

# 2010

# Instructions for Schedule H (Form 990)



Department of the Treasury  
Internal Revenue Service

## Hospitals

Section references are to the Internal Revenue Code unless otherwise noted.

### General Instructions

**Note.** Terms in **bold** are defined in the *Glossary* of the Instructions for Form 990.

**What's New.** Hospital organizations may not file 2010 Forms 990 (with Schedule H attached) before July 1, 2011, regardless of whether the hospital organization files an electronic return or a paper return.

**Note.** The Patient Protection and Affordable Care Act (Affordable Care Act), enacted March 23, 2010, Pub. L. No. 111-148, added section 501(r) to the Code. Section 501(r) includes additional requirements a **hospital organization** must meet to qualify for tax exemption under section 501(c)(3) in tax years beginning after March 23, 2010. These additional requirements address a hospital organization's financial assistance policy, policy relating to emergency medical care, billing and collections, and charges for medical care. Also, for tax years beginning after March 23, 2012, the Affordable Care Act requires hospital organizations to conduct community health needs assessments.

Because section 501(r) requires an organization to meet these requirements with respect to each of its **hospital facilities**, Part V, *Facility Information*, has been expanded to include a new Section A, *Hospital Facilities*, in which an organization must list its **hospital facilities**; that is, its facilities that at any time during the **tax year**, were required to be licensed, registered, or similarly recognized as a hospital under state law, and any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exempt status under section 501(c)(3), without regard to section 501(r). Part V also includes a new Section B, *Facility Policies and Practices*, for reporting of information on policies and practices addressed in section 501(r). The organization must complete a separate Section B for each of its hospital facilities listed in Section A for tax years beginning after March 23, 2010.

The provisions of section 501(r) are effective for tax years beginning after March 23, 2010, except for the community health needs assessment requirements of section 501(r)(3), which are effective for tax years beginning after

March 23, 2012. Accordingly, the questions in Part V, Section B, regarding community health needs assessments (lines 1 through 7) are optional for tax year 2010. Section B, lines 8-21, are optional for hospital organizations reporting a tax year beginning on or before March 23, 2010.

Section 6033(b)(15)(B) also requires hospital organizations to submit a copy of their audited financial statements to the IRS. Accordingly, an organization whose tax year begins after March 23, 2010 that is required to file Form 990, Schedule H, Part V, Section B, must attach its audited financial statements for the tax year to its Form 990 (see instructions for Form 990, Part IV, line 20b).

Part V also includes a new Section C, in which the organization must list all of its non-hospital health care facilities that it operated during the tax year, whether or not such facilities were required to be licensed or registered under state law. The organization should not complete Part V, Section B, for any of these non-hospital facilities.

### Purpose of Schedule

Schedule H (Form 990) must be completed by an organization that operated during the **tax year** at least one **hospital facility**: a facility that is, or is required to be, licensed, registered, or similarly recognized by a state as a **hospital**, and any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exempt status under section 501(c)(3), without regard to section 501(r).

The organization must file a single Schedule H (Form 990) that aggregates information from the following.

1. Hospitals directly operated by the organization.
2. Hospitals operated by **disregarded entities** of which the organization is the sole member.
3. Other facilities or programs of the organization or any of the entities described in 1 or 2, even if provided by a facility that is not a hospital or if provided separately from the hospital's license.
4. Hospitals and other health care facilities or programs operated by any **joint venture** treated as a partnership, to the extent of the organization's proportionate share of the joint venture.

Proportionate share is defined as the ending capital account percentage listed on the Schedule K-1 (Form 1065), Partner's Share of Income, Deductions, Credits, etc., Part II, line J, for the partnership tax year ending in the organization's tax year being reported on the organization's Form 990. If Schedule K-1 (Form 1065) is not available, the organization can use other business records to make a reasonable estimate, including the most recently available Schedule K-1 (Form 1065), adjusted as appropriate to reflect facts known to the organization, or information used for purposes of determining its proportionate share of the venture for the organization's financial statements.

5. In the case of a **group return** filed by the organization, hospitals operated directly by members of the **group exemption** included in the group return, hospitals operated by a disregarded entity of which a member included in the group return is the sole member, hospitals operated by a joint venture treated as a partnership to the extent of the group member's proportionate share (determined in the manner described in 4, earlier), and other facilities or programs of a member included in the group return even if such facilities are not hospitals or if such programs are provided separately from the hospital's license.

**Example.** The organization is the sole member of a disregarded entity. The disregarded entity owns 50% of a joint venture treated as a partnership. The partnership in turn owns 50% of another joint venture treated as a partnership that operates a hospital and a freestanding outpatient clinic that is not part of the hospital's license. (Assume the respective proportionate shares of the partnerships based on capital account percentages listed on the partnerships' Schedule K-1 (Form 1065), Part II, line J, are also 50%.) The organization would report 25% (50% of 50%) of the hospital's and outpatient clinic's aggregate information on Schedule H (Form 990).

Note that while information from all the above sources is aggregated for purposes of Schedule H (Form 990), the organization is required to report each of its **hospital facilities** in Part V, Sections A and B, whether operated directly by the organization or indirectly through a disregarded entity or joint venture treated as a partnership. In addition, the organization must report in Part V,

Section C, each of its other health care facilities for which it reports information on Schedule H (Form 990) (for example, two rehabilitation clinics, four diagnostic centers), whether operated directly by the organization or indirectly through a disregarded entity or a joint venture treated as a partnership.

Organizations are not to report information from hospitals located outside the **United States** in Parts I, II, III, or V. Information from foreign joint ventures and partnerships *must* be reported in Part IV, *Management Companies and Joint Ventures*. Information concerning foreign hospitals and facilities *can* be described in Part VI.

Except as provided in Part IV, do not report on Schedule H (Form 990) information from an entity organized as a separate legal entity from the organization and treated as a corporation for federal income tax purposes (except for members of a group exemption included in a group return filed by the organization), even if such entity is affiliated with or otherwise related to the organization (for example, part of an affiliated health care system).

## Who Must File

An organization that answered “Yes” on Form 990, Part IV, *Checklist of Required Schedules*, line 20, *must* complete and attach Schedule H to Form 990.

For purposes of Schedule H (Form 990), a **hospital** is a facility that is, or is required to be, licensed, registered, or similarly recognized by a state as a hospital. This includes a hospital operated through a disregarded entity or a **joint venture** treated as a partnership. It does not include hospitals that are located outside the **United States**. It also does not include hospitals operated by entities organized as separate legal entities from the organization that are treated as a corporation for federal tax purposes (except for members of a group exemption included in a group return filed by the organization). If the organization operates multiple hospitals, or if it files a group return for a group that operates one or more hospitals, complete one Schedule H (Form 990) for all of the hospitals operated by the filing organization or the group, and report aggregate information from all such hospitals as described in *Purpose of Schedule, General Instructions*.

If an organization is not required to file Form 990 but chooses to do so, it must file a complete return and provide all of the information requested, including the required schedules.

An organization that does not operate one or more facilities that satisfy the definition of a hospital, above, should not file Schedule H (Form 990).



*The definition of hospital for Schedule A (Form 990), Public Charity Status and Public Support, Part I, line 3, and the definition of hospital*

for Schedule H (Form 990) *are not the same. Accordingly, an organization that checks box 3 in Part I of Schedule A (Form 990) to report that it is a hospital or cooperative hospital service organization, must complete and attach Schedule H to Form 990 only if it meets the definition of hospital for purposes of Schedule H (Form 990), as explained above.*

## Specific Instructions

### Part I. Financial Assistance and Certain Other Community Benefits at Cost

Part I requires reporting of financial assistance policies, the availability of community benefit reports, and the cost of certain financial assistance and other community benefit programs. Worksheets and accompanying instructions are provided at the end of the instructions to this schedule to assist in completing the table in Part I, line 7.

**Line 1.** A financial assistance policy, sometimes referred to as a charity care policy, is a policy describing how the organization will provide financial assistance at its hospital(s) and other facilities, if any. Financial assistance includes free or discounted health services provided to persons who meet the organization’s criteria for financial assistance and are thereby deemed unable to pay for all or a portion of the services. Financial assistance does not include: bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to failure to pay by patients, or the cost of providing such care to such patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom; or contractual adjustments with any third-party payors.

**Line 2.** Check only one of the three boxes. “Applied uniformly to all hospitals” means that all of the organization’s **hospital facilities** use the same financial assistance policy. “Applied uniformly to most hospitals” means that the majority of the organization’s hospital facilities use the same financial assistance policy. “Generally tailored to individual hospitals” means that the majority of the organization’s hospital facilities use different financial assistance policies. If the organization operates only one hospital facility, check “Applied uniformly to all hospitals.”

**Line 3.** Answer lines 3a, 3b, and 3c based on the financial assistance eligibility criteria that apply to (1) the largest number of the organization’s patients based on patient contacts or encounters or (2) if the organization does not operate its own **hospital facility**, the

largest number of patients of a hospital facility operated by a **joint venture** in which the organization has an ownership interest. For example, if the organization has two hospital facilities, use the financial assistance eligibility criteria used by the hospital facility which has the most patient contacts or encounters during the **tax year**.

**Line 3a.** “Federal Poverty Guidelines” (FPG) are the Federal Poverty Guidelines established by the U.S. Department of Health and Human Services. If the organization has established a family or household income threshold that a patient must meet or fall below to qualify for free medical care, check the box in the “Yes” column and indicate the specific threshold by checking the appropriate box. For instance, if a patient’s family or household income must be less than or equal to 250% of FPG for the patient to qualify for free care, then check the box marked “Other” and enter “250%.”

**Line 3b.** If the organization has established a family or household income threshold that a patient must meet or fall below to qualify for discounted medical care, check the box in the “Yes” column and indicate the specific threshold by checking the appropriate box.

**Line 3c.** If applicable, describe the other income-based criteria, asset test, or other means test or threshold for free or discounted care in Part VI, line 1 of this schedule. An “asset test” includes (i) a limit on the amount of total or liquid assets that a patient or the patient’s family or household can own for the patient to qualify for free or discounted care, and/or (ii) a criterion for determining the level of discounted medical care patients can receive, depending on the amount of assets that they and/or their families or households own.

