References

Reference 1: Community Benefit Categories

Section 1.1: Charity Care 1.1
Section 1.2: Government-Sponsored Means-Tested Health Care 1.2
Section 1.3: Community Benefit Services 1.3

Reference 2: Inventory of Community Benefit Services for Homes and Services for the Aging

Reference 1

Community Benefit Categories

This reference can be downloaded from the CHA website at www.chausa.org/communitybenefit/guideresources.

This section represents recommendations for what counts as community benefit. It is not legal advice. Health care organizations should consult the most recent guidance from their state and the Internal Revenue Service regarding required reporting of community benefit information.

Community benefits are programs or activities that provide treatment or promote health and healing as a response to identified community needs and meet at least one of these objectives:

- Improve access to health care service.
- Enhance the health of the community.
- Advance medical or health care knowledge.
- Relieve or reduce the burden of government or other community efforts.

Following are recommendations for how services should be categorized and what should and should not be counted in the quantitative community benefit report. It is advised that health care organizations keep a record of the rationale for why a program or activity is a community benefit. What community need is it responding to? Does the need continue? What community benefit objective is being met?

Section 1.1 CHARITY CARE

Charity care is free or discounted health services provided to persons who cannot afford to pay and who meet the organization's financial assistance policy criteria. Generally, a patient record and bill is generated. Charity care is reported in terms of costs, not charges. Charity care does not include bad debt, which may be reported elsewhere but not as community benefit.

Count:

- Free and partially discounted care (discounted from cost, not charges).
- Expenses incurred by the provision of charity care.
- Provider taxes, assessments or fees if Medicaid DSH funds in your state are used in whole or in part to offset the cost of charity care.

Do not count:

- Bad debt.
- Discounts provided to self-pay (uninsured) patients who do not qualify for financial assistance.
- Contractual allowances or quick-pay discounts.

GOVERNMENT-SPONSORED MEANS-TESTED HEALTH CARE

Section 1.2

Government-sponsored means-tested health care community benefits include unpaid costs of public programs for low-income persons – 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.

Count:

Revenues and costs related to:

- Medicaid.
- State Children's Health Insurance Programs (SCHIP).
- State and local 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 as a community benefit).
- Other government programs that are not means-tested, such VA, CHAMPUS and Indian Health Service.

Section 1.3

COMMUNITY BENEFIT SERVICES

As a general rule:

Count:

- Programs that respond to an identified community need and are designed to accomplish one or more community benefit objectives.
- Programs and services directed to or including at-risk persons, such as underinsured and uninsured persons.
- Programs offered to the broad community (including at-risk persons) designed to improve community health.

Do not count:

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

A. Community Health Improvement Services

These activities are carried out to improve community health, extend beyond patient care activities and are usually subsidized by the health care organization. Such services do not generate patient care bills although they may involve a nominal fee.

Specific community health services to quantify include:

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

- Community-based chaplaincy programs and spiritual care.
- Social services programs for vulnerable populations in the community.
- Community health initiatives addressing specific health targets and goals.

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, staff preparation and indirect costs.

Count if the program addresses a community need and meets a community benefit objective:

- Caregiver training for persons caring for family members at home.
- Community newsletters primarily intended to educate the community about health issues and free community health programs.
- Consumer health libraries.
- Education on specific diseases or conditions, such as diabetes or heart disease.
- Health fairs (not primarily for marketing).
- Health law topics for consumers, such as the American Health Lawyers Association's public information series (www.healthlawyers.org/publicinterest/PIseries).
- Health promotion and wellness programs.
- Health education lectures and workshops by staff to community groups.
- Parish and congregational programs.
- 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, treatment news, health resources in the community, etc.).
- Radio call-in programs with health professionals to address community health need.
- 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 child birth programs for insured patients).
- Community calendars and newsletters, if they are primarily used as marketing tools.
- Patient education services that are part of 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.
- Advertisements with health messages when the purpose is marketing.

