OREGON'S CRITICAL ACCESS HOSPITALS

Fiscal Year 2018 Community Benefit Reporting Highlights

The Oregon Office of Rural Health, in partnership with the Oregon Association of Hospitals and Health Systems, created this report to break out community benefit reporting highlights for Oregon's 25 Critical Access Hospitals (CAHs). The Oregon Health Authority publishes community benefit data annually for all 60 nonprofit Oregon hospitals. The most recent community benefit data available is fiscal year 2018. This report describes community benefit reporting requirements, including the federal requirements for 501(c)(3) hospitals.

CONTENTS

OREGON OFFICE of RURAL HEALTH

In partnership with:

Oregon Association of Hospitals and Health Systems

We welcome your feedback. If you have any questions or suggestions on this report, please contact Rose Locklear at locklear@ohsu.edu. For previous year reports and resources on 501(c)(3) compliance, please visit the ORH website.

Published: September 2020

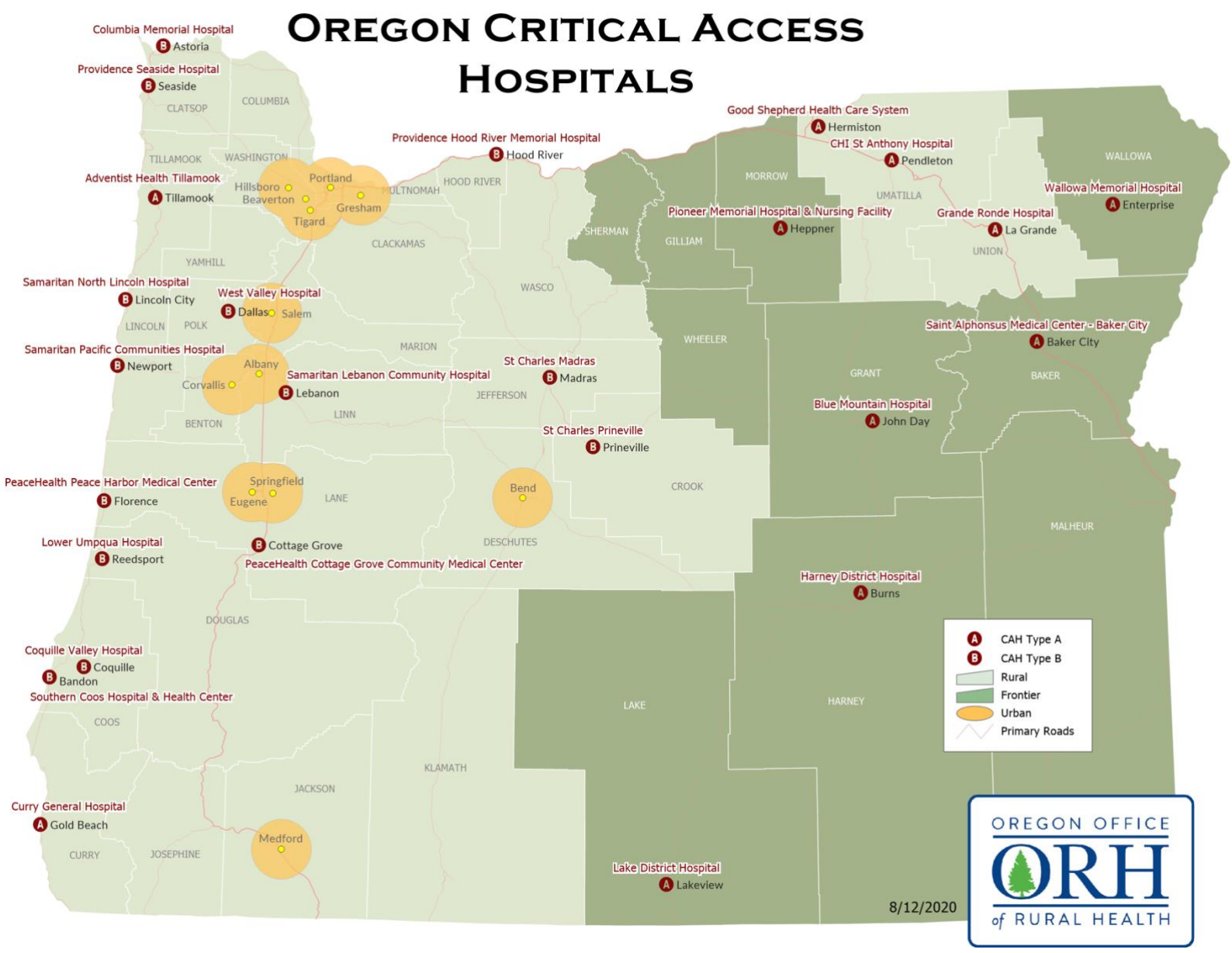
Oregon Critical Access Hospitals

Each year the Oregon Office of Rural Health (ORH) uses community benefit data compiled by the Oregon Health Authority (OHA) to highlight the community benefit that the 25 Oregon Critical Access Hospitals provide to their communities.

Small rural hospitals with 25 beds or less that meet geographic, and other criteria established by federal law can be classified as a Critical Access Hospital (CAH). All of Oregon's 25 CAHs maintain tax-exempt nonprofit status (see Appendix G).

Geographic criteria required for CAH designation:

- Located more than a 35-mile drive from any hospital; or
- Located more than a 15-mile drive from any hospital in mountainous terrain or on secondary roads; or
- Certificated as a CAH before January 1, 2006, based on designation as a "necessary provider."



