health Care- include unpaid costs of public programs—the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments. It does not include any shortfall that results from inefficiency or poor management.<br>**Count**: Losses related to: Medicare shortfall, Medicaid shortfall, State Children's Health Insurance Programs (SCHIP), Public and/or indigent care: Medical programs for low-income or medically indigent persons, Days, visits, or services not covered by Medicaid or other indigent care programs (see CBR-1 worksheets). | |
| 6; A | Percentage of charity care discounted at 100% of charges | For those patients receiving a charity write-off or discount, what percentage of the charity dollars written off were for patient accounts where the entire patient bill (100%) was written off? This percentage is the ratio of cumulative charges written off at 100% to all charity care write-offs or discounts (including those discounted at less than 100%). | | |
| 7; A | Encounters | Count each contact or encounter during the period, which means those persons with multiple contacts will be counted more than once (duplicated). Reasonable estimates may be used if necessary. | | |

## 2012 CBR-1 Form Instructions

| CBR-1 Line Item; Column | Field/Community Benefit Category | Instructions | Office for Oregon Health Policy & Research CBR-2 Version July 2008<br>Community Benefit Reporting Categories<br>(Adapted from CHA/VHA Community Benefit Categories) | |
|---|---|---|---|---|
| 7; A, B, C, D | Community health improvement services | These are activities that are carried out to improve community health. These services do not generate inpatient or outpatient bills. They may involve a nominal patient fee or sliding scale fee. These activities are based on an indentified community need. Count programs directed to or including at-risk persons and programs offered to the broad community designed to improve community health. Do not count programs that are primarily for marketing, time spent by volunteers, including employees on their own time, routine or required care. | Community Health Improvement Services- Activities carried out to improve community health are usually subsidized by the health care organization. Forgiving inpatient and outpatient care bills to low-income persons should be reported separately as charity care. Specific community health services to quantify include: Community health education, community-based clinical services, such as health services and screenings for underinsured and uninsured persons, support groups, 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, pastoral outreach programs, community-based chaplaincy programs and spiritual care, social services programs for vulnerable populations in the community. | Community Health Education- includes lectures, presentations, and other group programs and activities apart from clinical or diagnostic services. Community benefit in this area can include staff time, travel, materials, and indirect costs. Count: Baby-sitting courses, Caregiver training for persons caring for family members at home, Community calendars and newsletters primarily intended to educate the community about community health programs and free community events, consumer health libraries, education on specific diseases or conditions, such as diabetes or heart disease, health fairs, health promotion and wellness programs, health education lectures and workshops by staff to community groups, Parish and congregational programs, prenatal/childbirth classes serving at-risk and low-income persons, Information provided through news releases and other modes to the media (radio, television, and print) to educate the public about health issues (such as wearing bike helmets, new treatment news, health resources in the community, etc.), public service announcements with health messages, radio call-in programs with health professionals. |
| 7; A, B, C, D | Community health improvement services | | School health-education programs (Note: Report school-based programs on health care careers and workforce enhancement efforts in line 12: Community building activities. Report school-based health services for students in line 7), web-based consumer health information, worksite health education programs.<br>**Do not count**: Health education classes designed to increase market share (such as prenatal and childbirth programs for insured patients), community calendars and newsletters, if they are primarily used as marketing tools, patient education services understood as necessary for comprehensive patient care (e.g., diabetes education for patients), health education sessions offered for a fee, for which a profit is realized, volunteer time for parish and congregation-based services. | Support groups- Support groups typically are established to address social, psychological, or emotional issues related to specific diagnoses or occurrences: diseases and disabilities, grief, infertility, support for patients' families, or others. These groups may meet on a regular or an intermittent basis.<br>**Count**: Costs to run support groups.<br>**Do not count**: Support given to patients and families in the course of their inpatient or outpatient encounter, Childbirth education classes that are reimbursed or designed to attract paying or insured patients. |
| 7; A, B, C, D | Community health improvement services | | Self-help programs- These include wellness and health-promotion programs, such as those for smoking cessation, exercise, and weight loss.<br>**Count**: Anger management programs, Exercise classes, Smoking cessation programs, Stress management classes, Weight loss and nutrition programs.<br>**Do not count**: Employee wellness and health promotion provided by your organization as an employee benefit, the use of facility space to hold meetings for community groups (Report in line 11 "Cash and in-kind contributions"). | Community-Based Clinical Services- These are health services and screenings provided on a one-time basis or as a special event in the community. They do not include permanent subsidized hospital outpatient services; (report these in line 10 "Subsidized health services"). As with other categories of community benefit, these services and programs should be counted only if they are designed to meet identified community needs or to improve community health.<br><br>Screenings- Screenings are health tests conducted in the community as a public clinical 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, and can result in a referral to any community medical resource. To be considered community benefits, screenings should provide follow up care as needed, including assistance for persons who are uninsured and underinsured. |

