American Hospital Association

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September 24, 2012

Submitted electronically to: www.regulations.gov

CC:PA:LPD:PR (REG-130266-11)
Room 5203
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: REG—130266-11 Additional Requirements for Charitable Hospitals

To Whom It May Concern:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association appreciates the opportunity to provide comments on the proposed regulations issued on June 22 by the Department of the Treasury and the Internal Revenue Service (collectively the "Treasury") to implement Sections 501(r)(4) – (6) of the Internal Revenue Code enacted by the *Patient Protection and Affordable Care Act of 2010* (ACA).

The AHA and its members support the goals of Section 501(r); and hospitals are committed to meeting the requirements of the statute. These provisions require hospitals to implement a financial assistance policy (FAP) and an emergency medical care policy; to limit amounts charged to individuals eligible for assistance under a hospital facility's FAP (FAP-eligible individuals); and to refrain from certain collection actions prior to taking reasonable efforts to ascertain an individual's financial assistance status.

We appreciate the Treasury's stated objective to balance the patient protection goals of the statute with the efficient administration and operation of hospitals. Unfortunately, this balance has not yet been achieved. Overall, the proposed regulations consist of extremely detailed and prescriptive requirements that deprive hospitals of flexibility to use the most efficient and effective means to meet the requirements of Section 501(r) in their communities. The result – a time-intensive and costly compliance effort without commensurate benefit to the communities these hospitals serve and patients in need of financial assistance.

Hospitals are proud of the benefit they provide to their communities and their programs to aid patients in need of financial assistance. We are concerned that the approach taken in the proposed regulations sends a message that hospitals will not provide assistance, share information about its availability, or make efforts to qualify individuals for assistance unless the Treasury tells them each how to do it. **Rather than prescribing uniformity, we urge you to allow hospitals flexibility for how they meet the requirements with full disclosure of the policies and procedures each hospital will use to carry out the law. This would enable hospitals to continue implementing efficient and effective methods to meet the new tax-exemption requirements, while ensuring that individuals have the information needed to obtain financial assistance.**

The AHA's detailed comments on the proposed regulations follow. They are built on extensive work with members across the country in the summer 2011 to provide detailed and comprehensive comments to the Internal Revenue Service (IRS) on its incorporation of Section 501(r) requirements into its Schedule H (see the attached August 24, 2011 Letter to Sarah Hall Ingram), and reflect additional input received from members since the proposed regulations were released in June.

In addition to commenting on what is included in the proposed regulations, we raise two additional significant issues that must be addressed before the rules are finalized: 1) The timing of Section 501(r) taking effect in relation to implementation of two other ACA provisions that also will affect hospitals and the uninsured – expansion of coverage for the uninsured through the Medicaid program and the Health Insurance Exchanges; and 2) the lack of enforcement guidance on the consequences for failing to comply with the law.

EFFECTIVE DATE IN RELATION TO OTHER REGULATIONS

In addition to Section 501(r), hospitals are awaiting guidance on the expansion of coverage under the Medicaid program and the implementation of the Health Insurance Exchanges, both of which will have a direct effect on hospital assistance programs. Realistically, hospitals could be finalizing their operational compliance with final Section 501(r) regulations just at the point when information would become available regarding the changes they would have to build into their policies, procedures and systems under the Medicaid expansion and implementation of the exchanges. It would be unreasonable to place hospitals in that position and, as a result, premature for Section 501(r) regulations to take effect before those programs are in place, which would be January 2014 at the earliest. **We urge that the final regulations take effect no sooner than January 1, 2014 and that the Treasury issue a Notice advising the field that until that time hospital compliance will continue to be judged based on good faith interpretations of the provisions in the statute.**

ENFORCEMENT GUIDANCE

As the preamble acknowledges, there is no guidance on how the IRS will use its enforcement authority to address failures to comply with the law. Without that guidance, hospitals are caught between the statute's prescription that a hospital's 501(c)(3) status is conditioned on its compliance with Section 501(r), and the Treasury's approach to regulations, whereby every

instruction on what must be done, and every detail on how it must be done, is a potential trip-wire for a finding of noncompliance. If a facility is part of a system, a facility's noncompliance can have repercussions for the entire system.