Federal & State Nonprofit Hospital Community Benefit Reporting Requirements

Federal Reporting Requirements

The United States Internal Revenue Services (IRS) requires all nonprofit 501(c)(3) hospitals to provide and report (via the 990 Schedule H) on measurable benefits to the communities they serve. Incorporated as nonprofit through state law, a nonprofit organization is tax-exempt because it fills a socially charitable need that for-profit organizations have not found profitable enough to serve. Nonprofits can make a profit; however, they must reinvest those profits in community service or to the community's benefit. Community benefits are defined as programs or activities that hospitals provide to meet community needs regardless of a low or negative financial return in the following three categories:

1. Free and discounted care to those unable to afford health care;
2. Care to low-income beneficiaries of Medicaid and other indigent care programs; and
3. Services designated to improve community health and increase access to health care.

The Affordable Care Act (ACA) added Section 501(r) to the law enacting new requirements for 501(c)(3) hospitals that operate one or more hospital facilities (hospital organizations). This mandate requires hospital organizations to be responsible for additional reporting and excise tax requirements. Government hospital organizations are not excluded from Section 501(r) requirements.

Each 501(c)(3) hospital organization must meet the four general requirements:

1. Establish written financial assistance and emergency medical care policies:
   The financial assistance policy (FAP) must include:
   - Eligibility criteria for financial assistance and if assistance includes free or discounted care;
   - The basis for calculating amounts charged to patients;
   - The method for applying for financial assistance;
   - The actions the hospital organization may take in the event of nonpayment; and
   - The measures taken to widely publicize the FAP within the community served by the hospital.

   The emergency medical care policy and Emergency Medical Treatment and Labor Act (EMTALA 42 U.S.C. 1395DD), section 1867 of the Social Security Act, requires a hospital organization to provide, without discrimination, care for emergency medical conditions to individuals regardless of their ability to pay under the organization's FAP.

2. Limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's FAP;

3. Make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's FAP before engaging in extraordinary collection actions against the individual; and

4. Conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy at least once every three years. (These CHNA requirements became effective for tax years beginning after March 23, 2012). More information on CHNA requirements is available on the ORH website.

Section 4959 of the ACA imposes a $50,000 excise tax for each year that a 501(c)(3) hospital organization fails to meet these requirements.

State Reporting Requirements

In 2007, Oregon House Bill (HB) 3290 established a community benefit reporting law for all nonprofit hospitals statewide. Pursuant to this law, each hospital annually submits a form to the OHA that reports the hospital's cost of providing community benefits. In 2019, Oregon Revised Statues (ORS) 442.200 and 442.205 that defined and described community benefit reporting rules were renumbered as ORS 442.601 through 442.630.

Community benefit is described in ORS 442.601 as a program or activity that provides treatment or promotes health and healing, addresses health disparities or addresses the social determinants of health in response to an identified community need. In 2020, Medicare losses were removed from the community benefit categories:

- Charity care;
- Losses related to Medicaid, State Children's Health Insurance Program or other publicly funded health care program shortfalls other than Medicare;
- Community health improvement services;
- Research;
- Financial and in-kind contributions to the community; and
- Community building activities affecting health in the community.

**This report includes FY 2018 data, therefore losses related to Medicare are included and will be until FY 2020.*

ORS 442.602 (previously 442.205) describes community benefit reporting rules for hospitals operating in Oregon. Under this rule, hospitals are to submit a community benefit report (via the Community Benefit Reporting (CBR) form) to the authority of the community benefits within 90 days of filing a Medicare cost report. Detailed CBR instructions can be found here.

Oregon HB 4020 describes Hospital Financial Assistance Policies to meet the requirements of section 501(r) of the Internal Revenue Code and implementing regulations. Pursuant to this law, OHA was mandated to create a uniform financial assistance application available to hospitals and the public. This document may be used in any hospital in Oregon to request financial assistance. ORS 442.610 details hospital requirements for their financial assistance policies.

Beginning January 1, 2021, establishment of community benefit spending floor will go into effect. Every two years OHA will take into consideration numerous objective data and criteria described in the statute to establish the community benefit spending floor per hospital. ORS 442.624 describes these rules and the respective requirements of the authority and hospitals.

Reporting Limitations

1. All CAHs must report a CBR form annually to OHA; however, not all CAHs submit a 990 Schedule H to the IRS. These include:
    a. CAHs that are part of a hospital system: Regardless of how many hospitals are within the system, a hospital system can submit one 990 Schedule H under a system Employer Identification Number (EIN).
    b. Health tax district hospitals: A health tax district is a municipal corporation with a defined contiguous geographic area. Health districts receive tax revenues based on the voter approved permanent rate per $1,000 in assessed property value within the defined geographic area. There are currently 11 health districts supporting CAHs in Oregon. For more detail on health districts see ORS 440.320 and 440.360 and the ORH website. For more detail on the CAHs that are supported by health districts and those that do not report a 990 Schedule H to the IRS (see Appendix G).

2. The OHA CBR form does not require detail of specific activities or outcome data.

3. The IRS periodically revises the 990 Schedule H. As a result, OHA's CBR form and the IRS' 990 Schedule H are significantly different, which requires hospitals to submit two sets of reporting. Oregon legislators and health care stakeholders continue to work toward aligning reporting requirements and establishing minimum spending thresholds. To date, this work has not resulted in updated reporting requirements.

4. Hospital FY time periods vary. As a result, the most recent full FY data available for all CAHs is from 2018. See Appendix G for CAH FY period.

