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A Guide for Planning & Reporting Community Benefit

2022 Edition

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Chapter Four: Accounting for Community Benefit

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Chapter Four: Accounting for Community Benefit

Standardized accounting of community benefit allows policymakers, regulators and the public to compare hospital community benefit efforts accurately and improves the acceptance of reported information.

Tax-exempt hospital organizations are being asked to become more transparent and accountable. Standardized community benefit accounting is important in achieving these goals.

Standardized accounting of community benefit allows policymakers, regulators and the public to perform an accurate comparison of hospital community benefit reports and enhances the acceptance of reported information. Standardized accounting also allows organizations to assess their community benefit activities over time and permits multi-hospital systems to aggregate and analyze information from their facilities more reliably.

In this chapter, you will learn:

- How to adopt standardized principles and practices to account for community benefit.
- How to account for and report community benefit.
- How these guidelines compare to IRS Form 990, Schedule H, reporting requirements.

Throughout this chapter, the terms "cost" and "expense" are used interchangeably. Definitions for a number of terms relevant to community benefit accounting and reporting are included at the end of this chapter.

EQUITY NOTE

- In community benefit reporting, call out programs that address disparities and promote equity.
- Reach out to racial and ethnic minority community members with information about financial assistance policies.
- Align community benefit budget decisions with equity goals.
- As part of the organization's investment strategy, include investments in community organizations that will improve social determinants of health and advance equity.

The chapter is organized into four sections:

In Section 4.1, *Introduction*, you will learn why standardized accounting and reporting is important.

In Section 4.2, *Adopt Standardized Principles and Practices to Account for Community Benefit,* you will learn how to do the following:

Community Benefit Cost Measurement Principles

Guideline 1: Measure actual financial cost, not opportunity cost.
Guideline 2: Account for total and net community benefit expenses.
Guideline 3: Account for indirect costs as well as direct costs.
Guideline 4: Use the organization's most accurate cost accounting methods.
Guideline 5: Split program costs between community benefit and other purposes if warranted.

Community Benefit Accounting Principles

Guideline 6: Avoid double-counting community benefit expenses.
Guideline 7: Follow generally accepted accounting principles unless IRS instructions override those principles.
Guideline 8: Report zero net community benefit expense to the IRS for any category in which offsetting revenue exceeds the total community benefit expense.
Guideline 9: Maintain an audit trail.

Community Benefit Reporting Principles

Guideline 10: Report consistent counts for "number of programs or activities" and for "number of persons served."
Guideline 11: Develop appropriate community benefit accounting and reporting strategies for related organizations.
Guideline 12: Disclose accounting methods in community benefit reports.
Guideline 13: Reconcile and report differences in community benefit reports.

In Section 4.3, *Account for and Report Community Benefit*, you will learn how to do the following:

Guideline 1: Establish an effective administrative and accounting process.
Guideline 2: Calculate the cost of community health improvement services.
Guideline 3: Calculate the cost of community benefit operations.
Guideline 4: Determine the cost of health professions education.
Guideline 5: Include the cost of research that provides community benefit.
Guideline 6: Quantify cash and in-kind contributions for community benefit.
Guideline 7: Measure the cost of community-building activities.
Guideline 8: Calculate the ratio of patient care cost to charges.
Guideline 9: Establish the cost of subsidized health services.
Guideline 10: Determine the cost of Medicaid and other means-tested government programs.
Guideline 11: Determine the cost of financial assistance.

In Section 4.4, *Align Reporting with IRS Form 990, Schedule H,* you will learn how to do the following:

Guideline 1: Review and understand how CHA's community benefit accounting guidelines supplement and vary from IRS requirements.
Guideline 2: Value Medicare consistent with Schedule H instructions.

This chapter also is supported by the two-part **Appendix D**:

- Part I includes updated worksheets for community benefit accounting and reporting.
- Part II provides additional discussion of two topics:
  1. Approaches to developing indirect cost factors.
  2. How related organizations can approach community benefit reporting.

Tax-exempt hospital organizations *must* follow IRS instructions for purposes of completing Form 990, Schedule H. This *Guide* is not a substitute for those instructions. This *Guide* helps explain the principles behind community benefit accounting and provides help in navigating the accounting and reporting process.

INTRODUCTION

SECTION 4.1

Why Standardized Accounting and Reporting is Important

Since 1989, when the *Social Accountability Budget* was published, CHA has encouraged hospital organizations to adopt standardized community benefit accounting and reporting principles. There are several reasons why standardization is important:

- Standardization improves the comparability of reported community benefit information across hospital organizations.
- Standardization provides consistent valuation of community benefit amounts through time — allowing organizations to reliably assess trends in their community benefit investments.
- Multi-entity hospital systems frequently consolidate their community benefit results. Several state and national hospital associations also prepare association-wide community benefit reports. Consolidated reports are unreliable unless all participating entities have followed standardized accounting methods.
- Accounting principles that are standardized and well understood improve the reliability and acceptance of reported numbers — for both internal and external stakeholders.
- Standardization also facilitates staff education and training regarding the community benefit accounting and reporting process.

In 2007, the IRS released a redesigned Form 990, the annual information return filed by all tax-exempt entities. The redesigned form included a new Schedule H, which must be filed by all 501(c)(3) organizations that operate one or more hospitals. This form has been updated in subsequent years.

The community benefit accounting methods in Schedule H will be familiar to those who have followed past editions of this *Guide*, as Schedule H is derived from CHA's accounting framework. Schedule H requires hospital organizations to follow a common set of instructions for reporting the dollar value of the community benefits they provide. The incorporation of community benefit reporting into Schedule H thus also promotes standardization.

SECTION 4.2

ADOPT STANDARDIZED PRINCIPLES AND PRACTICES TO ACCOUNT FOR COMMUNITY BENEFIT

The following principles underlie the community benefit accounting framework.

Community benefit cost measurement principles

Guideline 1
Measure the actual financial cost borne by the organization, not the opportunity cost

The financial value of community benefit is measured and reported on the basis of actual cost. Community benefit accounting measures the auditable financial cost of activities and programs, not "opportunity costs." Opportunity costs, based on value or forgone revenue, are theoretical and not treated as actual cost in financial statements.

Examples of how the costs of community benefit activities are determined differently under the two approaches can be seen in the following table.

ACTIVITY	OPPORTUNITY COST (DO NOT REPORT)	ACTUAL FINANCIAL COST (REPORT)
Space provided to a community group	Market rate the community group would pay at a local hotel	Actual cost of the space (building depreciation, utilities, security) while in use by the community group
Financial assistance	"Gross charges" that could have been collected if financial assistance had not been granted	Patient care cost associated with the charges written off to financial assistance
Parking vouchers given by the hospital to low-income patients	Face value of the parking vouchers given to low-income patients	Actual cost of the parking garage per space while in use

Why are the actual financial costs used? Because they represent the amounts that the organization actually spends on community benefit. These costs are objective, auditable and less subject to judgment. They also are easily found and quantified in a hospital's general ledger (e.g., the remaining book value on a piece of equipment donated to a community clinic), a cost accounting system or cost report. This guideline is important to assuring that both the numerator (Net Community Benefit Expense) and the denominator (Total Expense) are determined based on the same accounting principles.