**Line 4.** “Medically indigent” means persons whom the organization has determined are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income or assets (for example, due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the generally applicable eligibility requirements for free or discounted care under the organization’s financial assistance policy.

**Line 5.** Answer lines 5a, 5b, and 5c based on the organization’s budgeted amounts under its financial assistance policy.

**Line 5a.** Answer “Yes,” if the organization established or had in place at any time during the **tax year** an annual or periodic budgeted amount of free or discounted care to be provided under its financial assistance policy. If “No,” skip to line 6a.

**Line 5b.** Answer “Yes,” if the free or discounted care the organization provided in the applicable period exceeded the

budgeted amount of costs or charges for that period. If “No,” skip to line 6a.

**Line 5c.** Answer “Yes,” if the organization denied financial assistance to any patient eligible for free or discounted care under its financial assistance policy solely because the organization’s financial assistance budget was exceeded.

**Line 6.** Answer lines 6a and 6b based on the community benefit report that the organization prepared during the **tax year**.

**Line 6a.** Answer “Yes” if the organization prepared a written report during the **tax year** that describes the organization’s programs and services that promote the health of the community or communities served by the organization. If the organization’s community benefit report is contained in a report prepared by a **related organization**, answer “Yes” and identify the related organization in Part VI, line 1. If “No,” skip to line 7.

**Line 6b.** Answer “Yes” if the organization made the community benefit report it prepared during the **tax year** available to the public.

**TIP** *Some of the ways in which an organization can make its community benefit report available to the public are to post the report on the organization’s website, to publish and distribute the report to the public by mail or at its facilities, or to submit the report to a state agency or other organization that makes the report available to the public.*

**Lines 7a through 7k.** Report on the table (lines 7a through 7k), at cost, the organization’s financial assistance and certain other community benefits. Report on line 7i **contributions** to community groups that the organization restricts to one or more of the community benefit activities listed in lines 7a through 7h. Do not report such contributions on lines 7a through 7h. To calculate the amounts to be reported on the table, use the worksheets or other equivalent documentation that substantiates the information reported consistent with the methodology used on the worksheets. See the instructions to the worksheets for definitions of the various types of community benefit (for example, community health improvement services, health professions education, subsidized health services, research, etc.) to be reported on lines 7a through 7k.

**TIP** *If the organization completed worksheets other than on an aggregate basis (for example, facility by facility, joint venture by joint venture), the organization should aggregate all information from these worksheets for purposes of reporting amounts on the table. Only the portion of each **joint venture** or partnership that represents the organization’s proportionate share, based on capital interest, can be reported on lines 7a*

*through 7k (see Purpose of Schedule for instructions on aggregation).*

Use the organization’s most accurate costing methodology (cost accounting system, cost-to-charge ratio, or other) to calculate the amounts reported on the table. If the organization uses a cost-to-charge ratio, it can use Worksheet 2. Ratio of Patient Care Cost to Charges, for this purpose. See the instructions for Part VI, line 1, regarding an explanation of the costing methodology used to calculate the amounts reported on the table.

If the organization included any costs attributable to a physician clinic as subsidized health services on Part I, line 7g, report these costs on Part VI, line 1.

If the organization included any bad debt expense on Form 990, Part IX, line 25 but subtracted this bad debt for purposes of calculating the amount reported on line 7f, report this bad debt expense on Part VI, line 1.

Do not report bad debt expense on lines 7a through 7k.

The following are descriptions of the type of information reported in each column of the table.

**Column (a).** “Number of activities or programs” means the number of the organization’s activities or programs conducted during the year that involve the community benefit reported on the line. Report each activity and program on only one line so that it is not counted more than once. Reporting in this column is optional.

**Column (b).** “Persons served” means the number of patient contacts or encounters in accordance with the filing organization’s records. Persons served can be reported in multiple rows, as services across different categories may be provided to the same patient. Reporting in this column is optional.

**Column (c).** “Total community benefit expense” means the total gross expense of the activity incurred during the year, calculated by using the pertinent worksheets for each line item. “Total community benefit expense” includes both “direct costs” and “indirect costs.” “Direct costs” means salaries and benefits, supplies, and other expenses directly related to the actual conduct of each activity or program. “Indirect costs” means costs that are shared by multiple activities or programs, such as facilities and administration costs related to the organization’s infrastructure (for example, space, utilities, custodial services, security, information systems, administration, materials management, and others).

**Column (d).** “Direct offsetting revenue” means revenue from the activity during the year that offsets the total community benefit expense of that activity, as calculated on the worksheets for each line item. “Direct offsetting revenue” includes any revenue generated by the activity or program, such as

payment or reimbursement for services provided to program patients. Direct offsetting revenue does not include restricted or unrestricted grants or contributions that the organization uses to provide a community benefit.

**Example.** The organization receives a restricted grant from an unrelated organization that must be used by the organization to provide financial assistance. The amount of the restricted grant is not reportable as direct offsetting revenue on line 7a, column (d).

**Column (e).** “Net community benefit expense” is “Total community benefit expense” (column (c)) minus “Direct offsetting revenue” (column (d)). If the calculated amount is less than zero, report such amount as a negative number.

**Column (f).** “Percent of total expense” is the “net community benefit expense” in column (e) divided by the sum of the amount on Form 990, Part IX, line 25, column (A) and the organization’s proportionate share of total expenses of all **joint ventures** for which it reports expenses on the table in Part I, to the extent that such expenses are not already reported in Form 990, Part IX, line 25, column (A). Report the percentage to two decimal places (x.xx%). Any bad debt expense included in the denominator should be removed prior to calculation, and the amount of bad debt expense that was included on Form 990, Part IX, line 25, column (A) but removed from this figure should be reported in Part VI, line 1.

**TIP** *Column (f) “percent of total expense” is based on column (e) “net community benefit expense,” rather than column (c) “total community benefit expense.” Organizations that report amounts of direct offsetting revenue also might wish to report total community benefit expense (Part I, line 9, column (c)) as a percentage of total expenses. Although this percentage cannot be reported in Part I, line 7, column (f), it can be reported on Schedule H (Form 990), Part VI, line 1.*

## Optional Worksheets for Part I, Line 7 (Financial Assistance and Certain Other Community Benefits At Cost)

Worksheets 1 through 8 are intended to assist the organization in completing Schedule H (Form 990), Part I, lines 7a through 7k. Use of the worksheets is not required and they should not be filed with Form 990. The organization can use alternative equivalent documentation, provided that the methodology described in these instructions (including the instructions to the worksheets) is followed. Regardless of whether the worksheets or alternative equivalent documentation is used to compile and

report the required information, such documentation must be retained by the organization to substantiate the information reported on Schedule H (Form 990). The worksheets or alternative equivalent documentation are to be completed using the organization's most accurate costing methodology, which can include a cost accounting system, cost-to-charge ratios, a combination thereof, or some other method.

If the organization is filing a group return or has a disregarded entity or an ownership interest in one or more **joint ventures**, the organization may find it helpful to complete the worksheets separately for the organization and for each disregarded entity, joint venture in which the organization had an ownership interest during the **tax year**, and group affiliate. In such case, the organization should aggregate all information from these worksheets for purposes of completing line 7. Complete the table by aggregating amounts from the organization's worksheets, amounts from disregarded entities or group affiliates, and amounts from joint ventures that are attributable to the organization's proportionate share of each joint venture, pursuant to the aggregation instruction in *Purpose of Schedule*.

See Worksheets 1 through 8 and specific instructions for the worksheets that begin on page 10.

## Part II. Community Building Activities

Report in this part the costs of the organization's activities that it engaged in during the tax year to protect or improve the community's health or safety, and that are not reportable in Part I or III of this schedule. An organization that reports information in this part must describe in Part VI how its community building activities promote the health of the communities it serves. Do not include activities in this part that are reported on Part I, line 7.

If the filing organization makes a grant to an organization to be used to accomplish one of the community building activities listed in this part, then the organization should include the amount of the grant on the appropriate line in Part II. If the organization makes a grant to a **joint venture** in which it has an ownership interest to be used to accomplish one of the community building activities listed in this part, report the grant on the appropriate line in Part II, but do not include in Part II the organization's proportionate share of the amount spent by the joint venture on such activities, to avoid double counting. Do not include any contribution made by the organization that was funded in whole or in part by a restricted grant, to the extent that such grant was funded by a **related organization**.

**Line 1.** "Physical improvements and housing" can include, but are not limited

to, the provision or rehabilitation of housing for vulnerable populations, such as removing building materials that harm the health of the residents, neighborhood improvement or revitalization projects, provision of housing for vulnerable patients upon discharge from an inpatient facility, housing for low-income seniors, and the development or maintenance of parks and playgrounds to promote physical activity.

**Line 2.** "Economic development" can include, but is not limited to, assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness.

**Line 3.** "Community support" can include, but is not limited to, child care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.

**Line 4.** "Environmental improvements" can include, but are not limited to, activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards. The organization cannot include on this line or in this part expenditures made to comply with environmental laws and regulations that apply to activities of itself, its disregarded entity or entities, a **joint venture** in which it has an ownership interest, or a member of a **group exemption** included in a **group return** of which the organization is also a member. Similarly, the organization cannot include on this line or in this part expenditures made to reduce the environmental hazards caused by, or the environmental impact of, its own activities, or those of its disregarded entities, joint ventures, or group exemption members.

**Line 5.** "Leadership development and training for community members" can include, but is not limited to, training in conflict resolution; civic, cultural, or language skills; and medical interpreter skills for community residents.

**Line 6.** "Coalition building" can include, but is not limited to, participation in community coalitions and other collaborative efforts with the community to address health and safety issues.

**Line 7.** "Community health improvement advocacy" can include, but is not limited to, efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation.

**Line 8.** "Workforce development" can include, but is not limited to, recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved, and collaboration with educational institutions to train and recruit health professionals needed in the community (other than the health professions education activities reported in Part I, line 7f).

**Line 9.** "Other" refers to community building activities that protect or improve the community's health or safety that are not described in the categories listed in lines 1 through 8 above.

Refer to the instructions to Part I, line 7, columns (a) through (f), for descriptions of the types of information that should be reported in each column of Part II.