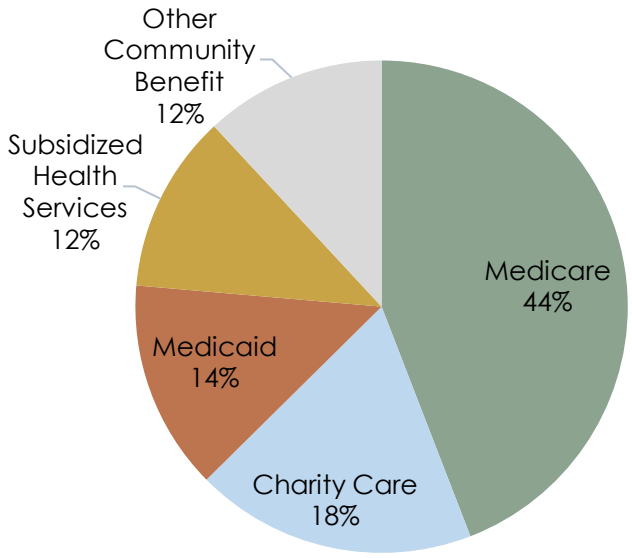
FY 2018 Critical Access Hospital Community Benefit Overview

During FY 2018, unreimbursed Medicare and Medicaid costs accounted for 58% of Critical Access Hospital community benefit.

In FY 2018, Oregon CAHs reported a total community benefit cost of $166,591,490 compared to $157,431,196 in FY 2017. While CAH community benefit cost per category largely remained consistent, the biggest increases from FY 2017 to FY 2018 can be attributed to charity care costs and losses related to Medicare. Community benefit expenses are allocated to the 11 categories listed below. See Appendix H for community benefit category definitions provided by the OHA.

Community Benefit Categories:

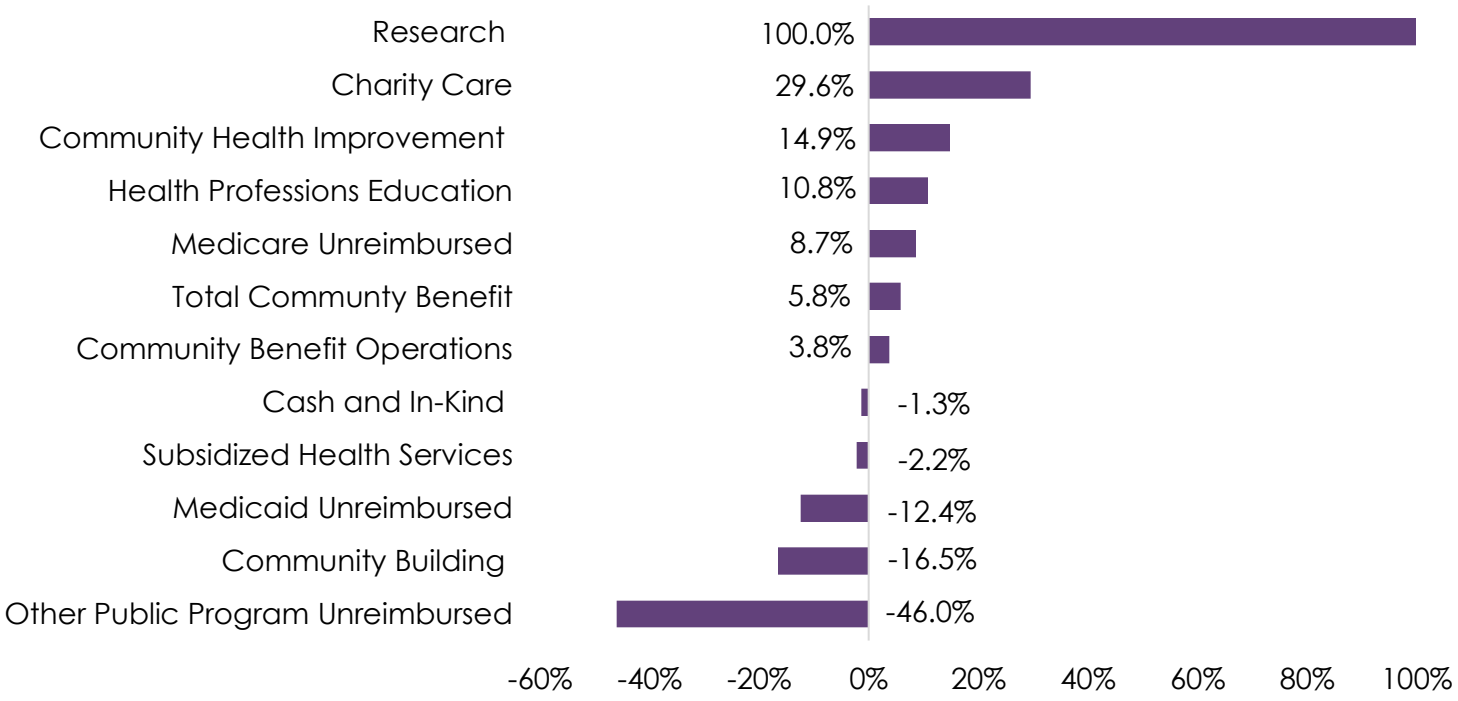
- Unreimbursed costs from Medicare
- Unreimbursed costs from Medicaid
- Charity care or financial assistance
- Subsidized health services
- Health professions education
- Community building activities
- Community health improvement
- Other public programs
- Cash and in-kind contributions
- Community benefit operations
- Research



