2013

Instructions for Schedule H (Form 990)

Hospitals

Volume 2 of 2

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

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 in a report

prepared by a **related organization**, and not in a separate report prepared by the organization, identify the related organization and list its employer identification number.

Part I, line 7g. If applicable, describe if 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 percentages in this column).

Part I, line 7. Provide an explanation of the costing methodology used to calculate the amounts reported for each line 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 if a cost-to-charge ratio was used for any of the figures 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 2. Describe the methodology used to determine the amount in Part III, line 2, including how the organization accounts for discounts and payments on patient accounts in determining bad debt expense.

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

Part III, line 4. Provide, if applicable, the text of the footnote to the organization's

financial statements that describes bad debt expense, or report the page number(s) of the organization's most recent **audited financial statements** on which the footnote appears. 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 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 in the policy that apply to patients who it knows qualify for financial assistance, whether the practices apply specifically to such patients or also cover other types of patients.

Line 2. Describe whether and how the organization assesses the health care needs of the community or communities it serves, in addition to any CHNA 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, applications for financial assistance, 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, applications for financial

assistance, and financial assistance contact information to patients as part of the intake process; provides a copy of the policy, or a summary thereof, applications for financial assistance, and financial assistance contact information to patients with discharge materials; includes the policy, or a summary thereof, an application for financial assistance, and 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) (urban, suburban, rural, etc.), the demographics of the community or communities (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 or specialties; 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 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, line 1 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 method to estimate financial assistance cost. An organization that does not use Worksheet 2 to determine a ratio of patient care cost to charges should make any necessary adjustments for patient care charges and community benefit programs to avoid double counting.

Line 4. Enter the Medicaid/provider taxes, fees, and assessments 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 the 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 the taxes or payments has not been made clear by state regulation or law, then the organization can allocate the 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 (portions of 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. If such payments are primarily to offset the cost of Medicaid services, then report this amount on Worksheet 3, line 7, column (A). If the primary purpose of the payments has not been made clear by state regulation or law, then the organization can allocate the 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.

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

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Gross patient charges

1.	Amount of gross patient charges written off under financial assistance policies	**1.**	

Total community benefit expense

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, fees, and assessments	**4.**	
5.	**Total community benefit expense** (add lines 3 and 4; enter on Part I, line 7a, column (c))	**5.**	

Direct offsetting revenue

6.	Revenue from uncompensated care pools or programs	**6.**	
7.	Other direct offsetting revenue	**7.**	
8.	**Total direct offsetting revenue** (add lines 6 and 7; enter on Part I, line 7a, column (d))	**8.**	
9.	**Net community benefit expense** (subtract line 8 from line 5; enter on Part I, line 7a, column (e))	**9.**	
10.	Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25)	**10.**	
11.	**Percent of total expense** (divide line 9 by line 10; enter on Part I, line 7a, column (f))	**11.**	%

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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. An organization that does not use Worksheet 2 to determine a ratio of patient care cost to charges should make any necessary adjustments for patient care charges and community benefit programs to avoid double counting.

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, fees, and assessments 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 included in “Total operating expense” on line 1 and 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 2. **Ratio of Patient Care Cost to Charges (can be used for other worksheets)**

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Patient care cost

1. Total operating expense . . . . . **1.** _____

Less adjustments

2. Nonpatient care activities . . . . . **2.** _____

3. Medicaid provider taxes, fees, and assessments . . . . . **3.** _____

4. Total community benefit expense . . . . . **4.** _____

5. Total community building expense . . . . . **5.** _____

6. Total adjustments (add lines 2 through 5) . . . . . **6.** _____

7. Adjusted patient care cost (subtract line 6 from line 1) . . . . . **7.** _____

Patient care charges

8. Gross patient charges . . . . . **8.** _____

Less: adjustments

9. Gross charges for community benefit programs . . . . . **9.** _____

10. Adjusted patient care charges (subtract line 9 from line 8) . . . . . **10.** _____

Calculation of ratio of patient care costs to charges

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.** _____ %

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

Worksheet 3 can be used to report the cost of Medicaid and other means-tested government health programs. A “means-tested government program” is a government health 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 health 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 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 health programs.

Line 4, column (A). Enter the Medicaid provider taxes, fees, and assessments 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 for services performed during prior years.

Organizations can describe in Part VI the amount of prior year Medicaid revenue included in Part I, line 7b.

Amounts received from a Medicaid program as “reimbursement for direct GME” or IME should be treated the way the Medicaid program that provides reimbursement 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 the 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 3. **Medicaid and Other Means-Tested Government Health Programs (Part I, lines 7b and 7c)**

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		(A) Medicaid	(B) Other means-tested government health programs
Gross patient charges			
1. Gross patient charges from the programs	**1.**		
Total community benefit expense			
2. Ratio of patient care 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, fees, and assessments	**4.**		
5. Total community benefit expense 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.**		
Direct offsetting revenue			
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. Net community benefit expense (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. Total expense (enter amount from Form 990, Part IX, line 25, Column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25, in both columns (A) and (B))	**11.**		
12. Percent of total expense (line 10 divided by line 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.**	%	%

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

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			(A) Total community benefit expense	(B) Direct offsetting revenue	(C) Net community benefit expense (subtract col. (B) from col. (A) for lines 1–5)
1.	Community health improvement services				
	a.	**1a.**			
	b.	**1b.**			
	c.	**1c.**			
	d.	**1d.**			
	e.	**1e.**			
	f.	**1f.**			
	g.	**1g**			
	h.	**1h.**			
	i.	**1i.**			
	j.	**1j.**			
2.	Worksheet subtotal (add lines 1a through 1j)	**2.**			
3.	Community benefit operations				
	a.	**3a.**			
	b.	**3b.**			
	c.	**3c.**			
	d.	**3d.**			
4.	Worksheet subtotal (add lines 3a through 3d)	**4.**			
5.	**Worksheet total** (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.**			
6.	Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25)	**6.**			
7.	**Percent of total expense** (line 5, column (C) divided by line 6; enter amount on Part I, line 7e, column (f)	**7.**			

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, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, 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,
- community benefit program administration, and

- 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 or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it 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 (employees and physicians of the organization).

