







Comparison of Recommendations Between The Catholic Health Association and VHA Inc.'s *A Guide for Planning and Reporting Community Benefit* and Community Benefit Mandated and Voluntary Reporting State Requirements

This document provides a comparison of the recommendations in the CHA/VHA "A Guide for Planning and Reporting Community Benefit" (GUIDE) with mandated state community benefit and related laws, guidelines or standards.

The final pages show a list of states with voluntary community benefit reporting through the state hospital associations.

The information has been formatted in different ways to meet the need of the reader.

Included in this document:

-  Overview
-  Summary-What the Following Charts Tell Us
-  General Summary of Comparisons
-  Comparison between the GUIDE and Multiple States with Mandated Reporting
-  Comparison between the GUIDE and Individual States with Mandated Reporting
-  List of States with Voluntary Reporting Through State Hospital Associations

OVERVIEW

Comparison of Recommendations Between CHA/VHA's *A Guide for Planning and Reporting Community Benefit* and Mandated State Community Benefit and Related Laws, Guidelines and Standards

This document provides a comparison of the recommendations in the CHA/VHA "A Guide for Planning and Reporting Community Benefit" (GUIDE) with mandated state community benefit and related laws, guidelines or standards. The final pages show a list of states with voluntary community benefit reporting through state hospital associations.

It is important to recognize that states may have (a) pending or more recently passed legislation and/or (b) state administrative clarification/guidance for implementing the law/guideline/standard that may not be reflected in the resources used and thus not captured in this comparison.

It is also important to recognize that most states have hospital financial reporting requirements not directly related to community benefit reporting. A hospital may be required to document both financial information and community benefit data on the same reporting template or alternately, data from two separate reports may be combined in discussing a hospital's contribution to its community. For example, all Indiana hospitals must file the Hospital Fiscal Report which requests Medicaid shortfall, Medicare shortfall and bad debt. At the same time, Indiana not-for-profit hospitals must additionally file a Community Benefit Statement. The financial and the community benefit data are combined when communicating to the Indiana legislature the value that Indiana not-for-profit hospitals bring to the communities they serve.

Therefore, it is advised that hospitals speak directly with the oversight authority in their respective states during the course of community benefit planning and implementation to assure accurate interpretation of the state law/guideline/standard.

The following chart lists key recommendations in the GUIDE categorized as process steps, what to count as a community benefit, accounting principles, and minimum levels of effort. Under each state that has a law/guideline/standard, if the law/guideline/standard speaks to one of the key recommendations in the GUIDE, the mandate is described. A block is left blank if the law/guideline/standard does not contain information specific to that GUIDE key recommendation.

Resources used in the comparison:

A Guide for Planning and Reporting Community Benefit - developed by The Catholic Health Association in cooperation with VHA Inc.; released June 2006

State Community Benefit Laws and Guidelines

- *The Federal Community Benefit Standard and Report on State Community Benefit Laws*, prepared by The Catholic Health Association, April 2006
- *Health Care Community Benefits: A Compendium of State Laws*, released by Community Catalyst, Inc., September 2003
- *State Law Approaches to Ensuring The Social Accountability of Nonprofit Health Care Organizations*, released by the Coalition for Nonprofit Health Care, July 1999
- The Office of the Massachusetts Attorney General summaries of state community benefit initiatives as presented on the web
- Individual state websites and phone interviews

This resource provides background on state community benefit laws, guidelines, and standards. The language is synthesized from state data bases. This resource is not intended to provide the position of CHA, VHA Inc. or any ministry organization on the state policy. This information is regularly updated, but some states are slower than others in updating their databases. If you have further questions or believe the information about your state is incomplete, please e-mail lgiden@chausa.org.
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SUMMARY—WHAT THE FOLLOWING CHARTS TELL US

A Guide for Planning and Reporting Community Benefit (GUIDE) is designed to help not-for-profit hospitals and long-term care facilities enhance and strengthen their community benefit programs. The GUIDE describes the basic steps in community benefit planning and implementation including recommendations on what to count and how to count using generally accepted accounting principles. The GUIDE is a significant contribution in moving toward standard definitions and reporting of community benefit. However, state laws/guidelines/standards, developed over past decades, yield both consistencies and discrepancies with the GUIDE.

Process Steps

States that identify community benefit as more than just the provision of charity and uncompensated care have fairly consistent requirements with the GUIDE on the process steps of developing and implementing a community benefit program. Consistent with the GUIDE, state requirements call for mission statements that reflect commitment to meeting community health needs which have been identified through a formal process. If mentioned in a state requirement, community needs assessments are generally required every three years.

Most states with requirements on process steps ask for community benefit plans although what needs to be included in the plans varies widely among the states. Seven states (CA, IN, MA, NH, RI, TX, UT) require the organization to specifically identify the population to be served; four of these states (CA, IN, NH, TX) limit the defined community to the geographic or patient populations receiving health services from the organizations.

Although only four states (CA, IN, MA, RI) specifically require organizations to evaluate their community benefit programs, seven states (CA, CT, IN, MA, NH, NY, RI) require community input in the development and/or operation of the programs. All states require a report, although similar to the community benefit plan, the scope of the report varies widely among states. Most of the reports require financial information and others additionally request specific program information.

What Counts

All but one (NY) of the states specifically list what to include as a community benefit or a reportable activity. The program/activities are similar to those listed in the GUIDE although not as expansive or always using the same labels.

A discrepancy between the GUIDE and states concerns Medicare shortfall and bad debt. The GUIDE strongly recommends that neither bad debt nor Medicare shortfall be counted as a community benefit. Eight states (CT, ID, IN, IL, NV, NY, PA, RI) specifically request that bad debt be included in reports and ten states (CA, CT, ID, IN, IL, NV, OR, PA, TX, UT) specifically mention that Medicare shortfall can be counted. However, most states require hospitals to report Medicare shortfall and bad debt on a hospital financial report so it is not clear whether Medicare shortfall and/or bad debt are counted as community benefit. It is not easily determined whether the requested reporting of Medicare shortfall and bad debt is for the hospital financial report or for community benefit reporting.

Additionally among the state laws, terminology is not consistent and often used interchangeably. For example, the terms "unreimbursed government-sponsored healthcare," "government-sponsored indigent care," and "medical care services" may refer to different financial categories (charity care, Medicaid shortfall, Medicare shortfall, bad debt) depending upon the state. Only one state (MA) specifically states that Medicare shortfall not be included; two states (MA, NH) specifically state that bad debt not be included.

Accounting Principles

One state (UT) requires using charges instead of costs whereas all other states, as far as we can determine, are consistent with the GUIDE in using costs instead of charges. Two states (MA, PA) specifically include both direct and indirect costs as recommended in the GUIDE; hospitals in other states may also be able to include both direct and indirect costs as instructed in state administrative guidance.

Minimum Level of Effort

Three states (PA, TX, UT) list minimum levels of community benefits.

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GENERAL SUMMARY OF COMPARISONS

California:

Process: very similar to GUIDE
 What counts: similar language to GUIDE; include Medicare shortfall
 Minimum: none

Connecticut:

Process: similar to but less specific than GUIDE
 What counts: consistent with GUIDE; include Medicare shortfall, bad debt
 Minimum: none

Idaho:

Process: requires report only
 What counts: similar to GUIDE, but not specific; include Medicare shortfall, bad debt
 Minimum: none

Indiana:

Process: very similar to GUIDE
 What counts: very similar language to GUIDE, include Medicare shortfall & bad debt in hospital fiscal report
 Minimum: none

Illinois:

Process: very similar to GUIDE
 What counts: very similar to GUIDE; include Medicare shortfall, bad debt
 Minimum: none

Maryland

Process: very similar to GUIDE
 What counts: similar to GUIDE; do not include Medicare shortfall and bad debt
 Minimum: none

Massachusetts (voluntary thru Attorney General)

Process: very similar to GUIDE
 What counts: very similar to GUIDE, include indirect costs; do not include Medicaid shortfall, Medicare shortfall and bad debt
 Minimum: none

Minnesota

Process: requires report only
 What counts: very similar to GUIDE; include Medicare shortfall and bad debt below the line
 Minimum: none

Nevada:

Process: report only
 What counts: similar to GUIDE, include Medicare shortfall, bad debt
 Minimum: none

New Hampshire:

Process: very similar to GUIDE
 What counts: similar to GUIDE, do not include bad debt
 Minimum: none

New York:

Process: similar to GUIDE
 What counts: silent, include bad debt
 Minimum: none

Oregon

Process: requires report only
 What Counts: similar language to GUIDE; include Medicare shortfall
 Minimum: none

Pennsylvania

Process: requires report only
 What counts: similar language to GUIDE; include Medicare shortfall, bad debt
 Minimum: meet one of 7 standards or provide payments in lieu of taxes

Rhode Island

Process: very similar to GUIDE
 What counts: similar language to GUIDE; include bad debt
 Minimum: none

Texas:

Process: very similar to GUIDE
 What counts: similar language to GUIDE; include Medicare shortfall
 Minimum: must meet one of 3 tests

Utah:

Process: similar to GUIDE
 What counts: similar to GUIDE; include Medicare shortfall; use charges
 Minimum: "community gift" must exceed value of property tax exemption each year

