

# Reference I.

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## COMMUNITY BENEFIT CATEGORIES

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They are not provided for marketing purposes. A community benefit must meet at least one of the following criteria:

- Generates a low or negative margin
- Responds to needs of special populations, such as persons living in poverty and other disenfranchised persons
- Supplies services or programs that would likely be discontinued—or would need to be provided by another not-for-profit or government provider—if the decision was made on a purely financial basis
- Responds to public health needs
- Involves education or research that improves overall community health

There are many outreach and community-based services provided for marketing purposes that truly help persons in the community. However, if a service is provided primarily for marketing purposes, it should not be counted in a quantitative community benefit report.

Following are recommendations for how services should be categorized and what should and should not be counted in the quantitative community benefit report.

### I. Charity care

Charity care is free or discounted health services provided to persons who cannot afford to pay and who meet the organization's criteria for financial assistance. Generally, a bill must be generated and recorded and the patient must meet the organization's criteria for charity care and demonstrate an inability to pay. Charity care should be reported in terms of costs, not charges. Charity care does not include bad debt.

#### **Count:**

- Free and discounted care
- Expenses incurred by the provision of charity care
- Indirect costs not already included in calculating costs

#### **Do not count:**

- Bad debt
- Contractual allowances or quick-pay discounts
- Any portion of charity care costs already included in the subsidized health care services category (This would constitute double-counting.)

## II. Government-Sponsored Health Care

Government-sponsored health care community benefits include unpaid costs of public programs—the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments. It does not include any shortfall that results from inefficiency or poor management.

### Count:

Losses related to:

- Medicaid shortfall
- State Children’s Health Insurance Programs (SCHIP)
- Public and/or indigent care: Medical programs for low-income or medically indigent persons
- Days, visits, or services not covered by Medicaid or other indigent care programs

### Do not count:

- Medicare shortfall (This can be included in other financial reports but not in a quantified community benefit report.)

### SHOULD MEDICARE BE COUNTED?

CHA recommends that hospitals not include Medicare losses as community benefit. The reasons are:

- If there are specific programs with large numbers of vulnerable Medicare patients, and if these programs lose money, then they can be included in “subsidized health services.”
- The point of prospective payment was to make facilities efficient. Medicare losses for some hospitals may be associated with inefficiency, not underpayment.
- In many communities, Medicare is one of the best payers. Per diem and per case payments can be higher for Medicare than for managed care payers.
- Serving Medicare patients is not a true, differentiating feature of not-for-profit health care. Hospitals of all kinds compete aggressively to attract Medicare patients. This is not true of Medicaid and charity care patients.
- Including Medicare jeopardizes the credibility of the community benefit report.

## III. Community Benefit Services

As a general rule:

- Count programs that respond to identified community need.
- Do not count programs primarily designed to be used for marketing or promotion.
- Count programs and services directed to at-risk persons, such as underinsured and uninsured persons, community members representing diverse cultures, and persons who have limited English proficiency.
- Count programs offered to the broad community designed to improve community health.

## A. COMMUNITY HEALTH IMPROVEMENT SERVICES

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These activities carried out to improve community health are usually subsidized by the health care organization. Such services do not generate inpatient or outpatient bills, although they may involve a nominal patient fee and/or sliding scale fee. Forgiving inpatient and outpatient care bills to low-income persons should be reported separately as charity care.

Specific community health services to quantify include:

- Community health education
- Community-based clinical services, such as health services and screenings for underinsured and uninsured persons
- Support groups
- Health care support services, such as enrollment assistance in public programs and transportation efforts
- Self-help programs, such as smoking cessation and weight loss programs
- Pastoral outreach programs
- Community-based chaplaincy programs and spiritual care
- Social services programs for vulnerable populations in the community

### A1. Community Health Education

Community health education includes lectures, presentations, and other group programs and activities apart from clinical or diagnostic services. Community benefit in this area can include staff time, travel, materials, and indirect costs.

