2013

Instructions for Schedule H (Form 990)

Hospitals

Volume 1 of 2

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Department of the Treasury **Internal Revenue Service** www.irs.gov

Contents

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

Future Developments

For the latest information about developments related to Form 990 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/form990*.

General Instructions

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

Background. 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 a hospital organization to meet these requirements for each of its **hospital facilities**, Part V, *Facility Information*, has been expanded to include a Section A, *Hospital Facilities*. In this new section a hospital 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. Part V also includes Section B, *Facility Policies and Practices*, for reporting of information on policies and practices

addressed in section 501(r). The hospital organization must complete a separate Section B for each of its hospital facilities or facility reporting groups listed in Section A.

Section 6033(b)(15)(B) also requires hospital organizations to submit a copy of their audited financial statements to the IRS. Accordingly, a hospital organization that is required to file Form 990 must attach a copy of its most recent audited financial statements to its Form 990. If the organization was included in consolidated audited financial statements but not separate audited financial statements for the tax year, then it must attach a copy of the consolidated financial statements, including details to consolidation (see instructions for Form 990, Part IV, line 20b).

Part V, Section D, requires an organization to 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

Hospital organizations use Schedule H (Form 990) to provide information on the activities and policies of, and community benefit provided by, its **hospital facilities** and other non-hospital health care facilities that it operated during the tax year. This includes facilities operated either directly or through disregarded entities or joint ventures.

Who Must File

An organization that answered “Yes” on Form 990, Part IV, line 20a must complete and attach Schedule H to Form 990.

Schedule H (Form 990) must be completed by a **hospital organization** that operated at any time during the **tax year** at least one **hospital facility.** A hospital facility is one that is required to be licensed, registered, or similarly recognized by a state as a **hospital**. A hospital organization may treat multiple buildings operated by a hospital organization

under a single state license as a single hospital facility.

The organization must file a single Schedule H (Form 990) that combines information from:

1. Hospital facilities directly operated by the organization.
2. Hospital facilities operated by **disregarded entities** of which the organization is the sole member.
3. Other health care facilities and programs of the hospital organization or any of the entities described in 1 or 2, even if provided separately from the hospital's license.
4. Hospital facilities and other health care facilities and programs operated by any **joint venture** treated as a partnership, to the extent of the hospital 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 hospital organization, hospital facilities operated directly by members of the **group exemption** included in the group return, hospital facilities operated by a disregarded entity of which a member included in the group return is the sole member, hospital facilities 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

health care facilities or programs of a member included in the group return even 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 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 combined information on Schedule H (Form 990).

Note that while information from all the above sources is combined for purposes of Schedule H (Form 990), the organization is required to list and provide information regarding each of its **hospital facilities** in Part V, Sections A,

B, and C whether operated directly by the organization or through a disregarded entity or joint venture treated as a partnership. In addition, the organization must list in Part V, Section D, each of its other health care facilities (for example, rehabilitation clinics, other outpatient clinics, diagnostic centers, skilled nursing facilities) that it operated during the tax year, whether operated directly by the organization or 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).

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 did not operate one or more facilities during the **tax year** that satisfy the definition of hospital facility, 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 facility*** *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 financial assistance and other community benefit activities and 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 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 a patient's failure to pay, 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 there from; self-pay or prompt pay discounts; 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 published annually 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 or under any of its hospital facilities' financial assistance policies solely because the organization's or the facility's financial assistance budget was exceeded.

Line 6. Answer lines 6a and 6b based on the community benefit report that the organization prepared for the organization as a whole 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.

Examples of how 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 (as defined in the instructions for line 1) and certain other community benefits. Report on line 7i **contributions** that the organization restricts, in writing, 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.

If the organization completed worksheets other than on a combined basis (for example, facility by facility, joint venture by joint venture), the organization should combine 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 for 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 7, column (f), 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

administrative costs related to the organization's infrastructure (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” also includes restricted grants or contributions that the organization uses to provide a community benefit, such as a restricted grant to provide financial assistance or fund research. “Direct offsetting revenue” does not include unrestricted grants or contributions that the organization uses to provide a community benefit.

