Conference Call Number: 1-888-808-6929
Public Participant Code: 915042#

Oregon Health Policy Board
AGENDA
May 2, 2017

OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

	#	Time	Item	Presenter	Purpose
Old Business	1	8:30	Welcome, Calendar Review, Minutes Approval	Zeke Smith, Chair	Action
	2	8:40	Director's Report	Lynne Saxton, Director, OHA	Update & Discussion
	3	8:50	Committee Liaison & Consult Updates	Board Members	Update & Discussion
	4	9:00	2017 Legislative Session Update	BethAnne Darby, External Relations Director, OHA	Update & Discussion
	5	9:20	Federal Health Policy Update	Leslie Clement, Health Policy & Analytics Director, OHA	Update & Discussion
	6	9:30	OHPB Committee Work-Planning	Jeff Scroggin, OHA	Discussion & Possible Action
	7	10:00	Break		
New Business	8	10:10	Public Testimony	Chair Smith	Public Testimony
	9	10:20	Community Benefit	Stacey Schubert, OHA Steve Ranzoni, OHA	Presentation & Report
	10	10:45	Community Benefit Panel	Keith Hearle, Founder & President Verite Healthcare Consulting Dan Field, Executive Director, Community Benefit & External Affairs at Kaiser Permanente Northwest Jesse Beason, Northwest Health Foundation, Vice President of Public Affairs	Discussion & Possible Action
	11	12:00	Adjourn	Chair Smith	

Next meeting:
June 6, 2017

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2017 OHPB CALENDAR

DRAFT

Updated 4/25/17

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items)	Board Priority Area	Reports	Legislative Mandates
Jan 19, 2017	• Retreat • Waiver Update • Federal Policy Update • Action Plan for Health Discussion • CCO 2.0 Planning	1. High Cost Drugs 2. Accelerated CCO Integration 3. Health Systems Transparency & Accountability 4. Health Equity 5. CCO Monitoring & Oversight	-CCO Quarterly Legislative Report	**Pending Sine Die 2017 Legislative Session**
Feb 7, 2017	• Legislative Update • Action Plan for Health Discussion	All		
Mar 7, 2017	• Legislative Update • OHPB Protocols • OHPB Committee Work Planning	All		
April 4, 2017	• Legislative Update • Federal Policy Update • High Cost Drugs Discussion • OHPB Committee Work Planning	High Cost Drugs, Monitoring & Oversight, Health Equity	-PHAB Annual Report	
May 2, 2017	• Legislative Update • Federal Policy Update • Hospital Community Benefits	Health Systems Transparency & Accountability, Health Equity	-Community Benefit Report	

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items)	Board Priority Area	Reports	Legislative Mandates
June 6, 2017	• Legislative Update • Federal Policy Update • Action Plan for Health Discussion • FLEX	All	-CCO Quarterly Legislative Report	**Pending Sine Die 2017 Legislative Session**
July 11, 2017	• Legislative Recap • Health Systems Transformation Metrics Report • Workforce Committee Report • Behavioral Health Governance Recommendations	CCO Monitoring & Oversight, Health System Transparency & Accountability, Equity	-CCO Metrics Report - Physician Workforce Survey Report -Workforce strategies report	
August 1, 2017	• Hospital Transformation Performance Program Report • Hospital Financial & Utilization Report • Hospital Common Procedures and Costs Report • CCO 2.0 Implementation Update	Health System Transparency & Accountability, CCO Oversight & Monitoring	-Hospital Transformation Performance Program Report -Hospital Financial Report -Hospital common inpt and outpt procedures report (SB 900) -CCO Quarterly Legislative Report	
September 12, 2017	• Workforce Composition & Promising Strategies • Public Health Modernization	CCO Oversight & Monitoring, Equity, Accelerated Integration	-WF composition report	

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items)	Board Priority Area	Reports	Legislative Mandates
	• HITOC Update			
October 3, 2017	• Behavioral Health Contractual/Rule Change Recommendations • High Cost Drugs • Health Plan Quality Metrics Progress Report	Accelerated integration, High Cost Drugs	-Oregon Health Insurance Survey Fact Sheets	**Pending Sine Die 2017 Legislative Session**
November 7, 2017	• Oregon Health Insurance Survey Findings • Quality Metrics Committee Update • Flex	Accelerated Integration, Oversight & Monitoring, Equity	-CCO Quarterly Legislative Report	
December 5, 2017	• Hospital Community Benefit Report • CCO 2.0 Implementation Update • HITOC Update	Accelerated Integration, Oversight & Monitoring, Equity	-Hospital Community Benefit Report	
January '18	• Retreat	n/a		

Oregon Health Policy Board
DRAFT April 4, 2017
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

Item	
Welcome and Call To Order, Chair Zeke Smith **Present**: Board members present: Chair Zeke Smith, Vice-Chair Carla McKelvey(phone), Joe Robertson, Oscar Arana, Brenda Johnson The Board voted to approve the March minutes. The Board discussed the new yearly calendar and how it works.	
OHPB Committee Liaison Update Dr. McKelvey gave and update on the Workforce committee. The new charter was presented to the Workforce committee, they looked at all deliverables, and signed up for subcommittees.	00:10:07
Director's Report, Lynne Saxton, OHA Lynne gave an update on the Rates that have been accepted. The agency has been working on the budget for this year. OHA has been working on identifying potential reduction. She gave a hiring update regarding the state hospital and noted the evolving federal policy landscape.	00:15:13

Oregon Health Policy Board
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2017 Legislative Session Update, BethAnne Darby, OHA BethAnne was unable to attend, Jeff Scroggin gave the update in her place. Jeff gave an update regarding bills which may impact the Board or relate to Board priorities including HB 2122, HB3261, HB2675, and SB934	00:28:49
Federal Health Policy Update Leslie gave a high level update. She noted that OHA staff continue to partner with DCBS to focus on potential federal policy changes which impact commercial insurance and said OHA is working with DHS to identify other impacts to other program areas under Medicaid waivers, such as long term services & supports. She said policy teams are working with communications staff to ensure http://www.95percentoregon.com/ is kept up to date.	00:36:33
High Cost Drugs Dr. Rickards gave a follow up on his presentation from last year. He noted high cost drug related work currently being considered and went into further depth about unified prescription drug lists and potential dependencies. His presentation can be found here.	01:16:18
OHPB Committees: Charters & Membership Jeff talked about the liaison and consultant role in the OHPB committees and the distinction between committees under the Board versus committees directly under OHA. Jeff brought forward various charters to be approved by the board including: Health Plan Quality Metrics Committee Charter – Board approved charter with amendments that were discussed.	00:55:29 02:07:26

Oregon Health Policy Board
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The PHAB committee brought their charter to the Board for approval – Vote was tabled until the next meeting pending quorum. Leslie and Oscar discussed the coming Equity Committee, they both noted excitement and support for the opportunity to establish the committee and to elevate the importance of this work related to achieving improved health outcomes for everyone. They said that using an equity lens and making progress on reducing health care disparities is a clear and urgent priority for both the Board and OHA. The Board should expect a draft charter for the committee at its next meeting.	
OHPB video and audio recording To view the video, or listen to the audio link, of the OHPB meeting in its entirety click here.	
Public Testimony None	
Adjourn	

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Oregon Health Policy Board

2017 Legislative Session Update

As of April 25, 2017

Bills with direct references to the Oregon Health Policy Board or its Committees:

Bill	Brief Summary	Impact on OHPB	Current Status
HB 2122 A	Modifies requirements for coordinated care organizations. Makes all meetings of governing body of coordinated care organization and community advisory council subject to open meetings law and requires coordinated care organization to spend earnings above specified threshhold on services designed to address health disparities and social determinants of health. Requires new coordinated care organizations and coordinated care organizations that transfer ownership to new entity to be community-based tax exempt organizations	OHPB impact reduced in adopted amendments	Passed House Health on 4/14; 5-4 vote on party lines
HB 2310	Modifies provisions regarding schedule by which local public health authorities must submit local plans for applying foundational public health capabilities and implementing foundational public health programs. Directs Oregon Public Health Advisory Board to establish accountability metrics for purpose of evaluating progress in achieving statewide public health goals. Establishes process by which governing body of county may transfer to state duties of county with respect to public health laws of state. Permits local public health authorities to enter into agreement with Oregon Health Authority under which local public health authority receives state funding for purpose of applying foundational capabilities and implementing foundational programs. Authorizes Oregon Health Authority to establish fees for providing public health data for public health purposes.	Required to review recommendations made by the Oregon Public Health Advisory Board on the incorporation and use of metrics to encourage the effective and equitable provision of public health services by local public health authorities.	Passed House Health unanimously on 4/17
SB 419	Establishes Task Force on Health Care Cost Review to study feasibility of creating rate-setting process modeled on process used by Health Services Cost Review	OHPB Chair designated to sit on Task Force	Passed Senate Health care on 4/18; currently in Ways & Means

	Commission in Maryland. Specifies membership. Requires report to interim committees of Legislative Assembly related to health no later than September 15, 2018. Sunsets task force December 31, 2018. Takes effect on 91st day following adjournment sine die.		
~~SB 51~~	~~Establishes Task Force on Behavioral Health. Requires task force to report findings and recommendations to interim committee related to health care on or before December 31, 2017.~~	~~Help in the appointment of members to the Task Force on Behavioral Health.~~	~~Behavioral Health Collaborative update given on 3/15; SB 51 no longer being pursued.~~
~~SB 236~~	~~Limits discretion of Oregon Health Authority with respect to contracts with and rules concerning coordinated care organizations and imposes new requirements. Imposes requirements on authority for rulemaking and collaborating with coordinated care organizations. Imposes additional responsibilities on Oregon Health Policy Board in oversight of authority, Health Evidence Review Commission and Office for Oregon Health Policy and Research. Requires Department of Consumer and Business Services to certify global budget before budget may take effect.~~	~~Adds duties to OHPB, including: (1) Provide independent oversight of OHA's compliance with state and federal requirements for the administration of medical assistance program and contracting with CCOs; (2) ensure that CCOs are reporting to OHA and OHA is compiling all required data including quality performance benchmarks; (3) investigate complaints or concerns expressed with respect to CCOs; and (4) approve proposed legislative measures that may be submitted to the Governor for approval.~~	~~Referred to Senate Health Care; no hearing yet scheduled~~
~~SB 816~~	~~Permits Oregon Health Authority to require hospitals to submit emergency department abstract records, in addition to ambulatory surgery and inpatient discharge abstract records. Permits authority to prescribe by rule abstract record data that hospitals and ambulatory surgery centers must include in records submitted. Permits authority to contract with third party to compile and process data from abstract records. Deletes requirement that authority reimburse hospital for cost of converting records to form specified by authority if different from form regularly used by hospital.~~	~~Required to approve hospital ambulatory surgery, inpatient discharge and emergency department abstract records.~~	~~Referred to Senate Health Care; no hearing yet scheduled~~

Measures related to Oregon Health Policy Board priorities:

Pay for Outcomes and Value			
Bill	**Summary**	**Relationship to OHPB**	**Current Status**
SB 233	Requires Oregon Health Authority to make publicly available specified information regarding administration of medical assistance and payments to coordinated care organizations. Specifies criteria and procedures for establishment of global budgets. Provides review by Department of Consumer and Business Services of global budget established by authority. Requires department to implement procedures for reviewing de novo global budget determination appealed to department by coordinated care organization.	Amends global budget setting and review process.	Passed Senate Health Care on 4/18; referred to Ways & Means
HB 2300	Removes carve-out for mental health drugs and would allow for an enforceable mental health preferred drug list (PDL)	Relates to Board's role in monitoring health system transformation and CCO implementation.	Passed House Health Care on 4/17; referred to Ways & Means
~~HB 3079~~	~~Removes factor based on payments to hospitals from determination of hospital assessment rate.~~	~~Impacts OHP funding.~~	~~Referred to House Health Care~~
Shift Focus Upstream			
Bill	**Summary**	**Relationship to OHPB**	**Current Status**
SB 934	Prohibits coordinated care organizations from spending less than 14.4 percent of global budget on primary care and community health	Relates to focus on preventative care	Passed Senate Health Care on 4/18
~~HB 2046~~	~~Specifies types of primary care providers eligible to participate in primary care provider loan repayment program.~~	~~Relates to promotion of, and access to, primary care.~~	~~Referred to House Health Care~~
Improve Health Equity			
Bill	**Summary**	**Relationship to OHPB**	**Current Status**
~~HB 3042~~	~~Requires OHA to use portion of moneys in Hospital Quality Assurance Fund to provide grants to culturally specific health care facilities beginning January 1, 2018.~~	~~Relates to improving health equity.~~	~~Awaiting referral.~~
Reduce Barriers to Care			

Bill	Summary	Relationship to OHPB	Current Status
SB 558 & HB 2726	Requires Oregon Health Authority to convene work group to advise and assist in implementing targeted outreach and marketing for Health Care for All Oregon Children program. Permits all children residing in Oregon and meeting financial eligibility requirements to enroll in program. Requires authority, in collaboration with Department of Consumer and Business Services if necessary, to seek necessary federal approval or waiver of federal requirements to secure federal financial participation in costs of outreach and marketing and in expansion of eligibility for program.	Would provide access to health care for all Oregon children.	Both bills passed health care committees and moved to Ways & Means
HB 3391	Requires health benefit plan coverage of specified health care services, drugs, devices, products and procedures related to reproductive health	Codifies ACA access to reproductive health services.	Passed House Health Care on 4/14
HB 2391	Requires Oregon Health Authority to submit blueprint for basic health plan to Centers for Medicare and Medicaid Services by December 31, 2017	Follows up on work done to create blueprint.	Sent to House Rules on 4/17
Enhance Care Coordination			
Bill	**Summary**	**Relationship to OHPB**	**Current Status**
HB 2675	Requires community health improvement plans adopted by coordinated care organizations and community advisory councils to focus on and develop strategy for integrating physical, behavioral and oral health care services	Emphasizing integration and community involvement	Public Hearing in Senate Health on 4/27
Engage Stakeholders and Community Partners			
Bill	**Summary**	**Relationship to OHPB**	**Current Status**
HB 2838	Requires authority to update and furnish information monthly to coordinated care organization about members enrolled in coordinated care organization. Establishes Oregon Health Authority Assister Fund consisting of contributions from coordinated care organizations and continuously appropriates moneys in fund to Oregon Health Authority to provide grants to independent nonprofit organizations for providing application and renewal assistance	Aims to ease process for OHP members and applicants	Passed House Health on 4/14
Measure Progress			

Bill	Summary	Relationship to OHPB	Current Status
~~SB 816~~	~~Permits Oregon Health Authority to require hospitals to submit emergency department abstract records, in addition to ambulatory surgery and inpatient discharge abstract records~~	~~Would increase data available to OHA to measure progress of health system transformation.~~	~~Public hearing on March 14th~~

Upcoming Dates of Note

- April 7th – Deadline to schedule Work Sessions for First Chamber measures – **PASSED**
- April 18th – Deadline for committees to hold Work Sessions on First Chamber measures – **PASSED**

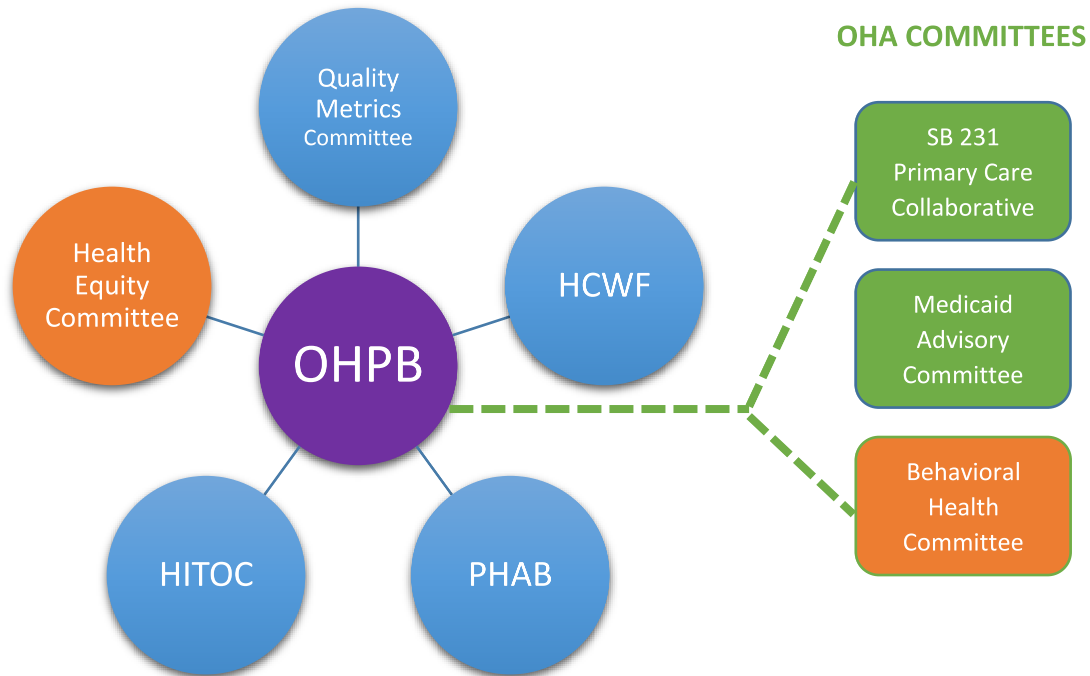
- May 19th – Deadline for Chairs to Schedule Work Sessions for Second Chamber Measures
- June 2nd – Deadline for Committees to Hold Work Sessions on Second Chamber Measures

- July 10th – Constitutional Sine Die

OHPB Committee Structure

OHPB Committees – 2017

Blue = Current OHPB Committees Orange = Newly Proposed
Green = Non-OHPB committees at OHA with opportunities for alignment and coordination



OHPB Committees	Statutory?	Duration	OHA Staffing Support	OHPB Liaison
Healthcare Workforce Committee (HCWF)	X	Standing committee	HPA – Health Policy	Carla McKelvey
Public Health Advisory Board (PHAB)	X	Standing committee	Public Health	Zeke Smith (Temp)
Health Information Technology Oversight Council (HITOC)	X	Standing committee	HPA - OHIT	Karen Joplin
Health Plan Quality Metrics	X	Standing committee	HPA - Analytics	Zeke Smith (Temp)
Health Equity Committee		Standing committee	OEI	Oscar Arana
OHA Committees Aligned w/ OHPB Priorities:		**Duration**	**OHA Leadership**	**OHPB Consult**
Behavioral Health Policy Committee		Ongoing	HPA – Behavioral Health Policy team	Brenda Johnson
Medicaid Advisory Committee*	X	Ongoing, Federally req'd	HPA – Office of Health Policy	
Primary Care Collaborative		Ongoing	HPA-Transformation Center	Carla McKelvey

OHPB Committee Structure

* Medicaid Advisory Committee is federally required for every state. It is responsible for developing and advising Medicaid policy recommendations at the request of the Governor, the Legislature and OHA.

Role of Liaison to OHPB Committees: Oversight & Direction

- Attend (in-person or via phone) subcommittee meetings (most are bimonthly or quarterly); ensure strong connection to OHPB through regular updates to committee, participation in crafting charter, and ensuring committee is carrying out OHPB deliverables as envisioned
- Prior to subcommittee meetings, review agenda with OHA staff via email or phone
- Provide updates to OHPB as needed regarding committee activities, membership, charter development, etc.

Role of OHPB members providing consultation to OHA Committees: Monitoring & Guidance

- Attend meetings as needed; ensure appropriate connection to OHPB by providing OHPB insight to the committee and providing OHPB members with updates on committee activities as needed.
- Provide guidance to relevant OHA staff (leadership and those staffing committee) related to the alignment of OHA committee work with OHPB priorities

Role of OHPB	**OHPB Committees**	**OHA Committees**
Establish Membership	Members chosen by OHPB and Gov's office	Membership chosen by OHA Leadership
Establish Work plan / Charter	OHPB formally adopts committee charter creating work plan and deliverables	Work plan and/or charters established by individual committees in conjunction with OHA Leadership and others based on state priorities
Role of OHPB Liaison / Consultant	Provides direction to help committee meet charter deliverables; leadership along with chair / vice	Enhance connection and alignment between OHPB priorities and & ongoing OHA work; provide guidance for OHA staff and leadership

HITOC Membership Additions
4/25/17

Name	Title	Organizational Affiliation	Location	Term (Yrs)
Steven Vance	Director of Information and Technology Services	Lake Health District Hospital	Lakeview	4
Description/Background: IT Director for frontier health district serving a critical access hospital, skilled nursing facility and community mental health program. Formally with Providence Health System.				
Amy Fellows	Executive Director	We Can Do Better	Eugene	4
Description/Background: ED for coalition that advocates for patient and consumer engagement in improving health care delivery and equity, with extensive work spreading the adoption of OpenNotes, which gives patients electronic access to clinical notes. Previously work with OCHIN on implementing EHRs with FQHCs and other safety net clinics.				

Current HITOC Members

Name	Title	Organizational Affiliation	Location	Term (Yrs)
Maili Boynay	IS Director Ambulatory Community Systems	Legacy Health	Portland, OR	3
As IT Director for Ambulatory Community Systems, very knowledgeable and experienced with health IT and quality improvement such as meaningful use/PQRS/Wellcentive. Member of implementation committee of the Unity hospital project (behavioral health solution), extending Epic to Albertina Kerr. Project managed dozens of EHR implementations (17 years of health IT experience).				
Erick Doolen	COO	PacificSource	Springfield, OR	4

Current HITOC Members				
Name	**Title**	**Organizational Affiliation**	**Location**	**Term (Yrs)**
As COO of PacificSource, brings the perspective of multiple lines of business (commercial, Medicare Advantage, and Medicaid (CCO)). They do business in other states so he brings that experience. His responsibilities include all aspects from strategy to day-to-day delivery of technology and operations. Former HITOC Member and HITOC Finance workgroup member.				
Chuck Fischer	IT Director	Advantage Dental	Redmond, OR	3
Advantage Dental has created an information exchange and is implementing connections with the Emergency Department Information Exchange (EDIE)/PreManage, with plans to extend to Epic and McKesson EHRs. Perspective is technology implementer, “someone in the trenches,” who deals with health IT daily. Previously worked for a critical access hospital in Idaho.				
Valerie Fong, RN	CNIO	Providence Health & Services	Portland, OR	2
Regional CNIO for Oregon Region of Providence (representing 8 acute hospitals and 90 ambulatory clinics). Previously served in several roles at Kaiser Permanente including EHR design and implementation, IS governance, transitions of care and strategic alignment. Adjunct faculty for graduate students on informatics. Registered nurse; practical hands-on and big picture view.				
Charles (Bud) Garrison	Director, Clinical Informatics	Oregon Health & Science University	Portland, OR	4
Represents academic medicine in addition to inpatient, perioperative and ambulatory clinical and operational workflows in a multi-site environment. In current role, he has gained experience in dealing with clinical workflows and EHR build related issues, governance, privacy, release of information, etc.				
Brandon Gatke	CIO	Cascadia Behavioral Healthcare	Portland, OR	3
Runs IT and analytics departments for largest nonprofit behavioral healthcare provider in Oregon. Brings in-depth experience on hurdles and technical opportunities for residential and outpatient care environments. Served on Oregon Health IT Task Force which developed the current Business Plan Framework for Health IT in Oregon.				
Amy Henninger, MD	Site Medical Director	Multnomah County Health Department	Portland, OR	2
Represents medical provider perspective as well as community health centers in the Portland Metro Area. Experienced in clinical operations and still see patients. Works closely with community services at Multnomah County. Leader in rolling out MyChart (patient portal) and experienced in EHR implementation and updating.				

Current HITOC Members				
Name	**Title**	**Organizational Affiliation**	**Location**	**Term (Yrs)**
Mark Hetz	CIO	Asante Health System	Medford, OR	4
Represents health system with one of the few inpatient behavioral units in the state; providing insight into handling/sharing behavioral health information. Involved in the formation and growth of Jefferson HIE in Southern Oregon. Served on previous HITOC workgroups and the Health IT Task Force.				
Sonney Sapra	CIO	Tuality Healthcare	Hillsboro, OR	3
Represents community-based health system in Hillsboro, risk accepting entity within Health Share CCO. As CIO, involved in security/privacy, informatics, health information exchange, etc. One of the few non-Epic EHR sites in the Portland Metro Area.				
Greg Van Pelt	President	Oregon Health Leadership Council	Portland, OR	2
Represents membership organization including major health plans, health systems, CCOs, and large medical groups and associations across the state. Works closely with OHA on EDIE/PreManage. Served as Chair of Health IT Task Force.				

Demographic Information (including proposed additions, removing one retiring member)

Gender: 33% female; 58% male
Race: 75% white; 17% Asian or Pacific Islander
Ethnicity: 11 members identify as non-Hispanic; 0 members identify as Hispanic
Geography: 58% from Portland area, 17% Willamette Valley, 8% Southern OR, 8% Central OR, 8% Eastern OR
Disability: 1 members identified as disabled
1 member declined to provide demographic information

Additional Information

3 open seats on HITOC remain

Oregon Health Policy Board
Public Health Advisory Board
Charter
DRAFT, March 2017

~~Approved by the Oregon Health Policy Board on April 5, 2016~~

I. Overview and Authority

The Public Health Advisory Board (PHAB) is established by ORS 431.122 as a body that reports to the Oregon Health Policy Board (OHPB).

The purpose of the PHAB is to be the accountable body for governmental public health in Oregon. The role of the PHAB includes:

- Alignment of public health priorities with available resources.
- Analysis and communication of what is at risk when there is a failure to invest resources in public health.
- Oversight for Oregon Health Authority, Public Health Division strategic initiatives, including the State Health Assessment and State Health Improvement Plan.
- Oversight for governmental public health strategic initiatives, including the implementation of public health modernization.
- Support for state and local public health accreditation.

This charter defines the objectives, responsibilities, and scope of activities of the PHAB. This charter will be reviewed periodically to ensure that the work of the PHAB is aligned with the OHPB's strategic direction.

II. Duties, Objectives, Membership, Terms, Officers

The duties of the PHAB as established by ORS 431.123 and the PHAB's corresponding objectives include:

PHAB Duties per ORS 431.123	PHAB Objectives
a. Make recommendations to the OHPB on the development of statewide public health policies and goals.	• Participate in and provide oversight for Oregon's State Health Assessment. • Regularly review state health data such as the State Health Profile to identify ongoing and emerging health issues. • Use best practices and an equity lens to provide recommendations to OHPB on policies needed to address priority health issues, including the social determinants of health.
b. Make recommendations to the OHPB on how other statewide priorities, such as the provision of early learning services and the delivery of health care services, affect and are affected	• Regularly review early learning and health system transformation priorities. • Recommend how early learning goals, health system transformation priorities, and statewide public health goals can best be aligned.

by statewide public health policies and goals.	• Identify opportunities for public health to support early learning and health system transformation priorities. • Identify opportunities for early learning and health system transformation to support statewide public health goals.
c. Make recommendations to the OHPB on the establishment of foundational capabilities and programs for governmental public health and other public health programs and activities.	• Participate in the administrative rulemaking process which will adopt the Public Health Modernization Manual. • Verify that the Public Health Modernization Manual is still current at least every two years. Recommend updates to OHPB as needed. •
d. Make recommendations to the OHPB on the adoption and updating of the statewide public health modernization assessment.	• Review initial findings from the Public Health Modernization Assessment. (completed, 2016) • Review the final Public Health Modernization Assessment report and provide a recommendation to OHPB on the submission of the report to the legislature. (completed, 2016) • Make recommendations to the OHPB on processes/procedures for updating the statewide public health modernization assessment.
e. Make recommendations to the OHPB on the development of and any modification to the statewide public health modernization plan.	• Review the final Public Health Modernization Assessment report to assist in the development of the statewide public health modernization plan. (completed, 2016) • Using stakeholder feedback, draft timelines and processes to inform the statewide public health modernization plan. (completed, 2016) • Develop the public health modernization plan and provide a recommendation to the OHPB on the submission of the plan to the legislature. (completed, 2016) • Update the public health modernization plan as needed based on capacity.
f. Make recommendations to the Oregon Health Authority (OHA) and the OHPB on the development of and any modification to plans developed for the distribution of funds to local public health authorities.	• Identify effective mechanisms for funding the foundational capabilities and programs. • Develop recommendations for how the OHA shall distribute funds to local public health authorities.
g. Make recommendations to the OHA and the OHPB on the total cost to local public health authorities of applying the foundational capabilities and implementing the foundational programs for governmental public health.	• Review the Public Health Modernization Assessment report for estimates on the total cost for implementation of the foundational capabilities and programs. (completed, 2016) • Support stakeholders in identifying opportunities to provide the foundational capabilities and programs in an effective and efficient manner.

h. Make recommendations to the OHPB on the use of incentives by the OHA to encourage the effective and equitable provision of public health services by local public health authorities.	• Develop models to incentivize investment in and equitable provision of public health services across Oregon. • Solicit stakeholder feedback on incentive models.
i. Provide support to local public health authorities in developing local plans to apply the foundational capabilities and implement the foundational programs for governmental public health.	• Provide support and oversight for the development of local public health modernization plans. • Provide oversight for Oregon's Robert Wood Johnson Foundation grant, which will support regional gatherings of health departments and their stakeholders to develop public health modernization plans.
j. Monitor the progress of local public health authorities in meeting statewide public health goals, including employing the foundational capabilities and implementing the foundational programs for governmental public health.	• Provide oversight and accountability for Oregon's State Health Improvement Plan by receiving quarterly updates and providing feedback for improvement. • Provide support and oversight for local public health authorities in the pursuit of statewide public health goals. • Provide oversight and accountability for the statewide public health modernization plan. • Develop outcome and accountability measures for state and local health departments.
k. Assist the OHA in seeking funding, including in the form of federal grants, for the implementation of public health modernization.	• Provide letters of support and guidance on federal grant applications. • Educate federal partners on public health modernization. • Explore and recommend ways to expand sustainable funding for state and local public health and community health.
l. Assist the OHA in coordinating and collaborating with federal agencies.	• Identify opportunities to coordinate and leverage federal opportunities. • Provide guidance on work with federal agencies.

Additionally, the Public Health Advisory Board is responsible for the following duties which are not specified in House Bill 3100:

Duties	**PHAB Objectives**
a. Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters.	• Provide guidance and recommendations on statewide public health issues and public health policy.
b. Act as formal advisory committee for Oregon's Preventive Health and Health Services Block Grant.	• Review and provide feedback on the Preventive Health and Health Services Block Grant work plan priorities.

c. Provide oversight for the implementation of health equity initiatives across the public health system.	• Receive progress reports and provide feedback to the Public Health Division Health Equity Committee. • Participate in collaborative health equity efforts.

Membership Composition

Per ORS 431.122, the PHAB shall consist of the following 13 members appointed by the Governor:

1. A state employee who has technical expertise in the field of public health;
2. A local public health administrator who supervises public health programs and public health activities in Benton, Clackamas, Deschutes, Jackson, Lane, Marion, Multnomah or Washington County;
3. A local public health administrator who supervises public health programs and public health activities in Coos, Douglas, Josephine, Klamath, Linn, Polk, Umatilla or Yamhill County;
4. A local public health administrator who supervises public health programs and public health activities in Clatsop, Columbia, Crook, Curry, Hood River, Jefferson, Lincoln, Tillamook, Union or Wasco County;
5. A local public health administrator who supervises public health programs and public health activities in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Wallowa or Wheeler County;
6. A local health officer who is not a local public health administrator;
7. An individual who represents the Conference of Local Health Officials created under ORS 431.330;
8. An individual who represents coordinated care organizations;
9. An individual who represents health care organizations that are not coordinated care organizations;
10. An individual who represents individuals who provide public health services directly to the public;
11. An expert in the field of public health who has a background in academia;
12. An expert in population health metrics;
13. An at large member.

PHAB shall also include the following nonvoting, ex-officio members:

1. The Oregon Public Health Director or the Public Health Director's designee;
2. If the Public Health Director is not the State Health Officer, the State Health Officer or a physician licensed under ORS chapter 677 acting as the State Health Officer's designee;
3. If the Public Health Director is the State Health Officer, a representative from the Oregon Health Authority who is familiar with public health programs and public health activities in this state; and
4. An Oregon Health Policy Board liaison.

Membership Terms

The term of office for a board member appointed under this section is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.
Of the PHAB members beginning their term in January 2016:

- Four shall serve for terms ending January 1, 2017.
- Three shall serve for terms ending January 1, 2018.
- Three shall serve for terms ending January 1, 2019.
- Three shall serve for terms ending January 1, 2020.

Officers

PHAB shall elect two of its voting members to serve as the chair and vice chair. Elections shall take place in January of each even-numbered year.

The chair and vice chair shall serve two year terms. If the chair were to vacate their position before their term is complete the vice chair shall become the new chair to complete the term. If a vice chair is unable to serve, or if the vice chair position becomes vacant, then a new election is held to complete the remainder of the vacant term(s).

The PHAB chair shall facilitate meetings and guide the PHAB in achieving its deliverables. The PHAB chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee. The PHAB chair may represent the PHAB at meetings with other stakeholders and partners, or designate another member to represent the PHAB as necessary.

The PHAB vice chair shall facilitate meetings in the absence of the PHAB chair. The PHAB vice chair shall represent the PHAB at meetings of the Oregon Health Policy Board as directed by the Oregon Health Policy Board designee when the PHAB chair is unavailable. The PHAB vice chair may represent the PHAB at meetings with other stakeholders and partners when the PHAB chair is unavailable or under the guidance of the PHAB chair, or may designate another member to represent the PHAB as necessary.

Both the PHAB chair and vice chair shall work with OHA Public Health Division staff to develop agendas and materials for PHAB meetings.

III. Actions and Deliverables

Actions

The PHAB may take the following actions:

- Make formal recommendations, provide informal advice, and reports to the OHPB;
- Review and advise the Director of the OHA Public Health Division and the public health system as a whole on important statewide public health issues or public health policy matters;
- Identify priorities for Oregon’s governmental public health system;
- Charter committees (for ongoing work) and/or work groups (for short-term work) on various topics related to governmental public health;
- Request data and reports to assist in preparing recommendations to the OHPB;
- Provide a member to serve as a liaison to other committees or groups as requested.

Deliverables/Actions

The PHAB shall deliver the following:

Deliverable	Time Frame
• **A work plan for the PHAB for 2016-2017**	Spring 2016
• **A proposal for reporting to the OHPB (e.g., frequency, format, etc.)**	Spring 2016
• **Report(s) to the OHPB (as agreed to with the OHPB)**	At least annually
• **Recommendations to the OHPB**	As needed
• **Public Health Modernization Assessment report**	June 2016 (complete)
• **Public Health Modernization Plan**	December 2016 (complete)
• **Report(s) to the legislature as requested**	As needed

In addition to the deliverables listed above, the PHAB shall charter committees and work groups as needed and take direction from the OHPB.

IV. Staff Resources

The PHAB is staffed by the OHA, Public Health Division, as led by the Policy Officer. Support will be provided by staff of the Public Health Division Policy Team and other leaders, staff, and consultants as requested or needed.

V. Expectations for PHAB Meetings

The following expectations apply to all PHAB meetings:

- The PHAB will meet monthly from January 2016 through July 2017. In July 2017, the PHAB will determine if meetings should continue monthly or move to an alternate schedule, with meetings occurring at least quarterly. More frequent and ad hoc meetings may be called for by the chairperson.
- The PHAB shall meet at times and places specified by the call of the chairperson or of a majority of the voting members of the board.
- A standard meeting time will be established (with special exceptions).
- Meetings shall be conducted in accordance with Oregon's Public Meetings Law (ORS 192.610 through 192.710) and Public Records Law (ORS 192.001 through 192.505) and documented on the PHAB website: www.healthoregon.org/phab.
- Official subcommittee meetings shall also be conducted in accordance with Oregon's Public Meetings Law (ORS 192.610 through 192.710) and Public Records Law (ORS 192.001 through 192.505) and documented on the PHAB website: www.healthoregon.org/phab.
- A public notice will be provided to the public and media at least 10 days in advance of each regular meeting and at least five days in advance of any special meeting.
- A majority of the voting members of the PHAB constitutes a quorum for the transaction of business during PHAB meetings.
- PHAB members are expected to review materials ahead of the meeting and come prepared to discuss and participate.
- Written minutes will be taken at all regular and special meetings. Minutes will include: members present; all motions, proposals, resolutions, orders, ordinances and measures proposed and their disposition; the substance of discussion on any matter; and a reference to any document discussed or distributed at the meeting.

Conflicts of Interest

The purpose of this conflict of interest policy is to maintain the transparency and integrity of the PHAB and its individual members, understanding that many voting members have a direct tie to governmental public health or other stakeholders in Oregon.

PHAB members shall verbally disclose any actual or perceived conflicts of interest prior to voting on any motion that may present a conflict of interest. If a PHAB member has a potential conflict related to a particular motion, the member should state the conflict. PHAB will then make a decision as to whether the member shall participate in the vote or be recused.

If the PHAB has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member and afford an opportunity to explain the alleged failure to disclose. If the PHAB determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate corrective action including potential removal from the body.

Lastly, PHAB members shall make disclosures of conflicts using a standard conflict of interest form at the time of appointment and at any time thereafter where there are material employment or other changes that would warrant updating the form.

VI. Amendments and Approval

This charter may be amended or repealed by the affirmative vote of two-thirds of the members present at any regular PHAB meeting. Notice of any proposal to change the charter shall be included in the notice of the meeting.

Oregon Health Policy Board
Health Equity Committee
Charter

Approved by the Oregon Health Policy Board on ________.

I. Authority

The Health Equity Committee is established by the Oregon Health Policy Board (OHPB). The purpose of the committee is to coordinate and develop policy that proactively promotes the elimination of health disparities and the achievement of health equity for all people in Oregon. Achieving health equity, including a healthcare workforce that reflects the demographics of the communities it serves, is a priority for the OHPB, the Oregon Health Authority (OHA) and the Governor. The Health Equity Committee will be responsible for reviewing health policy and leading efforts to develop best-practice policies which improve health equity.

DRAFT

II. Duties/Deliverables and Timeline

1. **Provide analysis, guidance and recommendations to OHPB on policy, including key legislation, using an equity lens**. Make substantive recommendations on proposed policies to be considered by OHPB, OHA and the broader health system in Oregon using an equity lens, which shall be clearly defined. Identify any gaps and assist in developing policy that will maximize progress and improve targeted outcomes. Evaluate policy impacts, including gathering feedback from affected communities regarding efficacy. Identify best-practice policies to reduce and eliminate disparities and achieve equity. Serve as an entry point, in collaboration with the OHA Office of Equity and Inclusion Division (OEI) and OHA External Relations Division for community organizations to share policy priorities, barriers, and solutions they have identified.

2. **Provide assessment and actionable recommendations. Analyze data and information and assess OHA's progress toward achieving defined health equity goals, including steps to becoming a more culturally responsive organization.** Develop best-practice, defined health equity policy framework and goals regarding culturally responsive policies and procedures, equitable access to resources to promote health, community engagement, and inclusion.

Coordinate and review health equity related policies as directed by the OHPB, including establishing health equity goals and metrics that are based on best-practice and measurable when appropriate. Provide guidance on policy development to ensure that substantive progress toward goals and metrics is made, including but not limited to health equity metrics established by the state.

3. **Collaboratively work with other OHPB committees and make recommendations to OHPB to:**

- Improve racial, cultural and ethnic diversity of Oregon's healthcare workforce to reflect communities served, showing a baseline and benchmarks by county;

- Serve as a resource for the Health Plan Quality Metrics Committee and identify quality measures relevant to advancing health equity in Oregon;
- Serve as a resource to the Workforce Committee to assist in the identification of strategies that support health equity and integrated health delivery;
- Collaborate with the OEI and PH Divisions regarding the scope of work to integrate health equity strategies into Public Health Modernization;
- Develop strategies to advance health equity related to the OHA workgroups focusing on Primary Care and Behavioral Health Reform efforts identified in OHA work groups.
- Identify strategies to advance health equity across policy domains relevant to the social determinants of health.
- Serve as a leader and catalyst for meaningful change in the health system related to health equity.