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|---|---|---|---|---|
| 7; A, B, C, D | Community health improvement services | | **Count**: Behavioral health screenings, blood pressure screening, lipid profile and/or cholesterol screening, eye examinations, general screening programs, health-risk appraisals, hearing screenings, mammography screenings (If these are done at a separate, free-standing breast diagnostic center, report in line 10 "Subsidized health services"), osteoporosis screenings, school physical examinations, skin cancer screenings, stroke risk screenings.<br>**Do not count**: Health screenings associated with conducting a health fair that include, screenings for which a fee is charged, unless there is a negative margin, screenings where referrals are made only to the health care organization or its physicians, screenings provided primarily for public relations or marketing purposes. | One-time or occasionally held clinics- **Count**: blood pressure and/or lipid profile/cholesterol screening clinics, cardiology risk factor screening clinics, colon cancer screening clinics, dental care clinics, immunization clinics, mobile units that deliver primary care to underserved populations on an occasional or one-time or occasionally held primary care clinics, school physical clinics, stroke screening clinics.<br>**Do not count**: clinics for which a fee is charged and a profit is realized (do report if there is a negative margin). Permanent, ongoing programs and outpatient services (Report in line 10 "Subsidized health services"). |
| 7; A, B, C, D | Community health improvement services | | Clinics for underinsured and uninsured persons- These programs, which in the past may have been called “free clinics,” provide free or low-cost health care to medically underinsured and uninsured persons through the use of volunteers who donate their time, including physicians and health care professionals.<br><br>**Count**: Hospital subsidies, such as grants, Costs for staff time, equipment, and overhead costs, Lab and medication cost.<br>**Do not count**: Volunteers’ time and contributions by other community partners<br><br>Mobile units- **Count**: Vans and other vehicles used to deliver primary care services.<br>**Do not count**: Mobile specialty care services that are an extension of the organization’s outpatient department, such as mammography, radiology, and lithotripsy (Report in line 10 "Subsidized health services"). | Health Care Support Services- Health care support services are provided by the hospital to increase access and quality of care in health services to individuals, especially persons living in poverty and those in other vulnerable populations. Count: Information and referral to community services for community members (not routine discharge planning), 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, Transportation programs for patients and families to enhance patient access to care (Include cab vouchers provided to patients and families.), Assistance to enrollment in public programs, such as SCHIP and Medicaid, Personal response systems, such as Lifeline.<br>**Do not count**: A physician referral, if it is primarily an internal marketing effort. However, you may count a physician referral from a call center if the call center makes referrals to other community organizations or physicians from across an area, without regard to admitting practices, Health care support given to patients and families in the course of an inpatient or outpatient encounter, Routine discharge planning, enrollment assistance programs designed to increase facility revenue. |
| 8; B, C, D | Research | Include research costs for research that is made publically available and is consistent with community need. | Research- Research includes clinical and community health research, as well as studies on health care delivery that are shared with others outside the organization. Do not count research where findings are used only internally. Priority should be placed on issues related to reducing health disparities and preventable illness. In this category, count the negative margin, the difference between operating costs and external subsidies such as grants. | Clinical Research- **Count**: Research development costs, using formal research protocols, Studies on therapeutic protocols (Be sure to offset with grants and other funds.) , Evaluation of innovative treatments, Research papers prepared by staff for professional journals.<br><br>Community Health Research - **Count**: Studies on health issues for vulnerable persons, Studies on community health, such as incidence rates of conditions for populations, Research papers prepared by staff for professional journals, Studies on innovative health care delivery models. |

