CHAPTER 5

Measuring Community Benefit

LEARNING OBJECTIVES

After studying this chapter, you should be able to do the following:

1. Describe the current basis for tax exemption of not-for-profit healthcare firms.
2. Describe the elements of community benefit listed by key policy groups.
3. Assess the relative community benefits provided by proprietary and not-for-profit hospitals.
4. Develop a methodology for estimating financial benefits received by not-for-profit healthcare firms.
5. Develop a methodology for estimating financial benefits provided by not-for-profit healthcare firms.

REAL-WORLD SCENARIO

Putnam Memorial Hospital has been the recipient of negative press coverage in their local paper. The negative publicity was precipitated by questions regarding the community benefit provided by the tax-exempt hospital in relationship to the taxes that the community has forgone, such as property taxes and local income tax. The paper has highlighted several key pieces of information regarding Putnam's recent performance. First, the newspaper documented the $1.6 million total compensation earned last year by the hospital's CEO, Douglas Marshall. Many of the paper's readers quickly identified with this point and questioned why any executive in a nonprofit setting should receive compensation at such lofty levels. The paper also noted that the hospital earned more than $40 million in profit last year and did not pay any tax on that profit nor did the hospital pay any property tax on their extensive real estate holdings. Furthermore, the paper cited huge cash reserves being held by the hospital—more than $100 million. The paper questioned why this money was not being used to pay the costs of uninsured patients. Levels of charity care provided by the hospital in the most recent year were less than 2% of revenue.

Mr. Marshall has been speaking with his financial staff about possible responses to the series of negative newspaper articles. Specifically, he wants to document the actual benefits that the hospital receives as a result of its tax-exempt status. He then wants to measure what benefits the hospital provides to the community that might not be provided if the hospital was not a charitable tax-exempt facility. Mr. Marshall believes that the benefits his hospital provides will far exceed the tax benefits received. He wants the computations done quickly and presented in a manner that a nonfinancial audience can understand so that he can diffuse the rising anger in the community against the hospital.

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Most of the current interest in **community benefit** is related to nonprofit hospitals. The term *community benefit* is generally used to describe the scope of services and support (financial assistance or other) that a hospital provides to its community in return for its tax-exempt status. While not-for-profit healthcare firms exist in other healthcare sectors, the sheer size of hospitals as healthcare businesses makes them a more visible target for public scrutiny. According to the American Hospital Association (AHA), in 2014 about 78% of the 4,974 U.S. community hospitals were nonprofit entities (58% private nonprofit and 20% operated by state or local governments). The remaining 22% are for-profit, investor-owned institutions. Tax exemption is the lightning rod that has attracted public attention. In addition to federal income tax exemptions, most not-for-profits receive taxation benefits in many other areas. For example, not-for-profits often do not pay any state or local income taxes; they usually do not pay property or sales taxes, and they can issue tax-exempt **bonds**.

Investor-owned hospitals have long argued that not-for-profit hospitals have received unfair tax advantages that make it harder for them to compete in markets where not-for-profit hospitals have large market share. More recently, federal and state governments have become interested in not-for-profit hospitals as a potential source of revenue. Most likely there will be significant changes in the tax profiles of not-for-profit hospitals and other not-for-profit firms in the decade ahead as demands for government funding accelerate.

Learning Objective 1

Describe the current basis for tax exemption of not-for-profit healthcare firms.

Tax Exemption Status

At the present time the Internal Revenue Service requires five factors to be present to support a hospital's tax-exempt status:

1. Operation of an emergency room open to all members of the community without regard to ability to pay
2. Governance board composed of community members
3. Use of surplus revenue for facilities improvement, patient care, medical training, education, and research
4. Provision of inpatient hospital care for all persons in the community able to pay, including those covered by Medicare and Medicaid
5. Open medical staff with privileges available to all qualifying physicians.

There is nothing in this list that references charitable care, but **not-for-profit** hospitals qualify for tax exemption under a provision of the Internal Revenue Code that relates to charitable purpose, **501(c)(3)**. Not-for-profit hospitals must accept all patients in their emergency rooms without regard to ability to pay, however they do not have to follow-up with additional care to those who are indigent unless they choose to do so. Still, **charity care**, which refers to the dollar value of services provided to patients at no cost or reduced cost has become a significant measurement area for not-for-profit hospitals in the community benefit discussion.

All not-for-profit firms with annual revenues greater than $25,000 and who are exempt from federal income tax are required to file **IRS Form 990** on an annual basis. That form contains a variety of financial information, including balance sheet and income statement data. The forms also contain information on compensation for the highest paid executives.

Since 2010 all not-for-profit hospitals must file **Schedule H** with their annual IRS 990 forms for filing year 2009. Schedule H is presented at the end of this chapter. The primary purpose of this form is to collect information regarding the provision of charity care by not-for-profit hospitals. At this point it is unclear how the data will be used, but most believe the federal government will implement specific standards for the provision of charity care and other community benefits. Not-for-profit hospitals that fail to meet these standards may then have their tax-exempt status removed. Schedule H has six sections:

1. Part I: Financial Assistance and Certain Other Community Benefits at Cost
2. Part II: Community Building Activities
3. Part III: Bad Debt, Medicare, and Collection Practices
4. Part IV: Management Companies and Joint Ventures
5. Part V: Facility Information
6. Part VI: Supplemental Information

There is little doubt that the areas identified in Part I will make the inclusion list for determining IRS community benefit. The other areas are less clear.

The Patient Protection and Affordable Care Act (ACA) of 2010 added Section 501(r) to the Internal Revenue Code, which contains four new requirements

related to community benefits that nonprofit hospitals must meet to qualify for 501(c)(3) tax-exempt status. They are as follows:

- Conduct a community health needs assessment with an accompanying implementation strategy at least once every 3 years.
- Establish a written financial assistance policy for medically necessary and emergency care.
- Comply with specified limitations on hospital charges for those eligible for financial assistance.
- Comply with specified billing and collections requirements.

