

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2010**

**Open to Public Inspection**

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, question 20.**  
▶ **Attach to Form 990. ▶ See separate instructions.**

Department of the Treasury  
Internal Revenue Service

Name of the organization

Employer identification number

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .		
<b>b</b> If "Yes," was it a written policy? . . . . .		
<b>2</b> 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. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> 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.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care to low income individuals? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: . . . . . <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____%		
<b>b</b> Did the organization use FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: . . . . . <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____%		
<b>c</b> If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria 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, to determine eligibility for free or discounted care.		
<b>4</b> 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"?		
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?		
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .		
<b>c</b> 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? . . . . .		
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .		
<b>b</b> If "Yes," did the organization make it available to the public? . . . . .		

**7 Financial Assistance and Certain Other Community Benefits at Cost**

	(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
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheets 1 and 2) . . . . .						
<b>b</b> Unreimbursed Medicaid (from Worksheet 3, column a) . . . . .						
<b>c</b> Unreimbursed costs—other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs . . . . .						
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .						
<b>f</b> Health professions education (from Worksheet 5) . . . . .						
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .						
<b>h</b> Research (from Worksheet 7) . . . . .						
<b>i</b> Cash and in-kind contributions to community groups (from Worksheet 8) . . . . .						
<b>j Total</b> Other Benefits . . . . .						
<b>k Total</b> Add lines 7d and 7j . . . . .						

**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**

- Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? . . . . .
- Enter the amount of the organization's bad debt expense (at cost) . . . . .
- Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy . . . . .
- Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.

	Yes	No
1		
2		
3		
4		
5		
6		
7		
9a		
9b		

**Section B. Medicare**

- Enter total revenue received from Medicare (including DSH and IME) . . . . .
- Enter Medicare allowable costs of care relating to payments on line 5 . . . . .
- Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .
- 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**

- Did the organization have a written debt collection policy during the tax year? . . . . .
- 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 . . . . .

**Part IV Management Companies and Joint Ventures**

(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				

**Part V Facility Information**

**Section A. Hospital Facilities**

(list in order of size, measured by total revenue per facility, from largest to smallest)

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

Name and address

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
<b>1</b>									
<b>2</b>									
<b>3</b>									
<b>4</b>									
<b>5</b>									
<b>6</b>									
<b>7</b>									
<b>8</b>									
<b>9</b>									
<b>10</b>									
<b>11</b>									
<b>12</b>									
<b>13</b>									
<b>14</b>									
<b>15</b>									
<b>16</b>									

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

Name of Hospital Facility: \_\_\_\_\_

Line Number of Hospital Facility (from Schedule H, Part V, Section A): \_\_\_\_\_

		Yes	No
<b>Community Health Needs Assessment</b> (Lines 1 through 7 are optional for 2010)			
<b>1</b>	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8 If "Yes," indicate what the Needs Assessment describes (check all that apply):		
	<ul style="list-style-type: none"> <li>a <input type="checkbox"/> A definition of the community served by the hospital facility</li> <li>b <input type="checkbox"/> Demographics of the community</li> <li>c <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community</li> <li>d <input type="checkbox"/> How data was obtained</li> <li>e <input type="checkbox"/> The health needs of the community</li> <li>f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups</li> <li>g <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs</li> <li>h <input type="checkbox"/> The process for consulting with persons representing the community's interests</li> <li>i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs</li> <li>j <input type="checkbox"/> Other (describe in Part VI)</li> </ul>		
<b>2</b>	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20__ __		
<b>3</b>	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted		
<b>4</b>	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI		
<b>5</b>	Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
	<ul style="list-style-type: none"> <li>a <input type="checkbox"/> Hospital facility's website</li> <li>b <input type="checkbox"/> Available upon request from the hospital facility</li> <li>c <input type="checkbox"/> Other (describe in Part VI)</li> </ul>		
<b>6</b>	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
	<ul style="list-style-type: none"> <li>a <input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community</li> <li>b <input type="checkbox"/> Execution of the implementation strategy</li> <li>c <input type="checkbox"/> Participation in the development of a community-wide community benefit plan</li> <li>d <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan</li> <li>e <input type="checkbox"/> Inclusion of a community benefit section in operational plans</li> <li>f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment</li> <li>g <input type="checkbox"/> Prioritization of health needs in its community</li> <li>h <input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community</li> <li>i <input type="checkbox"/> Other (describe in Part VI)</li> </ul>		
<b>7</b>	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs		
<b>Financial Assistance Policy</b>			
<b>8</b>	Did the hospital facility have in place during the tax year a written financial assistance policy that: Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?		
<b>9</b>	Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for free care: __ __ __ %		