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|---|---|---|---|---|
| 9; B, C, D | Health professions education | Educational programs that are available to Physicians/Medical students, Nurses/Nursing students and other Health Professionals that are not available exclusively to the hospital's employees. Costs are the direct costs of providing such programs. For the costs associated with proctoring students, time studies should be performed measuring the incremental time the hospital employees spend with the students, not the total time students spend within the facility. Include cost of medical libraries open to the general public. Expenses are to be offset by Medicare and Medicaid reimbursement for direct GME, continuing health professionals' education reimbursements and tuition from students. Do not count cost for in-services training, orientation programs, or other training programs for hospital employees. | Physicians/Medical Students: Helping to prepare future health care professionals is a distinguishing characteristic of not-for-profit health care and constitutes a significant community benefit.<br>**Count**: You may count the unpaid costs of: A clinical setting for undergraduate training, internships, clerkships, and residencies, Residency education, continuing medical education (CME) offered to physicians outside of the medical staff on subjects for which the organization has special expertise. (Be sure to subtract government subsidies from these costs before counting).<br>**Do not count**: Expenses for physician and medical student in-service training Joint appointments with educational institutions and medical schools, orientation programs, costs of CME restricted to members of the medical staff.<br><br>Other Health Professional Education: **Count**: A clinical setting for undergraduate training and internships for dietary professionals, technicians, physical therapists, social workers, pharmacists, and other health professionals. Training of health professionals in special settings, such as occupational health or outpatient facilities. Unpaid costs of medical translator training beyond what is mandated. Program costs associated with high-school student job shadowing and mentoring projects.<br>**Do not count**: Expenses associated with: Education required by staff, such as orientation and standard in-service programs. Expenses for standard in-service training. Joint appointments with educational institutions or schools of physical therapy (unless in response to community-wide shortages). On-the-job training, such as pharmacy technician and nursing assistant programs. Staff time delivering care concurrent with job shadowing. | Nurses/Nursing Students: **Count**: Providing a clinical setting for undergraduate/vocational training to students enrolled in an outside organization . Internships or externships when on-site training of nurses (e.g., LVN or LPN) is subsidized by the health care organization. Costs associated with underwriting faculty positions in schools of nursing in response to shortages of nurses and nursing faculty .<br>**Do not count:** Expenses associated with: Education required by nursing staff, such as orientation, in-service programs, and new graduate training. Expenses for standard in-service training and in-house mentoring programs. In-house nursing and nursing assistants.<br><br>Scholarships/funding for professional education -<br>**Count**: Funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and health improvement. Nursing scholarships or tuition payments for professional education to non- employees and volunteers. Other health professional and technical training scholarships for community members. Specialty in-service and videoconferencing programs made available to professionals in the community.<br>**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. |

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|---|---|---|---|---|
| 10; B, C, D | Subsidized health services | Include all subsidized services provided by the hospital, whether on or off campus. Subsidized health services are clinical service lines that meet an identified community need if it is reasonable to conclude that if the hospital no longer offers 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. To be included the service has a financial loss after removing losses associated with bad debt, charity care, Medicaid, Medicare, and other public programs. Be careful in this calculation to remove costs and offsetting revenues already counted in quantifying the unpaid cost of charity care, Medicaid, Medicare, and other public programs so as not to double count these community benefits. | Subsidized health services (negative margin services) are clinical services that are provided despite a financial loss, and the financial losses are so significant that negative margins remain after removing the effects of charity care, Medicaid and Medicare shortfalls. Nevertheless, the service is provided because it meets an identified community need and if no longer offered, it would either be unavailable in the area or fall to the responsibility of government or another not-for-profit organization to provide. Subsidized health services include costs for billed services that are subsidized by the health care organization because the facility experiences costs that are not reimbursed. In all categories, count the negative margin of departments or services. Do not include shortfalls that already have been accounted for, such as charity care, Medicaid or Medicare losses.<br>**Count**: The amount the health care organization subsidizes to maintain these services, but not what it subsidizes for individual patients.<br>**Do not count**: Charity care, Bad debt, Medicaid shortfalls, Medicare shortfalls. 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. | Emergency and Trauma Services- **Count**: Air ambulance, Emergency department , local community emergency medical technician (EMS) training, when there is a negative margin, trauma center. Neonatal Intensive Care (if subsidized).<br><br>Hospital Outpatient Services-Count: Subsidized permanent outpatient services and primary/ambulatory care centers, whether they are within the hospital facility or separate, freestanding facilities (e.g., urgent care center), Mobile units, including mammography and radiology units.<br><br>Burn Units.<br><br>Women's and Children's Services - As with all community benefits in the subsidized care category, count only those for which an identified community need exists and for which not providing the service would result in a shortage within the community. **Count**: Freestanding breast diagnostic centers, newborn care, obstetrical services, pediatrics, women's services.<br>**Do not count**: Services provided in order to attract physicians or health plans.<br>Renal dialysis services. |