The new ACA requirements do not include a specific minimum value of charity care that a hospital must provide to qualify for tax-exempt status.

State Efforts

There is significant variation among the states regarding the regulation and taxation of not-for-profit healthcare firms. The General Accounting Office (GAO) published a study in February 2009 titled "Nonprofit Hospitals Variation in Standards and Guidance Limits: Comparison of How Hospitals Meet Community Benefit Requirements." In this study they found 15 states with some form of community benefit reporting standards and or regulation. While these 15 states did have some form of community benefit standard, the GAO found that there was great variation among the states and their respective plans. All 15 of the states had some form of reporting—although in one state the reporting was voluntary. The two key elements of state regulatory plan were:

- How are community benefits defined?
- Is there a penalty for violation of a community benefit standard?

The GAO defined community benefit as "a legal standard that expressly obligates a hospital to provide healthcare services or benefits to the community served by the hospital as a condition of maintaining tax-exempt status or qualifying as a not-for-profit hospital. It is generally something that hospitals are required to do beyond their role of providing care for the sick and injured in exchange for remuneration or compensation. Most of the 15 states did not define the composition of community benefit in a manner that was consistent across all hospitals. In fact, of the 15 states, only 10 of them defined community benefit in a detailed manner that would enable measurement.

Of the 15 states with community benefit requirements, 4 had explicit penalties for failure to comply and 11 states did not specify a penalty. States with explicit penalties often imposed a civil penalty for failure to submit their annual reports in a timely fashion. Some states may also retain the right to remove tax exemption, most notably property tax exemption. For example, the Illinois department of revenue ruled that a Catholic hospital did not qualify for a local property tax exemption because they provided only "the illusion of charity." Free care represented only 0.7% of the hospital's revenues. This case has been watched closely in the United States as other states eye not-for-profit hospitals as a possible revenue target.

The Hilltop Institute published a comprehensive review of state community benefit legislation in November 2015, "Hospital Community Benefits after the ACA: Trends in State Community Benefit Legislation, January–October 2015." At the point of publication there were five states (Illinois, Utah, Nevada, Pennsylvania, and Texas) that had enacted specific minimum community benefit standards to be present in order to qualify for tax exemption.

Learning Objective 2

Describe the elements of community benefit listed by key policy groups.

Community Benefit Areas

We have just seen that there is some significant variation among the 15 states that have attempted to define community benefit for not-for-profit hospitals. In this section we will identify the specific areas of community benefit that have been mentioned by specific policy groups. The policy groups reviewed include:

- American Hospital Association (AHA)
- Healthcare Financial Management Association (HFMA)
- Internal Revenue Service (IRS)
- Voluntary Hospitals of America (VHA)
- Catholic Healthcare Association (CHA)

While all five groups are of interest, it is the IRS that we believe is the most important. Ultimately, they will determine what community benefit standards will be employed. In this regard, we pay especially close attention to Schedule H of the IRS 990 form that is presented in the appendix to this chapter.

Charity Care

All five of the policy groups recognize charity care as a legitimate community benefit. Furthermore, all five seem to be in agreement on the measurement

of charity care. Charity care is usually defined as the unreimbursed cost of providing the care. There are several critical areas to understand given this uniform definition. First, these are patients who have been specifically defined as charity care. This is different from a patient who is uninsured and is billed for a hospital visit but does not pay. This is a bad debt and will be discussed shortly. Second, only the costs of providing the services are recognized—not the charges. In order to estimate the costs of charity care some system of cost accounting must exist to define the actual production cost of services provided.

The IRS has asked 990 filers to specify the method of estimating cost. There are generally two specific methods:

- Cost accounting system
- Cost-to-charge ratio

Many hospitals will most likely use a ratio of cost to charge (RCC) methodology. This is the easiest method to use and is widely understood and accepted at this point in time. **TABLE 5-1** below illustrates the RCC methodology.

In the simple example of Table 5-1, the hospital has charges of $10,000,000 to charity patients. The actual cost of these services is defined as the RCC (35%) time the total charges. This produces an estimated cost of charity care of $3,500,000.

Unreimbursed Cost of Means Tested Government Health Programs

All five of the policy groups also agree that the unreimbursed costs of means tested programs such as Medicaid should be included as a community benefit. A **means tested program** is one in which government sponsorship is present and beneficiaries become eligible through specific means testing. Medicaid is of course the largest and best known example. There is an implicit assumption in their inclusion that most of these programs will make payment at levels well below the actual cost of providing services. Schedule H of the IRS 990 makes it clear that the actual cost of providing services to these programs must be offset against any revenues received from them. **TABLE 5-2** shows an example of a hospital that incurred $35,000,000 in cost to treat Medicaid beneficiaries, but it also received $22,000,000 in payments, which produced the $13,000,000 net cost that would be reported as an element of charity care.

TABLE 5-1 Estimation of Charitable Care Costs

Charity care charges	$10,000,000
Ratio of cost to charges	35%
Estimated cost of charity services	$3,500,000

TABLE 5-2 Estimation of Unreimbursed Medicaid Costs

Medicaid charges	$100,000,000
Ratio of cost to charges	35%
Estimated cost of Medicaid services	$35,000,000
Less Medicaid reimbursement	$22,000,000
Unreimbursed cost of Medicaid services	$13,000,000

Unreimbursed Cost of Medicare

Only the AHA and HFMA include this element as a legitimate element of community benefit. The IRS has not taken a position in the area to date, but does include it in Part III of Schedule H. However, to date the elements in Schedule H are not being designated as the primary areas of community benefit. The major rationale for exclusion has been the historical relationship between Medicare and payment of costs. Initially, Medicare set payments to hospitals that matched expected costs. While Medicare still pays substantially more than Medicaid, the vast majority of hospitals do lose money on Medicare beneficiaries. In 2014, CMS estimated the average loss on inpatient and outpatient services to be 5.8%.