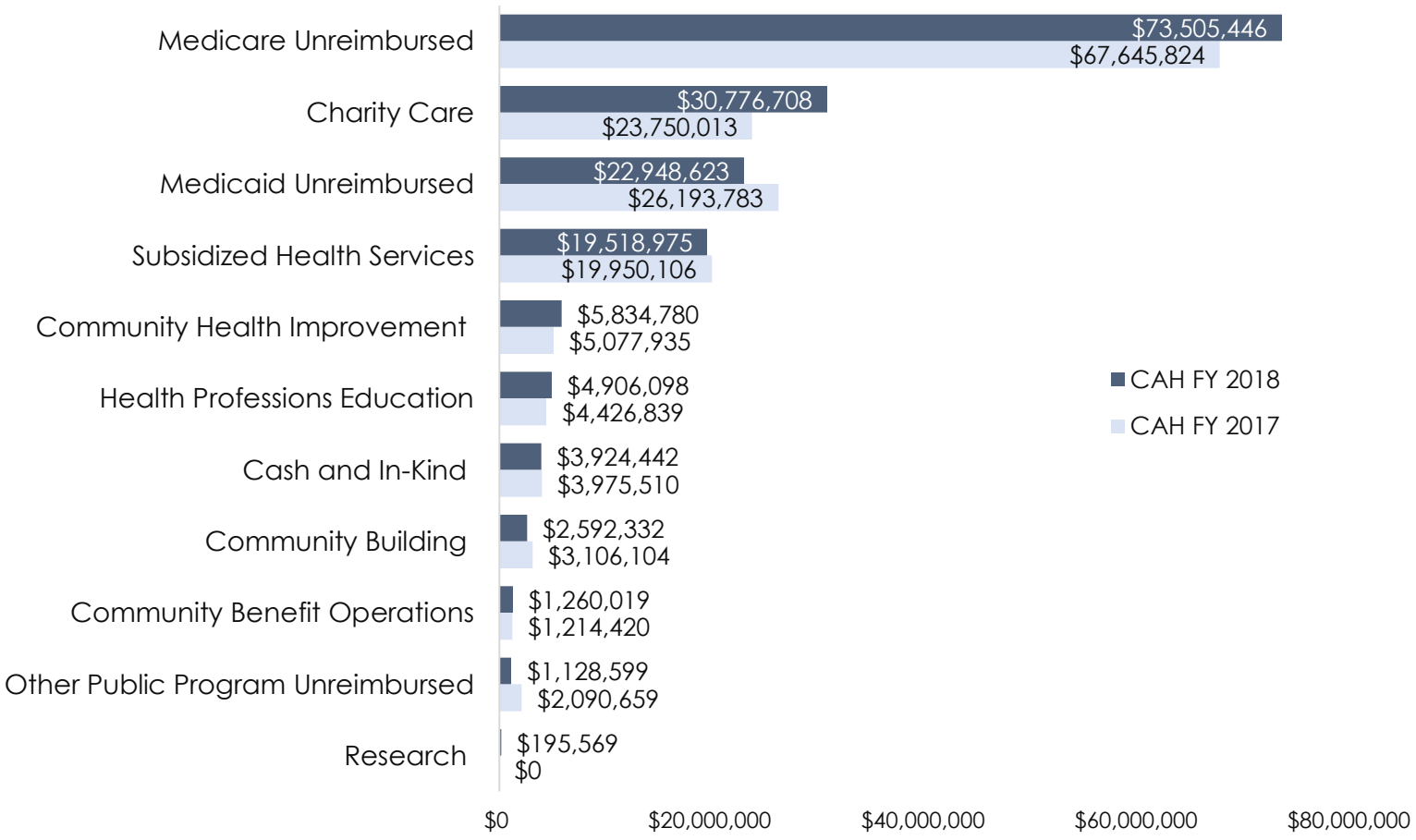
FY 2018 Statewide Trends

All Oregon nonprofit hospitals reported more than $2.5 billion in community benefit costs in FY 2018, an increase of approximately 9% from FY 2017 ($2.3 billion). Critical Access Hospitals reported spending $9,160,294 (~5.8%) more on total community benefit, compared to FY 2017. The total community benefit costs allocated to charity care increased by 29.6% from FY 2017. Unreimbursed Medicaid costs decreased (-12.4%), while unreimbursed Medicare costs increased (8.7%) between fiscal years. Of noteworthy importance—with no money spent in FY 2017 on research, the dramatic increase is attributed to one CAH that reported spending in this category. Appendix A illustrates the percent differences between FY 2017 and FY 2018 for CAHs.

Appendix A. Critical Access Hospital Community Benefit Cost Differences From FY 2017 to FY 2018



Appendix B. Total Critical Access Hospital Community Benefit Costs Per Category During FY 2017 & FY 2018



Appendix C. Highest to Lowest FY 2018 Critical Access Hospital Total Net Community Benefit Spend

