Community Benefit Reporting Form Instructions
State of Oregon

Background

Most hospitals in Oregon are recognized as nonprofit institutions. To maintain their tax-exempt status, nonprofit hospitals are expected to provide measurable benefits to the communities they serve. Community benefits generally are defined as programs or activities that hospitals provide to meet community needs despite a low or negative financial return. Examples of community benefits include providing free or discounted care to persons living in poverty, conducting education or research to promote community health, or donating funds or services to community groups.

In 2007, HB 3290 established Oregon's community benefit reporting law in order to document the benefits that hospitals provide to their communities. The statute defines community benefit as a "program or activity that provides treatment or promotes health and healing in response to an identified community need." It further requires the Oregon Health Authority (OHA) to adopt a cost-based community benefit reporting program that is consistent with established national standards for hospital reporting of community benefits.

In cooperation with the Oregon Association of Hospitals and Health System's Community Benefit Technical Advisory Committee, OHA developed the Community Benefit Reporting (CBR) form. It was agreed that the reporting categories and instructions should align closely with standards developed by the Catholic Health Association (CHA).[1] By building upon HB 3290, its administrative rules, and CHA's guidelines, the following instructions are intended to provide further clarity on how to fill out Oregon's CBR form in order to assure accurate and consistent community benefit reporting across hospitals.

Filing Instructions

Each hospital has 240 days following the close of its fiscal year to file a CBR form with OHA's Office of Health Analytics. Health systems operating more than one hospital should file a separate CBR form for each Oregon hospital.

Copies of the CBR form may be obtained on OHA's hospital reporting website:
http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx

The CBR form consists of two parts. In Section 1, hospitals are required to document the costs of providing community benefits. In the optional Section 2, a hospital may offer supplemental information describing its community benefit programs.

Completed submissions should be emailed to OHA.HealthAnalyticsDataSubs@state.or.us.

If a hospital cannot complete a CBR within 240 days of the end of its fiscal year, it may request an extension by emailing OHA.HealthAnalyticsDataSubs@state.or.us. Extension requests should be submitted 30 days prior to the hospital's reporting deadline and include facts or reasons in support of the request and describe a clear timeline for remediating delays and submitting the CBR from. OHA management will review all

[1] For additional information on the Catholic Health Association and its community benefit reporting program, see www.chausa.org/communitybenefit.

requests for approval. Failure to submit the required community benefit information could result in a civil penalty up to $500 per day (Oregon Administrative Rules 409-023-0105).

Line by Line Instructions, Section 1: Costs

The following provides detailed instructions for hospitals filling out Oregon's CBR form (Section 1). As noted above, the instructions and reporting categories are largely based on standards developed by CHA.

It is important to note, however, that at the same time Oregon developed the CBR form, the Internal Revenue Service (IRS) developed a new Form 990, Schedule H for nonprofit hospitals to quantify community benefits as part of the annual federal tax exemption process. The Schedule H and its reporting categories are also largely based on CHA guidance. For clarity, shaded boxes throughout these directions describe where Oregon's community benefit reporting is different from the IRS' Schedule H.

Upon submittal, OHA staff review each CBR form to check for consistency with each hospital's audited financial statement and CBR forms from previous years. As a result, OHA staff may contact hospitals with questions regarding the CBR form prior to publishing the data on the state's website. Accordingly, hospitals reporting large changes in community benefit from one year to the next may want to include additional information in their filing for clarity. For example, if a hospital reports that charity care costs increased by 25 percent over the previous year, the hospital may include a statement clarifying the reason for such a large increase (for example, a change in the hospital's financial assistance policy).

HOSPITAL INFORMATION

Hospital Name

The reporting entity 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.

Please report the hospital name as the organization would like it to appear in OHA's published reports of community benefit data.

Comparison with Schedule H: Unlike Oregon's CBR form, hospital systems may not be required to submit a separate Schedule H for each hospital. Hospital systems that operate multiple hospitals under a single Employee Identification Number submit a consolidated Schedule H (with the exception of Part V).

Additionally, for-profit hospitals and tax-exempt District hospitals are not required to submit a Form 990, Schedule H. Oregon requires all hospitals to submit the CBR form.

Hospital System

If the hospital is part of a larger hospital system or healthcare organization, include the system's name here. If not, please write "none."

Reporting Period

The reporting period should correspond to the hospital's fiscal year. For example, "July 1, 2013 - June 30, 2014."

Contact Information

Please include the contact information for the person OHA should contact if we have questions about the information submitted.