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 if the program addresses a community need and meets a community benefit objective:

- Support groups related to community need, such as for prevention of child abuse.
- Costs to run support groups.

Do not count:

- Support given to patients and families in the course of their inpatient or outpatient encounter.
- Childbirth and parenting 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 if the program addresses a community need and meets a community benefit objective:

- Anger management programs.
- Exercise classes.
- Mediation programs.
- 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 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 benefit, screenings should provide follow-up care as needed, including assistance for persons who are uninsured and underinsured.

Count if the program addresses a community need and meets a community benefit objective:

- 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 at a separate, free-standing breast diagnostic center, report in C5).
- Osteoporosis screenings.
- School and sports physical examinations (only if there is a demonstrated need).
- 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.
- Free school team physicals provided for public relations purposes.

One-time or occasionally held clinics

Count if the program addresses a community need and meets a community benefit objective:

- Blood pressure and/or lipid profile/cholesterol screening clinics.
- Cardiology risk factor screening clinics (take care not to include if screening is really marketing or case-finding).

- 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 to increase access to health care.
- Stroke screening clinics.

Do not count:

- Free school team physicals, unless there is a demonstrated need for this service.
- Flu shots or physical exams for employees.
- Clinics for which a fee is charged and a profit is realized (do report if there is a negative margin).
- Subsidized, 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, including physicians and health care professionals, who donate their time.

Count if the program addresses a community need and meets a community benefit objective:

- Costs for staff time, equipment, and overhead costs.
- Lab and medication costs.

Do not count:

- Volunteers' time and contributions by other community partners.
- Grants to an unrelated free clinic (report in E1, Cash Donations).

Mobile units

Count if the program addresses a community need and meets a community benefit objective:

- Vans and other vehicles used to deliver primary care services.

Do not count:

- Subsidized, 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 if the program addresses a community need and meets a community benefit objective:

- 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.
- Physician referral programs for Medicaid and uninsured persons.
- Transportation programs for patients and families meeting the organization's financial assistance guidelines to enhance patient access to care (include cab vouchers provided to low-income patients and families).
- Assistance to enroll in public programs, such as SCHIP and Medicaid.
- Personal response systems, such as Lifeline.
- Translation/interpreter services that go beyond what is required by law or for accreditation. For example, translation services for a group that comprises less than a prescribed percentage of the population.

Do not count:

- A physician referral program if it is primarily an internal marketing effort or only for attending physicians (unless for Medicaid or uninsured persons).
- Health care support given to patients and families in the course of an inpatient or outpatient encounter.
- Routine discharge planning.
- Enrollment assistance programs specifically designed to increase facility revenue.
- Translation/interpreter services required of all providers.

B. Health Professions Education

B1. Physicians/Medical Students

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 (unless for a specialty where there is a documented shortage).
- 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 (count time that staff nurses are taken away from their routine duties).
- 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 nurse's aide training programs.
- Programs where nurses are required to work for the organization.

B3. Other Health Professions Education

Count:

- A clinical setting for undergraduate training and internships for dietary professionals, technicians, chaplaincy/pastoral care, physical therapists, social workers, pharmacists, and other health professionals – when there is no work requirement tied to training.
- Training of health professionals in special settings, such as occupational health or outpatient facilities.
- Unpaid costs of medical translator training beyond what is mandated.
- Medical libraries open to the general public.

Do not count:

Expenses associated with:

- Education required by staff, such as orientation and standard in-service programs.
- Expenses for standard in-service training.
- On-the-job training, such as pharmacy technician and nurse's assistant programs.
- Programs where trainees are required to work for the organization.

B4. Scholarships/Funding for Professions Education

Count:

- Funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and community health improvement.
- Scholarships or tuition payments for nursing and health professional education to non-employees with no requirement to work for the organization as a condition of the scholarship.
- 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.
- Financial assistance where students/trainees are required to work for the organization.