<i>A Guide for Planning and Reporting Community Benefit</i>	California 1/1/1995 Mandatory	Connecticut 1/1/2001 updated 2003, 2006 Mandatory if have a CB program	Idaho 1/1/1999; retroactive to 1/1/96 Mandatory	Indiana 7/1/1994 Mandatory
GUIDE applies to nonprofit hospitals and long-term care organizations	Private, not-for-profit hospitals excluding children's hospitals that do not receive direct payment for services and small and rural hospitals Oversight: Office of Statewide Health Planning and Development (OSHPD), California Health & Welfare Agency	All hospitals and managed care organizations Oversight: Commissioner of Public Health	Nonprofit hospitals \geq 150 beds that are exempt from state property taxes Oversight: State Board of Equalization	All hospitals must file Hospital Fiscal Report; non profits additionally file Annual Nonprofit Hospital Community Benefit Statement Oversight: Indiana State Department of Health (ISDH)
Recommends that mission statement reflect commitment to meeting identified community needs	Must reflect the public's interest in ensuring the hospital fulfills its nonprofit responsibilities	Adopt a policy statement setting forth the commitment to a formal community benefits program.		Must identify the hospital's commitment to serving community health care needs
Recommends a community assessment to determine needs and existing competencies within the community	Must update a community needs assessment every 3 years	Must give priority to the public health needs in state health plan	Not required but hospitals must report in the annual report how community needs were determined	Required and ISDH encourages updating community needs assessment every 3 years
Recommends an annual community benefit plan	Must develop a plan in consultation with the community; annually submit plan to OSHPD			Must develop a plan responsive to community needs
Recommends clearly defining the community to be served	Limits community to the geographic areas or patient populations for which a hospital provides health care services: OSHPD has expanded to include other individuals	Particular attention be given to low & middle income, medically underserved populations and barriers to accessing health care; program shall consider health care needs of a broad spectrum of age groups and health conditions		Defined as the primary geographic area encompassing at least the entire county and patient categories for which the hospital renders healthcare services
Recommends a program evaluation for overall community benefit program and each community benefit activity	Requires mechanisms to evaluate the community benefit plan's effectiveness	Organization guidelines must state administrative mechanisms for regular program evaluation.		Requires that evaluation mechanisms be described in the plan
Recommends that community input be included in all aspects of a community benefit program	Must solicit community feedback on the community benefit plan's effectiveness in meeting community needs	Must seek meaningful participation in developing and implementing a community benefit program		Must describe in the community benefit plan a mechanism to gain community feedback
Recommends an annual community benefit report	Must submit annually, no later than 150 days after end of fiscal year, a report to OSHPD; Must notify public that the report is public information and filed with Department of Health and available upon request	Must submit a biennial report to the Commissioner and make the report available to the public upon request. Connecticut Hospital Association requests annual voluntary reporting of community benefits from all member hospitals to the	Required to file annual report by December 31 st with Board of Equalization; report must include the amount of unreimbursed services (charity care, bad debt and under reimbursed care covered through government programs); a summary of services and programs the hospital	Hospital Fiscal Report and the Annual Nonprofit Hospital Community Benefit Statement required to be filed within 120 days after close of fiscal year with ISDH and include the mission statement, the community benefit plan, a description of the community health needs, a description of

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<i>A Guide for Planning and Reporting Community Benefit</i>	California 1/1/1995 Mandatory	Connecticut 1/1/2001 updated 2003, 2006 Mandatory if have a CB program	Idaho 1/1/1999; retroactive to 1/1/96 Mandatory	Indiana 7/1/1994 Mandatory
		Connecticut Hospital Association.	provides below its actual cost; the amount of donated time, funds, subsidies, and in-kind services; the additions to capital; and the process to determine community needs	the amount and types of community benefits provided, the amount of charity care; The public must be notified that the annual report is available upon request from ISDH
<p>GUIDE details 7 community benefit categories:</p> <ol style="list-style-type: none"> (1) Community Health Improvement Services (2) Health Professions Education: (3) Subsidized Health Services (4) Research (5) Financial and In-kind contributions (6) Community-building activities (7) Community Benefit Operations <p><u>Plus</u> Charity care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</p> <p>Medicare shortfall and bad debt are not counted as community benefits.</p>	<p>Community Benefit defined as activities and services geared toward disease prevention and improvement of health status; includes</p> <ol style="list-style-type: none"> (1) Medical care services (include Medicare shortfall) (2) Other benefits for vulnerable populations (3) Other benefits for the broader community (4) Health research, education and training programs (5) Non-quantifiable benefits (6) Subsidized health services (7) Donations of time, money, equipment (8) Medical education (9) Govt. sponsored programs (10) Research (11) Community education <p>Must provide charity care</p>	<p>Described as voluntary programs that promote preventive care and improve the health status for working families and populations at risk in the communities within the geographic service areas</p> <p>Include Medicare shortfall and bad debt</p>	<p>Described as</p> <ol style="list-style-type: none"> (1) Special services and programs provided below actual hospital cost; (2) Donated time, funds, subsidies, and in-kind services; (3) Additions to capital such as physical plant and equipment (4) Charity care <p>Include unreimbursed services (charity care, bad debt and under reimbursed care covered through government programs including Medicare shortfall)</p>	<p>Community Benefits defined as allocation of funds, properties, services, and activities of a nonprofit hospital to address community needs and priorities – primarily thorough disease prevention and improvement of health status.</p> <p>Includes:</p> <ol style="list-style-type: none"> (1) Unreimbursed cost of government-sponsored indigent health care (2) Charity care (3) Donations of time, money and equipment (4) Community and professional education (5) Government-sponsored program services (6) Research (7) Subsidized health services. <p>Include Medicaid shortfall and Medicare shortfall and bad debt on state hospital Fiscal Report</p>
Use costs not charges				
Include both direct and indirect costs				
GUIDE does not recommend a specific level of community benefits				

<i>A Guide for Planning and Reporting Community Benefit</i>	Illinois 8/8/2003 Mandatory	Maryland 10/1/2001 Mandatory	Massachusetts 6/1994; revised 1/2002 Voluntary Guidelines from Attorney General	Minnesota 1/1/2008 Mandatory
GUIDE applies to nonprofit hospitals and long-term care organizations	Nonprofit hospitals excluding government hospital, hospital located outside a metropolitan statistical area or hospital with <100 beds Oversight: Attorney General	Nonprofit hospitals Oversight: Health Services Cost Review Commission	Nonprofit acute care hospitals excludes municipal hospitals and hospitals that do not charge for patient care services; Voluntary Guidelines also developed for HMOs Oversight: Attorney General	All hospitals reporting health care cost information under section 144.698 or 144.702 Oversight: Department of Health-Health Care Cost Information System – HCCIS.
Recommends that mission statement reflect commitment to meeting identified community needs	Must identify hospital's commitment to serving health care needs of community	Must be included in community benefit report	Must affirm commitment to serve a designated community or patient populations.	
Recommends a community assessment to determine needs and existing competencies within the community	Must disclose in annual report the health care needs of community considered in developing community benefit plan	Must annually identify unmet community health care needs and priorities and consider state or local health departments assessments	Must complete community needs assessment every 3 years with input from community	
Recommends an annual community benefit plan	Must have an operational plan for serving community's health needs		Must have an annual plan; can be submitted as part of the annual report	
Recommends clearly defining the community to be served			Community may extend beyond traditional service area	
Recommends a program evaluation for overall community benefit program and each community benefit activity			Requires that the governing board periodically evaluate the effectiveness of the community benefit plan including soliciting community feedback	
Recommends that community input be included in all aspects of a community benefit program			Requires community input in the needs assessment	
Recommends an annual community benefit report	Required to file annual report within 6 months of end fiscal year; must include copy of audited annual financial reports; Must notify public that report is public information and filed with Attorney General	Must submit an annual plan to the Commission	Must submit an annual report to Office of the Attorney General at the time the hospital files its Form PC; Reports are available for public inspection in the Office of the Attorney General	Must submit an annual report and include total dollars and as a percentage of total operating costs. Additionally, the Minnesota Hospital Association requests annual voluntary reporting of community benefits from all member hospitals to the Minnesota Hospital Association. This initiative may end when mandated reporting begins in January, 2008.

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<p>GUIDE details 7 community benefit categories:</p> <p>(1) Community Health Improvement Services</p> <p>(2) Health Professions Education: Subsidized Health Services</p> <p>(3) Research</p> <p>(4) Financial and In-kind contributions</p> <p>(5) Community-building activities</p> <p>(6) Community Benefit Operations</p> <p><u>Plus</u> Charity care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</p> <p>Medicare shortfall and bad debt are not counted as community benefits.</p>	<p>Defined as</p> <p>(1) Unreimbursed cost of providing charity care,</p> <p>(2) Language assistant services,</p> <p>(3) Government-sponsored indigent health care,</p> <p>(4) Donations,</p> <p>(5) Volunteer services,</p> <p>(6) Education,</p> <p>(7) Government-sponsored program services,</p> <p>(8) Research;</p> <p>(9) Subsidized health services;</p> <p>(10) Bad debts</p> <p>Include Medicaid shortfall, Medicare shortfall and bad debt</p>	<p>May include:</p> <p>(1) Health services for vulnerable or underserved populations,</p> <p>(2) financial or in kind support of public health programs</p> <p>(3) health care cost containment act</p> <p>(4) donations of resources that contribute to a community priority</p> <p>(5) health education, screening and prevention services</p> <p>Include Maryland Children's Health Program</p>	<p>Extensive list of programs defined in the Guidelines that are consistent with the GUIDE;</p> <p>Free care plus any shortfall allocation in connection with administering the Uncompensated Care Pool Trust Fund</p> <p>Do not include Medicaid shortfall or Medicare shortfall or bad debt</p>	<p>Includes the cost of:</p> <p>(1) Community care*,</p> <p>(2) Underpayment for services provided under state health care programs,</p> <p>(3) Research,</p> <p>(4) Community health services,</p> <p>(5) Financial and in-kind contributions,</p> <p>(6) Community building activities</p> <p>(7) Community benefit operations</p> <p>(8) Education</p> <p>(9) Subsidized services</p> <p>*Community care defined as: the costs fro medical care that a hospital has determined is charity care as defined under Minnesota Rules or for which the hospital determines after billing for the services that there is a demonstrated inability to pay.</p> <p>Medicare shortfall and bad debt are included below the line; Bad debt reported at charges</p>
Use costs not charges				Use costs
Include both direct and indirect costs			Include both direct and indirect costs	
GUIDE does not recommend a specific level of community benefits				