The Health Equity Committee in the first year will convene joint meetings with OHPB committees to review and develop health equity goals and make health equity recommendations to the OHPB. Joint meetings between the Health Equity Committee and each of the OHPB committees will be held annually. The Health Equity Committee is charged, in collaboration with other OHPB committees, with reporting and making recommendations regarding OHPB committee health equity policy development and goal setting.

DRAFT

III.Committee composition (demographics, geographic representation, skills, sector)

The committee is appointed by OHPB and shall consist of 15 individuals who are experienced and skilled in the review, analysis and development of health equity policy and results-proven implementation, including but not limited to the social determinants of health. Members shall include health equity professionals or individuals who have life experience in health equity policy advocacy and policymaking processes, community members, and health equity practitioners. Applications shall be solicited from a diverse group of candidates. Selection shall be made to ensure the committee is representative of communities experiencing health disparities, including, but not limited to racially and ethnically diverse populations, linguistically diverse populations, immigrant and refugee populations, LGBT populations, the aging population, people with disabilities, rural communities, and economically disadvantaged populations as well as individuals with experience transforming health equity in operational settings.

T

Terms will be two years, with staggered membership terms to ensure continuity.

IV.Dependencies

The committee will seek information from, provide information to, and collaborate with a wide range of partners, including but not limited to:

- Community partners and stakeholders representing communities impacted by health disparities

- OHA
- Committees of OHPB

V.Staff and Board Expectations

OEI will provide technical assistance, consultation and staff support to the committee on matters of health equity, health disparities, health policy goals, health policy development and equity and inclusion. OHPB will consult with the Health Equity Committee on an ongoing basis and involve the committee in regular discussion with and reports to the Board at their monthly meeting and annual retreats.

DRAFT

Hospital Community Benefit

Health Policy & Analytics Division
Office of Health Analytics

Steven Ranzoni
Hospital Policy Adviser

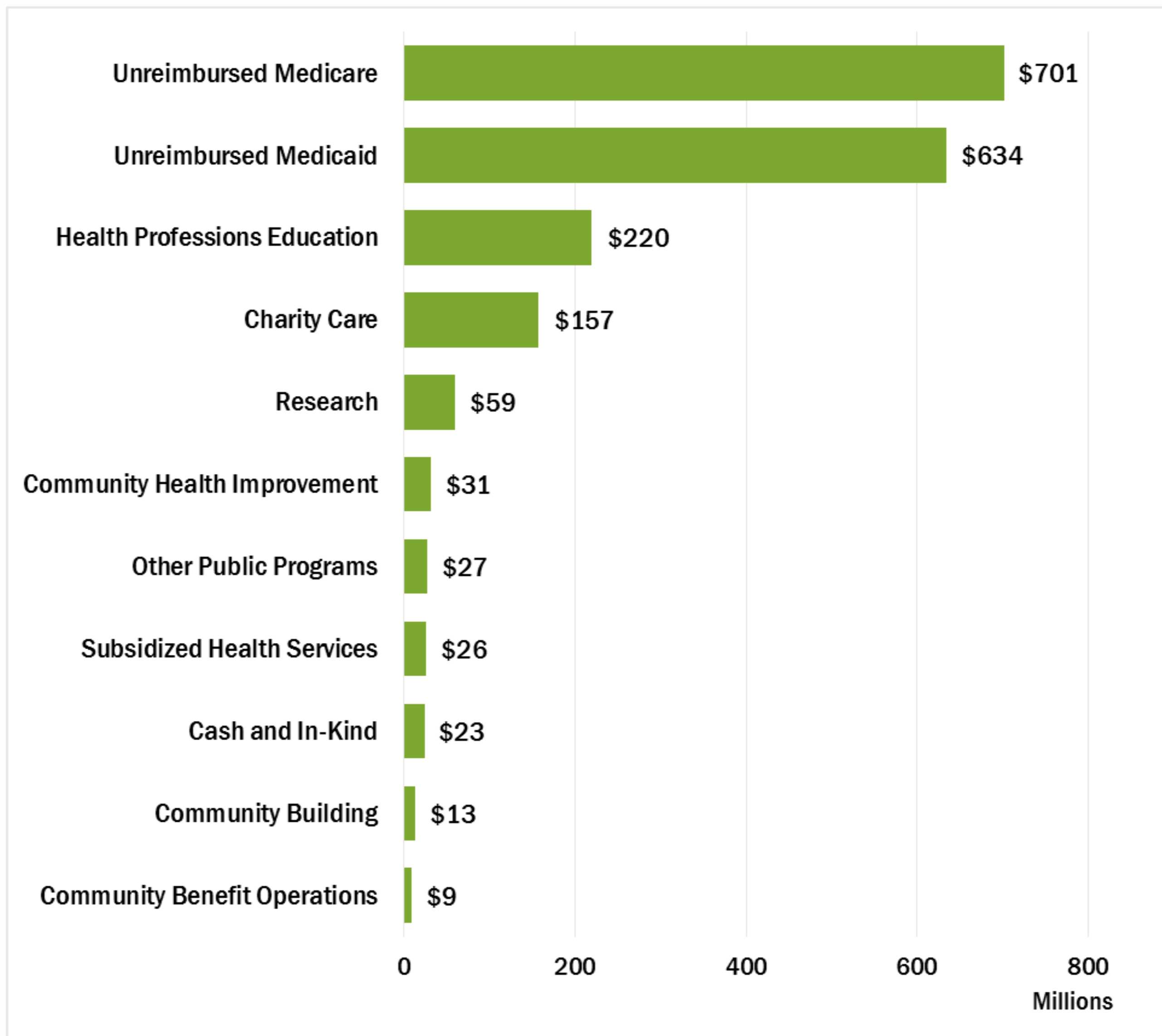
Stacey Schubert
Research and Data Manager

What are Hospital Community Benefits?

- Hospital community benefits are services, spending, or actions taken in the community a hospital serves, in exchange for its tax-exempt status.
- What counts as hospital community benefit is defined at both the state and federal level.
  - At the federal level on IRS tax form 990 and associated schedule H reporting form.
  - At the state level in Oregon Revised Statutes 442.200 and 442.205.
- There is no defined minimum community benefit a hospital must provide.

Oregon Health Authority

Oregon Hospital Community Benefits 2015



Oregon Health Authority

Unreimbursed Costs of Medicare and Medicaid

- Estimated costs of the expenses that are not reimbursed to the hospital for providing services to patients on Medicare or Medicaid.
- Unreimbursed costs may occur when the amount received in payment is less than expenses the hospital incurred, or when Medicare or Medicaid denies payment to the hospital.

Of Community Benefit

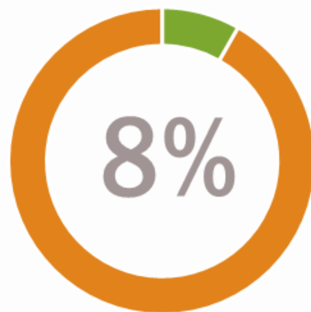
Oregon Health Authority

Unreimbursed Costs of Medicare and Medicaid

Oregon Health Authority

Charity Care Costs

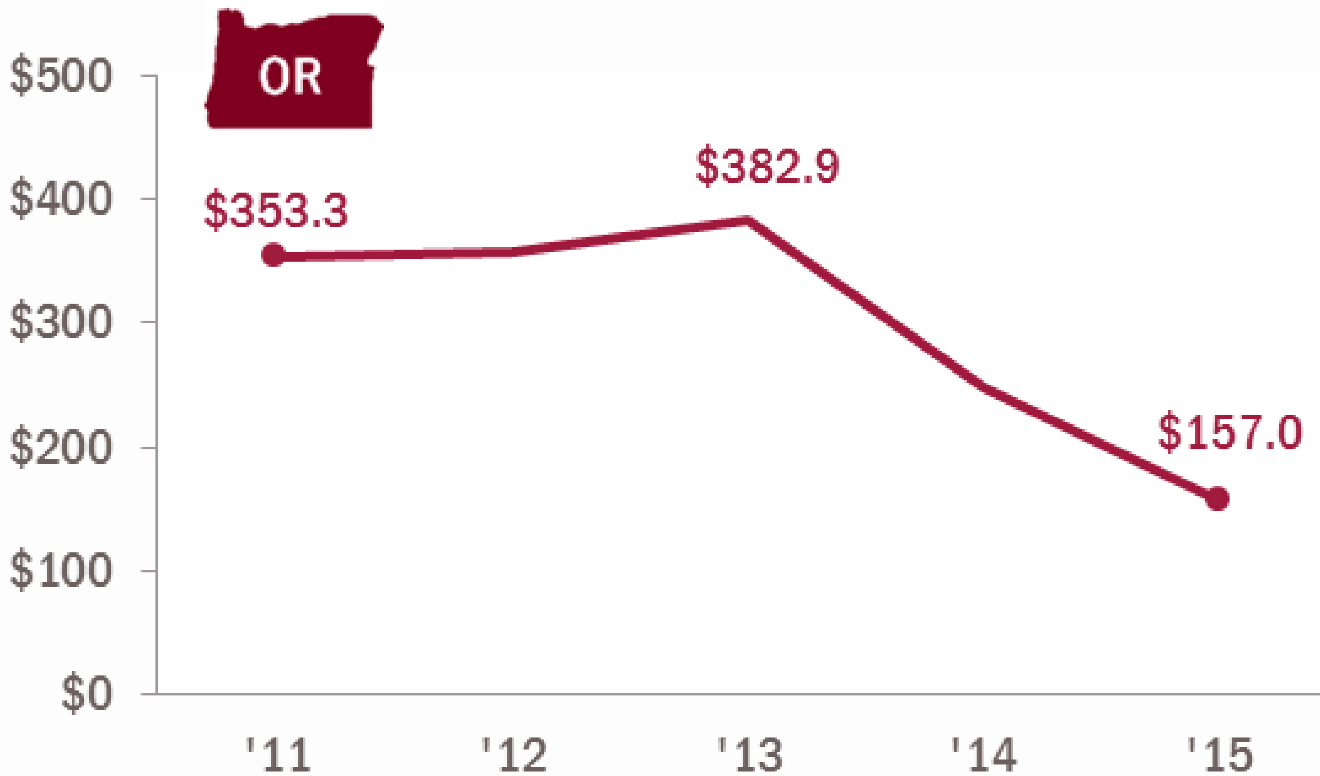
- Costs of services provided to people who are unable to pay all or part of their bill, and qualify for charity care based on the hospital's published policies.
- Charity care does not include bad debt, contractual allowances, or any other negotiated discount offered to a self-pay patient that does not qualify for the hospital's financial assistance policy.



Of Community Benefit

Oregon Health Authority

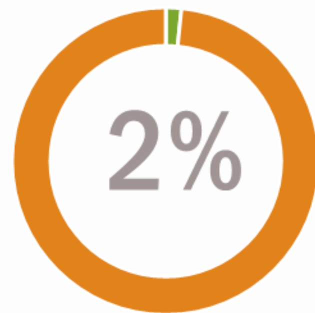
Charity Care Costs



Oregon Health Authority

Other Public Programs and Subsidized Health Services

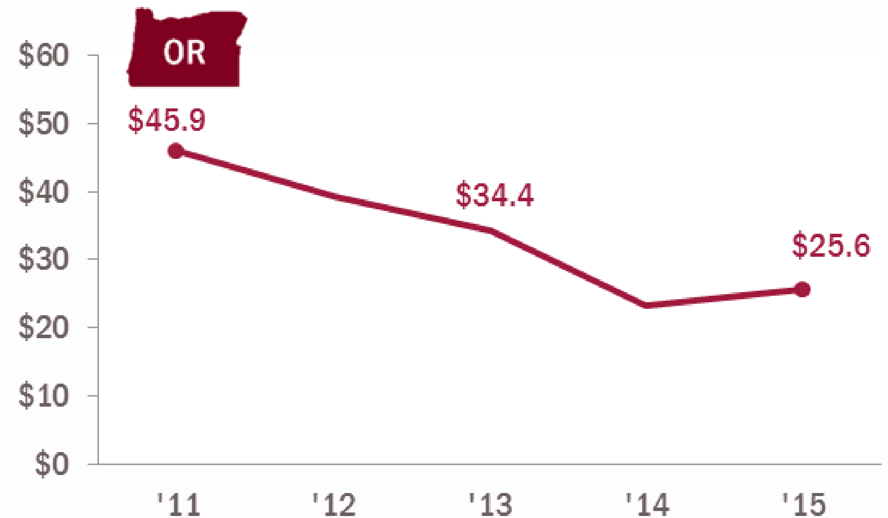
- Other public program costs are costs incurred supporting public programs such as Champus or Tricare, Veterans Health Administration, Indian Health Services and any other federal, state or local programs.
- Subsidized health services are those expenses incurred for clinical hospital services, provided at a financial loss, that meet an identified community need.



Of Community Benefit

Oregon Health Authority

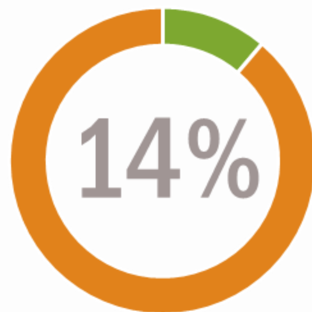
Other Public Programs and Subsidized Health Services



Oregon Health Authority

Health Professional Education and Research

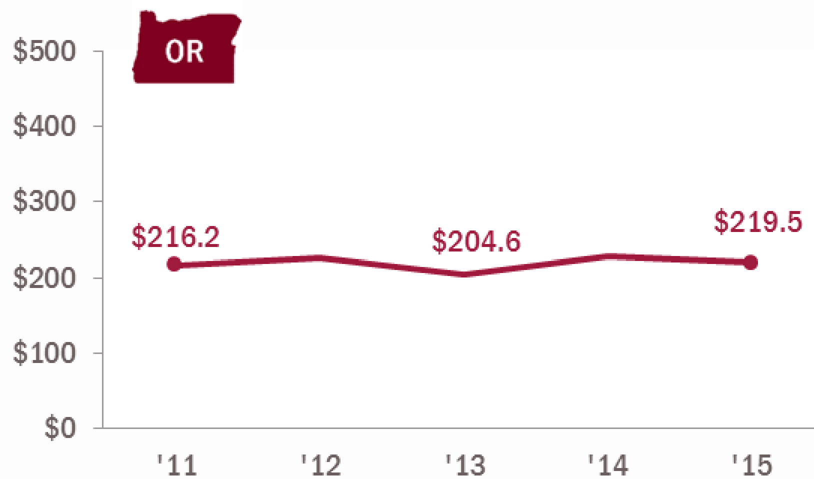
- Costs incurred for providing educational programs that result in a degree, certificate, or other training necessary to practice as a health professional.
- Does not include education or training programs exclusive to the organization.
- Costs incurred conducting any study or investigation in which the goal is to increase generalizable knowledge made available to the public.



Of Community Benefit

Oregon Health Authority

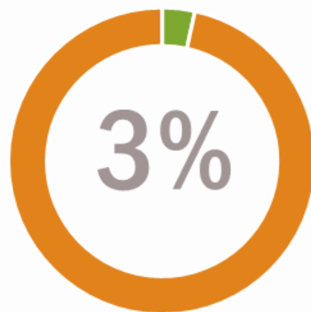
Health Professional Education and Research



Oregon Health Authority

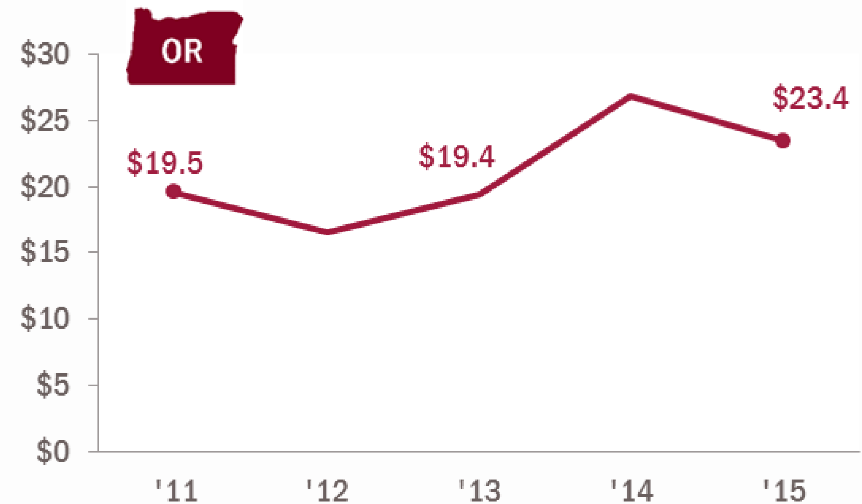
Community Health Improvement and Cash and In-Kind Contributions

- Costs incurred from activities or programs subsidized by the hospital that are carried out for the express purpose of improving community health.
- Direct donations of funds, supplies, space or employee time to another individual or community organization where the hospital is not the primary sponsor or organizer.



Of Community Benefit

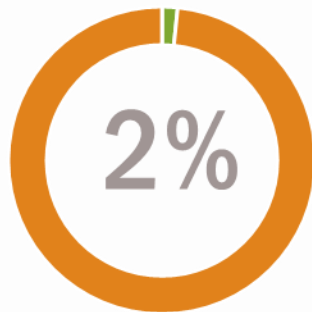
Community Health Improvement and Cash and In-Kind Contributions



Oregon Health Authority

Community Building and Community Building Operations

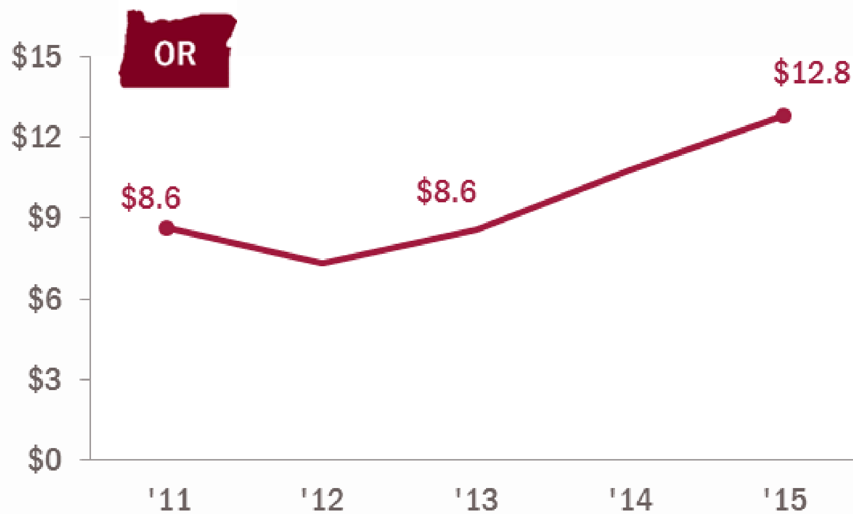
- Expenses related to activities in the community that are not directly related to providing health services, but address the root causes of health problems in the community.
- Expenses associated with staffing and coordinating the hospital's community benefit initiatives.

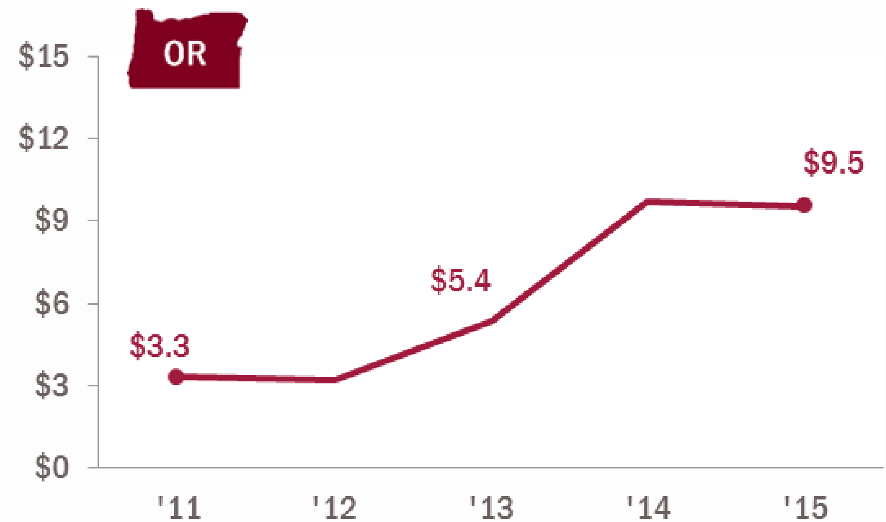


Of Community Benefit

Oregon Health Authority

Community Building and Community Benefit Operations





Oregon Health Authority

About Cost to Charge Ratios

- Unreimbursed costs of Medicare and Medicaid, charity care, public programs and subsidized health services all use cost to charge ratios to estimate expenses.
- The cost to charge ratio is the ratio between gross charges and operating expenses.

2011		2015	
Operating Expense	$45,000,000	Operating Expense +24%	$58,500,000
Gross Charges	$100,000,000	Gross Charges +33%	$133,000,000
Cost to Charge Ratio	**0.45**	**Cost to Charge Ratio**	**0.44**
Medicaid Charges	$5,000,000	Medicaid Charges +96%	$9,800,000
Medicaid Revenue	$2,000,000	Medicaid Revenue +62%	$3,240,000
Estimated Costs	$2,250,000	Estimated Costs	$4,310,526
Unreimbursed Cost	**$250,000**	**Unreimbursed Costs**	**$1,070,526**

Oregon Health Authority

Questions?

- Stacey Schubert – Research and Data Manager
- Steven Ranzoni – Hospital Policy Adviser

Oregon Health Authority

Oregon Acute Care Hospitals
Community Benefit Report

Fiscal Year 2015

Oregon Health Authority
Office of Health Analytics

Oregon Health Authority

ABOUT COMMUNITY BENEFIT REPORTING

In 2007, HB 3290 established Oregon's community benefit reporting law to document the benefits hospitals provide their communities. Oregon Revised Statutes 442.361, 442.362 and 442.991 require hospitals to report their yearly community benefit costs to the Oregon Health Authority within 240 days of the close of their fiscal year.

Oregon's 60 acute care hospitals are subject to reporting requirements for community benefit. However, McKenzie-Willamette Medical Center and Willamette Valley Medical Center are for-profit hospitals. These facilities have no obligation to provide community benefit because they are subject to property and income tax. In total, 58 of Oregon's 60 acute care hospitals are tax-exempt, not-for-profit hospitals.

Data are reported as costs to provide the service. These costs may be reported directly from accounting systems, or estimated using a cost to charge ratio. More information about cost to charge ratios can be found in the appendix. Any revenue received must be deducted so that only the expenses a hospital incurs are reported. Detailed information about what may or may not be included in each community benefit category can be found at the link provided at the bottom of the page.

The data are self-reported by hospitals directly to the Oregon Health Authority. Hospitals report data on a fiscal year basis. Fiscal years vary from hospital to hospital. The date range for each hospital's fiscal year is included in the community benefit data table provided on the Office of Health Analytics website.

Please direct questions or comments about this report to:

Steven Ranzoni, MPH
Hospital Policy Adviser
Oregon Health Authority
Office of Health Analytics
steven.ranzoni@state.or.us

Stacey Schubert, MPH
Research and Data Manager
Oregon Health Authority
Office of Health Analytics
stacey.s.schubert@state.or.us

More information and access to data tables can be found at:
http://www.oregon.gov/oha/analytics/Pages/Hospital-Reporting.aspx

Detailed descriptions of community benefit categories can be viewed at:
http://www.oregon.gov/oha/analytics/HospitalReporting/CBR-Directions.pdf

Types of Hospitals

In this report, hospital data is presented in four categories: All hospitals, DRG hospitals, Type A hospitals and Type B hospitals.

There are 60 acute care inpatient hospitals in Oregon. These are general care facilities and exclude federal hospitals, long term care and rehabilitation facilities.

There are 28 DRG hospitals in Oregon. These are typically large, urban hospitals that receive payments based on the prospective Diagnostic Related Group (DRG) system.

There are 12 Type A hospitals in Oregon. These hospitals are small - fewer than 50 beds - and are located more than 30 miles from another hospital.

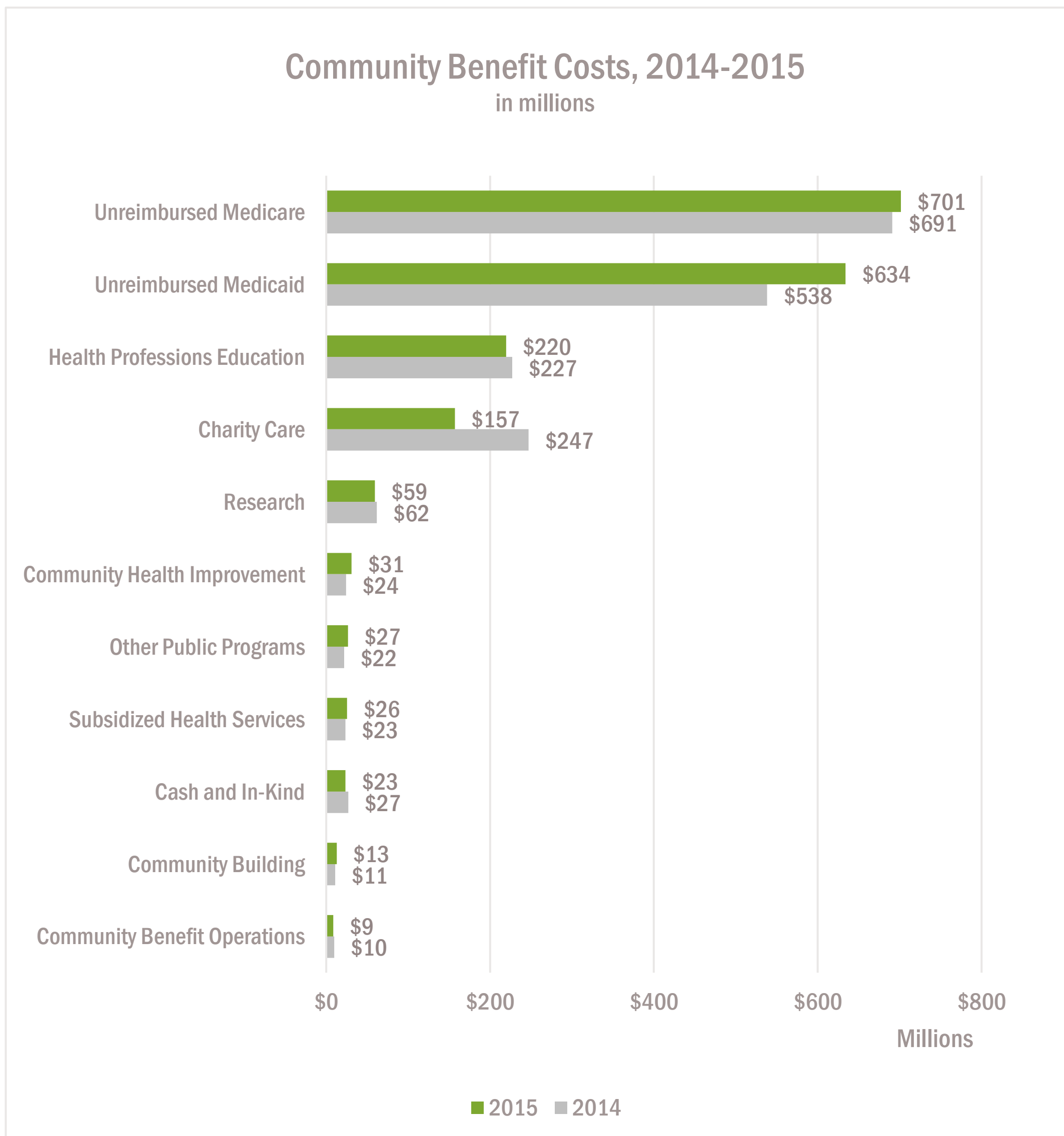
There 20 Type B hospitals in Oregon. These hospitals are small - fewer than 50 beds - and are located within 30 miles of another hospital.

A complete list of all hospitals and their individual performances can be found in the Appendix.

Hospital Icons by Freepik at www.flaticon.com

Executive Summary

For fiscal year 2015, Oregon hospitals provided nearly $1.9 billion in community benefit costs. This is about a 1% increase from the $1.88 billion reported for the fiscal year of 2014. Unreimbursed costs for providing Medicaid and Medicare services represent over 70% of all community benefit costs. Unreimbursed costs for Medicaid grew to $634 million from $538 million, an increase of about 18% from 2014. Charity care costs have continued to fall, dropping 37% from 2014 to $157 million. This follows a 36% decline from 2013. Hospital fiscal years vary, so fiscal year 2015 does not always align with the second year of Affordable Care Act implementation. Some hospitals may only be reporting one and a half years of community benefit costs under new provisions of the ACA.



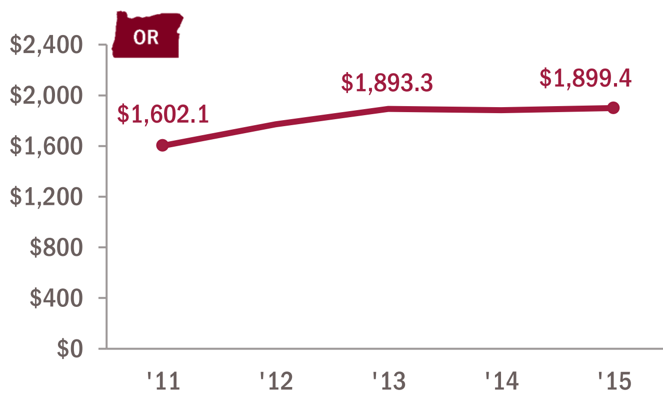
Total Community Benefit Costs

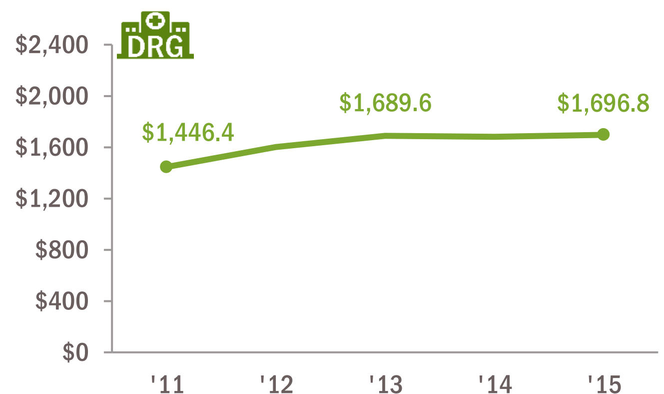
100% Of Community Benefit

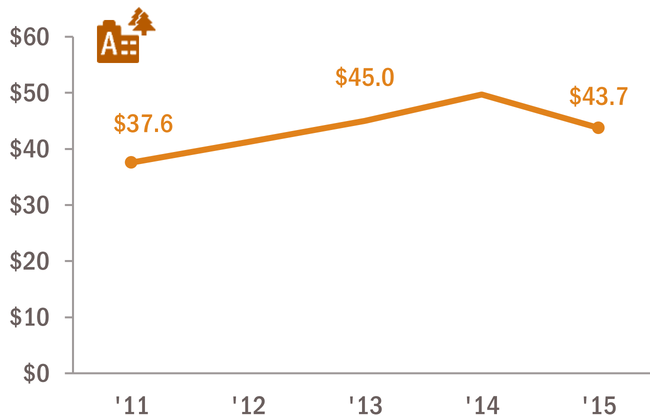
In fiscal year 2015 hospitals provided nearly $1.9 billion in total community benefit costs. The majority of these community benefit costs came from DRG hospitals, which accounted for nearly $1.7 billion in 2015. Total community benefit costs have increased 19% since 2011. This compares with over $23 billion in gross charges billed by hospitals and over $10.5 billion received in net patient revenue in 2015.

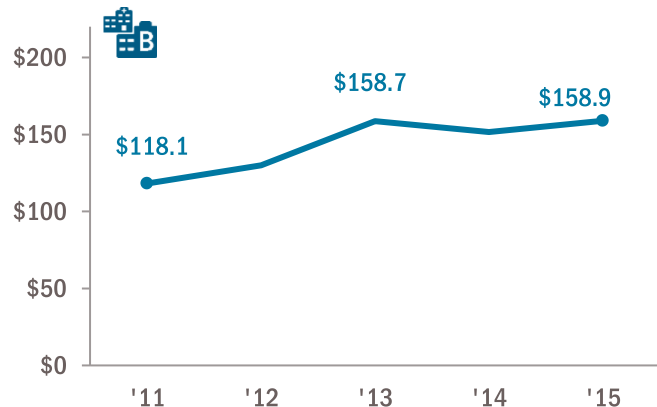
Oregon hospitals provided $1.9 billion in community benefit costs.

total unreimbursed costs in millions





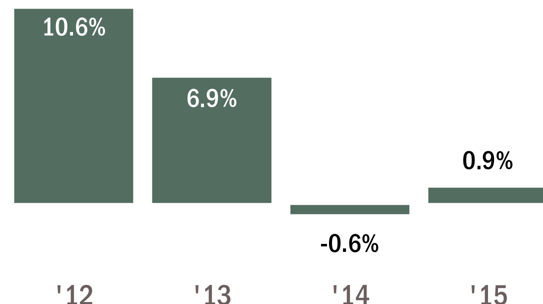




Total Community Benefit Costs are the sum of all community benefit categories listed in this report. Community benefits are reported as costs, however it is important to note that not all community benefit items are directly reportable expenses. For example, charity care or unreimbursed Medicare costs cannot be accounted for as an expense for accounting purposes.

Total community benefit cost growth.

Percent change from previous year



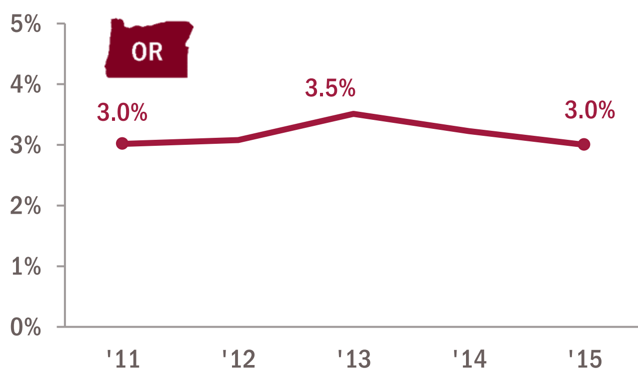
Unreimbursed Costs for Medicare Services

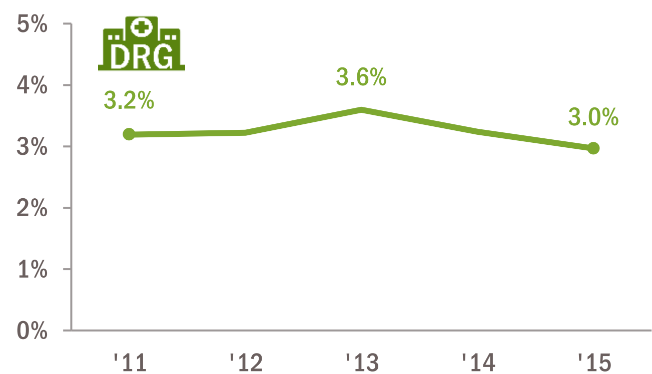
37% Of Community Benefit

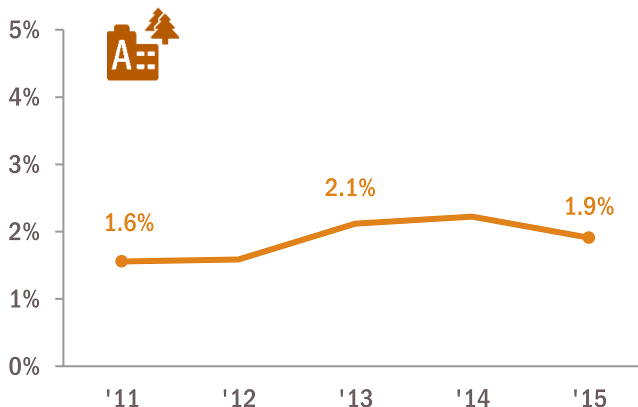
Statewide, all hospitals incurred just over $700 million in unreimbursed costs for Medicare services in 2015. This represents about 3% of gross patient revenue. DRG and Type A hospitals have decreased their unreimbursed costs as a percent of gross revenue since 2013, while Type B hospitals showed growth. Overall unreimbursed costs for Medicare services as a proportion of gross revenue have remained fairly steady since 2011.

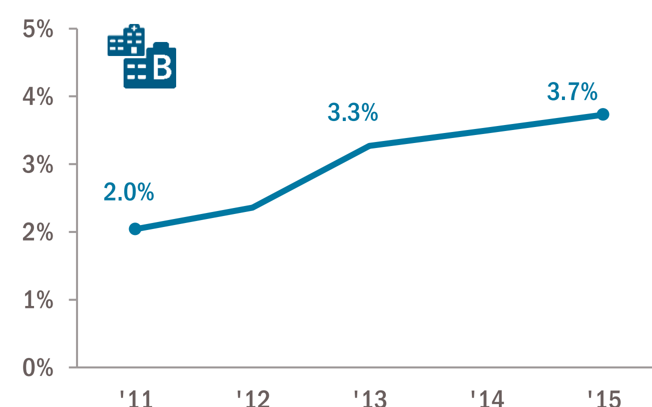
Type B hospitals showed growth in unreimbursed Medicare costs .

total unreimbursed costs as a percent of gross patient revenue









Unreimbursed Medicare Costs are an estimation of the costs that are not reimbursed to the hospital for providing Medicare services. A hospital may have unreimbursed costs when the amount received is less than expenses the hospital incurred, or because Medicare denied payment to the hospital.

In most cases, these costs are an estimation using a cost to charge ratio calculation. Cost to charge ratios are explained in the appendix.

Statewide unreimbursed Medicare costs.

Total unreimbursed costs in millions

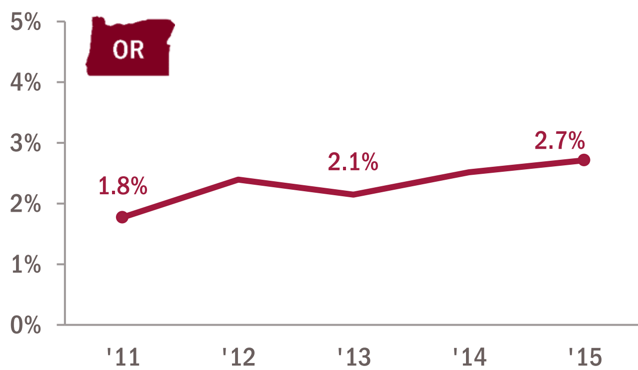
Unreimbursed Costs for Medicaid Services

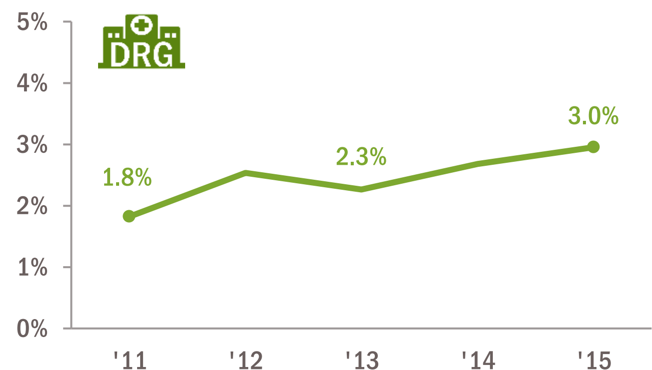
33% Of Community Benefit

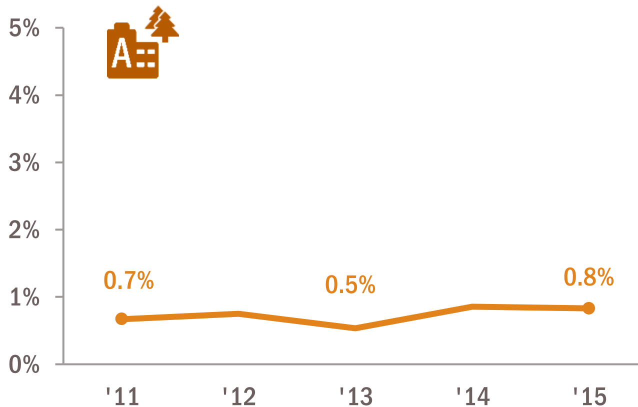
Statewide, all hospitals incurred about $630 million in unreimbursed costs for Medicaid services in 2015. This is about 2.7% of gross patient revenue. Hospitals showed growth in unreimbursed costs due to the expansion of Medicaid as a provision of the Affordable Care Act in 2014. This growth is offset by reductions in charity care costs (described later in this report) and bad debt charges.