Examples. 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 reportable as direct offsetting revenue on line 7a, column (d).

The organization receives an unrestricted grant from an unrelated organization. The organization decides to use the grant to increase the amount of financial assistance it provides. The amount of the unrestricted grant is not reportable as direct offsetting revenue on line 7a, column (d).

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 that case, the organization should combine all information from the worksheets for purposes of completing line 7. Complete the table by combining 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, under the aggregation instruction in *Purpose of Schedule*.

See Worksheets 1 through 8 and specific instructions for the worksheets later in these instructions.

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 of this schedule. Some community building activities may also meet the definition of community benefit. Do not report in Part II community building costs that are reported on Part I, line 7 as community benefit (costs of a community health improvement service reportable on Part I, line 7e). An organization that reports information in this Part II must describe in Part VI how its community building activities promote the health of the communities it serves.

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" 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” 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, unless the expenditures are for an environmental improvement activity that (i) is provided for the primary purpose of improving community health; (ii) addresses an environmental issue known to affect community health; and (iii) is subsidized by the organization at a net loss. An expenditure may not be reported on this line if the organization engages in the activity primarily for marketing purposes.

Line 5. "Leadership development and training for community members" includes, 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" includes, 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" includes, 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" includes, 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 combine the amounts from all such tables, according to the combined instructions in *Purpose of Schedule*, and include the combined information in Part II.

Part III. Bad Debt, Medicare, & Collection Practices

Section A. In this section, (a) report combined bad debt expense; (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 the organization's financial assistance policy; and (c) provide a rationale for what portion of bad debt, if any, the organization believes is 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 or page number of its footnote, if applicable, to its audited financial statements that describes the bad debt expense.

Line 1. Indicate if the organization reports bad debt expense in accordance with Statement 15.

Note. 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. If only a portion of a patient's bill for services is written off as a bad debt, include only the proportionate amount 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**.

Describe in Part VI the methodology used in determining the amount reported on line 2 as bad debt, including how the organization accounted for discounts and payments on

patient accounts in determining bad debt expense.

Line 3. Provide an estimate of the amount of bad debt reported on line 2 that reasonably is 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 insufficient information was obtained to determine 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.

Describe in Part VI the methodology used to determine the amount reported on line 3 and the rationale, if any, for including any portion of bad debt as community benefit.

Line 4. In Part VI, provide the footnote from the organization's **audited financial statements** on bad debt expense, if applicable, or the footnotes related to

“accounts receivable,” "allowance for doubtful accounts," or similar designations. Alternatively, report the page number(s) on which the footnote or footnotes appear in the organization's most recent audited financial statements, which must be attached to this return. 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 exact wording of the footnote or footnotes, or report the page numbers(s) in which the footnote or footnotes appear in the attached audited financial statements.

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, (a) combine allowable costs to provide services reimbursed by Medicare, (do not include community benefit costs included in Part I, line 7), (b) combine Medicare reimbursements attributable to such costs, and (c) combine 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. Do not include any Medicare-related expenses or revenue properly reported in Part I, line 7f or 7g.

In Part VI, the organization should describe what portion of its Medicare shortfall, if any, it believes should constitute community benefit, and explain its rationale for its position. As described below, 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 the 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), research as reported in Part I, line 7h (see Worksheet 7), 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, combine the revenue attributable to costs reported on the Medicare Cost Reports submitted under each provider number, and report the combined 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 A. If Worksheet A 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 combine the costs reported in the Medicare Cost Reports submitted under each

provider number and report the combined costs on line 6.

Worksheet A (optional)

Complete Worksheets 5 and 6 before completing this Worksheet A.

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.

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 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.

Line 8. Check the box that best describes the costing methodology used to report the

Medicare allowable costs 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.**

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**.

