May 16, 2012

Emily McMahon
Acting Assistant Secretary (Tax Policy)
U.S. Department of the Treasury
Room 3120 MT
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Joseph H. Grant
Acting Commissioner
IRS Tax-Exempt & Government Entities Division
Internal Revenue Service
1111 Constitution Ave., NW
Washington, DC 20224-0002

Re: Proposed Collection; Comment Request for Form 990 and Schedules, May 9, 2012 Federal Register

Dear Acting Assistant Secretary McMahon and Acting Commissioner Grant:

On behalf of the American Hospital Association's (AHA) more than 5,000 member hospitals, health systems and other health care organizations, and its 40,000 individual members; and the Healthcare Financial Management Association's (HFMA) more than 39,000 member health care financial management executives we are responding to the Department of the Treasury's (Department) invitation for public comment pursuant to the Paperwork Reduction Act (PRA) regarding the Internal Revenue Service's (IRS) collection of information (COI) from hospitals through the Form 990 Schedule H.

We welcome the acknowledgment in the Notice issued by the Department and IRS that, as a result of implementing the new requirements for tax-exempt hospitals under the *Accountable Care Act* (ACA), Part V of Schedule H has changed "significantly" since the "collection of information" (COI) contained in Schedule H was previously approved by the Office of Management and Budget (OMB). We are, however, troubled by the inconsistent messages in the Notice regarding the IRS's intent to comply with the PRA. While the Department presents the invitation for public comment as required by the PRA, the actions of the IRS remain at odds with PRA compliance. The IRS only affords five business days for the community to respond to the solicitation for comments, instead of the 60 days required by the section of the PRA cited in the Notice (44 U.S.C. 3506(c)(2)(A)). Moreover, the IRS continues to assert that the unapproved revisions to the COI contained in Part V of Schedule H remain mandatory. We urge that Part V Schedule H be withdrawn or, alternatively, that a Notice be issued making Part V of Schedule H optional while OMB reviews and approves the Schedule in light of public comments, as required by law.

Part V Schedule H is not compliant with the PRA.
The intent of the PRA is to minimize the paperwork and burden for individuals and educational and nonprofit institutions, among others, from whom the government requires the collecting and reporting of information. To achieve that goal, the law creates a process that agencies must follow before implementing a COI or making a material change to an existing COI. In addition to other requirements, the public must be provided two-rounds of Notice and an opportunity to comment. The first is to provide input as the agency develops its proposed COI; the second is to provide input to the OMB as it evaluates whether the COI should be approved. ***Hospitals have not been afforded the protections intended by the PRA.*** The failure to provide notice and comment is more than a process issue. The result is a Part V that contains redundancies, inconsistencies, onerous reporting requirements and undefined terms.

The revised Part V is a material change to the prior Schedule H (and previously approved COI). Part V was amended after Congress enacted new requirements for tax-exempt hospitals in Section 501(r). The IRS attempts to measure a hospital's compliance with the new requirements through the questions in Part V. As a result, responses to the revised Part V may affect the tax-exempt status of a hospital. The Notice is clear that Schedule H has "changed significantly" and that those changes were not approved by OMB. **As discussed above, OMB approval is required prior to making the form mandatory.** Attachment A to this letter (February 2, 2012 letter to Jeffrey Zients) provides a detailed discussion of the PRA requirements and the obligation to submit the revised Part V Schedule H, along with public comments, to OMB for approval.

Part V Schedule H does not meet the PRA-test for approval.
The Notice solicits comments on, among others, the necessity of the COI for the proper performance of the functions of the agency, the accuracy of the agency's estimate of the burden of the COI, and the ways to enhance the quality, utility, and clarity of the information to be collected.

The revised Part V Schedule H is not the least burdensome way for the proper performance of the IRS in implementing Section 501(r), nor is it necessary. Attachment B to this letter (August 24, 2011 letter to Sarah Hall Ingram) provides detailed and specific line-by-line recommendations to improve the form. In a side-by-side chart each of the requests for information is addressed and explanations for the recommended changes included.

The recommendations incorporate the direct input to our organizations from 300 hospitals, some of which belong to multi-hospital systems, which span the nation from New York to California to Texas and Michigan and beyond. They further reflect the experience of urban and rural hospitals, academic medical centers and teaching hospitals, and large and small multihospital systems, among others, which are required to complete and file Schedule H each year. The comments also reflect keen awareness that new 501(r) requirements apply to the largest of the nation's multihospital systems as well as to the smallest critical access and frontier hospitals. It

is critically important that Schedule H be revised in a manner that accounts for this immense diversity. We believe these comments will improve Schedule H reporting while reducing the paperwork burden for hospitals and providing the public with better and more accessible information about the benefits hospitals provide to their communities.

For example, because of the current structure of Schedule H multihospital systems that include more than one hospital will have to complete dozens of pages of text for each hospital to fulfill the reporting requirements of the Schedule. For a system that has the same policies and practices for each hospital it is a huge and unnecessary paperwork burden to fill in the very same answers multiple times. Professional tax counsel has estimated that *for some systems Schedule H could span as many as 200 pages.* We have recommended revisions to the Schedule that would enable such hospital systems to complete one set of answers for hospitals with identical answers while also enabling the Service to scrutinize an individual hospital to the extent the Service has questions about a specific hospital facility. As a result, hospitals will avoid unnecessary expenditure of resources and the public, in lieu of poring through pages of duplicative information, will have a streamlined presentation of key information.