#### Count:

- Baby-sitting courses
- Caregiver training for persons caring for family members at home
- Community calendars and newsletters primarily intended to educate the community about community health programs and free community events
- Consumer health libraries
- Education on specific diseases or conditions, such as diabetes or heart disease
- Health fairs
- Health promotion and wellness programs
- Health education lectures and workshops by staff to community groups
- Parish and congregational programs
- Prenatal/childbirth classes serving at-risk and low-income persons
- Information provided through news releases and other modes to the media (radio, television, and print) to educate the public about health issues (such as wearing bike helmets, new treatment news, health resources in the community, etc.)
- Public service announcements with health messages
- Radio call-in programs with health professionals
- School health-education programs (Note: Report school-based programs on health care careers and workforce enhancement efforts in F8. Report school-based health services for students in A2.)
- Web-based consumer health information
- Worksite health education programs

**Do not count:**

- Health education classes designed to increase market share (such as prenatal and childbirth programs for insured patients)
- Community calendars and newsletters, if they are primarily used as marketing tools
- Patient education services understood as necessary for comprehensive patient care (e.g., diabetes education for patients)
- Health education sessions offered for a fee, for which a profit is realized
- Volunteer time for parish and congregation-based services

**Support groups**

Support groups typically are established to address social, psychological, or emotional issues related to specific diagnoses or occurrences: diseases and disabilities, grief, infertility, support for patients' families, or others. These groups may meet on a regular or an intermittent basis.

**Count:**

- Costs to run support groups

**Do not count:**

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

**Self-help programs**

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

**Count:**

- Anger management programs
- Exercise classes
- Smoking cessation programs
- Stress management classes
- Weight loss and nutrition programs

**Do not count:**

- Employee wellness and health promotion provided by your organization as an employee benefit
- The use of facility space to hold meetings for community groups (Report in E3.)

**A2. Community-Based Clinical Services**

These are health services and screenings provided on a one-time basis or as a special event in the community. They do not include permanent subsidized hospital outpatient services; report these in C3. As with other categories of community benefit, these services and programs should be counted only if they are designed to meet identified community needs or to improve community health.

## **Screenings**

Screenings are health tests conducted in the community as a public clinical service, such as blood pressure measurements, cholesterol checks, and school physicals. They are a secondary prevention activity designed to detect the early onset of illness and disease, and can result in a referral to any community medical resource. To be considered community benefits, screenings should provide follow-up care as needed, including assistance for persons who are uninsured and underinsured.

### **Count:**

- Behavioral health screenings
- Blood pressure screening
- Lipid profile and/or cholesterol screening
- Eye examinations
- General screening programs
- Health-risk appraisals
- Hearing screenings
- Mammography screenings (If these are done at a separate, free-standing breast diagnostic center, report in C5.)
- Osteoporosis screenings
- School physical examinations
- Skin cancer screenings
- Stroke risk screenings

### **Do not count:**

- Health screenings associated with conducting a health fair (Report in A1.)
- Screenings for which a fee is charged, unless there is a negative margin
- Screenings where referrals are made only to the health care organization or its physicians
- Screenings provided primarily for public relations or marketing purposes

## ***One-time or occasionally held clinics***

### **Count:**

- Blood pressure and/or lipid profile/cholesterol screening clinics
- Cardiology risk factor screening clinics
- Colon cancer screening clinics
- Dental care clinics
- Immunization clinics
- Mobile units that deliver primary care to underserved populations on an occasional or one-time basis
- One-time or occasionally held primary care clinics
- School physical clinics
- Stroke screening clinics

### **Do not count:**

- Clinics for which a fee is charged and a profit is realized (Do report if there is a negative margin.)
- Permanent, ongoing programs and outpatient services (Report in C3.)

### ***Clinics for underinsured and uninsured persons***

These programs, which in the past may have been called “free clinics,” provide free or low-cost health care to medically underinsured and uninsured persons through the use of volunteers who donate their time, including physicians and health care professionals.

**Count:**

- Hospital subsidies, such as grants
- Costs for staff time, equipment, and overhead costs
- Lab and medication costs

**Do not count:**

- Volunteers’ time and contributions by other community partners

### ***Mobile units***

**Count:**

- Vans and other vehicles used to deliver primary care services

**Do not count:**

- Mobile specialty care services that are an extension of the organization’s outpatient department, such as mammography, radiology, and lithotripsy (Report in C3.)