If the organization is filing a **group return** or has a **disregarded entity** or an ownership interest in one or more **joint ventures**, the organization may find it helpful to complete Part II separately for itself and for each disregarded entity, joint venture in which the organization had an ownership interest during the tax year, and group affiliate. The organization should aggregate the amounts from all such tables, according to the aggregation instructions in *Purpose of Schedule*, and include the aggregated information in Part II.

## Part III. Bad Debt, Medicare, & Collection Practices

**Section A.** In this section (a) report aggregate bad debt expense, at cost; (b) provide an estimate of how much bad debt expense, if any, reasonably could be attributable to persons who likely would qualify for financial assistance under its financial assistance policy; and (c) provide a rationale for what portion of bad debt, if any, the organization believes should constitute community benefit. In addition, the organization must report whether it has adopted Healthcare Financial Management Association Statement No. 15, Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers ("Statement 15") and provide the text of its footnote, if applicable, to its audited financial statements that describes the bad debt expense.

**Line 1.** Indicate whether the organization reports bad debt expense in accordance with Statement 15. Statement 15 has not been adopted by the AICPA. The IRS does not require organizations to adopt Statement 15 or use it to determine bad debt expense or financial assistance costs. Some organizations may rely on Statement 15 in reporting bad debt expense and financial assistance in their audited financial statements. Statement 15 provides instructions for

recordkeeping, valuation, and disclosure for bad debts.

**Line 2.** Use the most accurate system and methodology available to the organization to report bad debt expense at cost. If using a cost accounting system or other costing methodology, enter the estimated cost of patient care services attributable to charges written off to bad debt. If using a cost-to-charge ratio methodology, the organization can use Worksheet A (optional). If only a portion of a patient's bill for services is written off as a bad debt, include only the proportionate amount of the cost of providing those services that is attributable to the bad debt. Include the organization's proportionate share of the bad debt expense of **joint ventures** in which it had an ownership interest during the **tax year**.

**Worksheet A (Optional)  
Estimated Bad Debt Expense (at Cost)**

This worksheet is used to estimate the bad debt expense reported in Part III, line 2, using one of the cost accounting methods identified in the organization's response to Part III, line 4.

- 1. Bad debt attributable to patient accounts \$ \_\_\_\_\_
- 2. Ratio of Patient Care cost to charges (from Worksheet 2, line 11) \_\_\_\_\_%
- 3. Estimated cost of bad debt attributable to patient accounts (line 1 multiplied by line 2). \$ \_\_\_\_\_  
Enter in Part III, line 2.

**Line 3.** Provide an estimate of the amount of cost reported on line 2 that reasonably could be attributable to patients who likely would qualify for financial assistance under the **hospital's** financial assistance policy as reported in Part I, lines 1 through 4, but for whom sufficient information was not obtained to make a determination of their eligibility. **Do not include this amount in Part I, line 7.** Organizations can use any reasonable methodology to estimate this amount, such as record reviews, an assessment of financial assistance applications that were denied due to incomplete documentation, analysis of demographics, or other analytical methods.

**Line 4.** In Part VI:

- 1. Provide the rationale and the costing methodology used to determine the amounts reported on lines 2 and 3. Describe how the organization accounts for discounts and payments on patient accounts in determining bad debt expense,
- 2. Describe the method the organization used on line 3 to determine the amount that reasonably could be attributable to patients who likely would qualify for financial assistance under the organization's financial assistance policy

if sufficient information had been available to make a determination of their eligibility, and

- 3. describe the rationale, if any, for including any portion of bad debt as community benefit.

Also, provide the footnote from the organization's **financial statements** on bad debt expense, if applicable, or the footnotes related to "accounts receivable," "allowance for doubtful accounts," or similar designations. If the footnote or footnotes address only the filing organization's bad debt expense or "accounts receivable," "allowance for doubtful accounts," or similar designations, provide the footnote or footnotes *verbatim*. If the organization's financial statements include a footnote on these issues that also includes other information, report in Part VI only the relevant portions of the footnote. If the organization is a member of a group with consolidated financial statements, the organization can summarize that portion, if any, of the footnote or footnotes that apply. If the organization's financial statements do not include a footnote that discusses bad debt expense, "accounts receivable," "allowance for doubtful accounts," or similar designations, include a statement in Part VI that the organization's **audited financial statements** do not include a footnote discussing these issues and explain how the organization's financial statements account for bad debt, if at all.

**Section B.** In this section report (a) aggregate allowable costs to provide services reimbursed by Medicare, (b) aggregate Medicare reimbursements attributable to such costs, and (c) aggregate Medicare surplus or shortfall. Include in Section B only those allowable costs and Medicare reimbursements that are reported in the organization's Medicare Cost Report(s) for the year, including its share of any such allowable costs and reimbursement from **disregarded entities** and **joint ventures** in which it has an ownership interest. The organization should in Part VI describe what portion of its Medicare shortfall, if any, it believes should constitute community benefit, and explain its rationale for its position. As described on this page, the organization also can enter in Part VI the amount of any Medicare revenues and costs not included in its Medicare Cost Report(s) for the year, and can enter a reconciliation of the amounts reported in Section B (including the surplus or shortfall reported on line 7) and the total revenues and costs attributable to all of the organization's Medicare programs.

**Line 5.** Enter all net patient service revenue (for Medicare fee for service (FFS) patients) associated with allowable costs the organization reports in its Medicare Cost Report(s) for the year, including payments for indirect medical education (IME) (except for Medicare

Advantage IME), Medicare disproportionate share hospital (DSH), revenue, coinsurance, patient deductibles, outliers, capital, bad debt, and any other amounts paid to the organization on the basis of its Medicare Cost Report. Do not include revenue related to subsidized health services as reported in Part I, line 7g (see Worksheet 6), or direct graduate medical education (GME) as reported in Part I, line 7f (see Worksheet 5). If the organization has more than one Medicare provider number, aggregate the revenue attributable to costs reported on the Medicare Cost Reports submitted under each provider number, and report the aggregate revenues on line 5.

**Line 6.** Enter all Medicare allowable costs reported in the organization's Medicare Cost Report(s), except those already reported in Part I, line 7g (subsidized health services) and costs associated with direct GME already reported in Part I, line 7f (health professions education). This can be determined using Worksheet B. If Worksheet B is not used, the organization still must subtract the costs attributable to subsidized health services and direct GME from the Medicare allowable costs it enters on line 6. If the organization has more than one Medicare provider number, it should aggregate the costs reported in the Medicare Cost Reports submitted under each provider number and report the aggregate costs on line 6.

**Worksheet B (optional)**

Complete Worksheets 5 and 6 before completing Worksheet B.

- 1. Total Medicare allowable costs (from Medicare Cost Report) \$ \_\_\_\_\_
- 2. Total Medicare allowable costs (from line 1) included in Worksheet 6, line 3, col. (A) \$ \_\_\_\_\_
- 3. Total Medicare allowable costs (from line 1) included in Worksheet 5, line 8 (direct GME) . . . . . \$ \_\_\_\_\_
- 4. Total adjustments to Medicare allowable costs (add lines 2 and 3) . . . . . \$ \_\_\_\_\_
- 5. Total Medicare allowable costs (line 1 minus line 4). Enter this value in Part III, line 6. . . . . \$ \_\_\_\_\_

**Line 7.** Subtract line 6 from the amount on line 5. If line 6 exceeds line 5, report the excess (the shortfall) as a negative number.

**Line 8.** Check the box that best describes the costing methodology used to determine the Medicare allowable costs reported in the organization's Medicare Cost Report(s), as reflected on line 6. Describe this methodology in Part VI.

The organization must also describe in Part VI its rationale for treating the amount reported in Part III, line 7, or any portion of it, as a community benefit. An organization's rationale must have a

reasonable basis. **Do not include this amount in Part I, line 7.** Do not include any Medicare-related expenses or revenue properly reported in Part I, line 7g or any Medicare-related expenses or revenue reported in Part I, line 7f in Part III, Section B.



*Lines 5, 6, and 7 do not include certain Medicare program revenues and costs, and thus cannot reflect all of the organization's revenues and costs associated with its participation in Medicare programs. The organization can describe in Part VI the amounts of any Medicare revenues and costs not included in its Medicare Cost Report(s) for the year (for example, revenues and costs for freestanding ambulatory surgery centers, physician services billed by the organization, clinical laboratory services, and revenues and costs of Medicare Part C and Part D programs). The organization can enter in Part VI, line 1 a reconciliation of amounts reportable in Section B (including the surplus or shortfall reported on line 7) and all of the organization's total revenues and total expenses attributable to Medicare programs.*

If the organization received any prior year settlements for Medicare-related services in the current tax year, it can provide an explanation in Part VI, line 1.

**Section C.** In this section report the organization's written debt collection policy.

**Line 9a.** Answer "Yes" if the organization had a written debt collection policy on the collection of amounts owed by patients during its **tax year**.

**Line 9b.** Answer "Yes" if the organization's written debt collection policy that applied to the facilities that served the largest number of the organization's patients during the **tax year** contained provisions for collecting amounts due from those patients who the organization knows qualify for financial assistance. If the organization answers "Yes," describe in Part VI the collection practices that it follows with respect to such patients, whether or not such practices apply specifically to such patients or more broadly to also cover other types of patients.

## Part IV. Management Companies and Joint Ventures

List any **management company, joint venture**, or other separate entity (whether treated as a partnership or a corporation), including joint ventures outside of the **United States**, of which the organization is a partner or shareholder,

1. In which persons described in 1a and/or 1b below owned, in the aggregate, more than 10% of the share of profits of such partnership or LLC interest, or stock of such corporation:

a. Persons who were **officers, directors, trustees, or key employees**

of the organization at any time during the organization's **tax year**, and

b. Physicians who were employed as physicians by, or had staff privileges with, one or more of the organization's **hospitals**; and

2. That either:

a. Provided management services used by the organization in its provision of medical care, or

b. Provided medical care, or owned or provided real property, tangible personal property, or intangible property used by the organization or by others to provide medical care.

Examples of such joint ventures and management companies include:

- An ancillary joint venture formed by the organization and its officers or physicians to conduct an exempt or unrelated business activity,
- A company owned by the organization's officers or physicians that owns and leases to the organization a hospital or other medical care facility, and
- A company that owns and leases to entities other than the organization diagnostic equipment or intellectual property used to provide medical care.