Other examples of ways to reduce the burden imposed by Schedule H on hospitals while enhancing the quality of collected information include facilitating hospitals in a community to work together in assessing the health needs of their community. Jointly developing a shared needs assessment fosters the optimum use of resources to meet community needs. The current requirement that each participating hospital develop a separate and independent community health needs assessment (CHNA) undermines the benefit to the community of hospitals working together and creates unnecessary paperwork. We have recommended a way to allow a shared CHNA among hospitals while meeting the transparency and accountability requirements of 501(r). Another burdensome and unnecessary Schedule H requirement includes the creation of data systems to collect and report information about nonhospital facilities. This requirement is unrelated to 501(r) and results in an unwarranted diversion of hospital resources. The focus of Section 501(r) is on hospitals and the justification for a mandate that shifts the focus should be subject to the highest scrutiny.

Lastly, as the examples above illustrate and the detailed recommendations attached will demonstrate, the estimated burden in the Notice significantly understates what will be required of hospitals to respond to the revised Schedule. Because of the duplicative questions posed and the redundant and excessive paperwork currently required by the Schedule, hospitals will not only spend excessive amounts of time completing the Schedule but they will also incur additional expenses and divert greater resources collecting information to comply with the Schedule. The attached recommendations demonstrate that a more streamlined reporting process would equally ensure accountability while enhancing transparency.

We stand ready to continue our assistance and work with you to improve the Schedule.

Please feel free to contact Melinda Hatton, Senior Vice President and General Counsel, at 202-626-2336 or mhatton@aha.org.

Sincerely,

Melinda Reid Hatton
Senior Vice President & General Counsel
AHA

Richard L. Gundling
Vice President Healthcare Financial Practices,
HFMA

Attachments

cc: Yvette B. Lawrence
Internal Revenue Service
Room 6129
1111 Constitution Avenue
Washington, DC 20224

ATTACHMENT A

February 2, 2012

Via U.S. Regular Mail

Jeffrey Zients, Acting Director
Office of Management and Budget
725 17th Street N.W.
Washington, D.C. 20530

Re: Form 990, Schedule H

Dear Acting Director Zients:

On December 16, 2011 representatives of the American Hospital Association, the Healthcare Financial Management Association, and VHA Inc. met with the Office of Management and Budget ("OMB") as well as with Internal Revenue Service ("IRS") personnel to discuss Section V.B. of the revised Schedule H of Form 990. Section V.B., which added eighty (80) additional questions to the Schedule H that hospitals must now answer, reflects the IRS' view of the new requirements for tax exempt hospitals enacted as part of the Patient Protection and Affordable Care Act (codified in Internal Revenue Code 501(r)). We welcomed the opportunity for that meeting.

The purpose of this letter is to set forth the specific manner in which the IRS failed to follow the requisite procedures under the Paperwork Reduction Act of 1995 ("PRA" or the "Act") for issuing the revised Schedule H. As a result, the Schedule, and in particular Section V.B. of the Schedule, contains redundancies, inconsistencies, onerous reporting requirements, and undefined terms, which compliance with the Act might have eliminated.

The failure to follow PRA procedures was compounded by IRS' failure to issue regulations or to otherwise provide the hospital field with a meaningful opportunity to comment on the Schedule H form and instructions. Equally concerning is that one day after publishing a notice on the IRS website on December 15, 2011 requesting comments on the "draft" Schedule H, IRS representatives told those attending the OMB meeting that the Schedule H form and instructions were final and that no further changes would be made. The result was that IRS finalized Schedule H and the instructions on January 23, 2012 without ever even planning to consider the comments it had requested a little more than a month earlier.

This letter summarizes the relevant aspects of the PRA and requests the IRS and OMB to adhere to the procedures established by the Act in an effort to produce a substantially improved Schedule H form and instructions and withdraw Section V.B. of the form until they do so.

The Paperwork Reduction Act

The Paperwork Reduction Act of 1995 was enacted to minimize the burden for, among others, individuals and educational and nonprofit institutions resulting from the collection of information

by government agencies. To achieve this goal, the Act prescribes a procedure that each agency must follow when engaging in or making a material change to an existing "collection of information." "Collection of information" or "COI" is a term of art used by the PRA to denote the activity of obtaining, soliciting or requiring the disclosure of facts or opinions by or to an agency. COI may be conducted in any format, including the use of report forms, application forms, schedules, questionnaires, surveys, reporting or record keeping requirements.

According to the PRA, an agency may not engage in a COI unless the following steps have been followed:

- Internally, the agency must:

  (1) Conduct a review of the COI to evaluate the need for the COI, to determine an objectively supported estimate of the burden imposed, and, if appropriate, to conduct a test of the COI through a pilot program,

  (2) Publish a 60-day notice in the Federal Register and consult with members of the public to solicit comments to evaluate whether the agency's estimate of the burden of the proposed COI is accurate and to enhance the quality and clarity of the information to be collected, and

  (3) Evaluate and take into account public comments received during the 60-day period.

- When submitting the COI to the OMB for approval, an agency must:

  (1) Include a certification that the COI is necessary for the proper performance of agency functions, is not unnecessarily duplicative of information otherwise reasonably available to the agency, reduces the burden on affected persons by clarifying, consolidating or simplifying compliance and reporting requirements, is written using plain, coherent and unambiguous terminology understandable to those who are to respond, and that the COI is to be implemented in ways consistent and compatible to the maximum extent practicable with existing reporting and record keeping practices of those who are to respond to the proposed COI,

  (2) Provide a summary to the OMB of the public comments received during the 60-day notice and the actions taken by the agency in response to the comments, and

  (3) Publish a notice in the Federal Register instructing the public to forward comments to OMB within 30 days of the notice's publication.

- An agency must also demonstrate that it has taken every reasonable step to ensure that the proposed COI is the least burdensome for the proper performance of the agency's function in complying with legal requirements and achieving program objectives and is not duplicative of information otherwise reasonably accessible to the agency.

IRS Failure to Comply with PRA in Revising Form 990, Schedule H

As indicated in the PRA, the foregoing process must be implemented whenever a material modification is made to a COI. Form 990, together with its schedules, constitutes a COI and the IRS must comply with the PRA mandates when making any material changes to Form 990.