<i>A Guide for Planning and Reporting Community Benefit</i>	Nevada 6/14/2005 Mandatory	New Hampshire 1/1/2000; amended 2001, 2004 Mandatory	New York 1/1/1991; amended 1996 Mandatory	Oregon 1/1/2008 Mandatory	Pennsylvania 11/26/1997 Mandatory
PROCESS STEPS					
GUIDE applies to nonprofit hospitals and long-term care organizations	Hospitals with ≥ 100 beds Oversight: Director, Nevada Department of Health and Human Services	Health care charitable trusts with fund balances > \$100,000. Includes hospitals, nursing homes, community health services, medical-surgical and other diagnostic or therapeutic facilities and other charitable trusts organized to provide health care services Oversight: Attorney General; Director Charitable Trusts	Non profit general hospitals Oversight: Commissioner New York State Department of Health	All hospitals in state Oversight: The Office for Oregon Health Policy and Research	Institutions of Purely Public Charity (IPPC) defined as an institution that: has a charitable purpose, operates freely from private profit motive, provides community service by donating or rendering gratuitously a substantial portion of its services, benefit substantial and indefinite class of persons who are legitimate subjects of charity and, and relieves the government of some of its burden by providing a service that the government otherwise would provide. Oversight: Department of State, Bureau of Charitable Organizations
Recommends that mission statement reflect commitment to meeting identified community needs		Be included in community benefit plan and be affirmed annually	Must identify populations and communities served and commitment to addressing community health care needs; be reviewed and amended every 3 years		
Recommends a community assessment to determine needs and existing competencies within the community		Must update community needs assessment every 5 years			
Recommends an annual community benefit plan		Must complete a community benefit plan within 90 days from the start of fiscal year; plus develop every 3 years a community service plan delineating operational and financial commitment to meeting identified community health care needs, providing charity care and improving access by the underserved			
Recommends clearly defining the community to be served		Defined as service area or patient populations provided health care services			
Recommends a program evaluation for overall community benefit program and each community benefit activity be evaluated					

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Recommends that community input be included in all aspects of a community benefit program		Must solicit community input in developing a community benefit plan and describe involvement in community benefit report	Must obtain community input on service priorities every 3 years		
Recommends an annual community benefit report	Must file a report annually by the 6th month after close of the fiscal year including (1) corporate home office allocation methodology of the hospital; (2) expenses incurred for providing community benefits and in kind services as described above; (3) policies and procedures for providing discounted services to or reducing charges for services provided to persons without health insurance that are in addition to any reduction or discount required pursuant to NRS 439B.260; (4) a statement of billing and collection policies	Must file a report within 90 days of the beginning of the fiscal year addressing performance in meeting community benefit objectives	Must submit a report within 120 days after end fiscal year, and file every 3 years a report detailing amendments to the mission statement and changes to operational and financial commitments to meeting identified community health care needs, providing charity care and improving access by the underserved	Must report within 90 days of filing a Medicare cost report on a form prescribed by the administrator. The administrator shall produce an annual report for the Governor, the President of the Senate and the Speaker of the House of Representatives; the report must be available to the Legislative Assembly during each regular session and shall be made available to the public.	Must file copy of the annual federal tax return within 135 days after close of fiscal year

WHAT COUNTS AS A COMMUNITY BENEFIT

GUIDE details 7 community benefit categories: (1) Community Health Improvement Services (2) Health Professions Education: (3) Subsidized Health Services (4) Research (5) Financial and In-kind contributions (6) Community-building activities (7) Community Benefit Operations <u>Plus</u> Charity care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall Medicare shortfall and bad debt are not counted as community benefits.	Described as (1) Goods, services and resources provided by a hospital to a community to address the specific needs and concerns of that community, (2) Services provided by a hospital to the uninsured and underserved persons in that community, (3) Training programs for employees in a community and (4) Health care services provided in areas of a community that have a critical shortage of such services for which the hospital does not receive full reimbursement Include Medicare shortfall and bad debt	Described as activities that address community health care needs including but not limited to (1) Charity care, (2) Financial or in-kind support of public health programs, (3) Allocation of funds, property, services, or other resources that contribute to community health needs identified in the community benefit plan, (4) Donation of funds, property, services or other resources which promote or support a healthier community, enhanced access to health care or related services, health education and prevention activities or services to a vulnerable	Include bad debt	A program or activity that provides treatment or promotes health and healing in response to an identified community need. Includes: (1) Charity care* (2) Medicaid losses (3) Medicare losses (4) SCHIP losses (5) Other publicly funded health care program shortfalls (6) Community health improvement services (7) Research (8) Financial and in-kind contributions (9) Community building activities	Described with a broad definition of (1) Uncompensated goods or services that includes the cost of charity care, bad debts, Medicare shortfall and Medicaid shortfall shortfalls, (2) Unreimbursed research and education activities, (3) Charitable donations, (4) The reasonable value of donated volunteer services, (5) Voluntary payments to government agencies, and (6) The unreimbursed cost of community services. Include Medicare shortfall and bad debt
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		population, (5) Support of medical research and (6) Education and training for health care practitioners Where possible, the statute requires that the trust's description of prior year activity should specifically include the amount of unreimbursed care provided by the trust and the ratio of gross receipts from operations to net operating costs; Do not include bad debt		*Charity care defined as free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. Does not include bad debt, contractual allowances or discounts for quick payment. Include Medicare shortfall	
ACCOUNTING PRINCIPLES					
Use costs not charges				Use costs	Use costs
Include both direct and indirect costs					Include direct and indirect
MINIMUM LEVEL OF EFFORT					
GUIDE does not recommend a specific level of community benefits					Required to provide a minimum amount of community service according to one of seven standards: (1) Providing uncompensated goods or services equal to at least 5% of costs, (2) Maintain an open admission policy and provide uncompensated good or services equal to at least 75% of net operating income, but not less than 3% of total operating expenses, (3) Providing goods or services for fees based On patient's ability to pay (4) Providing financial assistance or uncompensated services to at least 20% of those receiving similar services if at least 10% of the individuals receiving services either paid no fees

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					<p>or fees which were 90% or less of the cost of the services provided to them,</p> <p>(5) Providing wholly gratuitous goods or services to at least 5% of those receiving similar goods or services from the institution,</p> <p>(6) Providing goods or services at no fee or reduced fees to government agencies or individuals eligible for government programs,</p> <p>(7) Fundraising on behalf of or providing grants to an IPPC</p> <p>*May enter into voluntary agreements with local governments to provide payment in lieu of taxes (PILOTS) and credit between 150 and 350% of payment toward uncompensated care expenditure liability.</p>

<i>A Guide for Planning and Reporting Community Benefit</i>	Rhode Island 7/22/1997 Mandatory Revised 4/1/2007	Texas 9/1/1993 amended 1995, 1997, 2001 Mandatory	Utah 1990, Revised 2005 Standards issued by Utah Tax Commission to determine property tax exemption
GUIDE applies to nonprofit hospitals and long-term care organizations	Nonprofit and for profit hospitals Oversight: Rhode Island Department of Health	Public, private hospitals exempt those in health professional shortage areas with populations < 50,000 Oversight: Texas Department State Health Services and tax appraisal districts	Non profit hospitals and nursing homes Oversight: Utah State Tax Commission
Recommends that mission statement reflect commitment to meeting identified community needs	Must develop and make public a board-approved mission statement which notes a commitment to a formal community benefit plan	Must identify commitment to serving community health care needs	
Recommends a community assessment to determine needs and existing competencies within the community	Required in developing the community benefit plan and must include a statement of priorities consistent with the hospital's resources	Required in developing community benefit plan	Must consult annually with county officials to assess community needs that may be addressed
Recommends an annual community benefit plan	Must adopt a Board-approved community benefit plan; update and re-approve every 3 years	Must develop plan aimed at meeting identified community needs	Must have a "charity plan" that addresses an open access policy and procedures for integrating the public interest in policies
Recommends clearly defining the community to be served	Must identify specific community or communities, including racial or ethnic minorities	Primary geographic area and patient categories for which hospital provides health care services	Can be broader or narrower than geographic boundaries of a county
Recommends a program evaluation for overall community benefit program and each community benefit activity be evaluated	Must identify mechanism for annual evaluation		
Recommends that community input be included in all aspects of a community benefit program	Required in developing community benefit plan		Must consult annually with county officials to assess community needs that may be addressed
Recommends an annual community benefit report	Must file by March 1 st , a detailed description with supporting documentation including, but not limited to: (1) Cost of charity care (2) Cost of hospital bad debt, (3) Contracted Medicaid shortfalls	Must submit a report no later than April 30 th each year	To qualify for property tax exemption, nonprofit must be (1) properly organized and operating in good standing under the Utah law governing non-profit organizations; (2) demonstrate that no net earnings and received donations benefit private shareholders or other individuals; (3) maintain an open access policy, regardless of the patient's race, religion, gender or financial status; (4) assure that policies integrate and reflect the public's interest; (5) provide gifts to the community in excess of its annual property tax liability; (6) prove that related facilities enhance and improve the provider's missions in order for those facilities to also qualify for exemption.

<i>A Guide for Planning and Reporting Community Benefit</i>	Rhode Island 7/22/1997 Mandatory	Texas 9/1/1993 amended 1995,1997 Mandatory	Utah 1990 Standards issued by Utah Tax Commission to determine property tax exemption
<p>GUIDE details 7 community benefit categories:</p> <ol style="list-style-type: none"> (1) Community Health Improvement Services (2) Health Professions Education: (3) Subsidized Health Services (4) Research (5) Financial and In-kind contributions (6) Community-building activities (7) Community Benefit Operations <p><u>Plus</u> Charity care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</p> <p>Medicare shortfall and bad debt are not counted as community benefits.</p>	<p>"Community benefit means the provision of hospital services that meet the ongoing needs of the community for primary and emergency care in a manner that enables families and members of the community to maintain relationships with persons who are hospitalized or are receiving hospital services and shall also include, but not be limited to, charity care and uncompensated care"</p> <p>May also include</p> <ol style="list-style-type: none"> (1) Programs, procedures and protocols to help the medically indigent (2) Cooperative efforts to improve community residents' health and well-being (3) Non-revenue producing services such as fitness programs, health screenings or transportation services (4) Public health advocacy (5) Scientific, medical research or educational activities, <p>Include bad debt Do not include Medicare shortfalls</p>	<p>Includes the unreimbursed cost of providing</p> <ol style="list-style-type: none"> (1) Charity care, (2) Government-sponsored indigent health care, (3) Donations, (4) Education, (5) Government-sponsored program services, (6) Research, and (7) Subsidized health services. <p>Include Medicare shortfall in meeting minimum level of effort standard #2 below as well as in standard #3 below in calculating 5% of net patient revenue; can not be included in calculating standard #3 below 4% of net patient revenue</p>	<p>Defined as "gifts to the community" that include</p> <ol style="list-style-type: none"> (1) Unreimbursed indigent care (measured by charges), (2) Medical discounts (measured by the difference between standard charges and actual reimbursement), (3) Donations of time and money, (4) Volunteer and community service activities provided by the hospital or nursing home, including research and professional education programs. <p>Include Medicaid shortfall and Medicare shortfall</p>
Use costs not charges	Use costs		Use charges
Include both direct and indirect costs			
GUIDE does not recommend a specific level of community benefits	<p>May not discourage medically indigent patients from seeking essential medical services nor encourage them to seek essential medical services elsewhere</p> <p>As of 4/1/07, hospitals required to provide charity care:</p> <ul style="list-style-type: none"> ▪ Full charity care ≤ 200% FPL; if patient meets income criterion but not assets criterion, must provide highest discount offered by hospital; ▪ Partial between 200 – 300% FPL ▪ May deny charity care if patient does not provide necessary 	<p>Must provide a minimum amount of community benefits, including charity care and government-sponsored indigent health care, in accordance with one of three standards:</p> <ol style="list-style-type: none"> (1) Reasonableness Standard: Charity care and government-sponsored indigent healthcare are provided at a level that is reasonable in relation to community needs, as determined through the community needs assessment, the available resources of the hospital, and the tax-exempt benefits received by the hospital; (2) 100% of Tax-Exempt Benefits: charity care and government-sponsored 	<p>The institution must, in order to qualify for property tax exemption, show that the "community gift" exceeds on an annual basis its property tax obligation for that year, and the institution must return an amount equal to its tax exemption to the community every year</p>