Bad Debts

Only the AHA includes bad debts as an element of community benefit. The IRS includes bad debts in Part III of Schedule H along with unreimbursed Medicare costs. Most parties refuse to recognize bad debts because they believe that it is not true charity care. Historically, hospitals were required to determine charity care at the time of service provision. This has become quite difficult in today's economic climate. The HFMA Principles and Practices Board, which establishes reporting guidelines for hospitals, recently revised the long-standing guideline that eligibility for charity care must be decided based on the patient's financial status at the time of service. While appropriate for other business sectors, the complexities of healthcare delivery and coverage, compounded by federal regulations,

make this narrow interpretation of generally accepted accounting principles (GAAP) untenable for providers. The Principles and Practices Board has updated its guidelines to state that the timing period for determining eligibility should be addressed in the charity care policy. The IRS references HFMA's Statement number 15 in Part III of Schedule H.

FIGURE 5-1 illustrates the four major areas of charity care as reported in four states with community benefit reporting. The data show very clearly that in these states unreimbursed Medicare costs typically represent the largest area of charity care. The second largest area is usually bad debt. It is interesting to note that the two largest areas of potential charity care are areas that most policy groups have excluded.

Other Benefits

The IRS identifies five other areas that they refer to as "other benefits" in Part I of Schedule H. These areas include the following:

- Community health improvement
- Health profession education
- Subsidized health services
- Research
- Cash and in-kind contributions to community groups

All of these areas are netted against any revenue that may be realized.

Community Building Activities

The IRS also identifies a series of "community-building activities" in Part II of Schedule H. At this point, these areas are information only and are not defined as charity care or community benefit services that are listed in Part I.

Learning Objective 3

Assess the relative community benefits provided by proprietary and not-for-profit hospitals.

The Community Value Index®

Investor-owned hospitals have long contended that not-for-profit hospitals provide little community benefit in relation to the tax benefits that they receive. Our objective in this section is to assess whether there is a difference in community value provided by not-for-profit hospitals versus that of proprietary hospitals. We will adopt a national metric and scoring methodology that has been used since 2004 to assess community value.

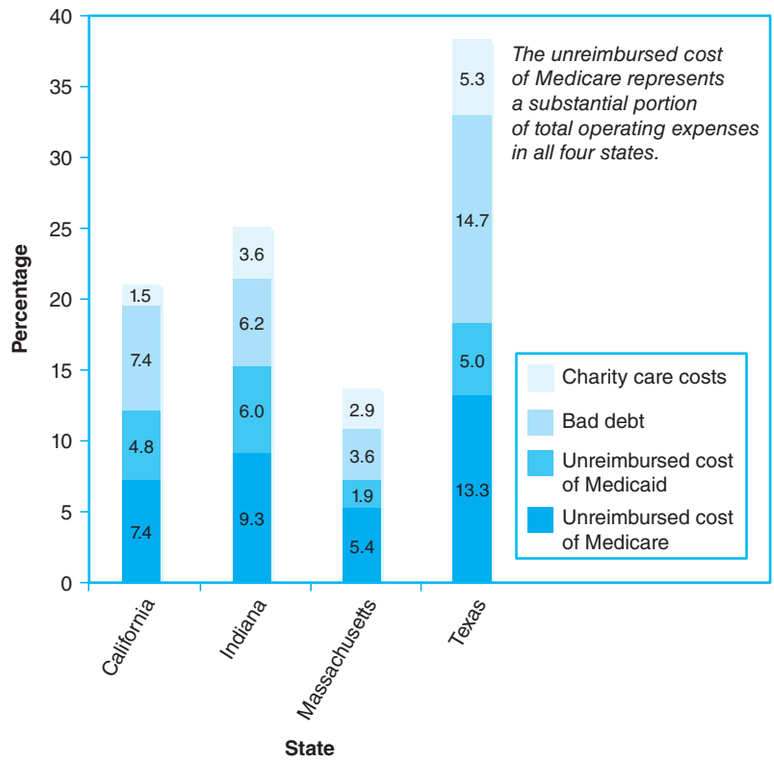

FIGURE 5-1 State Analysis of Charity Care Costs

GAO Analysis of 2006 California, Indiana, Massachusetts, and Texas data.

The **Community Value Index® (CVI)** was created to provide a measure of the value that a hospital provides to its community. The CVI is composed of 10 measures that assess a hospital's performance in four areas:

1. Financial viability and plant reinvestment
2. Hospital cost structure
3. Hospital charge structure
4. Hospital quality performance

Fundamentally, the CVI suggests that a hospital provides value to the community when it is financially viable, is appropriately reinvesting back into the facility, maintains a low cost structure, has reasonable charges, and provides high quality care to patients.

Within the four core areas, 10 measures (**TABLE 5-3**) were selected to determine hospital performance. A discussion of the core areas and individual measures follows:

Core Area One: Financial Viability and Plant Reinvestment

The first core area of the CVI examines a hospital's financial viability and facility reinvestment. A hospital must be financially viable in order to be a valuable asset in the community. Perhaps there is no greater disservice than to have a facility purport to be a leading care provider to citizens and then close due to poor financial management. Certainly, a strong financial position must be achieved in order for a hospital to continue its mission of care provision while at the same time, survive in the turbulent health services market. Of course, a hospital must also continue reinvestment back into the facility in order to provide for current and emerging health needs in the community. This does not imply that hospitals should spend money just for the sake of spending it, but rather making wise investments into capital equipment that will be used efficiently.