Hospital Name	Total Net Community Benefit Spend	Medicare Unreimbursed Net Cost	Medicaid Net Unreimbursed Cost	Charity Care Net Cost	Net Patient Revenue[1]	Total Community Benefit/Net Patient Revenue[1]
Columbia Memorial	$27,567,113	$25,703,614	$0	$1,147,993	$136,838,727	20.15%
Providence Hood River Memorial	$19,223,698	$11,896,334	$1,965,593	$3,237,425	$95,225,524	20.19%
Good Shepherd	$14,790,119	$1,041,398	$0	$2,553,187	$98,024,276	15.09%
Samaritan Lebanon Community	$14,678,697	$4,516,676	$3,787,433	$2,570,116	$28,501,966	51.50%
Providence Seaside	$14,209,973	$10,693,261	$604,728	$2,017,786	$63,615,756	22.34%
St. Charles - Prineville	$8,292,301	$550,661	$5,261,187	$1,818,458	$32,222,725	25.73%
Grande Ronde	$8,177,090	$1,986,977	$0	$2,678,490	$98,217,463	8.33%
Samaritan Pacific Communities	$7,452,830	$2,061,800	$548,918	$2,086,226	$65,176,549	11.43%
St. Charles Medical Center - Madras	$5,926,115	$1,090,429	$2,644,771	$1,722,286	$36,558,935	16.21%
Harney District	$5,448,652	$3,834,423	$1,068,693	$224,411	$22,684,653	24.02%
Adventist Health Tillamook	$5,415,037	$0	$0	$4,062,203	$85,693,738	6.32%
Lower Umpqua	$5,410,474	$1,421,024	$724,911	$88,088	$21,775,738	24.85%
Coquille Valley	$5,302,100	$4,459,297	$641,615	$75,208	$26,591,215	19.94%
Salem Health West Valley	$4,279,194	$0	$2,489,528	$661,212	$32,351,140	13.23%
Samaritan North Lincoln	$4,179,936	$0	$0	$1,746,188	$121,952,754	3.43%
Lake District	$3,229,096	$1,271,152	$56,449	$436,980	$25,830,613	12.50%
CHI St. Anthony	$2,539,358	$0	$0	$752,765	$73,927,000	3.43%
Wallowa Memorial Hospital	$1,836,768	$114,403	$479,779	$194,453	$22,884,209	8.03%
Saint Alphonsus - Baker City	$1,649,337	$799,015	$412,785	$368,438	$18,533,783	8.90%
Southern Coos	$1,507,133	$777,743	$574,907	$104,284	$97,899,041	1.54%
Curry General	$1,475,552	$1,142,432	$0	$165,432	$42,489,686	3.47%
PeaceHealth Peace Harbor	$1,212,569	$0	$0	$1,192,109	$70,806,751	1.71%
Pioneer Memorial - Heppner	$1,109,955	$144,807	$698,534	$203,840	$10,120,299	10.97%
Blue Mountain	$1,040,527	$0	$988,794	$37,763	$23,466,616	4.43%
PeaceHealth Cottage Grove	$637,866	$0	$0	$631,366	$35,794,076	1.78%
CRITICAL ACCESS HOSPITAL TOTAL	**$166,591,490**	**$73,505,446**	**$22,948,623**	**$30,776,708**	**$1,387,183,233**	**12.01%**

[1]Total Operating Expenses and Net Patient Revenues are from audited financial statements and FR-3 forms. Annual hospital financial reports, can be found here.

Appendix D. Highest to Lowest FY 2018 Critical Access Hospital Community Benefit as a Percent of Net Patient Revenue

Hospital Name	Total Net Community Benefit Spend	Medicare Unreimbursed Net Cost	Medicaid Net Unreimbursed Cost	Charity Care Net Cost	Net Patient Revenue[1]	Total Community Benefit/Net Patient Revenue[1]
Samaritan Lebanon Community	$14,678,697	$4,516,676	$3,787,433	$2,570,116	$28,501,966	51.50%
St. Charles - Prineville	$8,292,301	$550,661	$5,261,187	$1,818,458	$32,222,725	25.73%
Lower Umpqua	$5,410,474	$1,421,024	$724,911	$88,088	$21,775,738	24.85%
Harney District	$5,448,652	$3,834,423	$1,068,693	$224,411	$22,684,653	24.02%
Providence Seaside	$14,209,973	$10,693,261	$604,728	$2,017,786	$63,615,756	22.34%
Providence Hood River Memorial	$19,223,698	$11,896,334	$1,965,593	$3,237,425	$95,225,524	20.19%
Columbia Memorial	$27,567,113	$25,703,614	$0	$1,147,993	$136,838,727	20.15%
Coquille Valley	$5,302,100	$4,459,297	$641,615	$75,208	$26,591,215	19.94%
St. Charles Medical Center - Madras	$5,926,115	$1,090,429	$2,644,771	$1,722,286	$36,558,935	16.21%
Good Shepherd	$14,790,119	$1,041,398	$0	$2,553,187	$98,024,276	15.09%
Salem Health West Valley	$4,279,194	$0	$2,489,528	$661,212	$32,351,140	13.23%
Lake District	$3,229,096	$1,271,152	$56,449	$436,980	$25,830,613	12.50%
Samaritan Pacific Communities	$7,452,830	$2,061,800	$548,918	$2,086,226	$65,176,549	11.43%
Pioneer Memorial - Heppner	$1,109,955	$144,807	$698,534	$203,840	$10,120,299	10.97%
Saint Alphonsus - Baker City	$1,649,337	$799,015	$412,785	$368,438	$18,533,783	8.90%
Grande Ronde	$8,177,090	$1,986,977	$0	$2,678,490	$98,217,463	8.33%
Wallowa Memorial Hospital	$1,836,768	$114,403	$479,779	$194,453	$22,884,209	8.03%
Adventist Health Tillamook	$5,415,037	$0	$0	$4,062,203	$85,693,738	6.32%
Blue Mountain	$1,040,527	$0	$988,794	$37,763	$23,466,616	4.43%
Curry General	$1,475,552	$1,142,432	$0	$165,432	$42,489,686	3.47%
CHI St. Anthony	$2,539,358	$0	$0	$752,765	$73,927,000	3.43%
Samaritan North Lincoln	$4,179,936	$0	$0	$1,746,188	$121,952,754	3.43%
PeaceHealth Cottage Grove	$637,866	$0	$0	$631,366	$35,794,076	1.78%
PeaceHealth Peace Harbor	$1,212,569	$0	$0	$1,192,109	$70,806,751	1.71%
Southern Coos	$1,507,133	$777,743	$574,907	$104,284	$97,899,041	1.54%
CRITICAL ACCESS HOSPITAL TOTAL	**$166,591,490**	**$73,505,446**	**$22,948,623**	**$30,776,708**	**$1,387,183,233**	**12.01%**