For purposes of Part IV, ownership interests can be direct or indirect. For example, if a joint venture reported in Part IV is owned, in part, by a physician group practice owned by staff physicians of the organization's hospital, report the physicians' indirect ownership interest in the joint venture in proportion to their ownership share of the physician group practice.

**Note.** Do not include publicly traded entities or entities whose sole income is passive investment income from interest or dividends.

For purposes of Part IV, the aggregate percentage share of profits or stock ownership percentage of officers, directors, trustees, key employees, and physicians who are employed as physicians by, or have staff privileges with, one or more of the organization's hospitals is measured as of the earlier of the close of the tax year of the organization or the last day the organization was a member of the joint venture. All stock, whether common or preferred, is considered stock for purposes of determining the stock ownership percentage. Provide all the information requested below for each such entity.

**Column (a).** Enter the full legal name of the entity.

**Column (b).** Describe the primary business activity or activities conducted by the **management company, joint venture**, or separate entity.

**Column (c).** Enter the organization's percentage share of profits in the partnership or LLC, or stock in the entity that is owned by the organization.

**Column (d).** Enter the percentage share of profits or stock in the entity owned by

all of the organization's current **officers, directors, trustees, or key employees.**

**Column (e).** Enter the percentage share of profits or stock in the entity owned by all physicians who are **employees** practicing as physicians or who have staff privileges with one or more of the organization's hospitals.

If a physician described above is also a current officer, director, trustee, or key employee of the organization, include his or her profits or stock percentage in column (d). Do not include this in column (e).

## Part V. Facility Information

In Part V, the organization must list all of its **hospital facilities** in Section A, complete a separate Section B for each of its hospital facilities, and list its non-hospital health care facilities in Section C.

**Section A.** Complete Part V, Section A, by listing all of the organization's **hospital facilities** that it operated during the **tax year**. List these facilities in order of size from largest to smallest, measured by total revenue per facility. "Hospital facilities" are facilities that, at any time during the tax year, were required to be licensed, registered, or similarly recognized as a hospital under state law, and any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exempt status under section 501(c)(3), without regard to section 501(r). A facility is operated by an organization whether such facility is operated directly by the organization or indirectly through a **disregarded entity or joint venture** treated as a partnership. For each hospital facility, list its name and address and check the applicable column(s).

"Licensed hospital" is a facility licensed, registered, or similarly recognized by a state as a hospital.

"General medical and surgical" refers to a hospital primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with a wide variety of medical conditions, and that may provide outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services, and pharmacy services.

"Children's hospital" is a center for provision of health care to children, and includes independent acute care children's hospitals, children's hospitals within larger medical centers, and independent children's specialty and rehabilitation hospitals.

"Teaching hospital" is a hospital that provides training to medical students, interns, residents, fellows, nurses, or other health professionals and providers, provided that such educational programs are accredited by the appropriate national accrediting body.

“Critical access hospital” (CAH) is a hospital designated as a CAH by a state that has established a State Medicare Rural Hospital Flexibility Program in accordance with Medicare rules.

“Research facility” is a facility that conducts research.

“ER—24 hours” refers to a facility that operates an emergency room 24 hours a day, 365 days a year.

“ER—other” refers to a facility that operates an emergency room for periods less than 24 hours a day, 365 days a year.

Complete the “Other (Describe)” column for each hospital facility that the organization operates that is not described in the other columns of Part V, Section A.

In the upper left hand corner of the Part V, Section A table, list the total number of **hospital facilities** that the organization operated during the tax year.

If the organization needs additional space to list all of its hospital facilities, it should duplicate Section A and use as many duplicate copies of Section A as needed, number each page, and renumber the line numbers in the left hand margin (e.g., an organization with 15 facilities should renumber lines 1-5 on the 2nd page as lines 11-15).

**Section B.** Section B is optional for an organization whose tax year began on or before March 23, 2010. Section B requires reporting on a **hospital facility** by hospital facility basis; the organization must complete a separate Section B for each of its hospital facilities listed in Section A. At the top of Section B, list the name of the hospital facility and its line number from Section A.

**Lines 1 through 7. These lines are optional for tax year 2010.** A community health needs assessment (“Needs Assessment”) is an assessment of the health needs of the community. To meet the requirements of section 501(r)(3), which is effective for tax years beginning after March 23, 2012, a Needs Assessment must take into account 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, and must be made widely available to the public. Once section 501(r)(3) is effective, each **hospital facility** will be required to conduct a Needs Assessment at least once every three years, and adopt an implementation strategy to meet the community health needs identified through such assessment.

**Line 1.** Answer “Yes” if the **hospital facility** conducted a Needs Assessment in the current tax year or in any prior **tax year**. If “Yes,” indicate what the Needs Assessment describes by checking all applicable boxes. If the Needs Assessment describes information that does not have a corresponding checkbox, check line 1j, “Other,” and describe this

information in Part VI. If “No,” skip to line 8.

**Line 1i.** “Information gaps that limit the **hospital facility’s** ability to assess all of the community’s health needs” are areas where additional information is needed to assess whether a particular health need exists.

**Line 4.** Answer “Yes,” if the **hospital facility’s** Needs Assessment was conducted with one or more other hospital facilities. “One or more other hospital facilities” includes related and unrelated hospital facilities. If “Yes,” list in Part VI the other hospital facilities with which the hospital facility conducted its Needs Assessment.

**Line 5.** Answer “Yes,” if the **hospital facility** made its Needs Assessment widely available to the public. If “Yes,” indicate how the hospital facility made the Needs Assessment widely available to the public by checking all applicable boxes. If the hospital facility made the Needs Assessment widely available to the public by means other than those listed in lines 5a and 5b, check line 5c, “Other,” and describe these means in Part VI.

**Line 6.** Check all applicable boxes for lines 6a through 6h to indicate how the **hospital facility** addressed the needs identified in its most recently conducted Needs Assessment. If the hospital facility addressed the needs identified in its most recently conducted Needs Assessment by means other than those listed in lines 6a through 6h, check the box for line 6i, “Other,” and describe these means in Part VI. If the hospital facility has not addressed any of the needs identified in its most recently conducted Needs Assessment, skip to line 7.

**Line 6c.** Check this box if the **hospital facility** collaborated with others in the hospital facility’s community to develop a written description of the activities that hospital facilities and other community groups and public health agencies plan to undertake collectively to address specific health needs in their community.

**Line 6d.** Check this box if the **hospital facility** collaborated with others in the hospital facility’s community to carry out activities that hospital facilities and other community groups and public health agencies planned to undertake collectively to address specific health needs in their community.

**Line 7.** Answer “Yes,” if the **hospital facility** addressed all of the needs identified in its most recently conducted Needs Assessment. If “No,” explain in Part VI which community health needs the hospital facility did not address and the reasons why it did not address such needs. For example, a hospital facility might identify limited financial resources as a reason why it did not address a need identified in its most recently conducted Needs Assessment.

**Lines 8 through 14.** Refer to the instructions for Part I, Line 1 of Schedule

H (Form 990) for the definition of “financial assistance policy.”

**Line 8.** Answer “Yes,” if, during the **tax year**, the **hospital facility** had a written financial assistance policy that explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care.

**Line 9.** Refer to the instructions for Part I, Line 3a of Schedule H (Form 990), for the definition of “Federal Poverty Guidelines” (FPG). Answer “Yes,” if, during the **tax year**, the **hospital facility** had a written financial assistance policy that used FPG for determining eligibility for free medical care to low income individuals, and indicate the specific threshold by writing in the percentage amount.

**Line 10.** Refer to the instructions for Part I, Line 3a of Schedule H (Form 990) for the definition of “Federal Poverty Guidelines” (FPG). Answer “Yes,” if, during the **tax year**, the **hospital facility** had a written financial assistance policy that used FPG for determining eligibility for discounted medical care to low income individuals, and indicate the specific threshold by writing in the percentage amount.

**Line 11.** Answer “Yes,” if, during the **tax year**, the **hospital facility** had a written financial assistance policy that explained the basis for calculating amounts charged to patients. If “Yes,” indicate the factors used in calculating amounts charged to patients by checking all applicable boxes. If the hospital facility calculated amounts charged to patients using factors other than those listed in lines 11a through 11g, check the box for line 11h, “Other,” and describe these factors in Part VI.

**Line 11c.** Check this box if the **hospital facility** considered whether patients were “medically indigent,” as defined in the instructions for Part I, Line 4 of Schedule H (Form 990), in calculating amounts charged to patients during the **tax year**.

**Line 11h.** “Other” factors used in determining amounts charged to patients may include, but are not limited to, the amount budgeted for financial assistance.

**Line 12.** Answer “Yes,” if, during the **tax year**, the **hospital facility** had a written financial assistance policy that explained the method for applying for financial assistance.

**Line 13.** Answer “Yes,” if, during the **tax year**, the **hospital facility** had a written financial assistance policy that included measures to publicize the policy within the community served by the hospital facility. If “Yes,” indicate how the hospital facility publicized the policy by checking all applicable boxes. If the hospital facility publicized the policy within the community served by the hospital facility by means that are not listed in lines 13a-13f, check line 13g, “Other,” and describe in Part VI how the financial assistance policy was publicized within

the community served by the hospital facility.

**Line 13g.** “Other” measures to publicize the policy within the community served by the **hospital facility** may include, but are not limited to, having registration personnel refer uninsured and/or low income patients to financial counselors to discuss the policy.

**Line 14.** Answer “Yes,” if, during the **tax year**, the **hospital facility** had either a separate written billing and collections policy or a written financial assistance policy that explained actions the hospital facility may take upon non-payment. For purposes of line 14, the term “actions” includes, but is not limited to, collection actions and reporting to credit agencies.

**Lines 15 and 16.** “Other actions” do not include sending the patient a bill.

**Line 15.** Indicate what collection actions against a patient were permitted under the **hospital facility’s** policies at any time during the **tax year** by checking all applicable boxes. If collection actions against a patient other than those listed in lines 15a through 15d were permitted under the hospital facility’s policies at any time during the tax year, check line 15e, “Other actions,” and describe those collection actions in Part VI.