Final Section 501(r) regulations should not be issued until meaningful enforcement guidance is issued. We continue to urge that the Treasury issue guidance that includes:

- a transition period for hospitals to operationalize the requirements in the final rule;
- a "substantiality" standard for determining whether a violation has occurred; and
- a reasonable "cure period" to come into compliance.

We also urge that the Treasury take the initiative to establish an "intermediate sanctions" framework that recognizes infractions that are cured should not result in the loss of tax-exemption, and that any penalty should be calibrated to the significance of the violation. We plan to submit additional recommendations on this issue after further discussion with other stakeholders**.**

GOVERNMENT HOSPITALS

Finally, application of Section 501(r) to government hospitals with 501(c)(3) status represents a major change in how they are treated under the tax code. **While the preamble requests comments on how the requirements might be adapted for government-(c)(3) hospitals, we believe this is the one aspect of the proposed regulations where a public hearing is warranted.** Government hospitals do not file a Form 990, and their obligations flow from their government status. Applying Section 501(r) creates entirely new hospital-specific requirements. We appreciate that the Treasury recognizes that the special circumstances of these hospitals should be taken into account. The benefit of a hearing would be the exchange that could occur between these hospitals and the Treasury on the implications of applying all of Section 501(r) to these hospitals, including the community health needs assessment requirement that is not addressed in the proposed rule. **In the interim, we urge the Treasury to announce that these hospitals may continue their current policies and practices until final guidance is issued.**

The AHA welcomes an opportunity to meet with representatives of the Treasury to discuss our comments as you finalize these regulations. We believe the final regulations would be more effective in achieving the goals of the ACA if the Treasury consulted with representatives from the hospital field. Please feel free to contact me with any questions or comments at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President and General Counsel

AMERICAN HOSPITAL ASSOCIATION'S DETAILED COMMENTS PROPOSED SECTION 501(r) REGULATIONS

These comments focus on the American Hospital Association's (AHA) identified key issues, concerns and needed clarifications. We believe the approaches described below will achieve a true balance between the needs of hospitals and their patients, and would prevent inadvertent violations of Section 501(r) that would threaten a hospital's tax-exempt status. The AHA recognizes that the preamble requests comments on other aspects of the proposed regulations. Many Section 501(r) implementation issues also were addressed in our August 24, 2011 comment letter submitted to the Internal Revenue Service (IRS) in connection with its revision of Schedule H to incorporate Section 501(r) (see attached). As a general matter, our answer is "yes" whenever the question is whether greater flexibility should be provided or a less prescriptive approach used.

KEY ISSUES AND CONCERNS

The predominant theme that unites the key issues identified by AHA members is a lack of flexibility in meeting Section 501(r) requirements and the emphasis in the proposed regulations on uniform, and often-times administratively inefficient, standards that would apply regardless of the circumstances. AHA members are concerned that the lack of flexibility, in combination with overly detailed rules, would result in inadvertent violations that would place a charitable hospital's tax-exempt status in jeopardy. Outlined below are the issues that we believe need to be addressed in the final regulations as well as recommendations for greater flexibility, coupled with disclosure and transparency.

Interaction of the Definition of "FAP-eligible Individual" with Other Provisions Creates Significant Issues

The practical effect of the definition of "FAP-eligible individual" and the limitation on waivers is that every patient would have to submit an FAP application. A Financial Assistance Policy (FAP) -eligible individual is defined in Prop. Reg. § 1.501(r)-1(b)(13) as an "individual eligible for financial assistance under a hospital facility's FAP without regard to whether the individual has applied for assistance under the FAP." Prop. Reg. § 1.501(r)-6(c)(6) prevents a hospital from relying on an individual's waiver of FAP eligibility.

To assure compliance, hospitals would be effectively required to presume every individual is eligible for financial assistance until proven otherwise via the FAP application and the "reasonable efforts" process. That is an unnecessarily time-consuming and costly requirement. Currently, a hospital's routine registration process serves as a first step in identifying whether someone may need financial assistance. Many patients self-identify that they have insurance coverage or are otherwise able to pay for their care. Whether by a waiver or some other acknowledgment, they should not be required to complete an FAP application. For those without coverage, the hospital's assistance program may begin with determining eligibility for public programs. They should not have to complete required documentation to be considered for those

programs and the FAP application. For others, completion of the FAP application is the next step in the process. The proposed regulations effectively would require hospitals to displace efficient and reliable systems of determining eligibility and to engage in the cumbersome FAP application process with every patient, even when available information or other tools and methods can reliably determine a patient's eligibility or ineligibility at the outset of the process.