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

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health 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 carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. 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 they ceased 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 access to health care services or disparities in health status 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 increased general 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

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

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		Totals
Total community benefit expense		
1. Medical students	**1.**	
2. Interns, residents, and fellows	**2.**	
3. Nurses	**3.**	
4. Other allied health professions, students	**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.**	
Direct offsetting revenue		
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. **Net community benefit expense** (line 7 minus line 12; enter on Part I, line 7f, column (e))	**13.**	
14. Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25)	**14.**	
15. **Percent of total expense** (line 13 divided by line 14; enter amount on Part I, line 7f, column (f))	**15.**	%

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. See 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:

1. medical students,
2. 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,

3. 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,

4. and 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 or Medicaid.

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 associated with expenses reported in Worksheet 5, line 7.

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 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 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 need, or
- the service would become the responsibility of government or another tax-exempt organization.

Subsidized health services can include qualifying inpatient programs (for example, neonatal intensive care, addiction recovery, and inpatient psychiatric units) and outpatient programs (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 at 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 stand-alone physician clinics (not other facilities at which physicians provide services) 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.

Note: The organization can report a physician clinic as a subsidized health service only if the organization operated the clinic and

associated hospital services at a financial loss to the organization during the year.

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 health programs. For column (D), enter financial assistance amounts attributable to the subsidized health service measured by cost. Multiply line 1 by line 2 or enter the estimated expense of each subsidized health service based on the organization's cost accounting. Organizations with a cost accounting system or 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.

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Worksheet 6. **Subsidized Health Services (Part I, line 7g)**

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Program name: _____

		(A) Total subsidized health service program	(B) Bad debt	(C) Medicaid and other means-tested government health programs	(D) Financial assistance	(E) Totals (subtract columns (B), (C), and (D) from column (A))
Gross patient charges						
1. Gross patient charges from program(s)	1.					
Total community benefit expense						
2. Ratio of patient care cost to charges (from Worksheet 2, if used)	2.	%	%	%	%	
3. **Total community benefit expense** (multiply line 1 by line 2, or obtain from cost accounting; enter column (E) on Part I, line 7g, column (c))	3.					
Direct offsetting revenue						
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. **Net community benefit expense** (subtract line 6 from line 3; enter column (E) on Part I, line 7g, column (e))	7.					
8. Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25)	8.					$
9. **Percent of total expense** (line 7, column (E) divided by line 8; enter on Part I, line 7g, column (f))	9.					%

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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 increased generalizable knowledge made available to the public (for example: 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, 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, Health Insurance Portability and Accountability Act (HIPPA), etc.); and dissemination of research results.

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

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

Line 4. Enter license fees and royalties the organization received during the tax year that are directly associated with research that the organization has (in any tax year) reported on Schedule H as community benefit.

Line 5. An example of “other revenue” is Medicare reimbursement associated with any research expense reported as community benefit.

Worksheet 8. Cash and In-Kind Contributions for Community Benefit (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, and not on lines 7a through 7h.

“Cash and in-kind contributions” means contributions made by the organization to health care organizations and other community groups restricted, in writing, 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.

Do not report as cash or in-kind contributions any payments that the organization makes in exchange for a service, facility, or product, or that the organization makes primarily to obtain an economic or physical benefit; for example, payments made in lieu of taxes that the organization makes to prevent or forestall local or state property tax assessments, and a teaching hospital's payments to its affiliated medical school for intern or resident supervision services by the school's faculty members.

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 that are reportable in Part X of the core Form 990; 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.

Worksheet 7. **Research (Part I, line 7h)**

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Total community benefit expense

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.**	

Direct offsetting revenue

4.	License fees and royalties	**4.**	
5.	Other revenue	**5.**	
6.	**Total direct offsetting revenue** (add lines 4 and 5; enter on Part I, line 7h, column (d))	**6.**	
7.	**Net community benefit expense** (subtract line 6 from line 3; enter on Part I, line 7h, column (e))	**7.**	
8.	Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25)	**8.**	
9.	**Percent of total expense** (divide line 7 by line 8; enter on Part I, line 7h, column (f))	**9.**	%

Worksheet 8. **Cash and In-Kind Contributions for Community Benefit (Part I, line 7i)**

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		(A) Cash contributions	(B) In-kind contributions	(C) Total
1. **Total community benefit expense** (enter amount from column (C) on Part I, line 7i, column (c))	**1.**			
2. **Direct offsetting revenue** (enter amount from column (C) on Part I, line 7i, column (d))	**2.**			
3. **Net community benefit expense** (subtract line 2 from line 1; enter on Part I, line 7i, column (e))	**3.**			
4. Total expense (enter amount from Form 990, Part IX, line 25, column (A), including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25)	**4.**			
5. **Percent of total expense** (divide line 3 by line 4; enter on Part I, line 7i, column (f))	**5.**			%

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.

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