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If you wish, you can submit comments about draft or final forms, instructions, or publications on the Comment on Tax Forms and Publications page on IRS.gov. We cannot respond to all comments due to the high volume we receive, but we will carefully consider each one. Please note that we may not be able to consider many suggestions until the subsequent revision of the product.

2016

Instructions for Schedule H (Form 990)

Hospitals

Department of the Treasury
Internal Revenue Service

DRAFT AS OF September 6, 2016

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

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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*.

What's New

IRC sec. 501(r) final regulations are new this year, and are effective for tax years beginning after 12/29/15. See Treas. Reg. 1.501(r)–0 through –7, (TD 9708), Reg. 1.501(c)(9). This caused changes to occur in this product. These changes are found throughout this product.

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 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) isn't 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 isn't 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 aren't 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, don't 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 isn't 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).

TIP *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) *aren't 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 (FAP), 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 therefrom; 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%.”

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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 criteria used, such as 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.

TIP *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, and to make a paper copy of the CHNA report available for public inspection upon request and without charge at the hospital facility.*

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. Don't report such contributions on lines 7a through 7h. To calculate the amounts to be reported on the table, use the worksheets or other equivalent documentation that substantiates the information reported consistent with the methodology used on the worksheets. See the instructions to the worksheets for definitions of the various types of community benefit (for example, community health improvement services, health professions education, subsidized health services, research, etc.) to be reported on lines 7a through 7k.

TIP *If the organization completed worksheets other than on 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.

Don't 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 isn't 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

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fund research. "Direct offsetting revenue" does not include unrestricted grants or contributions that the organization uses to provide a community benefit. Organizations may describe any inconsistencies from reporting in prior years in Part VI.

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 isn't reportable as direct offsetting revenue on line 7a, column (d).

Columns (e) and (f). Don't report negative numbers. If the net community benefit expense is less than $0, enter "0." Similarly, don't report a negative percent in column (f), but enter "0."

Group return filers. The "total expense" denominator for purposes of determining the percent of total expense for column (f) is the amount reported on Form 990, Part IX, line 25, column (A) of the group return.

TIP *Column (f) "percent of total expense" is based on column (e) "net community benefit expense," rather than column (c) "total community benefit expense." Organizations that report amounts of direct offsetting revenue also might wish to report total community benefit expense (Part I, line 7, 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 isn't 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 aren't reportable in Part I of this schedule. Some community building activities may also meet the definition of community benefit. Don't 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 don't include in Part II the organization's proportionate share of the amount spent by the joint venture on such activities, to avoid double counting.

Line 1. "Physical improvements and housing" include, but aren't 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 isn't 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 isn't 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 aren't 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,

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but isn't limited to, training in conflict resolution; civic, cultural, or language skills; and medical interpreter skills for community residents.

Line 6. "Coalition building" includes, but isn't 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 isn't 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 isn't 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 aren't 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 hasn't 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. **Don't 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 number(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 don't 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** don't 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, (don't 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. Don't 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.

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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. Don't 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 isn't 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 surplus (the shortfall) as a negative number.

TIP *Lines 5, 6, and 7 don't 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. **Don't 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 a corporation), including joint ventures outside of the **United States**, of which the organization is a partner or shareholder;

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

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

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the joint venture in proportion to their ownership share of the physician group practice.

Note. Don't 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). Don't 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 if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility), 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 isn't 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 each page of Section B, list the name of the hospital facility or the facility reporting group letter. In the space provided, list the line number of the hospital facility, or line numbers of the hospital facilities in a facility reporting group (from Part V, 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.

Line 1. Answer "Yes" if the **hospital facility** was first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year.

Line 2. Answer "Yes" if the **hospital facility** was acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year. If "Yes," provide details in Section C.

Lines 3 through 12c. 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

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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 3. 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 12.

Line 3a. Check this box if the CHNA report defines the community served by the hospital facility and a description of how the community was determined.

Line 3c. Check this box if the CHNA report describes the resources potentially available to address the significant health needs identified through the CHNA, including existing health care facilities and resources within the community that are available to respond to the health needs of the community.

Line 3d. Check this box if CHNA report describes the process and methods used to conduct the CHNA.

Line 3g. Check this box if the CHNA report describes the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs.

Line 3h. Check this box if the CHNA report describes how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves.