TABLE 5-3 Community Value Components

Measure	Purpose
Core Area One: Financial Viability and Plant Reinvestment	
Total margin	Assess profitability at hospital
Growth in net fixed assets (2 years)	Assess level of hospital reinvestment
Fixed asset turnover	Assess efficiency of plant use
Debt financing percentage	Assess how hospital is financed
Core Area Two: Hospital Cost Structure	
Medicare cost per discharge (CMI/WI adj.)	Assess inpatient cost structure
Medicare cost per visit (RW/WI adj.)	Assess outpatient cost structure
Core Area Three: Hospital Charge Structure	
Medicare charge per discharge (CMI/WI adj.)	Assess level of inpatient charges
Medicare charge per visit (RW/WI adj.)	Assess level of outpatient charges
Medicaid days percentage	Assess level of low-income patients
Core Area Four: Hospital Quality Performance	
Hospital Quality Index	Assess process and outcomes of patient care

CMI, case mix index; WI, wage index; RW, relative weight

Appropriately combining these two concepts of financial strength and reinvestment enhances a hospital's value in the community. This core area of the CVI suggests that hospitals in both for-profit and nonprofit settings should be generating a return on operations; however, they should be using those resources to continue to improve the level of care provided to the communities they serve. The four measures used to determine a hospital's performance in this core area are: total margin, growth in net fixed assets, fixed asset turnover, and debt financing percentage.

Total margin, which is the ratio of net income to total revenue, provides information on the level of profitability at a hospital. Without appropriate returns, a hospital will be unable to continue serving the community's health needs. Perhaps this concept is confused in the nonprofit setting. At times, there seems to be a perception that because a hospital is "not-for-profit" it should not be making a profit. This could not be further from the truth. Just as individuals and for-profit businesses need resources in excess of expenses in order to meet current and future obligations, so too do nonprofit organizations require similar returns in order to ensure survival.

As suggested previously, however, providing value to the community also involves reinvestment back into the facility. To measure this concept, a growth rate in net fixed assets was determined for a 2-year period for each hospital in our study. This was balanced with an examination of how efficiently hospitals use their plant and equipment, as measured by the **fixed asset turnover ratio**. The combination of these two fixed asset measures balances any extreme results that may occur. For example, let us imagine that a hospital embarked on a major capital project that was not needed to fulfill a community health need. Of course, the hospital would have a high growth rate in net fixed assets, implying significant investment in the facility, However, the fixed asset turnover ratio would be low, suggesting that the project may not have been needed. The offsetting scores would reduce the hospital's final ranking.

Finally, **debt financing percentage** measures how the hospital is financing its capital investments. While debt is not a negative thing, too much debt certainly will cripple a hospital, putting it into jeopardy and compromising its ability to continue to meet the needs of the community it serves.

Core Area Two: Hospital Cost Structure

The next core area of the CVI involves a hospital's cost structure. Keeping costs low allows a hospital to provide efficient care that can result in lower costs for community members and third-party payers. Allowing for an appropriate margin on care provided to community members will be less costly to them if the hospital's underlying cost structure is lower. In the end, this efficient care also promotes value to the community.

In order to assess a hospital's performance in this area two measures were used: Medicare cost per discharge (adjusted for case mix and wage index), and Medicare cost per visit (adjusted for relative weight and wage index).

The CVI does not employ adjusted day/discharge measures to calculate cost positions or charge positions (as will be seen), because information based on these measures can often be misleading. Adjusted day/discharge measures were started in order to try and convert outpatient activity into a common inpatient unit (day or discharge). However, the methodology to do this can lead to flawed results. This issue will be further explored in Chapter 11.

Although the CVI cost measures are restricted to the Medicare population, this does not present a particularly strong case against applying the results to the rest of the hospital's patient population for two reasons. First, Medicare represents the largest patient population for almost every U.S. hospital. Second, because Medicare pays on a fixed, prospective payment methodology, hospitals have an incentive to keep costs low with these patients. If a hospital has high costs in treating Medicare patients, it can be reasonably assumed that it would also have high costs in treating other patients as well.

Core Area Three: Hospital Charge Structure

The third core area of the CVI examines a hospital's charges. Certainly, this area has received great attention in the past few years as health expenses, in general, have been rising. Obviously, consumers and third-party payers desire health care that is reasonably priced. However, hospitals are often in a difficult position because their pricing does not reflect actual payment that will be recovered for provided care. A patient's bill may appear less shocking if the individual knew what discounted price was actually compensated by the third-party payer. In the end, however, hospitals should strive for pricing that is reasonable and competitive with peer facilities. The CVI examines this by comparing hospital charges among hospitals in similar size/geographic classes.

Similar in methodology to assessing a hospital's cost structure; the CVI determines a hospital's charges based primarily on two measures: Medicare charge per discharge (adjusted for case mix and wage index) and Medicare charge per visit (adjusted for relative

weight and wage index). As stated in the cost discussion, the CVI's charge measures can be reasonably applied to the rest of the hospital's non-Medicare business because Medicare represents such a significant proportion of total business for most U.S. hospitals. Also, gross charges for Medicare patients should be applicable to gross charges for other payers as well, because prices for specific billable services do not vary by payer.

The *Medicaid days percentage* is the ratio of Medicaid and Medicaid HMO days to total patient days at the hospital. The purpose of this measure is to provide greater parity to relative charge structures at U.S. hospitals. Our belief, which is well documented, is that hospitals with higher levels of low-income patients have higher overall charge structures. The suggestion is clear: hospitals with high levels of low-income patients must set higher prices to cover financial deficiencies incurred in treating low-income patients. Including this measure does not totally erase a hospital's high charges; however, it does bring more balance to the overall charge score of the CVI.

Core Area Four: Hospital Quality Performance

The final core area of the CVI includes the quality dimension. Quality has always been a central component of value; however, until recently there were only a limited number of metrics that were publicly available for a large number of hospitals. In addition, some metrics that were available were not consistently reported across organizations or did not adequately address a larger breadth of quality areas. As standards and number of facilities reporting have improved, the comparison of quality data has become more meaningful. For these reasons, the quality dimension is now included in the CVI calculation.

To assess this area of performance, we have analyzed Medicare's process of care and outcome of care quality measures for the most current periods. Process of care measures are reported for the period April 2014 through March 2015 and outcome of care measures are reported for the period July 2011 through June 2014.