For purposes of Line 9a, a “written debt collection policy” includes a written billing and collections policy, or in the case of an organization that does not have a separate written billing and collections policy, a written financial assistance policy that includes the

actions the organization may take in the event of non-payment, including collection actions and reporting to credit agencies.

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 for 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 owned 10% or more by officers, directors, trustees, key employees, and physicians

List any management company, joint venture, or other separate entity (whether treated as a partnership or acorporation), 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 the 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 and its 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 IV can be duplicated if more space is needed to list additional management companies and joint ventures.

Part V. Facility Information

In Part V, the organization must list all of its **hospital facilities** in Section A, complete separate Sections B and C for each of its hospital facilities or facility reporting groups listed in Section A, and list its non-hospital health care facilities in Section D.

Facility reporting groups. If the organization is able to check the same checkboxes for all Part V, Section B questions

for more than one of its hospital facilities, it may file a single Section B and Section C for all facilities in that facility reporting group. For each of those facilities, the organization would assign and list the facility reporting group letter in the “Facility reporting group” column in Section A. Assign letter A to the facility reporting group with the greatest number of facilities, letter B to the group with the second greatest number of facilities, and so forth. For instance, three hospital facilities with identical answers to the Section B checkboxes would be assigned facility group letter A, while two other hospital facilities with identical answers would be assigned facility group letter B.

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 a reasonable method (for example, the number of patients served or 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. A hospital facility is operated by an organization whether the facility is operated directly by the organization or through a **disregarded entity** or **joint venture** treated as a partnership. For each hospital facility, list its name, address, primary website address, and state license number, 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 (an organization with 15 facilities should renumber lines 1-5 on the 2nd page as lines 11-15).

Section B. Section B requires reporting on a **hospital facility** by hospital facility basis. The organization must complete a Section B for each of its hospital facilities or facility reporting groups listed in Section A. At the top of Section B, list the name of the hospital facility or the facility reporting group letter. If reporting Section B for a single hospital facility, list its line number from Section A.

If the organization could check the same checkboxes for all Part V, Section B questions for more than one of its hospital facilities, it may file a single Section B for all facilities in that facility reporting group.

References in these Section B instructions to a “hospital facility” taking a certain action mean that the **hospital organization** took action through or on behalf of the hospital facility.

Lines 1 through 8c. A community health needs assessment (“CHNA”) is an assessment of the significant health needs of the community. To meet the requirements of section 501(r)(3), a CHNA 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. Each **hospital facility** must conduct a CHNA at least once every three years, and adopt an implementation strategy to meet the community health needs identified through such CHNA.

Line 1. Answer “Yes” if the **hospital facility** conducted a CHNA in the current tax year or in either of the two immediately preceding **tax years**. If “Yes,” indicate what the CHNA describes by checking all applicable boxes. If the CHNA describes information that does not have a corresponding checkbox, check line 1j, “Other,” and describe this information in Part V, Section C . If “No,” skip to line 9.

Line 1i. “Information gaps that limit the **hospital facility's** ability to assess the community's health needs” are areas for which the hospital facility has determined that additional information is needed to assess whether a particular health need exists.

Line 3. If “Yes,” describe in Part V, Section C how the hospital facility took into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise in public health, including a description of how it consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). Identify in Part

V, Section C any organizations and other groups that the hospital facility consulted in conducting its most recent CHNA. Individual members of community forums, focus groups, survey groups, and similar groups do not need to be listed.

Line 4. Answer “Yes,” if the **hospital facility's** CHNA 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 V, Section C the other hospital facilities with which the hospital facility conducted its CHNA.

Line 5. Answer “Yes,” if the **hospital facility** made its most recently conducted CHNA widely available to the public. If “Yes,” indicate how the hospital facility made the CHNA widely available to the public by checking all applicable boxes. If the hospital facility made the CHNA 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 V, Section C.

Line 5a. Check this box if the CHNA was made available on the hospital facility's website or the hospital organization's website. If line 5a is checked, list in the space provided the direct website address, or URL, where the CHNA can be accessed.