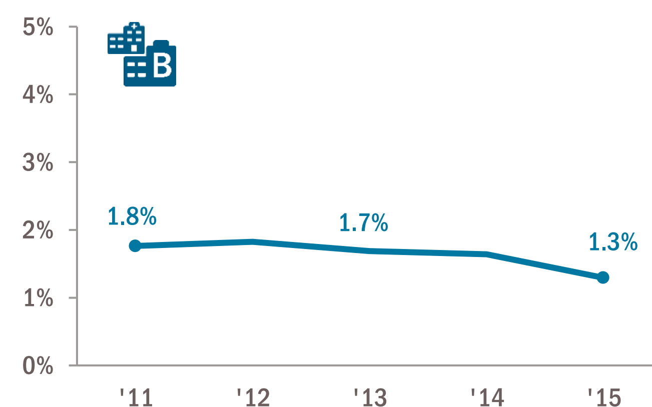
Unreimbursed costs for Medicaid services have steadily grown since 2011.

total unreimbursed as a percent of gross patient revenue







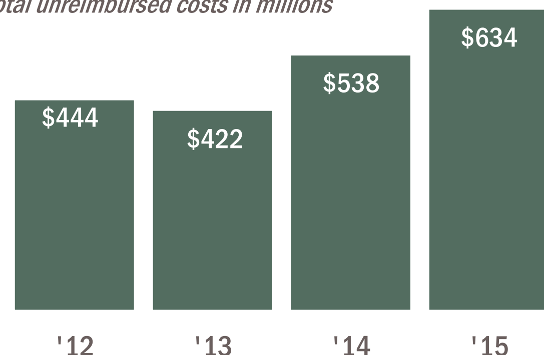


Unreimbursed Medicaid Costs are an estimation of the costs that are not reimbursed to the hospital for providing Medicaid services. A hospital may have unreimbursed costs when the amount received is less than expenses the hospital incurred, or because Medicaid denied payment to the hospital.

In most cases, these costs are an estimation using a cost to charge ratio calculation. Cost to charge ratios are explained in the appendix.

Statewide unreimbursed Medicaid costs.

Total unreimbursed costs in millions



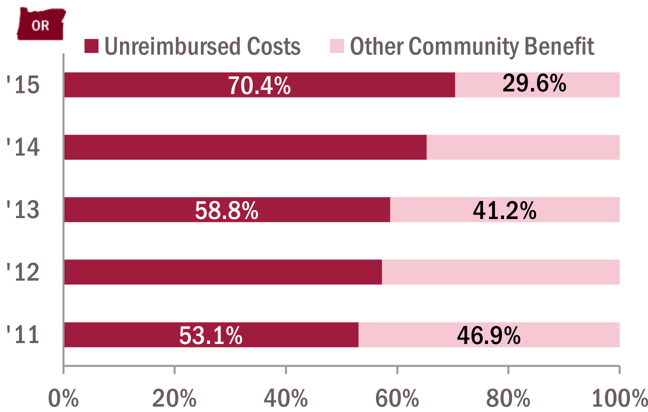
Community Benefit Public Payer Mix

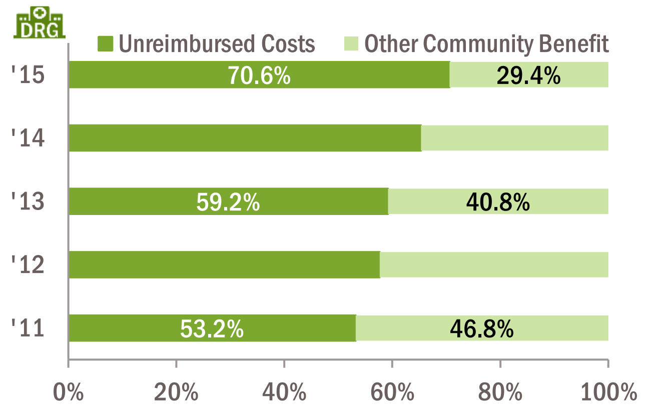
70% Of Community Benefit

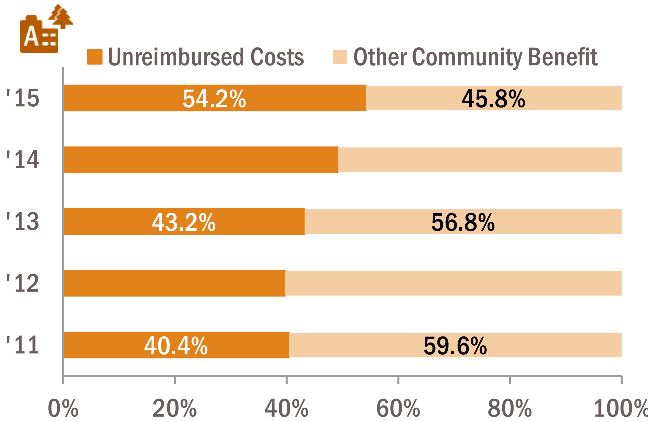
Since 2011, the proportion of total community benefit costs attributed to unreimbursed costs of Medicare and Medicaid has steadily increased. In 2015, hospitals provided over $1.9 billion in community benefit costs, 70% of which was unreimbursed Medicare and Medicaid costs. Across all hospital types, unreimbursed Medicare and Medicaid costs account for more than $1.3 billion.

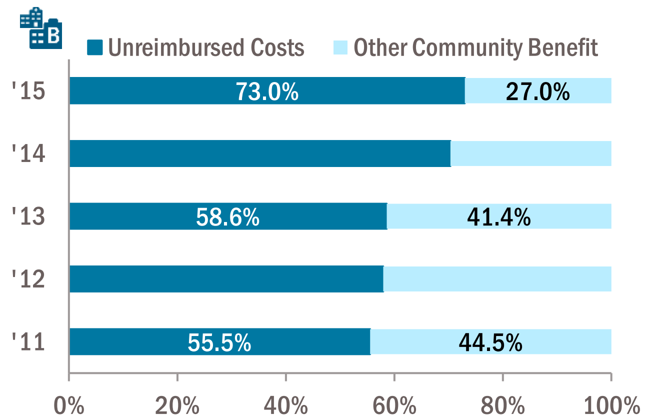
Medicare and Medicaid costs accounted for 70% of community benefit costs in 2015.

percent share of unreimbursed costs of public payers





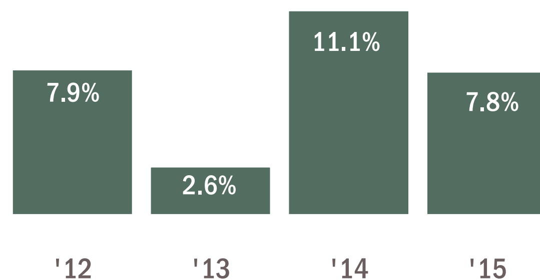




Community benefit cost mix shows the proportion of total community benefit costs that are due to the combined unreimbursed costs of Medicare and Medicaid services.

Unreimbursed costs of public payer growth.

percent change from the previous year



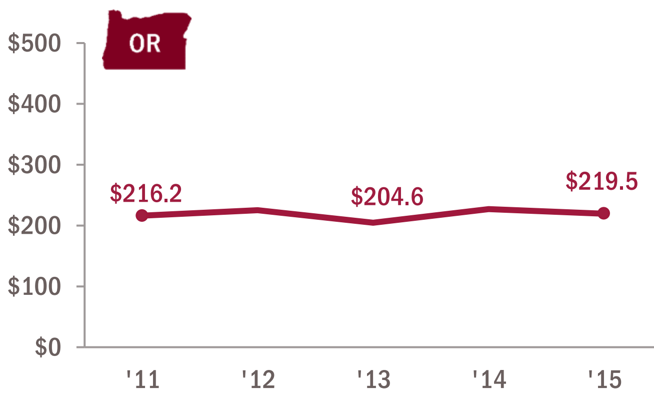
Health Professional Education Costs

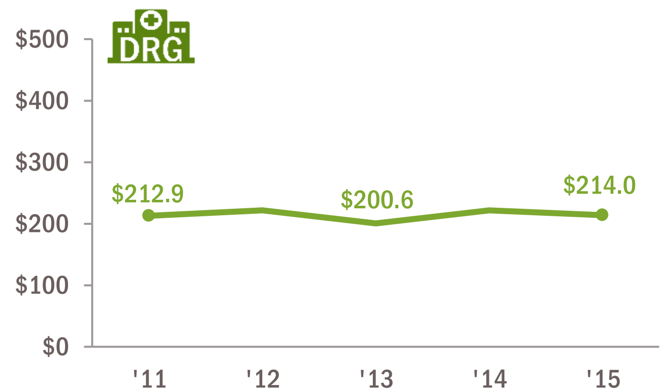
11% Of Community Benefit

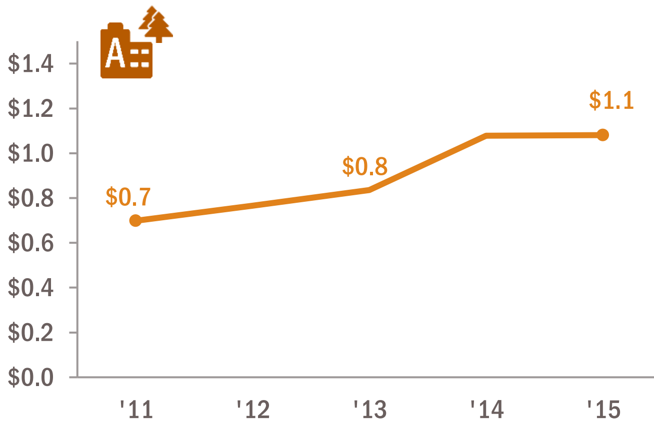
Overall, health professional education costs have remained fairly steady over the past five years. Type B hospitals had the most significant growth in health education costs, with costs growing 73% since 2011. OHSU accounts for nearly 75% of all health professional education costs in the state, reporting over $163 million in 2015.

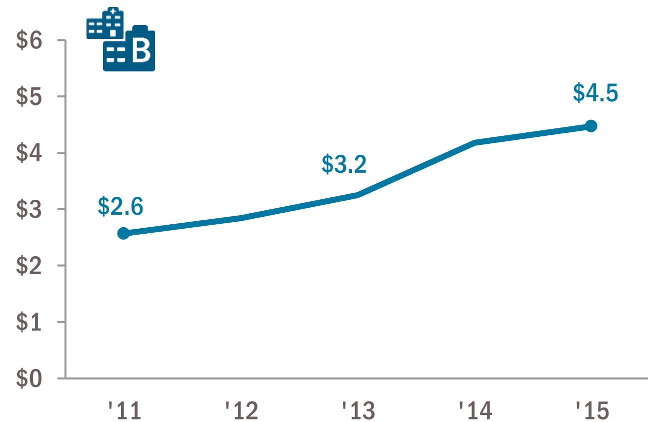
Statewide health professional education costs were steady from 2011 to 2015.

total costs in millions









Health professional education are costs incurred for providing educational programs that result in a degree, certificate or other training necessary to be licensed to practice as a health professional. It does not include education or training programs available exclusively to the organization's employees. Costs, including stipends, benefits, or scholarships, for medical residents or interns can be included even if such people can be considered employees for W-2 tax reporting purposes.

Health professional education cost growth.

Percent change from previous year

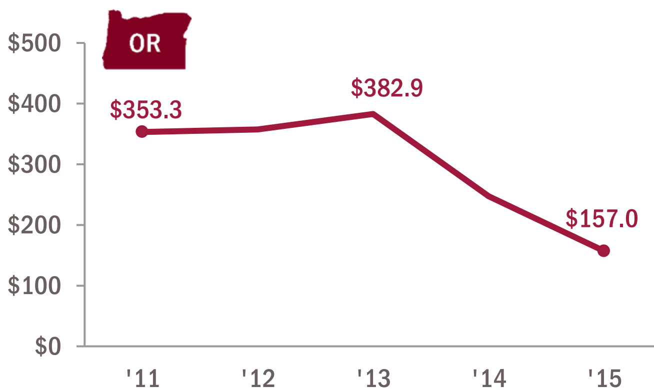
Charity Care Costs

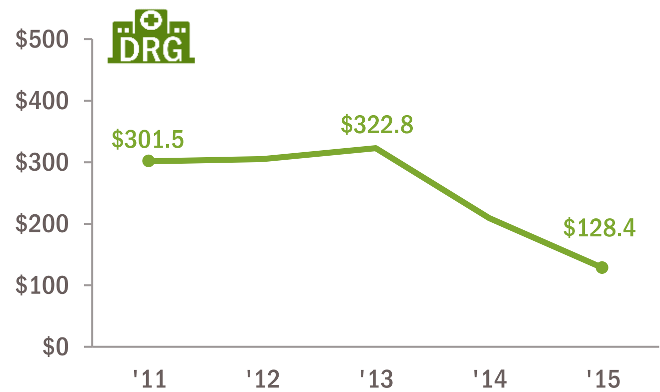
8% Of Community Benefit

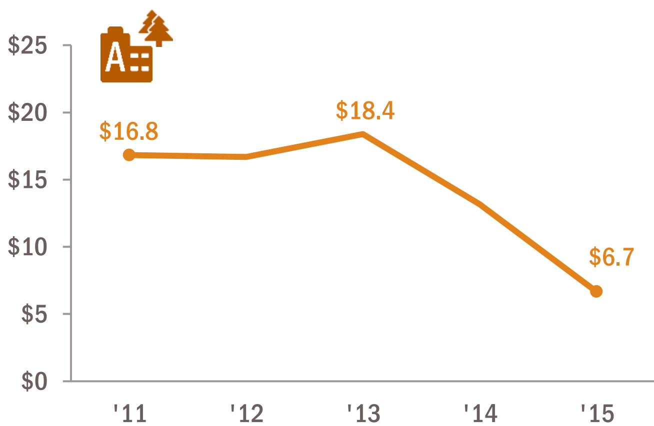
Charity care costs have decreased each year following implementation of the Affordable Care Act in January 2014. Charity care costs fell 35% from 2013 to 2014 and 37% from 2014 to 2015. This decline is likely related to the expansion of insurance coverage as a part of the ACA. According to the Oregon Health Insurance Survey, 14.5% of Oregonians did not have health insurance in 2013. In 2015 that number had fallen to 5.3%.

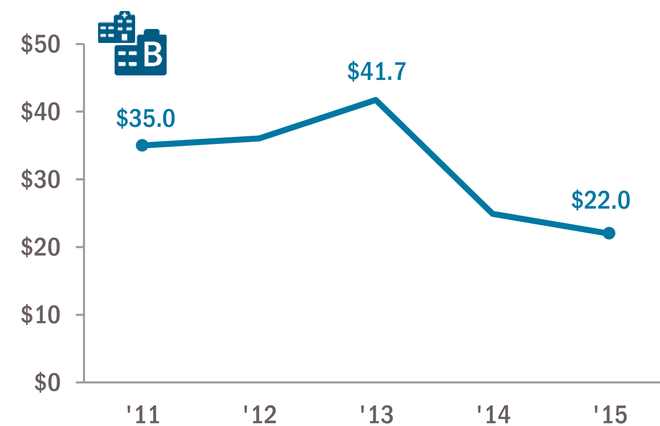
Charity care costs have fallen sharply since 2013.

total costs in millions







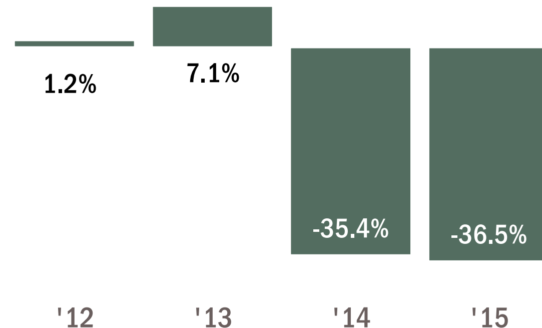


Charity care costs are the costs of services provided to people that are unable to pay all or part of their bill and qualify for charity care based on the hospital's published policies.

Similar to the unreimbursed costs from public payers, charity care costs are most commonly estimated using a cost to charge ratio.

Charity care cost growth.

Percent change from previous year



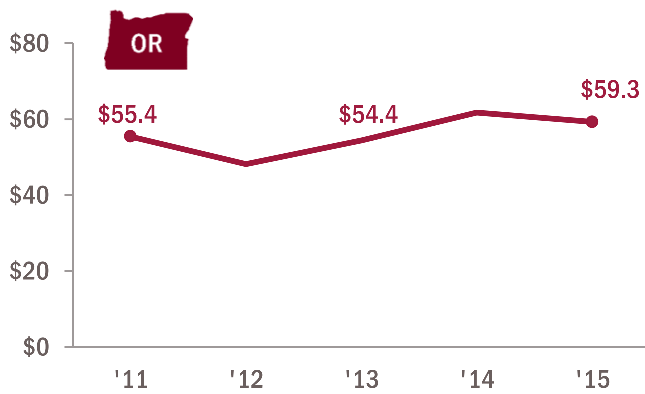
Research Costs

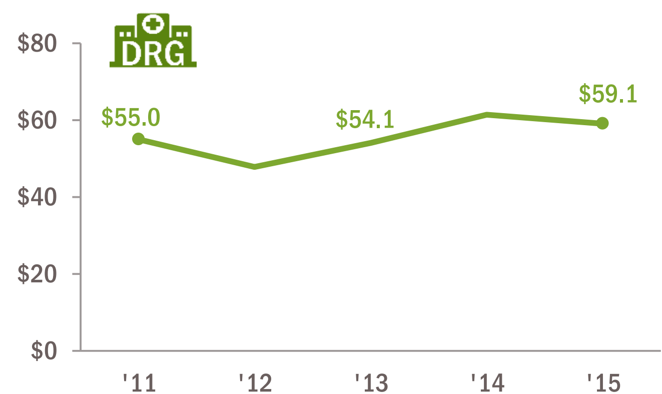
3% Of Community Benefit

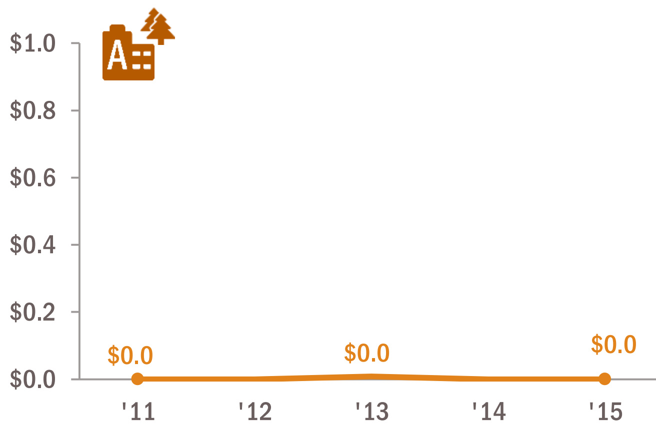
Costs for research have increased slightly since 2011. The majority of research is conducted at larger hospitals in Oregon, with DRG hospitals accounting for over 99% of all costs. Only 18 of the 60 hospitals in Oregon report research costs. OHSU accounted for more than half of all research costs in the state, reporting $33.9 million 2015. Research costs have increased 7% since 2011.

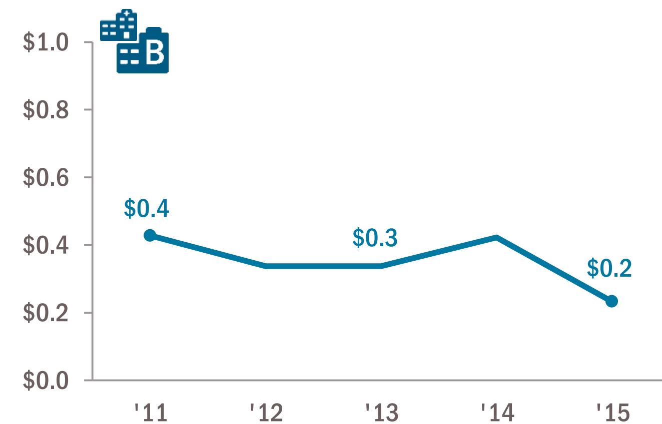
Statewide research costs have increased 7% since 2011.

total costs in millions









Research costs are expenses incurred conducting any study or investigation in which the goal is to increase generalizable knowledge made available to the public. Hospitals may include costs incurred conducting research that is funded by tax-exempt or government entities. It may not include research conducted on behalf of an individual or organization that is not tax-exempt. These costs may include salary and benefits for research staff as well as costs for equipment, facilities, computers, biosafety, accreditation and any number of other expenses.

Research cost growth.

Percent change from previous year

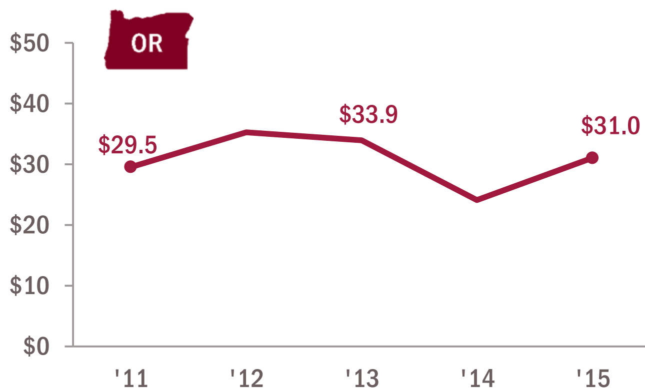
Community Health Improvement Costs

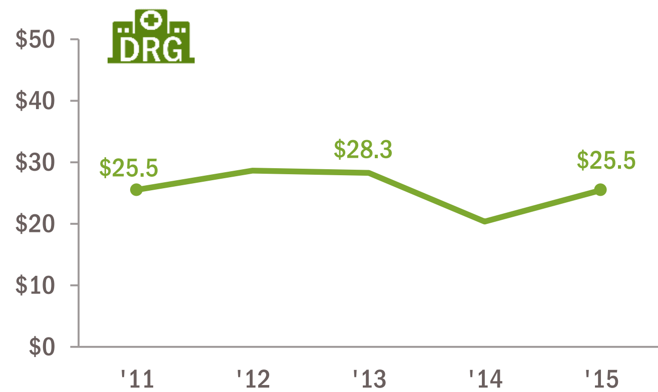
2% Of Community Benefit

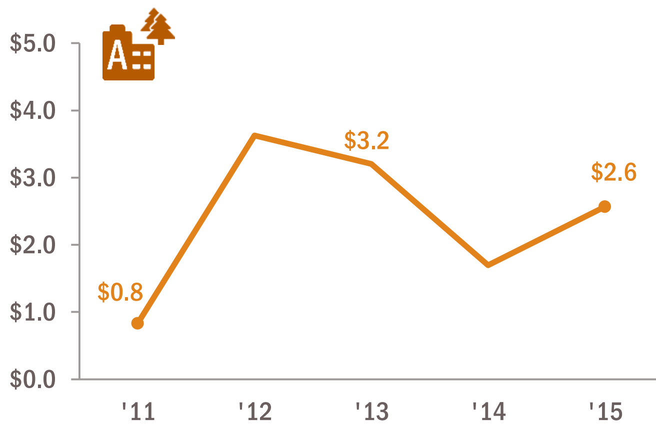
Costs for community health improvement have been relatively flat since 2011, increasing only 5%. Overall, hospitals provided $31 million in community health improvement costs in 2015.

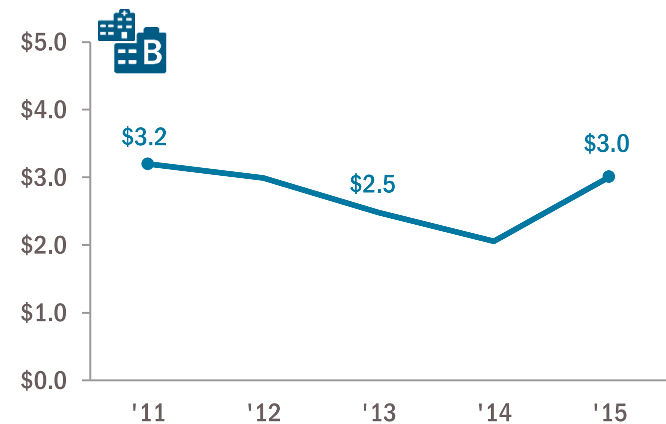
Statewide community health improvement costs have increased 5% since 2011.

total costs in millions





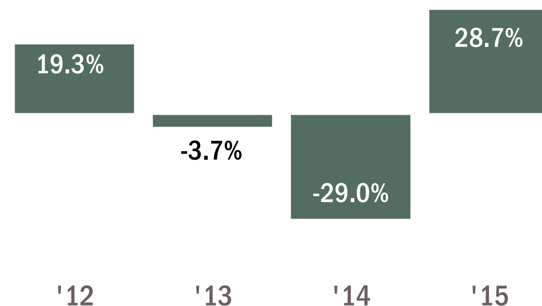




Community Health Improvement Costs are expenses from activities or programs subsidized by the hospital that are carried out for the express purpose of improving community health. Such activities cannot be counted if they are primarily for marketing purposes or for the purpose of increasing referrals to affiliated organizations. Such activities must also fill an established or documented need in the community.

Community health improvement cost growth.

Percent change from previous year



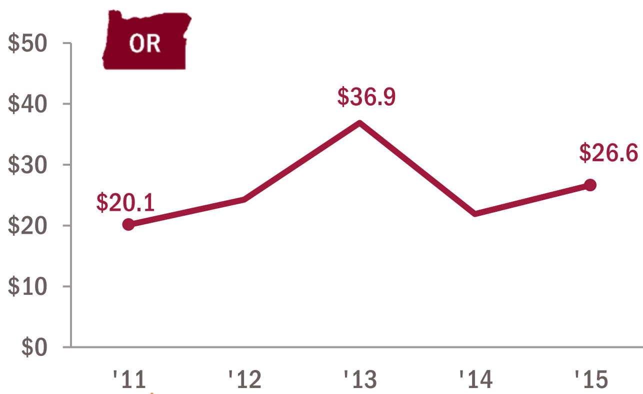
Other Public Program Costs

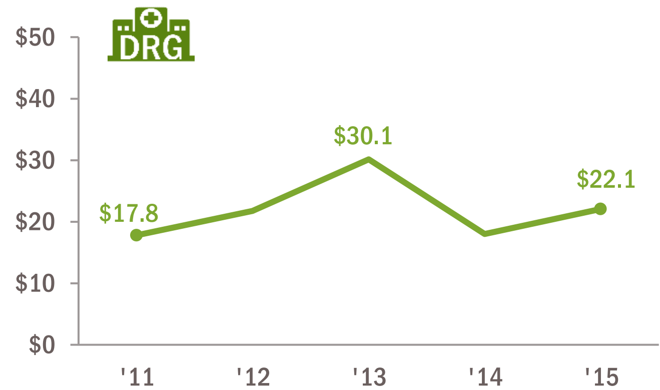
1% Of Community Benefit

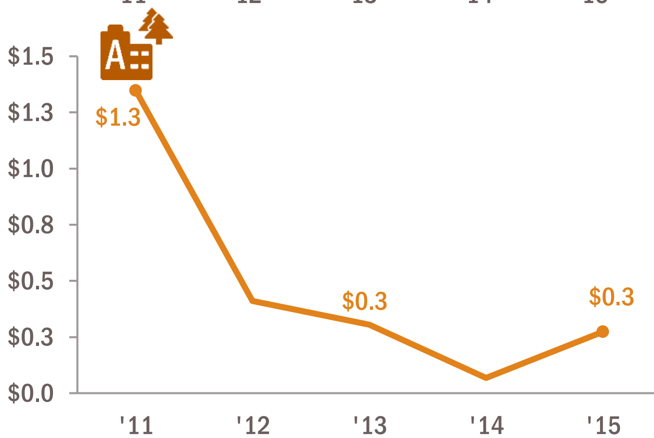
Costs for public programs increased between 2011 and 2013, then dropped down again in 2014. The expansion of Medicaid to 138% of the federal poverty level reduced the need for several smaller programs, particularly ones administered at the local level, to assist uninsured or under-insured Oregonians.

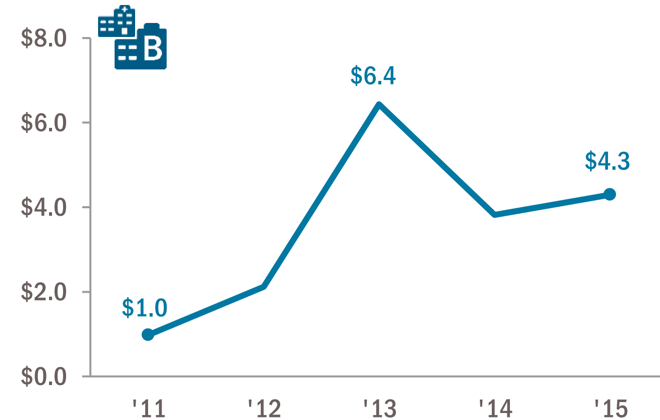
Costs for other public programs have increased 32% since 2011 .

total costs in millions





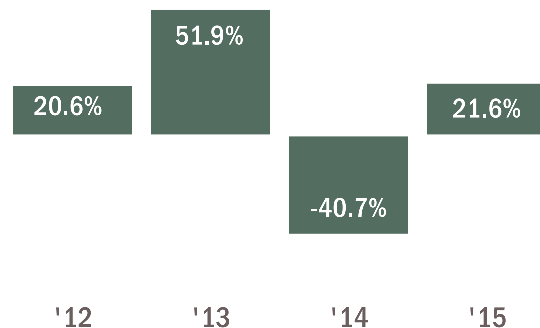




Public Program Costs are costs incurred supporting other public programs such as Champus, Tricare, Veterans Health Administration, Indian Health Service, and other federal, state or local programs. These programs exclude Medicare and Medicaid. Any offsetting revenue must be deducted from cost calculations.

Public program cost growth.

Percent change from previous year



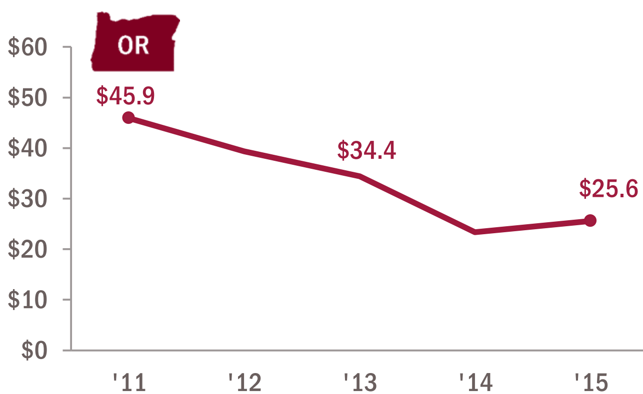
Subsidized Health Services Costs

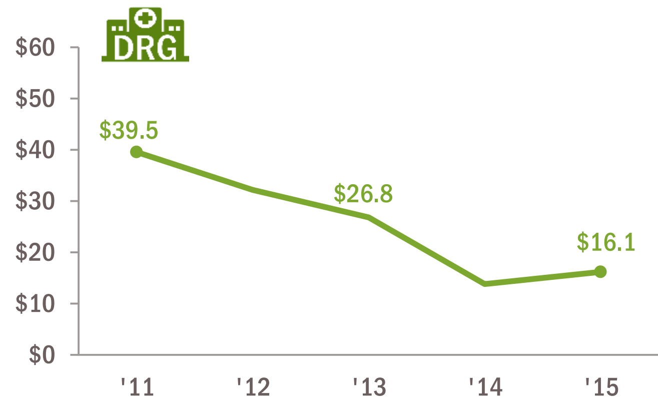
2% Of Community Benefit

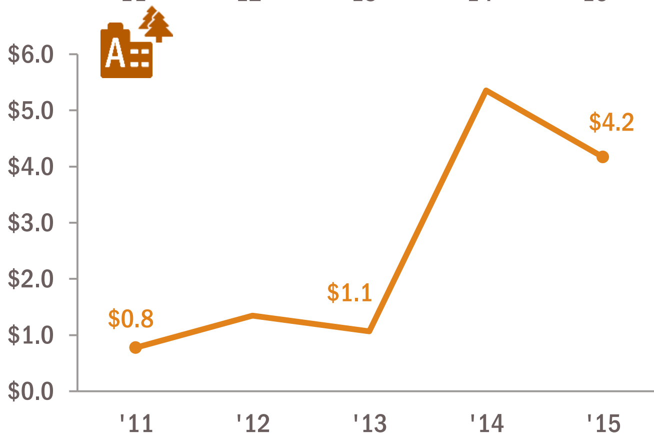
Subsidized health services costs fell consistently between 2011 and 2014, but appears to have stabilized in 2015. In total, hospitals provided $25.6 million in subsidized health services costs, compared with $45.9 million in 2011. Expansion of covered services under Medicaid and creation of the Coordinated Care Organization model can help explain the reduction in subsidized health services costs. The CCO model has expanded the types of services that are compensated, as well as worked to contain cost growth through improved coordination of care and patient outreach.

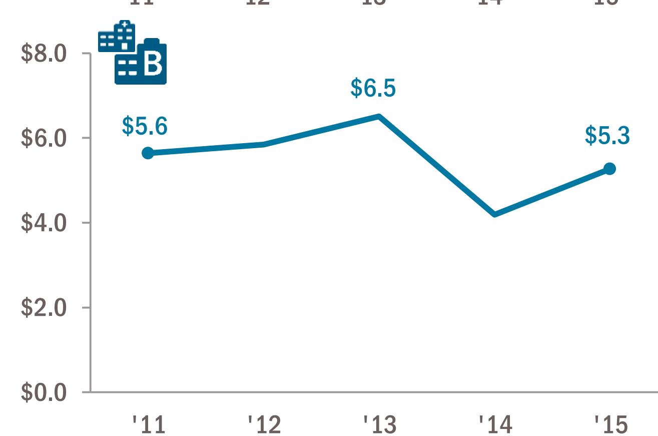
Statewide costs for subsidized health services have decreased 44% since 2011 .

total costs in millions





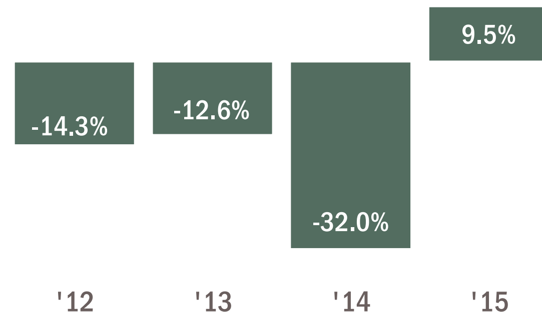




Subsidized health services costs are expenses for hospital clinical services that are provided at a financial loss because they meet an identified community need and it is reasonable to conclude that if the service was no longer offered it would not be available from another source in the community or the service would then become the responsibility of the government or other tax-exempt organization. Examples are 24-hour emergency departments at rural hospitals, inpatient and outpatient behavioral and mental health services, hospice, and home health services.

Subsidized health services cost growth.

Percent change from previous year



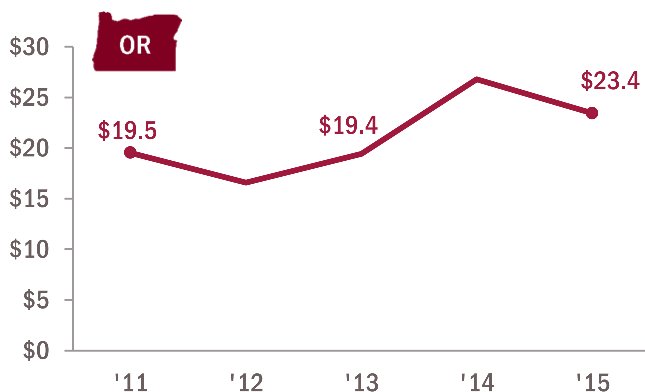
Cash and In-Kind Contributions

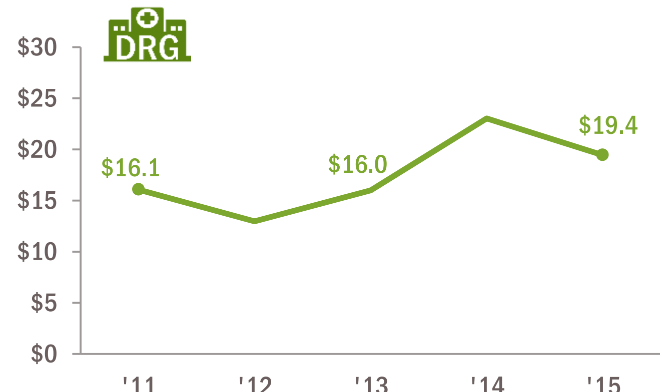
1% Of Community Benefit

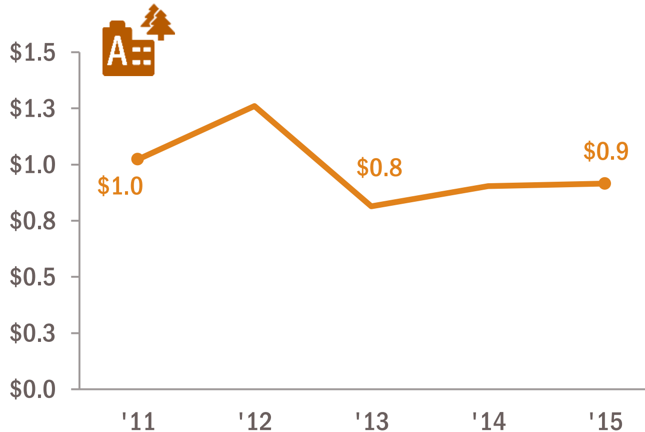
Statewide cash and in-kind contributions have increased 20% since 2011, but fell 13% between 2014 and 2015. The cause of the decline was DRG hospitals contributions decreasing by 16%.