To save hospitals the time and cost of overhauling current systems in order to engage in the FAP application process with every patient, we urge the Treasury to revise the definition of a "FAP-eligible individual," as well as the restriction on waivers. **The term "FAP-eligible individual" should be defined as "an individual known to be eligible for financial assistance under a hospital facility's FAP." The section relating to waivers should specify that hospitals may accept waivers of an individual's eligibility under a hospital facility's FAP, provided the hospital has no reason to believe that the waiving individual may be FAP eligible, and the individual is not later precluded from submitting an FAP application.**

The presumption of FAP eligibility created by the FAP-eligible definition and limitation on waivers in combination with the "presumptive eligibility safe harbor" effectively mandate that a hospital rely only on the FAP application and could reduce the pool of patients eligible for financial assistance. According to Prop. Reg. § 1.501(r)-6(c)(4)(iv), a hospital can only rely on information outside the FAP application to bypass the notification and application periods if the hospital offers a patient the most generous assistance available under a hospital's FAP. However, this "presumptive eligibility safe harbor" fails to take into account the variety of circumstances in which eligibility is determined without an application being completed and the range of financial assistance that hospitals may offer to patients. The proposed regulation is focused on a patient's completion of an application for assistance. In hospitals' experience, that is a welcome opportunity for many patients. For others, however, a lack of information or reluctance to provide information has led hospitals to look for other means to determine eligibility. In the absence of information, a hospital must begin the billing process. To avoid sending bills to individuals who, if information was known, might qualify for assistance, they have established presumptive eligibility programs that make use of third-party information to assess potential eligibility. That can lead to a complete write-off of financial responsibility or a bill that includes a discount based on a sliding scale.

The presumptive eligibility safe harbor, in tandem with the presumption of FAP-eligibility and the prohibition on waivers, overturns current hospital practices and would leave hospitals with one choice: to rely on the FAP application and follow the FAP application procedures, or offer the deepest discount under the FAP. This inadvertently could result in reducing the cohort of patients eligible for financial assistance.

The issues created by the proposed regulations are particularly acute when applied to services rendered to outpatients, some of whom may never be present at the hospital for services (e.g., blood work) or may incur relatively small balances. The proposed regulations would require hospitals to furnish all FAP materials and undergo the FAP application process for each such patient. Due to the volume of uninsured outpatients, the cost of engaging in the FAP application

process would be prohibitive and could discourage hospitals from including outpatients in their financial assistance eligibility criteria.

We recommend that, instead of the "reasonable efforts" requirements and the "presumptive eligibility safe harbor," the final regulations specify that a hospital facility will have made reasonable efforts to determine whether an individual is FAP eligible if it relies on the FAP application or other trustworthy methods disclosed and described on its Form 990 to determine an individual's eligibility for financial assistance. The bill sent to the patient would reflect any financial assistance provided. **If the patient responded in a timely manner (as defined in the hospital's FAP) and provided information indicating eligibility for a greater discount than provided, such discount would be extended to the patient.** This approach has the advantage of maintaining the option for a patient to make use of the FAP application while also enabling hospitals to continue utilizing other methods of determining qualification for assistance and offering a range of assistance sooner to those who are eligible under the FAP.

Presumption of FAP eligibility and amounts generally billed could limit financial assistance for patients with insurance. Section 501(r)(5) places limits on the amounts that a hospital can charge FAP-eligible individuals. Specifically, a hospital must limit amounts charged FAP-eligible individuals to no more than "amounts generally billed" (AGB) to individuals who have insurance. The insured individuals would thus be used as a benchmark for determining amounts that may be charged to FAP-eligible individuals. However, the definition of FAP-eligible individual is so broad that it suggests anyone, even an individual with insurance, is included.