There were 25 process of care metrics that were used in our analysis in the areas of heart attack, heart failure, pneumonia, and surgical infection prevention. These process of care areas refer to medical standards for treatment protocols (e.g., heart attack patients given aspirin on arrival). Hospitals report the percentage of time standards were met in each of the 25 areas. From this data, we determined the percentage the hospital was above or below the U.S. average and the frequency at which the hospital performed at or above the highest performing hospitals in the country. In sum, hospitals received high process of care composite scores when a higher number of areas were reported and when performance in those areas exceeded the U.S. average and high-performance levels.

Outcome quality measurement is conducted through risk-adjusted mortality rates established for each facility by Medicare. These rates are provided for hospitals in three areas: heart attack, heart failure, and pneumonia patients. The mortality rates estimate the risk-adjusted frequency of death within 30 days of patient discharge. From the data in these areas, we created a composite score to evaluate the percentage a hospital was above or below U.S. average levels. Hospitals that had lower levels of mortality had better composite scores.

The final step in our quality analysis was to create a *hospital quality index* (HQI) based on the review of data in the process of care and outcomes areas. Combining the composite scores of these two areas created the overall HQI score. The HQI served as the overall quality score for each hospital in the CVI study.

Comparative CVI Scores by Hospital Sector

TABLE 5-4 provides comparative 2016 CVI scores for alternative hospital sectors categorized by ownership. Higher scores indicate better relative performance. Proprietary hospitals show the worst overall CVI scores (59.6) compared to the U.S. median (62.8).

The primary reason for the relatively low proprietary scores is related to two areas. Proprietary hospitals have very low charge scores because their prices are significantly higher than other hospitals and their Medicaid patient mix is usually low relative to other hospitals. They also have lower financial scores that are the result of higher levels of debt and lower reinvestment rates in plant and equipment.

It should be expected that proprietary hospitals would have lower CVI scores than voluntary hospitals. Voluntary hospitals have an obligation to provide services back to their communities in return for the favorable tax benefits that they receive. We next try to establish a methodology for directly estimating tax benefits received and the actual cost of benefits provided to the community in a specific case example.

Learning Objective 4

Develop a methodology for estimating financial benefits received by not-for-profit healthcare firms.

TABLE 5-4 CVI Scores by Hospital Ownership

	CVI Scores				
Hospital Sectors	**Financial**	**Cost**	**Charges**	**Quality**	**Overall**
Proprietary	47.8	52.7	34.9	100.3	59.6
VNP Church	53.2	57.1	48.5	100.7	64.5
VNP Other	51.2	50.7	52.9	100.9	63.8
Government	47.4	38.6	58.9	99.4	60.9
All U.S.	50.5	50.5	50.2	100.5	62.8

VNP, Voluntary nonprofit

Estimating Financial Benefits In Not-For-Profit Healthcare Firms

There are a number of specific financial benefits that not-for-profit healthcare firms receive that have been cited by policy analysts over the years. In this section we will discuss the areas that are believed to be the largest in terms of financial magnitude and discuss a methodology for estimating the benefits in each area via a hypothetical example. The specific areas that will be discussed include:

- Property tax exemption
- Postal rate reduction
- Interest savings from tax-exempt bonds
- Sales tax exemption
- Federal unemployment tax exemption
- Income taxes
  - Local/city
  - State
  - Federal

Property Tax Exemption

Local communities often criticize the exemption from property tax that many not-for-profit and governmental entities enjoy. Proprietary healthcare firms must pay property taxes on their real estate investments and most agree that property taxes should be accounted for as one of the financial benefits received by not-for-profit healthcare firms.

Most property taxes are based on assessed valuations. There is usually an appraisal of the property, and that appraised value is often uniformly reduced by applying an assessment percentage. **TABLE 5-5** illustrates

TABLE 5-5 Estimation of Property Tax

Values reported in audit	
Land and land improvements	$36,000,000
Buildings and fixed equipment	450,000,000
Equipment	280,000,000
Construction in progress	14,000,000
Total gross property and equipment	780,000,000
Less allowance for depreciation	400,000,000
Net property plant and equipment	380,000,000
Property under assessment	
Land and land improvements	36,000,000
Buildings and fixed equipment	450,000,000
Construction in progress	14,000,000
Total	500,000,000
Assessment percentage	35%
Assessed value	175,000,000
Estimated tax rate	7%
Real estate tax liability	**12,250,000**

the estimation of property tax for our hypothetical example.

In Table 5-5 we started with information in the audited financial statements. Most likely, it would be possible to get specific property tax appraisals from the taxing **authority**—most likely the county. Note that only land and land improvements, combined with the building cost and the cost of fixed equipment such as boilers, are included. Other equipment would be exempt from real estate property tax. In our example we have taken the undepreciated cost from the property, plant, and equipment section of the balance sheet for a total of $500 million. In the county where our hospital is located, only 35% of the appraised value would be assessed. This creates an assessed value base of $175 million to which we apply tax rate of 7% (the estimated property tax rate for the geographical area of the hospital). Our estimated property tax then becomes $12,250,000.

Postal Rate Reduction

To some it may come as a surprise that not-for-profit firms are eligible for lower U.S. postal rates. Hospitals may during the course of a year send large volumes of mail, and the savings can be quite large. **TABLE 5-6** summarizes the savings for our hypothetical hospital.