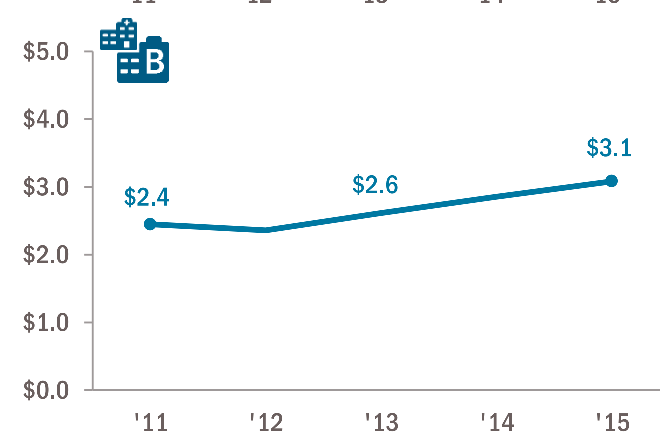
Statewide cash and in-kind contributions have increased 20% since 2011.

total costs in millions





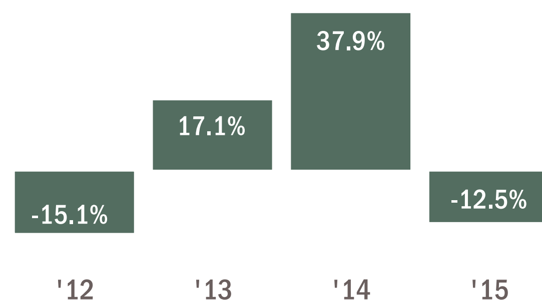




Cash and in-kind contributions are direct donations of funds, or donation of supplies, space, and employee time to other individual or community organizations where the hospital is not the primary sponsor or organizer. As a general rule, such donations should be consistent with the hospital's goals and mission. Donations of money, supplies or time must be representative of the hospital and individual activities performed by employees on their own time may not be counted.

Cash and in-kind contribution growth.

Percent change from previous year



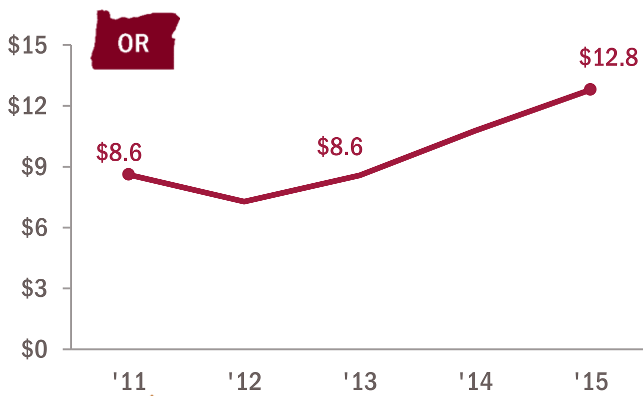
Community Building Costs

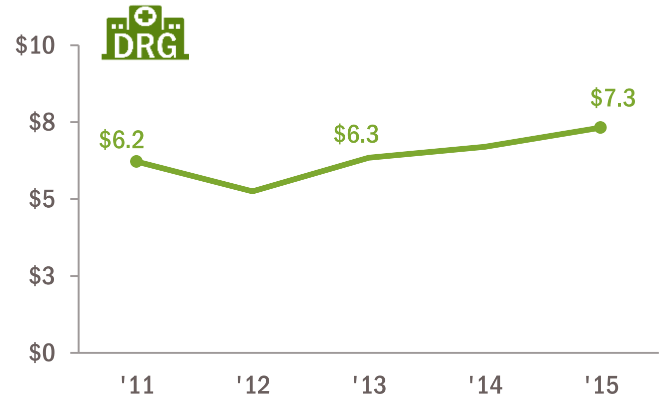
1% Of Community Benefit

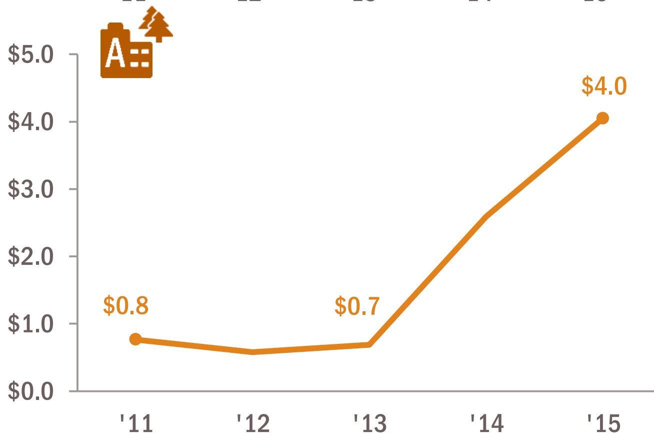
Hospitals have posted three straight years of double digit increases in community building costs. Most of these improvements come from Type A hospitals and specifically Tillamook County General Hospital, which have substantially increased their community building activities since 2013.

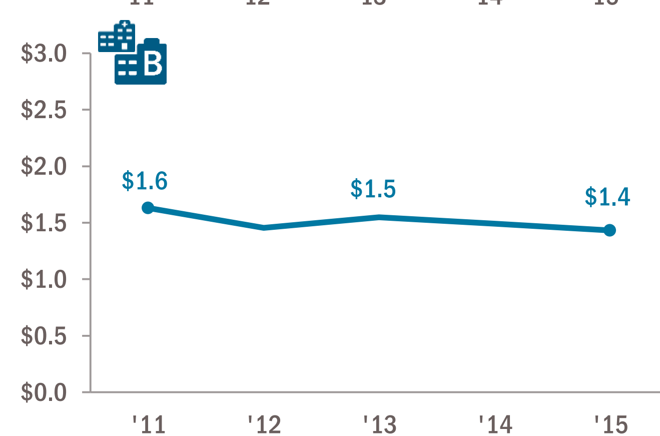
Statewide community building costs have increased 49% since 2011.

total costs in millions





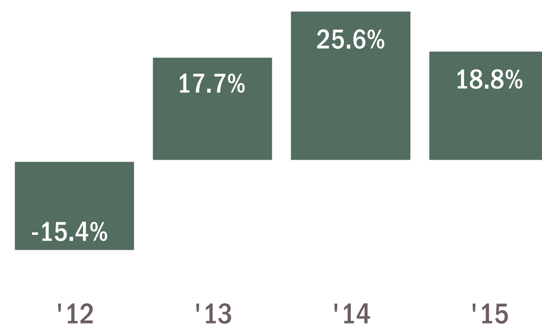




Community building costs are expenses related to activities in the community that are not directly related to providing health services but address root causes of health problems in the community. Such activities could address issues of poverty, homelessness or environmental issues. Examples of such activities are supporting economic development, physical environmental improvements, coalition building, and workforce development.

Community building cost growth.

Percent change from previous year



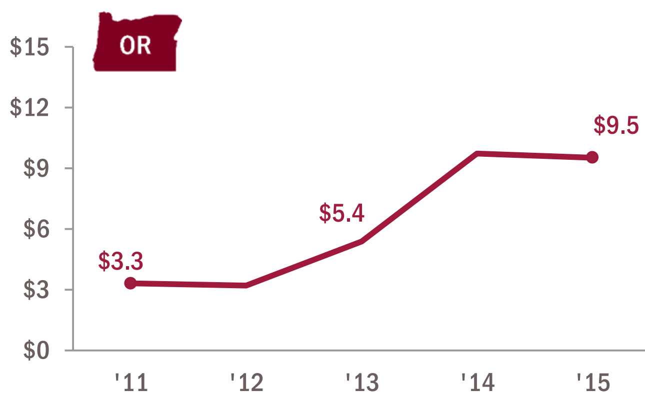
Community Benefit Operation Costs

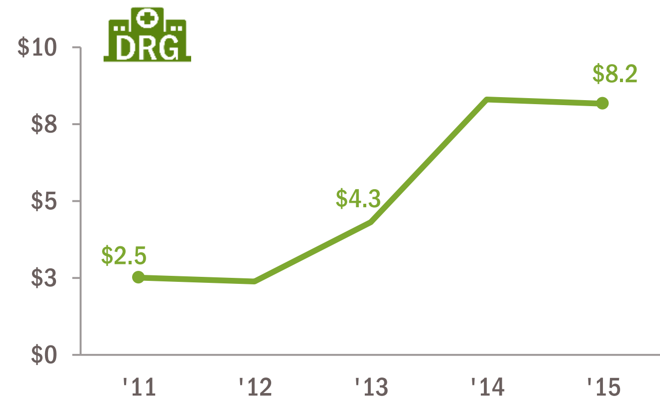
< 1% Of Community Benefit

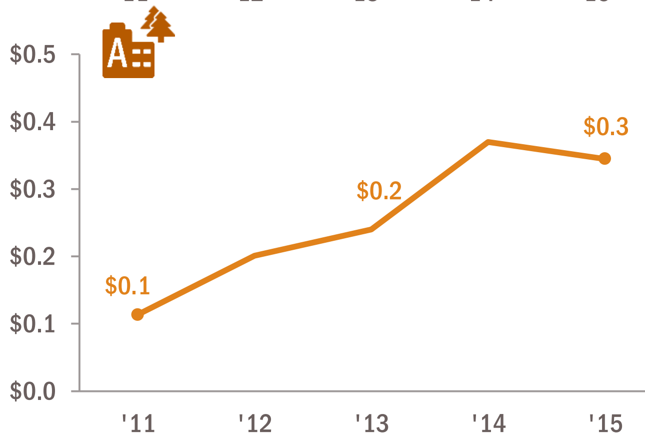
Community benefit operation costs have tripled from 2011 to 2015. This sharp increase can be attributed to provisions of the Affordable Care Act. Beginning in 2012, tax-exempt hospitals had new federal requirements for community benefits, the most significant of which was the requirement to conduct a community health needs assessment and to build a community health improvement plan or strategy. Hospitals are required to conduct this assessment every three years. The costs of coordinating and conducting this assessment are considered community benefit operation costs.

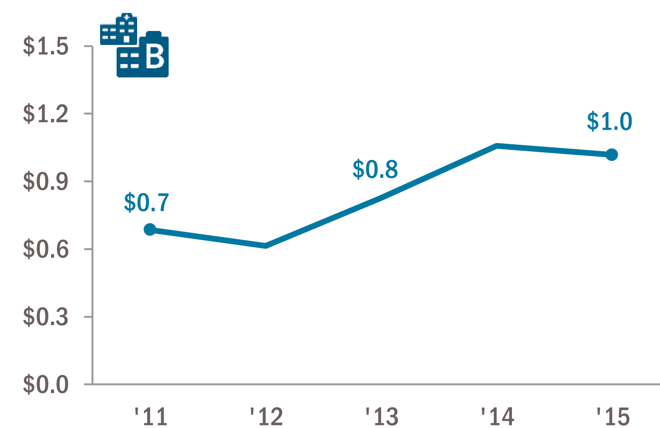
Statewide community benefit operation costs have increased 188% since 2011.

total costs in millions





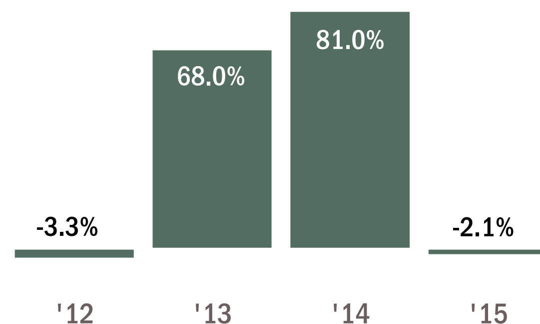




Community benefit operations are those costs associated with staffing and coordinating the hospital's community benefit initiatives. These costs include staffing and supply costs to manage or oversee community benefit program activities as well as the costs to perform community needs assessments and strategic implementation plans.

Community benefit operation cost growth.

Percent change from previous year



APPENDIX

Cost Estimations

The **Cost to Charge Ratio,** or CCR, is a critical element in estimating the costs associated with Medicaid, Medicare and charity care services. The CCR describes, on average, how much expense the hospital incurs for every dollar it charges. It is the ratio of operating expenses to total charges. If a hospital's total operating expenses were $45,000,000 and its total charges were $100,000,000 then the CCR would calculate to 0.45.

$45,000,000/$100,000,000 = 0.45

The CCR used for community benefit reporting has certain adjustments made to a hospital's expenses and charges. Every hospital that uses a CCR to estimate costs must calculate it the same way. The state of Oregon uses the same CCR calculation method the IRS requires on the federal 990 form for tax-exempt organizations. Detailed explanations of the CCR calculation can be viewed at: http://www.oregon.gov/oha/analytics/HospitalReporting/CBR-Directions.pdf

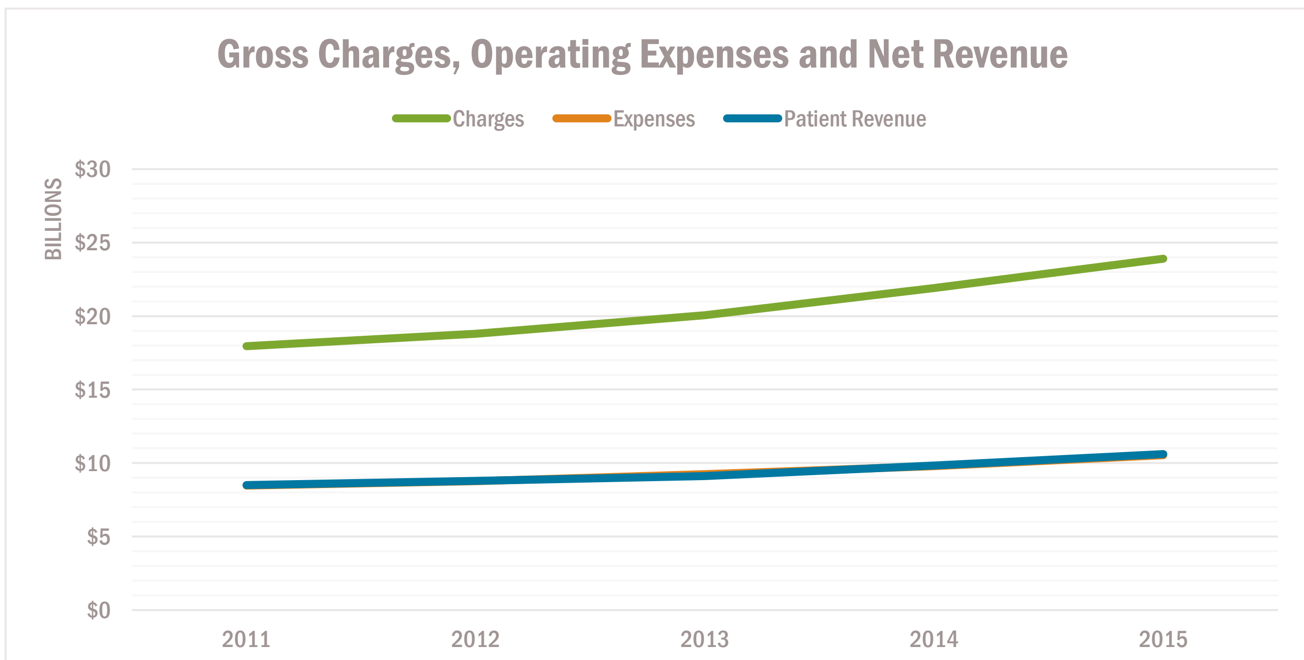
Hospitals are required to subtract offsetting revenue from their cost estimation. Offsetting revenue is any source of income for the provided service from the patient or the insurance provider. Final community benefit cost is reported as the estimated expense for the service minus offsetting revenue. For example:

Hospital A had a CCR calculated at 0.45. They had $5,000,000 in Medicaid charges in 2015. They received $2,000,000 in payments from Medicaid for those services.

$5,000,000 x 0.45 = $2,250,000 in estimated costs.

$2,250,000 - $2,000,000 = $250,000 in unreimbursed Medicaid costs. Hospital A will report this amount on their community benefit reporting form.

The rate in which gross charges increase in comparison to net revenue and operating expenses will influence both the cost to charge ratio and the amount of unreimbursed costs reported. This relationship is shown in the graph below. Note that net patient revenue and operating expense essentially overlap one another.



APPENDIX

Overall, gross charges have grown faster than operating expenses and net revenue. In the period of 2011 to 2015, gross charges for all hospitals increased 33%. In the same time period, operating expenses and net patient revenue increased 24%. Operating expenses and net patient revenue always track closely together for non-profit hospitals.

The table below illustrates the impact of gross charges growing faster than expenses and revenue using the previous example numbers as a base for 2011 and projecting 2015 numbers using actual growth reported by hospitals.

2011		2015	
Operating Expense	$45,000,000	Operating Expense +24%	$58,500,000
Gross Charges	$100,000,000	Gross Charges +33%	$133,000,000
Cost to Charge Ratio	**0.45**	**Cost to Charge Ratio**	**0.44**
Medicaid Charges	$5,000,000	Medicaid Charges +96%	$9,800,000
Medicaid Revenue	$2,000,000	Medicaid Revenue +62%	$3,240,000
Estimated Costs	$2,250,000	Estimated Costs	$4,310,526
Unreimbursed Cost	**$250,000**	**Unreimbursed Costs**	**$1,070,526**

Growth in gross charges above growth in operating expense (33% vs. 24%) results in a only a small decrease in the cost to charge ratio (0.45 vs 0.44), but a large increase in the estimated costs ($2,2500,000 vs $4,310,526). Revenue growth at a lower rate, tracking with operating expenses, results in an increase in unreimbursed costs.

Patient volume increases can intensify this effect because natural increases in gross charges that accompany growth in patient volume are amplified with associated increases in the base amounts hospitals charge for services. Hospitals have seen more patients and have increased gross charges.

Hospital Specific Community Benefit

As previously described, hospitals in Oregon are divided into three categories based on size and distance to other hospitals. In addition to these categories, designation as either a health district hospital or a critical access hospital can also impact community benefit costs.

A **health district hospital** is one that is under the control of a formal health district. In most cases the controlling entity is the local county government. Being part of a health district allows the hospitals access to additional funds from tax sources to contribute to operations. This access to tax funding allows many hospitals to continue to operate in rural areas when they otherwise could not afford to. Health districts may also provide funding to other types of clinics and providers.

A **critical access hospital** is designated by the Centers for Medicare & Medicaid Services (CMS). This designation impacts the reimbursement the hospital receives from Medicare. There are a number of specific criteria a hospital must meet to be considered a critical access hospital, but in general a hospital must be located in a rural area and serve a population with limited access to other hospitals. In exchange for providing additional services that the hospital might not otherwise provide due to the cost, Medicare will reimburse the hospital at a higher rate than other hospitals receive for the same services. These services mostly relate to expanded emergency services such as a 24-hour emergency room and ambulance transportation.

In the following pages health district hospitals are indicated with an asterisk (*), critical access hospitals are indicated with the Greek letter Phi (ϕ), and for-profit hospitals are indicated with a superscript 'p' (^{p}).

Total Community Benefit Cost

Hospital Group	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	OHSU Hospital	$307,558,785	$318,013,087	$341,020,625	$365,653,676	$369,088,156
	Providence Portland Med Center	$122,493,759	$143,401,466	$142,984,211	$133,134,716	$141,650,678
	PeaceHealth Sacred Heart Hospitals	$118,722,884	$149,825,649	$140,780,672	$127,585,677	$138,425,445
	Legacy Emanuel Med Center	$100,635,393	$133,998,605	$152,374,462	$151,501,923	$135,594,922
	Providence St Vincent Med Ctr	$124,102,761	$140,642,893	$140,705,794	$124,953,087	$131,525,827
	Salem Hospital	$106,904,775	$109,300,426	$90,704,776	$93,829,403	$101,616,568
	St Charles - Bend	$83,694,715	$96,696,868	$123,833,675	$101,331,817	$100,687,723
	Asante Rogue Med Center	$68,292,892	$75,069,148	$82,546,040	$68,227,657	$73,705,968
	Good Samaritan Regional Med Ctr	$69,525,357	$71,322,355	$73,039,765	$67,853,671	$63,523,852
	Providence Medford Med Center	$26,168,548	$33,674,752	$42,248,126	$49,855,412	$61,356,858
	Legacy Good Samaritan Med Ctr	$44,249,224	$44,455,289	$46,172,958	$48,204,132	$39,914,779
	Kaiser Sunnyside Med Center	$30,220,012	$30,989,873	$31,109,852	$33,877,436	$38,317,780
	Tuality Healthcare	$33,039,183	$42,806,204	$33,972,228	$37,879,141	$34,737,299
	Bay Area Hospital	$23,023,847	$24,532,416	$23,399,711	$26,768,387	$32,871,514
	Asante Three Rivers Med Center	$25,336,378	$29,410,919	$28,179,940	$26,714,642	$30,359,971
	Samaritan Albany Hospital	$22,581,916	$25,265,570	$29,485,095	$27,176,596	$27,862,062
	Adventist Med Center	$22,285,674	$24,130,549	$25,476,088	$33,220,163	$27,466,979
	Legacy Meridian Park Med Center	$16,780,128	$20,068,210	$23,754,211	$26,632,378	$23,496,173
	Providence Willamette Falls	$18,375,142	$17,609,271	$18,045,336	$19,083,446	$22,529,585
	Sky Lakes Med Center	$27,996,052	$25,217,427	$31,964,107	$35,864,627	$21,944,591
	Providence Milwaukie Hospital	$12,632,776	$14,872,478	$15,817,653	$16,762,162	$18,218,476
	Shriners	$0	$0	$8,961,772	$15,279,570	$17,322,682
	Legacy Mt Hood Med Center	$13,246,280	$15,071,092	$20,493,136	$16,202,279	$14,978,910
	Kaiser Westside Med Ctr	$0	$0	$4,147,006	$10,058,000	$11,401,464
	Willamette Valley Med Ctr[p]	$4,447,642	$2,664,765	$5,862,511	$10,741,588	$9,777,675
	Mercy Med Center	$18,844,295	$6,571,440	$7,698,347	$9,236,946	$8,353,262
	McKenzie-Willamette Med Ctr[p]	$5,199,929	$4,846,533	$4,812,606	$2,887,662	$30,085
Type A Hospitals	Tillamook County Gen Hospital[φ]	$6,900,177	$8,269,136	$10,833,800	$9,899,620	$10,225,245
	Grande Ronde Hospital[φ]	$3,901,922	$4,076,630	$4,005,618	$4,865,087	$5,545,841
	Good Shepherd Med Center[φ]	$4,321,323	$4,373,588	$6,088,743	$9,526,858	$4,979,708
	St Alphonsus Med Ctr-Ontario	$6,361,853	$8,402,885	$8,843,783	$6,281,695	$4,658,651
	St Anthony Hospital[φ]	$3,198,014	$2,845,098	$2,119,878	$2,425,881	$3,594,477
	Harney District Hospital*[φ]	$222,847	$827,846	$1,228,980	$2,535,114	$3,186,537
	Lake District Hospital*[φ]	$2,282,133	$1,914,538	$1,964,246	$4,873,680	$3,151,559
	Wallowa Memorial Hospital*[φ]	$2,338,903	$2,282,732	$2,196,977	$2,096,884	$2,485,169
	Blue Mountain Hospital*[φ]	$3,495,948	$1,409,765	$2,895,294	$2,190,708	$2,124,193
	St Alphonsus Med Ctr-Baker City[φ]	$1,707,568	$1,344,700	$1,309,440	$2,534,187	$1,539,735
	Curry General Hospital*[φ]	$1,962,253	$4,980,989	$2,602,086	$1,611,670	$1,169,970
	Pioneer Memorial Heppner*[φ]	$874,507	$521,405	$905,663	$867,657	$1,079,162
Type B Hospitals	Columbia Memorial Hospital[φ]	$9,528,643	$13,327,512	$17,244,654	$21,312,498	$22,211,203
	Providence Hood River Hospital[φ]	$8,245,890	$8,194,175	$10,793,858	$13,740,716	$18,167,786
	Providence Newberg Med Center	$14,950,713	$15,724,307	$15,640,033	$12,794,620	$15,286,793
	Mid-Columbia Med Center	$9,575,849	$8,957,134	$9,539,154	$12,034,211	$11,858,876
	Ashland Comm Hospital	$10,976,991	$12,660,226	$16,592,777	$11,533,304	$11,296,305
	Samaritan Lebanon Hospital[φ]	$6,946,978	$8,671,473	$10,937,549	$10,147,509	$10,414,075
	St Charles - Redmond	$12,825,567	$10,608,724	$12,961,790	$9,913,374	$8,680,584
	Providence Seaside Hospital*[φ]	$5,855,306	$4,693,536	$5,869,599	$4,346,725	$8,624,766
	Legacy Silverton Med Ctr	$10,460,069	$13,227,417	$16,841,014	$11,235,056	$7,213,552
	Samaritan Pacific Comm Hospital*[φ]	$7,660,730	$5,731,419	$6,323,448	$7,549,690	$7,152,083
	Santiam Memorial Hospital	$2,374,338	$3,989,684	$6,445,167	$7,780,347	$6,340,860
	St Charles - Madras*[φ]	$1,765,001	$2,696,753	$7,033,631	$6,893,853	$5,987,529
	Coquille Valley Hospital*[φ]	$1,028,691	$1,743,034	$1,577,175	$3,478,989	$4,516,802
	Samaritan North Lincoln Hospital*[φ]	$3,076,877	$4,483,279	$3,743,990	$4,648,239	$4,496,398
	Lower Umpqua Hospital*[φ]	$1,707,309	$2,519,849	$2,773,636	$3,282,457	$3,822,983
	Southern Coos Hospital*[φ]	$303,192	$416,066	$277,594	$484,588	$3,694,867
	PeaceHealth Peace Harbor[φ]	$3,033,005	$2,155,676	$5,354,257	$2,083,830	$3,036,069
	St Charles - Prineville[φ]	$3,181,570	$4,565,746	$5,306,714	$5,116,839	$3,026,635
	West Valley Hospital[φ]	$2,556,914	$2,510,925	$2,261,372	$2,525,402	$2,755,011
	PeaceHealth Cottage Grove[φ]	$2,083,987	$3,004,603	$1,207,260	$664,009	$301,160

Unreimbursed Medicare Costs

	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	OHSU Hospital	$50,468,338	$49,906,354	$72,463,064	$76,942,252	$96,869,440
	PeaceHealth Sacred Heart Hospitals	$58,627,050	$59,163,213	$70,729,211	$55,203,027	$66,397,470
	Providence St Vincent Med Ctr	$50,640,000	$57,260,000	$64,228,000	$63,107,767	$61,343,080
	Providence Portland Med Center	$45,694,000	$55,714,000	$56,014,000	$56,314,068	$55,745,129
	St Charles - Bend	$26,685,362	$25,766,872	$32,143,366	$49,301,536	$54,162,233
	Salem Hospital	$46,063,366	$46,087,256	$33,726,151	$37,132,763	$38,908,012
	Providence Medford Med Center	$12,588,000	$14,877,000	$20,257,000	$25,454,215	$31,806,509
	Asante Rogue Med Center	$33,066,447	$30,644,281	$37,080,028	$28,531,231	$30,707,162
	Good Samaritan Regional Med Ctr	$39,943,263	$34,991,893	$37,171,291	$34,926,031	$27,025,049
	Legacy Emanuel Med Center	$16,645,923	$37,249,286	$73,574,377	$40,206,239	$24,220,338
	Tuality Healthcare	$17,094,815	$20,590,957	$18,960,949	$19,601,061	$18,905,006
	Bay Area Hospital	$8,172,277	$9,253,444	$11,677,143	$12,274,822	$12,375,806
	Asante Three Rivers Med Center	$11,749,464	$11,045,685	$11,193,605	$9,766,392	$12,126,618
	Samaritan Albany Hospital	$11,179,998	$11,525,364	$14,060,501	$11,722,699	$11,844,662
	Legacy Meridian Park Med Center	$8,402,860	$10,557,867	$3,881,649	$15,779,324	$11,762,784
	Adventist Med Center	$5,683,263	$7,088,318	$6,711,962	$9,944,790	$11,694,983
	Legacy Good Samaritan Med Ctr	$15,980,442	$13,585,011	$12,984,892	$18,654,975	$10,152,660
	Sky Lakes Med Center	$14,267,580	$10,568,869	$14,904,031	$20,640,804	$8,785,517
	Providence Willamette Falls	$7,967,000	$7,322,000	$6,188,000	$7,719,585	$8,556,918
	Providence Milwaukie Hospital	$0	$606,000	$1,997,000	$3,158,005	$3,193,941
	Mercy Med Center	$4,851,154	$0	$1,878,410	$0	$1,993,310
	Legacy Mt Hood Med Center	$879,673	$998,103	$7,439,511	$1,236,321	$1,608,353
	Kaiser Westside Med Ctr	$0	$0	$0	$0	$0
	Willamette Valley Med Ctr[p]	$1,938,541	$503,696	$1,080,558	$2,961,507	$0
	Shriners	$0	$0	$0	$0	$0
	McKenzie-Willamette Med Ctr[p]	$1,150,177	$1,400,618	$3,345,137	$0	$0
	Kaiser Sunnyside Med Center	$0	$0	$0	$0	$0
Type A Hospitals	St Alphonsus Med Ctr-Ontario	$3,296,044	$4,252,115	$5,525,744	$3,253,401	$2,546,147
	Lake District Hospital*ϕ	$361,003	$140,281	$961,276	$3,068,595	$2,258,776
	Tillamook County Gen Hospitalϕ	$1,543,099	$83,747	$3,002,855	$3,876,519	$2,177,798
	Harney District Hospital*ϕ	$0	$0	$632,530	$1,654,782	$2,077,655
	Blue Mountain Hospital*ϕ	$1,717,000	$267,328	$1,697,210	$1,806,814	$2,018,167
	St Anthony Hospitalϕ	$411,612	$565,438	$20,753	$25,859	$1,948,725
	Wallowa Memorial Hospital*ϕ	$1,308,017	$1,274,849	$1,058,627	$1,646,931	$1,436,258
	Curry General Hospital*ϕ	$1,294,272	$3,865,916	$1,272,985	$451,051	$877,510
	Grande Ronde Hospitalϕ	$304,282	$472,613	$397,502	$792,134	$709,497
	Pioneer Memorial Heppner*ϕ	$387,789	$212,991	$321,509	$199,117	$410,185
	St Alphonsus Med Ctr-Baker Cityϕ	$0	$0	$0	$286,635	$53,620
	Good Shepherd Med Centerϕ	$0	$0	$637,369	$611,706	$0
Type B Hospitals	Columbia Memorial Hospitalϕ	$7,164,474	$9,653,892	$13,435,911	$15,941,274	$17,907,349
	Ashland Comm Hospital	$196,712	$469,028	$9,231,116	$10,510,597	$10,035,246
	Providence Newberg Med Center	$9,468,000	$9,325,000	$9,036,000	$9,039,816	$9,987,970
	Providence Hood River Hospitalϕ	$2,274,000	$2,863,000	$4,577,000	$7,172,969	$9,945,677
	Legacy Silverton Med Ctr	$2,284,968	$4,314,821	$8,848,426	$6,178,371	$5,081,076
	Providence Seaside Hospital*ϕ	$2,144,000	$1,241,000	$2,147,000	$2,187,165	$4,541,076
	St Charles - Redmond	$3,135,562	$1,838,521	$2,604,352	$4,312,136	$4,002,726
	Santiam Memorial Hospital	$490,461	$2,570,590	$4,556,234	$3,964,131	$3,987,230
	Samaritan Lebanon Hospitalϕ	$1,462,323	$2,665,766	$3,043,960	$3,983,860	$3,932,857
	Coquille Valley Hospital*ϕ	$667,459	$1,021,529	$948,405	$2,601,618	$3,502,079
	Samaritan Pacific Comm Hospital*ϕ	$3,228,574	$1,815,566	$327,377	$2,926,295	$3,139,242
	Southern Coos Hospital*ϕ	$0	$0	$0	$108,561	$2,361,743
	PeaceHealth Peace Harborϕ	$0	$0	$1,990,983	$0	$2,274,776
	Lower Umpqua Hospital*ϕ	$969,985	$1,724,339	$291,065	$909,282	$1,386,093
	Samaritan North Lincoln Hospital*ϕ	$543,249	$1,412,998	$0	$798,491	$1,290,186
	St Charles - Prinevilleϕ	$0	$0	$0	$1,630,019	$1,031,953
	St Charles - Madras*ϕ	$0	$362,778	$0	$320,616	$300,349
	PeaceHealth Cottage Groveϕ	$1,152,896	$1,170,907	$311,258	$0	$0
	West Valley Hospitalϕ	$0	$0	$0	$0	$0
	Mid-Columbia Med Center	$0	$0	$0	$0	$0

Unreimbursed Medicaid Costs

	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	Legacy Emanuel Med Center	$36,020,122	$51,335,252	$34,055,455	$65,433,082	$87,343,572
	PeaceHealth Sacred Heart Hospitals	$14,642,122	$60,794,638	$40,165,706	$50,853,787	$63,536,650
	OHSU Hospital	$25,058,322	$34,357,374	$41,034,494	$51,133,348	$52,269,814
	Providence Portland Med Center	$23,686,756	$31,301,204	$28,300,289	$36,617,365	$46,747,837
	Providence St Vincent Med Ctr	$22,222,568	$27,622,920	$24,640,945	$28,000,905	$41,357,044
	Salem Hospital	$18,209,353	$20,971,071	$18,065,496	$32,483,503	$39,028,269
	St Charles - Bend	$43,413,530	$55,157,170	$60,510,948	$40,214,408	$34,703,837
	Asante Rogue Med Center	$12,141,845	$18,711,034	$24,672,718	$25,391,925	$31,360,234
	Providence Medford Med Center	$4,356,000	$7,740,000	$9,408,000	$16,954,212	$20,696,710
	Legacy Good Samaritan Med Ctr	$6,270,781	$11,594,350	$15,491,594	$13,582,399	$18,551,596
	Bay Area Hospital	$10,683,924	$10,949,813	$6,937,881	$12,010,705	$17,897,271
	Good Samaritan Regional Med Ctr	$4,711,623	$10,538,767	$10,518,553	$16,233,989	$17,890,139
	Kaiser Sunnyside Med Center	$8,306,518	$9,261,310	$9,472,087	$12,669,276	$15,105,204
	Asante Three Rivers Med Center	$2,483,419	$7,294,829	$7,607,258	$11,121,470	$14,008,428
	Shriners	$0	$0	$2,156,243	$4,796,658	$11,379,139
	Adventist Med Center	$7,461,877	$6,602,752	$7,941,389	$14,172,507	$10,796,942
	Providence Willamette Falls	$6,061,000	$5,558,446	$5,307,165	$8,733,609	$10,649,700
	Samaritan Albany Hospital	$4,484,068	$6,344,393	$7,376,805	$9,214,881	$10,073,890
	Tuality Healthcare	$8,829,586	$13,687,797	$7,610,956	$11,154,263	$9,406,725
	Legacy Mt Hood Med Center	$2,604,451	$3,909,092	$3,533,508	$6,573,876	$9,094,925
	Legacy Meridian Park Med Center	$845,968	$2,404,052	$13,051,570	$4,414,759	$8,897,589
	Providence Milwaukie Hospital	$1,792,802	$3,246,088	$3,062,110	$5,724,826	$7,324,684
	Willamette Valley Med Ctr[p]	$2,177,100	$1,655,024	$3,086,302	$5,349,226	$7,118,677
	Mercy Med Center	$8,724,410	$2,408,600	$1,042,211	$4,950,931	$4,509,869
	Sky Lakes Med Center	$1,433,149	$0	$786,674	$3,604,492	$3,999,094
	Kaiser Westside Med Ctr	$0	$0	$802,609	$3,421,119	$3,707,780
	McKenzie-Willamette Med Ctr[p]	$2,976,792	$2,642,388	$0	$2,694,827	$0
Type A Hospitals	Grande Ronde Hospitalϕ	$301,895	$504,019	$146,698	$289,594	$1,763,293
	Tillamook County Gen Hospitalϕ	$821,574	$646,326	$244,064	$1,224,286	$1,650,543
	St Alphonsus Med Ctr-Baker Cityϕ	$305,850	$0	$376,001	$1,615,741	$1,171,457
	St Alphonsus Med Ctr-Ontario	$456,853	$1,205,405	$328,031	$754,790	$901,298
	Pioneer Memorial Heppner*ϕ	$281,398	$126,864	$460,050	$470,450	$517,230
	Harney District Hospital*ϕ	$0	$0	$268,536	$176,089	$492,427
	Wallowa Memorial Hospital*ϕ	$534,618	$501,620	$609,436	$212,442	$464,072
	Lake District Hospital*ϕ	$900,891	$761,717	$165,831	$975,593	$109,512
	Curry General Hospital*ϕ	$346,566	$760,143	$714,412	$509,615	$84,675
	St Anthony Hospitalϕ	$19,830	$16,968	$16,968	$488,320	$18,056
	Good Shepherd Med Centerϕ	$0	$0	$0	$0	$0
	Blue Mountain Hospital*ϕ	$602,629	$719,841	$592,326	$83,359	$0
Type B Hospitals	Mid-Columbia Med Center	$4,085,565	$3,546,844	$3,945,001	$6,823,238	$6,847,089
	St Charles - Madras*ϕ	$1,271,583	$1,448,119	$3,490,547	$4,389,625	$4,441,828
	Providence Hood River Hospitalϕ	$1,256,000	$557,000	$1,586,000	$2,876,240	$3,582,964
	Columbia Memorial Hospitalϕ	$714,671	$2,087,417	$2,055,347	$3,301,720	$1,959,603
	St Charles - Redmond	$6,720,093	$5,630,902	$3,403,181	$2,835,316	$1,802,034
	Samaritan Lebanon Hospitalϕ	$785,917	$906,020	$2,914,166	$2,098,031	$1,574,985
	West Valley Hospitalϕ	$895,185	$817,058	$626,113	$1,151,812	$1,550,026
	Santiam Memorial Hospital	$1,174,084	$600,553	$802,393	$2,760,298	$1,514,092
	Southern Coos Hospital*ϕ	$0	$0	$0	$270,983	$1,214,408
	St Charles - Prinevilleϕ	$2,047,580	$3,145,359	$3,101,678	$2,544,623	$1,104,051
	Coquille Valley Hospital*ϕ	$155,933	$514,379	$335,375	$734,257	$911,659
	Providence Newberg Med Center	$0	$0	$0	$83,717	$858,650
	Lower Umpqua Hospital*ϕ	$501,484	$523,345	$944,687	$762,822	$804,517
	Providence Seaside Hospital*ϕ	$0	$0	$0	$303,505	$762,581
	Samaritan North Lincoln Hospital*ϕ	$0	$203,317	$798,877	$1,241,112	$236,524
	Samaritan Pacific Comm Hospital*ϕ	$0	$0	$671,201	$557,992	$218,689
	Legacy Silverton Med Ctr	$2,438,141	$3,454,027	$2,883,670	$1,277,434	$0
	PeaceHealth Cottage Groveϕ	$318,181	$1,240,707	$0	$0	$0
	Ashland Comm Hospital	$8,024,794	$8,150,082	$4,083,709	$0	$0
	PeaceHealth Peace Harborϕ	$0	$0	$0	$0	$0