## **A3. Health Care Support Services**

Health care support services are provided by the hospital to increase access and quality of care in health services to individuals, especially persons living in poverty and those in other vulnerable populations.

**Count:**

- Information and referral to community services for community members (not routine discharge planning)
- Case management of underinsured and uninsured persons that goes beyond routine discharge planning
- Telephone information services, such as Ask a Nurse, medical and mental health service hotlines, and poison control centers
- Transportation programs for patients and families to enhance patient access to care (Include cab vouchers provided to patients and families.)
- Assistance to enrollment in public programs, such as SCHIP and Medicaid
- Personal response systems, such as Lifeline

**Do not count:**

- A physician referral, if it is primarily an internal marketing effort. However, you may count a physician referral from a call center if the call center makes referrals to other community organizations or physicians from across an area, without regard to admitting practices
- Health care support given to patients and families in the course of an inpatient or outpatient encounter
- Routine discharge planning
- Enrollment assistance programs designed to increase facility revenue

## B. HEALTH PROFESSIONS EDUCATION

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### B1. Physicians/Medical Students

Helping to prepare future health care professionals is a distinguishing characteristic of not-for-profit health care and constitutes a significant community benefit.

#### Count:

Be sure to subtract government subsidies from these costs before counting. You may count the unpaid costs of:

- A clinical setting for undergraduate training
- Internships, clerkships, and residencies
- Residency education
- Continuing medical education (CME) offered to physicians outside of the medical staff on subjects for which the organization has special expertise

#### Do not count:

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

### B2. Nurses/Nursing Students

#### Count:

- Providing a clinical setting for undergraduate/vocational training to students enrolled in an outside organization
- Internships or externships when on-site training of nurses (e.g., LVN or LPN) is subsidized by the health care organization
- Costs associated with underwriting faculty positions in schools of nursing in response to shortages of nurses and nursing faculty

#### Do not count:

Expenses associated with:

- Education required by nursing staff, such as orientation, in-service programs, and new graduate training
- Expenses for standard in-service training and in-house mentoring programs
- In-house nursing and nursing assistants

### B3. Other Health Professional Education

#### Count:

- A clinical setting for undergraduate training and internships for dietary professionals, technicians, physical therapists, social workers, pharmacists, and other health professionals
- Training of health professionals in special settings, such as occupational health or outpatient facilities
- Unpaid costs of medical translator training beyond what is mandated
- Program costs associated with high-school student job shadowing and mentoring projects

**Do not count:**

Expenses associated with:

- Education required by staff, such as orientation and standard in-service programs
- Expenses for standard in-service training
- Joint appointments with educational institutions or schools of physical therapy (unless in response to community-wide shortages)
- On-the-job training, such as pharmacy technician and nursing assistant programs
- Staff time delivering care concurrent with job shadowing

**B4. Scholarships/Funding for Professional Education****Count:**

- Funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and health improvement
- Nursing scholarships or tuition payments for professional education to non-employees and volunteers
- Other health professional and technical training scholarships for community members
- Specialty in-service and videoconferencing programs made available to professionals in the community

**Do not count:**

- Costs for staff conferences and travel other than those listed above
- Financial assistance for employees who are advancing their own educational credentials
- Staff tuition reimbursement costs provided as an employee benefit

## C. SUBSIDIZED HEALTH SERVICES

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Subsidized health services (negative margin services) are clinical services that are provided despite a financial loss, and the financial losses are so significant that negative margins remain after removing the effects of charity care and Medicaid shortfalls. Nevertheless, the service is provided because it meets an identified community need and if no longer offered, it would either be unavailable in the area or fall to the responsibility of government or another not-for-profit organization to provide.

Subsidized health services include costs for billed services that are subsidized by the health care organization because the facility experiences costs that are not reimbursed.