Congress enacted Internal Revenue Code Section 501(r) to impose additional requirements on hospitals to maintain tax-exempt status. The IRS attempts to measure a hospital's compliance with Section 501(r) requirements in the new Section V.B. of Schedule H, Form 990. As a result, responses to the new Section V.B. of Schedule H may affect the tax-exempt status of the responding hospital and, therefore, constitute a material change to Form 990 that requires OMB review.

However, the Federal Register and OMB records suggest that the IRS issued the revised Schedule H without performing the required internal review and without submitting the Form to OMB for review. None of the notices published in the Federal Register since the March 23, 2010 enactment of Section 501(r) refers to or indicates that the revised Part V.B. of Schedule H will be submitted to OMB for review. The IRS published only two notices in the Federal Register mentioning Schedule H dated March 4, 2010 and July 28, 2010. However, Section 501(r) was enacted after the March 4, 2010 notice was issued and both notices were published in connection with the IRS application to renew the OMB control number assigned to Form 990. ***The 2009 version of Schedule H, not the revised 2010 Schedule H (with the new 501(r) questions), was attached to Form 990 when it was submitted to OMB on July 28, 2010.*** Aside from the 2010 notices, the Federal Register is void of any reference to a review of Schedule H by OMB.

Further, releases by the IRS of draft Schedule H and subsequent publication of the final Schedule H confirm that IRS failed to submit the revised Schedule H to OMB for review. The IRS published identical draft Schedules H on October 14, 2011 and then on December 15, 2011. A note appended to these Schedules explained that the form is a draft, which the "IRS is providing for your information as a courtesy." The note stated that "forms generally are subject to OMB approval before they are officially released" and instructed the public to submit comments to the IRS. Believing that the draft Schedules issued in 2011 constituted the 60-day notice required under the PRA, some in the hospital field actually submitted comments to the IRS. However, on January 23, 2012 the IRS published the draft Schedule H in final without considering any of the comments it received.

The concerns registered by the hospital field in response to the draft Schedule H suggest the IRS has also failed to follow the internal review procedure prescribed by the PRA. The responses indicate that the IRS neglected to make an objective estimate of the burden imposed by the Schedule and to take reasonable steps to ensure that the COI instituted by the IRS is the least burdensome for complying with Section 501(r) requirements. In fact, it appears to us that the IRS could not submit the required certification to the OMB because the questions in the newly revised Schedule H are unnecessarily duplicative, burdensome, in certain instances, ambiguous, and generally inconsistent with hospitals' existing reporting and record keeping practices.

The Schedule H issued by the IRS on January 23, 2012 evidences the failure of the IRS to comply with the PRA-mandated process. The Schedule includes duplicative questions and redundant and excessive paperwork collection from individual hospital facilities when a more sensible reporting process would equally ensure accountability while enhancing transparency. The hospital community has previously provided to the IRS extensive detailed recommendations for changes that would address these problems.

The PRA prohibits an agency from engaging in a COI without following prescribed steps and the failure of the IRS to follow such steps indicates that Schedule H has not been validly issued. In light of this failure, we request that OMB direct the IRS to withdraw Part V.B. of Schedule H or to issue a notice that Part V.B. of Schedule H is optional for 2011 while IRS revises and seeks review and approval of Schedule H from OMB as required by law. We would be glad to engage with your agency and/or the IRS to resolve these issues, so that an appropriate Schedule H could take effect.

Please feel free to contact Melinda Hatton, Senior Vice President and General Counsel, at 202-626-2336 or mhatton@aha.org.

Sincerely,

Melinda Reid Hatton
Senior Vice President &
General Counsel
American Hospital
Association

Richard L. Gundling
Vice President Healthcare
Financial Practices,
Healthcare Financial
Management Association

Edward N. Goodman
Vice President, Public Policy
VHA Inc.

cc: The Honorable Darrell Issa, Chairman
House Oversight and Government Reform Committee

ATTACHMENT B

IRS Notice 2011-52

August 24, 2011

Sarah Hall Ingram
Commissioner
IRS Tax-Exempt & Government Entities Division
Internal Revenue Service
1111 Constitution Ave., NW
Washington, DC 20224

Dear Commissioner Ingram:

On behalf of the American Hospital Association's (AHA) more than 5,000 member hospitals, health systems and other health care organizations, and its 40,000 individual members; the Healthcare Financial Management Association's (HFMA) more than 37,000 member health care financial executives; and VHA Inc.'s 1,400 member hospitals and 23,000 non-acute health care organization members we are, pursuant to our previous meeting and subsequent discussions, providing detailed comments on the revised Schedule H and Instructions.

On April 20, 2011, our organizations provided comments to the Service on the then newly revised Schedule H that implemented Section 501(r) requirements found in the *Patient Protection and Affordable Care Act of 2010* (PPACA). Our comments focused on widely held concerns about the revised Schedule H. We also requested and were granted a meeting with you and your colleagues to discuss these concerns. At that meeting, you requested detailed line-by-line comments with our suggestions for improving the Schedule, to address the problems we had earlier identified. Sometime following our meeting, the Service released a notice that the questions in Part V, Section B (based on the 501(r) requirements) would be optional for the 2010 tax year. The Service later issued a request for comments on the Community Health Needs Assessment (CHNA) portion of the Schedule.

We appreciate the Service's request for comments from our organizations on the entire 501(r) section of the Schedule and from the tax-exempt hospital field on the CHNA portion. Our comments are attached.

The comments incorporate direct input to our organizations from 300 hospitals, some of which belong to multi-hospital systems, which span the nation from New York to California to Texas and Michigan and beyond. They further reflect the experience of urban and rural hospitals, academic medical centers and teaching hospitals, and large and small multihospital systems, among others, which are required to complete and file Schedule H each year. While this input is not a substitute for a formal notice and comment opportunity, we believe that the group's practical experience with the current Schedule H form and with providing myriad benefits to diverse communities throughout the country should provide the Service with an invaluable perspective on how best to achieve the PPACA's objectives.