Charity Care Costs

Group	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	OHSU Hospital	$29,806,794	$30,507,318	$38,837,542	$31,015,838	$16,386,904
	Providence St Vincent Med Ctr	$28,222,500	$33,582,000	$33,261,000	$16,603,460	$14,536,506
	Providence Portland Med Center	$28,131,500	$32,099,000	$32,404,000	$13,781,229	$13,044,207
	Legacy Emanuel Med Center	$36,052,825	$31,442,359	$29,870,424	$30,831,175	$11,139,320
	Salem Hospital	$22,198,854	$20,096,418	$24,729,956	$13,464,253	$8,902,565
	Kaiser Sunnyside Med Center	$7,367,388	$7,630,955	$7,691,503	$4,321,056	$8,406,130
	PeaceHealth Sacred Heart Hospitals	$30,490,886	$28,424,562	$27,246,922	$19,859,421	$6,103,664
	Good Samaritan Regional Med Ctr	$10,959,185	$10,049,142	$11,720,480	$3,289,527	$4,342,632
	Providence Medford Med Center	$7,868,000	$9,182,000	$11,104,000	$4,677,839	$4,139,265
	Legacy Good Samaritan Med Ctr	$15,577,688	$14,192,239	$12,776,298	$10,743,827	$3,954,509
	St Charles - Bend	$11,024,264	$13,114,048	$12,084,761	$5,900,372	$3,675,221
	Asante Rogue Med Center	$14,300,404	$13,931,585	$13,230,611	$7,332,577	$3,653,384
	Legacy Mt Hood Med Center	$8,897,803	$9,381,265	$8,617,698	$7,364,617	$3,378,822
	Kaiser Westside Med Ctr	$0	$0	$497,024	$1,100,743	$2,978,215
	Adventist Med Center	$6,981,328	$6,572,681	$6,032,214	$6,171,186	$2,920,438
	Tuality Healthcare	$4,073,160	$5,619,300	$5,006,529	$4,048,064	$2,823,741
	Shriners	$0	$0	$3,287,875	$4,551,457	$2,654,429
	Sky Lakes Med Center	$4,641,879	$5,072,988	$5,507,877	$3,957,108	$2,470,413
	Providence Willamette Falls	$3,977,000	$3,721,000	$5,724,000	$1,743,263	$2,455,381
	Samaritan Albany Hospital	$4,039,980	$3,816,085	$4,725,692	$2,145,778	$2,419,471
	Providence Milwaukie Hospital	$4,688,000	$5,328,000	$5,434,000	$2,269,339	$2,378,129
	Legacy Meridian Park Med Center	$6,731,814	$6,470,501	$6,120,508	$5,784,878	$2,166,491
	Asante Three Rivers Med Center	$7,093,119	$7,323,143	$7,301,105	$3,721,962	$2,047,157
	Bay Area Hospital	$3,295,242	$3,228,403	$3,694,201	$1,152,054	$687,458
	Mercy Med Center	$3,815,811	$3,136,778	$3,944,557	$2,868,682	$560,469
	Willamette Valley Med Ctr[p]	$219,579	$306,123	$557,097	$274,621	$163,992
	McKenzie-Willamette Med Ctr[p]	$1,027,932	$722,442	$1,385,667	$140,449	$2,210
Type A Hospitals	Tillamook County Gen Hospital[ϕ]	$4,264,198	$4,519,063	$4,830,639	$2,248,273	$2,363,858
	Good Shepherd Med Center[ϕ]	$3,581,396	$3,595,808	$4,684,887	$3,549,188	$1,255,546
	Grande Ronde Hospital[ϕ]	$2,805,632	$2,725,176	$2,204,092	$2,043,077	$952,748
	St Anthony Hospital[ϕ]	$1,891,500	$1,135,768	$1,161,958	$973,887	$553,296
	St Alphonsus Med Ctr-Ontario	$2,007,141	$2,242,528	$2,611,463	$1,966,068	$474,091
	Harney District Hospital*[ϕ]	$133,042	$153,119	$213,322	$339,610	$248,985
	St Alphonsus Med Ctr-Baker City[ϕ]	$758,912	$816,289	$863,966	$583,567	$200,410
	Lake District Hospital*[ϕ]	$250,436	$297,828	$320,479	$340,793	$196,827
	Curry General Hospital*[ϕ]	$273,296	$331,058	$595,895	$597,721	$163,185
	Blue Mountain Hospital*[ϕ]	$369,999	$422,596	$559,512	$206,909	$88,408
	Wallowa Memorial Hospital*[ϕ]	$316,332	$282,901	$237,235	$174,429	$88,180
	Pioneer Memorial Heppner*[ϕ]	$168,913	$154,971	$102,521	$150,708	$71,632
Type B Hospitals	Mid-Columbia Med Center	$3,047,979	$3,258,938	$3,471,890	$2,840,284	$2,820,844
	Providence Newberg Med Center	$4,198,000	$5,034,000	$5,378,000	$2,230,862	$2,742,307
	Providence Hood River Hospital[ϕ]	$3,245,000	$3,522,000	$3,815,000	$2,693,753	$2,473,590
	Samaritan Lebanon Hospital[ϕ]	$2,353,275	$2,754,300	$2,710,288	$1,750,713	$2,306,909
	Samaritan Pacific Comm Hospital*[ϕ]	$2,053,387	$2,206,317	$2,209,302	$1,294,398	$1,662,401
	Providence Seaside Hospital*[ϕ]	$3,169,000	$3,103,000	$3,462,000	$1,130,607	$1,644,748
	Samaritan North Lincoln Hospital*[ϕ]	$1,216,580	$1,554,449	$1,494,560	$1,208,371	$1,566,884
	St Charles - Redmond	$2,663,667	$2,687,551	$3,548,259	$1,400,753	$1,221,184
	Legacy Silverton Med Ctr	$3,952,013	$3,531,419	$4,051,741	$2,972,522	$1,115,247
	Columbia Memorial Hospital[ϕ]	$1,175,194	$1,214,969	$1,320,604	$937,716	$961,398
	PeaceHealth Peace Harbor[ϕ]	$2,922,151	$2,115,355	$3,350,482	$2,065,401	$733,900
	Ashland Comm Hospital	$866,868	$771,387	$949,636	$530,960	$554,216
	St Charles - Prineville[ϕ]	$790,742	$962,240	$1,307,840	$680,299	$516,864
	St Charles - Madras*[ϕ]	$443,079	$271,020	$1,098,116	$633,490	$459,659
	West Valley Hospital[ϕ]	$1,017,878	$1,038,198	$1,101,848	$635,968	$412,367
	PeaceHealth Cottage Grove[ϕ]	$607,797	$563,536	$896,002	$657,659	$280,512
	Santiam Memorial Hospital	$684,167	$731,925	$692,120	$419,910	$198,115
	Lower Umpqua Hospital*[ϕ]	$128,775	$148,823	$352,297	$581,205	$123,394
	Southern Coos Hospital*[ϕ]	$268,810	$385,161	$249,355	$85,958	$101,157
	Coquille Valley Hospital*[ϕ]	$188,699	$194,799	$280,181	$140,464	$89,658

Health Professional Education Costs

Group	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	OHSU Hospital	$161,602,098	$169,382,339	$151,074,608	$168,310,304	$163,345,333
DRG Hospitals	Good Samaritan Regional Med Ctr	$4,617,750	$6,387,692	$7,665,468	$8,699,891	$9,036,649
DRG Hospitals	Providence Portland Med Center	$7,006,495	$7,502,882	$8,072,356	$7,198,590	$6,240,278
DRG Hospitals	Legacy Good Samaritan Med Ctr	$4,980,827	$4,101,776	$4,194,485	$4,394,805	$6,065,344
DRG Hospitals	Legacy Emanuel Med Center	$7,500,666	$7,222,173	$7,178,260	$7,994,424	$5,844,018
DRG Hospitals	Providence St Vincent Med Ctr	$7,864,308	$6,646,039	$6,746,060	$6,482,063	$4,897,301
DRG Hospitals	Providence Milwaukie Hospital	$4,737,298	$4,466,649	$4,224,821	$4,922,530	$3,980,372
DRG Hospitals	Sky Lakes Med Center	$3,179,410	$4,030,687	$2,394,796	$2,507,905	$2,477,512
DRG Hospitals	Kaiser Sunnyside Med Center	$2,527,376	$2,470,452	$2,516,373	$2,049,994	$2,225,144
DRG Hospitals	Shriners	$0	$0	$1,353,084	$2,508,496	$2,137,654
DRG Hospitals	Salem Hospital	$1,129,577	$1,884,571	$1,779,525	$991,747	$1,597,096
DRG Hospitals	Willamette Valley Med Ctr[p]	$0	$0	$0	$876,024	$1,269,748
DRG Hospitals	Samaritan Albany Hospital	$653,297	$750,589	$606,777	$1,343,676	$1,199,429
DRG Hospitals	Kaiser Westside Med Ctr	$0	$0	$330,203	$758,217	$822,998
DRG Hospitals	Adventist Med Center	$329,647	$335,611	$497,861	$499,965	$757,470
DRG Hospitals	St Charles - Bend	$555,035	$593,562	$581,629	$503,576	$613,566
DRG Hospitals	Legacy Mt Hood Med Center	$340,526	$354,756	$341,841	$441,673	$392,659
DRG Hospitals	Legacy Meridian Park Med Center	$477,480	$418,414	$378,411	$431,136	$389,116
DRG Hospitals	Tuality Healthcare	$249,686	$250,505	$262,677	$376,069	$326,620
DRG Hospitals	Providence Medford Med Center	$88,047	$105,141	$134,824	$203,752	$208,315
DRG Hospitals	Asante Rogue Med Center	$2,972,023	$2,548,369	$11,649	$4,165	$75,250
DRG Hospitals	Bay Area Hospital	$254,442	$132,280	$208,406	$184,432	$37,920
DRG Hospitals	Asante Three Rivers Med Center	$1,080,844	$1,366,878	$4,530	$1,488	$26,875
DRG Hospitals	PeaceHealth Sacred Heart Hospitals	$783,562	$826,075	$0	$90,283	$4,672
DRG Hospitals	Mercy Med Center	$0	$92	$0	$130	$0
DRG Hospitals	Providence Willamette Falls	$0	$0	$0	$0	$0
DRG Hospitals	McKenzie-Willamette Med Ctr[p]	$0	$0	$0	$0	$0
Type A Hospitals	St Anthony Hospitalɸ	$164,057	$162,098	$179,966	$251,644	$302,690
Type A Hospitals	Lake District Hospital*ɸ	$105,652	$145,554	$180,001	$268,381	$284,694
Type A Hospitals	Good Shepherd Med Centerɸ	$149,667	$211,650	$169,450	$203,874	$233,088
Type A Hospitals	Grande Ronde Hospitalɸ	$197,894	$187,004	$245,397	$280,680	$191,188
Type A Hospitals	Curry General Hospital*ɸ	$8,700	$8,513	$6,792	$30,288	$32,173
Type A Hospitals	Harney District Hospital*ɸ	$0	$0	$0	$11,464	$22,265
Type A Hospitals	St Alphonsus Med Ctr-Baker Cityɸ	$34,400	$21,056	$43,347	$26,516	$10,725
Type A Hospitals	St Alphonsus Med Ctr-Ontario	$38,119	$30,000	$10,118	$3,526	$2,485
Type A Hospitals	Wallowa Memorial Hospital*ɸ	$0	$0	$903	$1,078	$942
Type A Hospitals	Pioneer Memorial Heppner*ɸ	$0	$0	$0	$0	$550
Type A Hospitals	Blue Mountain Hospital*ɸ	$0	$0	$0	$0	$0
Type A Hospitals	Tillamook County Gen Hospitalɸ	$0	$0	$0	$0	$0
Type B Hospitals	Samaritan Lebanon Hospitalɸ	$702,983	$741,909	$989,090	$1,380,897	$1,324,816
Type B Hospitals	Providence Hood River Hospitalɸ	$34,680	$32,786	$104,327	$142,384	$752,005
Type B Hospitals	Samaritan Pacific Comm Hospital*ɸ	$256,087	$456,003	$538,161	$734,043	$633,376
Type B Hospitals	Mid-Columbia Med Center	$468,643	$488,480	$554,754	$484,010	$462,398
Type B Hospitals	Providence Newberg Med Center	$240,061	$231,807	$312,481	$440,959	$364,658
Type B Hospitals	Samaritan North Lincoln Hospital*ɸ	$310,038	$326,271	$320,477	$413,585	$322,806
Type B Hospitals	Legacy Silverton Med Ctr	$218,059	$324,901	$101,550	$216,454	$156,569
Type B Hospitals	Providence Seaside Hospital*ɸ	$73,063	$24,671	$54,254	$151,289	$106,790
Type B Hospitals	Columbia Memorial Hospitalɸ	$9,461	$9,280	$10,300	$11,930	$104,609
Type B Hospitals	St Charles - Redmond	$91,919	$81,681	$91,687	$85,128	$83,284
Type B Hospitals	West Valley Hospitalɸ	$33,631	$40,315	$73,532	$53,571	$80,689
Type B Hospitals	St Charles - Madras*ɸ	$0	$949	$48,494	$43,077	$40,890
Type B Hospitals	St Charles - Prinevilleɸ	$49,866	$46,159	$45,420	$24,192	$21,248
Type B Hospitals	Coquille Valley Hospital*ɸ	$0	$0	$0	$0	$10,206
Type B Hospitals	Ashland Comm Hospital	$4,042	$2,370	$3,531	$298	$5,375
Type B Hospitals	Southern Coos Hospital*ɸ	$0	$0	$0	$0	$0
Type B Hospitals	PeaceHealth Cottage Groveɸ	$1,062	$16,859	$0	$0	$0
Type B Hospitals	PeaceHealth Peace Harborɸ	$75,940	$17,510	$0	$0	$0
Type B Hospitals	Lower Umpqua Hospital*ɸ	$0	$0	$0	$0	$0
Type B Hospitals	Santiam Memorial Hospital	$0	$0	$0	$0	$0

Research Costs

Group	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	OHSU Hospital	$34,479,250	$25,868,026	$31,962,265	$32,921,133	$33,908,767
	Providence Portland Med Center	$6,431,050	$5,847,910	$8,655,113	$11,094,747	$12,244,930
	Kaiser Sunnyside Med Center	$6,266,884	$5,449,601	$4,369,778	$4,167,178	$3,811,846
	Legacy Emanuel Med Center	$830,000	$3,797,022	$3,694,464	$3,590,778	$3,556,144
	Providence St Vincent Med Ctr	$4,176,632	$3,141,837	$1,316,474	$2,194,958	$2,592,259
	Kaiser Westside Med Ctr	$0	$0	$573,410	$1,541,285	$1,409,861
	Shriners	$0	$0	$1,632,499	$2,925,305	$547,509
	Asante Rogue Med Center	$50,912	$154,291	$176,040	$231,518	$270,710
	Good Samaritan Regional Med Ctr	$146,252	$336,980	$310,301	$362,040	$258,026
	Salem Hospital	$2,199,800	$2,829,923	$977,006	$1,901,005	$219,119
	Samaritan Albany Hospital	$59,944	$137,176	$141,219	$170,461	$120,907
	PeaceHealth Sacred Heart Hospitals	$0	$0	$0	$0	$101,046
	Adventist Med Center	$0	$74,772	$46,945	$13,026	$15,543
	Legacy Mt Hood Med Center	$0	$0	$0	$0	$0
	St Charles - Bend	$0	$0	$0	$0	$0
	Mercy Med Center	$0	$0	$0	$0	$0
	Bay Area Hospital	$0	$0	$0	$0	$0
	Willamette Valley Med Ctr[p]	$0	$0	$0	$0	$0
	Providence Medford Med Center	$165,128	$67,792	$88,851	$103,392	$0
	McKenzie-Willamette Med Ctr[p]	$0	$0	$0	$0	$0
	Providence Milwaukie Hospital	$119,181	$59,244	$60,528	$70,433	$0
	Sky Lakes Med Center	$0	$0	$0	$0	$0
	Legacy Good Samaritan Med Ctr	$0	$0	$0	$0	$0
	Tuality Healthcare	$0	$0	$0	$0	$0
	Legacy Meridian Park Med Center	$0	$0	$0	$0	$0
	Asante Three Rivers Med Center	$0	$0	$0	$0	$0
	Providence Willamette Falls	$82,427	$45,881	$54,374	$63,273	$0
Type A Hospitals	St Alphonsus Med Ctr-Baker City[ϕ]	$0	$0	$0	$0	$0
	Wallowa Memorial Hospital*[ϕ]	$0	$0	$0	$0	$0
	St Anthony Hospital[ϕ]	$0	$0	$0	$0	$0
	Curry General Hospital*[ϕ]	$0	$0	$0	$0	$0
	Pioneer Memorial Heppner*[ϕ]	$0	$0	$0	$0	$0
	Good Shepherd Med Center[ϕ]	$0	$0	$0	$0	$0
	St Alphonsus Med Ctr-Ontario	$0	$0	$0	$0	$0
	Grande Ronde Hospital[ϕ]	$0	$0	$0	$0	$0
	Tillamook County Gen Hospital[ϕ]	$0	$0	$0	$0	$0
	Harney District Hospital*[ϕ]	$0	$0	$8,255	$0	$0
	Blue Mountain Hospital*[ϕ]	$0	$0	$0	$0	$0
	Lake District Hospital*[ϕ]	$0	$0	$0	$0	$0
Type B Hospitals	Samaritan Lebanon Hospital[ϕ]	$36,228	$81,519	$78,525	$106,349	$72,273
	Samaritan Pacific Comm Hospital*[ϕ]	$28,779	$45,007	$65,227	$67,883	$56,170
	Providence Hood River Hospital[ϕ]	$116,413	$75,318	$47,199	$81,274	$53,846
	Samaritan North Lincoln Hospital*[ϕ]	$19,787	$32,836	$37,996	$47,518	$34,808
	Mid-Columbia Med Center	$13,728	$17,296	$18,301	$15,200	$15,651
	Santiam Memorial Hospital	$0	$0	$0	$0	$0
	Lower Umpqua Hospital*[ϕ]	$0	$0	$0	$0	$0
	St Charles - Madras*[ϕ]	$26,736	$0	$0	$0	$0
	Legacy Silverton Med Ctr	$0	$0	$0	$0	$0
	Columbia Memorial Hospital[ϕ]	$0	$0	$0	$0	$0
	PeaceHealth Cottage Grove[ϕ]	$0	$0	$0	$0	$0
	Coquille Valley Hospital*[ϕ]	$0	$0	$0	$0	$0
	PeaceHealth Peace Harbor[ϕ]	$0	$0	$0	$0	$0
	Southern Coos Hospital*[ϕ]	$0	$0	$0	$0	$0
	St Charles - Redmond	$0	$0	$0	$0	$0
	St Charles - Prineville[ϕ]	$0	$0	$0	$0	$0
	West Valley Hospital[ϕ]	$0	$0	$0	$0	$0
	Providence Seaside Hospital*[ϕ]	$69,615	$25,970	$34,748	$40,435	$0
	Ashland Comm Hospital	$0	$0	$0	$0	$0
	Providence Newberg Med Center	$116,605	$59,200	$55,275	$64,320	$0

Community Health Improvement Costs

Group	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	OHSU Hospital	$3,793,057	$5,446,362	$3,096,351	$3,081,563	$4,536,273
	Salem Hospital	$2,531,983	$2,159,267	$3,316,849	$2,182,058	$3,069,929
	Asante Rogue Med Center	$950,834	$833,860	$1,013,165	$1,626,534	$2,682,802
	Tuality Healthcare	$1,900,444	$1,907,170	$1,847,536	$1,870,558	$2,226,329
	Providence Portland Med Center	$4,325,108	$4,988,004	$4,857,512	$1,212,933	$1,650,990
	Providence St Vincent Med Ctr	$4,251,613	$5,257,017	$4,559,689	$1,155,920	$1,364,492
	Kaiser Sunnyside Med Center	$1,180,482	$1,209,999	$985,895	$1,125,528	$1,300,192
	St Charles - Bend	$432,658	$486,984	$589,573	$146,553	$1,081,603
	Adventist Med Center	$470,990	$692,395	$656,373	$868,865	$1,055,465
	Legacy Emanuel Med Center	$1,841,365	$1,479,635	$1,734,842	$1,924,517	$795,550
	PeaceHealth Sacred Heart Hospitals	$603,462	$512,677	$1,514,324	$697,222	$694,394
	Sky Lakes Med Center	$89,521	$66,643	$221,440	$497,296	$637,248
	Mercy Med Center	$93,499	$334,011	$39,719	$572,308	$611,337
	Bay Area Hospital	$416,610	$621,381	$351,931	$397,610	$539,330
	Good Samaritan Regional Med Ctr	$695,265	$534,972	$637,532	$423,954	$526,957
	Asante Three Rivers Med Center	$209,718	$71,759	$241,814	$380,896	$506,513
	Kaiser Westside Med Ctr	$0	$0	$129,371	$416,291	$480,893
	Shriners	$0	$0	$318,981	$334,156	$441,586
	Samaritan Albany Hospital	$220,580	$271,796	$482,902	$433,884	$312,441
	Legacy Good Samaritan Med Ctr	$195,806	$64,555	$0	$136,804	$201,898
	Providence Willamette Falls	$55,788	$541,999	$551,700	$99,621	$201,749
	Providence Medford Med Center	$317,880	$263,696	$274,348	$342,455	$196,374
	Providence Milwaukie Hospital	$653,878	$719,587	$658,804	$220,250	$157,647
	Legacy Mt Hood Med Center	$101,061	$51,705	$49,754	$75,732	$80,855
	Willamette Valley Med Ctr[p]	$60,056	$68,704	$44,677	$87,669	$68,547
	Legacy Meridian Park Med Center	$107,193	$35,882	$70,164	$38,625	$30,491
	McKenzie-Willamette Med Ctr[p]	$5,000	$5,000	$5,000	$5,000	$5,000
Type A Hospitals	Grande Ronde Hospitalϕ	$136,303	$97,838	$86,896	$724,875	$1,261,603
	St Anthony Hospitalϕ	$238,004	$276,558	$221,970	$274,357	$400,369
	Good Shepherd Med Centerϕ	$205,883	$188,325	$205,869	$194,043	$244,395
	Tillamook County Gen Hospitalϕ	$0	$2,710,000	$2,519,060	$177,622	$215,406
	Harney District Hospital*ϕ	$31,677	$66,005	$77,552	$90,585	$133,662
	Lake District Hospital*ϕ	$20,981	$30,585	$42,326	$88,121	$104,829
	St Alphonsus Med Ctr-Ontario	$115,177	$206,913	$8,277	$81,564	$92,344
	Pioneer Memorial Heppner*ϕ	$23,388	$15,809	$9,081	$22,525	$38,061
	Wallowa Memorial Hospital*ϕ	$12,670	$12,575	$8,345	$6,894	$34,441
	St Alphonsus Med Ctr-Baker Cityϕ	$9,628	$19,601	$15,317	$4,835	$19,170
	Blue Mountain Hospital*ϕ	$14,305	$0	$3,850	$25,798	$17,618
	Curry General Hospital*ϕ	$21,346	$4,824	$3,518	$4,248	$3,402
Type B Hospitals	Legacy Silverton Med Ctr	$732,075	$960,882	$693,704	$329,182	$542,655
	Columbia Memorial Hospitalϕ	$117,717	$101,429	$96,302	$139,950	$497,433
	Samaritan Pacific Comm Hospital*ϕ	$159,639	$132,767	$247,108	$168,488	$446,277
	Mid-Columbia Med Center	$657,998	$518,158	$453,344	$496,137	$422,997
	St Charles - Redmond	$17,609	$22,510	$85,228	$21,820	$205,337
	Providence Hood River Hospitalϕ	$809,708	$199,687	$194,330	$215,026	$175,768
	Providence Newberg Med Center	$129,452	$151,959	$163,953	$143,659	$143,790
	St Charles - Madras*ϕ	$13,487	$51,096	$48,149	$18,358	$110,083
	St Charles - Prinevilleϕ	$35,321	$195,042	$42,744	$7,190	$103,559
	Santiam Memorial Hospital	$21,479	$67,704	$58,347	$148,400	$94,441
	Ashland Comm Hospital	$73,759	$45,702	$5,252	$74,745	$89,739
	Providence Seaside Hospital*ϕ	$82,419	$93,293	$81,682	$116,034	$61,300
	Lower Umpqua Hospital*ϕ	$64,022	$79,315	$34,840	$34,083	$37,023
	West Valley Hospitalϕ	$84,071	$57,746	$40,754	$31,207	$25,548
	Samaritan Lebanon Hospitalϕ	$70,437	$100,678	$119,808	$63,374	$19,928
	Southern Coos Hospital*ϕ	$34,382	$30,905	$28,239	$19,086	$17,559
	Samaritan North Lincoln Hospital*ϕ	$52,877	$157,554	$84,401	$29,158	$12,866
	Coquille Valley Hospital*ϕ	$8,870	$2,812	$3,250	$1,650	$1,300
	PeaceHealth Peace Harborϕ	$28,169	$10,171	$0	$0	$0
	PeaceHealth Cottage Groveϕ	$4,051	$10,463	$0	$0	$0

Other Public Program Costs

Hospital Type	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	St Charles - Bend	$0	$0	$16,978,483	$4,052,143	$5,708,905
DRG Hospitals	Providence Medford Med Center	$460,000	$1,205,000	$650,000	$1,580,890	$3,718,114
DRG Hospitals	Salem Hospital	$8,109,513	$8,931,092	$2,112,934	$1,623,542	$2,121,075
DRG Hospitals	Providence St Vincent Med Ctr	$1,486,500	$2,707,000	$1,653,000	$1,710,995	$2,038,097
DRG Hospitals	Asante Rogue Med Center	$1,623,975	$2,467,465	$2,158,661	$2,172,367	$1,999,392
DRG Hospitals	Legacy Emanuel Med Center	$979,225	$917,187	$1,315,543	$378,484	$1,672,002
DRG Hospitals	Providence Portland Med Center	$1,007,500	$1,540,000	$1,065,000	$2,545,491	$1,634,896
DRG Hospitals	Good Samaritan Regional Med Ctr	$1,475,545	$1,633,090	$1,369,364	$772,387	$967,319
DRG Hospitals	Asante Three Rivers Med Center	$527,769	$611,038	$792,592	$667,688	$718,041
DRG Hospitals	Samaritan Albany Hospital	$369,778	$539,777	$536,384	$650,954	$363,535
DRG Hospitals	Providence Willamette Falls	$86,000	$231,000	$0	$413,849	$330,811
DRG Hospitals	Providence Milwaukie Hospital	$76,000	$50,000	$0	$0	$242,089
DRG Hospitals	Legacy Good Samaritan Med Ctr	$530,931	$209,212	$126,502	$290,518	$214,056
DRG Hospitals	Legacy Mt Hood Med Center	$282,065	$201,082	$346,290	$277,266	$137,288
DRG Hospitals	Willamette Valley Med Ctr[p]	$0	$89,783	$91,569	$148,836	$97,659
DRG Hospitals	OHSU Hospital	$659,427	$417,288	$944,122	$714,600	$87,939
DRG Hospitals	Sky Lakes Med Center	$0	$0	$0	$0	$0
DRG Hospitals	Kaiser Sunnyside Med Center	$0	$0	$0	$0	$0
DRG Hospitals	Tuality Healthcare	$0	$0	$0	$0	$0
DRG Hospitals	Legacy Meridian Park Med Center	$0	$0	$0	$0	$0
DRG Hospitals	Shriners	$0	$0	$0	$0	$0
DRG Hospitals	Kaiser Westside Med Ctr	$0	$0	$0	$0	$0
DRG Hospitals	PeaceHealth Sacred Heart Hospitals	$0	$0	$0	$0	$0
DRG Hospitals	McKenzie-Willamette Med Ctr[p]	$0	$0	$0	$0	$0
DRG Hospitals	Bay Area Hospital	$0	$0	$0	$0	$0
DRG Hospitals	Mercy Med Center	$123,430	$0	$0	$0	$0
DRG Hospitals	Adventist Med Center	$0	$0	$0	$0	$0
Type A Hospitals	St Alphonsus Med Ctr-Ontario	$0	$0	$64,778	$0	$273,420
Type A Hospitals	St Anthony Hospitalϕ	$0	$0	$0	$0	$0
Type A Hospitals	Pioneer Memorial Heppner*ϕ	$0	$0	$0	$0	$0
Type A Hospitals	Wallowa Memorial Hospital*ϕ	$0	$0	$0	$0	$0
Type A Hospitals	Good Shepherd Med Centerϕ	$0	$0	$0	$0	$0
Type A Hospitals	Curry General Hospital*ϕ	$0	$0	$0	$0	$0
Type A Hospitals	St Alphonsus Med Ctr-Baker Cityϕ	$0	$0	$0	$0	$0
Type A Hospitals	Grande Ronde Hospitalϕ	$0	$0	$0	$0	$0
Type A Hospitals	Tillamook County Gen Hospitalϕ	$0	$0	$0	$0	$0
Type A Hospitals	Harney District Hospital*ϕ	$0	$0	$0	$0	$0
Type A Hospitals	Blue Mountain Hospital*ϕ	$792,015	$0	$42,396	$67,828	$0
Type A Hospitals	Lake District Hospital*ϕ	$555,299	$409,880	$197,441	$0	$0
Type B Hospitals	St Charles - Redmond	$0	$0	$2,912,760	$920,687	$1,000,393
Type B Hospitals	Providence Newberg Med Center	$373,000	$522,000	$210,000	$395,871	$726,343
Type B Hospitals	Providence Hood River Hospitalϕ	$0	$426,000	$0	$0	$559,875
Type B Hospitals	Columbia Memorial Hospitalϕ	$0	$0	$0	$522,587	$522,587
Type B Hospitals	St Charles - Madras*ϕ	$0	$555,896	$2,200,852	$1,282,131	$493,906
Type B Hospitals	Ashland Comm Hospital	$8,078	$24,521	$3,009	$191,005	$394,077
Type B Hospitals	Santiam Memorial Hospital	$0	$0	$303,004	$206,278	$287,903
Type B Hospitals	St Charles - Prinevilleϕ	$0	$0	$569,494	$58,816	$158,353
Type B Hospitals	Providence Seaside Hospital*ϕ	$211,000	$140,000	$0	$240,330	$154,730
Type B Hospitals	PeaceHealth Cottage Groveϕ	$0	$0	$0	$0	$0
Type B Hospitals	Lower Umpqua Hospital*ϕ	$0	$0	$0	$0	$0
Type B Hospitals	Legacy Silverton Med Ctr	$0	$0	$0	$0	$0
Type B Hospitals	Coquille Valley Hospital*ϕ	$0	$0	$0	$0	$0
Type B Hospitals	Southern Coos Hospital*ϕ	$0	$0	$0	$0	$0
Type B Hospitals	Samaritan Lebanon Hospitalϕ	$0	$69,275	$29,380	$0	$0
Type B Hospitals	PeaceHealth Peace Harborϕ	$0	$0	$0	$0	$0
Type B Hospitals	Samaritan North Lincoln Hospital*ϕ	$156,148	$129,518	$107,386	$0	$0
Type B Hospitals	West Valley Hospitalϕ	$92,580	$151,049	$0	$0	$0
Type B Hospitals	Samaritan Pacific Comm Hospital*ϕ	$137,351	$99,723	$98,907	$0	$0
Type B Hospitals	Mid-Columbia Med Center	$0	$0	$0	$0	$0

Subsidized Health Services Costs

Group	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	Salem Hospital	$4,971,038	$5,183,217	$4,424,038	$2,020,855	$5,761,690
	Providence Portland Med Center	$3,495,198	$2,912,452	$2,251,181	$1,922,868	$2,438,230
	Sky Lakes Med Center	$3,188,365	$4,296,418	$6,857,805	$3,427,264	$2,262,182
	Good Samaritan Regional Med Ctr	$5,791,225	$5,323,081	$2,309,276	$1,794,615	$2,072,140
	Bay Area Hospital	$0	$94,123	$82,337	$182,579	$844,009
	Providence St Vincent Med Ctr	$2,116,695	$2,506,587	$2,086,687	$1,933,229	$783,441
	Providence Milwaukie Hospital	$241,654	$210,383	$177,706	$83,539	$568,325
	Asante Rogue Med Center	$2,742,539	$5,592,711	$3,606,409	$191,620	$532,774
	Samaritan Albany Hospital	$769,989	$893,461	$477,041	$477,423	$379,100
	Tuality Healthcare	$171,008	$203,194	$114,688	$125,158	$348,565
	Asante Three Rivers Med Center	$2,038,842	$1,643,300	$817,490	$68,436	$85,835
	Providence Willamette Falls	$33,936	$58,591	$63,169	$50,344	$35,215
	Providence Medford Med Center	$92,671	$59,945	$59,694	$41,368	$31,756
	Mercy Med Center	$0	$0	$0	$2,145	$1,205
	McKenzie-Willamette Med Ctr[p]	$0	$0	$0	$0	$0
	Adventist Med Center	$1,012,726	$2,561,922	$3,119,232	$1,193,545	$0
	Willamette Valley Med Ctr[p]	$0	$0	$0	$0	$0
	Kaiser Sunnyside Med Center	$0	$0	$0	$0	$0
	Legacy Mt Hood Med Center	$0	$0	$0	$0	$0
	Kaiser Westside Med Ctr	$0	$0	$0	$0	$0
	Shriners	$0	$0	$0	$0	$0
	Legacy Emanuel Med Center	$0	$0	$0	$0	$0
	St Charles - Bend	$0	$611,524	$100,514	$259,672	$0
	Legacy Good Samaritan Med Ctr	$0	$0	$183,506	$0	$0
	PeaceHealth Sacred Heart Hospitals	$12,848,742	$0	$87,572	$46,358	$0
	Legacy Meridian Park Med Center	$0	$0	$0	$0	$0
	OHSU Hospital	$0	$0	$0	$0	$0
Type A Hospitals	Good Shepherd Med Centerϕ	$30,735	$50,000	$35,000	$4,330,627	$2,774,923
	Grande Ronde Hospitalϕ	$80,649	$34,311	$758,420	$660,283	$593,504
	Wallowa Memorial Hospital*ϕ	$152,725	$196,951	$268,463	$54,015	$461,195
	Harney District Hospital*ϕ	$13,817	$589,349	$3,501	$231,770	$189,878
	St Alphonsus Med Ctr-Ontario	$69,996	$77,493	$0	$73,330	$80,352
	St Alphonsus Med Ctr-Baker Cityϕ	$425,015	$398,570	$0	$0	$67,145
	Pioneer Memorial Heppner*ϕ	$0	$0	$0	$0	$1,088
	Curry General Hospital*ϕ	$0	$0	$0	$6,875	$0
	St Anthony Hospitalϕ	$0	$0	$0	$0	$0
	Tillamook County Gen Hospitalϕ	$0	$0	$0	$0	$0
	Blue Mountain Hospital*ϕ	$0	$0	$0	$0	$0
	Lake District Hospital*ϕ	$0	$0	$0	$0	$0
Type B Hospitals	Lower Umpqua Hospital*ϕ	$0	$0	$1,149,322	$945,963	$1,398,922
	Providence Seaside Hospital*ϕ	$0	$4,284	$2,220	$4,520	$1,134,718
	Samaritan Pacific Comm Hospital*ϕ	$1,461,331	$770,719	$1,870,863	$1,593,279	$731,102
	Samaritan Lebanon Hospitalϕ	$996,296	$852,278	$451,775	$288,902	$670,708
	West Valley Hospitalϕ	$396,479	$393,813	$367,034	$602,014	$627,569
	Samaritan North Lincoln Hospital*ϕ	$228,908	$192,881	$324,107	$378,629	$425,553
	Santiam Memorial Hospital	$0	$0	$0	$253,751	$220,226
	Ashland Comm Hospital	$1,750,651	$3,157,447	$2,256,696	$13,687	$45,951
	Mid-Columbia Med Center	$281,432	$11,616	$19,177	$0	$4,994
	PeaceHealth Peace Harborϕ	$0	$0	$12,793	$9,429	$4,392
	Providence Hood River Hospitalϕ	$24	$0	$0	$0	$2,972
	Providence Newberg Med Center	$0	$9,722	$15,429	$5,513	$1,397
	Legacy Silverton Med Ctr	$358,918	$246,716	$0	$0	$0
	St Charles - Prinevilleϕ	$0	$81,536	$9,638	$24,900	$0
	St Charles - Madras*ϕ	$0	$0	$9,638	$24,900	$0
	Coquille Valley Hospital*ϕ	$0	$0	$0	$0	$0
	St Charles - Redmond	$0	$122,305	$17,900	$46,243	$0
	PeaceHealth Cottage Groveϕ	$0	$0	$0	$0	$0
	Columbia Memorial Hospitalϕ	$164,572	$0	$0	$0	$0
	Southern Coos Hospital*ϕ	$0	$0	$0	$0	$0

Cash and In-Kind Contributions

Group	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	Kaiser Sunnyside Med Center	$3,475,807	$3,810,770	$4,606,742	$7,934,326	$5,677,998
DRG Hospitals	Providence St Vincent Med Ctr	$2,597,081	$1,553,199	$1,766,601	$3,067,375	$1,915,240
DRG Hospitals	Kaiser Westside Med Ctr	$0	$0	$1,621,825	$2,224,837	$1,339,194
DRG Hospitals	PeaceHealth Sacred Heart Hospitals	$669,084	$104,484	$672,912	$535,358	$1,338,865
DRG Hospitals	Providence Portland Med Center	$2,299,392	$1,211,274	$1,027,919	$1,903,122	$1,237,900
DRG Hospitals	Willamette Valley Med Ctr[p]	$52,366	$41,435	$1,002,308	$1,043,705	$1,059,052
DRG Hospitals	Good Samaritan Regional Med Ctr	$883,822	$1,130,573	$892,191	$950,508	$931,553
DRG Hospitals	Samaritan Albany Hospital	$674,712	$815,771	$870,749	$825,577	$931,289
DRG Hospitals	Legacy Emanuel Med Center	$595,216	$427,669	$597,980	$487,882	$551,076
DRG Hospitals	Salem Hospital	$785,650	$525,528	$536,752	$402,810	$496,551
DRG Hospitals	Tuality Healthcare	$433,402	$418,125	$0	$492,293	$496,519
DRG Hospitals	St Charles - Bend	$1,417,380	$732,568	$518,790	$402,864	$433,399
DRG Hospitals	Providence Medford Med Center	$176,131	$122,500	$213,505	$368,857	$385,117
DRG Hospitals	Legacy Good Samaritan Med Ctr	$462,716	$467,491	$291,316	$368,904	$381,941
DRG Hospitals	Bay Area Hospital	$201,352	$252,972	$156,097	$254,555	$296,050
DRG Hospitals	Providence Milwaukie Hospital	$285,400	$155,023	$139,974	$243,422	$272,644
DRG Hospitals	OHSU Hospital	$155,790	$401,859	$281,499	$221,336	$267,038
DRG Hospitals	Sky Lakes Med Center	$1,031	$79,084	$144,823	$144,823	$247,367
DRG Hospitals	Providence Willamette Falls	$90,030	$108,553	$126,944	$210,384	$204,550
DRG Hospitals	Mercy Med Center	$178,539	$140,851	$110,490	$113,579	$195,653
DRG Hospitals	Legacy Mt Hood Med Center	$93,835	$117,884	$0	$184,867	$186,102
DRG Hospitals	Legacy Meridian Park Med Center	$160,318	$130,569	$0	$172,807	$158,930
DRG Hospitals	Asante Rogue Med Center	$113,321	$68,902	$70,550	$154,682	$143,879
DRG Hospitals	Shriners	$0	$0	$16,400	$17,750	$118,631
DRG Hospitals	Adventist Med Center	$212,922	$99,695	$269,506	$232,686	$108,345
DRG Hospitals	Asante Three Rivers Med Center	$44,069	$19,292	$27,436	$55,161	$50,089
DRG Hospitals	McKenzie-Willamette Med Ctr[p]	$2,867	$26,625	$27,316	$7,386	$10,000
Type A Hospitals	St Anthony Hospitalϕ	$182,137	$467,791	$323,702	$299,363	$266,961
Type A Hospitals	St Alphonsus Med Ctr-Ontario	$127,062	$82,633	$42,514	$128,463	$254,477
Type A Hospitals	Good Shepherd Med Centerϕ	$277,000	$272,510	$291,745	$313,800	$252,500
Type A Hospitals	Tillamook County Gen Hospitalϕ	$270,306	$309,000	$99,172	$52,790	$49,383
Type A Hospitals	Grande Ronde Hospitalϕ	$37,841	$22,214	$8,131	$32,455	$24,049
Type A Hospitals	Lake District Hospital*ϕ	$25,984	$25,088	$17,028	$20,216	$21,845
Type A Hospitals	Harney District Hospital*ϕ	$38,722	$19,372	$20,075	$30,814	$21,665
Type A Hospitals	St Alphonsus Med Ctr-Baker Cityϕ	$33,396	$39,269	$6,017	$14,096	$17,209
Type A Hospitals	Curry General Hospital*ϕ	$18,073	$10,535	$2,100	$9,400	$4,850
Type A Hospitals	Pioneer Memorial Heppner*ϕ	$0	$0	$1,896	$2,712	$2,119
Type A Hospitals	Wallowa Memorial Hospital*ϕ	$12,559	$12,290	$2,044	$0	$0
Type A Hospitals	Blue Mountain Hospital*ϕ	$0	$0	$0	$0	$0
Type B Hospitals	Mid-Columbia Med Center	$611,649	$676,622	$632,371	$874,614	$1,012,666
Type B Hospitals	Samaritan Lebanon Hospitalϕ	$357,222	$384,021	$481,677	$343,577	$382,018
Type B Hospitals	St Charles - Redmond	$175,567	$178,434	$250,957	$194,463	$314,925
Type B Hospitals	Legacy Silverton Med Ctr	$209,953	$140,902	$159,272	$185,314	$218,532
Type B Hospitals	Providence Newberg Med Center	$188,923	$137,155	$153,737	$202,518	$198,868
Type B Hospitals	Providence Seaside Hospital*ϕ	$81,610	$49,819	$67,458	$131,537	$164,931
Type B Hospitals	Providence Hood River Hospitalϕ	$185,076	$211,421	$190,980	$235,883	$161,428
Type B Hospitals	Samaritan Pacific Comm Hospital*ϕ	$137,367	$97,834	$137,109	$104,993	$156,484
Type B Hospitals	Columbia Memorial Hospitalϕ	$110,162	$147,425	$208,759	$246,644	$96,482
Type B Hospitals	Samaritan North Lincoln Hospital*ϕ	$124,610	$104,201	$143,331	$72,176	$94,425
Type B Hospitals	St Charles - Madras*ϕ	$7,712	$4,755	$42,869	$77,409	$74,446
Type B Hospitals	Lower Umpqua Hospital*ϕ	$43,042	$44,027	$1,425	$49,102	$73,034
Type B Hospitals	Santiam Memorial Hospital	$4,147	$18,912	$33,069	$21,875	$38,853
Type B Hospitals	St Charles - Prinevilleϕ	$120,075	$101,032	$46,080	$57,349	$36,111
Type B Hospitals	West Valley Hospitalϕ	$37,090	$12,746	$30,461	$30,042	$28,467
Type B Hospitals	PeaceHealth Peace Harborϕ	$5,926	$12,104	$0	$9,000	$10,501
Type B Hospitals	Ashland Comm Hospital	$38,167	$28,938	$28,108	$11,032	$10,018
Type B Hospitals	PeaceHealth Cottage Groveϕ	$0	$2,132	$0	$6,350	$8,148
Type B Hospitals	Coquille Valley Hospital*ϕ	$7,730	$6,600	$3,814	$1,000	$1,900
Type B Hospitals	Southern Coos Hospital*ϕ	$0	$0	$0	$0	$0