This resource provides background on state community benefit laws, guidelines, and standards. The language is synthesized from state data bases. This resource is not intended to provide the position of CHA, VHA Inc. or any ministry organization on the state policy. This information is regularly updated, but some states are slower than others in updating their databases. If you have further questions or believe the information about your state is incomplete, please e-mail lgilden@chausa.org. Copyright © 2008, The Catholic Health Association of the United States

<i>A Guide for Planning and Reporting Community Benefit</i>	Rhode Island 7/22/1997 Mandatory	Texas 9/1/1993 amended 1995, 1997 Mandatory	Utah 1990 Standards issued by Utah Tax Commission to determine property tax exemption
	<p>information to apply</p> <ul style="list-style-type: none"> ▪ Must render eligibility decision within 14 days of completed application ▪ Public disclosure of charity care policies ▪ Performance reporting annually ▪ Use standardized application 	<p>indigent health care are provided in an amount equal to at least 100% of the hospital's tax exempt benefits excluding Federal Income Tax:</p> <p>(3) Charity Care and Community Benefits Mix: Charity care and community benefit are provided in a combined amount equal to at least 5% of the hospital's net patient revenue, of which charity care and government-sponsored indigent health care are provided in an amount equal to 4% of the hospital's net patient revenue (as result of 1995 amendment, this requirement can be satisfied on a system-wide basis for disproportionate hospitals)</p>	

Guide for Planning and Reporting Community Benefit	California 1/1/1995 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Private, not-for-profit hospitals excluding children's hospitals that do not receive direct payment for services and small and rural hospitals Oversight: Office of Statewide Health Planning and Development (OSHPD), California Health & Welfare Agency
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	Must reflect the public's interest in ensuring the hospital fulfills its nonprofit responsibilities
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	Must update a community needs assessment every 3 years
<i>Recommends an annual community benefit plan</i>	Must develop a plan in consultation with the community; annually submit plan to OSHPD
<i>Recommends clearly defining the community to be served</i>	Limits community to the geographic areas or patient populations for which a hospital provides health care services: OSHPD has expanded to include other individuals
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	Requires mechanisms to evaluate the community benefit plan's effectiveness
<i>Recommends that community input be included in all aspects of a community benefit program</i>	Must solicit community feedback on the community benefit plan's effectiveness in meeting community needs
<i>Recommends an annual community benefit report</i>	Must submit annually, no later than 150 days after end of fiscal year, a report to OSHPD; Must notify public that the report is public information and filed with Department of Health and available upon request
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p><i>GUIDE details 7 community benefit categories:</i></p> <ol style="list-style-type: none"> (1) <i>Community Health Improvement Services</i> (2) <i>Health Professions Education:</i> (3) <i>Subsidized Health services</i> (4) <i>Research</i> (5) <i>Financial and in-kind contributions</i> (6) <i>Community-building activities</i> (7) <i>Community Benefit Operations</i> <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Community Benefit defined as activities and services geared toward disease prevention and improvement of health status; includes</p> <ol style="list-style-type: none"> (1) Medical care services (include Medicare shortfall) (2) Other benefits for vulnerable populations (3) Other benefits for the broader community (4) Health research, education and training programs (5) Non-quantifiable benefits (6) Subsidized health services (7) Donations of time, money, equipment (8) Medical education (9) Govt. sponsored programs (10) Research (11) Community education <p>Must provide charity care</p>
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Connecticut 1/1/2001 updated 2003; Mandatory if have a CB program
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	All hospitals and managed care organizations Oversight: Commissioner of Public Health (Connecticut Hospital Association also has voluntary reporting initiative)
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	
<i>Recommends an annual community benefit plan</i>	
<i>Recommends clearly defining the community to be served</i>	Particular attention be given to low & middle income, medically underserved populations and barriers to accessing health care; program shall consider health care needs of a broad spectrum of age groups and health conditions
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	Organization guidelines must state administrative mechanisms for regular program evaluation.
<i>Recommends that community input be included in all aspects of a community benefit program</i>	Must seek meaningful participation in developing and implementing a community benefit program
<i>Recommends an annual community benefit report</i>	Must submit a biennial report to the Commissioner and make the report available to the public upon request
WHAT COUNTS AS A COMMUNITY BENEFIT	
<i>GUIDE details 7 community benefit categories:</i> (1) Community Health Improvement Services (2) Health Professions Education: (3) Subsidized Health services (4) Research (5) Financial and in-kind contributions (6) Community-building activities (7) Community Benefit Operations <i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i> <i>Medicare shortfall and bad debt are not counted as community benefits.</i>	Described as voluntary programs that promote preventive care and improve the health status for working families and populations at risk in the communities within the geographic service areas. Include Medicare shortfall and bad debt.
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Idaho 1/1/1999; retroactive to 1/1/96 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Nonprofit hospitals \geq 150 beds that are exempt from state property taxes Oversight: State Board of Equalization
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	Not required but hospitals must report in the annual report how community needs were determined
<i>Recommends an annual community benefit plan</i>	
<i>Recommends clearly defining the community to be served</i>	
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	
<i>Recommends an annual community benefit report</i>	Required to file annual report by December 31 st with Board of Equalization; report must include the amount of unreimbursed services (charity care, bad debt and under reimbursed care covered through government programs); a summary of services and programs the hospital provides below its actual cost; the amount of donated time, funds, subsidies, and in-kind services; the additions to capital; and the process to determine community needs
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p><i>GUIDE details 7 community benefit categories:</i></p> <p>(1) <i>Community Health Improvement Services</i> (2) <i>Health Professions Education:</i> (3) <i>Subsidized Health services</i> (4) <i>Research</i> (5) <i>Financial and in-kind contributions</i> (6) <i>Community-building activities</i> (7) <i>Community Benefit Operations</i></p> <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Described as</p> <ol style="list-style-type: none"> (1) Special services and programs provided below actual hospital cost; (2) Donated time, funds, subsidies, and in-kind services; (3) Additions to capital such as physical plant and equipment (4) Charity care <p>Include unreimbursed services (charity care, bad debt and under reimbursed care covered through government programs including Medicare shortfall)</p>
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Indiana 7/1/1994 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	All hospitals must file Hospital Fiscal Report; non profits additionally file Annual Nonprofit Hospital Community Benefit Statement Oversight: Indiana State Department of Health (ISDH)
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	Must identify the hospital's commitment to serving community health care needs
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	Required and ISDH encourages updating community needs assessment every 3 years
<i>Recommends an annual community benefit plan</i>	Must develop a plan responsive to community needs
<i>Recommends clearly defining the community to be served</i>	Defined as the primary geographic area encompassing at least the entire county and patient categories for which the hospital renders healthcare services
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	Requires that evaluation mechanisms be described in the plan
<i>Recommends that community input be included in all aspects of a community benefit program</i>	Must describe in the community benefit plan a mechanism to gain community feedback
<i>Recommends an annual community benefit report</i>	Hospital Fiscal Report and the Annual Nonprofit Hospital Community Benefit Statement required to be filed within 120 days after close of fiscal year with ISDH and include the mission statement, the community benefit plan, a description of the community health needs, a description of the amount and types of community benefits provided, the amount of charity care; The public must be notified that the annual report is available upon request from ISDH
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p><i>GUIDE details 7 community benefit categories:</i></p> <ol style="list-style-type: none"> (1) Community Health Improvement Services (2) Health Professions Education: (3) Subsidized Health services (4) Research (5) Financial and in-kind contributions (6) Community-building activities (7) Community Benefit Operations <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Community Benefits defined as allocation of funds, properties, services, and activities of a nonprofit hospital to address community needs and priorities – primarily through disease prevention and improvement of health status.</p> <p>Includes:</p> <ol style="list-style-type: none"> (1) Unreimbursed cost of government-sponsored indigent health care (2) Charity care (3) Donations of time, money and equipment (4) Community and professional education (5) Government-sponsored program services (6) Research (7) Subsidized health services. <p>Include Medicaid shortfall and Medicare shortfall and bad debt on state hospital Fiscal Report</p>