The comments also reflect keen awareness that the new 501(r) requirements apply to the largest of the nation's multihospital systems as well as the smallest critical access and frontier hospitals. Consequently, it is critically important that the Service revise Schedule H in a manner that accounts for this immense diversity. To that end, we respectfully request the Service make Part V, Section B, optional for tax year 2011, unless it is able to make revisions sooner.

There is one additional comment attached on the revised requirements for reporting hospital facilities in Part V. This reporting requirement was discussed at length when Schedule H was initially developed. Among the concerns expressed by the hospital field was the excessive burden imposed by a reporting obligation that had no clear relationship to any requirement found in the law or that was clearly useful to the public. The accommodation reached at the time, seemed to balance the burden of reporting information desired by the Service in a reasonable manner. However, by recently adding new requirements for hospitals to list facilities by size and revenue from the largest to the smallest and to provide similar information for non-hospital facilities, the Service has vastly increased the reporting burden without any apparent commensurate benefit.

We recognize that revising Schedule H to incorporate the new 501(r) requirements was an arduous task. The comments attached reflect dozens of hours of intense scrutiny and wide-ranging discussions by the organizations that participated in formulating these recommendations. We believe these comments will improve Schedule H reporting while reducing the paperwork burden for hospitals and providing the public with better and more accessible information about the benefits hospitals provide to their communities.

We stand ready to continue our assistance and work with you to improve the Schedule.

Sincerely,

/S/	/S/	/S/
Melinda Reid Hatton	Richard L. Gundling	Edward N. Goodman
Senior Vice President & General Counsel	Vice President Healthcare Financial Practices,	Vice President, Public Policy
AHA	HFMA	VHA Inc.

Attachment

ATTACHMENT

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
Part V, 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? _____	This ranking information is not tracked by many organizations, would be burdensome, and is not required in the statute. Deleted	How many hospital facilities did the organization operate during the year? _____	In Part V, the organization must list all of its **hospital facilities** in Section A, complete a separate Section B for each of its hospital facilities except as provided. **Section A.** Complete Part V, Section A, by listing all of the organization's **hospital facilities** that it operated during the **tax year**. "Hospital facilities" are facilities that, at any time during the tax year, were required to be licensed, registered, or similarly recognized as a hospital under state law, and any other organization that the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exempt status under section 501(c)(3), without regard to section 501(r). A facility is operated by an organization whether such facility is operated directly by the organization or indirectly through a **disregarded entity** or **joint venture** treated as a partnership, but list only facilities for which the reporting organization treats the income as related income. For each hospital facility, list its name and address and check the applicable column(s). List in Part VI, line 1 the number of each type of health care facility, other than those required to be licensed, registered, or similarly recognized as a hospital facility under state law (for example, two rehabilitation clinics, four diagnostic centers, three skilled nursing facilities, etc.).

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
Part V, Section B. Facility Policies and Practices			
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)	The additional line item is added to reduce paperwork, and consolidate information so as to make the response more understandable.	**Section B. Facility Policies and Practices (optional for 2011)** Check this box and complete one Part V, Section B for all hospital facilities listed in Part V, Section A if each of these facilities has the same answers for all questions in Part V, Section B. Complete a separate Section B for each of the hospital facilities listed in Part V, Section A if the hospital facilities have different answers for questions in Part V, Section B. Name of Hospital Facility: _____ Line Number of Hospital Facility (from Schedule H, Part V, Section A)	**Section B.** Section B is optional for 2011. Section B requires reporting on a **hospital facility** by hospital facility basis; the organization must complete a separate Section B for each of its hospital facilities listed in Section A, unless all hospital facilities listed in Section A have the same answers for all questions in Section B. If hospital facilities listed in Section A have different answers for questions in Section B, the organization must complete a separate Section B for each hospital facility by indicating at the top of Section B the name of the hospital facility and its line number from Section A.
Community Health Needs Assessment			
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)	Clarified.	Community Health Needs Assessment (Lines 1 through 4 are applicable for tax years beginning after March 23, 2012)	**Lines 1 through 4.** These lines are currently not applicable.
1. 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): 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	Modified and deleted provisions to eliminate redundancy, reduce unnecessary paperwork, recognize equivalent state law reporting requirements, and conform reporting to that required in the statute. 501(r)(3)(A)(i) Amended	1. During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 5. If "Yes," indicate the most recent tax year in which the CHNA was made widely available: 20_ _. *Remove the questions regarding a community benefit report in Part I (lines 6a and b).*	**Line 1.** You may answer "Yes," if: a) The hospital prepared a concise written document that includes how the hospital organization took into account input from persons who represent the broad interests of the community, or b) The hospital conducted a community health needs assessment ("CHNA") required by state law that is substantially equivalent to these federal requirements. In Part VI identify the state law and describe how the facility met the requirements. An assessment may be conducted together with one or more other organizations, including related organizations. If a CHNA is conducted with other hospital facilities (related or unrelated) a single

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
d. How data was obtained e. The 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 all of the community's health needs j. Other (describe in Part VI)			document covering all identified participating facilities is sufficient. An assessment may be conducted over multiple tax years. Delete Instructions for Line 1j.
2. Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 _ _.	Relocated to line 1, above. Deleted		