Community Building Costs

Group	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	OHSU Hospital	$1,464,209	$1,654,667	$1,317,835	$1,303,714	$1,416,648
DRG Hospitals	Salem Hospital	$426,348	$337,885	$886,746	$1,288,187	$1,306,581
DRG Hospitals	Sky Lakes Med Center	$1,195,016	$1,083,177	$1,123,185	$1,060,286	$1,043,701
DRG Hospitals	Mercy Med Center	$1,057,452	$551,108	$682,960	$729,171	$481,419
DRG Hospitals	Legacy Emanuel Med Center	$170,051	$128,022	$353,117	$655,342	$472,902
DRG Hospitals	Legacy Good Samaritan Med Ctr	$250,033	$240,655	$124,365	$31,900	$392,775
DRG Hospitals	Good Samaritan Regional Med Ctr	$143,068	$283,447	$341,784	$293,894	$343,195
DRG Hospitals	Providence Portland Med Center	$295,985	$179,458	$220,966	$205,387	$282,698
DRG Hospitals	Providence St Vincent Med Ctr	$374,323	$215,127	$279,534	$239,216	$271,405
DRG Hospitals	PeaceHealth Sacred Heart Hospitals	$57,976	$0	$51,183	$0	$242,877
DRG Hospitals	Tuality Healthcare	$286,427	$128,333	$166,993	$209,669	$201,819
DRG Hospitals	Samaritan Albany Hospital	$63,727	$124,740	$159,710	$140,962	$156,144
DRG Hospitals	Asante Rogue Med Center	$73,636	$25,875	$27,070	$11,821	$148,415
DRG Hospitals	St Charles - Bend	$62,725	$21,808	$98,684	$127,752	$136,878
DRG Hospitals	Legacy Mt Hood Med Center	$46,866	$57,205	$57,138	$47,927	$99,906
DRG Hospitals	Legacy Meridian Park Med Center	$54,495	$50,925	$74,201	$10,849	$90,772
DRG Hospitals	Providence Medford Med Center	$44,488	$40,299	$37,359	$69,340	$56,752
DRG Hospitals	Providence Milwaukie Hospital	$23,528	$15,329	$42,139	$21,525	$41,128
DRG Hospitals	Adventist Med Center	$59,675	$42,506	$62,335	$36,403	$32,157
DRG Hospitals	Providence Willamette Falls	$14,747	$12,587	$17,045	$11,514	$31,688
DRG Hospitals	Asante Three Rivers Med Center	$9,207	$7,763	$0	$10,000	$29,000
DRG Hospitals	Shriners	$0	$0	$168,824	$145,748	$22,743
DRG Hospitals	McKenzie-Willamette Med Ctr[p]	$37,160	$49,460	$49,485	$40,000	$12,875
DRG Hospitals	Willamette Valley Med Ctr[p]	$0	$0	$0	$0	$0
DRG Hospitals	Kaiser Westside Med Ctr	$0	$0	$0	$0	$0
DRG Hospitals	Kaiser Sunnyside Med Center	$0	$0	$0	$0	$0
DRG Hospitals	Bay Area Hospital	$0	$0	$0	$0	$0
Type A Hospitals	Tillamook County Gen Hospitalϕ	$1,000	$1,000	$138,010	$2,320,130	$3,768,257
Type A Hospitals	Lake District Hospital*ϕ	$53,775	$71,680	$70,210	$104,385	$100,516
Type A Hospitals	St Anthony Hospitalϕ	$286,775	$144,388	$187,028	$107,224	$98,273
Type A Hospitals	Pioneer Memorial Heppner*ϕ	$4,032	$7,667	$7,187	$20,253	$34,863
Type A Hospitals	St Alphonsus Med Ctr-Ontario	$251,461	$305,798	$252,858	$20,553	$33,246
Type A Hospitals	Grande Ronde Hospitalϕ	$0	$0	$15,153	$13,067	$9,370
Type A Hospitals	Curry General Hospital*ϕ	$0	$0	$0	$2,472	$4,175
Type A Hospitals	Wallowa Memorial Hospital*ϕ	$277	$277	$11,924	$1,095	$82
Type A Hospitals	Blue Mountain Hospital*ϕ	$0	$0	$0	$0	$0
Type A Hospitals	Good Shepherd Med Centerϕ	$26,000	$0	$0	$0	$0
Type A Hospitals	Harney District Hospital*ϕ	$3,283	$0	$0	$0	$0
Type A Hospitals	St Alphonsus Med Ctr-Baker Cityϕ	$140,141	$49,915	$4,792	$277	$0
Type B Hospitals	Samaritan North Lincoln Hospital*ϕ	$403,076	$358,058	$419,979	$445,177	$494,595
Type B Hospitals	Providence Hood River Hospitalϕ	$250,507	$168,585	$217,314	$190,036	$265,522
Type B Hospitals	Mid-Columbia Med Center	$408,855	$439,180	$377,193	$423,538	$260,129
Type B Hospitals	Samaritan Lebanon Hospitalϕ	$44,351	$88,357	$92,605	$100,423	$93,063
Type B Hospitals	Samaritan Pacific Comm Hospital*ϕ	$167,231	$92,249	$136,315	$82,287	$79,891
Type B Hospitals	Legacy Silverton Med Ctr	$251,980	$218,722	$95,714	$53,847	$72,355
Type B Hospitals	Providence Newberg Med Center	$25,174	$9,937	$11,083	$9,236	$34,557
Type B Hospitals	West Valley Hospitalϕ	$0	$0	$21,630	$20,788	$30,344
Type B Hospitals	St Charles - Madras*ϕ	$2,404	$0	$14,875	$32,143	$27,761
Type B Hospitals	St Charles - Princevilleϕ	$14,891	$6,129	$57,568	$21,440	$23,742
Type B Hospitals	St Charles - Redmond	$6,916	$4,779	$7,436	$22,629	$22,664
Type B Hospitals	PeaceHealth Cottage Groveϕ	$0	$0	$0	$0	$12,500
Type B Hospitals	Ashland Comm Hospital	$6,285	$7,141	$28,108	$16,750	$9,400
Type B Hospitals	Providence Seaside Hospital*ϕ	$14,803	$4,834	$8,758	$10,437	$4,818
Type B Hospitals	PeaceHealth Peace Harborϕ	$0	$536	$0	$0	$0
Type B Hospitals	Columbia Memorial Hospitalϕ	$32,852	$52,997	$52,894	$63,418	$0
Type B Hospitals	Lower Umpqua Hospital*ϕ	$0	$0	$0	$0	$0
Type B Hospitals	Santiam Memorial Hospital	$0	$0	$0	$0	$0
Type B Hospitals	Coquille Valley Hospital*ϕ	$0	$2,915	$6,150	$0	$0
Type B Hospitals	Southern Coos Hospital*ϕ	$0	$0	$0	$0	$0

Community Benefit Operations Costs

	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	Asante Rogue Med Center	$256,956	$90,775	$499,139	$2,579,217	$2,131,966
	Kaiser Sunnyside Med Center	$1,095,557	$1,156,786	$1,467,474	$1,610,078	$1,791,266
	Asante Three Rivers Med Center	$99,927	$27,232	$194,110	$921,149	$761,416
	Kaiser Westside Med Ctr	$0	$0	$192,564	$595,508	$662,523
	Providence St Vincent Med Ctr	$150,541	$151,167	$167,804	$457,199	$426,962
	Providence Portland Med Center	$120,775	$105,282	$115,875	$338,916	$383,583
	Salem Hospital	$279,293	$294,198	$149,323	$338,680	$205,681
	Bay Area Hospital	$0	$0	$291,715	$311,630	$193,670
	St Charles - Bend	$103,761	$212,332	$226,927	$422,941	$172,081
	Good Samaritan Regional Med Ctr	$158,359	$112,718	$103,525	$106,835	$130,193
	Providence Medford Med Center	$12,203	$11,379	$20,545	$59,092	$117,946
	Adventist Med Center	$73,246	$59,897	$138,271	$87,190	$85,637
	Providence Willamette Falls	$7,214	$9,214	$12,939	$38,004	$63,573
	Samaritan Albany Hospital	$65,843	$46,418	$47,314	$50,301	$61,194
	Providence Milwaukie Hospital	$15,035	$16,175	$20,571	$48,293	$59,517
	Sky Lakes Med Center	$100	$19,561	$23,475	$24,649	$21,557
	Shriners	$0	$0	$27,866	$0	$20,991
	PeaceHealth Sacred Heart Hospitals	$0	$0	$312,843	$300,221	$5,807
	Tuality Healthcare	$656	$822	$1,899	$2,006	$1,974
	Legacy Good Samaritan Med Ctr	$0	$0	$0	$0	$0
	Legacy Mt Hood Med Center	$0	$0	$107,396	$0	$0
	Legacy Meridian Park Med Center	$0	$0	$177,708	$0	$0
	Legacy Emanuel Med Center	$0	$0	$0	$0	$0
	McKenzie-Willamette Med Ctr[p]	$0	$0	$0	$0	$0
	Willamette Valley Med Ctr[p]	$0	$0	$0	$0	$0
	Mercy Med Center	$0	$0	$0	$0	$0
	OHSU Hospital	$71,500	$71,500	$8,845	$9,588	$0
Type A Hospitals	Good Shepherd Med Centerϕ	$50,642	$55,295	$64,423	$323,620	$219,256
	Lake District Hospital*ϕ	$8,112	$31,925	$9,654	$7,596	$74,560
	Grande Ronde Hospitalϕ	$37,426	$33,456	$143,328	$28,922	$40,588
	St Anthony Hospitalϕ	$4,099	$76,089	$7,533	$5,227	$6,107
	Pioneer Memorial Heppner*ϕ	$8,987	$3,103	$3,419	$1,892	$3,434
	St Alphonsus Med Ctr-Ontario	$0	$0	$0	$0	$791
	Harney District Hospital*ϕ	$2,306	$0	$5,210	$0	$0
	Wallowa Memorial Hospital*ϕ	$1,705	$1,269	$0	$0	$0
	Tillamook County Gen Hospitalϕ	$0	$0	$0	$0	$0
	St Alphonsus Med Ctr-Baker Cityϕ	$226	$0	$0	$2,520	$0
	Curry General Hospital*ϕ	$0	$0	$6,384	$0	$0
	Blue Mountain Hospital*ϕ	$0	$0	$0	$0	$0
Type B Hospitals	Providence Newberg Med Center	$211,498	$243,527	$304,075	$178,149	$228,253
	Providence Hood River Hospitalϕ	$74,482	$138,378	$61,708	$133,151	$194,139
	Columbia Memorial Hospitalϕ	$39,540	$60,103	$64,537	$147,259	$161,742
	Ashland Comm Hospital	$7,636	$3,612	$3,612	$184,230	$152,283
	Providence Seaside Hospital*ϕ	$9,796	$6,665	$11,479	$30,866	$49,074
	St Charles - Madras*ϕ	$0	$2,141	$80,091	$72,104	$38,607
	Samaritan Lebanon Hospitalϕ	$137,946	$27,350	$26,275	$31,383	$36,518
	St Charles - Prinevilleϕ	$123,095	$28,249	$126,252	$68,011	$30,754
	Samaritan Pacific Comm Hospital*ϕ	$30,984	$15,234	$21,878	$20,032	$28,451
	St Charles - Redmond	$14,234	$42,041	$40,030	$74,199	$28,037
	Legacy Silverton Med Ctr	$13,961	$35,027	$6,937	$21,932	$27,118
	Samaritan North Lincoln Hospital*ϕ	$21,604	$11,196	$12,876	$14,022	$17,751
	PeaceHealth Peace Harborϕ	$819	$0	$0	$0	$12,500
	Mid-Columbia Med Center	$0	$0	$67,123	$77,190	$12,108
	Lower Umpqua Hospital*ϕ	$0	$0	$0	$0	$0
	Santiam Memorial Hospital	$0	$0	$0	$5,704	$0
	Coquille Valley Hospital*ϕ	$0	$0	$0	$0	$0
	West Valley Hospitalϕ	$0	$0	$0	$0	$0
	PeaceHealth Cottage Groveϕ	$0	$0	$0	$0	$0
	Southern Coos Hospital*ϕ	$0	$0	$0	$0	$0

Medicare and Medicaid Proportion of Total Community Benefit Cost

Group	Hospital Name	2011	2012	2013	2014	2015
DRG Hospitals	PeaceHealth Sacred Heart Hospitals	61.7%	80.1%	78.8%	83.1%	93.9%
DRG Hospitals	Bay Area Hospital	81.9%	82.4%	79.6%	90.7%	92.1%
DRG Hospitals	St Charles - Bend	83.8%	83.7%	74.8%	88.3%	88.3%
DRG Hospitals	Legacy Meridian Park Med Center	55.1%	64.6%	71.3%	75.8%	87.9%
DRG Hospitals	Asante Three Rivers Med Center	56.2%	62.4%	66.7%	78.2%	86.1%
DRG Hospitals	Providence Medford Med Center	64.7%	67.2%	70.2%	85.1%	85.6%
DRG Hospitals	Providence Willamette Falls	76.3%	73.1%	63.7%	86.2%	85.3%
DRG Hospitals	Asante Rogue Med Center	66.2%	65.7%	74.8%	79.0%	84.2%
DRG Hospitals	Legacy Emanuel Med Center	52.3%	66.1%	70.6%	69.7%	82.3%
DRG Hospitals	Adventist Med Center	59.0%	56.7%	57.5%	72.6%	81.9%
DRG Hospitals	Tuality Healthcare	78.5%	80.1%	78.2%	81.2%	81.5%
DRG Hospitals	Samaritan Albany Hospital	69.4%	70.7%	72.7%	77.0%	78.7%
DRG Hospitals	Providence St Vincent Med Ctr	58.7%	60.4%	63.2%	72.9%	78.1%
DRG Hospitals	Mercy Med Center	72.0%	36.7%	37.9%	53.6%	77.9%
DRG Hospitals	Salem Hospital	60.1%	61.4%	57.1%	74.2%	76.7%
DRG Hospitals	Willamette Valley Med Ctr[p]	92.5%	81.0%	71.1%	77.4%	72.8%
DRG Hospitals	Providence Portland Med Center	56.6%	60.7%	59.0%	69.8%	72.4%
DRG Hospitals	Legacy Good Samaritan Med Ctr	50.3%	56.6%	61.7%	66.9%	71.9%
DRG Hospitals	Legacy Mt Hood Med Center	26.3%	32.6%	53.5%	48.2%	71.5%
DRG Hospitals	Good Samaritan Regional Med Ctr	64.2%	63.8%	65.3%	75.4%	70.7%
DRG Hospitals	Shriners	NA	NA	24.1%	31.4%	65.7%
DRG Hospitals	Sky Lakes Med Center	56.1%	41.9%	49.1%	67.6%	58.3%
DRG Hospitals	Providence Milwaukie Hospital	14.2%	25.9%	32.0%	53.0%	57.7%
DRG Hospitals	OHSU Hospital	24.6%	26.5%	33.3%	35.0%	40.4%
DRG Hospitals	Kaiser Sunnyside Med Center	27.5%	29.9%	30.4%	37.4%	39.4%
DRG Hospitals	Kaiser Westside Med Ctr	NA	NA	19.4%	34.0%	32.5%
DRG Hospitals	McKenzie-Willamette Med Ctr[p]	79.4%	83.4%	69.5%	93.3%	0.0%
Type A Hospitals	Blue Mountain Hospital*ϕ	66.4%	70.0%	79.1%	86.3%	95.0%
Type A Hospitals	Pioneer Memorial Heppner*ϕ	76.5%	65.2%	86.3%	77.2%	85.9%
Type A Hospitals	Curry General Hospital*ϕ	83.6%	92.9%	76.4%	59.6%	82.2%
Type A Hospitals	Harney District Hospital*ϕ	0.0%	0.0%	73.3%	72.2%	80.7%
Type A Hospitals	St Alphonsus Med Ctr-Baker Cityϕ	17.9%	0.0%	28.7%	75.1%	79.6%
Type A Hospitals	Wallowa Memorial Hospital*ϕ	78.8%	77.8%	75.9%	88.7%	76.5%
Type A Hospitals	Lake District Hospital*ϕ	55.3%	47.1%	57.4%	83.0%	75.1%
Type A Hospitals	St Alphonsus Med Ctr-Ontario	59.0%	64.9%	66.2%	63.8%	74.0%
Type A Hospitals	St Anthony Hospitalϕ	13.5%	20.5%	1.8%	21.2%	54.7%
Type A Hospitals	Grande Ronde Hospitalϕ	15.5%	24.0%	13.6%	22.2%	44.6%
Type A Hospitals	Tillamook County Gen Hospitalϕ	34.3%	8.8%	30.0%	51.5%	37.4%
Type A Hospitals	Good Shepherd Med Centerϕ	0.0%	0.0%	10.5%	6.4%	0.0%
Type B Hospitals	Coquille Valley Hospital*ϕ	80.0%	88.1%	81.4%	95.9%	97.7%
Type B Hospitals	Southern Coos Hospital*ϕ	0.0%	0.0%	0.0%	78.3%	96.8%
Type B Hospitals	Columbia Memorial Hospitalϕ	82.7%	88.1%	89.8%	90.3%	91.9%
Type B Hospitals	Ashland Comm Hospital	74.9%	68.1%	80.2%	91.1%	88.8%
Type B Hospitals	Santiam Memorial Hospital	70.1%	79.5%	83.1%	86.4%	86.8%
Type B Hospitals	St Charles - Madras*ϕ	72.0%	67.2%	49.6%	68.3%	79.2%
Type B Hospitals	PeaceHealth Peace Harborϕ	0.0%	0.0%	37.2%	0.0%	74.9%
Type B Hospitals	Providence Hood River Hospitalϕ	42.8%	41.7%	57.1%	73.1%	74.5%
Type B Hospitals	Providence Newberg Med Center	63.3%	59.3%	57.8%	71.3%	71.0%
Type B Hospitals	St Charles - Prinevilleϕ	64.4%	68.9%	58.4%	81.6%	70.6%
Type B Hospitals	Legacy Silverton Med Ctr	45.2%	58.7%	69.7%	66.4%	70.4%
Type B Hospitals	St Charles - Redmond	76.8%	70.4%	46.3%	72.1%	66.9%
Type B Hospitals	Providence Seaside Hospital*ϕ	36.6%	26.4%	36.6%	57.3%	61.5%
Type B Hospitals	Mid-Columbia Med Center	42.7%	39.6%	41.4%	56.7%	57.7%
Type B Hospitals	Lower Umpqua Hospital*ϕ	86.2%	89.2%	44.6%	50.9%	57.3%
Type B Hospitals	West Valley Hospitalϕ	35.0%	32.5%	27.7%	45.6%	56.3%
Type B Hospitals	Samaritan Lebanon Hospitalϕ	32.4%	41.2%	54.5%	59.9%	52.9%
Type B Hospitals	Samaritan Pacific Comm Hospital*ϕ	42.1%	31.7%	15.8%	46.2%	47.0%
Type B Hospitals	Samaritan North Lincoln Hospital*ϕ	17.7%	36.1%	21.3%	43.9%	34.0%
Type B Hospitals	PeaceHealth Cottage Groveϕ	70.6%	80.3%	25.8%	0.0%	0.0%

House Bill 2115

Sponsored by Representative GREENLICK; Representative NOSSE (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Specifies requirements for property of nonprofit hospitals and nonprofit health systems to be exempt from taxation.

Takes effect on 91st day following adjournment sine die.

1 **A BILL FOR AN ACT**

2 Relating to the provision of community benefits by health services providers; creating new pro-
3 visions; amending ORS 305.842, 307.112, 307.130, 307.162, 442.200, 442.205 and 442.991; and pre-
4 scribing an effective date.

5 **Be It Enacted by the People of the State of Oregon:**

6 **SECTION 1. (1) As used in this section:**

7 **(a) "Health services" has the meaning given that term in ORS 442.015.**

8 **(b) "Health system" means a corporate entity that owns or operates at least one hospital**
9 **licensed by the Oregon Health Authority under ORS chapter 441.**

10 **(c) "Hospital" has the meaning given that term in ORS 442.015.**

11 **(d) "Nonprofit" means a corporation that:**

12 **(A) Is organized not for profit, pursuant to ORS chapter 65 or any predecessor of ORS**
13 **chapter 65; or**

14 **(B) Is organized and operated as described under section 501(c) of the Internal Revenue**
15 **Code as defined in ORS 305.842.**

16 **(2) Upon compliance with ORS 307.162, all real or personal property owned or being pur-**
17 **chased by a nonprofit hospital or a nonprofit health system shall be exempt from property**
18 **taxation if:**

19 **(a) The real or personal property is occupied or used to provide:**

20 **(A) Health services; or**

21 **(B) Administrative services necessary to provide the health services; and**

22 **(b)(A) The Oregon Health Authority has issued to the hospital or health system a certi-**
23 **fication under ORS 442.205; or**

24 **(B) The hospital is:**

25 **(i) A type A hospital, as described in ORS 442.470; or**

26 **(ii) A rural critical access hospital, as defined in ORS 315.613.**

27 **SECTION 2.** ORS 442.200 is amended to read:

28 442.200. As used in this section and ORS 442.205:

29 (1) "Charity care" means free or discounted health services provided to persons who cannot af-
30 ford to pay and from whom a hospital **or health system** has no expectation of payment. "Charity
31 care" does not include bad debt, contractual allowances or discounts for quick payment.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(2) "Community benefit" means a program or activity that provides treatment or promotes health and healing in response to an identified community need. "Community benefit" includes:

(a) Charity care;

[*(b) Losses related to Medicaid, Medicare, State Children's Health Insurance Program or other publicly funded health care program shortfalls;*]

[*(c)*] **(b)** Community health improvement services;

[*(d)*] **(c)** Research;

[*(e)*] **(d)** Financial and in-kind contributions to the community; and

[*(f)*] **(e)** Community building activities affecting health in the community.

(3) "Gross receipts" means total Oregon sales as determined under ORS 314.665.

(4) "Health system" means a corporate entity that owns or operates at least one hospital licensed by the Oregon Health Authority under ORS chapter 441.

(5) "Hospital" does not include type A hospitals, as described in ORS 442.470, or rural critical access hospitals, as defined in ORS 315.613.

SECTION 3. ORS 442.205 is amended to read:

442.205. (1) The Oregon Health Authority shall [*by rule*] adopt a cost-based community benefit reporting system for hospitals **and health systems** operating in Oregon that is consistent with established national standards for hospital reporting of community benefits.

(2) Within 90 days of filing a Medicare cost report, a hospital **or health system** must submit **to the authority, in the form and manner prescribed by the authority,** a [*community benefit report to the authority of*] **report and supporting documentation regarding** the community benefits provided by the hospital[*, on a form prescribed by the authority.*] **or health system. The report must include, for the tax year immediately preceding the report:**

(a) The gross receipts of the hospital or health system;

(b) A description of the community benefits provided by the hospital or health system; and

(c) The expenditures of the hospital or health system on the reported community benefits.

(3) The authority shall establish a procedure for a hospital or health system to obtain a written certification that the hospital or health system had:

(a) Total expenditures for community benefits in an amount greater than or equal to five percent of the gross receipts of the hospital or health system; or

(b) Good cause, according to criteria adopted by the authority by rule, for spending on community benefits an amount that was less than five percent of the gross receipts of the hospital or health system.

[*(3) The authority shall produce an annual report of the information provided under subsections (1) and (2) of this section. The report shall be submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives. The report shall be presented to the Legislative Assembly during each odd-numbered year regular session and shall be made available to the public.*]

(4) The authority [*may*] **shall** adopt all rules necessary to carry out the provisions of this section.

SECTION 4. ORS 442.991 is amended to read:

442.991. (1) Any reporting entity that fails to report as required by rules of the Oregon Health Authority adopted pursuant to ORS **442.205 and** 442.362 may be subject to a civil penalty.

(2) The authority shall adopt a schedule of penalties, not to exceed $500 per day of violation,

1 that are based on the severity of the violation.
2 (3) Civil penalties imposed under this section shall be imposed as provided in ORS 183.745.
3 (4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and
4 conditions as the authority considers proper and consistent with the public health and safety.
5 (5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose
6 of rate determination or for reimbursement by a third-party payer.
7 **SECTION 5.** ORS 307.162 is amended to read:
8 307.162. (1)(a) Before any real or personal property may be exempted from taxation under ORS
9 307.092, 307.110 (3)(h), 307.115, 307.118, 307.130 to 307.140, 307.145, 307.147, 307.150, 307.160, 307.181
10 (3), 307.513 or 307.580 **or section 1 of this 2017 Act** for any tax year, the institution or organization
11 entitled to claim the exemption must file a claim with the county assessor, on or before April 1
12 preceding the tax year for which the exemption is claimed. The claim must contain statements,
13 verified by the oath or affirmation of the president or other proper officer of the institution or or-
14 ganization, that:
15 (A) List all real property claimed to be exempt and show the purpose for which the real property
16 is used; and
17 (B) Cite the statutes under which exemption for personal property is claimed.
18 (b) If the ownership of all property, other than property described in ORS 307.110 (3)(h) **or**
19 **section 1 of this 2017 Act**, included in the claim filed with the county assessor for a prior year
20 remains unchanged, a new claim is not required.
21 (c) When the property designated in the claim for exemption is acquired after March 1 and be-
22 fore July 1, the claim for that year must be filed within 30 days from the date of acquisition of the
23 property.
24 (2)(a) Notwithstanding subsection (1) of this section, a claim may be filed under this section for
25 the current tax year:
26 (A) On or before December 31 of the tax year, if the claim is accompanied by a late filing fee
27 of the greater of $200, or one-tenth of one percent of the real market value as of the most recent
28 assessment date of the property to which the claim pertains.
29 (B) On or before April 1 of the tax year, if the claim is accompanied by a late filing fee of $200
30 and the claimant demonstrates good and sufficient cause for failing to file a timely claim, is a
31 first-time filer or is a public entity described in ORS 307.090.
32 (b)(A) Notwithstanding subsection (1) of this section, a claimant that demonstrates good and
33 sufficient cause for failing to file a timely claim, is a first-time filer or is a public entity described
34 in ORS 307.090 may file a claim under this section for the five tax years prior to the current tax
35 year:
36 (i) Within 60 days after the date on which the county assessor mails notice of additional taxes
37 owing under ORS 311.206 for the property to which the claim filed under this subparagraph pertains;
38 or
39 (ii) At any time if no notice is mailed.
40 (B) A claim filed under this paragraph must be accompanied by a late filing fee of the greater
41 of $200, or one-tenth of one percent of the real market value as of the most recent assessment date
42 of the property to which the claim pertains, multiplied by the number of prior tax years for which
43 exemption is claimed.
44 (c) If a claim filed under this subsection is not accompanied by the late filing fee or if the late
45 filing fee is not otherwise paid, an exemption may not be allowed for the tax years sought by the

1 claim. A claim may be filed under this subsection notwithstanding that there are no grounds for
2 hardship as required for late filing under ORS 307.475.
3 (d) The value of the property used to determine the late filing fee under this subsection and the
4 determination of the county assessor relative to a claim of good and sufficient cause are appealable
5 in the same manner as other acts of the county assessor.
6 (e) A late filing fee collected under this subsection must be deposited in the county general fund.
7 (3)(a) In a claim for exemption of property described in ORS 307.110 (3)(h), the county or city,
8 town or other municipal corporation or political subdivision of this state that is filing the claim must
9 substantiate that the property is used for affordable housing or that it is leased or rented to persons
10 of lower income, as applicable.
11 (b) A claim filed under this subsection must be filed annually on a form prescribed by the De-
12 partment of Revenue.
13 **(4) In a claim for exemption of property described in section 1 of this 2017 Act, the hos-**
14 **pital, other than a hospital described in section 1 (2)(b)(B) of this 2017 Act, or health system**
15 **that is filing the claim must include with the filing a certification issued by the Oregon**
16 **Health Authority under ORS 442.205.**
17 [*(4)*] **(5)** As used in this section:
18 (a) "First-time filer" means a claimant that:
19 (A) Has never filed a claim for the property that is the subject of the current claim; and
20 (B) Did not receive notice from the county assessor on or before December 1 of the tax year for
21 which exemption is claimed regarding the potential property tax liability of the property.
22 (b)(A) "Good and sufficient cause" means an extraordinary circumstance beyond the control of
23 the taxpayer or the taxpayer's agent or representative that causes the failure to file a timely claim.
24 (B) "Good and sufficient cause" does not include hardship, reliance on misleading information
25 unless the information is provided by an authorized tax official in the course of the official's duties,
26 lack of knowledge, oversight or inadvertence.
27 (c) "Ownership" means legal and equitable title.
28 [*(5)(a)*] **(6)(a)** Notwithstanding subsection (1) of this section, if an institution or organization
29 owns property that is exempt from taxation under a provision of law listed in subsection (1) of this
30 section and fails to file a timely claim for exemption under subsection (1) of this section for additions
31 or improvements to the exempt property, the additions or improvements may nevertheless qualify for
32 exemption.
33 (b) The organization must file a claim for exemption with the county assessor to have the addi-
34 tions or improvements to the exempt property be exempt from taxation. The claim must:
35 (A) Describe the additions or improvements to the exempt property;
36 (B) Describe the current use of the property that is the subject of the application;
37 (C) Identify the tax year and any preceding tax years for which the exemption is sought;
38 (D) Contain any other information required by the department; and
39 (E) Be accompanied by a late filing fee equal to the product of the number of tax years for
40 which exemption is sought multiplied by the greater of $200 or one-tenth of one percent of the real
41 market value as of the most recent assessment date of the property that is the subject of the claim.
42 (c) Upon the county assessor's receipt of a completed claim and late filing fee, the assessor shall
43 determine for each tax year for which exemption is sought whether the additions or improvements
44 that are the subject of the claim would have qualified for exemption had a timely claim been filed
45 under subsection (1) of this section. Any property that would have qualified for exemption had a

timely claim been filed under subsection (1) of this section is exempt from taxation for each tax year for which the property would have qualified.

(d) A claim for exemption under this subsection may be filed only for tax years for which the time for filing a claim under subsections (1) and (2)(a) of this section has expired. A claim filed under this subsection, however, may serve as the claim required under subsection (1) of this section for the current tax year.

(e) A late filing fee collected under this subsection must be deposited in the county general fund.

[*(6)*] **(7)** For each tax year for which an exemption granted pursuant to subsection (2) or [*(5)*] **(6)** of this section applies:

(a) Any tax, or interest attributable thereto, that was paid with respect to the property that is declared exempt from taxation must be refunded. Refunds must be made without interest from the unsegregated tax collections account established under ORS 311.385.

(b) Any tax, or interest attributable thereto, that remains unpaid as of the date the exemption is granted must be abated.

[*(7)*] **(8)** If an institution or organization owns property that is exempt from taxation under a provision of law listed in subsection (1) of this section and changes the use of the property to a use that would not entitle the property to exemption from taxation, the institution or organization must notify the county assessor of the change to a taxable use within 30 days.

SECTION 6. ORS 307.112 is amended to read:

307.112. (1) Real or personal property of a taxable owner held under lease, sublease or lease-purchase agreement by an institution, organization or public body, other than the State of Oregon, or a public university listed in ORS 352.002, granted exemption or the right to claim exemption for any of its property under ORS 307.090, 307.130, 307.136, 307.140, 307.145, 307.147 or 307.181 (3) **or section 1 of this 2017 Act**, is exempt from taxation if:

(a) The property is used by the lessee or, if the lessee is not in possession of the property, by the entity in possession of the property, in the manner, if any, required by law for the exemption of property owned, leased, subleased or being purchased by it; and

(b) It is expressly agreed within the lease, sublease or lease-purchase agreement that the rent payable by the institution, organization or public body has been established to reflect the savings below market rent resulting from the exemption from taxation.

(2) To obtain the exemption under this section, the lessee or, if the lessee is not in possession of the property, the entity in possession of the property, must file a claim for exemption with the county assessor, verified by the oath or affirmation of the president or other proper officer of the institution or organization, or head official of the public body or legally authorized delegate, showing:

(a) A complete description of the property for which exemption is claimed.

(b) If applicable, all facts relating to the use of the property by the lessee or, if the lessee is not in possession of the property, by the entity in possession of the property.

(c) A true copy of the lease, sublease or lease-purchase agreement covering the property for which exemption is claimed.

(d) Any other information required by the claim form.

(3) If the assessor is not satisfied that the rent stated in the lease, sublease or lease-purchase agreement has been established to reflect the savings below market rent resulting from the tax exemption, before the exemption may be granted the lessor must provide documentary proof, as specified by rule of the Department of Revenue, that the rent has been established to reflect the savings

1 below market rent resulting from the tax exemption.
2 (4)(a) The claim must be filed on or before April 1 preceding the tax year for which the ex-
3 emption is claimed, except:
4 (A) If the lease, sublease or lease-purchase agreement is entered into after March 1 but not later
5 than June 30, the claim must be filed within 30 days after the date the lease, sublease or lease-
6 purchase agreement is entered into if exemption is claimed for that year; or
7 (B) If a late filing fee is paid in the manner provided in ORS 307.162 (2), the claim may be filed
8 within the time specified in ORS 307.162 (2).
9 (b) The exemption first applies for the tax year beginning July 1 of the year for which the claim
10 is filed.
11 (5)(a) An exemption granted under this section continues as long as the use of the property re-
12 mains unchanged and during the period of the lease, sublease or lease-purchase agreement.
13 (b) If the use changes, a new claim must be filed as provided in this section.
14 (c) If the use changes due to sublease of the property or any portion of the property from the
15 tax exempt entity described in subsection (1) of this section to another tax exempt entity, the entity
16 in possession of the property must file a new claim for exemption as provided in this section.
17 (d) If the lease, sublease or lease-purchase agreement expires before July 1 of any year, the ex-
18 emption terminates as of January 1 of the same calendar year.
19 **SECTION 7.** ORS 307.130 is amended to read:
20 307.130. (1) As used in this section:
21 (a) "Art museum" means a nonprofit corporation organized to display works of art to the public.
22 (b) "History museum or science museum" means a nonprofit corporation organized to display
23 historical or scientific exhibits, or both, to the public.
24 (c) "Nonprofit corporation" means a corporation that:
25 (A) Is organized not for profit, pursuant to ORS chapter 65 or any predecessor of ORS chapter
26 65; or
27 (B) Is organized and operated as described under section 501(c) of the Internal Revenue Code
28 as defined in ORS 305.842.
29 **(d) "Rehabilitation facility" means a facility defined in ORS 344.710 or a facility that**
30 **provides individuals who have physical, mental or emotional disabilities with occupational**
31 **rehabilitation activities of an educational or therapeutic nature, even if remuneration is re-**
32 **ceived by the individual.**
33 [*(d)*] **(e)** "Volunteer fire department" means a nonprofit corporation organized to provide fire
34 protection services in a specific response area.
35 **(f) "Welfare program" means a program to provide food, shelter, clothing or health care,**
36 **including dental service, to needy persons without charge.**
37 (2) Upon compliance with ORS 307.162, the following property owned or being purchased by art
38 museums, volunteer fire departments, or incorporated literary, benevolent, charitable and scientific
39 institutions shall be exempt from taxation:
40 (a) Except as provided in ORS 748.414, only [*such*] real or personal property, or **a** proportion
41 [*thereof, as*] **of the property, that** is actually and exclusively occupied or used in the literary, be-
42 nevolent, charitable or scientific work carried on by such institutions.
43 (b) Parking lots used for parking or any other use as long as that parking or other use is per-
44 mitted without charge for no fewer than 355 days during the tax year.
45 (c) All real or personal property of a rehabilitation facility or any retail outlet [*thereof*] **of the**

facility, including inventory. [*As used in this subsection, "rehabilitation facility" means either those facilities defined in ORS 344.710 or facilities which provide individuals who have physical, mental or emotional disabilities with occupational rehabilitation activities of an educational or therapeutic nature, even if remuneration is received by the individual.*]

(d) All real and personal property of a retail store dealing exclusively in donated inventory, [*where*] **if** the inventory is distributed without cost as part of a welfare program or where the proceeds of the sale of any inventory sold to the general public are used to support a welfare program. [*As used in this subsection, "welfare program" means the providing of food, shelter, clothing or health care, including dental service, to needy persons without charge.*]

(e) All real and personal property of a retail store if:

(A) The retail store deals [*primarily and*] on a regular basis in **inventory at least one-half of which is** donated and consigned [*inventory*];

(B) The individuals who operate the retail store are all individuals who work as volunteers; and

(C) The inventory is either distributed without charge as part of a welfare program, or sold to the general public and the sales proceeds used exclusively to support a welfare program. [*As used in this paragraph, "primarily" means at least one-half of the inventory.*]

(f) The real and personal property of an art museum that is used in conjunction with the public display of works of art or used to educate the public about art, but not including any portion of the art museum's real or personal property that is used to sell, or hold out for sale, works of art, reproductions of works of art or other items to be sold to the public.