C. Subsidized Health Services

Subsidized health services are clinical programs that are provided despite a financial loss so significant that negative margins remain after removing the effects of charity care, bad debt 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 services do not include ancillary services that support service lines, such as lab and radiology (if these services are provided to low-income persons, they should be reported as charity care/financial assistance).

CAREFULLY EXAMINE SUBSIDIZED SERVICES
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 service satisfies all criteria for being included as a subsidized health service that provides community benefit.

Exclude from subsidized health services losses amounts that already have been accounted for, such as charity care or Medicaid losses. In addition, the Internal Revenue Service (IRS) in Instructions for Form 990, Schedule H for Hospitals (Schedule H), requires excluding the shortfall from bad debt.

Count:

- Clinical programs or service lines that the organization subsidizes.
- The amount the health care organization subsidizes to provide these services.

Do not count:

- Ancillary services (such as lab, radiology). (Note: free or discounted ancillary services for low-income persons should be reported as charity care.)
- Charity care.
- Bad debt.
- Medicaid shortfall.

Example of Services that Frequently Qualify as Subsidized Health Services

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.
- Fees to physicians to see Medicaid and uninsured patients.

Do not count:

- Payment for routine on-call physician services.

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.

(Note: IRS instructions require describing subsidies to physician clinics.)

C4. Burn Units

C5. Women's and Children's Services

Report services designed to increase access and quality of care for women and children, especially those living in poverty, and other vulnerable populations. 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.
- 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.
- Adult 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:

- Outpatient and outreach palliative care programs.

Do not count:

- The organization's inpatient palliative care program.

D. Research

Research includes clinical and community health research, as well as studies on health care delivery that are generalizable, shared with the public and funded by the government or a tax-exempt entity (including the organization itself). Do not count research where findings are used only internally or are proprietary. Count the total cost of the qualifying research programs, including direct and indirect costs. Grant funding does not need to be accounted for as offsetting revenue but should be tracked for budget and planning purposes.

D1. Clinical Research

Count:

- Research development costs, using formal research protocols.
- Studies on therapeutic protocols.
- Evaluation of innovative treatments.
- Research papers prepared by staff for professional journals and presentations.

Do not count:

- Research where findings are used only internally.
- Research that yields knowledge used for proprietary purposes.

D2. Community Health Research

Count:

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

Do Not Count:

- Market research.
- Research where findings are only used internally or by the funder.

E. Cash and In-Kind Contributions

This category includes funds and in-kind services donated to individuals not affiliated with the organization or to community groups and other not-for-profit organizations. In-kind services include hours contributed 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 the donation of food, equipment, and supplies.

The IRS, in its instructions to Form 990, Schedule H, requires that donations in this category must be restricted to services or activities that would qualify as community benefit if provided by the organization itself. If the contribution is used for a community-building activity or program, it should be reported as part of community building.

E1. Cash Donations

Only count those donations to organizations and programs that are for the same type of activities and programs that would count as community benefit provided by the hospital:

- Contributions provided to not-for-profit community organizations.
- Contributions for providing technical assistance or evaluation of community coalition efforts.
- Contributions to charity events of not-for-profit organizations, after subtracting the market value of participation by the employees or organization.
- Financial assistance given outside the local community in response to natural disasters or poverty.

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 grants made by the organization to community and other not-for-profit entitities, projects, and initiatives.

Count if contribution will address a community need and meets a community benefit objective:

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

Do not count:

Grants passed through from an affiliated organization if already reported as community benefit.

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 (includes national and international donations with the greatest proportion of donations being local).
- 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.
- Employee costs on work time associated with community health-related boards and other community involvement.
- Food donations, including Meals on Wheels subsidies and donations to food shelters.
- Donations to community organizations and community members (not employees).
- Laundry services for community organizations.
- Other free ancillary services such as lab, radiology and pharmacy services to other providers in the community, such as clinics or shelters.
- Technical assistance to community organizations, such as information technology, grant writing, accounting, human resource support and 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 not on behalf of the organization.
- Volunteer hours provided by hospital employees on their own time for community events.
- Salary expenses paid to employees deployed on military services or jury duty (considered employee benefits).
- Provision of facility parking vouchers for patients and families in need unless space would otherwise be filled by a paying customer.