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
3. 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.	Consistent with Instructions for Part II; examples are provided; identification of persons is not required in the statute. 501(r)(3)(B)(i) Amended	2. In conducting its most recent CHNA, 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 the input into account or provide a description of how the most recent information may be accessed on the website of the hospital facility or another website available to the public.	**Line 2.** A facility may seek and receive input from the community through a variety of means. It must, at a minimum, include input from those with special knowledge of or expertise in public health, which may include use of current information collected by a public health agency or nonprofit organization. Input from the community may include, but is not limited to government agencies with relevant data; representatives of special needs populations; healthcare consumer advocates; academic experts; community-based organizations; health care providers; private businesses; and health insurance and managed care organizations.
4. 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.	Relocated to instructions for line 1, above. Deleted		
5. 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): a. Hospital facility's website b. Available upon request from the hospital facility c. Other (describe in Part VI)	Amended to make consistent with Form 990 definition of “widely available”. 501(r)(3)(B)(ii) Amended	3. Did the hospital facility make its CHNA widely available to the public? If “Yes,” indicate how the most recent CHNA was made widely available (check all that apply): a. Hospital facility's website b. Available upon request from the hospital facility c. Other (describe in Part VI)	**Line 3.** Answer "Yes," if the **hospital facility** made its CHNA widely available to the public. If "Yes," indicate how the hospital facility made the most recent CHNA widely available to the public by checking all applicable boxes. If the hospital facility made the CHNA widely available to the public by means other than those listed in lines 3a and 3b, check line 3c, "Other," and describe these means in Part VI.A. The most recent CHNA will be considered widely available if the written report is posted on the hospital facility’s website, or another website (if that location or link is included on the hospital’s website).

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
6. If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply): a. Adoption of an implementation strategy to address the health needs of the hospital facility's community b. Execution of the implementation strategy c. Participation in the development of a community-wide community benefit plan d. Participation in the execution of a community-wide community benefit plan e. Inclusion of a community benefit section in operational plans f. Adoption of a budget for provision of services that address the needs identified in the Needs Assessment g. Prioritization of health needs in its community h. Prioritization of services that the hospital facility will undertake to meet health needs in its community i. Other (describe in Part VI)	Modified to make it consistent with recent update in filing instructions for Form 990 Part VI: Governance – Policies Adopted by Authorized Board Committees. Reduces paperwork needed to comply with the statute. 501(r)(3)(A)(ii) Amended	4. Did the hospital facility adopt an implementation strategy that addresses the priorities identified through the CHNA?	**Line 4.** Answer "Yes," if the hospital facility has documented which of the community health needs identified through a CHNA were determined to be priorities related to the exempt purpose of the hospital, which of those priority needs the facility intends to address, and how it will do so. In Part VI describe, or provide a copy of a document that describes, the priority needs the hospital is addressing directly or in coordination with others, and if not all priority needs are addressed, the selection criteria used in deciding which needs to address. Priorities may include continuation of an effort to address a previously determined unmet priority need. An implementation strategy is adopted on the date the implementation strategy is approved by an authorized governing body of the hospital organization. For these purposes, an authorized governing body means-- (1) The governing body (i.e., the board of directors, board of trustees, or authorized committee) of the hospital organization; or (2) To the extent permitted under State law, other parties authorized by the governing body of the hospital organization to act on its behalf by following procedures specified by the governing body in approving an implementation strategy. An implementation strategy may be adopted any time before the end of the tax year following the tax year in which the CHNA was conducted; provided that the CHNA and implementation strategy are both completed within the three-year cycle required by the statute.

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
7. 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.	The statutory requirement is addressed in new question 4. 501(r)(3)(A)(ii) Deleted		
Financial Assistance Policy			
8. Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	501(r)(4)(A)(i) No change	5. Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	**Line 5.** Answer "Yes," if, during the **tax year**, the **hospital facility** had a written financial assistance policy that explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care.
9. 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:	Redundant to Part I, Line 3a. Not a statutory requirement. Deleted		
10. Used FPG to determine eligibility for providing discounted care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for discounted care:	Redundant to Part I, Line 3b. Not a statutory requirement. Deleted		
11. Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply): a. Income level b. Asset level	Statute does not require organizations to list such factors. 501(r)(4)(A)(ii) Amended	6. Explained the basis for calculating amounts billed to patients?	**Line 6.** Answer "Yes," if, during the **tax year**, the **hospital facility** had a written financial policy that explained the basis for calculating amounts billed to patients. For purposes of Line 6, "amounts billed" means the net amount indicated on the bill after discounts have been applied.

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
c. Medical indigency d. Insurance status e. Uninsured discount f. Medicaid/Medicare g. State regulation h. Other (describe in Part VI)			
12. Explained the method for applying for financial assistance?	501(r)(4)(A)(iii) No change	7. Explained the method for applying for financial assistance?	**Line 7.** Answer "Yes," if, during the **tax year**, the **hospital facility** had a written financial assistance policy that explained the method for applying for financial assistance.
13. 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 policy was posted on the hospital facility's website b The policy was attached to billing invoices c. The policy was posted in the hospital facility's emergency rooms or waiting rooms d. The policy was posted in the hospital facility's admissions offices e. The policy was provided, in writing, to patients on admission to the hospital facility	Redundant to Section VI, Line 3. Additionally, the statute does not require hospitals to indicate how the policy was publicized. However, because this information is already requested in Part VI, Line 3, to further eliminate redundancies, the revised Line 8 should refer to Part VI, Line 3. 501(r)(4)(A)(v) Amended	8. Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy in Part VI, Line 3. NOTE: To avoid confusion, Part VI, Line 3 should be revised to refer to a hospital facility, rather than the organization as follows: Describe how the *hospital facility* informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under the hospital facility's financial assistance policy or under federal, state, or local government programs.	**Line 8.** Answer "Yes," and describe in Part VI, Line 3 if, during the **tax year**, the **hospital facility** had a written financial assistance policy that included measures to publicize the policy within the community served by the hospital facility. If the hospital facility has a written financial assistance policy, describe in Part VI, Line 3 how the hospital facility informs and educates patients and persons who are billed for patient care about their eligibility for assistance under the hospital facility's financial assistance policy or under federal, state, or local government programs. For example, enter whether the hospital facility posts its financial assistance policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of the hospital facility where eligible patients are likely to be present; provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients as part of the intake process; provides a copy of the policy, or a