**Line 16.** Answer “Yes” if the **hospital facility** engaged in or authorized a third party to engage in any of the collection actions listed in lines 16a through 16d at any time during the **tax year**. If “Yes,” indicate the collection actions in which the hospital facility or a third party engaged by checking all applicable boxes. If the hospital facility or a third party engaged in collection actions other than those listed in lines 16a through 16d, answer “Yes,” check the box for line 16e, “Other actions,” and describe those collection actions in Part VI.

**Line 17.** Indicate which actions the **hospital facility** undertook before initiating any of the collection actions checked in lines 16a through 16d or described in Part VI by checking all applicable boxes in lines 17a through 17d. If the hospital facility undertook actions other than those listed in lines 17a through 17d before initiating any of the collection actions checked in lines 16a through 16d or described in Part VI, check the box for line 17e, “Other,” and describe in Part VI.

If the hospital facility took no action before initiating any of the collection actions checked in lines 16a through 16d or described in Part VI, check the box for line 17e, “Other,” and state in Part VI that the hospital facility took no action.

**Line 17c.** The term “communications” includes, but is not limited to, in-person interactions, telephone calls, and invoices.

**Line 18.** Answer “Yes,” if, during the **tax year**, the **hospital facility** had in place a written policy relating to emergency medical care that required the

hospital facility to provide, without discrimination, care for emergency medical conditions to individuals without regard to their eligibility under the hospital facility’s financial assistance policy. If “No,” indicate the reasons why the hospital facility did not have a nondiscriminatory policy relating to emergency medical care by checking all applicable boxes. If the reason the hospital facility did not have a nondiscriminatory policy relating to emergency medical care is not listed in lines 18a through 18c, check line 18d, “Other,” and describe the reason(s) in Part VI.

For purposes of line 18, the term “emergency medical conditions” means:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. serious impairment to bodily functions, or
3. serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions--

1. that there is inadequate time to effect a safe transfer to another hospital before delivery, or
2. that transfer may pose a threat to the health or safety of the woman or the unborn child.

**Line 19.** Indicate how the **hospital facility** determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care by checking all applicable boxes.

**Line 20.** Answer “Yes,” if, during the **tax year**, the **hospital facility** charged any patient who was eligible for financial assistance under the hospital facility’s financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care. If “Yes,” explain in Part VI.

**Line 21.** Answer “Yes,” if, during the **tax year**, the **hospital facility** charged any of its patients an amount equal to the gross charge for any service provided to that patient, and explain in Part VI the circumstances in which it used gross charges. A bill that itemizes a reduction applied to a gross charge for a service does not need to be reported if the amount charged to the patient for such service is less than the amount of the gross charge.

**Section C.** Complete Part V, Section C, by listing all of the non-hospital health care facilities that the organization

operated during the **tax year**. A facility is operated by an organization whether it is operated directly by the organization or indirectly through a **disregarded entity** or **joint venture** treated as a partnership. List each of these facilities in order of size from largest to smallest, measured by total revenue per facility. For each non-hospital health care facility, list its name and address and describe the type of facility. These types of facilities may include, but are not limited to, rehabilitation and other outpatient clinics, diagnostic centers, long-term acute care facilities, and skilled nursing facilities.

In the upper left hand corner of the Part V, Section C table, list the total number of non-hospital health care facilities that the organization operated during the tax year.

If the organization needs additional space to list all of its non-hospital health care facilities, it should duplicate Section C and use as many duplicate copies of Section C as needed, number each page, and renumber the line numbers in the left hand margin (e.g., an organization with 15 such facilities should renumber lines 1-5 on the 2nd page as lines 11-15).

## Part VI. Supplemental Information

Use Part VI to provide the narrative explanations required by the following questions, and to supplement responses to other questions on Schedule H (Form 990). Identify the specific part, section, and line number that the response supports, in the order in which they appear on Schedule H (Form 990). Part VI can be duplicated if more space is needed.

**Line 1.** Provide the following supplemental information:

**Part I, line 3c.** If applicable, describe the income-based criteria for determining eligibility for free or discounted care under the organization’s financial assistance policy. Also describe whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.

**Part I, line 6a.** If the organization’s community benefit report is contained in a report prepared by a **related organization**, rather than in a separate report prepared by the organization, identify the related organization.

**Part I, line 7g.** If applicable, describe whether the organization included as subsidized health services any costs attributable to a physician clinic, and report such costs the organization included.

**Part I, line 7, column (f).** If applicable, enter the bad debt expense included on Form 990, Part IX, line 25, column (A), but subtracted for purposes of calculating the percentage in this column.

**Part I, line 7.** Provide an explanation of the costing methodology used to calculate the amounts reported in the table. If a cost accounting system was used, indicate whether the cost accounting system addresses all patient segments (for example, inpatient, outpatient, emergency room, private insurance, Medicaid, Medicare, uninsured, or self pay). Also, indicate whether a cost-to-charge ratio was used for any of the figures reported in the table. Describe whether this cost-to-charge ratio was derived from Worksheet 2, *Ratio of Patient Care Cost-to-Charges*, and, if not, what kind of cost-to-charge ratio was used and how it was derived. If some other costing methodology was used besides a cost accounting system, cost-to-charge ratio, or a combination of the two, describe the method used.

**Part II.** Describe how the organization's community building activities, as reported in Part II, promote the health of the community or communities the organization serves.

**Part III, line 4.** Provide the rationale and the costing methodology used to determine the amount reported in Part III, lines 2 and 3. Describe how the organization accounts for discounts and payments on patient accounts in determining bad debt expense. Also describe the method the organization uses to determine the amount that reasonably could be attributable to patients who likely would qualify for financial assistance under the hospital's financial assistance policy, if sufficient information had been available to make a determination of their eligibility. Also describe the rationale, if any, for including any portion of bad debt as community benefit.

Also provide, if applicable, the text of the footnote to the organization's financial statements that describes bad debt expense. If the organization's financial statements include a footnote on these issues that also includes other information, report only the relevant portions of the footnote. If the organization's financial statements do not contain such a footnote, enter that the organization's financial statements do not include such a footnote, and explain how the financial statements account for bad debt, if at all.

**Part III, line 8.** Describe the costing methodology used to determine the Medicare allowable costs reported in the organization's Medicare Cost Report, as reflected in the amount reported in Part III, line 6. Describe, if applicable, the extent to which any shortfall reported in Part III, line 7, should be treated as a community benefit, and the rationale for the organization's position.

**Part III, line 9b.** If the organization has a written debt collection policy and answered "Yes," to Part III, line 9b, describe the collection practices set forth in the policy that apply to patients who it knows qualify for financial assistance,

whether or not such practices apply specifically to such patients or more broadly to also cover other types of patients.

**Part V, Section B.** Identify the specific **hospital facility** name and line number (from Schedule H (Form 990), Part V, Section A), to which each set of responses relates. For instance, if the organization reported five hospital facilities in Part V, Section A, it should list the first facility's name and number (1) as a heading, followed by the responses to applicable Part V, Section B, questions for that facility, followed by four additional headings and sets of responses for each of the other four hospital facilities listed in Part V, Section A.

- Line 1j: If the organization checked line 1j, describe the other content included in the hospital facility's Needs Assessment.

- Line 3: If the organization checked "Yes," describe how the hospital facility took into account input from persons who represent the community served by the hospital facility, and identify the persons whom the hospital facility consulted, in conducting its most recent Needs Assessment.

- Line 4: If the organization checked "Yes," list the other hospital facilities with which the hospital facility conducted its Needs Assessment.

- Line 5c: If the organization checked line 5c, describe the other means that the hospital facility used to make its Needs Assessment widely available.

- Line 6i: If the organization checked line 6i, describe the other ways that the hospital facility addressed the needs identified in its most recently conducted Needs Assessment.

- Line 7: If the organization checked "No," to line 7, explain which needs identified in the hospital facility's most recently conducted Needs Assessment that it did not address, together with the reasons why it did not address such needs.

- Line 11h: If the organization checked line 11h, describe the other factor(s) that the hospital facility used in calculating amounts charged to patients.

- Line 13g: If the organization checked line 13g, describe other ways that the hospital facility publicized its financial assistance policy.

- Line 15e: If the organization checked line 15e, describe the other collection actions that were permitted under the hospital facility's policies at any time during the tax year.

- Line 16e: If the organization checked line 16e, describe the other collection actions that the hospital facility or a third party engaged in during the tax year.

- Line 17e: If the organization checked line 17e, describe the other actions that the hospital facility took or state that the facility took no action before initiating any of the collection actions checked in line 16 or described in Part VI.

- Line 18d: If the organization checked line 18d, describe the other reasons why

the hospital facility did not have a nondiscriminatory policy related to emergency medical care.

- Line 19d: If the organization checked line 19d, explain what other means the hospital facility used to determine amounts billed to individuals who did not have insurance that covered emergency or other medically necessary care.

- Line 20: If the organization checked "Yes" to line 20, explain.

- Line 21: If the organization checked "Yes," to line 21, explain the circumstances in which the hospital facility used gross charges in billing any of its patients for any service provided to that patient.

**Line 2.** Describe whether, and, if so, how, the organization assesses the health care needs of the community or communities it serves, in addition to any community health needs assessment reported in Part V, Section B.

**Line 3.** Describe how the organization informs and educates patients and persons who are billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy. For example, enter whether the organization posts its financial assistance policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of the organization's facilities where eligible patients are likely to be present; provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients as part of the intake process; provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients with discharge materials; includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; or discusses with the patient the availability of various government benefits, such as Medicaid or state programs, and assists the patient with qualification for such programs, where applicable.

**Line 4.** Describe the community or communities the organization serves, taking into account the geographic service area(s) (for example, urban, suburban, rural, etc.), the demographics of the community or communities (for example, population, average income, percentages of community residents with incomes below the federal poverty guideline, percentage of the hospital's and community's patients who are uninsured or Medicaid recipients, etc.), the number of other hospitals serving the community or communities, and whether one or more federally-designated medically underserved areas or populations are present in the community.

**Line 5.** Provide any other information important to describing how the organization's **hospitals** or other health care facilities further its exempt purpose by promoting the health of the community

or communities, including but not limited to whether:

- A majority of the organization's **governing body** is comprised of persons who reside in the organization's primary service area who are neither **employees** nor **independent contractors** of the organization, nor **family members** thereof;
- The organization extends medical staff privileges to all qualified physicians in its community for some or all of its departments; and
- How the organization applies surplus funds to improvements in patient care, medical education, and research.