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|---|---|---|---|---|
| 10; B, C, D | Subsidized health services | | Subsidized health services includes services or care provided by physician clinics and skilled nursing facilities if such clinics or facilities satisfy the general criteria for subsidized health services.<br><br>Includes: Qualifying inpatient programs: Neonatal intensive care, addiction recovery, and inpatient psychiatric units, burn units and ambulatory programs such as emergency and trauma services, satellite clinics designed to serve low-income communities, home health programs, and outpatient hospice and palliative care services.<br>Excludes: Ancillary services that support inpatient and ambulatory programs such as anesthesiology, radiology, and laboratory departments.<br><br>Subsidized Continuing Care-<br>**Count**: Hospice care, home care services, skilled nursing care or nursing home services, senior day health programs , durable medical equipment.<br>**Do not count**: Step-down or post-acute services provided in order to discharge outlier patients, to the financial advantage of the facility.<br><br>Behavioral Health Services-<br>**Count**: Inpatient and outpatient behavioral health services.<br><br>Palliative Care-<br>**Count**: Special programs to address the palliative care needs of patients. These programs usually involve the formation of an expert team and go beyond the routine pain control efforts expected of all health care facilities.<br>**Do not count**: Routine pain control program. | |

## 2012 CBR-1 Form Instructions

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|---|---|---|---|---|
| 11; B, C, D | Cash and in-kind contributions to other community groups | Cash includes funds donated by the hospital, not funds donated by hospital employees. Includes funds and in-kind services donated to individuals or the community at large for health related activities that address a community need. In-kind donations include hours spent by the staff, overhead expenses of space donated to not-for-profit community groups, donation of food, equipment and supplies. | Financial and in-kind contributions- This category includes funds and in-kind services donated to individuals or the community at large. In-kind services include hours donated by staff to the community while on health care organization work time, overhead expenses of space donated to not-for-profit community groups (such as for meetings), and donation of food, equipment, and supplies.<br><br>Grants- These include contributions and/or matching funds provided as a community grant to not-for-profit community organizations, projects, and initiatives. **Count**: Program, operating, and education grants, Matching grants, Event sponsorship, General contributions to not-for-profit organizations or community groups. | Cash Donations- As a general rule, count donations to organizations and programs that are consistent with your organization's goals and mission. **Count**: Contributions and/or matching funds provided to not-for-profit community organizations, Contributions to charity events of not-for-profit organizations, after subtracting the market value of participation by the employees or organization, Contributions provided to individuals for emergency assistance, Scholarships to community members not specific to health care professions. **Do not count**: Employee-donated funds, Emergency funds provided to employees, Fees for sporting event tickets, Time spent at golf outings or other primarily recreational events.<br><br>In-Kind Donations- **Count**: Meeting room overhead and space for not-for-profit organizations and community, groups (such as coalitions, neighborhood associations, and social service networks), Equipment and medical supplies, Emergency medical care at a community event, Costs of coordinating community events not sponsored by the health care organization, such as March of Dimes Walk America. (Report health care organization-sponsored community events in line 13 "Community benefit operations.") Include, provision of facility parking vouchers for patients and families in need, employee costs associated with board and community involvement on work time, food donations, including Meals on Wheels subsidies and donations to food shelters, gifts to community organizations and community members (not employees), laundry services for community organizations, technical assistance, such as information technology, accounting, human resource, process support, planning, and marketing, technical assistance, such as information technology, accounting, human resource, process support, planning, and marketing. |