[1]Total Operating Expenses and Net Patient Revenues are from audited financial statements and FR-3 forms.

Annual hospital financial reports can be found here.

Appendix E. Top 10 Categories of Critical Access Hospital Community Benefit by Percentage Spent During FY 2018

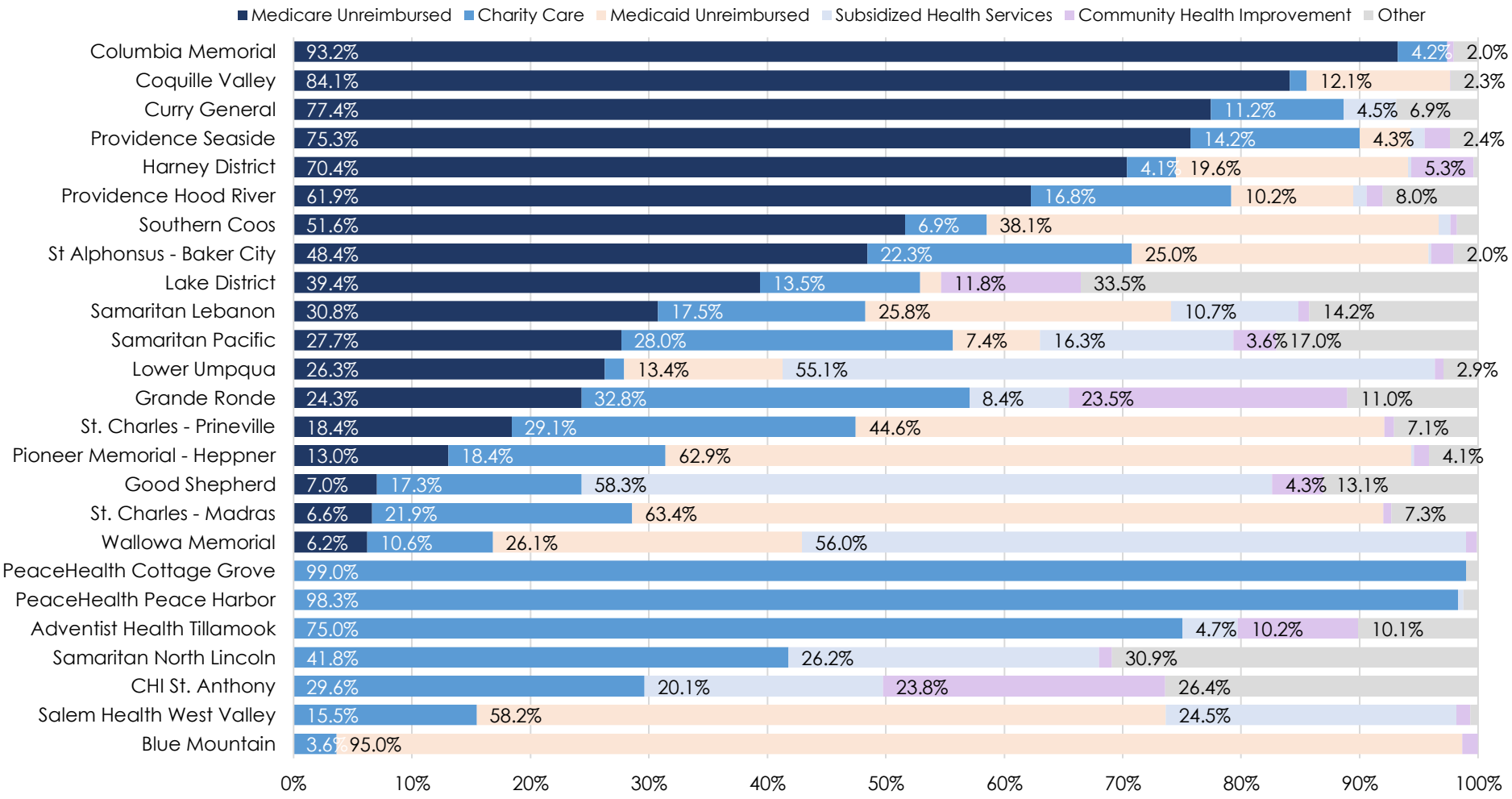
(in alphabetical order)