Community benefit accounting reports do not measure the *value* of community benefit programs. For example, an evaluation may show that an immunization program for low-income children substantially reduces health spending; however, community benefit accounting includes only the cost of the program itself. Reductions in spending and improvements in health achieved by the community benefit programs can be highlighted in the narrative that accompanies the community benefit report.

CAPITAL EXPENDITURES

Note that capital "expenditures" are not reportable as "expense" all in one year. Capital expenditures (e.g., amounts spent to construct or renovate a clinic building that houses a community benefit program) are not reported as community benefit expense or in total operating expense all at once in the year the expenditure is made. Under GAAP, a capital expenditure is expensed (reported as depreciation expense) over the years that the asset has a useful life (e.g., over five, seven or 30 years depending on the asset). Example:

- In 2012, a hospital spends $1 million to renovate a clinic building that houses a community benefit program. The full $1 million is not reported as "expense" in the hospital's financial statements for 2012, nor is the full amount reportable as community benefit expense in that year.
- According to the accounting records, the remaining "useful life" of the clinic building is 10 years.
- The hospital thus would record $100,000 annually ($1 million divided by 10 years) as depreciation expense and thus would spread the cost associated with the $1 million expenditure over the 10 years it provides use.
- The full $100,000 would be reportable as community benefit expense each year, if 100 percent of the building continues to be used exclusively to house a community benefit program. If only a portion of the building is used for a community benefit purpose, then a relevant proportion of the $100,000 amount would be reportable during each of the 10 years.

If, at some point, the building no longer is used for community benefit, then the organization no longer would report the depreciation expense as community benefit.

Guideline 2
Account for total and net community benefit expenses

Community benefit accounting establishes both the *total* amount organizations spend in providing community benefit and the *net* community benefit expense associated with each activity. The two categories of community benefit expense can help answer two different questions:

1. What amount and proportion of the organization's total expenses are devoted to community benefit programs?
2. How much of the organization's total community benefit expense is being funded by its own surplus?

The IRS provides the following definitions of these terms in the Schedule H instructions.

IRS NOTE

IRS

From the Schedule H instructions:

"Total community benefit expense" means the total gross expense of the activity incurred during the year. "Total community benefit expense" includes both "direct costs" and "indirect costs."

"Direct costs" means salaries and benefits, supplies, and other expenses directly related to the actual conduct of each activity or program. "Indirect costs" means costs that are shared by multiple activities or programs, such as facilities and administrative costs related to the organization's infrastructure.

"Direct offsetting revenue" means revenue from the activity during the year that offsets the total community benefit expense of that activity. "Direct offsetting revenue" includes any revenue generated by the activity or program, such as reimbursement for services provided to program patients.

"Direct offsetting revenue" also includes restricted grants or contributions that the organization uses to provide a community benefit, such as a restricted grant to provide financial assistance or fund research. "Direct offsetting revenue" does not include unrestricted grants or contributions that the organization uses to provide a community benefit.

"Net community benefit expense" is calculated by subtracting "direct offsetting revenue" from "total community benefit expense."

Use the categories and data elements shown in the following table to report quantifiable community benefits for persons living in poverty and for the broader community.

	Number of Programs or Activities	Persons Served	Total Community Benefit (CB) Expense	Total CB as Percent of Total Expense	Direct Offsetting Revenue	Net CB Expense	Net as Percent of Total Expense
BENEFITS FOR PERSONS LIVING IN POVERTY							
Financial assistance at cost							
Means-tested public programs • Medicaid • Other indigent programs							
Community health improvement services							
Health professions education							
Subsidized health services							
Cash and in-kind contributions for community benefit							
Community-building activities							
Total quantifiable community benefits for persons living in poverty							
(continued)							

	Number of Programs or Activities	Persons Served	Total Community Benefit (CB) Expense	Total CB as Percent of Total Expense	Direct Offsetting Revenue	Net CB Expense	Net as Percent of Total Expense
BENEFITS FOR THE BROADER COMMUNITY							
Community health improvement services							
Health professions education							
Subsidized health services							
Research funded by tax-exempt or government sources[1]							
Cash and in-kind contributions for community benefit							
Community-building activities[2]							
Community benefit operations							
Total quantifiable community benefits for the broader community							
TOTAL QUANTIFIABLE COMMUNITY BENEFITS							

[1] The tax-exempt organization can include the cost of internally funded (not donor restricted) research it conducts as long as the results of the research are made publicly available. Not to be included in Part I, Line 7 of Schedule H unless instructions change.

[2] To be reported in Part II of Schedule H.

Notes: Completing the columns for "Number of Programs or Activities" and for "Persons Served" is optional on Schedule H. The column "Total CB as Percent of Total Expense" is not included on Schedule H.

Guideline 3
Account for indirect costs as well as direct costs

Both direct costs and reasonable indirect (or "overhead") costs should be included in the accounting for each type of community benefit. The IRS supports this view.

IRS

IRS NOTE

From the Schedule H instructions:

"Total community benefit expense" includes both "direct costs" and "indirect costs."

"Direct costs" means salaries and benefits, supplies, and other expenses directly related to the actual conduct of each activity or program.

"Indirect costs" means costs that are shared by multiple activities or programs, such as facilities and administration costs related to the organization's infrastructure (space, utilities, custodial services, security, information systems, administration, materials management, and others).

Direct costs typically are *directly assigned* to each unique community benefit activity. Because indirect costs typically are shared, they need to be *allocated* across multiple activities or programs. The statistics used to allocate indirect costs vary, depending on the type of indirect cost involved. For example, building depreciation expense can be allocated based on the square footage occupied by each program, while the cost of a hospital business office can be allocated based on patient revenue.

Cost accounting systems allocate indirect costs to programs based on sophisticated techniques. In the absence of a cost accounting system, indirect cost factors can be derived from the Medicare Cost Report or from values provided by the finance department. These factors are applied to direct costs as follows.

The indirect cost factor typically is expressed as a percentage:

(Total Indirect and Direct Costs)/Direct Costs – 1 = Indirect Cost Factor

The factor then is applied as follows:

Direct Costs × (1 + Indirect Cost Factor) = Total Community Benefit Expense

See Appendix D for additional information and examples on how organizations can develop indirect cost rates for community benefit programs.

CHA recommends having at least two indirect cost rates for community health improvement services and for community-building activities – one rate for "hospital-based" programs and a second, lower rate for programs that are "community-based." One program might be housed in hospital space (thus absorbing utilities, maintenance, and other costs) and for that program a higher, "hospital-based" rate would be appropriate. Another program might be based in a non-hospital community setting and rely much less on the hospital for support and administrative services, and a lower "community-based" rate would apply.

Whatever indirect cost rates are used, they should be reasonable and supportable.

Guideline 4
Use the organization's most accurate cost accounting methods

Community benefit accounting requires assigning costs to individual programs and to services provided to specific patient groups (e.g., Medicaid recipients).

Organizations have several options for how costs are determined, including using cost accounting systems (if available), applying a cost-to-charge ratio (*see Section 4.3, Guideline 8, on how to calculate a cost-to-charge ratio*) to relevant charges or using program cost reports (e.g., the Medicaid Cost Report). Each of these options has strengths and weaknesses:

- Cost accounting systems generally provide the most accurate portrayal of the true cost of community benefit activities if the systems have been kept up to date; however, not all organizations have these systems in place.
- Overall cost-to-charge ratios are comparatively simple to calculate but can be inaccurate when they are applied to small product lines or programs.
- Medicaid and Medicare Cost Reports exclude certain costs as "non-allowable" and thus typically understate the full cost of services provided.