The proposed regulations seem to require that financial assistance for the insured may be provided only if AGB is applied. Section 501(r) was enacted to provide the uninsured in need of assistance the benefit of rates paid by the insured. Many hospitals also provide assistance to the insured (e.g., for deductibles or co-pays) in certain circumstances. Requiring the use of AGB for the insured could inadvertently reduce the availability of financial assistance for insured patients. The Treasury should make clear that the proposed regulations were not intended to displace assistance policies specific to the insured. **The final regulations should specify that the AGB applies only to uninsured individuals.**

Options for Determining the AGB are Unreasonably Limited

Allowing hospitals only two methods for calculating AGB, both of which must include Medicare, departs from legislative history and is impractical and costly. Prop. Reg. § 1.501(r)-5, would limit the options for determining the AGB to two methods: a look-back method using either past payments from Medicare or a combination of Medicare and commercial insurer payments; or a prospective method using only Medicare rates. **The AHA urges that the available methods for determining AGB be expanded.**

Hospitals have relied on a variety of methods to determine the amount generally billed since this requirement took effect, such as the options included in the Joint Tax Committee Report, state-

mandated discounts, and averages of various combinations of commercial insurance rates (in the case of state-mandated discounts, they were established through a public process, are fully transparent, and are uniform in the communities served). **Fully disclosing and describing the method hospitals use on their Form 990s will provide transparency and accountability. The price of uniformity will be costly, particularly for small hospitals with limited resources.** Allowing flexibility is also important to avoid penalizing those hospitals serving a large Medicare population for whom the payments do not cover the costs of their care.

Switching AGB methods should be permitted. According to Prop. Reg. § 1.501(r)-5(b), once a hospital elects a method for calculating AGB it must use the selected method indefinitely. The prohibition on choosing another method is arbitrary and fails to account for unpredictable changes that can occur in a hospital's environment. **Hospitals should be permitted to change methods at their discretion, provided it does not occur more frequently than annually.** The same disclosure and transparency requirements that apply when the initial election is made would apply when a change is made.

The period for implementing the AGB should be extended. The 45-day period allowed to implement the AGB is also too limited. At least 45 days may be needed to complete the calculation. Additional time will then be needed to operationalize the change (including updating policies, processes, systems and communications). **At least 120 days should be permitted to achieve the calculation and implementation. The same should be permitted for future updates or changes.**

A system-wide AGB calculation should be an option for hospital systems. While Prop. Reg. § 1.501(r)-4(d)(4) permits a hospital system with multiple facilities to adopt a uniform method for calculating AGB, Prop. Reg. § 1.501(r)-5 appears to require a facility-specific calculation of the percentage. **A hospital system should have the option to use facility-specific calculations or a system- or region-based calculation.** Many hospital systems have centralized patient financial services operations, including assistance policies. Permitting a system-based calculation would avoid the significant administrative cost for implementing different calculations. The cost includes more than developing the calculation; it includes policies, notices, postings and other communications. For patients and their families served by multiple facilities it would avoid confusion about differences in financial responsibilities based on location.

Billing and Collection Section is Unreasonably Detailed and Prescriptive

Section 501(r)(6) of the Code prevents a hospital from engaging in certain collection actions before a hospital has made reasonable efforts to determine whether the individual is FAP-eligible. In addition to the concerns raised earlier about application of the "reasonable efforts" provision, implementation of this requirement would require the unnecessary expenditure of significant resources without commensurate benefit.

"Reasonable efforts" requirements would require unnecessary, entirely new sets of hospital procedures and parallel tracking systems. The proposed regulations define "reasonable efforts" by creating a labyrinth of steps and timelines that must be navigated over a period of eight months. This process is out of step with state laws and regulations and the practices of hospitals. The procedure consists of a notification period and an application period with excessively detailed requirements that must be met during each period. Hospital practices already include notification requirements and a waiting period. Many hospitals have implemented billing and collection policies that comply with time periods imposed by state law. There is no need for hospitals to implement and administer different and overlapping waiting periods that increase complexity and costs.

The final regulations should allow hospitals to continue to rely on their notification processes and on state-mandated waiting periods or timeframes that align with hospitals' financial accounting policies, so long as full disclosure is made on a hospital's Form 990. The proposed "reasonable efforts" requirements should be excluded from the final regulations. We plan to submit additional comments on notice to individuals after further discussion with other stakeholders.

FAP eligibility determinations should continue at the discretion of the hospital as described in its policy. A hospital should not be required to re-determine whether an individual is FAP-eligible every time the individual receives care. **A hospital should have the discretion to determine for how long a prior FAP-eligibility determination may be relied upon, provided it is disclosed in its FAP policy.** A patient could, at any time, provide additional information and make a request for further review.