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| CBR-1 Line Item; Column | Field/Community Benefit Category | Instructions | Office for Oregon Health Policy & Research CBR-2 Version July 2008<br>Community Benefit Reporting Categories<br>(Adapted from CHA/VHA Community Benefit Categories) | |
|---|---|---|---|---|
| 12; B, C, D | Community building activities | Include programs that provide opportunities to address the root causes of health problems (e.g. poverty, environmental problems and homelessness). Activities include Physical Improvements/Housing, Economic Development, Community Support, Environmental Improvements, Leadership Training for Community, Coalition Building, Community Health Improvement Advocacy, Workforce development. | Community building activities- include programs that, while not directly related to health care, provide opportunities to address the root causes of health problems, such as poverty, homelessness, and environmental problems. These activities support community assets by offering the expertise and resources of the health care organization. Costs for these activities include cash, in-kind donations, and budgeted expenditures for the development of a variety of community health programs and partnerships. When funds or in-kind donations are given directly to another organization, report in line 11 "Cash and in-kind contributions." Remember to subtract any subsidies or grant amounts from total expenses incurred in this category.<br><br>Physical Improvements and Housing- **Count**: Community gardens, Neighborhood improvement and revitalization projects, Public works, lighting, tree planting, and graffiti removal, Housing rehabilitation, contributions to community-based assisted living, and senior and low-income housing projects, Habitat for Humanity activities, Smoke detector installation programs.<br>**Do not count**: Housing costs for employees, Projects having their own community benefit reporting process (e.g., a senior housing program that issues a community benefit report), Health facility construction and improvements, such as a meditation garden or parking lot.<br><br>Economic Development - **Count**: Small business development, Participation in an economic development council or chamber of commerce.<br>**Do not count**: Routine financial investments | **Do not count**: Employee costs associated with board and community involvement when these are done on an employee's own time and he or she is not engaged on behalf of his or her organization, Volunteer hours provided by hospital employees on their own time for community events (These hours belong to the volunteer, not to the health care organization.), Promotional and marketing costs concerning the health care organization's services and programs, Salary expenses paid to employees deployed on military services or jury duty (These expenses are considered employee benefit.).<br>Cost of Fundraising for Community Programs- **Count**: Grant writing and other fundraising costs specific to community programs and resource development assistance not captured under line 13, community benefit operations.<br><br>Community Support- This includes efforts to enhance the operational structures of the community and community networks, such as neighborhood watch groups and child care cooperatives. Activities include both community based initiatives and facility based initiatives.<br>**Count**: Child care for community residents with qualified need, Mentoring programs, Neighborhood systems, such as watch groups, Youth asset development or America's Promise initiatives, including support of these programs' principles, such as Safe Places, Healthy Start, Marketable Skills, and Opportunities to Serve, Disaster readiness over and above licensure requirements. Be careful not to double-count with in-kind donations. Include costs associated with: Changes made to accommodate prospective disasters, including costs associated with lockdown capability, enhanced security measures, package handling, air machines and filters, water purification equipment, expanded mortuary facilities, facilities for personnel quarantine, expanded patient isolation facilities, shower facilities, and storage space for stockpiles, Creating new or refurbishing existing decontamination facilities. This could include water supply communications facility and equipment costs or equipment changes to ensure interoperability of communications systems. (Include depreciation expenses). |
| 13; B, C, D | Community benefit operations | Include costs associated with assigned staff and community health needs assessment, staff costs to coordinate community benefit volunteer programs, costs associated with developing a community benefit plan and reporting community benefit, cost of community benefit tracking software. Do not count costs of market share assessment and marketing surveys. | Community benefit operations- include costs associated with dedicated staff and community health needs and/or assets assessment, as well as other costs associated with community benefit strategy and operations.<br><br>Dedicated Staff- **Count**: Staff costs for managing or overseeing community benefit program activities that are not included in other categories of community services, Staff costs to coordinate community benefit volunteer programs.<br>**Do not count**: Staff time to coordinate in-house volunteer programs, including outpatient volunteer programs. Volunteer time of individuals for community benefit volunteer programs. | Community Health Needs/Health Assets Assessment - **Count**: Community health needs assessment, Community assessments, such as a youth asset survey.<br>Do not count: Costs of a market share assessment and marketing survey process, Economic impact survey costs or results.<br><br>Other Resources- **Count**: Cost of fundraising for hospital-sponsored community benefit programs, including, grant writing and other fundraising costs, 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 exclusive of fundraising.<br>**Do not count**: Recognition or awards for volunteer staff, Grant writing and other fundraising costs of hospital projects (such as capital funding of buildings and equipment) that are not hospital community benefit programs. |
| 7-13; E | Description of activities | For Other Benefits provided to the community on lines 7-13, provide a BRIEF description of the significant activities or programs that are included in each community benefit category. | | |