CHA encourages organizations to use their most accurate cost accounting method for community benefit. The IRS adopted this principle in the Schedule H instructions.

IRS

IRS NOTE

From the Schedule H instructions, regarding Part I, Line 7:

Use the organization's most accurate costing methodology (cost accounting system, cost-to-charge ratio, or other) to calculate the amounts reported on the table.

Many organizations use a blend of the above approaches to obtain the most accurate values, such as cost accounting systems for Medicaid shortfalls and subsidized health services and a cost-to-charge ratio to determine the cost of financial assistance.

Guideline 5
Split program costs between community benefit and other purposes, if warranted

Some programs and activities serve dual purposes: They provide both community benefit and organizational benefit. While organizations should use caution in this area, it is appropriate to split program costs between community benefit and other purposes (e.g., marketing) if you can document that the program **primarily** serves a community benefit purpose.

IRS

IRS NOTE

From the Schedule H instructions:

Activities or programs may not be reported if they are provided primarily for marketing purposes and the program is more beneficial to the organization than to the community. For example, if the activity or program 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).

For example, a hospital provides a cash donation to help build an athletic field in a low-income neighborhood. The hospital's recent CHNA identified obesity among children and adults as a high-priority health need, and through conversations with community groups, the hospital found that there were no places for residents to exercise or play sports. While the primary purpose of the athletic field is to meet a community benefit need, the hospital will have its name displayed on a small sign as a donor so there is a slight marketing benefit. The hospital reports the donation amount in the "cash and in-kind donation" category and subtracts the actual costs of marketing, such as the sign.

Community benefit accounting principles

Guideline 6
Avoid double-counting community benefit expenses

Community benefit costs may not be double-counted. For example:

- If a hospital accounts for the cost of research in full as a discrete community benefit program, yet does not adjust research costs out of the numerator of the "ratio of patient care cost to charges" applied to financial assistance and subsidized health services, a portion of research costs would be counted twice.
- Double-counting also occurs if a hospital reports financial assistance costs or Medicaid shortfalls in full but then includes Medicaid and financial assistance losses again when accounting for the cost of subsidized health services.

The "ratio of patient care cost to charges" in this *Guide* includes adjustments designed to prevent double-counting community benefit expenses. Accounting guidelines for valuing subsidized health services also adjust for double-counting by subtracting financial assistance, Medicaid and bad debt from the total revenues and costs of each qualifying program.

Organizations that rely on a cost accounting system to determine the cost of various community benefit categories (e.g., Medicaid or subsidized health services) should use care to avoid double-counting. For example, a cost accounting system may allocate the cost of health professions education programs to Medicaid; however, health professions education costs are reported in full on another line in community benefit reports. Adjustments to amounts allocated by cost accounting systems may be needed to avoid double-counting.

Guideline 7
Follow generally accepted accounting principles (GAAP) unless IRS instructions override those principles

As much as possible, community benefit accounting should follow the same rules as the GAAP that guide preparation of financial statements. This makes it easier for accounting and finance professionals to support their community benefit program colleagues and also promotes standardization.

Community benefit accounting in Schedule H varies from GAAP in notable ways:

- First, "total expense" on Schedule H (used to calculate community benefit as a percent of expense) is to come from the IRS Form 990 and not from the organization's audited financial statements (prepared using GAAP). "Total expense" also must include relevant proportions of the total expense of joint ventures in which the organization maintains an ownership interest.
- Second, community benefit activities provided by joint ventures must be included based on the "proportionality rule" rather than following GAAP (which indicates using the "equity method" of accounting if ownership interests are below 50 percent).

Additionally, Schedule H requires community benefit to be reported on an "EIN-by-EIN" basis (aggregating results for hospitals and any other activities that operate under the same federal employer identification number [EIN]). On Schedule H, community benefits are reported for the entire organization (EIN), not only the hospital facility. This means that Schedule H results may not match system-wide or some individual hospital community benefit reports that do not follow the EIN approach.

CHA recommends following the Schedule H instructions for measuring community benefits provided by joint ventures but also recommends the following refinements:

- It should be noted that the IRS requires "total expense" to be derived from the IRS Form 990. "Total expense" reported on IRS Form 990 is different from total expense reported based on GAAP — even after subtracting bad debt expense. Organizations may decide to derive "total expense" from GAAP-prepared financial statements for their annual community benefit reports or for reporting interim (or stub) period results. Organizations should disclose how "total expense" was determined in community benefit reports.

Guideline 8

Report zero net community benefit expense to the IRS for any category in which offsetting revenue exceeds the total community benefit expense.

If offsetting revenue exceeds the total community benefit expense (e.g., if Medicaid net patient service revenue exceeds the cost associated with treating Medicaid patients), the result is a gain — or a negative net community benefit expense.

The IRS instructs filers not to report negative numbers in Schedule H, Part I, column (e) ("Net community benefit expense") or in column (f) ("Percent of total expense"); instead, negative net community benefit expense is to be reported as zero in column (e). Likewise, a negative percent of total expense is to be reported as zero.

The IRS has not yet provided instructions as to whether hospitals should exclude or include any gains for a particular community benefit category when calculating and reporting total net community benefit expense. For example, if a hospital's direct offsetting revenue for Medicaid ($20 million) exceeds its Medicaid expense ($18 million) for a particular year, resulting in zero net community benefit expense for Medicaid being reported on Schedule H, Part I, line 7b, column (e), it's not clear whether the hospital should subtract that $2 million gain from any gross community benefit expense in calculating and reporting its net community benefit expense for financial assistance and means-tested government programs (reported on Schedule H, Part I, line 7d, column (e)) or whether it should disregard that $2 million gain.

CHA recommends continuing to prepare community benefit reports based on the guidelines throughout this chapter. However, when reporting to the IRS, any negative numbers for net community benefit expense (and net community benefit expense as a percent of total expense) should be reported as zero. CHA recommends that, to maximize transparency in the community benefit report, any gains should be carried into overall totals (lines 7d and 7j of the community benefit table) so that the total net community benefit expenses reported in column (e) for lines 7d and 7j should be calculated by subtracting the direct offsetting revenue in column (d) from the total (gross) community benefit expense in column (c), rather than adding the totals in lines 7a–c and 7e–i. However, because the IRS has not provided specific instructions regarding this issue, hospitals with negative net community benefit expense in any community benefit category should use their best judgment when calculating and reporting totals and use the same methodology consistently in its Schedule H, Part I, community benefit reporting.

If gains result from extraordinary events, such as the receipt of substantial prior-year revenue (e.g., from a Medicaid Cost Report settlement), these circumstances should be explained in the Schedule H, Part VI, narrative section so readers understand the basis for reported community benefit amounts.

Guideline 9
Maintain an audit trail

Organizations are encouraged to maintain an audit trail for reported community benefit information so internal staff and external reviewers can understand the basis for reported information. An audit trail can be maintained using worksheets, such as those included in this Guide and in the Schedule H instructions, and supporting work papers and community benefit software, such as the Community Benefit Inventory for Social Accountability, and values should reconcile with the organization's general ledger.