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

		Yes	No
<b>10</b>	Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? . . . . . If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>  </u> <u>  </u> %	<b>10</b>	
<b>11</b>	Explained the basis for calculating amounts charged to patients? . . . . . If "Yes," indicate the factors used in determining such amounts (check all that apply):	<b>11</b>	
<b>a</b>	<input type="checkbox"/> Income level		
<b>b</b>	<input type="checkbox"/> Asset level		
<b>c</b>	<input type="checkbox"/> Medical indigency		
<b>d</b>	<input type="checkbox"/> Insurance status		
<b>e</b>	<input type="checkbox"/> Uninsured discount		
<b>f</b>	<input type="checkbox"/> Medicaid/Medicare		
<b>g</b>	<input type="checkbox"/> State regulation		
<b>h</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>12</b>	Explained the method for applying for financial assistance? . . . . .	<b>12</b>	
<b>13</b>	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):	<b>13</b>	
<b>a</b>	<input type="checkbox"/> The policy was posted on the hospital facility's website		
<b>b</b>	<input type="checkbox"/> The policy was attached to billing invoices		
<b>c</b>	<input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
<b>d</b>	<input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
<b>e</b>	<input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
<b>f</b>	<input type="checkbox"/> The policy was available on request		
<b>g</b>	<input type="checkbox"/> Other (describe in Part VI)		

**Billing and Collections**

<b>14</b>	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment? . . . . .	<b>14</b>	
<b>15</b>	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:		
<b>a</b>	<input type="checkbox"/> Reporting to credit agency		
<b>b</b>	<input type="checkbox"/> Lawsuits		
<b>c</b>	<input type="checkbox"/> Liens on residences		
<b>d</b>	<input type="checkbox"/> Body attachments		
<b>e</b>	<input type="checkbox"/> Other actions (describe in Part VI)		
<b>16</b>	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year? . . . . . If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):	<b>16</b>	
<b>a</b>	<input type="checkbox"/> Reporting to credit agency		
<b>b</b>	<input type="checkbox"/> Lawsuits		
<b>c</b>	<input type="checkbox"/> Liens on residences		
<b>d</b>	<input type="checkbox"/> Body attachments		
<b>e</b>	<input type="checkbox"/> Other actions (describe in Part VI)		
<b>17</b>	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):		
<b>a</b>	<input type="checkbox"/> Notified patients of the financial assistance policy on admission		
<b>b</b>	<input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
<b>c</b>	<input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
<b>d</b>	<input type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance		
<b>e</b>	<input type="checkbox"/> Other (describe in Part VI)		

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

**Policy Relating to Emergency Medical Care**

		Yes	No
<b>18</b>	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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? . . . . .		
	If "No," indicate the reasons why (check all that apply):		
<b>a</b>	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
<b>b</b>	<input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
<b>c</b>	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
<b>d</b>	<input type="checkbox"/> Other (describe in Part VI)		

**Charges for Medical Care**

<b>19</b>	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):		
<b>a</b>	<input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility		
<b>b</b>	<input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility		
<b>c</b>	<input type="checkbox"/> The hospital facility used the Medicare rate for those services		
<b>d</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>20</b>	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? . . . . .		
	If "Yes," explain in Part VI.		
<b>21</b>	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient? . . . . .		
	If "Yes," explain in Part VI.		

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

**Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many non-hospital 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	