Line 3i. Check this box if the CHNA report describes the evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

Line 5. Answer "Yes" if the hospital facility took into account input from persons who represent the broad interests of the community served by the hospital facility, including at least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health described in section 338J of the Public Health Service Act (42 U.S.C. 254r), with knowledge, information, or expertise relevant to the health needs of that community, members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations; and written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.

If the organization checked "Yes," summarize, in general terms, how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, written comments, and between what dates); the names of any organizations providing input; and describe the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input. A CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA. In the event a hospital facility solicits, but cannot obtain, input from a source required by line 5, the hospital facility's CHNA report also must describe the hospital facility's efforts to solicit input from such source.

Line 6a. 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 6b. Answer "Yes," if the **hospital facility's** CHNA was conducted with one or more organizations other than hospital facilities. If "Yes," list in Part V, Section C, the other organizations with which the hospital facility conducted its CHNA.

Line 7. 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 7a through 7c, check line 7d, "Other," and describe these means in Part V, Section C.

Line 7a. Check this box if the CHNA was made available on the hospital facility's website or the hospital organization's website. If line 7a is checked, list in the space provided the direct website address, or URL, where the CHNA can be accessed.

Line 7b. 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 7b is checked, list in the space provided the direct website address, or URL, where the CHNA can be accessed.

Line 7c. Check this box if a paper copy of the CHNA was made available for public inspection upon request and without charge at the hospital facility.

Line 8. Answer "Yes" if the **hospital facility** adopted an implementation strategy to meet the significant health needs identified through its most recently conducted CHNA. If "No," skip to line 11.

Line 10. Answer "Yes" if the **hospital facility's** most recently adopted implementation strategy is posted on a website. If "Yes," answer line 10a. If "No," skip to line 10b.

Line 10a. List in the space provided the direct website address, or URL, where the implementation strategy can be accessed and skip to line 11.

Line 10b. Answer "Yes" if the **hospital facility's** most recently adopted implementation strategy is attached.

Line 11. Explain in Part V, Section C, how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that aren't being addressed together with the reasons why such needs aren't being addressed. 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 12a. 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 12b. Answer "Yes" to line 12b if the organization answered "Yes" to line 12a 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 12c. If line 12b is "Yes," report the total amount of section 4959 excise tax the organization reported on Form 4720

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for all of its hospital facilities that incurred the tax.

Lines 13 through 16. See the instructions for Part I, line 1 of Schedule H (Form 990) for the definition of "financial assistance policy (FAP)."

Line 13. 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. If "Yes," indicate the eligibility criteria explained in the FAP by checking all applicable boxes. If the FAP describes information that does not have a corresponding checkbox, check line 13h, "Other," and describe this information in Part V, Section C.

Line 13a. See the instructions for Part I, line 3a of Schedule H (Form 990), for the definition of "Federal Poverty Guidelines" (FPG). Check this box if, during the **tax year**, the **hospital facility** had a written financial assistance policy that used FPG for determining eligibility for free or discounted medical care. Show the specific threshold by writing in the percentage amount. If the hospital facility used FPG for determining eligibility for free or discounted medical care, but not both free and discounted medical care, enter "000" in the percentage amount for which FPG was not used.

Line 13b. Check this box if the hospital facility used an income level other than FPG and explain in Part V, Section C what criteria the hospital facility used to determine eligibility for free or discounted care (including whether the hospital facility used the income level of patients, patients' families, or patients' guarantors as a factor).

Line 13c. Check this box if the **hospital facility** used the asset level of patients, patients' families, or patients' guarantors as a factor in determining eligibility for financial assistance.

Line 13d. 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 determining eligibility for financial assistance.

Line 13e. Check this box if the **hospital facility** used the insurance status of patients, patients' families, or patients' guarantors as a factor in determining eligibility for financial assistance.

Line 13g. Check this box if the **hospital facility** considered residency as a factor in determining eligibility for financial assistance.

Line 14. 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.

Line 15. 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. If "Yes," indicate how the hospital facility's FAP or FAP application form (including the accompanying instructions) explained the method for applying for financial assistance by checking all applicable boxes. If the FAP explains a method(s) for applying for financial assistance other than those listed in lines 15a through 15d, check 15e, "Other," and explain the method(s) in Part V, Section C.

Line 15a. Check this box if the **hospital facility** described all of the information it may require an individual to provide as part of his or her application.

Line 15b. Check this box if the **hospital facility** described all of the supporting documentation it may require an individual to submit as part of his or her application.