Guideline 10
Report consistent counts for "number of programs or activities" and for "number of persons served"

The Summary of Quantifiable Community Benefits table (Appendix D, Worksheet A) includes columns in which organizations can report the number of community benefit programs or activities they provide and also the number of persons served. Schedule H also includes these columns, but reporting these values on Schedule H is optional. The Schedule H instructions define "persons served" as the number of patient contacts or encounters in accordance with the hospital's records.

To improve standardization and assist organizations with reporting these statistics, the table on the following page recommends metrics that organizations can use if they choose to report these counts.

COMMUNITY BENEFIT	NUMBER OF PROGRAMS OR ACTIVITIES	NUMBER OF PERSONS SERVED
Financial Assistance	One for each hospital or facility	Number of inpatient and outpatient accounts
Medicaid	One for each state Medicaid program (whether fee-for-service or managed care) in which each hospital or facility participates	Number of inpatient and outpatient accounts
Other Means-Tested Government Programs	One for each means-tested government program	Number of inpatient and outpatient accounts
Community Health Improvement Services	One for each discrete program A "program" has the following characteristics: same target audience, same purpose, same approach (including an activity with multiple facets)	Options: • Number of attendees at each program event • Number of registrants or enrollees in ongoing programs For broad community and public education programs, "one" unless there is a response mechanism to gauge actual attendance
Community Benefit Operations	Usually "one" for each dedicated community benefit department	N/A
Community Building	One for each discrete program	When program is for individuals, use enrollment, attendance or encounters; when program is for overall community, use "one" unless there is a mechanism to indicate how many benefited

COMMUNITY BENEFIT (*continued*)	NUMBER OF PROGRAMS OR ACTIVITIES (*continued*)	NUMBER OF PERSONS SERVED (*continued*)
Subsidized Health Services	One for each qualifying program or service	Number of inpatient and outpatient accounts (for each hospital and facility, including appropriate proportions of joint ventures)
Health Professions Education	One for each separately accredited education program (e.g., family practice residency, radiology technician program), one for each continuing medical education program open to the public and one for each scholarship program	Number of students Number of attendees at approved continuing medical education programs Number of persons receiving scholarships
Research	One for each qualifying research study or investigation	N/A or, alternatively, the number of subjects in the study
Contributions for Community Benefit	One for each grant made by the organization	N/A

Organizations that are part owners of one or more joint ventures can include each community benefit program provided by the joint venture as a "one" and then also include a proportion of each joint venture's "number of persons served." The proportion should be based on the organization's ownership interest in each venture.

Guideline 11
Develop appropriate community benefit accounting and reporting strategies for related organizations

Some organizations operate multiple entities within the same EIN, including hospitals, one or more foundations, wholly owned taxable corporations, and joint ventures. Many include operations for a single hospital only. These differences in corporate structure can make comparing one Schedule H to another a challenge.

Hospital organizations also can be affiliated with other entities that provide community benefit (e.g., community clinics, medical schools, faculty practice plans, research institutes and Graduate Medical Education consortia). These corporate structures can be complex and create issues when reporting community benefit — both on Schedule H and elsewhere.

The following principles are offered to support appropriate community benefit accounting and reporting:

- Each tax-exempt organization that has an ownership interest in one or more joint ventures should report community benefit, bad debt, Medicare and other values from those entities based on the "proportionality rule." However (pursuant to IRS instructions), if the organization makes a grant to be used for community benefit to a joint venture in which it has an ownership interest, it should not include the organization's proportionate share of the amount spent by the joint venture on such activities to avoid double-counting.
- As a general goal, it is appropriate to ensure that the hospital organization (the EIN that files a Schedule H) is able to report as much of the community benefit provided by the organization and its affiliates as possible. For example, if a hospital pays a management fee that helps to support a system office community benefit department, the hospital can report an appropriate portion of the management fee as a community benefit expense. In these circumstances, documentation is necessary to show that such amounts were actually used for community benefit purposes. If the hospital has a separate, related foundation that files its own Form 990, contributions for community benefit can be made by the hospital organization rather than by the foundation. The foundation can provide unrestricted funds to the hospital for this purpose.

- If a hospital operates a foundation under the same EIN, transfers of funds from the foundation to the hospital for community benefit activities will not be separately reported as community benefit expense because they are "intra-company" transfers. When the organization then spends the funds to support community benefit activities, it can report the expense on its Schedule H as community benefit, with no offsetting revenue unless the funds are restricted when received by the foundation.
- When the hospital and foundation exist in separate but related organizations, each with its own EIN, grants or transfers of funds from the foundation to the hospital that are restricted to being used for community benefit activities will be separately reported by the hospital organization in "direct offsetting revenue." The foundation then will report such grants to the hospital as an expense on its core Form 990 and the hospital will report the receipt of the funds as grant revenue on its core Form 990. When the hospital uses such funds to support community benefit activities, it will report the total community benefit expense on its Schedule H and would report the amount of the grants used during the period for these expenses as direct offsetting revenue.

Guideline 12
Disclose accounting methods in community benefit reports

Organizations also are encouraged to include footnotes (or endnotes) in their published community benefit reports that summarize the accounting methods used to prepare the report. Notes can indicate, for example, whether the report was prepared based on these CHA guidelines or whether exceptions were made. This is so readers of the information understand how reported amounts were determined. The IRS requires similar disclosures in Part VI of Schedule H.

CHA also encourages organizations to include information about financial assistance policies and the CHNAs they have conducted in published community benefit reports. These reports provide another opportunity to "widely publicize" the financial assistance policy and the CHNA, as required by federal law.

Guideline 13
Reconcile and report differences in community benefit reports

Many states require hospitals to prepare and submit community benefit reports. In other states, hospitals prepare reports voluntarily. Community benefit amounts reported on Schedule H can vary from the values reported in state community benefit reports. Differences between amounts reported on Schedule H and amounts in other reports will be present because:

- The IRS requires reporting on an EIN-by-EIN basis rather than on a hospital facility-by-facility basis.
- Many states have different definitions of community benefit and different accounting methods.

It's always important to follow state requirements when preparing state-required forms and reports. Complying with state and federal regulations often requires producing two sets of community benefit reports: one that meets state requirements and a second that follows Schedule H instructions.

Organizations should explain and quantify differences among the various reports so stakeholders can understand why such differences are present and what they mean.

SECTION 4.3

ACCOUNT FOR AND REPORT COMMUNITY BENEFIT

Appendix D contains worksheets that support accounting for community benefit based on the principles discussed in Section 4.2. The worksheets are organized as follows:

COMMUNITY BENEFIT WORKSHEETS	
These worksheets can be used to account for and report community benefit programs and services, bad debt expense, and Medicare.	
A	Summary of Quantifiable Community Benefits
1	Financial Assistance at Cost
2	Ratio of Patient Care Cost to Charges
3	Medicaid and Other Means-Tested Government Programs
4a	Community Health Improvement Services
4b	Community Benefit Operations
5	Health Professions Education
6	Subsidized Health Service
7	Research
8	Cash and In-Kind Donations for Community Benefit
B	Community Building
C	Medicare

The worksheets are numbered to align with those included in the Schedule H instructions. The worksheets in Appendix D include several enhancements to those in the Schedule H instructions. The modifications are designed to help organizations with the accounting process.

The accounting values produced by the worksheets in Appendix D are equivalent to those produced by using Schedule H. The worksheets can be completed for each entity that provides community benefit and can be aggregated at an EIN or system level.

See Chapter 2 for definitions and examples of each community benefit category.