<i>A Guide for Planning and Reporting Community Benefit</i>	Indiana 7/1/1994 - Mandatory
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Illinois 8/8/2003 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Nonprofit hospitals excluding government hospital, hospital located outside a metropolitan statistical area or hospital with <100 beds Oversight: Attorney General
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	Must identify hospital's commitment to serving health care needs of community
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	Must disclose in annual report the health care needs of community considered in developing community benefit plan
<i>Recommends an annual community benefit plan</i>	Must have an operational plan for serving community's health needs
<i>Recommends clearly defining the community to be served</i>	
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	
<i>Recommends an annual community benefit report</i>	Required to file annual report within 6 months of end fiscal year; must include copy of audited annual financial reports; Must notify public that report is public information and filed with Attorney General
WHAT COUNTS AS A COMMUNITY BENEFIT	
<i>GUIDE details 7 community benefit categories:</i> (1) <i>Community Health Improvement Services</i> (2) <i>Health Professions Education:</i> (3) <i>Subsidized Health services</i> (4) <i>Research</i> (5) <i>Financial and in-kind contributions</i> (6) <i>Community-building activities</i> (7) <i>Community Benefit Operations</i> <i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i> <i>Medicare shortfall and bad debt are not counted as community benefits.</i>	Defined as (1) Unreimbursed cost of providing charity care, (2) Language assistant services, (3) Government-sponsored indigent health care, (4) Donations, (5) Volunteer services, (6) Education, (7) Government-sponsored program services, (8) Research; (9) Subsidized health services; (10) Bad debts Include Medicaid shortfall, Medicare shortfall and bad debt
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Maryland 10/1/2001 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Nonprofit hospitals Oversight: Health Services Cost Review Commission
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	Must be included in community benefit report
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	Must annually identify unmet community health care needs and priorities and consider state or local health departments assessments
<i>Recommends an annual community benefit plan</i>	
<i>Recommends clearly defining the community to be served</i>	
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	
<i>Recommends an annual community benefit report</i>	Must submit an annual plan to the Commission
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p><i>GUIDE details 7 community benefit categories:</i></p> <ol style="list-style-type: none"> <i>(1) Community Health Improvement Services</i> <i>(2) Health Professions Education:</i> <i>(3) Subsidized Health services</i> <i>(4) Research</i> <i>(5) Financial and in-kind contributions</i> <i>(6) Community-building activities</i> <i>(7) Community Benefit Operations</i> <p><i><u>Plus:</u> Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	Include charity care and Maryland Children's Health Program
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Massachusetts 6/1994; revised 1/2002- Voluntary Guidelines with Attorney General
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Nonprofit acute care hospitals excludes municipal hospitals and hospitals that do not charge for patient care services; Voluntary Guidelines also developed for HMOs Oversight: Attorney General
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	Must affirm commitment to serve a designated community or patient populations.
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	Must complete community needs assessment every 3 years with input from community
<i>Recommends an annual community benefit plan</i>	Must have an annual plan; can be submitted as part of the annual report
<i>Recommends clearly defining the community to be served</i>	Community may extend beyond traditional service area
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	Requires that the governing board periodically evaluate the effectiveness of the community benefit plan including soliciting community feedback
<i>Recommends that community input be included in all aspects of a community benefit program</i>	Requires community input in the needs assessment
<i>Recommends an annual community benefit report</i>	Must submit an annual report to Office of the Attorney General at the time the hospital files its Form PC; Reports are available for public inspection in the Office of the Attorney General
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p><i>GUIDE details 7 community benefit categories:</i></p> <ol style="list-style-type: none"> (1) Community Health Improvement Services (2) Health Professions Education: (3) Subsidized Health services (4) Research (5) Financial and in-kind contributions (6) Community-building activities (7) Community Benefit Operations <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Extensive list of programs defined in the Guidelines that are consistent with the GUIDE;</p> <p>Free care plus any shortfall allocation in connection with administering the Uncompensated Care Pool Trust Fund</p> <p>Do not include Medicaid shortfall or Medicare shortfall or bad debt</p>
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	Include both direct and indirect costs
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Minnesota 1/1/2008 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	All hospitals reporting health care cost information under section 144.698 or 144.702 Oversight: Department of Health- Health Care Cost Information System – HCCIS
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	
<i>Recommends an annual community benefit plan</i>	
<i>Recommends clearly defining the community to be served</i>	
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	
<i>Recommends an annual community benefit report</i>	Must submit an annual report and include total dollars and as a percentage of total operating costs. Additionally, the Minnesota Hospital Association requests annual voluntary reporting of community benefits from all member hospitals to the Minnesota Hospital Association. This initiative may end when mandated reporting begins in January, 2008.
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p><i>GUIDE details 7 community benefit categories:</i></p> <ul style="list-style-type: none"> <i>(1) Community Health Improvement Services</i> <i>(2) Health Professions Education:</i> <i>(3) Subsidized Health services</i> <i>(4) Research</i> <i>(5) Financial and in-kind contributions</i> <i>(6) Community-building activities</i> <i>(7) Community Benefit Operations</i> <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Includes the cost of:</p> <ul style="list-style-type: none"> (1) Community care*, (2) Underpayment for services provided under state health care programs, (3) Research, (4) Community health services, (5) Financial and in-kind contributions, (6) Community building activities (7) Community benefit operations (8) Education (9) Subsidized services <p>*Community care defined as: the costs for medical care that a hospital has determined is charity care as defined under Minnesota Rules or for which the hospital determines after billing for the services that there is a demonstrated inability to pay.</p>

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<i>A Guide for Planning and Reporting Community Benefit</i>	Minnesota 1/1/2008 - Mandatory
	Medicare shortfall and bad debt (charges) are reported below the line
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	Use costs
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Nevada 6/14/2005 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Hospitals with ≥ 100 beds Oversight: Director Nevada Department of Health and Human Services
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	
<i>Recommends an annual community benefit plan</i>	
<i>Recommends clearly defining the community to be served</i>	
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	
<i>Recommends an annual community benefit report</i>	Must file a report annually by the 6th month after close of the fiscal year including (1) corporate home office allocation methodology of the hospital; (2) expenses incurred for providing community benefits and in kind services as described above; (3) policies and procedures for providing discounted services to or reducing charges for services provided to persons without health insurance that are in addition to any reduction or discount required pursuant to NRS 439B.260; (4) a statement of billing and collection policies
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p><i>GUIDE details 7 community benefit categories:</i></p> <ol style="list-style-type: none"> (1) <i>Community Health Improvement Services</i> (2) <i>Health Professions Education:</i> (3) <i>Subsidized Health services</i> (4) <i>Research</i> (5) <i>Financial and in-kind contributions</i> (6) <i>Community-building activities</i> (7) <i>Community Benefit Operations</i> <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Described as</p> <ol style="list-style-type: none"> (1) Goods, services and resources provided by a hospital to a community to address the specific needs and concerns of that community, (2) Services provided by a hospital to the uninsured and underserved persons in that community, (3) Training programs for employees in a community and (4) Health care services provided in areas of a community that have a critical shortage of such services for which the hospital does not receive full reimbursement <p>Include Medicare shortfall and bad debt</p>
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	New Hampshire 1/1/2000; amended 2001, 2004 - Mandatory
PROCESS STEPS	
GUIDE applies to nonprofit hospitals and long-term care organizations	Health care charitable trusts with fund balances > \$100,000. Includes hospitals, nursing homes, community health services, medical-surgical and other diagnostic or therapeutic facilities and other charitable trusts organized to provide health care services Oversight: Attorney General; Director Charitable Trusts
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	Be included in community benefit plan and be affirmed annually
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	Must update community needs assessment every 5 years
<i>Recommends an annual community benefit plan</i>	Must complete a community benefit plan within 90 days from the start of fiscal year; plus develop every 3 years a community service plan delineating operational and financial commitment to meeting identified community health care needs, providing charity care and improving access by the underserved
<i>Recommends clearly defining the community to be served</i>	Defined as service area or patient populations provided health care services
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	Must solicit community input in developing a community benefit plan and describe involvement in community benefit report
<i>Recommends an annual community benefit report</i>	Must file a report within 90 days of the beginning of the fiscal year addressing performance in meeting community benefit objectives
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p>GUIDE details 7 community benefit categories:</p> <ol style="list-style-type: none"> (1) Community Health Improvement Services (2) Health Professions Education: (3) Subsidized Health services (4) Research (5) Financial and in-kind contributions (6) Community-building activities (7) Community Benefit Operations <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Described as activities that address community health care needs including but not limited to</p> <ol style="list-style-type: none"> (1) Charity care, (2) Financial or in-kind support of public health programs, (3) Allocation of funds, property, services, or other resources that contribute to community health needs identified in the community benefit plan, (4) Donation of funds, property, services or other resources which promote or support a healthier community, enhanced access to health care or related services, health education and prevention activities or services to a vulnerable population, (5) Support of medical research and (6) Education and training for health care practitioners <p>Where possible, the statute requires that the trust's description of prior year activity should specifically include the amount of unreimbursed care provided by the trust and the ratio of gross receipts from operations to net operating costs; Do not include bad debt</p>
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	New York 1/1/1991; amended 1996 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Non profit general hospitals Oversight: Commissioner New York State Department of Health
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	Must identify populations and communities served and commitment to addressing community health care needs; be reviewed and amended every 3 years
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	
<i>Recommends an annual community benefit plan</i>	
<i>Recommends clearly defining the community to be served</i>	
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	Must obtain community input on service priorities every 3 years
<i>Recommends an annual community benefit report</i>	Must submit a report within 120 days after end fiscal year; And file every 3 years a report detailing amendments to the mission statement and changes to operational and financial commitments to meeting identified community health care needs, providing charity care and improving access by the underserved
WHAT COUNTS AS A COMMUNITY BENEFIT	
<i>GUIDE details 7 community benefit categories:</i> <i>(1) Community Health Improvement Services</i> <i>(2) Health Professions Education:</i> <i>(3) Subsidized Health services</i> <i>(4) Research</i> <i>(5) Financial and in-kind contributions</i> <i>(6) Community-building activities</i> <i>(7) Community Benefit Operations</i> <i><u>Plus:</u> Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i> <i>Medicare shortfall and bad debt are not counted as community benefits.</i>	Include bad debt
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Oregon 1/1/2008 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Applies to all hospitals Oversight: The Office for Oregon Health Policy and Research
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	
<i>Recommends an annual community benefit plan</i>	
<i>Recommends clearly defining the community to be served</i>	
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	
<i>Recommends an annual community benefit report</i>	Must report within 90 days of filing a Medicare cost report on a form prescribed by the administrator. The administrator shall produce an annual report for the Governor, the President of the Senate and the Speaker of the House of Representatives; the report must be available to the Legislative Assembly during each regular session and shall be made available to the public.
WHAT COUNTS AS A COMMUNITY BENEFIT	
<i>GUIDE details 7 community benefit categories:</i> (1) <i>Community Health Improvement Services</i> (2) <i>Health Professions Education:</i> (3) <i>Subsidized Health services</i> (4) <i>Research</i> (5) <i>Financial and in-kind contributions</i> (6) <i>Community-building activities</i> (7) <i>Community Benefit Operations</i> <i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i> <i>Medicare shortfall and bad debt are not counted as community benefits.</i>	A program or activity that provides treatment or promotes health and healing in response to an identified community need. Includes: (1) Charity care* (2) Medicaid losses (3) Medicare losses (4) SCHIP losses (5) Other publicly funded health care program shortfalls (6) Community health improvement services (7) Research (8) Financial and in-kind contributions (9) Community building activities *Charity care defined as free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. Does not include bad debt, contractual allowances or discounts for quick payment.
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	Use costs
<i>Include both direct and indirect costs</i>	
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	