Line 15c. Check this box if the **hospital facility** provided contact information of hospital facility staff that the hospital facility has identified as an available source of assistance with FAP applications.

Line 15d. Check this box if the **hospital facility** provided the contact information of a nonprofit organization or government agency that the hospital facility has identified as an available source of assistance with FAP applications.

Line 16. Answer "Yes," if, during the **tax year**, the FAP was widely publicized 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 aren't listed in lines 16a–16i, check line 16j, "Other," and describe in Part V, Section C how the financial assistance policy was publicized within the community served by the hospital facility.

Line 16g. Check the box if individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention.

Line 16i. Check this box if the FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations, such as by translating these documents into the language(s) spoken by each LEP language group that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital facility or the population likely to be affected or encountered by the hospital facility.

Line 16j. "Other" measures to publicize the policy within the community served by the **hospital facility** may include, but aren't limited to, having registration personnel refer uninsured and/or low-income patients to financial counselors to discuss the policy. Check the box for line 16j if, instead of the detailed policy, the hospital facility provided a summary of the policy in a manner listed in lines 16a–i.

Line 17. 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 described any actions that the hospital facility (or other authorized party) may take related to obtaining payment of a bill for medical care, including, but not limited to, any extraordinary collection actions (ECAs); the process and time frames the hospital facility (or other authorized party) uses in taking those actions (including, but not limited to, the reasonable efforts it will make to determine whether an individual is FAP-eligible before engaging in ECAs); and the office, department, committee, or other body with the final authority or responsibility for determining that the hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible and may therefore engage in ECAs against the individual.

Lines 18 and 19. "Other similar actions" don't 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.

Line 18. 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.

Line 18a. Check this box if the FAP permitted reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

Line 18b. Check this box if the FAP permitted selling an individual's debt to another party. Do not check the box if, prior to the sale, the hospital facility entered into a legally binding written agreement with the purchaser of the debt

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pursuant to which the purchaser is prohibited from engaging in any ECAs to obtain payment for the care; the purchaser is prohibited from charging interest on the debt in excess of the rate in effect under section 6621(a)(2) at the time the debt is sold; the debt is returnable to or recallable by the hospital facility upon a determination by the hospital facility or the purchaser that the individual is FAP-eligible; and, if the individual is determined to be FAP-eligible and the debt isn't returned to or recalled by the hospital facility, the purchaser is required to adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the purchaser and the hospital facility together more than he or she is personally responsible for paying as a FAP-eligible individual.

Line 18c. Check this box if the FAP permitted deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the hospital facility's FAP.

Line 18d. Check this box if the FAP permitted actions that require a legal or judicial process, including but not limited to: placing a lien on an individual's real property; attaching or seizing an individual's bank account or any other personal property; commencing a civil action against an individual; causing an individual's arrest; causing an individual to be subject to a writ of body attachment or garnishing an individual's wages. Do not include any liens that a hospital facility is entitled to assert under state law on the proceeds of a judgment settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the hospital facility provided care and if it files a claim in bankruptcy proceeding.

Line 18e. 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 18a through 18d before making reasonable efforts to determine the individual's eligibility under the facility's FAP, check line 18e, "Other similar actions," and describe those actions in Part V, Section C.

Line 18f. If the hospital facility was permitted to make no such actions, check the box for line 18e, "None of these actions or similar actions were permitted."

Line 19. Indicate any of the actions against an individual that the hospital facility took during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP by checking all applicable boxes. For purposes of this question, actions against an individual include actions to obtain payment for the care against any other individual who has accepted or is required to accept responsibility for the individual's hospital bill for the care, and actions of the hospital facility includes actions of any purchaser of the individual's debt, any debt collection agency or other party to which the hospital facility has referred the individual's debt, or any substantially-related entity.

Line 19a. Check this box if the hospital facility reported adverse information about the individual to consumer credit reporting agencies or credit bureaus before making reasonable efforts to determine the individual's eligibility under the facility's FAP.

Line 19b. Check this box if the hospital facility sold an individual's debt to another party before making reasonable efforts to determine the individual's eligibility under the facility's FAP. Do not check the box if, prior to the sale, the hospital facility entered into a legally binding written agreement with the purchaser of the debt pursuant to which the purchaser is prohibited from engaging in any ECAs to obtain payment for the care; the purchaser is prohibited from charging interest on the debt in excess of the rate in effect under section 6621(a)(2) at the time the debt is sold; the debt is returnable to or recallable by the hospital facility upon a determination by the hospital facility or the purchaser that the individual is FAP-eligible; and, if the individual is determined to be FAP-eligible and the debt isn't returned to or recalled by the hospital facility, the purchaser is required to adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the purchaser and the hospital facility together more than he or she is personally responsible for paying as a FAP-eligible individual.