Guideline 1
Establish an effective administrative and accounting process

Each organization should establish a robust administrative process for compiling community benefit program, statistical and accounting information. Although Schedule H is filed on an annual basis, many organizations find that preparing community benefit reports on a more frequent, interim basis enhances the accuracy and completeness of their information. Some have developed approaches to gathering program statistics and accounting information monthly or quarterly. Organizations also are finding it valuable to have one or more designated finance staff members become an expert in community benefit accounting and serve as an ongoing resource to their other community benefit colleagues.

More frequent data compilation can help programs avoid being missed or forgotten, allows active community benefit program monitoring, and facilitates midyear course corrections. On the other hand, monthly procedures can be resource intensive both for accounting and community benefit staff and for staff who supply information.

The community benefit worksheets should be completed in a specific sequence. To help avoid double-counting, the "ratio of patient care cost to charges" should be determined as one of the last calculations, as described in Guideline 8 of this section.

Guideline 2
Calculate the cost of community health improvement services

Worksheet 4a in Appendix D can be used to calculate the net cost of each community health improvement service. Unlike Worksheet 4 in the Schedule H instructions, CHA's Worksheet 4a includes separate columns for direct expense and indirect expense. Worksheet 4a also provides the opportunity to document community health improvement services separately from community benefit operations expense.

Organizations frequently quantify direct expense by multiplying the number of hours employed staff members have worked on each program by an hourly wage statistic and then by adding in factors for employee benefit costs, direct supply costs and other costs that should be directly assigned to the program. The "hourly wage statistic" is most accurate if it is department or program specific rather than hospital-wide.

Indirect expense is included based on the indirect cost factors discussed in Section 4.2, Guideline 3.

Guideline 3
Calculate the cost of community benefit operations

In Worksheet 4b, include the costs of community benefit operations, such as:

- Salaries and benefits for staff assigned to community benefit program administration.
- The cost to prepare CHNAs and develop associated implementation strategies.
- The cost of community benefit accounting software.
- The portion of the cost of the organization's grant writing and fundraising functions designed to yield revenue that supports community benefit.
- The portion of any system overhead or management fees used by the system office to support community benefit activities.
- The other costs associated with community benefit operations, such as participation in related educational programs.

Multi-hospital systems are finding it helpful to allocate the cost of any community benefit operations incurred by the system office to system hospitals. This allows each affiliated hospital to include these costs in community benefit reports and Schedule H.

Guideline 4
Determine the net cost of health professions education

In Worksheet 5, include the cost of health professions education programs. Health professions education that is reportable as community benefit is defined in the Schedule H instructions.

IRS

IRS NOTE

From the Schedule H instructions:

"Health professions education" means educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law, or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education or training programs available only to the organization's employees and medical staff or scholarships provided to those individuals. However, it does include education programs if the primary purpose of such programs is to educate health professionals in the broader community. Costs for medical residents and interns can be included, even if they are considered "employees" for purposes of Form W-2, Wage and Tax Statement.

Continued on next page ...

IRS

IRS NOTE *(continued)*

Direct costs of health professions education include:

- Stipends and fringe benefits for interns, residents and fellows in accredited graduate medical education programs.
- Salaries and fringe benefits for faculty directly related to intern and resident education.
- Salaries and fringe benefits for faculty directly related to teaching:
  - Medical students,
  - Students enrolled in nursing programs that are licensed by state law or, if licensing is not required, accredited by the recognized national professional organization for the particular activity.
  - Students enrolled in allied health professions education programs, licensed by state law or, if licensing is not required, accredited by the recognized national professional organization for the particular activity, including programs in pharmacy, occupational therapy, dietetics and pastoral care.
  - Continuing health professions education that is open to all qualified individuals in the community, including payment for development of online or other computer-based training that is accepted as continuing health professions education by the relevant professional organization.
- Scholarships provided by the organization to community members.

Direct costs of health professions education do not include costs related to doctoral students and postdoctoral students, which are to be reported on Worksheet 7, Research.

The above definition means that care should be taken not to report costs for unaccredited programs or for training that is not required to obtain or maintain professional licensure.

Direct offsetting revenue for health professions education does not include indirect medical education (IME) payments provided by Medicare, Children's Hospital Graduate Medical Education payment or Medicaid. IME revenue is considered by the Association of American Medical Colleges and by the IRS to be "clinical dollars" that should be accounted for either as Medicare revenue (in Part III of Schedule H) or as Medicaid revenue (in Part I of Schedule H) as appropriate. This treatment follows the view that graduate medical education programs have certain "indirect" effects on the costs of patient care (e.g., more laboratory tests ordered). Estimates for these "indirect" patient care costs are not to be included in the cost of health professions education and are not to be confused with "indirect costs" that represent hospital overhead and administrative expense allocated to community benefit programs.

Hospitals incur health professions education costs when nursing or other undergraduate medical education students who are enrolled in an accredited education program obtain clinical experience on-site. These students are mentored by nurses and other professionals on the hospital staff. The teaching that occurs (e.g., didactic or classroom training) can pull hospital staff away from normal clinical duties and can increase hospital staffing needs. The costs associated with mentoring trainees can be challenging to estimate.

Care should be taken not to overstate the actual cost of these activities. Having students on-site may not materially affect staff productivity. Students may perform work that otherwise would fall to staff. Costs associated with program administration and didactic training should be counted. Other cost implications should be estimated based on consensus reached by staff interacting directly with the students. More information about accounting for these community benefits is available on the CHA website at https://www.chausa.org/whatcounts on the What Counts Q&A page under the category of Health Professions Education.

Guideline 5
Include the costs of research that provides community benefit

Worksheet 7 portrays community benefit accounting for research. Only studies funded by tax-exempt or government entities are to be included in Part I of Schedule H. Costs reported for these studies are to be offset by any license fees or royalties associated with research that has been reported as community benefit. Direct offsetting revenue also includes Medicare or other third-party reimbursement for patients participating in studies (such as clinical trials) that have been reported as community benefit.

The cost of industry-sponsored research designed to yield generalizable knowledge (i.e., intended for publication) is not reportable on Part I of Schedule H but can be described in Part VI of the form. Such industry-sponsored research costs are not to be reported in the total community benefit costs in the organization's financial statements or annual reports. CHA encourages hospital organizations to report separately the costs they incur for research studies that are intended for publication and that are funded by the industry.

CHA's Worksheet 7 therefore includes two columns. The first accounts for costs incurred by the hospital organization for research studies that are funded by tax-exempt entities (e.g., foundations or the hospital's own funds) or by government (e.g., NIH) — and thus qualify to be reported as community benefit on Schedule H. Costs reported in the second column

would not be reported on Part I, Line 7, of Schedule H unless the IRS changes the definition of reportable research. Costs in that column can be reported in Part VI of Schedule H and in the hospital organization's own community benefit reports.

See Chapter 2 for more information about what research activities should count as community benefit.

The second column accounts for the cost of industry-sponsored research that the organization believes yields generalizable knowledge because research protocols call for publication. That amount currently is not reportable on Schedule H, but the instructions indicate that this type of research may be described in Part VI of Schedule H.

Worksheet 7 (and other worksheets) include a line for "direct offsetting revenue" provided by restricted grants or contributions received by the organization for a community benefit purpose, such as NIH research grants. Restricted grant revenue for community benefit is to be based on the amount of such revenue actually used for the activity or program during the year (rather than recording the full amount of the grant when received or when receipt is assured).