Line 5b. Check this box if the CHNA was made available on a website other than the hospital facility's website or the hospital organization's website. If line 5b is checked, list in the space provided the direct website address, or URL, where the CHNA can be accessed.

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

Line 6a. Check this box if the **hospital facility** adopted an implementation strategy that addresses each of the significant health needs identified through the CHNA by either (1) describing how the facility plans to meet the health need; or (2) identifying the health need as one the hospital facility does not intend to meet, and explaining why the hospital facility does not intend to meet that health need.

Line 6b. Check the box if the hospital facility has begun, continued, or completed execution of its implementation strategy.

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** took action to address all of the needs identified in its most recently conducted CHNA. If "No," explain in Part V, Section C which community health needs the hospital facility did not take action to address and the reasons why it did not take action to address such needs. For example, a hospital facility might identify limited financial or other resources as reasons why it did not take action to address a need identified in its most recently conducted CHNA.

Line 8a. Answer "Yes" if the organization was liable, at any time during the tax year, for the $50,000 excise tax incurred under section 4959 for failure to conduct a CHNA and adopt an implementation strategy as required under section 501(r)(3). Section 501(r)(3) requires each **hospital facility** to conduct a CHNA, in the tax year or in either of the immediately preceding two tax years, that takes into account input from persons who represent the

broad interests of the community served by the facility, including those with special knowledge of or expertise in public health, and to make the CHNA widely available to the public. Section 501(r)(3) also requires each hospital facility to adopt an implementation strategy to meet the community health needs identified through its CHNA.

Line 8b. Answer " Yes" to line 8b if the organization answered "Yes" to line 8a and filed Form 4720, Return of Certain Excise Taxes Under Chapters 41 and 42 of the Internal Revenue Code, to report the section 4959 excise tax it incurred. Answer "Yes" if the organization filed Form 4720 during the tax year or after the tax year but prior to the filing of this return.

Line 8c. If line 8b is "Yes," report the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities that incurred the tax.

Lines 9 through 14. See the instructions for Part I, Line 1 of Schedule H (Form 990) for the definition of "financial assistance policy."

Line 9. 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 10. See 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, and show the specific threshold by writing in the percentage amount. If “No,” explain in Part V, Section C what criteria the hospital facility used to determine eligibility for free care, or state that the hospital facility did not provide any free care.

Line 11. See 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, and show the specific threshold by writing in the percentage amount. If “No,” explain in Part V, Section C what criteria the hospital facility used to determine eligibility for discounted care, or state that the hospital facility did not provide any discounted care.

Line 12. 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, including factors used in determining eligibility for any discounts, by checking all applicable boxes. If the hospital facility calculated amounts charged to patients using factors other than those listed in lines 12a through 12g, check the box for line 12h, “Other,” and describe these factors in Part V, Section C.

Line 12a. Check this box if the **hospital facility** used the income level of patients, patients' families, or patients' guarantors as a

factor in calculating amounts charged to patients during the **tax year**.

Line 12b. Check this box if the **hospital facility** used the asset level of patients, patients' families, or patients' guarantors as a factor in calculating amounts charged to patients during the **tax year**.

Line 12c. 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 12d. Check this box if the **hospital facility** used the insurance status of patients, patients' families, or patients' guarantors as a factor in calculating amounts charged to patients during the **tax year**.

Line 12h. Check this box if the **hospital facility** considered residency as a factor in calculating amounts charged to patients during the **tax year**.

Line 12i. "Other" factors used in determining amounts charged to patients may include, but

are not limited to, the amount budgeted for financial assistance.

Line 13. 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 14. 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 14a-14f, check line 14g, "Other," and describe in Part V, Section C how the financial assistance policy was publicized within the community served by the hospital facility.

Line 14g. "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. Check the box for line 14g if, instead of the detailed policy, the hospital facility provided a summary of the policy in a manner listed in lines 14a-f.