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
f. The policy was available on request g. Other (describe in Part VI)			summary thereof, and financial assistance contact information to patients with discharge materials; includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; or discusses with the patient the availability of various government benefits, such as Medicaid or state programs, and assists the patient with qualification for such programs, where applicable.
Billing and Collections			
14. 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?	The first part of the question is redundant to Part III, Line 9a. For consistency, Part III, Line 9a terminology should be revised. 501(r)(4)(A)(iv) Amend Part III, Line 9a (When revising Schedule H, Part III, Line 9a should be deleted to eliminate redundancy to revised Part V, Section B, Line 9)	9. 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? NOTE: For consistency in terminology, **Part III, Line 9a** should be rewritten as follows: Did the organization have in place a written *billing and collection*s policy during the tax year?	**Line 9.** Answer "Yes," if, during the **tax year**, the **hospital facility** had either a separate billing and collections policy or a written financial assistance policy that explained actions the hospital facility may take upon non-payment. For purposes of line 9, the term "actions" includes, but is not limited to, collection actions and reporting to credit agencies. REVISED INSTRUCTIONS FOR PART III, LINE 9a: ***Line 9a***. Answer "Yes," if the organization had a written *billing and collections policy* on the collection of amounts owed by patients during the **tax year**.

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
15. 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: a. Reporting to credit agency b. Lawsuits c. Liens on residences d. Body attachments e. Other actions (describe in Part VI)	Redundant to Part III, Line 9b. For consistency, Part III Line 9b terminology should be revised. Not required in the statute. Deleted Amend Part III, Line 9b	NOTE: For consistency in terminology, **Part III, Line 9b** should be rewritten as follows: If “Yes,” did the organization’s *billing and collections 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.	REVISED INSTRUCTIONS FOR PART III, LINE 9b: ***Line 9b.*** Answer "Yes" if the organization's written *billing and collections policy* that applied to the facilities that served the largest number of the organization's patients during the **tax year** contained provisions for collecting amounts due from those patients who the organization knows qualify for financial assistance. If the organization answers "Yes," describe in Part VI the collection practices that it follows with respect to such patients, whether or not such practices apply specifically to such patients or more broadly to also cover other types of patients.
16. 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): a. Reporting to credit agency b. Lawsuits c. Liens on residences d. Body attachments e. Other actions (describe in Part VI)	Revisions reflect statutory intent – prohibition on extraordinary collection actions *before* determining if patient qualifies for financial assistance; reporting to credit agencies is not an extraordinary collection action. 501(r)(6) Amended	10. Did the hospital facility engage in or authorize a third party to perform any of the following extraordinary collection actions during the tax year **before** making reasonable efforts to determine whether the non-paying individual was eligible for financial assistance under the hospital facility’s financial assistance policy? If “No,” check one of the following to indicate that the hospital facility or a third party: a. Did not engage in extraordinary collection actions during the tax year (skip to line 12) b. Did not engage in extraordinary collection actions before making reasonable efforts to determine whether the non-paying individual was eligible for financial assistance under the hospital facility’s financial assistance policy If “Yes,” check each of the following extraordinary collection actions in which the hospital facility or a third party engaged (check all that apply):	**Line 10.** Answer “No” and indicate whether the hospital facility did not engage and did not authorize a third party to engage in extraordinary collection actions during the tax year or if the hospital facility did not engage in extraordinary collection actions before making reasonable efforts to determine if the non-paying individual was eligible for financial assistance under the hospital facility’s financial assistance policy. If the hospital facility did not engage and did not authorize a third party to engage in extraordinary collection actions during the tax year, skip to line 12. Answer “Yes,” if the **hospital facility** engaged or authorized a third party to engage in any of the extraordinary collection actions listed in lines 10a and 10b during the **tax year** before making reasonable efforts to determine whether the non-paying individual was eligible for financial assistance. If “Yes,” indicate the extraordinary collection actions in which the hospital facility or a

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
		a. Lawsuits b. Liens on residences c. Other actions (describe in Part VI)	third party engaged by checking all applicable boxes. If the hospital facility or a third party engaged in extraordinary collection actions other than those listed in lines 10a and 10b, answer "Yes," check the box for line 10c, "Other actions," and describe those extraordinary collection actions in Part VI. "Other actions" do not include sending the patient a bill or reporting the patient to a credit agency.
17. Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply): a. Notified patients of the financial assistance policy on admission b. Notified patients of the financial assistance policy prior to discharge c. Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills d. Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance e. Other (describe in Part VI)	Revisions reflect statutory intent – prohibition on extraordinary collection actions *before* determining if patient qualifies for financial assistance; options (b) and (d) were not mentioned in legislative history; option (e) is redundant to Line 8 and also to Part VI, Line 3. 501(r)(6) Amended	11. Indicate which actions the hospital facility took **before** initiating the extraordinary collection actions indicated in line 10 (check all that apply): a. Notified patients of the financial assistance policy on admission or discharge b. Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills c. Other reasonable efforts (describe in Part VI, Line 3)	**Line 11.** Indicate which actions the **hospital facility** undertook to determine whether a non-paying individual was eligible for financial assistance before initiating extraordinary collection actions checked in lines 10a and 10b or described in Part VI by checking all applicable boxes in lines 11a and 11b. If the hospital facility undertook reasonable actions other than those listed in lines 11a and 11b to notify patients of the availability of financial assistance before initiating any of the extraordinary collection actions checked in lines 10a and 10b or described in Part VI, check the box for line 11c, "Other reasonable efforts," and describe in Part VI, Line 3. If the hospital facility took no action before initiating any of the extraordinary collection actions checked in lines 10a and 10b or described in Part VI, check the box for line 11c, "Other," and state in Part VI, Line 3 that the hospital facility took no action. **Line 11b.** The term "communications" includes, but is not limited to, in-person interactions, telephone calls, and invoices.