**Line 6.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served by the system. For purposes of this question, an "affiliated health care system" is a system that includes affiliates under common governance or control, or that cooperate in providing health care services to their community or communities.

**Line 7.** Identify all states with which the organization files (or a **related organization** files on its behalf) a community benefit report. Report only those states in which the organization's own community benefit report is filed, either by the organization itself or by a related organization on the organization's behalf.

## Worksheet 1. Financial Assistance at Cost (Part I, Line 7a)

Worksheet 1 can be used to calculate the organization's financial assistance (sometimes referred to as "charity care") at cost reported on Part I, line 7a. Refer to instructions for Part I for the definition of financial assistance.

**Line 1.** Enter the gross patient charges written off to financial assistance pursuant to the organization's financial assistance policies. "Gross patient charges" means the total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

**Line 3.** Multiply line 1 by line 2, or enter estimated cost based on the organization's cost accounting methodology. Organizations with a cost accounting system or a cost accounting method more accurate than the ratio of patient care cost to charges from Worksheet 2 can rely on that system or method to estimate financial assistance cost.

**Line 4.** Enter the Medicaid/provider taxes paid by the organization, if payments received from an uncompensated care pool or DSH program in the organization's home state are intended primarily to offset the cost of financial assistance. If such payments are primarily intended to offset the cost of Medicaid services, then report this amount on Worksheet 3, line 4, column (A). If the primary purpose of such taxes or payments has not been made clear by state regulation or law, then the

organization can allocate portions of such taxes or payments proportionately between Worksheet 1, line 4, and Worksheet 3, line 4, column (A) based on a reasonable estimate of which portions are intended for financial assistance and Medicaid, respectively. "Medicaid provider taxes" means amounts paid or transferred by the organization to one or more states as a mechanism to generate federal Medicaid DSH funds (the cost of the tax generally is promised back to organizations either through an increase in the Medicaid reimbursement rate or through direct appropriation).

**Line 6.** "Revenue from uncompensated care pools or programs" means payments received from a state, including Upper Payment Limit (UPL) funding and Medicaid DSH funds, as direct offsetting revenue for financial assistance or to enhance Medicaid reimbursement rates for DSH providers. If such payments are primarily intended to offset the cost of Medicaid services, then report this amount on Worksheet 3, line 7, column (A). If the primary purpose of such payments has not been made clear by state regulation or law, then the organization can allocate portions of such payments proportionately between Worksheet 1, line 6, and Worksheet 3, line 7, column (A) based on a reasonable estimate of which portions are intended for financial assistance and Medicaid, respectively.

### Worksheet 1. Financial Assistance at Cost (Part I, line 7a)

Keep for Your Records



<b>Gross patient charges</b>		
1. Amount of gross patient charges written off pursuant to financial assistance policies . . . . .	1.	_____
<b>Total community benefit expense</b>		
2. Ratio of patient care cost to charges (from Worksheet 2, if used) . . . . .	2.	_____
3. Estimated cost (multiply line 1 by line 2, or obtain from cost accounting) . . . . .	3.	_____
4. Medicaid provider taxes . . . . .	4.	_____
5. Total community benefit expense (add lines 3 and 4; enter on Part I, line 7a, column (c))	5.	_____
<b>Direct offsetting revenue</b>		
6. Revenues from uncompensated care pools or programs (enter on Part I, line 7a, column (d)) . . . . .	6.	_____
7. Net community benefit expense (subtract line 6 from line 5; enter on Part I, line 7a, column (e)) . . . . .	7.	_____
8. Total expense (enter amount from Form 990, Part IX, Line 25, column (A), and include the organization's share of joint venture expenses.) . . . . .	8.	_____
9. Percent of total expense (divide line 7 by line 8; enter on Part I, line 7a, column (f)) . . . . .	9.	_____ %

## Worksheet 2. Ratio of Patient Care Cost to Charges

Worksheet 2 can be used to calculate the organization's ratio of patient care cost to charges.

**Line 1.** Enter the organization's total operating expenses (excluding bad debt expense) from its most recent audited financial statements.

**Line 2.** Enter the cost of nonpatient care activities. "Nonpatient care activities" include health care operations that generate "other operating revenue" such as nonpatient food sales, supplies sold to nonpatients, and medical records abstracting. The cost of nonpatient care activities does not include any total community benefit expense reported on Worksheets 1 through 8.

If the organization is unable to establish the cost associated with nonpatient care activities, use other operating revenue from its most recent audited financial statement as a proxy for these costs. This proxy assumes no markup exists for other operating revenue compared to the cost of nonpatient care activities. Alternatively, if other operating revenue provides a markup compared to the cost of nonpatient care activities, the organization can assume such a markup exists when completing line 2.

**Line 3.** Enter the Medicaid provider taxes paid by the organization included on line 1, so this expenditure is not double-counted when the ratio of patient care cost to charges is applied.

**Line 4.** Enter the sum of the total community benefit expenses reported on Part I, lines 7e, 7f, 7h, and 7i, column (c), so these expenses are not double-counted when the ratio of patient care cost to charges is applied.

Also include in line 4 the total community benefit expense reported on Part I, lines 7a, 7b, 7c, and 7g, column (c), if the organization has not relied on the ratio of patient care cost to charges from this worksheet to determine these expenses, but rather has relied on a cost accounting system or other cost accounting method to estimate costs of financial assistance, Medicaid or other means-tested government programs, or subsidized health services.

**Line 5.** Enter the gross expense of community building activities reported in Part II of Schedule H (Form 990).

**Line 9.** Enter the gross patient charges for any community benefit activities or programs for which the organization has not relied on the ratio of patient care cost to charges from this worksheet to determine the expenses of such activities or programs. For example, if the organization uses a cost accounting system or another cost accounting method to estimate total community benefit expense for Medicaid or any other means-tested government programs,

enter gross charges for those programs in line 9.

## Worksheet 3. Unreimbursed Medicaid and Other Means-Tested Government Programs (Part I, lines 7b and 7c)

Worksheet 3 can be used to report the net cost of Medicaid and other means-tested government programs. A "means-tested government program" is a government program for which eligibility depends on the recipient's income or asset level.

"Medicaid" means the **United States** health program for individuals and families with low incomes and resources. "Other means-tested government programs" means government-sponsored health programs where eligibility for benefits or coverage is determined by income or assets. Examples include:

- The State Children's Health Insurance Program (SCHIP), a **United States** federal government program that gives funds to states in order to provide health insurance to families with children; and
- Other federal, state, or local health care programs.

Report Medicaid and other means-tested government program revenues and expenses from all states,

not just from the organization's home state.

**Line 1, column (A).** Enter the gross patient charges for Medicaid services. Include gross patient charges for all Medicaid recipients, including those enrolled in managed care plans. In certain states, SCHIP functions as an expansion of the Medicaid program, and reimbursements from SCHIP are not distinguishable from regular Medicaid reimbursements. Hospitals that cannot distinguish their SCHIP reimbursements from their Medicaid reimbursements can report SCHIP charges, costs, and offsetting revenue under column (A).

**Line 1, column (B).** Enter the amount of gross patient charges for other means-tested government programs.

**Line 3, column (A).** Enter the estimated cost for Medicaid services. Multiply line 1, column (A) by line 2, column (A), or enter estimated cost based on the organization's cost accounting system or method. Organizations with a cost accounting system or a cost accounting method more accurate than the ratio of patient care cost to charges from Worksheet 2 can rely on that system or method to estimate the cost of Medicaid services. Organizations relying on a cost accounting system or method other than the ratio of patient care cost to charges from Worksheet 2 should use care not to double-count community benefit

## Worksheet 2. Ratio of Patient Care Cost to Charges (can be used for other worksheets)

Keep for Your Records



<b>Patient care cost</b>		
1. Total operating expense . . . . .		1. _____
<b>Less adjustments</b>		
2. Nonpatient care activities . . . . .	2.	_____
3. Medicaid provider taxes . . . . .	3.	_____
4. Total community benefit expense . . . . .	4.	_____
5. Total community building expense . . . . .	5.	_____
6. <b>Total adjustments</b> (add lines 2 through 5) . . . . .	6.	_____
7. <b>Adjusted patient care cost</b> (subtract line 6 from line 1) . . . . .	7.	_____
<b>Patient care charges</b>		
8. Gross patient charges . . . . .	8.	_____
<b>Less: adjustments</b>		
9. Gross charges for community benefit programs . . . . .	9.	_____
10. <b>Adjusted patient care charges</b> (subtract line 9 from line 8) . . . . .	10.	_____
<b>Calculation of ratio of patient care costs to charges</b>		
11. Ratio of patient care cost to charges (divide line 7 by line 10; report on the applicable lines of Worksheets 1, 3, or 6) . . . . .	11.	_____ %

expenses fully accounted for elsewhere on Schedule H (Form 990) Part I, line 7, such as the cost of health professions education, community health improvement services, community benefit operations, subsidized health services, and research.

**Line 3, column (B).** Enter the estimated cost for services provided to patients who receive health benefits from other means-tested government programs.

**Line 4, column (A).** Enter the Medicaid provider taxes paid by the organization if payments received from an uncompensated care pool, UPL program, or Medicaid DSH program in the organization's home state are intended primarily to offset the cost of Medicaid services. If such payments are primarily intended to offset the cost of financial assistance, then report this amount on Worksheet 1, line 4. If the primary purpose of such taxes or payments has not been made clear by state regulation or law, then the organization can allocate portions of such taxes or payments proportionately between Worksheet 1,

line 4, and Worksheet 3, line 4, column (A), based on a reasonable estimate of which portions are intended for financial assistance and Medicaid, respectively.

**Line 6, column (A).** Enter the net patient service revenue for Medicaid services, including revenue associated with Medicaid recipients enrolled in managed care plans. Do not include Medicaid reimbursement for direct graduate medical education (GME) costs, which should be reported on Worksheet 5, line 9. Include Medicaid reimbursement for indirect GME costs, including the indirect IME portion of children's health GME. The direct portion of children's health GME should be reported on Worksheet 5, line 10. Also include Medicaid disproportionate share hospital (DSH) revenue and UPL funding. "Net patient service revenue" means payments expected to be received from patients or third-party payers for patient services performed during the year. "Net patient service revenue" also includes revenue recorded in the organization's audited financial statements for services

performed during prior years. Organizations can enter in Part VI the amount of prior year Medicaid revenue included in Part I, line 7b.