### ACCOUNTING NOTE

Care should be taken not to double-count information. Services in this category should be separated from charity care and Medicaid shortfalls. For example, assume a situation in which a hospital emergency department operates at an annual loss of \$200,000. The Medicaid shortfall and charity care account for half the total loss and are reported elsewhere. Only half, or \$100,000, of the emergency department loss would be counted as a community benefit in the subsidized health services area.

The category of subsidized services is not a catch-all category for services that operate at a loss. Care needs to be taken to ascertain whether the negative contribution margin is truly community benefit and is being provided because of community need.

In all categories, count the negative margin of departments or services. Do not include shortfalls that already have been accounted for, such as charity care or Medicaid losses. Extract data from your cost accounting system.

If cost accounting systems are not available, follow the guidelines in Chapter 4 of this Guide for determining costs of subsidized health services.

#### Count:

- The amount the health care organization subsidizes to maintain these services, but not what it subsidizes for individual patients

#### Do not count:

- Charity care
- Bad debt
- Medicaid shortfalls

## C1. Emergency and Trauma Services

#### Count:

- Air ambulance
- Emergency department
- Local community emergency medical technician (EMS) training, when there is a negative margin
- Trauma center

## **C2. Neonatal Intensive Care (if subsidized)**

## **C3. Hospital Outpatient Services**

### **Count:**

- Subsidized permanent outpatient services and primary/ambulatory care centers, whether they are within the hospital facility or separate, freestanding facilities (e.g., urgent care center)
- Mobile units, including mammography and radiology units

## **C4. Burn Units**

## **C5. Women's and Children's Services**

As with all community benefits in the subsidized care category, count only those for which an identified community need exists and for which not providing the service would result in a shortage within the community.

### **Count:**

- Freestanding breast diagnostic centers
- Newborn care (Report NICU in C2.)
- Obstetrical services
- Pediatrics
- Women's services

### **Do not count:**

- Services provided in order to attract physicians or health plans

## **C6. Renal Dialysis Services**

## **C7. Subsidized Continuing Care**

### **Count:**

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

### **Do not count:**

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

## **C8. Behavioral Health Services**

### **Count:**

- Inpatient and outpatient behavioral health services

## **C9. Palliative Care**

### **Count:**

- Special programs to address the palliative care needs of patients. These programs usually involve the formation of an expert team and go beyond the routine pain control efforts expected of all health care facilities.

### **Do not count:**

- Routine pain control program

## **D. RESEARCH**

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Research includes clinical and community health research, as well as studies on health care delivery that are shared with others outside the organization. Do not count research where findings are used only internally. Priority should be placed on issues related to reducing health disparities and preventable illness. In this category, count the negative margin, the difference between operating costs and external subsidies such as grants.

### **D1. Clinical Research**

**Count:**

- Research development costs, using formal research protocols
- Studies on therapeutic protocols (Be sure to offset with grants and other funds.)
- Evaluation of innovative treatments
- Research papers prepared by staff for professional journals

### **D2. Community Health Research**

**Count:**

- Studies on health issues for vulnerable persons
- Studies on community health, such as incidence rates of conditions for populations
- Research papers prepared by staff for professional journals
- Studies on innovative health care delivery models

## E. FINANCIAL AND IN-KIND CONTRIBUTIONS

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

### E1. Cash Donations

As a general rule, count donations to organizations and programs that are consistent with your organization's goals and mission.

**Count:**

- Contributions and/or matching funds provided to not-for-profit community organizations
- Contributions to charity events of not-for-profit organizations, after subtracting the market value of participation by the employees or organization
- Contributions provided to individuals for emergency assistance
- Scholarships to community members not specific to health care professions

**Do not count:**

- Employee-donated funds
- Emergency funds provided to employees
- Fees for sporting event tickets
- Time spent at golf outings or other primarily recreational events

### E2. Grants

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

**Count:**

- Program, operating, and education grants
- Matching grants
- Event sponsorship
- General contributions to not-for-profit organizations or community groups

### E3. In-Kind Donations

**Count:**

- Meeting room overhead and space for not-for-profit organizations and community groups (such as coalitions, neighborhood associations, and social service networks)
- Equipment and medical supplies
- Emergency medical care at a community event
- Costs of coordinating community events not sponsored by the health care organization, such as March of Dimes Walk America (Report health care organization-sponsored community events in G1.)
- Provision of facility parking vouchers for patients and families in need