Hospital Name	Total Net Community Benefit Cost	Medicare Unreimbursed	Charity Care	Medicaid Unreimbursed	Subsidized Health Services	Community Health Improvement	Health Professions Education	Cash and In-Kind	Community Building	Community Benefit Operations	Other Public Program Unreimbursed
Adventist Health Tillamook	$5,415,037	0.0%	75.0%	0.0%	4.7%	10.2%	3.2%	1.4%	5.6%	0.0%	0.0%
Blue Mountain	$1,040,527	0.0%	3.6%	95.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%
CHI St. Anthony	$2,539,358	0.0%	29.6%	0.0%	20.1%	23.8%	8.5%	11.1%	6.2%	0.6%	0.0%
Columbia Memorial	$27,567,113	93.2%	4.2%	0.0%	0.0%	0.6%	0.0%	0.2%	0.2%	0.3%	1.3%
Coquille Valley	$5,302,100	84.1%	1.4%	12.1%	0.0%	0.0%	0.2%	0.4%	1.7%	0.0%	0.0%
Curry General	$1,475,552	77.4%	11.2%	0.0%	4.5%	0.0%	1.7%	4.3%	0.0%	0.9%	0.0%
Good Shepherd	$14,790,119	7.0%	17.3%	0.0%	58.3%	4.3%	2.5%	6.3%	0.0%	4.3%	0.0%
Grande Ronde	$8,177,090	24.3%	32.8%	0.0%	8.4%	23.5%	9.7%	0.2%	0.0%	1.1%	0.0%
Harney District	$5,448,652	70.4%	4.1%	19.6%	0.2%	5.3%	0.0%	0.3%	0.1%	0.0%	0.0%
Lake District	$3,229,096	39.4%	13.5%	1.7%	0.0%	11.8%	5.3%	23.7%	4.1%	0.4%	0.0%
Lower Umpqua	$5,410,474	26.3%	1.6%	13.4%	55.1%	0.7%	0.0%	2.9%	0.0%	0.0%	0.0%
PeaceHealth Cottage Grove	$637,866	0.0%	99.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%
PeaceHealth Peace Harbor	$1,212,569	0.0%	98.3%	0.0%	0.5%	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%
Pioneer Memorial - Heppner	$1,109,955	13.0%	18.4%	62.9%	0.2%	1.3%	0.0%	0.3%	3.6%	0.2%	0.0%
Providence Hood River	$19,223,698	61.9%	16.8%	10.2%	1.1%	1.3%	3.8%	1.7%	1.5%	1.1%	0.0%
Providence Seaside	$14,209,973	75.3%	14.2%	4.3%	1.2%	2.1%	0.1%	1.7%	0.1%	0.4%	0.0%
Saint Alphonsus - Baker City	$1,649,337	48.4%	22.3%	25.0%	0.2%	1.9%	1.6%	0.1%	0.1%	0.2%	0.0%
Salem Health West Valley	$4,279,194	0.0%	15.5%	58.2%	24.5%	1.2%	0.5%	0.2%	0.0%	0.0%	0.0%
Samaritan Lebanon	$14,678,697	30.8%	17.5%	25.8%	10.7%	0.9%	8.1%	2.6%	3.1%	0.4%	0.0%
Samaritan North Lincoln	$4,179,936	0.0%	41.8%	0.0%	26.2%	1.1%	10.2%	5.4%	14.7%	0.6%	0.0%
Samaritan Pacific Communities	$7,452,830	27.7%	28.0%	7.4%	16.3%	3.6%	8.6%	3.1%	4.8%	0.6%	0.0%
Southern Coos	$1,507,133	51.6%	6.9%	38.1%	1.0%	0.5%	1.6%	0.0%	0.2%	0.0%	0.0%
St. Charles - Madras	$8,292,301	6.6%	21.9%	63.4%	0.0%	0.7%	0.5%	0.7%	0.3%	0.1%	5.6%
St. Charles - Prineville	$5,926,115	18.4%	29.1%	44.6%	0.0%	0.8%	0.5%	0.6%	0.7%	0.1%	5.1%
Wallowa Memorial	$1,836,768	6.2%	10.6%	26.1%	56.0%	0.9%	0.1%	0.0%	0.0%	0.0%	0.0%
Total	**$166,591,490**										

*darker cell shading indicates a higher value

Appendix F. Categories of Critical Access Hospital Community Benefit by Percentage Spent During FY 2018

(Hospitals listed in alphabetical order of decreasing Medicare unreimbursed percentage)



Appendix G. Critical Access Hospital Fiscal Year, Tax District, I 990 & 501(c)(3) Status

Hospital Name	FY End	Health Tax District (Y/N)	I 990 Schedule H Available (Year)	501(c)(3) (Y/N)
Adventist Health Tillamook	December	N	No	Y
Blue Mountain	June	Y	No	Y
CHI St. Anthony	June	N	2017	Y
Columbia Memorial	December	N	2018	Y
Coquille Valley	June	Y	No	Y
Curry General	June	Y	No	Y
Good Shepherd	June	N	2017	Y
Grande Ronde	April	N	2017	Y
Harney District	June	Y	No	Y
Lake District	June	Y	No	Y
Lower Umpqua	June	Y	No	Y
PeaceHealth Cottage Grove Community	June	N	No	Y
PeaceHealth Peace Harbor	June	N	No	Y
Pioneer Memorial	June	Y	2018	Y
Providence Hood River Memorial	December	N	No	Y
Providence Seaside	December	N	No	Y
Saint Alphonsus - Baker City	June	N	No	Y
Salem Health West Valley	June	N	2017	Y
Samaritan Lebanon Community	December	N	2018	Y
Samaritan North Lincoln	December	Y	2018	Y
Samaritan Pacific Communities	December	Y	2018	Y
Southern Coos	June	Y	No	Y
St. Charles -Madras	December	N	No	Y
St. Charles -Prineville	December	N	No	Y
Wallowa Memorial	June	Y	No	Y