This resource provides background on state community benefit laws, guidelines, and standards. The language is synthesized from state data bases. This resource is not intended to provide the position of CHA, VHA Inc. or any ministry organization on the state policy. This information is regularly updated, but some states are slower than others in updating their databases. If you have further questions or believe the information about your state is incomplete, please e-mail lgilden@chausa.org.
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<i>A Guide for Planning and Reporting Community Benefit</i>	Pennsylvania 11/26/1997 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Institutions of Purely Public Charity (IPPC) defined as an institution that: has a charitable purpose, operates freely from private profit motive, provides community service by donating or rendering gratuitously a substantial portion of its services, benefit substantial and indefinite class of persons who are legitimate subjects of charity and, and relieves the government of some of its burden by providing a service that the government otherwise would provide. Oversight: Department of State, Bureau of Charitable Organizations
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	
<i>Recommends an annual community benefit plan</i>	
<i>Recommends clearly defining the community to be served</i>	
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	
<i>Recommends an annual community benefit report</i>	Must file copy of the annual federal tax return within 135 days after close of fiscal year
WHAT COUNTS AS A COMMUNITY BENEFIT	
<i>GUIDE details 7 community benefit categories:</i> <i>(1) Community Health Improvement Services</i> <i>(2) Health Professions Education:</i> <i>(3) Subsidized Health services</i> <i>(4) Research</i> <i>(5) Financial and in-kind contributions</i> <i>(6) Community-building activities</i> <i>(7) Community Benefit Operations</i> <i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i> <i>Medicare shortfall and bad debt are not counted as community benefits.</i>	Described with a broad definition of <ol style="list-style-type: none">(1) Uncompensated goods or services that includes the cost of charity care, bad debts, Medicare shortfall and Medicaid shortfall shortfalls,(2) Unreimbursed research and education activities,(3) Charitable donations,(4) The reasonable value of donated volunteer services,(5) Voluntary payments to government agencies, and(6) The unreimbursed cost of community services. Include Medicare shortfall and bad debt
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	Use costs
<i>Include both direct and indirect costs</i>	Include both direct and indirect

<p><i>A Guide for Planning and Reporting Community Benefit</i></p>	<p>Pennsylvania 11/26/1997 - Mandatory</p>
<p>MINIMUM LEVEL OF EFFORT</p>	
<p><i>GUIDE does not recommend a specific level of community benefits</i></p>	<p>Required to provide a minimum amount of community service according to one of seven standards:</p> <ol style="list-style-type: none"> (1) Providing uncompensated goods or services equal to at least 5% of costs, (2) Maintain an open admission policy and provide uncompensated good or services equal to at least 75% of net operating income, but not less than 3% of total operating expenses, (3) Providing goods or services for fees based on patient's ability to pay (4) Providing financial assistance or uncompensated services to at least 20% of those receiving similar services if at least 10% of the individuals receiving services either paid no fees or fees which were 90% or less of the cost of the services provided to them, (5) Providing wholly gratuitous goods or services to at least 5% of those receiving similar goods or services from the institution, (6) Providing goods or services at no fee or reduced fees to government agencies or individuals eligible for government programs, (7) Fundraising on behalf of or providing grants to an IPPC <p>*May enter into voluntary agreements with local governments to provide payment in lieu of taxes (PILOTS) and credit between 150 and 350% of payment toward uncompensated care expenditure liability.</p>

<i>A Guide for Planning and Reporting Community Benefit</i>	Rhode Island 7/22/1997 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Nonprofit and for profit hospitals Oversight: Rhode Island Department of Health
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	Must develop and make public a board-approved mission statement which notes a commitment to a formal community benefit plan
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	Required in developing the community benefit plan and must include a statement of priorities consistent with the hospital's resources
<i>Recommends an annual community benefit plan</i>	Must adopt a Board-approved community benefit plan; update and re-approve every 3 years
<i>Recommends clearly defining the community to be served</i>	Must identify specific community or communities, including racial or ethnic minorities
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	Requires annual mechanism for regular evaluation
<i>Recommends that community input be included in all aspects of a community benefit program</i>	Required in developing community benefit plan
<i>Recommends an annual community benefit report</i>	Must file by March 1 st , a detailed description with supporting documentation of (1) Charity and uncompensated care provided, (2) Hospital bad debt, (3) Medicaid shortfall shortfalls
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p><i>GUIDE details 7 community benefit categories:</i></p> <ol style="list-style-type: none"> (1) Community Health Improvement Services (2) Health Professions Education: (3) Subsidized Health services (4) Research (5) Financial and in-kind contributions (6) Community-building activities (7) Community Benefit Operations <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Includes the</p> <ol style="list-style-type: none"> (1) Provision of emergency and primary care through charity and uncompensated care, (2) Scientific or education activities, (3) Public health advocacy, (4) Free public health services, (5) Cooperative efforts to improve community residents' health, and (6) Programs to help the medically indigent <p>Include bad debt</p>
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	

<i>A Guide for Planning and Reporting Community Benefit</i>	Rhode Island 7/22/1997 - Mandatory
MINIMUM LEVEL OF EFFORT	
<i>GUIDE does not recommend a specific level of community benefits</i>	May not discourage medically indigent patients from seeking essential medical services nor encourage them to seek essential medical services elsewhere

<i>A Guide for Planning and Reporting Community Benefit</i>	Texas 9/1/1993 amended 1995,1997, 2001 - Mandatory
PROCESS STEPS	
<i>GUIDE applies to nonprofit hospitals and long-term care organizations</i>	Public, private hospitals exempt those in health professional shortage areas with populations < 50,000 Oversight: Texas Department State Health Services and tax appraisal districts
<i>Recommends that mission statement reflect commitment to meeting identified community needs</i>	Must identify commitment to serving community health care needs
<i>Recommends a community assessment to determine needs and existing competencies within the community</i>	Required in developing community benefit plan
<i>Recommends an annual community benefit plan</i>	Must develop plan aimed at meeting identified community needs
<i>Recommends clearly defining the community to be served</i>	Primary geographic area and patient categories for which hospital provides health care services
<i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i>	
<i>Recommends that community input be included in all aspects of a community benefit program</i>	
<i>Recommends an annual community benefit report</i>	Must submit a report no later than April 30 th each year
WHAT COUNTS AS A COMMUNITY BENEFIT	
<p><i>GUIDE details 7 community benefit categories:</i></p> <ol style="list-style-type: none"> (1) <i>Community Health Improvement Services</i> (2) <i>Health Professions Education:</i> (3) <i>Subsidized Health services</i> (4) <i>Research</i> (5) <i>Financial and in-kind contributions</i> (6) <i>Community-building activities</i> (7) <i>Community Benefit Operations</i> <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Includes the unreimbursed cost of providing</p> <ol style="list-style-type: none"> (1) Charity care, (2) Government-sponsored indigent health care, (3) Donations, (4) Education, (5) Government-sponsored program services, (6) Research, and (7) Subsidized health services. <p>Include Medicare shortfall in meeting minimum level of effort standard #2 below as well as in standard #3 below in calculating 5% of net patient revenue; can not be included in calculating standard #3 below 4% of net patient revenue</p>
ACCOUNTING PRINCIPLES	
<i>Use costs not charges</i>	
<i>Include both direct and indirect costs</i>	

<p><i>A Guide for Planning and Reporting Community Benefit</i></p>	<p>Texas 9/1/1993 amended 1995,1997, 2001 - Mandatory</p>
<p>MINIMUM LEVEL OF EFFORT</p>	
<p><i>GUIDE does not recommend a specific level of community benefits</i></p>	<p>Must provide a minimum amount of community benefits, including charity care and government-sponsored indigent health care, in accordance with one of three standards:</p> <ul style="list-style-type: none"> (1) Reasonableness Standard: Charity care and government-sponsored indigent healthcare are provided at a level that is reasonable in relation to community needs, as determined through the community needs assessment, the available resources of the hospital, and the tax-exempt benefits received by the hospital; (2) 100% of Tax-Exempt Benefits: charity care and government-sponsored indigent health care are provided in an amount equal to at least 100% of the hospital's tax exempt benefits excluding Federal Income Tax; (3) Charity Care and Community Benefits Mix: Charity care and community benefit are provided in a combined amount equal to at least 5% of the hospital's net patient revenue, of which charity care and government-sponsored indigent health care are provided in an amount equal to 4% of the hospital's net patient revenue (as result of 1995 amendment, this requirement can be satisfied on a system-wide basis for disproportionate hospitals)