Line 19c. Check this box if the hospital facility deferred or denied, or required a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the hospital facility's FAP.

Line 19d. Check this box if the hospital facility took legal action or pursued a judicial process, including but not limited to: placing a lien on an individual's real property; attaching or seizing an individual's bank account or any other personal property; commencing a civil action against an individual; causing an individual's arrest; causing an individual to be subject to a writ of body attachment, or garnishing an individual's wages. Do not include any liens that a hospital facility is entitled to assert under state law on the proceeds of a judgment settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the hospital facility provided care and if it filed a claim in bankruptcy proceeding.

Line 19e. If the hospital facility took an action or actions against an individual during the tax year similar to those listed in lines 19a through 19d before making reasonable efforts to determine the individual's eligibility under the facility's FAP, check line 19e, "Other similar actions," and describe those actions in Part V, Section C.

Line 20. Indicate which efforts the **hospital facility** or other authorized party made before initiating any of the actions listed (whether or not checked) in lines 19a through 19c or described in Part V, Section C (describing "other similar actions" checked on line 18e or line 19e) by checking all applicable boxes in lines 20a through 20d. If the hospital facility made efforts other than those listed in lines 20a through 20d before initiating any of the actions listed in lines 19a through 19c or described in Part V, Section C (describing "other similar actions" checked on line 18e or line 19e), check the box for line 20e, "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 19a through 19c or described in Part V, Section C (describing "other similar actions" checked on line 18e or line 19e), check the box for line 20f, "None of these efforts were made."

Line 20a. Check this box if the hospital facility or other authorized party provided individuals with a written notice that indicated financial assistance is available for eligible individuals, identified the ECA(s) that the hospital facility (or other authorized party) intended to initiate to obtain payment for the care, and stated a deadline after which such ECA(s) may be initiated that was no earlier than 30 days after the date that the written notice was provided, along with a plain language summary of the FAP. If not, describe in Section C.

Line 20b. Check this box if the hospital facility or other authorized party made a reasonable effort to orally notify individuals about the hospital facility's FAP and about how the individual may obtain assistance with the FAP application process at least 30 days before initiating ECAs. If not, describe in Section C.

Line 20c. Check this box if (1) when an individual who submitted an incomplete FAP application during the application period, the hospital facility or other authorized party notified the individual about how to complete the FAP application and gave the individual a

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reasonable opportunity to do so in accordance with in accordance with Treas. Reg. § 1.501(r)-6(c)(5); and (2) when an individual who submitted an complete FAP application during the application period, the hospital facility or other authorized party determined whether the individual is FAP-eligible for the care and otherwise met the requirements described in Treas. Reg. § 1.501(r)-6(c)(6). If not, describe in Section C.

Line 20d. Check this box if the hospital facility or other authorized party made presumptive eligibility determinations in accordance with Treas. Reg. § 1.501(r)-6(c)(2). If not, describe in Section C.

Line 21. 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. A hospital facility's emergency medical care policy does not meet this requirement unless it prohibits the hospital facility from engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. 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 isn't listed in lines 21a through 21c, check line 21d, "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 21, 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 22–24. For purposes of lines 22–24, the term "FAP-eligible" means eligible for assistance under the hospital facility's financial assistance policy.

Line 22. 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 23. 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 if: the charge in excess of amounts generally billed (AGB) was not made or requested as a pre-condition of providing medically necessary care to the FAP-eligible individual; as of the time of the charge, the FAP-eligible individual had not submitted a complete FAP application and had not otherwise been determined by the hospital facility to be FAP-eligible for the care; and, if the individual subsequently submits a complete FAP application and is determined to be FAP-eligible for the care, the hospital facility refunds any amount that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than $5.

Line 24. 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 for any medical care covered under the FAP if: the charge in excess of AGB was not made or requested as a pre-condition of providing medically necessary care to the FAP-eligible individual; as of the time of the charge, the FAP-eligible individual had not submitted a complete FAP application and had not otherwise been determined by the hospital facility to be FAP-eligible for care; and, if the individual subsequently submits a complete FAP application and is determined to be FAP-eligible for the care, the hospital facility refunds any amount that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than $5.