- Employee costs associated with board and community involvement on work time
- Food donations, including Meals on Wheels subsidies and donations to food shelters
- Gifts to community organizations and community members (not employees)
- Laundry services for community organizations
- Technical assistance, such as information technology, accounting, human resource process support, planning, and marketing

**Do not count:**

- Employee costs associated with board and community involvement when these are done on an employee's own time and he or she is not engaged on behalf of his or her organization
- Volunteer hours provided by hospital employees on their own time for community events (These hours belong to the volunteer, not to the health care organization.)
- Promotional and marketing costs concerning the health care organization's services and programs
- Salary expenses paid to employees deployed on military services or jury duty (These expenses are considered employee benefit.)

#### **E4. Cost of Fundraising for Community Programs**

**Count:**

- Grant writing and other fundraising costs specific to community programs and resource development assistance not captured under category G, Community Benefit Operations

## F. COMMUNITY-BUILDING ACTIVITIES

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Community-building activities include programs that, while not directly related to health care, provide opportunities to address the root causes of health problems, such as poverty, homelessness, and environmental problems. These activities support community assets by offering the expertise and resources of the health care organization. Costs for these activities include cash, in-kind donations, and budgeted expenditures for the development of a variety of community health programs and partnerships. When funds or in-kind donations are given directly to another organization, report in E3. Remember to subtract any subsidies or grant amounts from total expenses incurred in this category.

### F1. Physical Improvements and Housing

**Count:**

- Community gardens
- Neighborhood improvement and revitalization projects
- Public works, lighting, tree planting, and graffiti removal
- Housing rehabilitation, contributions to community-based assisted living, and senior and low-income housing projects
- Habitat for Humanity activities
- Smoke detector installation programs

**Do not count:**

- Housing costs for employees
- Projects having their own community benefit reporting process (e.g., a senior housing program that issues a community benefit report)
- Health facility construction and improvements, such as a meditation garden or parking lot

### F2. Economic Development

**Count:**

- Small business development
- Participation in an economic development council or chamber of commerce

**Do not count:**

- Routine financial investments

### F3. Community Support

This includes efforts to enhance the operational structures of the community and community networks, such as neighborhood watch groups and child care cooperatives. Activities include both community-based initiatives and facility-based initiatives.

**Count:**

- Child care for community residents with qualified need
- Mentoring programs
- Neighborhood systems, such as watch groups

- Youth asset development or America’s Promise initiatives, including support of these programs’ principles, such as Safe Places, Healthy Start, Marketable Skills, and Opportunities to Serve
- Disaster readiness over and above licensure requirements. Be careful not to double-count with in-kind donations. Include costs associated with:
  - ▶ Changes made to accommodate prospective disasters, including costs associated with lockdown capability, enhanced security measures, package handling, air machines and filters, water purification equipment, expanded mortuary facilities, facilities for personnel quarantine, expanded patient isolation facilities, shower facilities, and storage space for stockpiles
  - ▶ Creating new or refurbishing existing decontamination facilities. This could include water supply communications facility and equipment costs or equipment changes to ensure interoperability of communications systems. (Include depreciation expenses.)
  - ▶ Additional disaster-related purchase of pagers, cell phones, mobile data terminals, and laptop computers specific to the communications component of the disaster plan; include depreciation expenses
  - ▶ Community disease surveillance and reporting infrastructure, updating laboratory diagnostic capability and associated training for laboratory personnel, informatics updating and patient tracking systems, detection instruments and monitors to detect radiation, tests and assays for detection of chemical agents and toxic industrial materials, and tests for identification of biologic agents
  - ▶ Purchase of personal protective equipment (PPE) for stockpiles, including gloves, masks, gowns, and other items
  - ▶ Facility areas, waste water containment systems, decontamination tables, storage, shower systems, tents, soap dispensers, and linen
  - ▶ Stockpiling medical, surgical, and pharmaceutical supplies, including barriers, respirators, clothing, IV pumps and poles, IV fluids, suction machines, stretchers, wheelchairs, linens, bandages, and dressings
  - ▶ New or expanded training, task force participation, and drills
  - ▶ Mental health resource costs associated with training, community partnerships, and outreach planning
  - ▶ Pre- and post-planning