Amounts received from the Medicaid program as "reimbursement for direct GME" or IME should be treated consistently with the way the Medicaid program in the hospital's home state classifies the funds.

**Line 7, column (A).** Enter revenue received from uncompensated care pools or programs if payments received from an uncompensated care pool, UPL program, or Medicaid DSH program in the organization's home state are intended primarily to offset the cost of Medicaid services. If such payments are primarily intended to offset the cost of charity care, then report this amount on Worksheet 1, line 6. If the primary purpose of such payments has not been made clear by state regulation or law, then the organization can allocate portions of such payments proportionately between Worksheet 1, line 6, and Worksheet 3, line 7, column (A), based on a reasonable

**Worksheet 3. Unreimbursed Medicaid and Other Means-Tested Government Programs (Part I, lines 7b and 7c)**

Keep for Your Records 

	(A) Medicaid	(B) Other means-tested government programs
1. Gross patient charges from the programs . . . . .	1.	
<b>Total community benefit expense</b>		
2. Ratio of patient cost to charges (from Worksheet 2, if used) . . . . .	2.	%
3. Cost (multiply line 1 by line 2, or obtain from cost accounting) . . . . .	3.	
4. Medicaid provider taxes . . . . .	4.	
5. Total community benefit expense (add lines 3 and 4; enter amount from column (A) on Part I, line 7b, column (c); and enter amount from column (B) on Part I, line 7c, column (c)) . . . . .	5.	
<b>Direct offsetting revenue</b>		
6. Net patient service revenue . . . . .	6.	
7. Payments from uncompensated care pools or programs . . . . .	7.	
8. Other revenue . . . . .	8.	
9. Total direct offsetting revenue (add lines 6 through 8; enter amount from column (A) on Part I, line 7b, column (d) and enter amount from column (B) on Part I, line 7c, column (d)) . . . . .	9.	
10. <b>Net community benefit expense</b> (subtract line 9 from line 5; enter amount from column (A) on Part I, line 7b, column (e); enter amount from column (B) on Part I, line 7c, column (e)) . . . . .	10.	
11. <b>Total expense</b> (enter amount from Form 990, Part IX, line 25, Column (A), and include the organization's share of all joint ventures, in both columns (A) and (B)) . . . . .	11.	
12. <b>Percent of total expense</b> (line 10 divided by 11; enter amount from column (A) on Part I, line 7b, column (f); enter amount from column (B) on Part I, line 7c, column (f)) . . . . .	12.	%



		(A) Total community benefit expense	(B) Direct offsetting revenue	(C) Net community benefit expense (subtract col. (B) from col. (A) for lines 1–5)
<b>1. Community health improvement services</b>				
a. _____	1a.			
b. _____	1b.			
c. _____	1c.			
d. _____	1d.			
e. _____	1e.			
f. _____	1f.			
g. _____	1g.			
h. _____	1h.			
i. _____	1i.			
j. _____	1j.			
<b>2. Worksheet subtotal</b> (add lines 1a through 1j) . . . . .		2.		
<b>3. Community benefit operations</b>				
a. _____	3a.			
b. _____	3b.			
c. _____	3c.			
d. _____	3d.			
<b>4. Worksheet subtotal</b> (add lines 3a through 3d) . . . . .		4.		
<b>5. Worksheet total</b> (add lines 2 and 4; enter amounts from columns (A), (B), and (C) on Part I, line 7e, columns (c), (d), and (e), respectively) . . . . .		5.		
<b>6. Total expense</b> (enter amount from Form 990, Part IX, Line 25, column (A) and include the organization’s share of joint venture expenses) . . . . .		6.		
<b>7. Percent of total expense</b> (line 5, column (C) divided by line 6; enter amount on Part I, line 7e, column (f) . . . . .		7.		%

estimate of which portions are intended for financial assistance and Medicaid, respectively.

**Worksheet 4. Community Health Improvement Services and Community Benefit Operations (Part I, Line 7e)**

Worksheet 4 can be used to report the net cost of community health

improvement services and community benefit operations.

“Community health improvement services” means activities or programs carried out or supported for the express purpose of improving community health that are subsidized by the health care organization. Such services do not generate inpatient or outpatient bills,

although there may be a nominal patient fee or sliding scale fee for these services.

“Community benefit operations” means activities associated with community health needs assessments as well as community benefit planning and administration. Community benefit operations also include the organization’s activities associated with fundraising or grant-writing for community benefit programs.

Activities or programs cannot be reported if they are provided primarily for marketing purposes and the program is more beneficial to the organization than to the community; for instance, if the activity or program is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization.

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following.

- A community health needs assessment developed or accessed by the organization.
- Documentation that demonstrated community need or a request from a public agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program.

Community benefit activities or programs also seek to achieve objectives, including improving access to health services, enhancing public health, advancing generalizable knowledge, and relief of government burden. This includes activities or programs that do the following.

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in health care among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance generalizable knowledge through education or research that benefits the public.

**Lines 1a through 1j, column (A).** Enter the name of each reported community health improvement activity or program and total community benefit expense for each. Include both direct costs and indirect costs in total community benefit expense. Use additional worksheets if the

organization reports more than 10 community health improvement activities or programs.

**Lines 3a through 3d, column (A).** Enter the name of each reported community benefit operations activity or program and total community benefit expense for each. Include both direct costs and indirect costs in total community benefit expense. Use additional worksheets if the organization reports more than four community benefit operations activities or programs.

Report total community benefit expense, direct offsetting revenue, and net community benefit expense for each line item.

## Worksheet 5. Health Professions Education (Part I, Line 7f)

Worksheet 5 can be used to report the net cost of health professions education.

“Health professions education” means educational programs that result in a degree, certificate, or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual’s health profession specialty. It does not include education or training programs available exclusively to the organization’s **employees** and medical staff or scholarships provided to those individuals. However, it does include education programs if the primary purpose of such programs is to educate health professionals in the broader community. Costs for medical residents and interns can be included, even if they are considered “employees” for purposes of Form W-2, Wage and Tax Statement.

Examples of health professions education activities or programs that should and should not be reported are as follows.

Activity or Program	Report	Example Rationale
Scholarships for community members	Yes	More benefit to community than organization
Scholarships for staff members	No	More benefit to organization than community
Continuing medical education for community physicians	Yes	Accessible to all qualified physicians
Continuing medical education for own medical staff	No	Restricted to own medical staff members
Nurse education if graduates are free to seek employment at any organization	Yes	More benefit to community than organization
Nurse education if graduates are required to become the organization’s employees	No	Program designed primarily to benefit the organization

**Lines 1 through 6.** Include both direct and indirect costs. Direct costs of health professions education do not include costs related to Ph.D. students and post-doctoral students, which are to be reported on Worksheet 7, Research. Refer to the instructions for Part I, line 7, column (c) for the definition of “indirect costs.” “Indirect costs” do not include the estimated cost of “indirect medical education.”

Direct costs of health professions education include the following.

- Stipends, fringe benefits of interns, residents, and fellows in accredited graduate medical education programs.
- Salaries and fringe benefits of faculty directly related to intern and resident education.
- Salaries and fringe benefits of faculty directly related to teaching of medical students.
- Salaries and fringe benefits of faculty directly related to teaching of students enrolled in nursing programs that are licensed by state law or, if licensing is not required, accredited by the recognized national professional organization for the particular activity.
- Salaries and fringe benefits of faculty directly related to teaching of students enrolled in allied health professions education programs, licensed by state law or, if licensing is not required, accredited by the recognized national professional organization for the particular activity,

including, but not limited to, programs in pharmacy, occupational therapy, dietetics, and pastoral care.

- Salaries and fringe benefits of faculty for teaching continuing health professions education open to all qualified individuals in the community, including payment for development of online or other computer-based training accepted as continuing health professions education by the relevant professional organization.
- Scholarships provided by the organization to community members.

**Line 8.** Enter Medicare reimbursement for direct GME, reimbursement for approved nursing and allied health education activities, and direct GME reimbursement received for services provided to Medicare Advantage patients. For a children's hospital that receives children's GME payments from Health Resources and Services Administration (HRSA), count that portion of the payment equivalent to Medicare direct GME. Do not include indirect GME reimbursement provided by Medicare.

**Line 9.** Enter Medicaid reimbursement for direct GME, including only that portion of Medicaid GME payment equivalent to Medicare direct GME and that can be explicitly segregated by the organization from other Medicaid net patient revenue. Do not include indirect GME reimbursement provided by Medicaid, which is to be reported on Worksheet 3, Unreimbursed Medicaid and Other Means-Tested Government Programs. Include Medicaid reimbursement for nursing and allied health education. If your state pays Medicaid GME reimbursement as a lump sum that includes both direct and indirect payments, use reasonable methods to estimate the portion of the lump sum that is direct (for example, the percent of total Medicare GME payments that is direct).

**Line 10.** Enter revenue received for continuing health professions education reimbursement or tuition.

**Line 11.** Enter other revenue received for health professions education activities.

## Worksheet 6. Subsidized Health Services (Part I, Line 7g)

Worksheet 6 can be used to calculate the net cost of subsidized health services. Complete Worksheet 6 for each subsidized health service and report in Part I the total for all subsidized health services combined.