CHARITY CARE AND PUBLIC PROGRAMS

All hospitals should report the costs of providing charity care and operating public programs when those costs exceed any payments, grants, donations, or other offsetting revenue hospitals received for those programs. In other words, hospitals should only report categories for which costs exceed revenue. For example, if the hospital's cost of providing Medicaid is less than the revenue received from Medicaid, then the hospital should leave the Medicaid rows blank.

Comparison with Schedule H: Hospitals report public programs on the Schedule H even if the programs do not result in a financial loss for the hospital.

Prior to 2012, the Schedule H did not include grant revenue as offsetting revenue. Beginning in 2013, however, the IRS requires hospitals to report restricted grants and contributions as offsetting revenue, while unrestricted grants remain excluded.

Patient Visits (Column A): 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.

Total Community Benefit Expense (Column B): Enter the total cost of providing those programs that generate a negative margin. A cost accounting system or cost-to-charge ratio (CCR) methodology may be used for establishing costs.

In quantifying Total Community Benefit Expense, care should be taken not to count the same costs in more than one community benefit category. For instance, if a CCR method is being used to calculate the cost of charity care, Medicaid, or Medicare, the cost of other community benefits on rows 7-13 (except for row 10 if the CCR is being used to quantify subsidized health services) should be removed from the total operating expenses included in calculating the CCR so as not to double count costs.

The CCR Worksheet provided on the next page may be used as a guide to calculate the hospital's CCR.

Direct Offsetting Revenue (Column C): Organizations should enter as direct offsetting revenue any reimbursement associated with the total community benefit costs. Offsetting revenue includes any payments, grants, or donations. The instructions for each individual line below provide more details about what should be included as offsetting revenue for each category.

Net Community Benefit Expense (Column D): This column should be the difference between Columns B and C. It should be a positive number. The Excel spreadsheet will calculate this value automatically.

CCR Worksheet
Patient Care Cost-to-Charge Ratio Calculation

		Amount
Patient Care Cost		
1. Total operating expense	1.	
Less: Adjustments		
2. Bad debt expense (if included in total operating expense above)	2.	
3. Non-patient care activities	3.	
4. Medicaid provider taxes	4.	
5. Other community benefit expenses counted separately on CBR, such as Community Health Improvement Services or Community Building Activities (except for Subsidized Health Services, if also calculated using CCR)	5.	
6. Total adjustments (add lines 2-5)	6.	
7. Adjusted patient care cost (subtract line 6 from line 1)	7.	
Patient Care Charges		
8. Gross patient charges	8.	
Less: Adjustments		
9. Gross charges for community benefit programs, if any (except for Subsidized Health Services, as in line 5 above)	9.	
10. Adjusted patient care charges (subtract line 9 from line 8)	10.	
11. Patient care cost-to-charge ratio (divide line 7 by line 10; use this percentage on Charity Care, Medicaid, and Medicare cost worksheets)	**11.**	

Charity Care at Cost (Row 1)

Charity care means free or discounted health services provided to persons who cannot afford to pay and who meet the eligibility criteria of the organization's financial assistance policy. Charity care is reported in terms of costs, not charges.

The Charity Care Worksheet on the next page provides a guide for calculating charity care using a CCR.

Count:

- The costs of providing free and discounted care to those who meet the eligibility criteria for the hospital's financial assistance policy.
- Expenses incurred by the provision of financial assistance.

Do Not Count:

- Bad debt, contractual allowances, quick-pay discounts, or discounts provided to all self-pay patients (i.e. those who do not qualify for the hospital's financial assistance policy).

- Payments to and reimbursement from Oregon's hospital provider tax program.[2] These should be included in Medicaid (row 2).

Charity Care Worksheet
Calculation of Charity Care at Cost

		Amount
Gross Patient Charges		
1. Amount of gross patient charges written off as charity care……	1.	
Total Community Benefit Expense		
2. Cost-to-charge ratio (from CCR Worksheet, if used)……	2.	
3. Estimated cost (multiply line 1 by line 2)……	3.	
4. Total community benefit expense (line 3 above; enter on CBR, row 1, column B)……	**4.**	
Direct Offsetting Revenue		
5. Revenue from uncompensated care pools or programs, if any (enter on CBR, row 1, column C)	**5.**	
6. Net community benefit expense (subtract line 5 from 4; enter result on CBR, row 1, column D)	**6.**	

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

Medicaid/Managed Medicaid Plans (Row 2)

Report the unpaid costs of Medicaid, the shortfall created when a facility receives payments that are less than the cost of caring for Medicaid beneficiaries.