Interest Savings from Tax-exempt Bonds

Proprietary healthcare firms have long cited the ability of not-for-profit healthcare firms to issue **tax-exempt bonds** as a decisive cost advantage. Without the availability of tax-exempt financing most not-for-profit healthcare firms would find their relative cost of capital increased. **TABLE 5-7** summarizes the savings from issuance of tax-exempt bonds at the hypothetical hospital:

TABLE 5-6 Estimate of Postal Rate Savings

Postage rate first class (for-profit)	$0.47
Postage rate first class (nonprofit)	$0.23
Difference	$0.24
Number of first class pieces mailed	3,500,000
Savings in postage	$840,000

TABLE 5-7 Estimate of Savings from Issuance of Tax-exempt Bonds

Tax-exempt bonds audited statements	300,000,000
Expected taxable interest rate	6.75%
Current tax-exempt interest rate	5.00%
Difference	1.75%
Estimate of interest saved	5,250,000

In the example of Table 5-7, it is fairly easy to estimate the potential savings realized from tax-exempt bonds. The only real difficult part is the determination of "expected taxable interest rate." We know with certainty the effective interest rate on the bonds currently, but it may be hard to define what the equivalent taxable rate would be for several reasons. First, what time period should be used? Using the current taxable rate would give a valid value if the taxable financing were done today; however, it is being compared to a tax-exempt interest rate of a prior period. Second, can we really create an equivalent taxable financing package that mimics the tax-exempt issue in terms of maturity, interest rate swaps, and other financing features? In our example we have assumed that the current spread between a taxable and a tax-exempt issue is 175 basis points or 1.75%. Because we have $300 million of outstanding tax-exempt bonds, our expected savings is $5,250,000.

Sales Tax Exemption

Not-for-profit firms are also exempt from state sales taxes. This can also become a sizable benefit to a not-for-profit healthcare firm. One issue that becomes important is what areas would be subject to the sales tax. Salaries and fringe benefits are not subject to state sales tax, which leaves supplies and drugs as the two biggest areas for healthcare firms. In many states drugs may be exempt from sales tax, which leaves supplies. **TABLE 5-8** below summarizes the sales tax computation for our hypothetical hospital.

TABLE 5-8 Estimation of Sales Tax

Annual purchase of supplies	125,000,000
State sales tax rate	7.00%
Estimated sales tax	8,750,000

Federal Unemployment Tax Exemption

The federal government exempts not-for-profit firms from paying federal unemployment tax assessments (FUTA). States may still assess unemployment taxes, but the not-for-profit firm can choose among several alternative ways to finance its state unemployment liability. For our sample hospital, there is no FUTA tax for not-for-profits in their state. **TABLE 5-9** below summarizes the computations for the FUTA.

Income Taxes

Exemption from income taxes is the area where most people associate an advantage with not-for-profit healthcare firms. As described earlier there are three areas of income taxes for most not-for-profit healthcare firms:

- Local/city income taxes
- State income taxes
- Federal income taxes

Usually, there is a hierarchy of income taxation that proceeds as follows. Taxable income at the city level is not adjusted for state or federal income taxes. State income taxable income is reduced by city income taxes. Finally, federal taxable income is reduced by both city and state taxes. **TABLE 5-10** summarizes the estimation of income taxes at all three levels for our hypothetical hospital.

Notice that we have started with unadjusted net income as reported in the audited financial statements. To the reported level of net income we must start by adding some items that may be recognized as expenses in computing net income but are not recognized as legitimate expenses for computing income taxes. These are the so-called "disallowed items" represented in Table 5-9. The two areas shown in Table 5-9 are:

1. 50% of meals and entertainment
2. Officer life insurance premiums

TABLE 5-9 Federal Unemployment Tax Assessment Benefit

Federal unemployment wage base	$ 7,000
Number of FTEs	6,000
Salary base subject to FUTA	$ 42,000,000
FUTA rate	6.00%
FUTA liability	$ 2,520,000

FTEs, full time equivalents; FUTA, federal unemployment tax assessments

TABLE 5-10 Income Tax Estimation

Net income from audited	$ 72,000,000
Add disallowed items	
50% of meals and entertainment	$ 1,800,000
Officer life insurance premiums	$ 1,200,000
Total disallowed	$ 3,000,000
Revised net income	$ 75,000,000
Less additional deductions	
Sales tax	$ 8,750,000
Property tax	$ 12,250,000
Federal unemployment tax	$ 2,520,000
Postage expense increase	$ 840,000
Additional interest expense	$ 5,250,000
Total additional expenses	$ 29,610,000
Net income subject to local income tax	$ 45,390,000
City income tax rate	2.00%
City income tax	**$ 907,800**
Net income subject to state income tax	$ 44,482,200
State income tax rate	8.50%
State income tax	**$ 3,780,987**
Net income subject to federal tax	$ 40,701,213
Federal tax rate	35.0%
Federal income tax	**$ 14,245,425**

For taxable corporations only 50% of the expense associated with business meals and entertainment are deductible. We have therefore added back 50% of the cost of expenses in this area to our net income. The life insurance premiums paid on behalf of an officer of a corporation are also not deductible for tax return

purposes. We have also added back these expenditures to our original net income figure. This meant that our revised net income would be increased from $72 million to $ 75 million. From that $75 million we subtract all of those expenses that we would have incurred if the hospital had been taxable. For example, we would have paid $12,250,000 of property taxes if we were a taxable entity. These reductions reduced our city income taxable basis to $45,390,000. The tax then due the city at 2% was $907,800. This amount was then subtracted to determine the state income tax basis of $44,482,200. The state income tax of $3,780,987 is then subtracted to determine the federal income taxable basis of $40,701,213.

We can now summarize the total amount of financial benefits realized by our hypothetical not-for-profit hospital in **TABLE 5-11**:

In this case example, our not-for-profit hospital received $48,544,212 in taxation benefits that resulted from its not-for-profit status. The question becomes very simple. Did this hospital provide more than $48,544,212 in benefits to the community? This is the simple relationship that many are seeking to document. Do not-for-profit healthcare firms provide more benefits than they receive?

Learning Objective 5

Develop a methodology for estimating financial benefits provided by not-for-profit healthcare firms.