Section C. Use Section C to provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 21c, 21d, 23, and 24, 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 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

- Line 2: If the organization checked "Yes," provide details regarding the **hospital facility(ies)** acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year.
- Line 3j: If the organization checked line 3j, describe the other content included in the hospital facility's CHNA report.
- Line 5: If the organization checked "Yes," summarize, in general terms, how and over what time period such input was provided (for example, whether through

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meetings, focus groups, interviews, surveys, or written comments, and between what dates); the names of any organizations providing input; and describe the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input. A CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA. In the event a hospital facility solicits, but cannot obtain, input from a source required by line 5, the hospital facility's CHNA report also must describe the hospital facility's efforts to solicit input from such source.

- Line 6a: If the organization checked "Yes," list the other hospital facilities with which the hospital facility conducted its CHNA.
- Line 6b: If the organization checked "Yes," list the organizations other than hospital facilities with which the hospital facility conducted its CHNA.
- Line 7d: If the organization checked line 7d, describe the other means that the hospital facility used to make its CHNA widely available.
- Line 11: Describe how the hospital facility is addressing the significant health needs identified in its most recently conducted CHNA and any such needs that aren't being addressed together with the reasons why such needs aren't being addressed.
- Line 13b: Describe the criteria the hospital facility used to determine eligibility for free or discounted care (including whether the hospital facility used the income level of patients, patients' families, or patients' guarantors as a factor).
- Line 13h: If the organization checked line 13h, describe the other eligibility criteria used.
- Line 15e: If the organization checked line 15e, describe the other methods for applying for financial assistance.
- Line 16j: If the organization checked line 16j, describe other ways that the hospital facility publicized its financial assistance policy.
- Line 18e: If the organization checked line 18e, 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 19e: If the organization checked line 19e, 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 20e: If the organization checked line 20e, describe the other efforts that the hospital facility made.
- Line 21c: If the organization checked line 21c, describe how the hospital facility limited who was eligible to receive care for emergency services.
- Line 21d: If the organization checked line 21d, describe the other reasons why the hospital facility did not have a written nondiscriminatory policy for emergency medical care.
- Line 23: If the organization checked "Yes" to line 23, 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 24: If the organization answered "Yes" to line 24, 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 aren't limited to, rehabilitation and other outpatient clinics, diagnostic centers, mobile clinics, and skilled nursing facilities.

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).

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). In addition, use Part VI to make disclosures described in section 7 of Rev. Proc. 2015-21. 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.

Rev. Proc. 2015-21, 2015-13 I.R.B. 817, provides guidance regarding correction and disclosure procedures for hospital organizations to follow so that certain failures to meet the requirements of section 501(r) will be excused for purposes of sections 501(r)(1) and 501(r)(2)(B). Section 7 of the revenue procedure provides that certain information must be disclosed on the organization's Form 990. Provide this information in Part VI.

Line 1. Provide the following supplemental information:

Part I, line 3c. If applicable, describe the criteria used 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

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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 don't contain such a footnote, enter that the organization's financial statements don't 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. If applicable, 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 hasn't 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

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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 hasn't 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.

Line 7. Include the amount of any other offsetting revenue, including any restricted grants received by the organization.

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.	%

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 isn't 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 aren't 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 hasn't 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 hasn't 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 cost 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.** _____ %

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 aren't 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 hasn't 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. Don't 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 hasn't 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

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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.			

are intended for financial assistance and Medicaid, respectively.

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

Worksheet 4 can be used to report the net cost of community health improvement services and community benefit operations.

"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services don't

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 conducting 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.
- Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.
- 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

Lines 1 through 6. Include both direct and indirect costs. Direct costs of health professions education don't 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" don't 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 isn't 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 isn't required, accredited by the recognized national professional organization for the particular activity, including, but not limited to,

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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. Don't 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. Don't 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 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. %

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 aren't 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

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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.

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 isn't a tax-exempt or government entity. However, the organization can describe in Part VI any research it conducts that isn't 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 aren't 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 (HIPAA), 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.

Don't 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. Don't 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.

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 don't 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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Worksheet 6. **Subsidized Health Services (Part I, line 7g)** *Keep for Your Records*

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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.**					%

Worksheet 7. **Research (Part I, line 7h)** *Keep for Your Records*

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.**	%

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

			(A) Cash contrib-utions	(B) In-kind contrib-utions	(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.**			%

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