Said another way, direct offsetting revenue for restricted grants is to be determined based on "net assets released from restrictions." Spending the funds on a designated purpose (e.g., research or a community health improvement program) releases the restrictions and leads to being recognized as revenue that offsets community benefit activities.

Guideline 6
Quantify cash and in-kind contributions for community benefit

Tax-exempt hospitals provide financial or in-kind contributions to support community benefit activities provided by other organizations. In-kind contributions include noncash goods and services donated by the organization to another organization that provides community benefit, such as hours worked by staff at a community clinic or food or supplies given to a homeless shelter.

IRS instructions indicate that, in order to be reported on the Form 990 Schedule H, cash contributions for community benefit must be documented in writing that the organization restricted each cash contribution to a community benefit purpose (e.g. by including a restrictions letter with the contribution).

Unrestricted grants or gifts may not be reported as a community benefit (e.g. contributions to the capital of another organization that are reported in Part X of the core Form 990 (the organization's Balance Sheet)). Any payments the organization makes in exchange for a service, facility, or product, or any payment that the organization makes primarily to obtain an economic or physical benefit may not be reported.

Some organizations have raised questions about whether payments in lieu of taxes (PILT) are reportable as community benefit contributions. While PILTs relieve government burden, Form 990 Schedule H instructions explicitly do not allow reporting them if they are made "to prevent local or state property tax assessments." In CHA's view, PILTs may be counted as community benefit only if they are provided voluntarily (our of a sense of "disinterested generosity") and are used by the government for community benefit purposes.

In-kind contributions should be valued reasonably and based on actual cost. For example, meeting room costs would not be valued based on what a community group would need to pay at a local hotel for comparable space. Actual cost is based on utilities, depreciation, security and other carrying costs to maintain the space — in other words, the “break-even rate” the organization would charge the community group.

In Worksheet 8, include the costs of all qualifying cash contributions and grants and the value of all qualifying in-kind donations, such as meeting rooms, supplies and staff time (salaries and benefits).

To be consistent with community benefit accounting on Schedule H, cash and in-kind contributions that support community-building activities should be reported on Worksheet B of this *Guide* and on Part II of Schedule H.

The value of in-kind contributions should be established reasonably, and the expense should be included on Schedule H only if the expense also is included in Part XI of the core Form 990 (Statement of Functional Expenses). For example, if donated equipment has been fully depreciated or if supplies have no accounting value in inventory, only transportation and handling costs for delivery to recipients of the contributions should be reported.

Staff time for employees who have assisted other organizations while on the hospital's payroll can be valued based on their hourly compensation rates (including benefits and an allowance for indirect costs). The value of time donated by salaried (exempt) employees also can be based on the average hourly compensation for these employees — if the employees are participating during paid work time rather than on their own time and if participation in these activities is part of their job responsibilities. The case for inclusion is stronger if job descriptions for these employees indicate that involvement in these types of activities is expected.

Guideline 7
Measure the cost of community-building activities

Worksheet B can be used to account for the cost of community-building activities that are not reported on Worksheet 4a. IRS instructions state that community-building activities that meet the definition of community benefit are to be reported as community health improvement.

Guideline 8
Calculate the ratio of patient care cost to charges

Worksheet 2 or equivalent calculations can be used to determine the "ratio of patient care cost to charges." While calculating an overall ratio of cost to charges is a relatively simple matter (total expense divided by total gross charges), a simple approach would result in double-counting community benefit expenses. As a result, several adjustments are made both to the numerator and the denominator of this ratio, as follows:

- The "non-patient-care" adjustment in Line 2 accounts for the cost of activities that generate "other operating revenue." Organizations are allowed to use "other operating revenue" as a proxy for the cost of these activities. Organizations are encouraged to use the most accurate approach they have available.
- Record in Line 3 of Worksheet 2 any bad debt expense that is in the "total operating expense" from the organization's Statement of Revenues and Expenses prepared based on GAAP so bad debt expense is not allocated to the cost of financial assistance or to other community benefit categories to which the ratio is applied.
- Line 4 accounts for any Medicaid or provider taxes (sometimes referred to as assessments or fees) if those amounts also are included in the "total operating expense." These taxes or fees are subtracted from the numerator of the ratio of patient care cost to charges (if they have been included in total operating expense) because they are included in full as a community benefit expense in the Medicaid and financial assistance worksheets.
- Line 5 is where the total costs of community benefit activities and programs that have been determined without using the ratio of patient care cost to charges are recorded (such as health professions education, research, community benefit operations and others). These costs are deducted from the numerator of the ratio of patient care costs to charges so that they also are not double-counted in the cost of financial assistance or other programs to which the ratio is applied. Once again, if amounts (e.g., contributions for community benefit) have not been included in the "total operating expense," they should not be adjusted out of the numerator of that ratio.
- Line 9 is where any gross patient charges for programs not relying on the ratio are recorded so both the numerator and denominator of the ratio are adjusted appropriately.

The resultant ratio aligns with Schedule H instructions.

Guideline 9
Establish the cost of each subsidized health service

Worksheet 6 can be used to establish the total and net community benefit expense for programs that qualify as "subsidized health services." Chapter 2 (and also the Schedule H instructions) describes the criteria for classifying programs such as behavioral health units, burn units, trauma services and others as subsidized health services.

A worksheet should be completed for *each* program. Worksheets for each qualifying program then should be added together to provide values for Worksheet A (the Summary of Quantifiable Community Benefits). Worksheets that document the net cost of physician clinics included in subsidized health services can be used for Part VI of Schedule H as well. The IRS requires organizations to disclose whether any physician clinic costs have been included in subsidized health services and also requires that the hospital generate losses both on the hospital (technical) component of the service and on the physician (professional) component of the service before physician clinics can be reported.

IRS

IRS NOTE

From the Schedule H instructions:

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 the amount of 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.

Worksheet 6 begins with the total gross charges, cost and revenue for each program. Costs can be established by using the "ratio of patient care cost to charges" or another cost accounting method if more accurate.

Charges, costs and revenues associated with Medicaid and other means-tested government programs, financial assistance, and bad debt amounts are then subtracted to quantify the net cost of subsidized health services reportable as community benefit. The subtractions are made to prevent double-counting of amounts that have been reported in full elsewhere on Schedule H and in other community benefit reports.

CHA's Worksheet 6 also includes a separate column for recording Medicare charges, costs and revenue for each subsidized health service. Values in this column are not to be subtracted from the revenues and costs for subsidized health services but are designed to help organizations with their accounting for Medicare on Part III of Schedule H. As specified in the IRS instructions, Medicare amounts reported in Part III are to exclude any amounts reported in Part I as community benefit. This includes amounts reported in the subsidized health services category.

Guideline 10
Determine the net cost of Medicaid and other means-tested government programs

Losses incurred when caring for patients with Medicaid or other public program coverage for which patients qualify based on their household means are to be included in community benefit reports. Worksheet 3 can be used to account for these community benefits. Services reimbursed on a fee-for-service basis *and* those reimbursed through managed care plans are included in the accounting. Medicaid and other means-tested government programs from *all* states, not only the organization's home state, should be reported.

If revenue is greater than cost, then net community benefit expense should be set to zero. However, subtotals and totals are to include total community benefit expenses and revenue values.