**2012 CBR-1 Worksheets**
**Hospital Name: Community Hospital**
**Fiscal Year:**

# RCC Worksheet

## Patient Care Ratio of Cost-to-Charges Calculation

| | | Amount | Sample |
|---|---|---|---|
| **Patient Care Cost** | | | |
| 1. Total operating expense | 1 | 28,442,337 | 95,000,000 |
| **Less: Adjustments** | | | |
| 2. Bad debt expense (if included in total operating expense above) | 2 | 1,841,464 | 2,500,000 |
| 3. Non-patient care activities | 3 | 0 | 7,900,000 |
| 4. Medicaid provider taxes | 4 | 172,346 | 1,000,000 |
| 5. Other community benefit expense counted separately on CBR-1, such as community health improvement or community building expenses (except for subsidized health services, see CBR-1 Form Line by Line Instructions) | 5 | 0 | 950,000 |
| 6. Total adjustments (add lines 2-5) | 6 | 2,013,810 | 12,350,000 |
| **7. Adjusted patient care cost (subtract line 6 from line 1)** | 7 | 26,428,527 | 82,650,000 |
| **Patient Care Charges** | | | |
| 8. Gross patient charges | 8 | 49,844,409 | 170,000,000 |
| **Less: Adjustments** | | | |
| 9. Gross charges for community benefit programs (except for subsidized health services, as in line 5 above) | 9 | 0 | 50,000 |
| 10. Adjusted patient care charges (subtract line 9 from line 8) | 10 | 49,844,409 | 169,950,000 |
| **11. Ratio of patient care cost to charges (divide line 7 by line 10; use this percentage on Charity Care, Medicaid, and Medicare cost worksheets)** | 11 | 53.0% | 48.6% |

**2012 CBR-1 Worksheets**
**Hospital Name: Community Hospital**
**Fiscal Year:**

# Charity Care Worksheet

## Calculation of Charity Care at Cost

| | | Amount | Sample |
|---|---|---|---|
| **Gross patient charges** | | | |
| 1. Amount of gross patient charges written off as charity care | 1 | 1,539,527 | 4,500,000 |
| **Total community benefit expense** | | | |
| 2. Ratio of patient care cost to charges (from RCC Worksheet, if used) | 2 | 53.0% | 48.6% |
| 3. Estimated cost (multiply line 1 by line 2, or obtain from cost accounting system) | 3 | 816,289 | 2,188,438 |
| **4. Total community benefit expense (line 3 above; enter on CBR-1, line1, column B)** | 4 | **816,289** | **2,188,438** |
| **Direct offsetting revenue** | | | |
| **5. Revenues from uncompensated care pools or programs, if any (enter on CBR-1, line 1, column C)** | 5 | | **0** |
| **6. Net community benefit expense (subtract line 5 from 4; enter result on CBR-1, line 1, column D)** | 6 | **816,289** | **2,188,438** |

Note: If line 6 above is negative (indicating a gain), do not enter results from lines 4, 5, or 6 on Form CBR-1, as gains are not reportable