The Medicaid worksheet on the next page provides a guide for calculating the unreimbursed cost of Medicaid. Direct offsetting revenue should include any revenues related to Medicaid, including patient payments, cost report settlements, lump sum adjustments, capitated payments, and Medicaid disproportionate share hospital (DSH) revenue. As shown in the Medicaid worksheet, payments to the Oregon hospital provider tax program should be counted as a Medicaid expense, while the hospital reimbursement adjustment (HRA) payment should be counted as Medicaid offsetting revenue.[2]

Count:

- Revenues and costs related to Medicaid and State Children's Health Insurance Programs (SCHIP).

[2]This is subject to change in 2014 with the planned implementation of the Hospital Access to Care Program (uncompensated care pool) and Hospital Transformation Performance Program. At this time, however, for hospital fiscal years ending through December 31, 2013, the provider tax program should be treated exclusively as a Medicaid program.

Medicaid Worksheet
Calculation of Unreimbursed Costs of Medicaid Programs

		Amount
Gross Patient Charges		
1. Gross patient charges from Medicaid programs, including managed Medicaid ……	1.	
Total Community Benefit Expense		
2. Cost-to-charge ratio (from CCR Worksheet, if used)……..	2.	
3. Cost (multiply line 1 by line 2, or obtain from cost accounting system)……	3.	
4. Medicaid provider taxes……..	4.	
5. **Total community benefit expense (add lines 3 and 4; enter result on CBR, row 2, column B)**	**5.**	
Direct Offsetting Revenue		
6. Net patient service revenue from Medicaid programs, including managed Medicaid……	6.	
7. Other revenue (such as Medicaid provider tax reimbursement, if not included on line 6)……	7.	
8. Total direct offsetting revenue (add lines 6 and 7; enter result on CBR, row 2, column C)……	**8.**	
9. Net community benefit expense (subtract line 8 from line 5; enter result on CBR, row 2, column D)…….	**9**.	

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

Medicare/Managed Medicare Plans (Row 3)

Report the unpaid costs of Medicare, the shortfall created when a facility receives payments that are less than the cost of caring for Medicare beneficiaries.

The Medicare worksheet on the next page provides a guide for calculating the unreimbursed cost of Medicare. Direct offsetting revenue should include, but is not limited to, patient payments, cost report settlements, lump sum adjustments, capitated payments, and indirect medical education payments.

Count:

- Revenues and costs related to Medicare.

Do Not Count:

- Direct Graduate Medical Education (GME) costs and reimbursements, which should be reported in the Health Professions Education category (row 9).

Comparison with Schedule H: Unreimbursed Medicare costs are reported in Part III of the Schedule H, but not included in the calculation of a hospital's total community benefits. Oregon's CBR form includes the unreimbursed cost of Medicare in a hospital's community benefits total.

Medicare Worksheet
Calculation of Unreimbursed Costs of Medicare Programs

		Amount
Gross Patient Charges		
1. Gross patient charges from Medicare programs, including managed Medicare ……	1.	
Total Community Benefit Expense		
2. Cost-to-charge ratio (from CCR Worksheet, if used)……..	2.	
3. Cost (multiply line 1 by line 2, or obtain from cost accounting system)……	3.	
4. Direct GME costs……	4.	
5. **Total community benefit expense (subtract line 4 from line 3; enter result on CBR, row 3, column B)…….**	**5.**	
Direct Offsetting Revenue		
6. Net patient service revenue from Medicare programs, including managed Medicare……	6.	
7. Medicare GME net revenue/reimbursement (if included in line 6); enter as a **negative** amount…	7.	
8. Other Revenue……	8.	
9. Total direct offsetting revenue (add lines 6 through 8; enter result on CBR, row 3, column C)…	**9.**	
10. Net community benefit expense (subtract line 9 from line 5; enter result on CBR, row 3, column D)……..	**10.**	

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

Other Public Programs (Row 4)

Report the unpaid costs of other public programs, the shortfall created when a facility receives payments that are less than the cost of caring for other public medical programs including Tricare, Champus, Veterans Health Administration, Indian Health Service, and other federal, state, or local programs.

Count:

- Revenues and costs related to other government medical programs not covered by Medicaid or Medicare.

Do Not Count:

- If the offsetting revenue exceeds the expense. In other words, if the result in Column D is negative, remove the amounts in Columns B and C to report nothing for Other Public Programs.
- Any amounts already included in Medicaid or Medicare totals.

Comparison with Schedule H: Schedule H only allows hospitals to include the unpaid costs of "means-tested government programs"—a health program for which eligibility depends on the recipient's income or asset level. As a result, several government programs eligible for inclusion on Oregon's CBR, like Veterans Health Administration and Indian Health Service, are not reported on the Schedule H because they are not means-tested programs.