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
Policy Relating to Emergency Medical Care			
18. 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): a. The hospital facility did not provide care for any emergency medical conditions b. The hospital facility did not have a policy relating to emergency medical care c. The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI) d. Other (describe in Part VI)	In practice, a policy related to emergency medical care is adopted by the organization, not each individual hospital facility. If an organization complies with EMTALA, they will satisfy this statutory requirement. To simplify reporting, if an organization lacks such a policy, the organization should provide an explanation in Part VI. 501(r)(4)(B) Amended	12. Did the organization have in place during the tax year a written policy relating to emergency medical care that requires a hospital facility operated by the organization to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? Indicate "Yes," if the organization had in place a policy that required compliance with 42 U.S.C. 1395dd (Emergency Medical Treatment and Active Labor Act). If "No," indicate the reasons why in Part VI.	**Line 12.** Answer "Yes," if, during the **tax year**, the organization had in place a written policy relating to emergency medical care that required a **hospital facility** or hospital facilities operated by the organization to provide, without discrimination, care for emergency medical conditions to individuals without regard to their eligibility under the hospital facility's financial assistance policy. Indicate "Yes," if the hospital facility had in place a policy that required compliance with 42 U.S.C. 1395dd (Emergency Medical Treatment and Active Labor Act). If "No," describe the reason(s) why the hospital facility did not have a nondiscriminatory policy relating to emergency medical care in Part VI. For purposes of line 12, the term "emergency medical conditions" means: (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in-- 1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2. serious impairment to bodily functions, or 3. serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant woman who is having contractions-- 1. that there is inadequate time to effect a safe transfer to another hospital before delivery, or 2. that transfer may pose a threat to the health and safety of the woman or the unborn child.

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
Charges for Medical Care			
19. 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): a. The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility b. The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility c. The hospital facility used the Medicare rate for those services d. Other (describe in Part VI)	Revision reflects statutory requirement that the amounts charged to *patients that are known to qualify for financial assistance* may not exceed amounts charged to patients with insurance for emergency and other medically necessary care; the question closely tracks statutory language and eliminates redundancy to line 20; the question is redrafted to focus on the underlying intent of the statute – results, rather than the methodology "used" by a hospital facility; as originally drafted, most hospital facilities would check "Other" because the check-the-box options are limited, so the list of options was expanded; the negative connotation associated with checking the "Other" option is removed. 501(r)(5)(A) Amended	13. Did the hospital facility limit the amounts billed to individuals known to qualify for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, to not more than the amounts generally billed to individuals who had insurance covering such care? Indicate whether the hospital facility billed such individuals not more than (check all that apply): a. The lowest average negotiated commercial insurance rate (or the highest average commercial insurance discount) b. The average of the three lowest negotiated commercial insurance rates (or the average of the three highest negotiated commercial insurance discounts) c. The Medicare rate d. The average rate billed all commercially insured patients e. The average rate billed patients of the largest commercial payor f. Other, reasonably determined rate or discount that results in an amount that is less than the amount indicated in either of line a through e, above (describe in Part VI)	**Line 13.** Indicate whether the **hospital facility** limited the amounts billed to individuals known to qualify for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, to not more than the amounts generally billed to individuals who had insurance covering such care by checking all applicable boxes. Check the box, "Other," and describe in Part VI, if the hospital facility determined amounts billed to individuals who were known to qualify for financial assistance by reasonable means other than those described in lines 13a through 13e that resulted in an amount billed to a patient that was less than the amount indicated in either of lines 13a through 13e. For purposes of Line 13, a hospital facility should provide an answer based on the average rate or discount provided to all patients for all services during the **tax year** and not on a service-by-service basis. An average rate means either the total net revenue divided by total gross revenue or a weighted average of percentage of discount. An insurance rate may be either a negotiated discount or a flat fee. For purposes of line 13 "amounts billed" means the net amount indicated on the bill after all discounts have been applied. For purposes of line 13, "emergency or other medically necessary services" can be determined pursuant to the hospital facility's policy for such care so long as the policy complies with the

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
			Emergency Medical Treatment and Active Labor Act or with similar federal, state, or local laws and regulations related to the provision of emergency or medically necessary services. For purposes of line 13, “amounts generally billed” means an amount billed by the hospital facility that is a function of a hospital facility’s arrangements with various insurers or payors covering hospital patients.
20. 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.	Redundant to Line 13, as redrafted. Deleted		
21. 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.	Reflects legislative history that gross charges are prohibited for patients who are known to qualify for financial assistance. 501(r)(5)(B) Amended	14. Did the hospital facility bill its patients known to qualify for assistance under the hospital facility’s financial assistance policy an amount equal to the gross charge for emergency or other medically necessary services provided to the patients? If “Yes,” explain in Part VI.	**Line 14.** Answer “Yes,” if, during the **tax year**, the **hospital facility** billed its patients known to qualify for financial assistance under the hospital facility’s financial assistance policy an amount equal to the gross charge for emergency or other medically necessary services provided to the patients, and explain in Part VI the circumstances in which it used gross charges. A bill that itemizes a reduction applied to a gross charge for a service does not need to be reported if the amount billed to the patient for such service is less than the amount of the gross charge. For purposes of line 14, a hospital facility should provide an answer based on its overall performance, not on an individual patient basis.