Line 15. 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 (“FAP”) that explained actions the hospital facility may take upon non-payment under its policy, including, but not limited to, the actions listed in lines 16 and 17, if applicable.

Lines 16 and 17. “Other similar actions” do not include sending the patient a bill.

Note: Section 501(r)(6) requires a hospital facility to forego extraordinary collections actions before the facility has made reasonable efforts to determine the individual's eligibility under the facility's FAP. No inference should be made regarding whether the actions listed in lines 16a through 16d, 17a through 17d, or described in Part V, Section C as “other similar actions,” are “extraordinary collection actions.”

Line 16. Indicate what actions against an individual the **hospital facility** was permitted to take during the tax year under its policies before making reasonable efforts to determine the individual's eligibility under the facility's FAP by checking all applicable boxes. If a hospital facility's policies permitted the facility to take an action or actions against an individual during the tax year similar to those listed in lines 16a through 16d before making reasonable efforts to determine the individual's eligibility under the facility's FAP, check line 16e, "Other similar actions," and describe those actions in Part V, Section C.

Line 16e. If the organization checked line 16e, describe in Part V, Section C the other similar actions that the hospital facility was permitted to take under its policies during the tax year before making reasonable efforts to determine the individual's eligibility under the **hospital facility**'s FAP.

Line 17. Answer "Yes" if the hospital facility or an authorized third party performed any of the actions listed in lines 17a through 17d during the tax year before making reasonable

efforts to determine the individual's eligibility under the facility's FAP. If “Yes,” indicate the actions the hospital facility or an authorized third party performed before making reasonable efforts to determine the individual's eligibility under the facility's FAP by checking all applicable boxes. If the hospital facility or an authorized third party performed actions similar to those listed in lines 17a through 17d before making reasonable efforts to determine the individual's eligibility under the facility's FAP, answer “Yes,” check the box for line 17e, “Other similar actions,” and describe those actions in Part V, Section C.

Line 18. Indicate which efforts the **hospital facility** took before initiating any of the actions listed (whether or not checked) in lines 17a through 17d or described in Part V, Section C (describing “other similar actions” checked on line 16e or line 17e) by checking all applicable boxes in lines 18a through 18d. If the hospital facility made efforts other than those listed in lines 18a through 18d before initiating any of the actions listed in lines 17a through 17d or described in Part V, Section C

(describing "other similar actions" checked on line 16e or line 17e) check the box for line 18e, “Other,” and describe in Part V, Section C.

If the hospital facility made no such efforts before initiating any of the actions listed (whether or not checked) in lines 17a through 17d or described in Part V, Section C (describing “other similar actions” checked on line 16e or line 17e), check the box for line 18e, “Other,” and state in Part V, Section C that the hospital facility made no such efforts.

Line 18c. The term “communications” includes, but is not limited to, in-person interactions, telephone calls, and invoices.

Line 19. Answer “Yes,” if, during the **tax year**, the **hospital facility** had in place a written policy about 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 written nondiscriminatory

policy relating to emergency medical care by checking all applicable boxes. If the reason the hospital facility did not have a written nondiscriminatory policy relating to emergency medical care is not listed in lines 19a through 19c, check line 19d, “Other,” and describe the reason(s) in Part V, Section C.

The hospital facility may check “Yes” if it had a written policy that required compliance with 42 U.S.C. 1395dd (Emergency Medical Treatment and Active Labor Act (EMTALA)).

For purposes of line 19, 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, for 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) for 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.

Lines 20-22. For purposes of lines 20-22, the term “FAP-eligible” means eligible for assistance under the hospital facility's financial assistance policy.

Line 20. Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care by checking the appropriate box.

Note. Under Section 501(r)(5), the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically

necessary care are the amounts generally billed to individuals who have insurance covering such care.

Line 21. Answer “Yes,” if, during the **tax year**, the **hospital facility** charged any FAP-eligible individual 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 V, Section C.

The **hospital facility** may check “No” if it charged more than the amounts generally billed to individuals who had insurance covering such care to an individual who had not submitted a complete FAP application to the hospital facility as of the time of the charge, and the hospital facility corrected the bill within a reasonable period of time after learning that the individual was eligible.