Liability for actions of third-party collection agents could inappropriately make hospitals responsible for actions of which they are unaware. According to Prop. Reg. § 1.501(r)-6(c)(7), a hospital that sells or refers debt to a third party must enter into a legally binding agreement with that party to restrict the contract party from engaging in certain collection actions until the hospital has made reasonable efforts to determine FAP eligibility. If any such actions are undertaken by the third party, the hospital would be deemed to be liable as if the action had been undertaken directly by the hospital.

While hospitals should impose legally binding obligations on a third-party collection agency, hospitals should not be rendered absolutely liable for the actions of a collection agency taken in contravention of an agreement. Hospitals are simply unable to monitor all of the actions of contract parties and should not be required to serve as guarantors for the actions taken by third parties when an agreement is in place requiring compliance from the third party with IRS requirements.

Hospitals should not be liable for the actions of contract parties unless a hospital's staff knows of a material violation and fails to take remedial steps, including terminating the contract. That is the approach adopted by the *Health Insurance Portability and Accountability*

Act of 1996 (HIPAA) regarding the protection of personal health information. The final regulations should borrow from the HIPPA rules.

REQUESTS FOR CLARIFICATION

The following discussion incorporates AHA members' requests for clarification regarding certain aspects of the proposed regulations. The comments contained in this section do not advocate for substantive changes to the proposed regulations; rather, these comments could be addressed by providing an explanation in the preamble to the final regulations.

EMTALA Should Control Interactions with Patients in the ED

Prop. Reg. § 1.501(r)-4(c)(2) prohibits a hospital from conducting "debt collection activities in the emergency department." Because of the ambiguity created by the term "debt collection activities in the emergency department," AHA members are concerned whether the proposed regulations are intended to override hospitals' policies and procedures in the emergency department that are based on the *Emergency Medical Treatment and Labor Act* (EMTALA). The regulations under EMTALA establish basic rules for registration processes and discussions regarding a patient's ability to pay. When EMTALA obligations have been met and a patient is being discharged, it is customary to discuss financial responsibility and assistance, including responsibility for co-pays or deductibles. **The AHA and its members request confirmation that EMTALA will continue to be the controlling federal guidance for a hospital's interaction with patients in the emergency department.**

"Medically Necessary Services" Covered Under an FAP are at Discretion of the Hospital

Section 501(r)(5) of the Code together with Prop. Reg. § 1.501(r)-5 prohibit a hospital from charging more than AGB to FAP-eligible individuals for emergency and medically necessary services. **We ask that the Treasury please confirm in the final regulations that the proposed regulations purposefully did not define the term "medically necessary services" in order to preserve hospitals' discretion in determining how nonemergency and elective services are considered for hospitals' financial assistance policies.**

Liens in Third-Party Liability Litigation are not ECAs

Prop. Reg. § 1.501(r)-6(b) outlines the types of actions that are considered extraordinary collection actions (ECAs). A common practice not addressed by the proposed guidance is for hospitals to place a "lien" on a potential settlement to be received by a patient where the patient has sued a third party due to an auto accident or other type of accident in which the patient receives reimbursement for medical bills as part of the settlement. This type of action ensures that the hospital will receive an amount designated in the settlement for hospital bills. The Treasury should confirm that this common practice will not be treated as an ECA.

Paperless Forms may be Used to Satisfy the FAP Requirements

Provisions in the proposed regulations that require hospitals to widely publicize an FAP and to notify individual patients about an FAP suggest that the plain language summary of the FAP, the FAP application, along with the translated versions of such documents, must be printed. Hospitals are trending away from printed forms and have implemented paperless systems and methods of communicating with patients, including by having patients sign forms electronically. The shift to paperless forms reduces cost and increases efficiency for both hospitals and patients. **Accordingly, the Treasury should confirm that the plain language summary of the FAP, the FAP application and translated versions of these documents may be available and presented to patients in electronic format, unless the patient indicates that the patient lacks access to the Internet.**

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.

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
			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

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
			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.

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
			• 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.

Line on Original Schedule H	Explanation 501(r) Reference, if any Action Taken	Line on Revised Schedule H	Revised Instructions
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.