F. Community-Building Activities

Community-building activities include programs that 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-building programs and partnerships.

(Note: The IRS in Form 990, Schedule H, does not include community-building activities in the community benefit section but asks that they be reported in another section specifically for community-building activities.)

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.
- Grants to community businesses for the purpose of economic development.

Do not count:

- Routine financial investments.
- Contribution to the arts (unless part of a comprehensive plan for economic development of the community).

F3. Community Support

This includes efforts to establish or enhance community support networks, such as neighborhood watch groups and childcare cooperatives. Activities include both community-based initiatives and facility-based initiatives.

Count:

- Child care for community residents with qualified need.
- Mentoring programs (other than for health professions, which are counted in F8).
- Neighborhood systems, such as watch groups.
- Youth asset development or America's Promise initiatives.
- Disaster readiness over and above licensure requirements. Be careful not to double-count with in-kind donations or grants. *See CHA What Counts website for full recommendation for what to count.*

Do not count:

- Costs associated with subsidizing salaries of employees deployed in military action (considered employee benefits).
- 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 helping to paint public housing apartments or lead or radon programs.
- Neighborhood and community improvements, such as toxin removal in parks.
- Safe removal or treatment of garbage and other waste products.

Do not Count

- Costs related to complying with laws and regulations.
- Costs related to reducing environmental hazards caused by the organization's own activities. (Some organizations may decide to report their own efforts to reduce waste, emission and energy use in a narrative report, but the IRS does not want them reported on Schedule H.)

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:

- Above services for employees.
- Interpreter training programs for hospital staff as required by law.

F6. Coalition Building

Count:

- Hospital representation to community coalitions related to community health.
- Collaborative partnerships with community groups to improve community health.
- Costs for community coalition meetings.
- Costs for task force-specific projects and initiatives.

F7. Advocacy for Community Health Improvements

Count:

- Local, state, and national advocacy on behalf of such areas such as:
    - Access to health care.
    - Public health.
    - Transportation.
    - Housing.
- Advocacy for Social Justice and Human Rights, including:
    - Dues, grants, and gifts to organizations that support social justice (such as NETWORK).
    - Costs associated with advocating for social justice, environmental responsibility, and human rights (such as fair treatment of workers) through investments as shareholders, including:
        - Dues to organizations such as the Interfaith Center for Corporate Responsibility.
        - Voting proxy management fees.
        - Consultant fees.
        - Staff time.

Do not count:

- Advocacy specific to hospital operations and financing.
- Advocacy related to community building (report as community building).
- Normal investing costs (only additional costs specifically related to socially responsible investing should count as community benefit).

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) or other community needs assessment.
- 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 work force shortage.
- Workforce development programs that benefit the community, such as English as a Second Language (ESL) training.
- School-based programs on health care careers.
- Community programs that drive entry into health careers and nursing practice.
- Health career mentoring projects

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

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

G1. Assigned Staff

Count:

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

Do not count:

- Staff time to coordinate in-house 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.
- Marketing surveys.

G3. Other Resources

Count:

- Costs associated with community benefit evaluation.
- Cost of fundraising for hospital-sponsored community benefit programs, including grant writing.
- 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.
- Dues to an organization that specifically support the community benefit program, such as the Association for Community Health Improvement.
- Software that supports the community benefit program, such as CBISA by Lyon Software.
- Costs associated with attending educational programs to enhance community benefit program planning and reporting.

Do not count:

- Grant writing and other fundraising costs of hospital capital projects (such as funding of buildings and equipment) that are not hospital community benefit programs.
- Dues to hospital and professional organizations not specifically and directly related to community benefit.