What percentage of Charity Care represented a discount of 100%? (Row 6)

This percentage is the ratio of cumulative charges for patients who had the entire patient bill written off to all charity care and discounted charges.

OTHER BENEFITS

The Other Benefits section quantifies the **unreimbursed cost** of providing community benefits outside of charity care and government-sponsored medical programs. In reporting these community benefits, it is important to remember the general principles regarding community benefits:

Count:

- Programs that respond to an identified community need.
- Programs and activities directed to or including at-risk persons, such as underinsured and uninsured persons.
- Programs offered to the broad community designed to improve community health.

Do not count:

- Programs primarily designed for marketing or promotion purposes.
- Time spent by volunteers and employees on their own time.
- Routine or required care and services.

Community Health Improvement Services (Row 7)

These are activities that are carried out to improve community health based on an identified community need. These services do not generate inpatient or outpatient bills. They may involve a nominal patient fee or sliding scale fee.

For Encounters in Column A, 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.

Community Health Improvement Services are grouped into several categories:

1. 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 open to the community that goes beyond routine discharge planning.

- Telephone information services, such as medical and mental health service hotlines and poison control centers.
- Transportation programs for patients and families to enhance patient access to care.
- Assistance for enrollment in public programs, such as SCHIP and Medicaid.
- Personal response systems, such as Lifeline.

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.

2. 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.

Count:

- Costs to run support groups related to community need.

Do not count:

- Support given to patients and families in the course of their inpatient or outpatient encounter.
- Classes that are reimbursed or designed to attract paying or insured patients.

3. Self-Help Programs

These include wellness and health-promotion programs, such as those for smoking cessation, exercise, and weight loss.

Count:

- 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 your organization as an employee benefit.
- The use of facility space to hold meetings for community groups (Report in row 11, Cash and In-kind Contributions).

4. Community Health Education

This 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:

- 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, and health education lectures and workshops in response to community need (not primarily for marketing).
- Parish and congregational programs.
- 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.).
- School health-education programs (report school-based programs on health care careers and workforce enhancement efforts in row 12, Community Building Activities. Report school-based health services for students in this category).
- Web-based consumer health information.
- Worksite health education programs.

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.

5. Community-Based Clinical Services

These are health services and screenings provided on a one-time basis or as a special event in the community. These programs could include free clinics for medically underinsured and uninsured individuals. 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. To be considered community benefit, screenings should provide follow-up care as needed, including assistance for persons who are uninsured and underinsured.

Count:

- The hospital's costs (such as grants, staff time, equipment, overhead, labs and medication) of providing one-time or occasionally held clinics including blood pressure or cholesterol screening clinics, cardiology risk factor screening clinics, colon cancer screening clinics, dental care clinics, immunization clinics, primary care clinics, school physical clinics, stroke screening clinics, and mobile units that deliver primary care to underserved populations on an occasional or one-time basis.
- Offsetting revenue from other community partners.

Do not count:

- Clinics for which a fee is charged and a profit is realized.
- Permanent, ongoing programs and outpatient services. These should be reported in row 10, Subsidized Health Services.
- Screenings where referrals are made only to the health care organization or its physicians.
- Screenings provided primarily for public relations or marketing purposes.
- Volunteers' time.

Comparison with Schedule H: On the Schedule H, Community Health Improvement Services (row 7 on the CBR) and Community Benefit Operations (row 13 on the CBR) are combined as a single category.

Research (Row 8)

Include research costs for research that is made publically available and is consistent with community need. 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.

Grant funding should be accounted for as offsetting revenue. That is, the net community benefit expense for research is the difference between operating costs and external subsidies such as grants.

Count:

- Research development costs.
- Studies on therapeutic protocols.
- Evaluation of innovative treatments.
- Research papers prepared by staff for professional journals.
- Studies on health issues for vulnerable persons.
- Studies on community health, such as incidence rates of conditions for populations.
- Studies on innovative health care delivery models.
- Offsetting grant revenue.

Do not count:

- Research where findings are only used internally or for proprietary purposes.

Comparison with Schedule H: Beginning in 2013, hospitals must include restricted research grants as offsetting revenue on the Schedule H. Unrestricted grants, however, are not included as offsetting revenue on the Schedule H.

Health Professions Education (Row 9)

This category includes educational programs that are available to physicians, medical students, interns, residents, nurses and 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.

1. 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.

Count:

- The unpaid costs of a clinical setting for undergraduate training, internships, clerkships, and residencies.
- Continuing medical education (CME) offered to physicians outside of the medical staff on subjects for which the organization has special expertise.
- The offsetting revenue from government subsidies and tuition.