<p><i>A Guide for Planning and Reporting Community Benefit</i></p>	<p align="center">Utah 1990; Revised 2005 - Standards issued by Utah Tax Commission to determine property tax exemption</p>
<p>PROCESS STEPS</p>	
<p><i>GUIDE applies to nonprofit hospitals and long-term care organizations</i></p>	<p>Non profit hospitals and nursing homes Oversight: Utah State Tax Commission</p>
<p><i>Recommends that mission statement reflect commitment to meeting identified community needs</i></p>	
<p><i>Recommends a community assessment to determine needs and existing competencies within the community</i></p>	<p>Must consult annually with county officials to assess community needs that may be addressed</p>
<p><i>Recommends an annual community benefit plan</i></p>	<p>Must have a "charity plan" that addresses an open access policy and procedures for integrating the public interest in policies</p>
<p><i>Recommends clearly defining the community to be served</i></p>	<p>Can be broader or narrower than geographic boundaries of a county</p>
<p><i>Recommends a program evaluation for overall community benefit program and each community benefit activity</i></p>	
<p><i>Recommends that community input be included in all aspects of a community benefit program</i></p>	<p>Must consult annually with county officials to assess community needs that may be addressed</p>
<p><i>Recommends an annual community benefit report</i></p>	<p>To qualify for property tax exemption, nonprofit must be (1) properly organized and operating in good standing under the Utah law governing non-profit organizations; (2) demonstrate that no net earnings and received donations benefit private shareholders or other individuals; (3) maintain an open access policy, regardless of the patient's race, religion, gender or financial status; (4) assure that policies integrate and reflect the public's interest; (5) provide gifts to the community in excess of its annual property tax liability; (6) prove that related facilities enhance and improve the provider's missions in order for those facilities to also qualify for exemption.</p>
<p>WHAT COUNTS AS A COMMUNITY BENEFIT</p>	
<p><i>GUIDE details 7 community benefit categories:</i> <i>(1) Community Health Improvement Services</i> <i>(2) Health Professions Education:</i> <i>(3) Subsidized Health services</i> <i>(4) Research</i> <i>(5) Financial and in-kind contributions</i> <i>(6) Community-building activities</i> <i>(7) Community Benefit Operations</i></p> <p><i>Plus: Charity Care and unreimbursed costs of indigent government sponsored programs including Medicaid shortfall</i></p> <p><i>Medicare shortfall and bad debt are not counted as community benefits.</i></p>	<p>Defined as "gifts to the community" that include (1) Unreimbursed indigent care (measured by charges), (2) Medical discounts (measured by the difference between standard charges and actual reimbursement), (3) Donations of time and money, (4) Volunteer and community service activities provided by the hospital or nursing home, including research and professional education programs.</p> <p>Include Medicaid shortfall and Medicare shortfall</p>
<p>ACCOUNTING PRINCIPLES</p>	
<p><i>Use costs not charges</i></p>	<p>Use charges</p>

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<p><i>A Guide for Planning and Reporting Community Benefit</i></p>	<p style="text-align: center;">Utah 1990; Revised 2005 - Standards issued by Utah Tax Commission to determine property tax exemption</p>
<p><i>Include both direct and indirect costs</i></p>	
<p>MINIMUM LEVEL OF EFFORT</p>	
<p><i>GUIDE does not recommend a specific level of community benefits</i></p>	<p>The institution must, in order to qualify for property tax exemption, show that the "community gift" exceeds on an annual basis its property tax obligation for that year, and the institution must return an amount equal to its tax exemption to the community every year</p>

State Hospital Association Voluntary Community Benefit Reporting

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/VHA Guide-Lines	Bad debt Medicare Shortfall
Alabama Hospital Assoc. 500 North East Blvd. Montgomery, AL 36117 (334) 272-8781 (334) 270-9527 Fax www.alaha.org	No	No	Rosemary Blackmon Executive Vice President (334) 272-8781 rblackmon@alaha.org		
Alaska Hospital Assoc. 426 Main Street Juneau, AK 99801 (907) 586-1790 (907) 463-3573 Fax 943 West 6th Street, #120 Anchorage, AK (907) 646-1444 (907) 646-3964 Fax www.ashnha.org	No	Yes	Geoff Bullock Government Relations (907) 586-1790 lobby@gci.net	Yes	Below the line
Arizona Hospital and Healthcare Association 2901 North Central Avenue, Suite 900 Phoenix, Arizona 85012-2729 (602) 445-4300 (602) 445-4299 Fax www.azhha.org	No	Yes	Bridget O’Gara, VP Communication (602) 445-4300 ext. 4318 bogara@azhha.org	Current survey w/ member; 2008 Board review for final reporting decisions	

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/VHA Guide-Lines	Bad debt Medicare Shortfall
Arkansas Hospital Assoc. 419 Natural Resources Drive · Little Rock, AR 72205 (501) 224-7878 (501) 224-0519 Fax www.arkhospitals.org	No	No	Paul Cunningham Sr. Vice President pcunningham@arkhospitals.org Phil Matthews, President & CEO philmatthews@arkhospitals.org Elisa White, VP & General Counsel elisawhite@arkhospitals.org		
California Hospital Assoc. 1215 K Street, Suite 800 Sacramento, CA 95814 (916) 443-7401 (916) 552-7596 Fax www.calhealth.org	Yes	No	Anne M. McLeod Vice President Reimbursement and Economic Analysis (916) 552-7536 (916) 554-2236 Fax amcleod@calhospital.org		
Colorado Hospital Assoc. 7335 East Orchard Road, Suite 100 Greenwood Village, CO 80111 (720) 489-1630 www.cha.com	No	No	Richard Haugh VP of Communications (720) 330-6019 rick.haugh@cha.org		
Connecticut Hospital Assoc. 110 Barnes Road P.O. Box 90 Wallingford, CT 06492 www.cthosp.org	Yes	Yes	Diane M. Tanksley Assistant Director, Finance (203) 294-7284 (203) 265-9910 Fax Tanksley@chime.org	Yes	Include both

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/ VHA Guide-Lines	Bad debt Medicare Shortfall
Delaware Healthcare Assoc. 1280 South Governors Avenue Dover, DE 19904-4802 302-674-2853 302-734-2731 Fax www.deha.org	No	Yes	Michael Duva Director Health Policy (302) 674-2853 mike@deha.org	Yes	Include both
District of Columbia Hospital Assoc. 1250 I Street NW, Suite 700 Washington, DC 20005 www.dcha.org	No	Pend-ing	Machelle Yingling VP Information Services (202) 682-1585 myingling@dcha.org		
Florida Hospital Assoc. 306 E. College Avenue Tallahassee, FL 32301 (850)222-9800 (850)561-6230 Fax 307 Park Lake Circle Orlando, FL 32803 (407)841-6230 www.fha.org	No	No	Kim Streit, VP Healthcare Research and Information (407) 841-6230 Orlando office kims@fha.org		
Georgia Hospital Assoc. 1675 Terrell Mill Road Marietta, GA 30067 (770) 249-4500 (770) 955-5801 Fax www.gha.org	No	Yes	Joyce Reid, RN Director Community Health Connection (770) 249-4545 jreid@gha.org		

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/ VHA Guide-Lines	Bad debt Medicare Shortfall
(Hawaii) The Healthcare Association of Hawaii 932 Ward Avenue, Suite 430 Honolulu, HI 96814-2126 (808) 521-8961 (808) 599-2879 Fax www.hah.org	No	Yes thru E&Y	Richard Meiers President and CEO (808) 521-8961 rmeiers@hah.org	similar	Include bad debt
Idaho Hospital Assoc. 615 North Seventh St. P.O. Box 1278 Boise, ID 83701 (208) 338-5100 (208) 338-7800 Fax www.teamiha.org	Yes	No	Darryl-lynn Oakes Director of Communications (208) 338-5100 ext. 204 doakes@teamiha.org		
Illinois Hospital Assoc. 1151 East Warrenville Road Naperville, IL 60566 (630) 276-5400 www.ihatoday.org	Yes	No	Sandy Kraiss Finance (630) 276-5522 skraiss@ihastaff.org		Include both
Indiana Hospital Assoc. One American Square P.O. Box 82063 Indianapolis, IN 46282 (317) 663-4870 (317) 663-4875 fax www.inhha.org	Yes	Yes	Allison Wharry Director of Health Policy (317) 423-7740 awharry@inhha.org		
Iowa Hospital Assoc. 100 East Grand Street Suite 100 Des Moines, Iowa 50309 (515) 288-1955 www.iaonline.org	No	Yes	Perry Meyer Sr. VP Information Center meyerp@iaonline.org Kelly Coe-DeVore Director Data Analysis coek@iaonline.org	Yes Charges & costs reported	Both reported below line

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/ VHA Guide-Lines	Bad debt Medicare Shortfall
Kansas Hospital Assoc. 215 SE 8 th Avenue Topeka, KS 66603-3906 (785) 233-7436 (785) 233-6955 Fax www.kha-net.org	No	Yes	Fred Lucky Sr. Vice President (785) 233-7436 ext. 128 flucky@kha-net.org Tish Hollingsworth Director of Reimbursement (785) 233-7436 ext. 132 thollingsworth@kha-net.org		
Kentucky Hospital Assoc. 2501 Nelson Miller Pky. Louisville, KY 40223 (502) 426-6220 (502) 814-0363 Fax www.kyha.org	No	Pend-ing	Pam Mullaney Director Membership Services (502) 426-6220 pmullaney@kyha.com		
Louisiana Hospital Assoc. 9521 Brookline Avenue Baton Rouge, Louisiana 70809 (225) 928-0026 (225) 923-1004 Fax www.lhaonline.org	No	No	Michelle Clement Director Communications/PR (225) 928-0026 mclement@lhaonline.org		
(Maine) Assoc. of Maine Hospitals and Healthcare Organizations 33 Fuller Street Augusta, ME 04330 (207) 622-4794 (207) 622-3073 Fax www.themha.org	No	No	Mary Mayhew VP Government Affairs and Communication (207) 622-4794 mmayhew@themha.org		

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/VHA Guide-Lines	Bad debt Medicare Shortfall
Maryland Hospital Assoc. 6820 Deerpath Road Elkridge, MD 21075 (410) 379-6200 www.mhaonline.org	Yes	No	Nancy Fiedler Sr.VP Communications (410) 379-6200 nfiedler@mhaonline.org Ing-Jye Cheng Asst. VP Health Care Finance (410) 379-6200 icheng@mhaonline.org		
Massachusetts Hospital Assoc. 5 New England Executive Park Burlington, MA 01803 (781) 272-8000 101 Arch Street, Suite 1741 Boston, MA 02109 (617) 367-9667 www.mhalink.org	No	Yes thru Attor. Gen.	Anuj Goel, Esq. Sr. Director Regulations and Staff Counsel (781) 272-8000 ext. 140 agoel@mhalink.org		
Michigan Hospital Assoc. 6215 W. St. Joseph HWY Lansing, MI 48917 (517) 323-3443 (517) 323-0946 Fax www.mha.org	No	Yes	Laura Schmidt Director Health Care Information (517) 886-8353 (517) 323-0946 Fax lschmidt@mha.org	Yes	Both reported below line