(g) All real and personal property of a volunteer fire department that is used in conjunction with services and activities for providing fire protection to all residents within a fire response area.

(h) All real and personal property, including inventory, of a retail store owned by a nonprofit corporation if:

(A) The retail store deals exclusively in donated inventory; and

(B) Proceeds of the retail store sales are used to support a not-for-profit housing program whose purpose is to:

(i) Acquire property and construct housing for resale to individuals at or below the cost of acquisition and construction; and

(ii) Provide loans bearing no interest to individuals purchasing housing through the program.

(3)(a) Upon compliance with ORS 307.162, real and personal property owned or leased by a history museum or science museum shall be exempt from property taxes if the property:

(A) Is used to fulfill the mission of the museum as provided in the articles of incorporation and bylaws of the museum; and

(B) Is used or occupied for one or more of the following purposes:

(i) As a food service facility or concession stand selling food and refreshments to museum visitors, volunteers or staff within the museum buildings or on museum grounds.

(ii) As a retail store selling inventory, at least 90 percent of which is museum-related, within the museum buildings or on museum grounds.

(iii) As a parking lot, the use of which is permitted without charge for not fewer than 355 days during the property tax year, for museum visitors, volunteers or staff employed by the museum.

(iv) As a theater located in a museum building showing entertainment or educational features, at least 75 percent of which are museum-related.

(v) As unimproved land that is not specially assessed and that is contiguous with the land on which the museum is situated.

1 (vi) For displays, storage areas, educational classrooms or meeting areas.
2 (b) The exemption granted under this subsection does not apply to property used or occupied
3 as a hotel, water park or chapel or for any commercial enterprise.
4 (4) An art museum or institution shall not be deprived of an exemption under this section solely
5 because its primary source of funding is from one or more governmental entities.
6 (5) An institution shall not be deprived of an exemption under this section because its purpose
7 or the use of its property is not limited to relieving pain, alleviating disease or removing constraints.
8 **(6) This section does not apply to a hospital or health system that is eligible for ex-**
9 **emption from taxation under section 1 of this 2017 Act.**
10 **SECTION 8.** ORS 307.130, as amended by section 48, chapter 701, Oregon Laws 2015, is
11 amended to read:
12 307.130. (1) As used in this section:
13 (a) "Art museum" means a nonprofit corporation organized to display works of art to the public.
14 (b) "Nonprofit corporation" means a corporation that:
15 (A) Is organized not for profit, pursuant to ORS chapter 65 or any predecessor of ORS chapter
16 65; or
17 (B) Is organized and operated as described under section 501(c) of the Internal Revenue Code
18 as defined in ORS 305.842.
19 **(c) "Rehabilitation facility" means a facility defined in ORS 344.710 or a facility that**
20 **provides individuals who have physical, mental or emotional disabilities with occupational**
21 **rehabilitation activities of an educational or therapeutic nature, even if remuneration is re-**
22 **ceived by the individual.**
23 [*(c)*] **(d)** "Volunteer fire department" means a nonprofit corporation organized to provide fire
24 protection services in a specific response area.
25 **(e) "Welfare program" means a program to provide food, shelter, clothing or health care,**
26 **including dental service, to needy persons without charge.**
27 (2) Upon compliance with ORS 307.162, the following property owned or being purchased by art
28 museums, volunteer fire departments, or incorporated literary, benevolent, charitable and scientific
29 institutions shall be exempt from taxation:
30 (a) Except as provided in ORS 748.414, only [*such*] real or personal property, or **a** proportion
31 [*thereof, as*] **of the property, that** is actually and exclusively occupied or used in the literary, be-
32 nevolent, charitable or scientific work carried on by such institutions.
33 (b) Parking lots used for parking or any other use as long as that parking or other use is per-
34 mitted without charge for no fewer than 355 days during the tax year.
35 (c) All real or personal property of a rehabilitation facility or any retail outlet [*thereof*] **of the**
36 **facility**, including inventory. [*As used in this subsection, "rehabilitation facility" means either those*
37 *facilities defined in ORS 344.710 or facilities which provide individuals who have physical, mental or*
38 *emotional disabilities with occupational rehabilitation activities of an educational or therapeutic nature,*
39 *even if remuneration is received by the individual.*]
40 (d) All real and personal property of a retail store dealing exclusively in donated inventory,
41 [*where*] **if** the inventory is distributed without cost as part of a welfare program or where the pro-
42 ceeds of the sale of any inventory sold to the general public are used to support a welfare program.
43 [*As used in this subsection, "welfare program" means the providing of food, shelter, clothing or health*
44 *care, including dental service, to needy persons without charge.*]
45 (e) All real and personal property of a retail store if:

(A) The retail store deals [*primarily and*] on a regular basis in **inventory at least one-half of which is** donated and consigned [*inventory*];

(B) The individuals who operate the retail store are all individuals who work as volunteers; and

(C) The inventory is either distributed without charge as part of a welfare program, or sold to the general public and the sales proceeds used exclusively to support a welfare program. [*As used in this paragraph, "primarily" means at least one-half of the inventory.*]

(f) The real and personal property of an art museum that is used in conjunction with the public display of works of art or used to educate the public about art, but not including any portion of the art museum's real or personal property that is used to sell, or hold out for sale, works of art, reproductions of works of art or other items to be sold to the public.

(g) All real and personal property of a volunteer fire department that is used in conjunction with services and activities for providing fire protection to all residents within a fire response area.

(h) All real and personal property, including inventory, of a retail store owned by a nonprofit corporation if:

(A) The retail store deals exclusively in donated inventory; and

(B) Proceeds of the retail store sales are used to support a not-for-profit housing program whose purpose is to:

(i) Acquire property and construct housing for resale to individuals at or below the cost of acquisition and construction; and

(ii) Provide loans bearing no interest to individuals purchasing housing through the program.

(3) An art museum or institution shall not be deprived of an exemption under this section solely because its primary source of funding is from one or more governmental entities.

(4) An institution shall not be deprived of an exemption under this section because its purpose or the use of its property is not limited to relieving pain, alleviating disease or removing constraints.

(5) This section does not apply to a hospital or health system that is eligible for exemption from taxation under section 1 of this 2017 Act.

SECTION 9. ORS 305.842, as amended by section 15, chapter 33, Oregon Laws 2016, is amended to read:

305.842. As used in ORS 307.130, 307.147, 308A.450, 310.140 and 310.800 **and section 1 of this 2017 Act**, "Internal Revenue Code" means the federal Internal Revenue Code as amended and in effect on December 31, 2015.

SECTION 10. Section 1 of this 2017 Act and the amendments to ORS 305.842, 307.112, 307.130 and 307.162 by sections 5 to 9 of this 2017 Act apply to property tax years beginning on or after July 1, 2017.

SECTION 11. The amendments to ORS 442.200, 442.205 and 442.991 by sections 2 to 4 of this 2017 Act become operative on January 1, 2018.

SECTION 12. This 2017 Act takes effect on the 91st day after the date on which the 2017 regular session of the Seventy-ninth Legislative Assembly adjourns sine die.

OREGON HOSPITAL COMMUNITY BENEFIT

OREGON HEALTH POLICY BOARD

MAY 2, 2017

OVERVIEW

- National Community Benefit Policy
  - Keith Hearle, Founder and President
  - Verité Healthcare

- Oregon Hospital Community Benefit
  - Dan Field, Executive Director
  - Community Benefit and External Affairs
  - Kaiser Permanente Northwest

- Social Determinants of Health
  - Jesse Beason, Vice President of Public Affairs
  - Northwest Health Foundation

National Community Benefit Policy Review

Keith Hearle

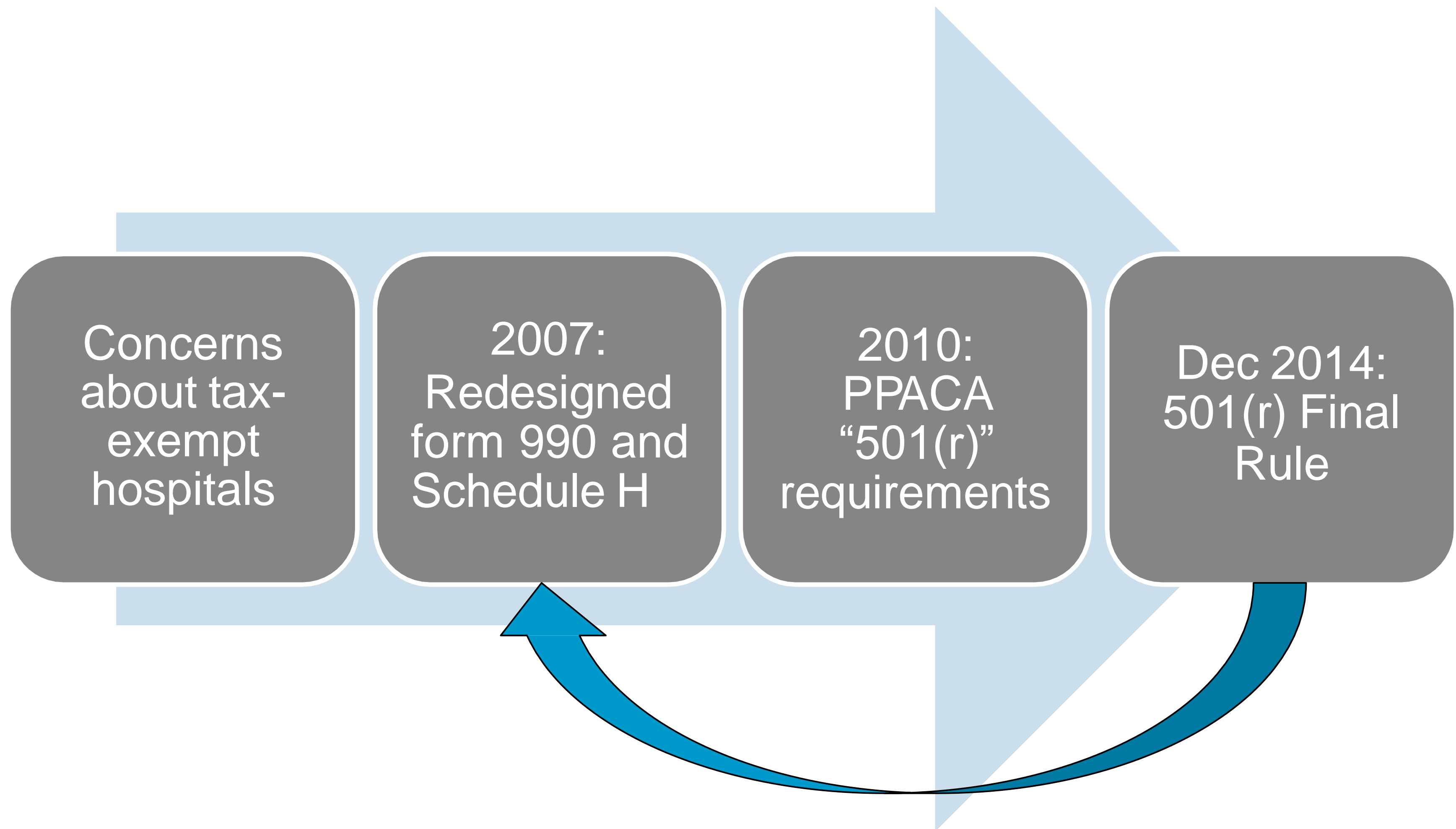
Keith.Hearle@veriteconsulting.com

VERITÉ HEALTHCARE CONSULTING

Background Information: Keith Hearle

- Experience at KPMG, The Lewin Group, and San Francisco Department of Public Health
- Lead architect of CHA's community benefit accounting framework, (*Social Accountability Budget*, 1989)
- Lead author of accounting chapter in CHA's *Guide to Planning and Reporting Community Benefit* (2006, 2008, 2012, 2015)
- Contributor to "what counts as community benefit" guidelines; serve on What Counts Task Force
- Drafted sections of IRS Form 990, Schedule H instructions; contributed to subsequent updates
- Specialize in all 501(r)-related topics: policy and practice
- Broad practice in strategic and financial planning
- Board President of FQHC in Alexandria, Virginia

Federal Policy: Brief History and Context



Current Federal Tax-Exemption Framework

- 1956 and 1969 Revenue rulings
- IRS Form 990, Schedule H
- PPACA (2010) and Final Regulations
  - Added 501(r) to the Internal Revenue Code:
    - Community Health Needs Assessment
    - Implementation Strategy (to address significant needs needs)
    - Charity care (financial assistance) policy requirements
    - Policy prohibiting discrimination in emergency care
    - Billing and collections requirements
  - The requirements apply to each 501(c)(3) "hospital facility"
- IRS is actively reviewing 501(r) compliance

Community Benefit Reporting: Schedule H, Part I, Line 7

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						

VERITÉ HEALTHCARE CONSULTING

IRS: What Counts as Community Benefit?

- To count, a program or activity must respond to a demonstrated health/related community need and seek to achieve at least one community benefit objective:
  - Improve Access to Health Services
  - Enhance Public Health
  - Advance Generalizable Knowledge
  - Relief of a Government Burden to Improve Health

VERITÉ HEALTHCARE CONSULTING

COMMUNITY BENEFIT IS MORE THAN CHARITY CARE

Community benefit encompasses a wide range of services that respond to specific, identified health needs.

WHAT COUNTS AND WHAT DOESN'T?

COUNTS	DOESN'T COUNT
CHARITY CARE	
• Free and partially discounted care (discounted from the actual cost, not the charge) • Unpaid co-pays for Medicaid and low-income patients	• Bad debt • Discounts provided to self-pay patients who do not qualify for financial assistance
UNFUNDED PORTION OF GOVERNMENT PROGRAMS	
• Underpayment from Medicaid • Underpayment from Medicare • Other government programs: SCHIP, indigent care	• Government programs that are not means-tested, such as VA and Indian Health Service
COMMUNITY HEALTH IMPROVEMENT SERVICES	
• Health fairs (not for marketing purposes) • Smoking cessation programs • Transportation for patients & families to access care • Assistance to enroll in public programs • Community-based spiritual care and support groups	• Patient education that is part of comprehensive patient care (e.g., diabetes education only provided to patients) • Employee wellness and health promotion • Screenings when the primary purpose is to generate referrals to the health care organization
HEALTH PROFESSIONS EDUCATION	
Unpaid costs of: • Internships, residencies and fellowships • Training health professionals in special settings, such as occupational health	• Staff tuition that is provided as an employee benefit • On-the-job training • Training for non-health related professions
SUBSIDIZED HEALTH SERVICES	
• Clinical programs or service lines that the organization subsidizes (e.g., palliative care programs, behavioral health services, mobile units, women's & children's services)	• Financial assistance • Bad debt • Ancillary services like lab or radiology
RESEARCH	
• Evaluation of innovative treatments or delivery models • Research papers by staff for professional journals and presentations • Studies on health issues for vulnerable people	• Research where findings are only used internally • Market research • Research that yields proprietary knowledge
GRANTS AND IN-KIND CONTRIBUTIONS	
• Contributions to nonprofit community organizations • Grants to organizations, projects or initiatives that address a community need	• Fees for sporting event tickets • Time spent at recreational events
COMMUNITY BUILDING ACTIVITIES	
• Neighborhood improvement and revitalization projects • Child care for people with a qualified need • Waste reduction activities • Collaborative partnerships with community groups to improve economic stability	• Health facility construction & improvements such as a meditation garden or parking lot • Housing costs for employees • Expenditures to comply with environmental laws

Issue Areas: Community Health Needs Assessments and Implementation Strategies

- Defining "community"
- Assuring input from public health officials and other key stakeholders
- Allowing / encouraging collaboration while not diluting local focus
- How needs are determined to be "significant" and how strategies are selected
- Evaluating impacts

VERITÉ HEALTHCARE CONSULTING

Pennsylvania

- Hospitals may choose from among seven alternative community benefit standards (six specify minimum community benefit levels), e.g.:
  - "Uncompensated goods or services" equal to at least 75% of net operating income, but not less than 3% of total operating expenses
  - Providing goods or services based on recipient's ability to pay (charity care), with 20% paying no fee or below cost, 10% receiving at least a 10% discount, no individual paying more than cost
  - Providing "wholly gratuitous" goods or services to at least 5% of patients

Pennsylvania

- Alternative community benefit standards (continued):
  - Providing financial assistance or uncompensated goods or services to at least 20% of those receiving similar services if at least 10% paid no fees or paid fees at 90% or less than the cost of the goods or services
  - Providing uncompensated goods or services equal to at least 5% of the cost of providing the goods or services
  - Providing fundraising on behalf of (or grants to) an institution of purely public charity
- "Uncompensated goods or services" includes net cost of charity care, education and research, Medicaid or Medicare, and community services

Texas

- As a condition of tax-exemption, one of three quantitative standards must be met:
  - Charity care and government-sponsored indigent health care at a "reasonable" level
  - Charity care and government-sponsored indigent health care equal to at least 100% of hospital's tax-exempt benefits, excluding federal income tax
  - Charity care and community benefits equal to at least 5 percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care equal at least 4 percent of net patient revenue
- Excluded hospitals: Medicaid DSH, located in county of 58,000 or less and that is a HPSA

Texas

- Hospitals complete “Annual Statement of Community Benefits Standard” each year
  - Calculation of “tax exempt benefits”
  - Compared to “shortfall in charity care and government-sponsored indigent health care”
- Unreimbursed costs of charity care =
  - Unadjusted, prior year RCC x charity charges, minus
  - Third party and patient payments (including relevant tax appropriations for public hospitals), plus
  - Support to financially indigent patients provided through others
  - Grants are not to be subtracted

Texas

- Estimated Value of Tax Exempt Benefits includes:
  - Franchise Tax
  - Ad Valorem Taxes (property, school district, …)
  - Sales Tax
  - Value of contributions received
  - Value of tax-exemption for bond financing
- Texas requires disclosing charity care policy information and information about community benefits projects/activities

OREGON HOSPITAL COMMUNITY BENEFIT UPDATE

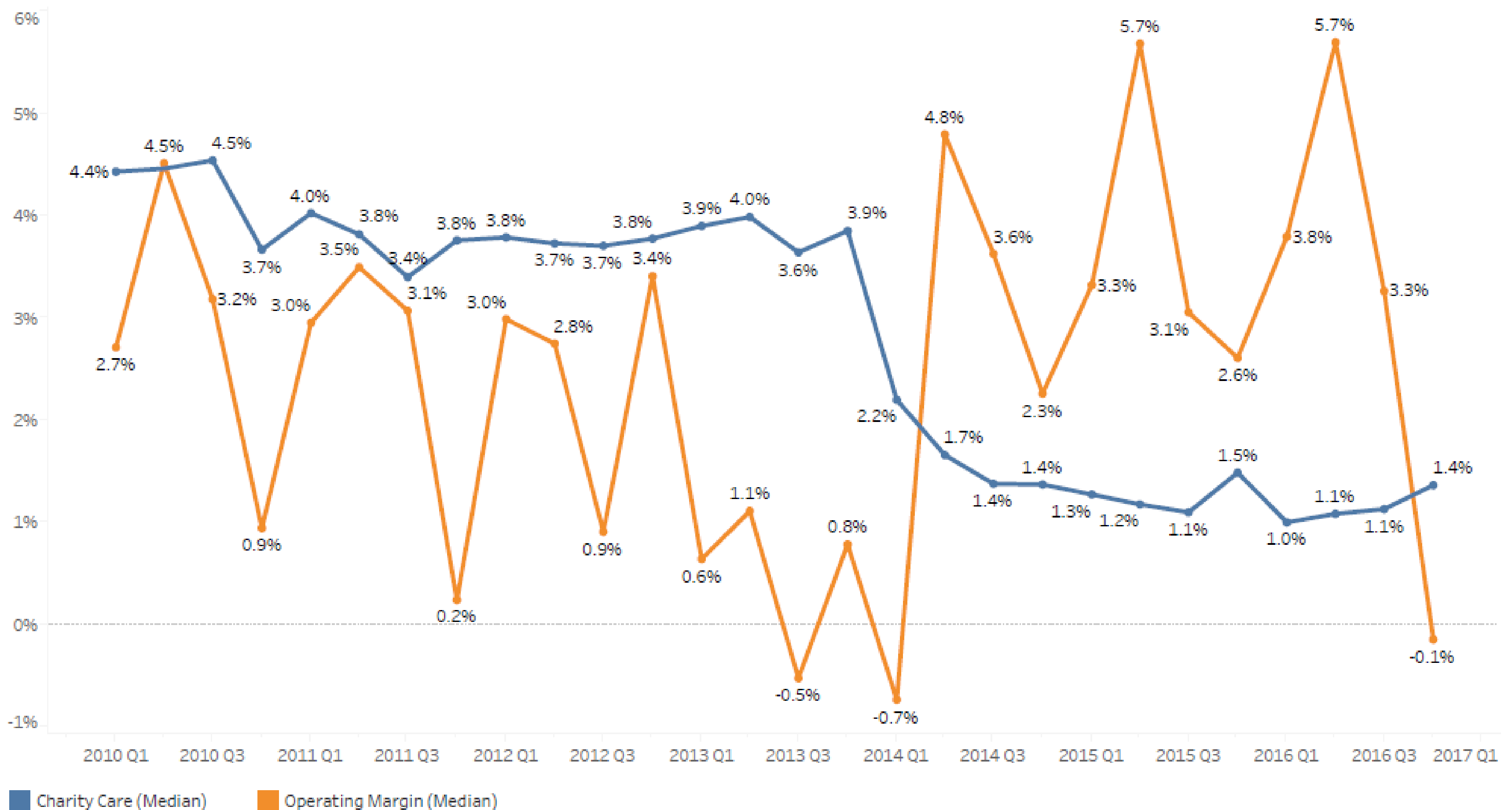
Oregon Association
of Hospitals and Health Systems

COMMUNITY BENEFIT
UPDATE

FEBRUARY 2017

OPERATING MARGIN vs CHARITY CARE

2010-2016 Oregon Hospitals (Median)



All data are based on a MEDIAN calculation, consistent with the Oregon Health Authority Office of Health Analytics methodology. This metric avoids highly-influential outliers by taking the midpoint of all hospitals with reported data. Operating Margin Percent is based on the percent of operating revenues retained as profit. Charity Care Percent is based on the percent of total charges written off as charity care.

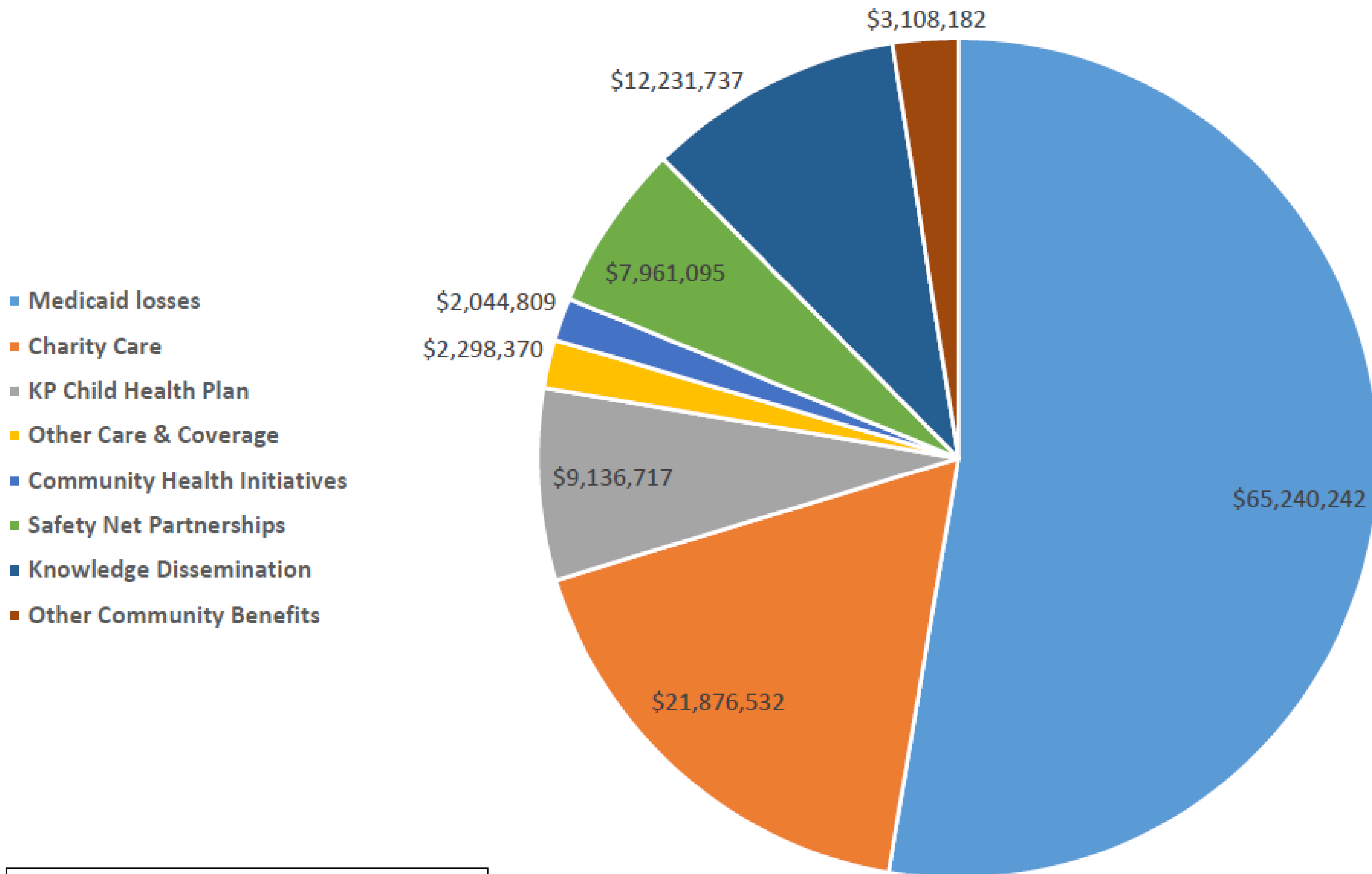
Source: All data for this report come from the state-mandated DATABANK hospital reporting system (ORS 442.425) for CY 2010-2016. Kaiser hospitals are excluded due to current statutory exemption.
http://www.oregon.gov/oha/analytics/Pages/Hospital-Reporting.aspx

apprise HEALTH INSIGHTS
A subsidiary of the Oregon Association of Hospitals & Health Systems

COMMUNITY BENEFIT POLICY PACKAGE (ADOPTED 2015)

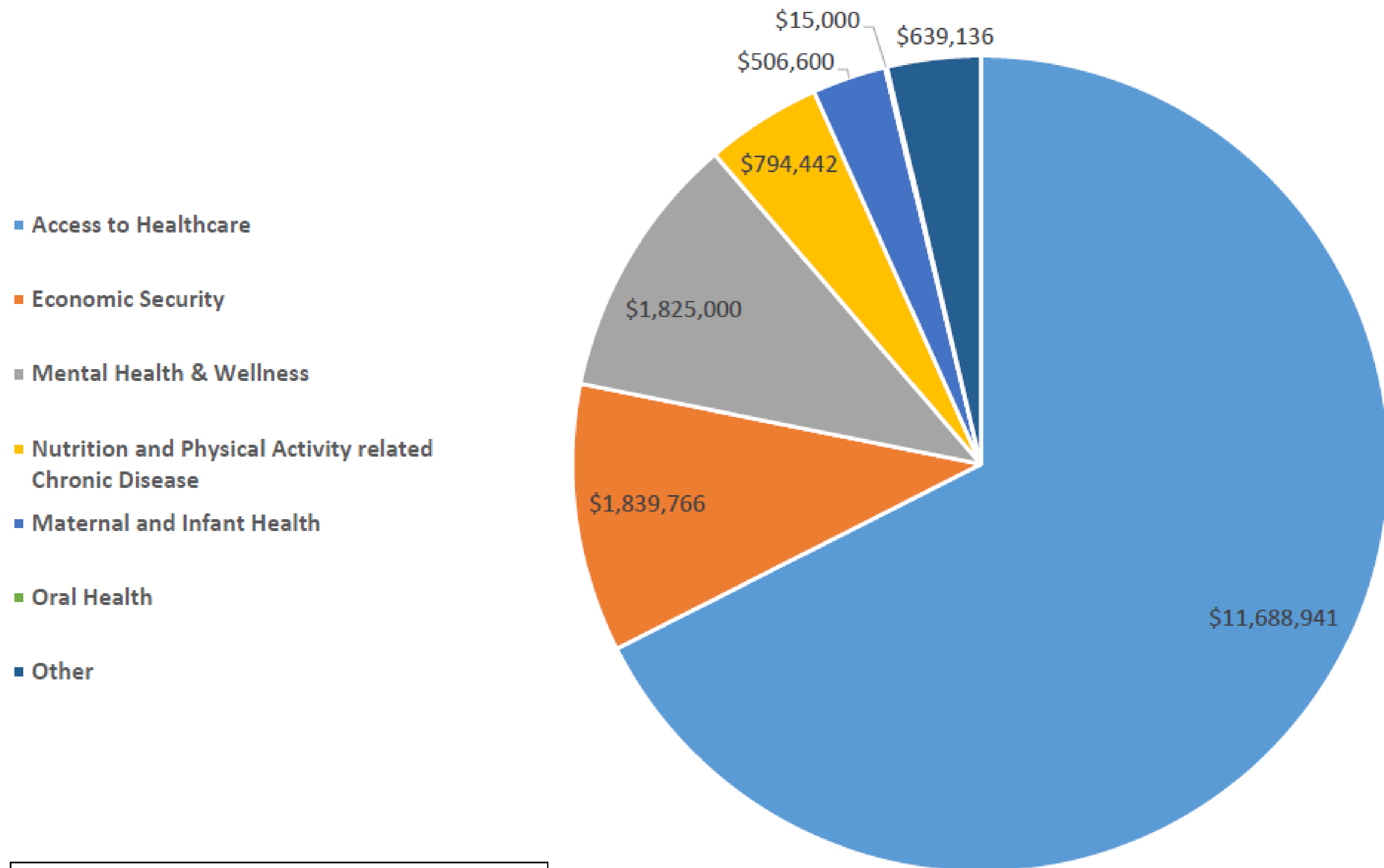
- ✓ A common floor of 200% federal poverty level for free care

- ✓ Hospitals commit to maintain or increase current community benefit levels in aggregate as a hospital community (relative to multi-year average).



March 2017

2016 Kaiser Permanente Northwest Community Benefit Grants by Priority Health Needs



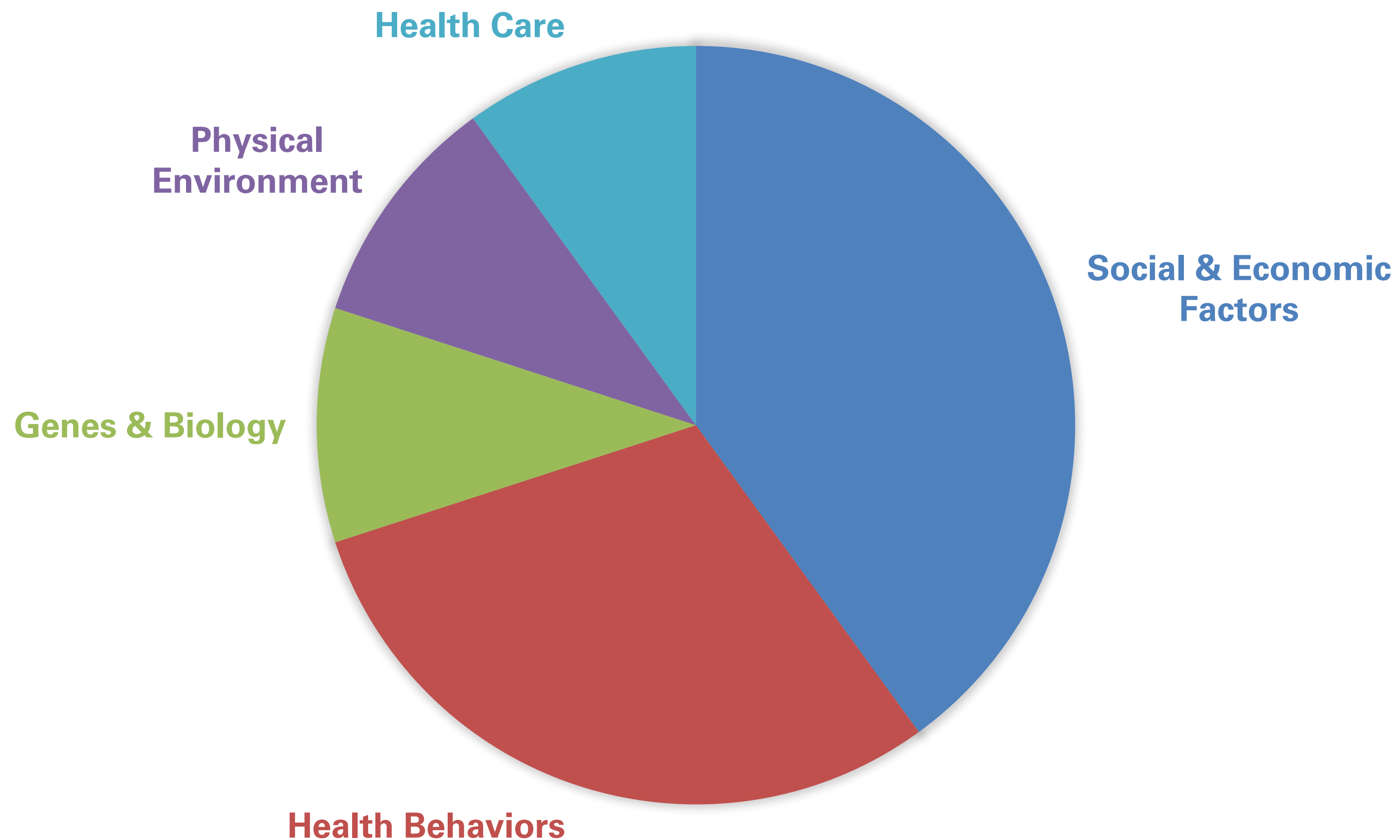
Total 2016 KPNW CB Grants Spending: $17,308,885
(Includes KP Community Fund at NWHF)

March 2017

NORTHWEST HEALTH
FOUNDATION

Social Determinants & Community Benefit

What Determines Health

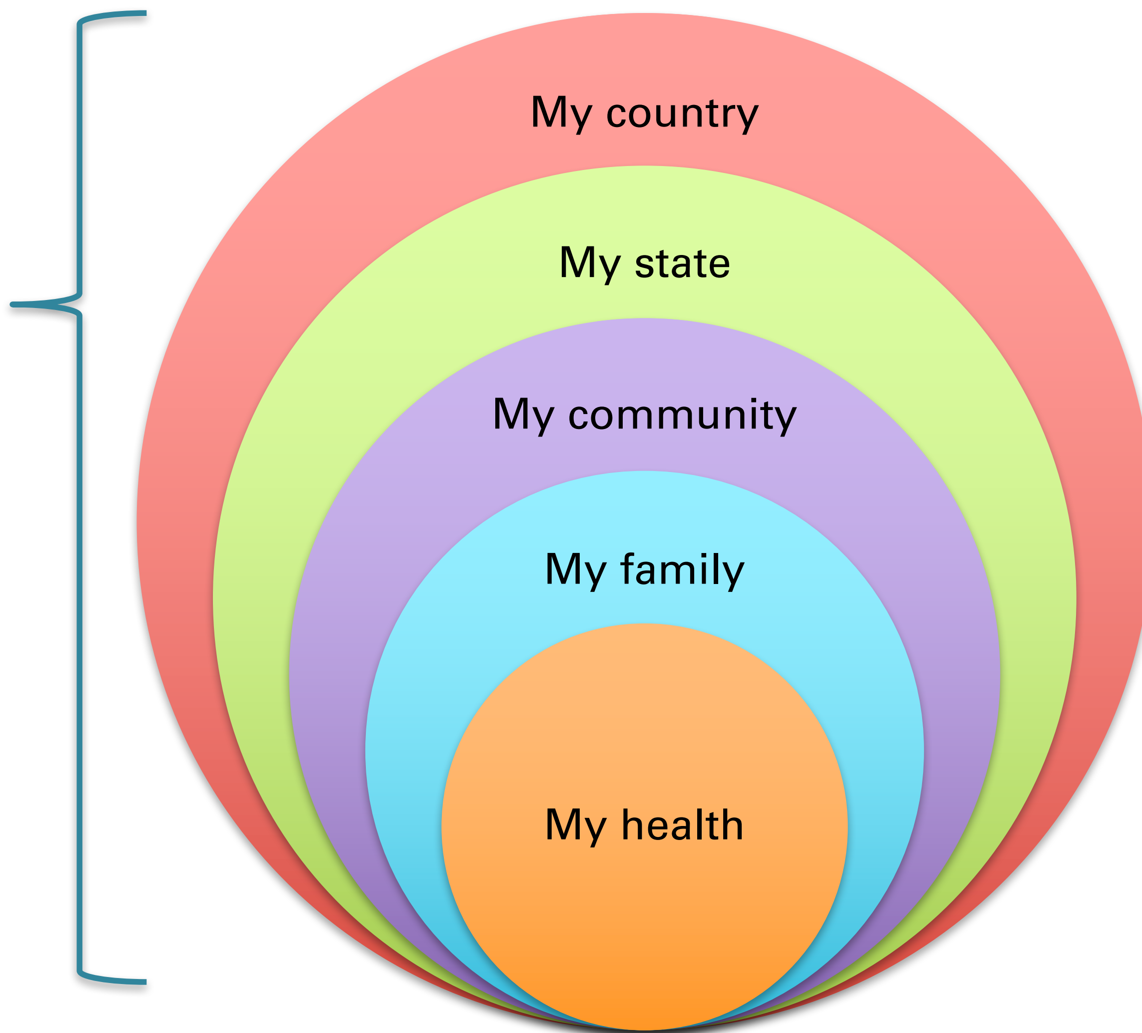


Source: Tarlov AR. Public policy frameworks for improving population health. Ann NY Acad Sci 1999

NWHF

Forces Affecting Health

Social
Cultural
Economic



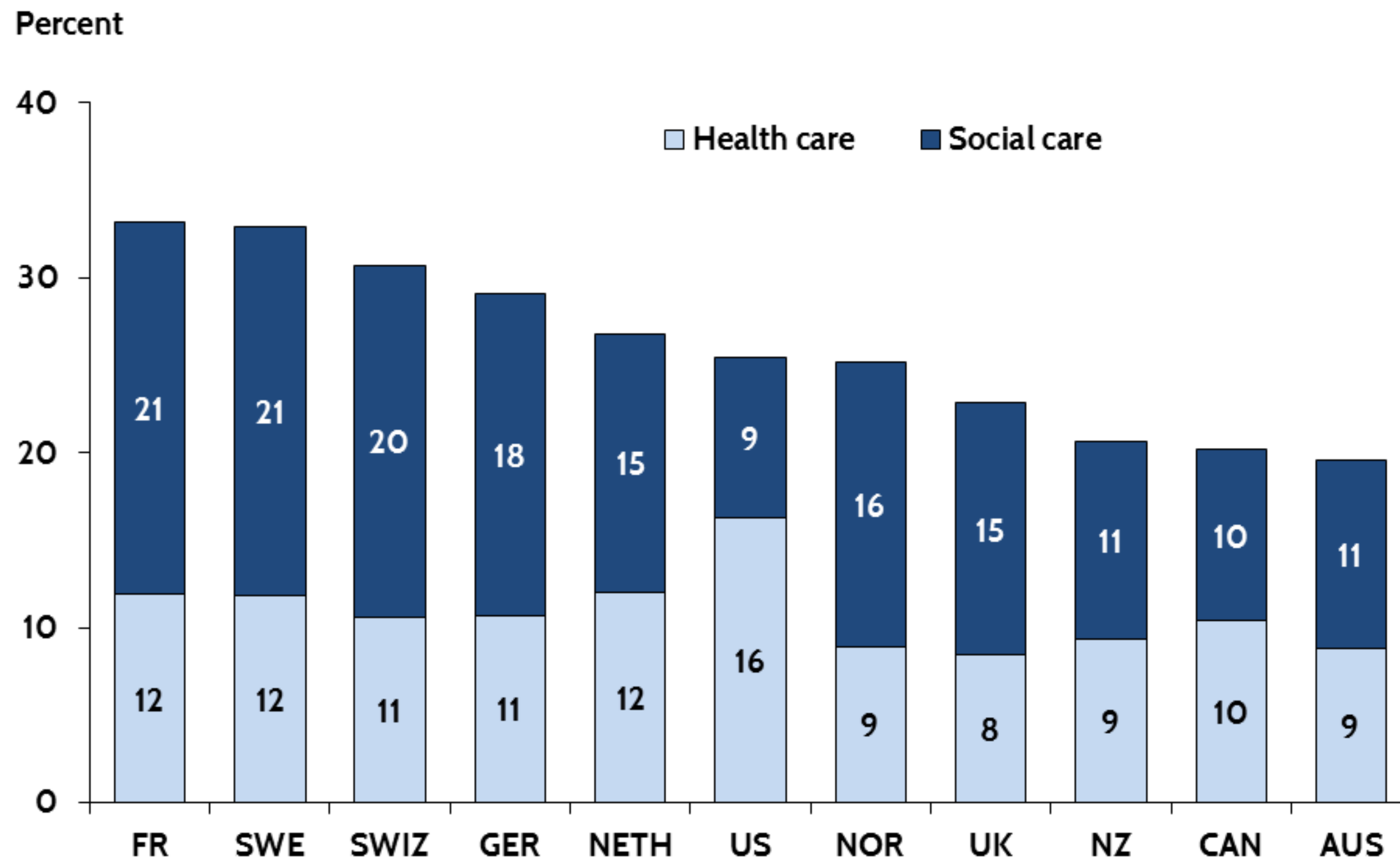
Where changes are most impactful.