Do not count:

- Expenses for physician and medical student in-service training and orientation programs.
- Joint appointments with educational institutions and medical schools.
- Costs of CME restricted to members of the medical staff.

2. 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.

Do not count:

- Education required for 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 assistant training programs.

3. 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.

Do not count:

- Education required by staff, such as orientation and standard in-service programs.
- On-the-job training, such as pharmacy technician and nursing assistant programs.
- Staff time delivering care concurrent with job shadowing.

4. Scholarships/Funding for Health Professions Education

Count:

- Funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and health improvement.
- Scholarships or tuition payments for professional education or training to non-employees, volunteers, or community members.

- Specialty in-service and videoconferencing programs 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.

Subsidized Health Services (Row 10)

Subsidized health services are clinical service lines that are provided despite a financial loss because they meet an identified community need and it is reasonable to conclude that if the hospital no longer offers the service, then 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.

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. In other words, to be included the service should have a financial loss after removing losses associated with bad debt, charity care, Medicaid, Medicare, and other public programs.

Count:

- Clinical programs or service lines meeting a community need that the hospital subsidizes.
- The amount the health care organization subsidizes to provide these services.

Do not count:

- Charity care, bad debt, Medicaid shortfalls, and Medicare shortfalls.

Several services frequently qualify for Subsidized Health Services to the extent they are subsidized:

1. ***Emergency and Trauma Services***

Count:

- Air ambulance.
- Emergency department.
- Local community emergency medical technician (EMS) training.
- Trauma center.

Do not count:

- Payment for routine on-call physician services.

2. ***Neonatal Intensive Care***
3. ***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.

4. ***Burn Units***
5. ***Women's and Children's Services***

Count:

- Freestanding breast diagnostic centers.
- Newborn care.
- Obstetrical services.
- Pediatrics.
- Women's services.

Do not count:

- Services provided in order to attract physicians or health plans.

6. Renal Dialysis Services

7. Subsidized Continuing Care

Count:

- Hospice care.
- Home care services.
- Skilled nursing care or nursing home services.
- Senior day health programs.
- Durable medical equipment.

Do not count:

- Step-down or post-acute services provided in order to discharge outlier patients, to the financial advantage of the facility.

8. Behavioral Health Services

Count:

- Inpatient and outpatient behavioral health services.

9. Palliative Care

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.

Do not count:

- Routine pain control program.

Cash and In-Kind Contributions to Other Community Groups (Row 11)

This category includes funds and in-kind services donated to individuals or the community. In-kind services include hours donated by staff to the community while on work time, overhead expenses of space donated to not-for-profit community groups (such as for meetings), and donation of food, equipment, and supplies.

1. 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 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.

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.

2. Grants

These include contributions and matching funds provided as a community grant to not-for-profit community organizations, projects, and initiatives.

Count:

- Program, operating, and education grants.
- Matching grants.

Do not count:

- Grants passed through from a related organization.

3. 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.
- Employee costs associated with board and community involvement on work time.
- Food donations, including Meals on Wheels subsidies and donations to food shelters.
- Laundry services for community organizations.
- Technical assistance to community organizations, such as information technology, accounting, human resource support, process support, planning, and marketing.

Do not count:

- Employee costs associated with board and community involvement when these are done on an employee's own time.
- Volunteer hours provided by hospital employees on their own time for community events.

Community Building Activities (Row 12)

These are 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.

Activities include physical improvements and housing, economic development, community support, environmental improvements, leadership training for community members, coalition building, community health Improvement advocacy, and workforce development.

Remember to subtract any subsidies or grant amounts from total expenses incurred in this category.

Community Benefit Operations (Row 13)

This category includes the costs associated with staffing and coordinating the hospital's community benefit initiatives.

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.
- Staff costs for internal tracking and reporting of community benefit.
- Costs associated with developing community health needs assessment and strategic implementation plan.
- Fundraising or grant writing costs related to community benefit services and activities.

Do not count:

- Staff time to coordinate in-house volunteer programs.
- Market share analysis or marketing surveys.
- Grant writing or other fundraising costs for hospital programs that are not related to community benefit.

Comparison with Schedule H: On the Schedule H, Community Health Improvement Services (row 7 on the CBR) and Community Benefit Operations (row 13 on the CBR) are combined as a single category.

Instructions, Section 2: Supplemental Information

Section 2 of this form is **optional** pursuant to OAR 409-023-0105. 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.

The supplemental information questions are modeled after IRS Form 990, Schedule H, Section VI. The section is intended to provide hospitals on opportunity to provide more information on the community benefits quantified in Section 1.

The following questions appear in Section 2:

1. Describe how the organization assesses the health care needs of the communities it serves.
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 program or under the organization's charity care 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.