Appendix H. Community Benefit Cost Categories and Definitions

Cash and In-Kind Contributions Cost	Funds and services donated to individuals or groups of the community. Typical contributions include grants, scholarships, staff hours, hospital space, food, and equipment.
Charity Care Cost	Charity care: health care services provided to people who are determined by the hospital to be unable to pay for the services. Hospitals will determine a patient's inability to pay based on established hospital policy, as required by the Affordable Care Act. These financial assistance policies examine a variety of factors, such as individual and family income, assets, employment status, family size, or availability of alternative sources of payment. A hospital may establish inability to pay at the time care is provided or through later efforts to gather adequate financial information to make an eligibility determination. Charity care may cover all or just a portion of the owed bill. Hospitals may use different methodologies to estimate the costs of charity care.
Community Benefit Operations Cost	Costs associated with developing and maintaining community benefit programs, such as staff hours, grant writing, needs assessments, and fundraising.
Community Building Activities Cost	Costs associated with non-health care programs provided by the hospital to minimize potential health problems. Examples include neighborhood revitalization, tree planting, low-income housing projects, mentoring groups, air quality improvement, conflict resolution training, and workforce development programs.
Community Health Improvement Cost	Costs associated with activities geared towards improving the health of the community including educational lectures/presentations, special community health screening events, clinics, telephone information services, poison control services, and hotlines.
Health Professions Education Cost	Costs associated with training future health care professionals by providing a clinical setting for training, internships, vocational training, and residencies.
Medicaid Unreimbursed Cost	An estimate of the costs not reimbursed by Medicaid, the federal health insurance program that provides health and long-term care services to low-income populations.
Medicare Unreimbursed Cost	An estimate of the costs not reimbursed by Medicare, the federal health insurance program for citizens over 65 and those determined disabled by the Social Security Administration.
Net Patient Revenue	The amount of revenue received (or expected to be received) from all payers for patient services. (Obtained from a hospital's FR-3 form.)
Total Community Benefit	The total amount of unreimbursed expenditures by a hospital toward their community benefit programs. Direct offsetting revenues have been deducted from these data.
Other Public Programs Cost	An estimate of the costs not reimbursed by public health programs other than Medicaid and Medicare, such as Tricare, Champus, Indian Health Service, or other federal, state, or local programs.
Research Cost	The cost of clinical and community health research, as well as studies on health care delivery. Requires that results of studies are shared with entities outside the hospital organization.
Subsidized Health Services Cost	Clinical services that meet a particular community need that are provided despite a financial loss to the hospital. Emergency services may be included, such as an air ambulance or a trauma center.
Total Operating Expense	All expenses associated with operating the hospital, such as salaries, employee benefits, purchased services, supplies, professional fees, and insurance (Obtained from a hospital's FR-3 form).
Health District Hospital	A hospital that operates in a Health District and receives funding from property tax as one of the revenue sources to cover the cost of providing healthcare services in the Health District.

Appendix I. Critical Access Hospital Community Health Needs Assessments

All 25 Oregon CAHs maintain their tax-exempt/charitable status under section 501(c)(3) of Federal Internal Revenue Code by providing benefit to the community that they serve. The IRS requires that 501(c)(3) hospitals publicly show community benefit by conducting a community health needs assessment (CHNA) and adopting an implementation strategy to meet identified needs. This must be done at least once every three years and can be done in collaboration with other clinical, public health, population health focused organizations, with opportunities for public participation. See ORS 442.630 (community health needs assessment and three year strategy).

Resources to support CHNA development and compliance are available on the ORH website. An interactive map of the most recent CHNAs and Community Health Improvement Plans (CHIPs) for Oregon nonprofit hospitals, local public health authorities (LPHAs) and coordinated care organizations (CCOs) can be accessed here.

Hospital Name	CHNA (Y/N)	Online (Y/N)	Most Recent	Partnership with Local Health Department (*Y/N)
Adventist Health Tillamook	Y	Y	2019-2022	Y
Blue Mountain	Y	Y	2019-2022	N
CHI St Anthony	Y	Y	2018-2021	Y
Columbia Memorial	Y	Y	2020-2022	N
Coquille Valley	Y	Y	2018-2021	Y
Curry General	Y	Y	2018-2021	Y
Good Shepherd	Y	Y	2018-2021	Y
Grande Ronde	Y	Y	2018-2021	Y
Lake District	Y	Y	2017-2020	Y
Lower Umpqua	Y	Y	2017-2020	N
PeaceHealth Cottage Grove	Y	Y	2019-2022	N
PeaceHealth Peace Harbor	Y	Y	2019-2022	N
Pioneer Memorial	Y	Y	2018-2021	Y
Providence Hood River Memorial	Y	Y	2019-2022	Y
Providence Seaside	Y	Y	2019-2022	N
Saint Alphonsus—Baker City	Y	Y	2019-2022	Y
Salem Health West Valley	Y	Y	2019-2022	Y
Samaritan Lebanon Community	Y	Y	2020-2023	N
Samaritan North Lincoln	Y	Y	2020-2023	N
Samaritan Pacific Communities	Y	Y	2020-2023	N
Southern Coos	Y	Y	2017-2020	Y
St. Charles Madras	Y	Y	2020-2022	N
St. Charles Prineville	Y	Y	2020-2022	N
Wallowa Memorial	Y	Y	2019-2022	Y

* Local Health Department (LHD) partnership means the LHD is listed as a partner in CHNA.