Line 22. Answer “Yes,” if, during the **tax year**, the **hospital facility** charged any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual, and explain in Part V, Section C

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 individual for such service is less than the amount of the gross charge.

The hospital facility may check “No” if it charged gross charges to one or more individuals, provided that none of the individuals had submitted a complete FAP application to the hospital facility as of the time of the charge, and the hospital facility corrected the bill within a reasonable period of time after learning the individuals were eligible.

Section C. Use Section C to provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22, as applicable. Complete a separate Section C for each **hospital facility** or facility reporting group for which the organization completed Section B; complete one Section C for each Section B.

If completing Section C for a single hospital facility, identify the specific name and line number (from Schedule H (Form 990), Part V, Section A) of the hospital facility to which the responses in Section C relate.

If completing Section C for a facility reporting group, list the reporting group letter, then list each hospital facility in that group separately by name and line number (from Section A). For each hospital facility, provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22, as applicable.

- Line 1j: If the organization checked line 1j, describe the other content included in the hospital facility's CHNA.
- Line 3: If the organization checked “Yes,” describe how the hospital facility took into account input from persons who represent the broad interests of the community served by the hospital facility. Include a description of how the organization consulted with these persons (whether through meetings, focus groups,

interviews, surveys, written correspondence, etc.). Identify any organizations and other groups that the hospital facility consulted in conducting its most recent CHNA. Individual members of community forums, focus groups, survey groups, and similar groups do not need to be listed.

- Line 4: If the organization checked “Yes,” list the other hospital facilities with which the hospital facility conducted its CHNA.
- Line 5c: If the organization checked line 5c, describe the other means that the hospital facility used to make its CHNA 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 CHNA.
- Line 7: If the organization checked “No,” to line 7, explain which needs identified in the hospital facility's most recently conducted CHNA that it did not take action

to address, and why it did not take action to address such needs.

- Line 10: If the organization checked “No,” explain what criteria the hospital facility used to determine eligibility for free care, or state that the hospital facility did not provide any free care.
- Line 11: If the organization checked “No,” explain what criteria the hospital facility used to determine eligibility for discounted care, or state that the hospital facility did not provide any discounted care.
- Line 12h: If the organization checked line 12h, describe the other factor(s) that the hospital facility used in calculating amounts charged to patients.
- Line 14g: If the organization checked line 14g, describe other ways that the hospital facility publicized its financial assistance policy.
- Line 16e: If the organization checked line 16e, describe the other similar actions that the hospital facility was permitted to take under its policies during the tax year

before making reasonable efforts to determine the individual's eligibility under the facility's FAP.

- Line 17e: If the organization checked line 17e, describe the other similar actions that the hospital facility was permitted to take under its policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP.
- Line 18e: If the organization checked line 18e, describe the other efforts that the hospital facility made or state that the facility made no such efforts before initiating any of the actions checked in line 17 or described in Section C.
- Line 19d: If the organization checked line 19d, describe the other reasons why the hospital facility did not have a written nondiscriminatory policy for emergency medical care.
- Line 20d: If the organization checked line 20d, explain what other means the hospital facility used to determine the

maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- Line 21: If the organization checked "Yes" to line 21, explain the circumstances in which the hospital facility charged any FAP-eligible individual more than the amounts generally billed to individuals who had insurance covering such care.
- Line 22: If the organization checked "Yes" to line 22, explain the circumstances in which the hospital facility charged any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual.

Section D. Complete Part V, Section D, 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 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 a reasonable method (for

example, the number of patients served or 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, mobile clinics, and skilled nursing facilities.

In the upper left hand corner of the Part V, Section D 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 D and use as many duplicate copies of Section D as needed, number each page, and renumber the line numbers in the left hand margin (for example, an organization with 15 such facilities should renumber lines 1-5 on the 2nd page as lines 11-15).