TABLE 5-11 Summary of Taxation Benefits

Federal income tax	$ 14,245,425
State income tax	$ 3,780,987
City income tax	$ 907,800
Forgone FUTA tax	$ 2,520,000
Sales tax	$ 8,750,000
Property tax	$ 12,250,000
Additional postage expense	$ 840,000
Interest savings on tax-exempt bonds	$ 5,250,000
Total value of tax exemption	$ 48,544,212

Estimating Financial Benefits Provided By Not-For-Profit Healthcare Firms

In the last section of this chapter we will identify the amount of benefits provided by our hypothetical hospital to its community. The areas to be included will match those described earlier. Specifically, the benefits to be included are:

- Traditional charity care
- Unpaid cost of Medicaid
- Medical education
- Other benefits
  - Subsidized health services
  - Community health services
  - Cash and in-kind donations to the community
  - Research

Traditional Charity Care

Charity care is defined as the free or discounted health services provided to persons who cannot afford to pay, as defined by the hospital's charity care policies and procedures. Most hospitals have enacted specific discount policies in relationship to Federal Poverty Guidelines. **TABLE 5-12** provides the 2016 Federal Poverty Guideline levels. In our hypothetical hospital we will assume that all patients with income less than

TABLE 5-12 2016 Federal Poverty Guidelines

Household Size	Poverty Level
1	$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890

TABLE 5-13 Estimation of Charity Care Benefit

Charity care charge write-offs	$ 120,000,000
Times cost-to-charge ratio	38.0%
Cost of charity care provided	$ 45,600,000
Less state disproportionate share payments	$ 9,000,000
Net cost of charity care	$ 36,600,000

200% of the Federal Poverty Guideline will receive a 100% discount.

TABLE 5-13 summarizes the computation of charity care benefits for the hospital. Note that in this example the state has made a $9,000,000 disproportionate payment to help cover the costs of indigent care. This payment is netted against the cost to produce the net cost of charity care of $36,600,000.

Unpaid Cost of Medicaid and Other Means Tested Programs

The hospital has only included Medicaid and Medicaid managed-care patients. There are no other means tested programs that have been identified. **TABLE 5-14** summarizes the net cost to the hospital.

Medical Education Programs

The hospital has defined this area to include the education and training of health professionals above and beyond the requirements mandated by the employer and for certification and licensure. This would typically include interns, residents, and nursing student training. Any offsetting payments that were received are deducted from the cost of program delivery. Medicare payments for direct medical education costs would be included as payments. **TABLE 5-15** summarizes the benefits:

TABLE 5-14 Net Cost of Medicaid Programs

Medicaid and Medicaid managed-care total charges	$ 100,000,000
Times cost-to-charge ratio	38.0%
Cost of Medicaid and Medicaid managed-care programs	$ 38,000,000
Less payments	$ 31,000,000
Unpaid cost of Medicaid programs	$ 7,000,000

TABLE 5-15 Medical Education Benefits Provided

Direct Costs of Medical Education	$ 20,000,000
Less payments	$ 10,000,000
Net cost of medical education	$ 10,000,000

Other Benefits

There are a variety of different categories of benefits included here. **TABLE 5-16** summarizes the costs of these areas.

Comparison of Benefits Provided to Benefits Received

We have now completed the computation of both benefits received and benefits provided by the hospital. **TABLE 5-17** summarizes the analysis.

In this example, our hypothetical hospital has received tax benefits of $48,544,212 and it has provided community benefits of $56,800,000 for a net contribution to the community of $8,255,788. This excess benefit was derived without including unreimbursed costs of Medicare or bad debt. The key remaining question is whether this level of excess community

TABLE 5-16 Other Benefits

Subsidized health services	$ 1,800,000
Community health services	$ 1,000,000
Cash and in-kind donations to the community	$ 300,000
Unsubsidized research costs	$ 100,000
Total	$ 3,200,000

TABLE 5-17 Summary of Community Benefit Analysis

Charity care (net cost)	$ 36,600,000
Net cost of Medicaid programs	$ 7,000,000
Net cost of medical education	$ 10,000,000
Subsidized health services	$ 1,800,000
Community health services	$ 1,000,000
Cash and in-kind contributions	$ 300,000
Research	$ 100,000
Total benefits provided	**$ 56,800,000**
Federal income tax	$ 14,245,425
State income tax	$ 3,780,987
City income tax	$ 907,800
Forgone FUTA tax	$ 2,520,000
Sales tax	$ 8,750,000
Property tax	$ 12,250,000
Additional postage expense	$ 840,000
Interest savings on tax-exempt bonds	$ 5,250,000
Total value of tax exemption	**$ 48,544,212**
Excess community benefit	**$ 8,255,788**

benefit justifies the tax exemptions. Many would argue the two largest areas—charity care and Medicaid—are merely costs of doing business. Others point out that proprietary hospitals provide similar benefits and are not accorded tax-exempt status.

SUMMARY

The majority of hospitals in the United States are not-for-profit firms that are exempt from federal income tax and also many other state and local taxes. Increasingly, communities are asking a very simple question. Do these hospitals provide benefits to the community in an amount greater that the taxation benefits that they receive? This is not an easy question to answer but one that the federal government seems intent on addressing. The IRS has required not-for-profit hospitals to file Schedule H as part of their annual IRS Form 990 submissions. Schedule H will collect detailed information in a number of areas regarding the provision of charity and other community benefits. At some point the data will be fully analyzed and decisions will be made regarding the future of tax exemption for not-for-profit hospitals and other not-for-profit healthcare firms. It seems that many, perhaps most, not-for-profit hospitals will be required to pay some taxes either in the form of property taxes or income taxes. This decision to tax will then force these same not-for-profit hospitals to assess the continued advantages and disadvantages of their current ownership structure. Some not-for-profits will no doubt migrate to a proprietary ownership basis to take advantage of easier access to capital. The long-term effects of these possible changes are not clear at this point, but they could be monumental.

ASSIGNMENTS

TABLE 5-18 is a footnote from an actual audited financial statement of a major healthcare system. From the information in that footnote, please answer the following questions:

1. What is the single largest area of community benefit provided by Dignity Health and what dollar amount of benefit was provided?
2. What is the total dollar amount of community benefit provided by Dignity Health?
3. Why is Medicare not listed as a community benefit?
4. If Medicare were to be included as a legitimate area of community benefit, what percentage of Dignity's total expenses would be allocated to community benefit activities?