"Subsidized health services" means clinical services provided despite a financial loss to the organization. The financial loss is measured after removing losses, measured by cost, associated with bad debt, financial assistance, Medicaid and other means-tested government programs. Losses attributable to these items are not included when determining which clinical services are subsidized health services

## Worksheet 5. Health Professions Education (Part I, line 7f)

Keep for Your Records



	Totals
<b>Total community benefit expense</b>	
1. Medical students . . . . .	1. _____
2. Interns, residents, and fellows . . . . .	2. _____
3. Nursing . . . . .	3. _____
4. Other allied health professions . . . . .	4. _____
5. Continuing health professions education . . . . .	5. _____
6. Other students . . . . .	6. _____
7. Total community benefit expense (add lines 1 through 6; enter on Part I, line 7f, column (c)) . . . . .	7. _____
<b>Direct offsetting revenue</b>	
8. Medicare reimbursement for direct GME . . . . .	8. _____
9. Medicaid reimbursement for direct GME . . . . .	9. _____
10. Continuing health professions education reimbursement/tuition . . . . .	10. _____
11. Other revenue . . . . .	11. _____
12. Total direct offsetting revenue (add lines 8 through 11; enter on Part I, line 7f, column (d)) . . . . .	12. _____
13. <b>Net community benefit expense</b> (line 7 minus line 12; enter on Part I, line 7f, column (e)) . . . . .	13. _____
14. <b>Total expense</b> (enter amount from Form 990, Part IX, line 25, column (A), and include the organization's share of joint venture expenses) . . . . .	14. _____
15. <b>Percent of total expense</b> (line 13 divided by line 14; enter amount on Part I, line 7f, column (f)) . . . . .	15. _____ %

because they are reported as community benefit elsewhere in Part I or as bad debt in Part III. Losses attributable to these items are also excluded when measuring the losses generated by the subsidized health services. In addition, in order to qualify as a subsidized health service, the organization must provide the service because it meets an identified community need. A service meets an identified community need if it is reasonable to conclude that if the organization no longer offered the service, the service would be unavailable in the community, the community's capacity to provide the service would be below the community's responsibility of government or another tax-exempt organization.

Subsidized health services generally include qualifying inpatient programs such as neonatal intensive care, addiction recovery, and inpatient psychiatric units, and ambulatory programs such as emergency and trauma services, satellite clinics designed to serve low-income communities, and home health programs. Subsidized health services generally exclude ancillary services that support

inpatient and ambulatory programs such as anesthesiology, radiology, and laboratory departments. Subsidized health services include services or care provided by physician clinics and skilled nursing facilities if such clinics or facilities satisfy the general criteria for subsidized health services. An organization that includes any costs associated with physician clinics as subsidized health services in Part I, line 7g, must describe that it has done so and report in Part VI such costs included in Part I, line 7g.

**Line 3, columns (A) through (D).** Enter the estimated cost for each subsidized health service. For column (B), enter bad debt amounts attributable to the subsidized health service measured by cost. For column (C), enter amounts attributable to the subsidized health service for patients who are recipients of Medicaid and other means-tested government programs measured by cost. For column (D), enter financial assistance amounts attributable to the subsidized health service measured by cost. Multiply line 1 by line 2 or enter estimated cost based on the organization's cost accounting. Organizations with a cost accounting system or a cost accounting



	(A) Total subsidized health service program	(B) Bad debt	(C) Medicaid and other means-tested government programs	(D) Financial assistance	(E) Totals (subtract columns (B), (C), and (D) from column (A))
<b>Program name:</b> _____					
1. Gross patient charges from program(s) . . . . .	1.				
<b>Total community benefit expense</b>					
2. Ratio of patient cost to charges (from Worksheet 2, if used) . . . . .	2.	%	%	%	%
3. Cost (multiply line 1 by line 2, or obtain from cost accounting; enter column (E) on Part I, line 7g, column (c)) . . . . .	3.				
<b>Direct offsetting revenue</b>					
4. Net patient service revenue . . . . .	4.				
5. Other revenue . . . . .	5.				
6. Total direct offsetting revenue (add lines 4 and 5; enter column (E) on Part I, line 7g, column (d)). . . . .	6.				
7. <b>Net community benefit expense</b> (subtract line 6 from line 3; enter column (E) on Part I, line 7g, column (e)) . . . . .	7.				
8. <b>Total expense</b> (enter amount from Form 990, Part IX, line 25, column (A), and include the organization's share of joint venture expenses)	8.				\$
9. <b>Percent of total expense</b> (line 7, column (E) divided by line 8; enter on Part I, line 7g, column (f)) . . . . .	9.				%

method more accurate than the ratio of patient care cost to charges from Worksheet 2 can rely on that system or

method to estimate the cost of each subsidized health service.



<b>Total community benefit expense</b>	
1. Direct costs . . . . .	1. _____
2. Indirect costs . . . . .	2. _____
3. Total community benefit expense (add lines 1 and 2; enter on Part I, line 7h, column (c)) . . . . .	3. _____
4. <b>Direct offsetting revenue</b> (enter on Part I, line 7h, column (d)) . . . . .	4. _____
5. <b>Net community benefit expense</b> (subtract line 4 from line 3; enter on Part I, line 7h, column (e)) . . . . .	5. _____
6. <b>Total expense</b> (enter amount from Form 990, Part IX, line 25, column (A), and include the organization's share of joint venture expenses.) . . . . .	6. _____
7. Percent of total expense (divide line 5 by line 6; enter on Part I, line 7h, column (f)) . . . . .	7. _____ %

## Worksheet 7. Research (Part I, Line 7h)

Worksheet 7 can be used to report the cost of research conducted by the organization.

Research means any study or investigation the goal of which is to generate generalizable knowledge made available to the public such as knowledge about underlying biological mechanisms of health and disease, natural processes, or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory-based studies; epidemiology, health outcomes, and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations, including publication in a medical journal. The organization can include the cost of internally funded research it conducts, as well as the cost of research it conducts funded by a tax-exempt or government entity.

The organization cannot include in Part I, line 7h, the direct or indirect costs of research funded by an individual or an organization that is not a tax-exempt or government entity. However, the organization can describe in Part VI any research it conducts that is not funded by tax-exempt or government entities, including the cost of such research, the identity of the funder, how the results of such research are made available to the public, if at all, and whether the results are made available to the public at no cost or nominal cost.

Examples of costs of research include, but are not limited to, salaries and benefits of researchers and staff, including stipends for research trainees (Ph.D. candidates or fellows); facilities for collection and storage of research, data, and samples; animal facilities; equipment; supplies; tests conducted for research rather than patient care; statistical and computer support; compliance (for example, accreditation for human subjects protection, biosafety, HIPAA, etc.); and dissemination of research results.

**Line 1.** Define direct costs pursuant to guidelines and definitions published by the National Institutes of Health.

**Line 2.** Define indirect costs pursuant to guidelines and definitions published by the National Institutes of Health.

## Worksheet 8. Cash and In-Kind Contributions to Community Groups (Part I, Line 7i)

Worksheet 8 can be used to report cash contributions or grants and the cost of in-kind contributions that support financial

assistance, health professions education, and other community benefit activities reportable in Part I, lines 7a through 7h. Report such contributions on line 7i, rather than on lines 7a through 7h. Do not include any contributions funded in whole or in part by a restricted grant, to the extent that such grant was from a **related organization**, as illustrated in the examples on this page and the next.

“Cash and in-kind contributions” means contributions made by the organization to health care organizations and other community groups restricted to one or more of the community benefit activities described in the table in Part I, line 7 (and the related worksheets and instructions). “In-kind contributions” include the cost of staff hours donated by the organization to the community while on the organization’s payroll, indirect cost of space donated to tax-exempt community groups (such as for meetings), and the financial value (generally measured at cost) of donated food, equipment, and supplies.

Report cash contributions and grants made by the organization to entities and community groups that share the organization’s goals and mission. Do not report cash or in-kind contributions contributed by **employees**, or emergency funds provided by the organization to the organization’s employees; loans, advances, or contributions to the capital of another organization; or unrestricted grants or gifts to another organization that

can, at the discretion of the grantee organization, be used other than to provide the type of community benefit described in the table in Part I, line 7.

**Special rule for grants to joint ventures.** If the organization makes a grant to a **joint venture** in which it has an ownership interest to be used to accomplish one of the community benefit activities reportable in the table, in Part I, line 7, report the grant on line 7i, but do not include the organization’s proportionate share of the amount spent by the **joint venture** on such activities in any other part of the Table, to avoid double-counting.

**Example 1.** The filing organization (A) and foundation (B) are **related organizations**. B makes a grant to A that must be used by A to conduct a community health needs assessment in a community served by A. A can report the cost of conducting the community health needs assessment in Part I, line 7e, column (c) in the year it conducts the health needs assessment, but A need not report the restricted grant from B in Part I, line 7e, column (d). The same result is obtained if B is unrelated to A, or if the grant is unrestricted rather than required to be used by A to provide community benefit.

**Example 2.** Use the same facts as in Example 1, except A may also use the grant from B to make a grant to another organization (C), which must be used by

## Worksheet 8. Cash and In-Kind Donations to Community Groups (Part I, line 7i)

Keep for Your Records



	(A) Cash contrib- utions	(B) In-kind contrib- utions	(C) Total
<b>1. Total community benefit expense</b> (enter amount from column (C) on Part I, line 7i, column (c)) . . . . .			
<b>2. Direct offsetting revenue</b> (enter amount from column (C) on Part I, line 7i, column (d)) . . . . .			
<b>3. Net community benefit expense</b> (subtract line 2 from line 1; enter on Part I, line 7i, column (e)) . . . .			
<b>4. Total expense</b> (enter amount from Form 990, Part IX, line 25, column (A), and include the organization’s share of joint venture expenses) . .			
<b>5. Percent of total expense</b> (divide line 3 by line 4; enter on Part I, line 7i, column (f)) . . . . .			%

C to provide community benefit. A makes such a grant to C. A cannot report the grant to C in Part I, line 7i, because it is funded by a related organization, but A need not report the grant from B in Part I, line 7, column (d) for any line 7 item. This is the result regardless of whether B and C are related organizations.

**Example 3.** A is a related organization with respect to each of B, C, and D. Each of the organizations files a

Form 990 and a Schedule H (Form 990). A makes a restricted grant to B that is restricted to one or more of the community benefit activities described in the table in Part I, line 7 (and the related worksheets and instructions). A's grant is not funded by a related organization. B makes a restricted grant to C that is funded by A's restricted grant. C makes an unrestricted grant to D that is not funded by B's restricted grant. Under

these circumstances, A can report the grant to B on A's Schedule H (Form 990), Part I, line 7i, but neither B nor C can report their respective grants to C and D on Part I, line 7i of their own Schedule H (Form 990). If D uses the grant funds to make a grant restricted to one or more of the community benefit activities described in the Table in Part I, D can report the grant on line 7i.