**2012 CBR-1 Worksheets**
**Hospital Name: Community Hospital**
**Fiscal Year:**

# Medicaid Worksheet

## Calculation of Unreimbursed Costs of Medicaid Programs

| | | Amount | Sample |
|---|---|---|---|
| **Gross patient charges** | | | |
| 1. Gross patient charges from Medicaid programs, including managed Medicaid | 1 | 7,784,757 | 23,000,000 |
| **Total Community Benefit Expense** | | | |
| 2. Ratio of patient cost to charges (from RCC Worksheet, if used) | 2 | 53.0% | 48.6% |
| 3. Cost (multiply line 1 by line 2, or obtain from cost accounting system) | 3 | 4,127,638 | 11,185,349 |
| 4. Medicaid provider taxes | 4 | 172,346 | 1,000,000 |
| **5. Total community benefit expense (add lines 3 and 4; enter result on CBR-1, line 2, column B** | 5 | **4,299,984** | **12,185,349** |
| **Direct Offsetting Revenue** | | | |
| 6. Net patient service revenue from Medicaid programs, including managed Medicaid | 6 | 4,472,346 | 7,000,000 |
| 7. Other revenue (such as Medicaid provider tax reimbursement, if not included on line 6) | 7 | | 1,000,000 |
| **8. Total direct offsetting revenue (add lines 6 and 7; enter result on CBR-1, line 2, column C)** | 8 | **4,472,346** | **8,000,000** |
| **9. Net community benefit expense (subtract line 8 from line 5; enter result on CBR-1, line 2, column D)** | 9 | **-172,362** | **4,185,349** |

Note: If line 9 above is negative (indicating a gain), do not enter results from lines 5, 8, or 9 on Form CBR-1, as gains are not reportable

**2012 CBR-1 Worksheets**
**Hospital Name: Community Hospital**
**Fiscal Year:**

# Medicare Worksheet

## Calculation of Unreimbursed Costs of Medicare Programs

| | | Amount | Sample |
|---|---|---|---|
| **Gross patient charges** | | | |
| 1. Gross patient charges from Medicare programs, including managed Medicare | 1 | | 83,000,000 |
| **Total Community Benefit Expense** | | | |
| 2. Ratio of patient cost to charges (from RCC Worksheet, if used) | 2 | 53.0% | 48.6% |
| 3. Cost (multiply line 1 by line 2, or obtain from cost accounting system) | 3 | 0 | 40,364,519 |
| 4. Direct GME costs (if included in Health Professions Education on CBR-1, line 24); enter as positive amount | 4 | | 500,000 |
| **5. Total community benefit expense (subtract line 4 from line 3; enter result on CBR-1, line 3, column B)** | 5 | **0** | **39,864,519** |
| **Direct Offsetting Revenue** | | | |
| 6. Net patient service revenue from Medicare programs, including managed Medicare | 6 | | 30,000,000 |
| 7. Medicare GME net revenue/reimbursement (if included in line 6); enter as a **negative** amount | 7 | | -500,000 |
| 8. Other revenue | 8 | | 0 |
| **9. Total direct offsetting revenue (add lines 6 through 8; enter result on CBR-1, line 3, column C)** | 9 | **0** | **29,500,000** |
| **10. Net community benefit expense (subtract line 9 from line 5; enter result on CBR-1, line 3, column D)** | 10 | **0** | **10,364,519** |

Note: If line 10 above is negative (indicating a gain), do not enter results from lines 5, 9, or 10 on Form CBR-1, as gains are not reportable

## Optional Supplemental Information (adapted from IRS Schedule H, Sect. VI)

**Complete this section of the form by attaching additional documents addressing these questions. Please identify the question being addressed on any supplemental information provided.**

1. Describe how the organization assesses the health care needs of the communities it serves (Needs Assessment).

2. Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's charity care policy (financial assistance policy).

3. Describe the community the organization serves, taking into account the geographic area and the demographic constituents it serves.

4. Describe how the organization's community building activities promote the health of the communities the organization serves.

5. If the organization is part of an affiliated health system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.