**Do not count:**

- Costs associated with subsidizing salaries of employees deployed in military action (This is considered employee benefit.)
- Costs associated with routine and mandated disaster preparedness

## **F4. Environmental Improvements**

**Count:**

- Efforts to reduce community environmental hazards in the air, water, and ground
- Residential improvements, such as lead or radon programs
- Neighborhood and community improvements, such as air pollution and toxin removal in parks
- Community waste reduction and sharps disposal programs
- Health care facility environmental responsibility, such as waste and mercury reduction, green purchasing, and other ecology initiatives

## **F5. Leadership Development and Leadership Training for Community Members**

### **Count:**

- Conflict resolution training
- Community leadership development
- Cultural skills training
- Language skills development
- Life or civic skills training programs
- Medical interpreter training for community members

### **Do not count:**

- Interpreter training programs for hospital staff as required by law

## **F6. Coalition Building**

### **Count:**

- Hospital representation to community coalitions
- Collaborative partnerships with community groups to improve community health
- Costs for community coalition meetings, visioning sessions, or task force meetings
- Costs for task force-specific projects and initiatives

## **F7. Community Health Improvement Advocacy**

### **Count:**

- Local, state, and national advocacy on behalf of community health relative to policies and funding to improve:
  - ▶ Access to health care
  - ▶ Public health
  - ▶ Transportation
  - ▶ Housing

### **Do not count:**

- Advocacy specific to hospital operations and financing

## **F8. Workforce Development**

These programs address community-wide workforce issues—not the workforce needs of the health care organization, which should be considered human resource activities rather than community benefit.

### **Count:**

- Recruitment of physicians and other health professionals for areas identified by the government as medically underserved (MUAs)
- Recruitment of underrepresented minorities
- Job creation and training programs
- Participation in community workforce boards, workforce partnerships, and welfare-to-work initiatives
- Partnerships with community colleges and universities to address the health care workforce shortage

- Workforce development programs that benefit the community, such as English as a Second Language (ESL) training
- Programs to teach staff members languages spoken in the community
- School-based programs on health care careers
- Community programs that drive entry into health careers and nursing practice
- Community-based career mentoring and development support

**Do not count:**

- Routine staff recruitment and retention initiatives
- Programs primarily designed to address workforce issues of the health care organization
- In-service education and tuition reimbursement programs for current employees
- Scholarships for nurses and other health professionals (Report in B.)
- Scholarships for community members not specific to health care professions (Report in E1.)
- Employee workforce mentoring, development, and support programs

## **G. COMMUNITY BENEFIT OPERATIONS**

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Community benefit operations include costs associated with dedicated staff and community health needs and/or assets assessment, as well as other costs associated with community benefit strategy and operations.

### **G1. Dedicated Staff**

**Count:**

- Staff costs for managing or overseeing community benefit program activities that are not included in other categories of community services
- Staff costs to coordinate community benefit volunteer programs

**Do not count:**

- Staff time to coordinate in-house volunteer programs, including outpatient volunteer programs
- Volunteer time of individuals for community benefit volunteer programs

### **G2. Community Health Needs/Health Assets Assessment**

**Count:**

- Community health needs assessment
- Community assessments, such as a youth asset survey

**Do not count:**

- Costs of a market share assessment and marketing survey process
- Economic impact survey costs or results

### **G3. Other Resources**

**Count:**

- Cost of fundraising for hospital-sponsored community benefit programs, including grant writing and other fundraising costs
- Grant writing and other fundraising costs related to equipment used for hospital-sponsored community benefit services and activities
- Costs associated with developing a community benefit plan, conducting community forums, and reporting community benefit
- Overhead and office expenses associated with community benefit operations exclusive of fundraising

**Do not count:**

- Recognition or awards for volunteer staff
- Grant writing and other fundraising costs of hospital projects (such as capital funding of buildings and equipment) that are not hospital community benefit programs