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			For purposes of line 14 “amounts billed” means the net amount indicated on the bill after all discounts have been applied. For purposes of line 14, the term “gross charges” means the hospital facility’s full established rates for emergency or other medically necessary services provided to patients. For purposes of line 14, “emergency or other medically necessary services” can be determined pursuant to the hospital facility’s policy for such care so long as the policy complies with the Emergency Medical Treatment and Active Labor Act or with similar federal, state, or local laws and regulations related to the provision of emergency or medically necessary services.

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
Part V, 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? _____	Restored 2009 Schedule H Instructions in Part V, Section A; reduces unnecessary paperwork, not required by statute. Deleted		

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
Part VI. Supplemental Information – TECHNICAL CORRECTIONS TO REFLECT REVISIONS TO PART V, ABOVE.			
1. **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 12, 13c, 14e, 15d, 16d, 17, and 18.		1. **Required descriptions.** Provide the descriptions required for Part I, lines 3c and 6; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1, 2, 3c, 4, 10c, 12, 13f, and 14.	***Part V, Section A.*** List the number of each type of health care facility, other than those required to be licensed, registered, or similarly recognized as a hospital facility under state law (for example, two rehabilitation clinics, four diagnostic centers, three skilled nursing facilities, etc.). ***Part V, Section B.*** Identify the specific **hospital facility** name and line number (from Schedule H (Form 990), Part V, Section A), to which each set of responses relates. For instance, if the organization reported five hospital facilities in Part V, Section A, it should list the first facility's name and number (1) as a heading, followed by the responses to applicable Part V, Section B, questions for that facility, followed by four additional headings and sets of responses for each of the other four hospital facilities listed in Part V, Section A. However, if each of the facilities listed in Part V, Section A has the same answers for all questions in Part V, Section B, provide one answer in Part VI for all hospital facilities listed in Part V, Section A. • Line 1: If the hospital facility checked "Yes," identify the state law that requires a hospital facility to conduct a community health needs assessment ("CHNA") that is substantially equivalent to the federal requirements and describe how the facility met the requirements. • Line 2: If the hospital facility checked "Yes," describe how the hospital facility took into account input from persons who represent the community served by the hospital facility or provide a description of how that information

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			may be accessed on the website of the hospital facility or another website for the most recent CHNA. • Line 3c: If the hospital facility checked line 3c, indicate how the most recent CHNA was made widely available to the public. • Line 4: If the hospital facility checked "Yes," describe, or provide a copy of a document that describes, the priority needs the hospital facility is addressing, and if not all priority needs are addressed, the selection criteria used in deciding which needs to address. Priorities may include continuation of an effort to address a previously determined unmet priority need. • Line 10c: If the hospital facility checked line 10c, describe other extraordinary collection actions in which the hospital facility or a third party engaged **before** making reasonable efforts to determine whether the non-paying individual was eligible for financial assistance. • Line 12: If the hospital facility checked "No," to line 12, describe the reason(s) why the hospital facility did not have a nondiscriminatory policy relating to emergency medical care in Part VI. • Line 13f: If the hospital facility checked line 13f, describe how the hospital facility determined amounts billed to individuals known to qualify for financial assistance by reasonable means other than those described in lines 13a through 13e that resulted in an amount billed to a patient that was less than the amount indicated in either of lines 13a through 13e.

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			• Line 14: If the hospital facility checked "Yes," explain the circumstances in which the hospital facility used gross charges to bill its patients known to qualify for assistance under the hospital facility's financial assistance policy for emergency or other medically necessary services provided to the patients.
2. **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.	Eliminate redundancy with reporting requirements under CHNA. Amended (When revising Schedule H, this line should be deleted to eliminate redundancy to revised Part V, Section B, Lines 1 through 4)	2. **Needs assessment.** If not included in the most recent CHNA made widely available, describe how the organization assesses the health care needs of the communities it serves.	**Line 2.** Describe how the organization assesses the health care needs of the community or communities it serves if this information is not included in the most recent CHNA made widely available.
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.		3. **Patient education of eligibility for assistance.** Describe how the hospital facility informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under the hospital facility's financial assistance policy or under federal, state, or local government programs.	**Line 3.** Describes how the hospital facility informs and educates patients and persons who are billed for patient care about their eligibility for assistance under the hospital facility's financial assistance policy or under federal, state, or local government programs. For example, enter whether the hospital facility posts its financial assistance policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of the hospital facility where eligible patients are likely to be present; provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients as part of the intake process; provides a copy of the policy, or a summary thereof, and financial assistance contact

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
			information to patients with discharge materials; includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; or discusses with the patient the availability of various government benefits, such as Medicaid or state programs, and assists the patient with qualification for such programs, where applicable.
4. **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.	Redundant to reporting requirements under CHNA. Amended (When revising Schedule H, this line should be deleted to eliminate redundancy to revised Part V, Section B, Lines 1 through 4)	4. **Community Information.** If not included in the most recent CHNA made widely available, describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.	**Line 4.** Describe the community or communities the organization serves, taking into account the geographic area and demographic constituents it serves, if this information is not included in the most recent CHNA made widely available.
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.).		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.).	**Line 5.** Provide any other information important to describing how the organization's **hospitals** or other health care facilities further its exempt purpose by promoting the health of the community or communities, including but not limited to whether: • A majority of the organization's **governing body** is comprised of persons who reside in the organization's primary service area who are neither **employees** nor **independent contractors** of the organization, nor **family members** thereof; • The organization extends medical staff privileges to all qualified physicians in its community for some or all of its departments; and • How the organization applies surplus funds to improvements in patient care, medical education, and research.

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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.		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.	**Line 6.** 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 by the system. For purposes of this question, an "affiliated health care system" is a system that includes affiliates under common governance or control, or that cooperate in providing health care services to their community or communities.
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.		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.	**Line 7.** Identify all states with which the organization files (or a related organization files on its behalf) a community benefit report. Report only those states in which the organization's own community benefit report is filed, either by the organization itself or by a related organization on the organization's behalf.