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/ VHA Guide-Lines	Bad debt Medicare Shortfall
Minnesota Hospital Assoc. 2550 University Ave. W Suite 350-S St. Paul, MN 55114 www.mnhospitals.org	Yes	Yes	Matt Anderson VP Regulatory Joe Schindler Sr. Dir. Finance & Data Policy (651) 641-1121 (651) 659-1477 Fax jschindler@mnhospitals.org Amy Harris Director Communications (651) 603-3549 aharris@mnhospitals.org	Yes	Both reported below line; Bad debt at charges
Mississippi Hospital Assoc. PO Box 1909 116 Woodgreen Place Madison, MS 39110-1909 (800) 289-8884 (601) 368-3200 Fax www.mhanet.org	No	No	Michael Bailey CFO (601) 982-3251 mbailey@mhanet.org		
Missouri Hospital Assoc. 4712 Country Club Drive Jefferson City, MO 65102 (573) 893-3700 (573) 893-2809 Fax www.mhanet.com	No	Yes	Mary Becker Sr. VP Strategic Communications & Research (573) 893-3700 x 1303 mbecker@mail.mhanet.com	Limited categories	Include both
Montana Hospital Assoc. 1720 Ninth Avenue Helena, MT 59601 (406) 442-1911 (406) 443-3894 Fax www.mtha.org	No	Yes	Bob Olsen, VP bob@mtha.org Roberta Yager Information Services Coord. roberta@mtha.org	Yes	Both reported below line

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/ VHA Guide-Lines	Bad debt Medicare Shortfall
Nebraska Hospital Assoc. 3255 Salt Creek Circle Lincoln, NE 68504 (402) 742-8153 (402) 742-8191 Fax www.nhanet.org	No	Yes	Carly Runestad Dir. Health Policy (402) 742-8153 crunestad@nhanet.org David Burd, CHFP Sr. Dir. Of Finance (402)742-8144 dburd@nhanet.org	Yes	Medicare included; Bad debt reported below line
Nevada Hospital Assoc. 5250 Neil Road, Suite 302 Reno, NV 89502 (775) 827-0184 www.nvha.net	Yes	No	Dwight Hansen Director Financial Services (775) 827-0184 Dwight@nvha.net	Yes	Both included
New Hampshire Hospital Assoc. 125 Airport Road Concord, NH 03301 (603) 225-0900 (603) 225-4346 Fax www.nhha.org	Yes	No	Leslie Melby VP State Government Relations (603) 225-0900 lmelby@nhha.org		
New Jersey Hospital Assoc. 760 Alexander Road Princeton, NJ 08543 (609) 275-4000 (609) 452-8097 Fax www.njha.com	No	Yes	Valerie Sellers, Sr. VP Health Planning & Research (609) 275-4261 vsellers@njha.com	Yes	Optional to include one or both
New Mexico Hospital Assoc. P.O. Box 92200 2121 Osuna Road, NE. 87113 Albuquerque, NM 87199-2200 (505) 343-0010 (505) 343-0012 Fax www.nmhhsa.org	No	No	Jeff Dye President & CEO (505) 343-0010 jdye@nmhsc.com		

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/ VHA Guide-Lines	Bad debt Medicare Shortfall
New York Healthcare Assoc. of New York State One Empire Drive Rensselaer, NY 12144 (518) 431-7600 (518) 431-7812 Fax www.hanys.org	Yes	No	Sue Ellen Wagner VP Community Health 518-431-7837 swagner@hanys.org		Include bad debt
North Carolina Hospital Assoc. 2400 Weston Pkw. Cary, NC 27513 (919) 677-2400 (919) 677-4200 Fax www.ncha.org	Yes if bonds thru Med. Care Com.	Yes	Sarah Broome Dir. Economic Research (919) 677-4137 andi@ncha.org	Similar	Both included
North Dakota Healthcare Assoc. PO Box 7340 1622 E. Interstate Ave. Bismarck, ND 58507 (701) 224-9732 (701) 224-9529 Fax www.ndha.org	No	No	Karen Haskins VP (701) 224-9732 karenhaskins@ndha.org		
Ohio Hospital Assoc. 155 E. Broad Street 15 th Floor Columbus, OH 43215 (614) 221-7614 (614) 221-4771 Fax www.ohanet.org	No	Yes	Mary Yost VP Public Affairs (614) 221-7614 maryy@ohanet.org	Yes	Both reported below line
Oklahoma Hospital Assoc. 4000 Lincoln Blvd. Oklahoma City, Okla. 73105 (405) 427-9537 (405) 424-4507 Fax www.okoha.com	No	No	Rick Snyder, VP Finance & IS (405) 427-9537 rsnyder@okoha.com		

This resource provides background on state community benefit laws, guidelines, and standards. The language is synthesized from state data bases. This resource is not intended to provide the position of CHA, VHA Inc. or any ministry organization on the state policy. This information is regularly updated, but some states are slower than others in updating their databases. If you have further questions or believe the information about your state is incomplete, please e-mail lgilden@chausa.org.
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State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/ VHA Guide-Lines	Bad debt Medicare Shortfall
Oregon Association of Hospitals and Health Systems 4000 Kruse Way Place Building 2, Suite 100 Lake Oswego, OR 97035 (503) 636-2204 (503) 636-8310 Fax www.oahhs.org	Yes	No	Gwen Dayton, Ex. VP and General Counsel (503) 479-6009 gdayton@oahhs.org Kevin Earls VP Finance & Health Policy (503)-479-6004 kcearls@oahhs.org	Yes	Include Medicare shortfalls; Not bad debt
(Pennsylvania) The Hospital & Healthsystem Association of Pennsylvania 4750 Lindle Road P.O. Box 8600 Harrisburg PA, 17105-8600 (717) 564-9200 www.haponline.org	Yes	No	Paula Bussard Sr. VP Policy & Regulatory Services (717) 561-5344 pbussard@haponline.org		Include both
Rhode Island Hospital Association of Rhode Island 100 Midway Road - Suite 21 Cranston, RI 02920 (401) 946-7887 (401) 946-8188 Fax www.hari.org	Yes	No	Amanda Barney VP Communications (401)946-7887 ext. 111 amandab@hari.org		
South Carolina Hospital Assoc. 1000 Center Point Road Columbia, SC 29210 (803) 744-3503 (803) 796-2938 Fax www.scha.org	No	Yes	Patty Smoake VP Communications (803) 744-3503 psmoake@scha.org	Yes	Not decided yet

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/ VHA Guide-Lines	Bad debt Medicare Shortfall
South Dakota South Dakota Association of Healthcare Organizations 3708 W. Brooks Place Sioux Falls, SD 57106 (605) 361-2281 (605) 361-5175 Fax www.sdaho.org	No	No	Gilbert Johnson Director Health Data Systems (605)361-2281 gilbert@sdaho.org		
(Tennessee) Hospital Alliance of Tennessee 211 Seventh Avenue North Suite 400 Nashville, TN 37219 (615) 254-1941 (615) 254-1942 Fax www.hospitalalliancetn.com	No	Yes	LaDonna McDaniel-Merville VP (615) 254-1941 ladonna@hospitalalliancetn.com	Yes	Include Medicare; separate line item for bad debt
Texas Hospital Assoc. 6225 East Highway 290 P.O. Box 15587 Austin, TX 78761-5587 (512) 465-1000 (512) 465-1090 Fax www.texashospitalsonline.org	Yes	No	Charles Bailey General Counsel (512) 465-1038 cbailey@tha.org Ernie Schmid Sr. Dir. Policy Analysis (512) 465-1557 eschmid@tha.org		
Utah Hospitals and Health System Assoc. 2180 South 1300 East Suite 440 Salt Lake City, Utah 84106 (801) 486-9915 (801) 486-0882 Fax www.uha-utah.org	Yes	No	Jill Vicory Director Member & Community Affairs (801) 486-9915 jill@uha-utah.org		

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/VHA Guide-Lines	Bad debt Medicare Shortfall
Vermont Assoc. of Hospitals and Health Systems 148 Main Street Montpelier, VT 05602 (802) 223-3461 (802) 223-0364 Fax www.vahhs.org	No	No	Michael Del Trecco VP Finance (802) 223-3461 Michael@vahhs.org		
Virginia Hospital Assoc. 4200 Innslake Drive Glen Allen, VA 23060 (804) 965-1213 (804) 965-0475 Fax www.vhha.com	No	Yes	Betty Long VP (804) 965-1213 blong@vhha.com	Hospitals report a total community benefit \$; encouraged to use CHA/VHA guidelines	Pending decision
Washington Hospital Assoc. 300 Elliott Avenue West Suite 300 Seattle, WA 98119 (206) 216-2505 (206) 577-1901 Fax www.wsha.org	No	Yes	Jane Feldman, Ph.D. Director Analytical Services (206) 216-2505 jane@wsha.org	Yes	Neither are included
West Virginia Hospital Assoc. 100 Association Drive Charleston, WV 25311-1571 (304) 344-9744 (304) 344-9745 Fax www.wvha.com	No	No	Mike Robbins VP Financial Policy (304) 353-9721 mrobbins@wvha.org		

State Hospital Association	State Govt. Mandated Reporting	Voluntary Reporting	State Hospital Association Community Benefit Contact	Use CHA/ VHA Guide-Lines	Bad debt Medicare Shortfall
Wisconsin Hospital Assoc. 5510 Research Park Dr. Madison, WI 53711 (608) 274-1820 (608) 274-8554 Fax www.wha.org	No	Yes	Brian Potter VP Finance & Operations bpotter@wha.org Mandy Ayers Dir. Administration mayers@wha.org Mary Kay Grasmick VP Communications mgrasmick@wha.org	Yes	Both reported in footnotes
Wyoming Hospital Assoc. Box 249 2005 Warren Cheyenne, WY 82003 (307) 632-9344 (307) 632-9347 Fax www.wyohospitals.com	No	No	Dan Perdue President (307) 632-9344 dan@wyohospitals.com		