Summary of Dignity Health's community benefits for 2015, in terms of services to the poor and benefits for the broader community, which has been prepared in accordance with Internal Revenue Service Form 990, Schedule H, and the CHA publication, *A Guide for Planning and Reporting Community Benefit* (dollars in thousands).

TABLE 5-18 Community Benefit Footnote

	Unaudited				
	Persons Served	Total Benefit Expense	Direct Offsetting Revenue	Net Community Benefit	% of Total Expense
Benefits for the poor					
Traditional charity care	155,869	145,519	(1,476)	144,043	1.2%
Unpaid costs of Medicaid	1,529,842	3,541,533	(2,958,545)	582,988	4.9%
Other means-tested programs	269,823	12,299	(3,098)	9,201	0.1%
Community services					
Community health services	376,686	46,687	(4,931)	41,756	0.3%
Health professions education	79	3	–	3	0.0%
Subsidized health services	96,294	28,890	(4,018)	28,872	0.2%
Donations	123,504	37,313	(780)	36,533	0.3%
Community building activities	7,795	2,658	(840)	1,818	0.0%
Community benefit operations	143	7,347	(223)	7,124	0.1%
Total community services for the poor	604,501	122,898	(10,792)	112,106	0.9%
Total benefits for the poor	2,560,035	3,822,249	(2,973,911)	848,338	7.1%
Benefits for the broader community					
Community services					
Community health services	278,419	13,225	(1,179)	12,046	0.1%
Health professions education	27,306	77,257	(9,342)	67,915	0.6%

(continues)

TABLE 5-18 Community Benefit Footnote *(continued)*

	Unaudited				
	Persons Served	Total Benefit Expense	Direct Offsetting Revenue	Net Community Benefit	% of Total Expense
Subsidized health services	3,641	2,704	(1,263)	1,441	0.0%
Research	14,806	31,768	(20,858)	10,910	0.1%
Donations	31,341	8,688	(26)	8,662	0.1%
Community building activities	7,583	3,966	(144)	3,822	0.0%
Community benefit operations	31	1,333	-	1,333	0.0%
Total benefits for the broader community	363,127	138,941	(32,812)	106,129	.9%
Total community benefits	2,923,162	$3,961,190	($3,006,723)	$954,467	8.0%
Unpaid costs of Medicare	1,042,065	3,003,473	(2,247,364)	756,109	6.3%
Total community benefits including unpaid costs of Medicare	3,965,227	$6,964,663	($5,254,087)	$1,710,576	14.3%

SOLUTIONS

CHW responses:

1. Unpaid costs of Medicaid programs amounted to $582,988,000 at Dignity and accounted for 4.9% of total expenses.
2. Dignity provided $954,467,000 of community benefit, which represented 8.0% of total expenses.
3. Dignity is a part of the Catholic Healthcare Association, which does not recognize unpaid costs of Medicare as a community benefit. The dollar amount of $756,109 is reported but not included in the community benefit total.
4. If unpaid Medicare costs were included in community benefit totals, CHW would be providing $1,710,576,000 or 14.3% of their total expenses in community benefits.

Appendix 5–A Schedule H Form

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization | **Employer identification number**

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a		
b	If "Yes," was it a written policy?	1b		
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____%	3a		
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____%	3b		
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4		
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a		
b	If "Yes," did the organization make it available to the public?	6b		

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						

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Part II **Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	**Total**						

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5		
6	Enter Medicare allowable costs of care relating to payments on line 5	6		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☐ Cost to charge ratio ☐ Other			

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a		
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI . . .	9b		

Part IV **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Schedule H (Form 990) 2015

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Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year? _____

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)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

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Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		
2	Was the hospital facility 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 of the acquisition in Section C	2		
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3		
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The significant health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20___			
5	In conducting its most recent CHNA, did the hospital facility 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? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5		
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		
7	Did the hospital facility make its CHNA report widely available to the public?	7		
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☐ Hospital facility's website (list url): _____			
b	☐ Other website (list url): _____			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8		
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20___			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		
a	If "Yes," (list url): _____			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12 a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

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Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group _____

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:		
a	☐ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of _ _ _ % and FPG family income limit for eligibility for discounted care of _ _ _ %		
b	☐ Income level other than FPG (describe in Section C)		
c	☐ Asset level		
d	☐ Medical indigency		
e	☐ Insurance status		
f	☐ Underinsurance status		
g	☐ Residency		
h	☐ Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?		
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a	☐ Described the information the hospital facility may require an individual to provide as part of his or her application		
b	☐ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	☐ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	☐ Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a	☐ The FAP was widely available on a website (list url): _____		
b	☐ The FAP application form was widely available on a website (list url): _____		
c	☐ A plain language summary of the FAP was widely available on a website (list url): _____		
d	☐ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	☐ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	☐ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	☐ Other (describe in Section C)		

Billing and Collections

17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?		
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Actions that require a legal or judicial process		
d	☐ Other similar actions (describe in Section C)		
e	☐ None of these actions or other similar actions were permitted		

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Part V Facility Information *(continued)*

Name of hospital facility or letter of facility reporting group _____

		Yes	No
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? 19		
	If "Yes," check all actions in which the hospital facility or a third party engaged:		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Actions that require a legal or judicial process		
d	☐ Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a	☐ Notified individuals of the financial assistance policy on admission		
b	☐ Notified individuals of the financial assistance policy prior to discharge		
c	☐ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d	☐ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e	☐ Other (describe in Section C)		
f	☐ None of these efforts were made		
Policy Relating to Emergency Medical Care			
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? 21		
	If "No," indicate why:		
a	☐ The hospital facility did not provide care for any emergency medical conditions		
b	☐ The hospital facility's policy was not in writing		
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d	☐ Other (describe in Section C)		
Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)			
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.		
a	☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	☐ Other (describe in Section C)		
23	During the tax year, did the hospital facility charge 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? 23		
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? 24		
	If "Yes," explain in Section C.		

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

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Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

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Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.