Where most health interventions happen.

Adapted from Institute of Population and Public Health

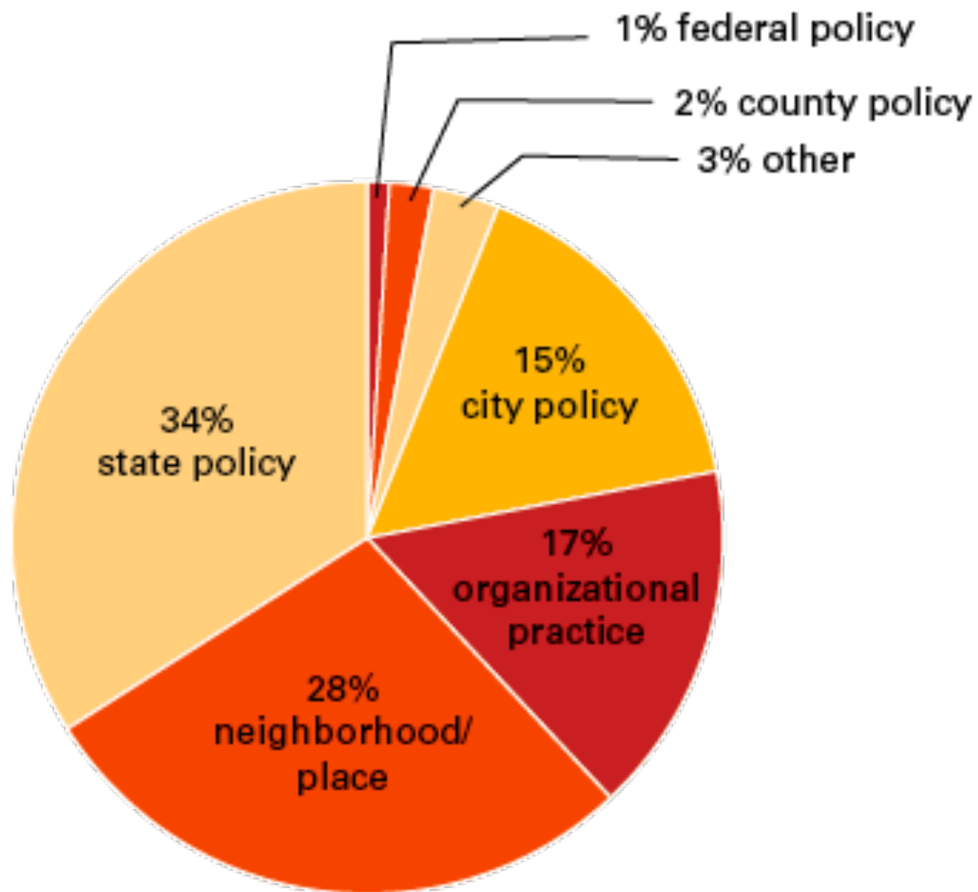
NWHF

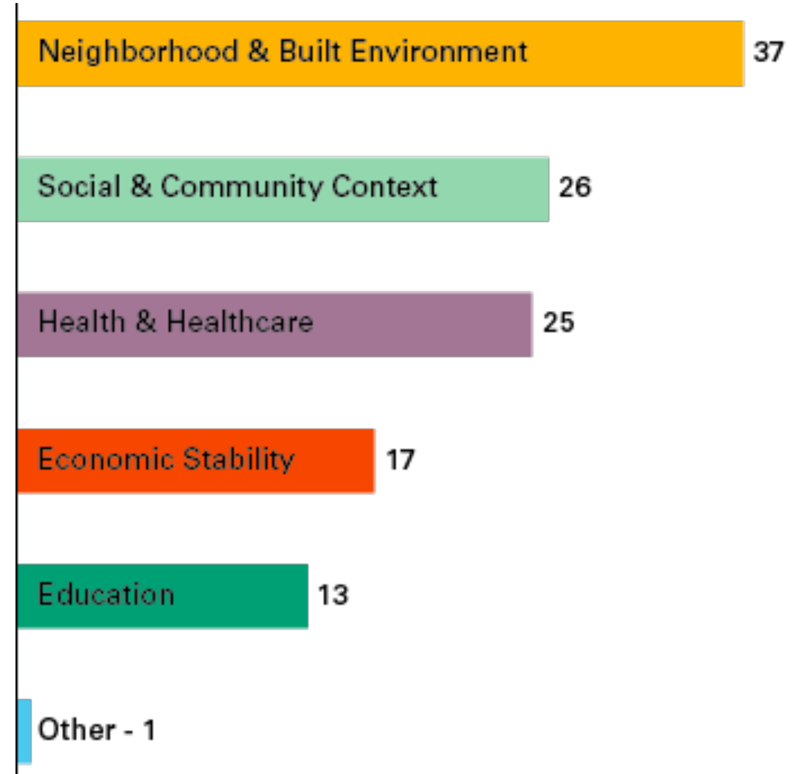
Health & Social Spending by % of GDP



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

COMMUNITY BENEFIT





NWHF

Oregon Association of Hospitals and Health Systems

COMMUNITY BENEFIT UPDATE

FEBRUARY 2017

A COMMITMENT TO COMMUNITY

Each day, Oregon's community hospitals voluntarily provide programs and services beyond simply caring for the sick and injured. Driven by a mission to provide high-quality health care that extends beyond the hospital walls, they make available free and discounted care, community health services, health education, wellness programs, and more, with the goal of saving and improving lives.

Hospitals are dedicated to strengthening the community by helping the Oregonians who need it most. Tens of thousands of Oregonians are served every year through voluntary community benefit programs that improve the overall quality of life. These programs help manage the health needs that are unique to each community.

In 2015, Oregon's community hospitals provided $1.9 billion in community benefit activities, as reported to the Oregon Health Authority. In the same year, hospitals experienced 346,000 inpatient stays, 1.4 million emergency room visits, and 11 million outpatient visits, and welcomed more than 44,000 new babies into the world.

Hospitals Exceed Pledge to Maintain Community Benefit Spending

In early 2015 Oregon hospitals announced a new community benefit policy knowing that the health care model was rapidly shifting with the expansion of Medicaid in Oregon. With the policy, hospitals pledged to maintain, or increase, the amount they spend on community benefit, despite a drop in charity care as a result of the Affordable Care Act.

At the same time, they announced a voluntary expansion of their policy for free care, which allows people and families who earn up to 200 percent of the federal poverty level to receive free care.

Data from the **Oregon Health Authority shows that Oregon hospitals not only achieved their 2015 pledge to maintain their overall community benefit levels, but they exceeded it.** Hospitals increased services in community benefit categories other than charity care by $230 million in 2015, as compared with average levels over the previous three years.

What Counts as COMMUNITY BENEFIT?

Community benefit refers to health care-related services that Oregon's nonprofit hospitals provide – with little or no compensation – to address critical health needs in the community. In 2007, the Oregon Legislature created the categories for community benefit, which is defined as health care-related services that hospitals provide without the expectation of compensation. In 2015, hospitals reported community benefit in the following categories:

$157 million
in Charity Care

Free or discounted health services provided to people who cannot afford to pay and who meet the eligibility criteria of the hospital's financial assistance policy.

$59 Million
in Research

Clinical and community health research, as well as studies on health care delivery, that are shared outside the hospital.

$23 Million
in Cash and In-Kind Contributions

Funds and services donated to the community, including contributions to nonprofit community organizations, grants and meeting room space for nonprofit organizations.

$1.3 billion
in Underpayment

The shortfall created when a hospital receives payments that are less than the cost of caring for patients on Medicaid, Medicare, State Children's Health Insurance Programs (SCHIP), and other public programs.

$219 Million
in Health Professions Education

Educational programs that are available to physicians, medical students, interns, residents, nurses and nursing students, and other health professionals that are not available exclusively to the hospital's employees.

$12 Million
in Community Building Activities

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.

$31 Million
in Community Health Improvement Services

Activities that improve community health based on an identified community need. They include support groups, self-help programs, health screenings and health fairs.

$25 Million
in Subsidized Health Services

Clinical service lines that would not be available in the community if the hospital stopped providing them. This includes things like air ambulance, neonatal intensive care, burn units, mobile units, and hospice and palliative care.

$8.5 Million
in Community Benefit Operations

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

GIVING BACK

HIGHLIGHTS OF OREGON HOSPITAL'S COMMUNITY BENEFIT PROGRAMS AND THEIR IMPACTS.

THE ABCS OF ASANTE'S SCHOOL NURSE PROGRAM

For many kids, the school nurse is the important link between well-being and academic success. If a student has an asthma attack, gets hurt on the playground, or needs quick diabetic care, it's the school nurse who gets the child back to class or to a doctor.

The Asante School Nurse Program includes three nurses, who work with students in kindergarten through eighth grade in the Ashland and Phoenix-Talent school districts.

Primary funding for the Asante School Nurse Program is provided by Asante, with additional support from school districts and a grant from the Oregon Community Foundation Walker Fund.

"This is a great resource that Asante provides," said Steve Retzlaff, principal of Ashland Middle School.

School nurses provide case management for kids with chronic health conditions, such as diabetes and asthma; they also triage concussions, fractures, headaches and allergic reactions.

"No two days are the same," said Belinda Brown, RN, Asante School Nurse Program coordinator.

Also provided are health screenings for hearing, vision, dental, and height and weight, to help promote overall wellness. Mental health counseling and a suicide prevention program are also available.

"One of the unique opportunities we have is to develop long-term trusting relationships with kids and their families," said Brown. "I've known some of these kids since kindergarten, and I have a really good understanding of their health history."

Principal Retzlaff has known Brown since she began serving Ashland Middle School.

"She goes way beyond the Band-Aids and ice packs; she's like a social worker," he said. "Belinda is great at finding out what support the students need outside of school and connects them to those resources. And not just for the student but for the family too."

With nearly 2,800 students in the district, Brown said some require individualized care plans for chronic conditions such as allergies and seizures.

"We work with doctors and parents to develop health plans as well as train teachers and office staff about what a child needs to be safe at school."

HOUSING IS HEALTH:

CENTRAL CITY CONCERN PROJECT

Health providers invest $21.5 million for innovative housing and medical services

Five major hospitals and a nonprofit health care plan in Portland invested $21.5 million in a unique partnership with Central City Concern to respond to the city's urgent challenges in affordable housing, homelessness and health care.

The contributions – from Adventist Health, Kaiser Permanente Northwest, Oregon Health and Science University, Legacy Health, Providence Health & Services Oregon, and CareOregon – will support 382 new housing units at three locations, including one with an integrated health center in Southeast Portland.

"This project reflects what we've known for a long time – health begins where we live, learn, work and play," said Governor Kate Brown. "Stable, affordable housing and health care access are so often intertwined, and I'm gratified to see collaborative solutions coming from some of our state's leading organizations. I applaud the efforts of all those involved and am grateful for the partnership in moving Oregon forward and making ours a home where each Oregonian thrives."

The Eastside Health Center will serve medically fragile people and people in recovery from addictions and mental illness with a first-floor clinic and housing for 176 people. The center will also become the new home for an existing Central City Concern program, Eastside Concern, and will offer 24-hour medical staffing.

The Stark Street Apartments in East Portland will provide 155 units of workforce housing; and the Interstate Apartments in North Portland will provide 51 units designed for families.

"Health and home go hand-in-hand," said Nan Roman, President & CEO of the National Alliance to End Homelessness. "This is a breakthrough collaboration with the health care community and a partnership that has the potential to change the landscape of how we can end homelessness in this country."

Here is what health care leaders had to say about the project:

"It's a privilege to live our mission focused on improving the health of our community. Adventist Health's long history of preventive care and wellness compels us to align our services with the changing needs of the community. We are proud to support safe, affordable housing for residents of East Portland through this collaborative effort."

– David Russell President and CEO
Adventist Health Portland

"We see this unique housing partnership as supportive of both mental and physical health at a time when people are most in need. We know that health is more than medical care. And we need to eliminate barriers to health for the most vulnerable members of our community."

– Andrew McCulloch President
Kaiser Permanente Northwest

"Part of Legacy Health's mission is good health for our community. As an individual and as a leader at Legacy Health, I believe that adequate housing is a component of good health for our community. Legacy needs to make this investment if we truly want to fulfil our mission. I'm proud to work with Central City Concern and my health care colleagues to make a contribution to a housing project that will truly make a difference within our community and our world."

– George J. Brown, M.D. President &
Chief Executive Officer Legacy Health

"OHSU is proud to join with other local health systems in support of Central City Concern's Eastside Health Center. We recognize that good health requires more than good health care. We understand the value of transitional housing as a key component of improving health for vulnerable populations. No one meets those needs better than Central City Concern."

– Joe Robertson, MD, MBA President OHSU

"In health care, we are moving from a focus on caring for disease and acute illness toward ongoing care and treatment of a patient's overall needs. We know that access to housing helps stabilize people's lives – and as a result, puts them in a better position to get the best level of care to keep them well."

– Dave Underriner Chief executive
Providence Health & Services – Oregon

"People with health issues, who don't have stable housing, just can't make the changes they need, whether they're recovering from hospitalization, managing chronic health conditions or overcoming addiction. Housing not only improves health outcomes, but helps reduce the overall costs of health care. CareOregon's support is an investment in preventive health care and our members' futures."

– Eric C. Hunter President & Chief
Executive Officer CareOregon

BAY AREA HOSPITAL AIMS FOR EARLY DETECTION & PREVENTION

Free cancer screenings as Bay Area Hospital in Coos Bay always draw a crowd. With highly qualified surgeons and other specialists donating their time, more than 1,100 people have taken advantage of the annual cancer screenings since 2010.

In addition to screening events, Bay Area Hospital and local doctors offer free screenings for other conditions throughout the year, identifying such health conditions as diabetes and high blood pressure.

People who otherwise lack access to health care make up a large share of the participants, but everyone is welcome.

As an accredited Community Cancer Program, Bay Area Hospital has a responsibility to offer screenings to all community members. More importantly, early detection saves lives.

One example of screening offered to the community is for throat cancer.

“We’re seeing an epidemic of throat cancer, but it’s a silent disease,” noted Steven Shimotakahara, MD, an ear, notes, throat, head and neck surgeon at Bay Area Hospital. “People don’t usually look in their own throats. The mission of the hospital is to improve the health of our community, so it makes a lot of sense that we check for throat cancer.”

Over the past five years, about one in four people attending Bay Area Hospital’s cancer screenings was referred for medical follow-up. Some underwent additional testing for suspected malignancies. Others were treated for unrelated medical conditions spotted by the volunteer providers.

Year-round screenings motivate South Coast residents to get the care they need. In one year alone, Bay Area Hospital provided 966 blood pressure screenings, 118 diabetes screenings, 49 screenings for varicose veins, and 246 screenings for head and neck cancer.

“These services don’t make money,” said Paul G. Janke, FACHE, President & CEO of Bay Area Hospital. “But that’s okay. Bay Area Hospital was created in 1974 to improve the community’s health, not turn a big profit.”

GRANDE RONDE HOSPITAL ENSURES FAMILIES AFFECTED BY AUTISM HAVE SUPPORT AND RESOURCES

Five-year-old Johnes Winn was properly diagnosed with autism spectrum disorder (ASD) nearly a year ago. He and his sister, Rosie, are twins. As a first-time mom, Maree Winn knew if she hadn't had Rosie to compare, she might not have realized there were significant delays in Johnes' early development. He didn't respond when spoken to or make eye contact, and there was no babbling or early effort at speech.

"When Rosie began to scoot and teach herself to crawl, then stand and take her first steps, Johnes did none of that on his own," Maree said. "After he watched his sister, only then did he pattern her behavior."

The Winn family was the first to go through the local ASD Early Identification Team Program, a broad community partnership offered through the Grande Ronde Hospital Children's Clinic. They proudly refer to themselves as the team's guinea pigs and are still receiving support.

"I can't imagine what it would be like without this program," said Maree. "There are so many steps along the way. Every other month we have an evaluation of where we are and what we need to accomplish next. That helps keep me on task, so I accomplish my goals."

Johnes has progressed leaps and bounds in the past year. He went from not communicating to full sentences.

"Just hearing him say 'Mommy, can I have a drink of milk?' is so amazing to me," Maree said.

The ASD Early Identification Team Program is made up of medical staff from Grande Ronde Hospital Children's Clinic, education staff from InterMountain Educational Service District, community partners from OHSU, and the Center for Human Development, as well as the families of children being identified, and a local parent who has raised a child with ASD.

The education staff includes early childhood specialists and a speech-language pathologist. The medical staff includes two Grande Ronde Hospital pediatricians, a public health home visiting nurse, local mental health professionals and the clinic site coordinator.

"The main benefit for the community, as I see it, is that this testing we do here paves the way for these families to get the therapies and interventions they need," said Dr. Kevin Grayson, pediatrician.

Before this program, there were no local experts and no process in place to point parents in the right direction for help.

"Often families were thrown from one agency to the next," said Dr. Melindres Lim, pediatrician. "Now these parents are informed. It's very beneficial for them to have a formal diagnosis and our referral to other services and educational benefits that will help these children reach their potential."

KAISER PERMANENTE LAUNCHES EFFORT TO FIGHT STIGMA AROUND DEPRESSION

Depression and other mental health issues are common and touch nearly all of our lives, directly or through connections to friends, family, or colleagues. But it can be hard to talk about, even with loved ones.

More than 1 in 5 adults in the United States live with a mental health condition, and approximately 20 percent of youth ages 13 to 18 have experienced or will experience a mental health condition. In about 5 percent, the condition will be severe.

But treatment works, and there is hope. Kaiser Permanente is committed to tackling the stigma and is teaming up with other organizations, including the National Alliance on Mental Illness, National Suicide Prevention Lifeline, Crisis Text Line and Mental Health America, to change the conversation around mental illness.

The public health awareness effort, "Find Your Words," focuses on mental health and wellness with spots for TV, theater, digital and radio featuring lyrics that talk about depression in an honest and inspiring way.

The spots drive viewers to FindYourWords.org, a website that provides information about depression, offers resources and invites the public to engage in a conversation about mental health and wellness through an interactive component.

Total health includes mind, body and spirit — with the understanding that physical health and mental health are closely connected. Just as someone would go to the doctor for strep throat or a broken arm, it's important to seek care for mental health issues.

However, people might be reluctant to get help because they feel ashamed or embarrassed. With this campaign, Kaiser Permanente and its partners aim to help reduce the stigma around depression and motivate people across the country to talk about it.

"The entire nation faces challenges when it comes to providing high-quality mental health care to those who need it, but we want people to know that mental health treatment works and that there is hope," said Don Mordecai, MD, national leader for Mental Health and Wellness, and director of The Permanente Medical Group Mental Health & Chemical Dependency Services. "We are building partnerships with national mental health organizations, and standing together as a strong voice against the stigma and shame that can hinder some from seeking help."

PEACEHEALTH SACRED HEART PROVIDES SAFE HOUSING FOR RECOVERY

For the past three years, PeaceHealth Sacred Heart RiverBend Hospital has partnered with ShelterCare to provide free housing for patients who leave the hospital with no safe place to go to continue their recuperation and recovery. The program is offered to at-risk patients at PeaceHealth Sacred Heart to ensure emergency and transitional housing, along with prescriptions, medical equipment and transportation assistance.

At 54 years old, Rubee had been on her own since age 19 when her mother died. She had recently moved to Eugene and lived at a homeless shelter for only a week when she was admitted to the hospital for shortness of breath and weakness. She was found to have Stage IV lung cancer and needed to undergo chemotherapy if she wanted any chance to prolong her life. With no friends or family to turn to and a high susceptibility to infection if she returned to living at the homeless shelter, her prospects for successful treatment looked very grim.

The care management team at Sacred Heart RiverBend approached Rubee about entering the ShelterCare Medical Recuperation Program, and she was very optimistic about the possibility. In July 2016 she was admitted to the program and, from the beginning, had a safe place to live and reliable transportation to and from chemotherapy appointments.

She was assisted in establishing a relationship with a primary care physician who coordinated her treatments, and helped get her covered by Medicaid, ensuring her ongoing access to needed medical services.

Many weeks later, Rubee was offered an extension in the program to provide her more time to progress with her care and find a safe, permanent place to live. In October 2016 she transitioned in stabilized condition to an adult foster home where she will receive quality long-term care.

The ShelterCare Medical Recuperation Program has helped more than 220 vulnerable patients like Rubee. The number of patients receiving housing after hospitalization through this program continues to expand annually.

PEACEHEALTH WORKER PROGRAM AIDS IMMIGRANT FAMILIES

For the past five years, PeaceHealth Cottage Grove Community Medical Center has provided immigrant families and children access to health care and community services through the Community Health Worker Program.

Working in partnership with the Family Resource Center at South Lane School District, the Community Health Worker Program supports success in the classroom by ensuring kids get and stay healthy and receive the family services, including food, shelter, transportation and language skills, that are needed to position them to succeed.

PeaceHealth Community Health Worker Ana-Maria Dudley met Alicia's family a year ago after they had emigrated from Guatemala. Alicia was four years old at the time, and her mother had brought her to the Family Relief Center because of a concern for her health. On examination, it was discovered Alicia had a significant heart abnormality and required immediate care.

Her family was assisted in making appointments with pediatric cardiology specialists and applying for the medical coverage and services she and her family needed to obtain her care. Alicia's heart abnormality was found to be surgically correctable, and she underwent a successful heart repair in 2016.

"When I first came here I thought she would live with this problem all her life, but when I found Anamaria at the school, she helped us find a doctor here in the hospital who could help us," said Alicia's father. "Since her surgery, Alicia is doing well – she smiles a lot and hugs a lot, and started kindergarten in September."

The Community Health Worker Program has helped more than 300 immigrant children and families like Alicia's, and continues to expand annually.

PEACEHEALTH'S COURAGEOUS KIDS PROGRAM HELPS HEAL GRIEVING YOUTH

For the past 21 years, the Courageous Kids Program at Sacred Heart Medical Center University District has provided free grief support to children and their families who have experienced the death of a loved one.

Courageous Kids offers support groups, summer camp and a Teen Theater Troupe, providing childhood grief information and understanding to a broad audience.

Shelly, a painfully shy, emotionally lost little 11-year-old girl, started coming to the Courageous Kids support groups soon after her father's sudden death. Her dad had been working underneath a car when the jack slipped and the car crushed him. Shelly participated in support groups, attended summer camp, and also joined the Teen Theater Troupe, where she was able to publicly give voice to the agonies and vulnerabilities of her grief.

Eventually she began to heal and decided to become a volunteer with the program to help other children experiencing their own loss. Shelly blossomed into a brilliant, accomplished and confident young woman, who at age 29 is completing her PhD in sociology at UC Berkeley. She now volunteers five days every summer to run the art program at Courageous Kids summer camp and supervise counselors-in-training.

Like Shelly, many of the young adult volunteers at Courageous Kids became involved after experiencing their own loss, and each has a special gift of connecting with the hearts and spirits of those served by the program.

They hear things like: "I know what it's like to feel so sad, nothing else exists." "My loved one died too when I was little."

Through playing, laughing, crying and grieving with the young survivors, they serve as a shining light and as role models, giving hope to children in the program that they can survive and be happy.

The Courageous Kids program has helped thousands of vulnerable and at-risk youth like Shelly, providing early intervention to the effects of Adverse Childhood Events (ACEs) that are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan.

SAINT ALPHONSUS OFFERS ON-CAMPUS ACCESS TO PHYSICAL THERAPY

Saint Alphonsus Regional Medical Center – Baker City and Saint Alphonsus Rehabilitation Services encourage their employees to be involved in activities that enrich and assist members of the community, especially in areas of need.

In 2009 it was determined that there was a need in the community for on-campus access to physical therapy services at Baker High School to better assist students that were either uninsured or that would benefit from missing less class time by being able to go to therapy appointments on the high school campus.

At Baker High School, Saint Alphonsus therapists assess students' muscular and skeletal pain and injuries, as well as to evaluate their "brain status" after suffering a concussion.

The most common complaints from students include back/neck pain and knee pain. Many times these pains are able to be treated with education on proper posture and spine alignment, as well as with strength building (core and hip strength) to better address knee and trunk function and stability.

Because there was a need in the Baker City community for more in-depth post-concussion care, Saint Alphonsus now provides computerized neurocognitive testing at no charge to student athletes.

Progressive exertional training can also be performed by therapists to help prepare students to safely return to play after injuries or a concussion. Within the last two years, further needs for sports medicine were identified, so the services have been extended to Mondays after school.

Student athletes that need to be quickly screened and treated by a physical therapist are taking advantage of this community benefit.

SAINT ALPHONSUS EMPOWERS LOW-INCOME STUDENTS TO BECOME HEALTH PROFESSIONALS

Saint Alphonsus Regional Medical Center in Ontario is a major supporter of Malheur County's Poverty to Prosperity program.

Poverty to Prosperity is a grassroots initiative committed to creating and robust, thriving economy by removing barriers to overcoming poverty and empowering citizens to maximize their potential.

Poverty to Prosperity focuses on expanding the county's current career technical education services for high school juniors and seniors. Health classes are taught to high school students to enable them to graduate with a certified nursing assistant degree and basic health certificates.

The initiative is working on two fronts: ensuring that people and families who are currently living in poverty have access to critical resources, and addressing the root causes of poverty, clearing systemic barriers to increasing prosperity.

"My mother died when I was 10 years old from cancer, and her illness left a lasting mark in my heart," said one student at Vale High School who participated in the program. "Our family has struggled to make ends meet and I have even had to work in the fields to help out at home. No one in our family has ever gone beyond high school. Because of my mom, I have always wanted to be a CNA and help take care of others. I was thrilled to be able to be in the program. As I began to learn more about the health field, I became more excited about my future."

SALEM HEALTH REMOVES BARRIERS FOR DIABETES PATIENTS

When Christina was admitted to Salem Health for the third time in one month with complications related to diabetes, she had little hope for a healthy life. Her diabetes was out of control; she was losing her eyesight and her kidneys were beginning to fail.

Christina had no insurance and no doctor. The insulin and other medications she needed cost more than she earned. Much of the information she could get about her illness was not in her native language. She began to get some answers, though, as Salem Health launched the Diabetes CARE Collaborative. This new community care program aims to reduce the prevalence of obesity and diabetes in areas served by Salem Health. Those regions reported that 3 percent of all deaths within their borders had been caused by diabetes. Christina became one of the first people helped by the collaborative.

The Diabetes CARE Collaborative helps patients like Christina by working with a network of community partners that share Salem Health's commitment to prevent and control diabetes. All the partners work together to improve the lives of people who have diabetes through education, awareness and advocacy.

Salem Free Clinic provided Christina's primary care and helped her access specialty endocrine services through their network of providers. A Salem Health Foundation-funded medication assistance program ensured that she had the medicine she needed. The Diabetes CARE Collaborative provided diabetes education in a language Christina could understand, coupled with culture-appropriate support.

Christina's health improved dramatically within 90 days of her first visit with her diabetes community case manager. She will soon have cataract surgery and her kidney failure is slowing down. More importantly, she hasn't been readmitted to the hospital since enrolling in the program.

The collaborative is co-chaired by Salem Health's diabetes community case manager and a nurse from Northwest Human Services, a regional, federally funded community health center. Other partners include the Salem Free Medical Clinic, American Diabetes Association, Salem Clinic, Willamette Valley Partners Health Authority, the YMCA, Yakima Valley Farm Worker's Clinic, Legacy Health and the Marion County Health Department.

SAMARITAN HEALTH SERVICES COMMITS TO TACKLING FOOD INSECURITY

Les Adams jokes about the time he missed a St. Vincent de Paul food pantry meeting. In his absence, he was promoted to food buyer for the Lebanon agency that feeds 11,700 people a year.

The food pantry is supported by donations, fundraising and grants, including a grant from Samaritan Lebanon Community Hospital, which provides funding to purchase food.

Adams is among a dozen regular volunteers from St. Edward's Catholic Church who run the food pantry. Not only does he order all the food from Linn-Benton Food Share, but he also helps to unload, stock and distribute it.

One time in their distribution, there were several large cans of escargot. Adams wasn't sure what to do with the cooked snail, so he asked each recipient if they liked it. Most people said no.

"One woman said she loved it, so I gave her the rest," Adams recalled.

Another time, a grocery store ordered too many bananas, and the pantry ended up with 1,200 pounds.

Adams knew they wouldn't keep another week, so they contacted other area food programs and shared their banana bounty.

The food pantry strives to be attentive to the needs of the people it serves, said its bookkeeper Bernadette Ferraro. Most of the people who access the food boxes are single parents, people who are unemployed or underemployed, seniors and people with disabilities and those who are homeless.

A typical food box feeds four people, including children who need nutritious food to grow.

"We do milk for kids, canned vegetables, pasta and peanut butter," she said. "It's not just a block of cheese."

The agency is also able to provide appropriate food for people with diabetes and other dietary restrictions or food allergies.

Families can receive a three-day emergency food box once a month, but they can come every week for fresh fruits and vegetables.

Volunteers also collect food donated by local grocers to expand their offerings.

Ferraro said someone once asked if she had any cake for a child's birthday. Among the donated items from a bakery, there was a cake!

"We have lots of stories," Ferraro said.

TUALITY HEALTHCARE LIBRARIAN KEEPS OTHERS UP-TO-DATE ON HEALTH INFORMATION

For 23 years, Judith Hayes has served as medical librarian for Tuality Healthcare, which has a clinical library for providers and a public library as part of the Washington County Library system.

Hayes not only helps the public find health information, but also serves as a mentor and teacher to other librarians. Her class "Finding Health Information Online," which she has taught for 15 years, educates librarians throughout Washington County on how to provide medical information to the community.

Librarians deal with challenges finding increasingly complex and technical health information for the public. "We don't get those easy health questions anymore. People can find answers to easy questions online," said Hayes. "So questions are getting harder."

Patrons seek information on numerous topics, including diabetes, childbirth, complex trauma issues, and information about specific providers. Librarians today have to be equipped with skills to promptly assist people seeking complicated health literature.

With the internet, everyone can access general information immediately. Librarians struggle to keep up with the demand for information when it comes to more technical material located in medical journals. Another issue is the expectation to have information available immediately.

"One of my quality markers is timeliness," Hayes said. "I try to get an answer in 24 hours."

Judith teaches the class but also serves as a resource for librarians any time they need assistance finding health information. "I receive calls from librarians needing help finding things," Hayes said. "Go see Judith; here is her phone number, go call Judith. Or they will call from their desk while a patron is waiting."

Judith customizes her class based on questions she receives from librarians. She also assists libraries with updating their health reference collections, which happens frequently due to the changing nature of the medical field.

"Everything updates. You don't want to give someone older information," Hayes said. "If the copyright is more than five years old, you have to think hard about keeping that item in the collection. It might be outdated."

Judith reads current medical journals to keep up with recent health trends.

Currently, Tuality has roughly 30 print and 2,000 online journals, and a large collection of general health reference materials. Reference librarians from eight of the 15 public libraries in Washington County attended a class held in March 2016. As the public seeks out more health information, her skills will be in even more demand as librarians tackle more complex and challenging reference questions.

WILLAMETTE VALLEY MEDICAL CENTER'S *WALK WITH EASE* PROGRAM ENCOURAGES STAYING ACTIVE WITH ARTHRITIS

For the past six years, the Joint Replacement Institute of Oregon has provided care for patients undergoing hip and knee replacement surgery at Willamette Valley Medical Center in McMinnville. Key components of this program include early mobilization after surgery and emphasis on health and wellness. Natalie Reed, a physical therapist and the program's manager, believes the emphasis on mobility and health has completely revolutionized recovery after surgery.

"Eight years ago, we would have been happy to get a patient out of bed and into a chair for lunch the day after surgery," said Reed. "Now patients are up walking the day of surgery and most go home the next day."

As a physical therapist, Reed has long believed that many health conditions and pain management issues could be significantly improved if people simply moved more. This belief and her experience working with patients with arthritis led Reed to a program through the Arthritis Foundation called Walk with Ease.

According to the Arthritis Foundation, walking is one of the safest and most beneficial forms of exercise for people with arthritis and other chronic health conditions. Walk with Ease is an 18-class program, taught two or three times a week, that has been shown to reduce the pain and discomfort of arthritis while increasing balance, strength and walking pace. Each class includes a mini-lecture about arthritis and time for both walking and stretching. Participants adjust the program to their individual needs and fitness levels. Participants also receive a Walk with Ease book which provides additional information and resources. WVMC helps with funding so the classes are free.

Reed became certified to teach the course through online training and taught her first class to McMinnville-area residents in last September. Her first class had 15 participants; her fourth session which started in June, had over 30 sign-ups.

"This is a great community outreach program," Reed said. "We are able to offer the class free to participants and have partnered with both the McMinnville Community Center and McMinnville Senior Center. Several people have noted improvement in their walking endurance, overall health and pain management. "

Dr. Jacqueline Eriksen, a family medicine physician in McMinnville, agrees. "I have the class information posted in all of my patient rooms. One of my patients was struggling with her health so I encouraged her to sign up. At that time, I was seeing her monthly in the clinic and she could barely walk a block. Now she can walk more than a mile and she comes in only every few months for care."

Carrol and Roy Bowerman, a married couple, attend the class together to stay accountable to their walking program. "It is hard to stay consistent on your own; we get caught up with other things at home and with our property. With this class we schedule time to walk," said Carol.

COMMUNITY BENEFIT IS MORE THAN CHARITY CARE

Community benefit encompasses a wide range of services that respond to specific, identified health needs.

WHAT COUNTS AND WHAT DOESN'T?

+ COUNTS — DOESN'T COUNT

Charity Care

+ Free and partially discounted care *(discounted from the actual cost, not the charge)*
+ Unpaid co-pays for Medicaid and low-income patients
– Bad debt
– Discounts provided to self-pay patients who do not qualify for financial assistance

Unfunded Portion of Government Programs

+ Underpayment from Medicaid
+ Underpayment from Medicare
+ Other government programs: SCHIP, indigent care
– Government programs that are not means-tested, such as VA and Indian Health Service

Subsidized Health Services

+ Clinical programs or service lines that the organization subsidizes *(e.g., palliative care programs, behavioral health services, mobile units, women's & children's services)*
– Financial assistance
– Bad debt
– Ancillary services like lab or radiology

Community Health Improvement Services

+ Health fairs *(not for marketing purposes)*
+ Smoking cessation programs
+ Transportation for patients & families to access care
+ Assistance to enroll in public programs
+ Community-based spiritual care and support groups
– Patient education that is part of comprehensive patient care *(e.g., diabetes education only provided to patients)*
– Employee wellness and health promotion
– Screenings when the primary purpose is to generate referrals to the health care organization

Health Professions Education

+ Unpaid costs of:
  - Internships, residencies and fellowships
  - Training health professionals in special settings, such as occupational health
– Staff tuition that is provided as an employee benefit
– On-the-job training
– Training for non-health related professions

Research

+ Evaluation of innovative treatments or delivery models
+ Research papers by staff for professional journals and presentations
+ Studies on health issues for vulnerable people
– Research where findings are only used internally
– Market research
– Research that yields proprietary knowledge

Community Building Activities

+ Neighborhood improvement and revitalization projects
+ Child care for people with a qualified need
+ Waste reduction activities
+ Collaborative partnerships with community groups to improve economic stability
– Health facility construction & improvements such as a meditation garden or parking lot
– Housing costs for employees
– Expenditures to comply with environmental laws

WHAT IS A COMMUNITY HEALTH NEEDS ASSESSMENT?

Community health needs assessments are required of tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act. These assessments provide hospitals the information they need to provide impactful community benefits which address the needs of their communities. They ensure that hospital community benefit programs align with other community health improvement programs. By statute, the assessments must incorporate input from “persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.”

Community health needs assessments use such principles as:

- Collaborations that support shared ownership of all phases of community health improvement
- Proactive, broad and diverse community engagement to improve results
- A definition of community that allows for population-wide interventions and measurable results, and includes a targeted focus to address disparities
- Maximum transparency to improve community engagement and accountability
- Use of evidence-based interventions and encouragement of innovative health improvement practices
- Evaluation to inform a continuous improvement process
- Use of the highest-quality data pooled from, and shared among, diverse public and private sources

WHAT IS A COMMUNITY HEALTH IMPROVEMENT PLAN?

A community health improvement plan (or CHIP) is a long-term, systematic effort to address public health problems based on the results of a community health needs assessment. A plan is typically updated every three to five years.

This plan is used by community partners, including hospitals, to set priorities, and coordinate and target resources. A community health improvement plan defines the vision for the health of the community through a collaborative process and addresses strengths, weaknesses, challenges and opportunities that exist in the community to improve the health of that community.

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COMMUNITY HEALTH IMPROVEMENT SERVICES	
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Unpaid costs of: • Internships, residencies and fellowships • Training health professionals in special settings, such as occupational health	• Staff tuition that is provided as an employee benefit • On-the-job training • Training for non-health related professions
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RESEARCH	
• Evaluation of innovative treatments or delivery models • Research papers by staff for professional journals and presentations • Studies on health issues for vulnerable people	• Research where findings are only used internally • Market research • Research that yields proprietary knowledge
GRANTS AND IN-KIND CONTRIBUTIONS	
• Contributions to nonprofit community organizations • Grants to organizations, projects or initiatives that address a community need	• Fees for sporting event tickets • Time spent at recreational events
COMMUNITY BUILDING ACTIVITIES	
• Neighborhood improvement and revitalization projects • Child care for people with a qualified need • Waste reduction activities • Collaborative partnerships with community groups to improve economic stability	• Health facility construction & improvements such as a meditation garden or parking lot • Housing costs for employees • Expenditures to comply with environmental laws