Zero values may occur for organizations with substantial amounts of Medicaid disproportionate share hospital (DSH) revenue, large delivery system reform incentive payments (DSRIP), or significant prior-year revenue.

To be consistent with Schedule H accounting, CHA recommends applying GAAP when accounting for patient revenue (i.e., recording prior-year and other revenue when collection is reasonably assured and in alignment with amounts included in audited financial statements). Including a footnote in community benefit reports (and statements in Part VI of Schedule H) explaining why the organization is reporting zero net community benefit expense is important.

Worksheet 3 thus includes a row for recording prior-year revenue.

Include any Medicaid DSH, Upper Payment Limit (UPL) funding and DSRIP payments in revenue (and any associated provider taxes, assessments or fees) if the primary purpose of those funds is to fund Medicaid services. If DSH or UPL funds are designated to offset the cost of financial assistance in your state, those amounts should be recorded on Worksheet 1 (financial assistance). If the primary purpose of the funds is not specified or is unclear, then allocate the revenue and associated fees to Medicaid and financial assistance using a reasonable method. The same approach should be used for uncompensated care pool revenues and assessments.

Guideline 11
Determine the cost of financial assistance

Worksheet 1 can be used to determine the cost of financial assistance provided pursuant to the organization's financial assistance policy. Unlike Schedule H, CHA's Worksheet 1 includes one column for "free care," under which patients receive a 100 percent discount, and a second column for "partially discounted care," granted pursuant to a sliding-fee scale.

Hospitals establish financial assistance policies under which they forgive (and do not bill patients) all or portions of gross charges. These policies specify criteria for identifying patients who are *unable* to pay for all or part of their care and include a sliding-fee scale of partial discounts at different levels of household means and size.

Criteria typically consider a patient's (or guarantor's) annual household income in relation to federal poverty or other well-established guidelines, such as those published by the U.S. Department of Housing and Urban Development. Some policies consider household assets in qualifying patients for assistance. Many hospitals grant free or discounted care for patients with large (or "catastrophic") health care bills in relation to income. These patients are considered "medically indigent."

The Affordable Care Act (ACA) established Section 501(r) in the Internal Revenue Code and added several requirements for financial assistance and collections policies and practices to be followed by 501(c)(3) hospital organizations.

The law requires that tax-exempt hospital facilities must have a written financial assistance policy that includes:

- Eligibility criteria for financial assistance and whether such assistance includes free or discounted care.
- The basis for calculating amounts charged to patients.
- The method for applying for financial assistance.
- The actions the organization may take in the event of nonpayment, including collections action and reporting to credit agencies.

The ACA also requires all 501(c)(3) hospital organizations "to limit amounts charged for emergency or other medically necessary care that is provided to individuals eligible for assistance under the organization's financial assistance policy to not more than amounts generally billed to individuals who have insurance covering such care." Once the hospital knows that a patient qualifies for financial assistance, that patient is not to be billed an amount greater than what the hospital generally receives for care provided to insured individuals.

Importantly, the ACA also requires an exempt hospital to forgo "extraordinary collection actions … before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the … financial assistance policy." Regulations for Section 501(r) indicate the following represent "extraordinary collection actions:"

- Taking actions that require a legal or judicial process (liens, foreclosures, garnishments, seizure of bank accounts or property, civil action, arrest, body attachment).
- Selling debt to third parties.
- Reporting adverse information to credit agencies or bureaus.
- Deferring or denying (or requiring a payment before providing) medically necessary care because of nonpayment for previously provided care that is covered under the financial assistance policy.

Please check the IRS or CHA websites for updates regarding the 501(r) regulations.

The Healthcare Financial Management Association (HFMA), American Hospital Association and other organizations have sponsored efforts to help hospitals examine and refine their financial assistance policies. These associations recommend that:

- The organization should have clear and publicly accessible policies on financial assistance, discounts, payment plans and collection practices.
- The decision to grant financial assistance should be made as early as possible in the patient experience: pre-service, at time of service or post-service. However, the determination can be made at any time during the revenue cycle.
- Financial assistance should be reported on the basis of cost, not gross charges.

MISSION NOTE

Financial assistance should be granted as early in the patient experience as possible. Early financial assistance determinations are best for patients, who benefit from knowing about their financial obligations as early as possible, and for the hospital, which can avoid a costly, fruitless collections process if patients are unable to pay.

Many health care organizations struggle with maintaining a clear distinction between financial assistance and bad debt, particularly when patients do not provide all required documentation.

The HFMA Principles and Practices Board issued Statement 15 in December 2006 (and updated in June 2019) to help organizations with this process: https://www.hfma.org/content/dam/hfma/Documents/policies-and-practices/pp-board-statement-15-061519.pdf.

ALIGN REPORTING WITH IRS FORM 990, SCHEDULE H

SECTION 4.4

Sections of Schedule H were based on CHA's community benefit reporting guidelines. The guidelines in this chapter are closely aligned with Schedule H but supplement Schedule H requirements in a few ways.

Guideline 1

Review and understand how CHA's community benefit accounting guidelines supplement and vary from IRS requirements

CHA's guidelines differ from Schedule H requirements in the following ways.

CHA recommends reporting both "total" and "net community benefit as a percent of total expense."

- When calculating community benefit as a percent of total expense in reports other than Schedule H, derive "total expense" from the organization's GAAP-prepared financial statements (excluding bad debt) rather than obtaining "total expense" from the core Form 990. This allows tracking "community benefit as a percent of total expense" throughout the year rather than needing to wait until the core Form 990 is prepared.
- Organizations can continue reporting community benefit in two overall categories, for "persons living in poverty" and "benefits for the broader community," and then consolidate these two categories for purposes of Schedule H reporting.
- Worksheets can include additional details not present in worksheets included in the Schedule H instructions that support the community benefit accounting process:
    - Separate columns for direct and indirect costs.
    - Separate columns for "free care" and "partial discounts" in the financial assistance care worksheet.

- Separate disclosure of prior-year revenue.
- The amount of Medicare revenues and costs included in each subsidized health service.
- Separate rows for restricted grant revenue used for a community benefit purpose (net assets released from restrictions).

Guideline 2
Value Medicare consistent with IRS requirements

CHA recommends that if organizations want to include Medicare in community benefit reports, it should be reported "below the line" and also net of amounts already reported as community benefit (e.g., in health professions education, subsidized health services and research). Worksheet C can be used to report Medicare revenues and costs for this purpose.

Accounting-Related Definitions

Audited Financial Statements

An organization's statements of revenue and expenses and balance sheet, or similar statements prepared regarding the financial operations of the organization, accompanied by a formal opinion or report prepared by an independent, certified public accountant with the objective of assessing the accuracy and reliability of the organization's financial statements.

Source: Adapted from Glossary to IRS Form 990.

Control

One or more persons (whether individuals or organizations) *control* a nonprofit organization if they have the power to remove and replace a majority of an organization's directors or trustees. Such power can be exercised directly by a (parent) organization through one or more of the (parent) organization's officers, directors, trustees or agents, acting in their capacity as officers, directors, trustees or agents of the (parent) organization. Also, a (parent) organization controls a (subsidiary) nonprofit organization if a majority of the subsidiary's directors or trustees are trustees, directors, officers, employees or agents of the parent.

Source: Adapted from Glossary to IRS Form 990.

Cost Accounting

Measurement of the costs associated with specific activities and programs to provide information meaningful to management. For example, cost accounting is used to determine the amount of an organization's total expense that reasonably can be attributed to community benefit, to assign indirect (overhead) expense to the direct cost of a program, and to estimate the cost associated with serving a subset of patients, such as Medicaid recipients. Unlike financial accounting, cost accounting rules are not dictated by the Financial Accounting Standards Board (FASB) or the American Institute of Certified Public Accountants (AICPA).

Source: Instructions for Schedule H (IRS Form 990).

Depreciation

Represents the usage of an asset over time (its useful life). For example, a hospital purchases a piece of equipment that has a useful life of seven years. Under GAAP, the full cost of this equipment is not recorded as expense in the year it was purchased; instead, the cost of the equipment is depreciated (or "amortized") over time. Under the straight line method, the amount of expense would be one-seventh of the purchase price each year. The value of the equipment on the hospital's balance sheet would be reduced each year by the amount of the depreciation expense.

Direct Costs

Salaries and benefits, supplies, and other expenses directly related to the actual conduct of each activity or program.

Source: Instructions for Schedule H (IRS Form 990).

Direct and Indirect Medical Education Reimbursement

The Medicare program (and the Children's Hospital Graduate Medical Education program and Medicaid programs in certain states) provides two categories of reimbursement to hospitals with graduate medical education (GME) programs: direct GME and indirect GME (referred to as IME). The formula for direct GME payments is based in part on historical costs incurred by teaching hospitals for intern and resident salaries and fringe benefits and the costs for faculty supervision. The formula for IME is based in part on the number of interns and residents in relation to the number of hospital beds. In community benefit accounting, direct GME payments are included in "direct offsetting revenue" for health professions education programs. IME payments, however, are viewed as a resource that offsets increased patient care costs at teaching hospitals. These increased patient care costs are not the same as "indirect cost" (overhead including administrative expense). IME payments thus are included in direct offsetting revenue for Medicaid or Medicare patient care services.

Source: Instructions for Schedule H (IRS Form 990).

Disregarded Entity

An entity that is *wholly owned* by the organization and that is generally not treated as a separate entity for federal tax purposes (e.g., a single-member limited liability company of which the organization is the sole member). Revenues, expenses and other activities of the disregarded entity flow to the owner.

Source: Adapted from Glossary to IRS Form 990. See IRS Regulations sections 301.7701-2 and 301.7701.3 for more information.

Generally Accepted Accounting Principles (GAAP)

The principles set forth by the FASB and the AICPA that guide the work of accountants in reporting financial information and preparing audited financial statements for organizations.

Source: Adapted from Glossary to IRS Form 990.

Gross Patient Charges

The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Source: Instructions for Schedule H (IRS Form 990).

Indirect Costs

Costs that are shared by multiple activities or programs, such as facilities and administration costs related to the organization's infrastructure (space, utilities, custodial services, security, information systems, administration, materials management and others). Indirect costs do not include the estimated cost of "indirect medical education." Because the costs are shared, they are allocated to activities or programs using various cost accounting methods.

Source: Instructions for Schedule H (IRS Form 990).

In-Kind Contributions

Donations made (or received) using resources that are not legal tender (e.g., cash, checks, credit cards). Donations of supplies (e.g., pharmaceuticals), equipment or staff time that benefits another organization are examples of in-kind contributions. In community benefit accounting, in-kind contributions should be valued fairly. For example, the hospital donates a two-year-old computer to a community clinic. The hospital purchased the computer for $3,000, but it has been used for two years. As a result, it has depreciated to $1,000 in the hospital's books and thus should be reported as a $1,000 community benefit.

Joint Venture

An entity or contractual undertaking that involves two or more parties. Unless otherwise provided, a partnership, limited liability company, or other entity treated as a partnership for federal tax purposes. Hospital organizations that file Schedule H are to include in Parts I, II and III their proportionate shares of community benefit, total expense, community building, bad debt, and Medicare from joint ventures in which they participate.

Source: Adapted from Glossary to IRS Form 990. See IRS Regulations sections 301.7701-1 through 301.7701-3.

Medicaid Provider Taxes, Fees and Assessments

Almost all states have some form of Medicaid provider tax (or fees and assessments) in place. Hospital provider taxes are assessed in over 30 states. Through these arrangements, providers pay funds to states that then are appropriated to Medicaid agencies and serve as a source of matching funds that yield federal Medicaid revenue. These taxes, fees and assessments are included in community benefit accounting as a Medicaid cost, and any revenues they yield also are included in Medicaid "direct offsetting revenue."

Source: *Medicaid financing issues: Provider taxes.* Kaiser Commission on Medicaid and the Uninsured. https://www.kff.org/wp-content/uploads/2013/01/8193.pdf.

Notes to Audited Financial Statements

Additional information added to the end of audited financial statements. Notes to financial statements help explain specific items in the financial statements as well as provide a more comprehensive assessment of a company's financial condition. Notes to financial statements can include information on debt, going concern criteria, accounts, contingent liabilities or contextual information explaining the financial numbers (e.g., to indicate a lawsuit).

Source: Adapted from definition provided by Wikipedia.

Opportunity Cost

"Opportunity cost" represents the value of an activity or program based on the cost of something else that has been given up. For example, if a hospital provides free access to meeting space to a community group, the "opportunity cost" is the amount the hospital could have received if instead it had rented the space (at full market value) to someone else.

Organization

The entity that files IRS Form 990. Note that an "organization" may include one or more hospitals *and non-hospital* entities, such as a foundation, physician practices, a research institute and others. Schedule H requires community benefit amounts to be reported for the entire organization and (on a proportionate basis) for joint ventures in which it participates, not only for the hospital.

Payments In Lieu of Taxes (PILT)

Payments made by an organization "in lieu of taxes." These payments generally are made to local governments in lieu of paying property taxes. They frequently are determined after negotiations and may be calibrated to a percentage of the amount of property tax that the organization would pay if taxable or the amount of public services (e.g., fire and police protection) the organization uses. Because they generally represent a *quid pro quo* arrangement, they are not to be reported on IRS Form 990, Schedule H.

Prompt-Pay Discount

A discount offered to patients if they pay their out-of-pocket liabilities "promptly" — that is, within 30 days or less. The cost of prompt-pay discounts is not reported as financial assistance (charity care).

Related Organization
An entity that has one or more of the following relationships to the organization at any time during the year:

- Parent: an entity that **controls** the filing organization.
- Subsidiary: an entity **controlled** by the organization.
- Brother or Sister: an entity **controlled** by the same person or persons that control the filing organization.

Source: Adapted from Glossary to IRS Form 990.

Restricted Contributions (Grants)
Donations, gifts, bequests and other transfers of money or property made by a donor or grantor that has stipulated a temporary or permanent use for the resources provided. Donors or grantors provide restricted contributions with the intent of supporting a particular activity or program. Restrictions generally are stated in writing by the donor or grantor when they make the gift or grant.

Self-Pay Discount
A discount from gross patient charges provided to uninsured patients, including those that do not qualify for financial assistance. The cost of self-pay discounts provided is not reported as financial assistance (charity care).

SILOTs
Similar to PILTs, SILOTs are "services in lieu of taxes." Instead of monetary payments, SILOTs involve organizations providing free or low-cost services generally in lieu of paying property taxes.

Unrestricted Contributions (Grants)
Donations, gifts, bequests and other transfers of money or property that are free from any external restrictions and are available for general use.

Notes: