Highlights

1. The Definition of "Hospital" for "Who Must File" and the Definition of "Facility"

   - For purposes of Schedule H and Line 20 of Part IV of the Form 990, a "hospital" is defined as a facility that is, or is required to be, licensed or certified in its state as a hospital, regardless of whether operated directly by the organization or indirectly through a disregarded entity or joint venture taxed as a partnership. The organization should not include on its Schedule H information from a hospital operated by a separate tax-exempt or taxable corporation. In the case of group returns, the organization must report information on Schedule H from all hospital facilities operated by a member of the group.

   - If the organization operates multiple hospitals meeting this 'state-licensed' definition, it should only complete one Schedule H for all hospitals, with information aggregated as described below.

   - For purposes of Schedule H, Part V, a "facility" is defined to include a campus (or component thereof), building, structure, or other physical location or address at which the organization provides medical or hospital care, including a hospital, outpatient facility, surgery center, urgent care clinic, or rehabilitation facility, whether operated directly by the filing organization or indirectly through a disregarded entity or joint venture taxed as a partnership. The organization must separately list in Part V each facility to which any portion of the information reported on Schedule H is attributed.

2. Part I, Line 7: Charity Care and Certain Other Community Benefits at Cost

   - The Part I Table and related Worksheets do not require that grants restricted for community benefit activities be deducted from the grantee organization's gross community benefit expenses in determining its net community benefit expenses.

   - Any contributions made by the organization that were funded in whole or in part by a restricted grant from a related organization cannot be included in Part I, line 7i (see instructions to Worksheet 8 below).

   - The attached Worksheets are designed to help calculate amounts that need to be reported on the Table, and direct the filing organization where to enter those amounts on the Table. While the Worksheets are provided to assist the organization in completing the Schedule H, the organization may use alternative, equivalent documentation, provided that the organization follows the methodology for calculating community benefit described in these instructions (including the instructions to the Worksheets).

   - Organizations are to report costs under their most accurate costing methodology, whether that is the cost to charge ratio calculated in Worksheet 2, a different cost to charge ratio, a cost accounting system, a hybrid thereof, or some other method. Costs include direct and indirect costs, as described in the instructions.

   - Organizations are to report both gross and net community benefit expense. "Net community benefit expense" is the gross expense of the activity less direct offsetting

revenue. If the calculated amount is less than zero, report such amount in Column (e) as a negative number.

- "Percent of total expense" is based on net community benefit expense compared to the organization's total expenses, as reported on the Form 990, exclusive of bad debt,. The IRS requests comments regarding the calculation of total expenses to make certain the denominator includes the organization's share of total expenses of all joint ventures, so that the numerator and the denominator consistently treat items attributable to such joint ventures.

3. Joint Ventures

- The organization is to include 100% of the items of each disregarded entity of which it is the sole member, and its proportionate share of each joint venture taxed as a partnership, for purposes of Schedule H reporting. This applies, for example, to community benefit costs reported in Part I, community building costs reported in Part II, and bad debt and Medicare costs reported in Part III. Proportionate share is defined as the ending capital account percentage listed on the Form 1065 K-1, Part II, Line J for the partnership tax year ending in the organization's tax year that is being reported on the Form 990. If no K-1 is available, the organization may use its business records or a reasonable estimate such as the most recently available K-1, adjusted as necessary.

- In Part IV, reporting of joint ventures and management companies of which the organization is a partner or shareholder is required only if the organization's officers, directors, trustees, key employees, or physicians who have staff privileges with one or more of the organization's hospitals own in the aggregate more than 10% of the share of profits of such partnership or stock of such corporation.

4. Medicare, Bad Debt, and Other Items:

- The instructions clarify that for Parts I and III, HFMA Statement No. 15 is not required to be used by the filing organization to determine bad debt expense or charity care costs.

- The instructions clarify that bad debt expense is not to be reported in the Part I Table under any circumstances, and that Medicare may be reported in the Table only to the extent that Medicare revenues and expenses are related either to programs or activities that are reportable as subsidized health services on the Table (see instructions for Worksheet 6 below) or to Medicare GME that is reportable as health professions education (see instructions for Worksheet 5 below). All other Medicare must be reported in Part III.

- The instructions clarify that only revenues and expenses related to Medicare parts A and B may be reported in Part III.

- The IRS seeks comments on how filing organizations should report the cost of Medicaid and provider taxes (Worksheet 1, line 4) and revenue from uncompensated care pools or programs, including Medicaid Disproportionate Share Hospital ("DSH") funds (Worksheet 1, line 6), as costs and revenues associated with charity care (Worksheet 1) or with Medicaid and other means tested government programs (Worksheet 3). The Service is contemplating use of either a primary purpose requirement (the costs and

revenues would be reported on the worksheet that best reflects the primary purpose of those payments in the organization's home state—either to offset charity care or Medicaid) or a proportionality requirement (the costs and revenue must be split between Worksheets 1 and 3 according to how the organization's home state allocates DSH payments and other uncompensated care pool payments made to hospitals. The draft instructions adopt the primary purpose test.

- The IRS seeks comments on whether filing organizations should report data from foreign hospitals on Schedule H. The draft instructions do not require or permit the inclusion of foreign hospitals in Parts I, II, III, or V. Information from foreign joint ventures and partnerships *must* be included in Part IV. Information concerning foreign hospitals and facilities *may* be included in Part VI.

- The IRS requests comments on whether, and if so under what circumstances, subsidized health services should include any portion of costs to conduct a physician clinic or skilled nursing facility.

- The IRS seeks comments on whether any of the worksheets can be further simplified or streamlined. In particular, the IRS is interested in comments regarding the types and numbers of examples used to illustrate various types of community benefit and other activities.

2008 Schedule H (Form 990) Instructions
Hospitals

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

General Instructions

Purpose of Schedule

Schedule H is a new schedule and must be completed by an organization that operates at least one facility that is required to be or is licensed or certified in its state as a hospital. For 2008, every organization is required to complete Part V, *Facility Information*, and may complete the other Parts of the Schedule. For 2009, all Parts are required to be completed.

The organization must file a single Schedule H. This Schedule H should aggregate information from the following sources:

1. Hospitals directly operated by the organization.
2. Hospitals operated by disregarded entities for which the organization is the sole member.
3. Hospitals operated directly by members of a group exemption for which a group return is filed, and hospitals operated by a disregarded entity or entities for which a member of the group exemption is the sole member.
4. The organization or any of the entities described in 1 through 3, even if not provided by a hospital or provided separate from the hospital's license.
5. Hospitals operated by any joint venture taxed as a partnership to the extent of the organization's proportionate share of the joint venture. Proportionate share is defined as the ending capital account percentage listed on the Form 1065 K-1, Part II, Line J for the partnership tax year ending in the organization's tax year that is being reported on the organization's Form 990. If no K-1 is available, the organization may use its business records or a reasonable estimate such as the most recently available K-1, adjusted as necessary.
6. EXAMPLE: The organization is the sole member of a disregarded entity. The disregarded entity owns 50% of a joint venture taxed as a partnership. The partnership in turn owns 50% of another joint venture taxed as a partnership that operates a hospital and a freestanding outpatient clinic that is not part of the hospital's license. The organization would report 25% (50% of 50%) of the hospital's and outpatient clinic's aggregated information.

Note that while information from all of the above sources should be aggregated for purposes of Schedule H, each facility to which any portion or component of the information reported is attributable must be separately listed in Part V, *Facility Information*.

Who Must File

Any organization that answered "Yes" on Form 990, Part IV, *Checklist of Required Schedules,* line 20, must complete and attach Schedule H to Form 990.

For purposes of Schedule H, a "hospital" is a facility that is, or is required to be, licensed or certified as a hospital under state licensing or certification laws. This includes a hospital that is operated through a disregarded entity or a joint venture taxed as a partnership, but does not

include hospitals that are located outside the United States or are operated by a separate organization that is tax-exempt or treated as an association taxable as a corporation for federal tax purposes. If the organization operates multiple hospitals, or if it files a group return for a group that operates one or more hospitals, complete one Schedule H for all of the hospitals operated by the filing organization or the group, and report aggregate information from all such hospitals as described above.

If the organization is not required to file Form 990, it is not required to file Schedule H.

Specific Instructions

Part I – Charity Care and Certain Other Community Benefits at Cost (OPTIONAL FOR 2008)

Part I requires reporting of charity care policies, the availability of community benefit reports, and the cost of certain charity care and other community benefit programs. Worksheets and accompanying instructions are provided to assist in completing the line 7 table.

Line 1. A "charity care policy" is a policy describing how the organization will provide "charity care," which means free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are thereby deemed unable to pay for all or a portion of the services. "Charity care" does not include (i) bad debt or uncollectible charges that the hospital recorded as revenue but wrote off due to failure to pay by patients who did not qualify for charity care, or the cost of providing such care; (ii) the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom; or (iii) contractual adjustments with any third party payors.

Line 2. Check only one of the three boxes. "Applied uniformly to all hospitals" means that all of the organization's hospitals use the same charity care policy. "Applied uniformly to most hospitals" means that the majority of the organization's hospitals use the same charity care policy. "Generally tailored to individual hospitals" means that the majority of the organization's hospitals use different charity care policies. If the organization only operates one hospital, check "applied uniformly to all hospitals."

Line 3. Answer Lines 3a, 3b, and 3c based upon the charity care eligibility criteria that apply to the largest number of the organization's patients based on patient contacts or encounters. For example, if the organization has two hospitals, use the charity care eligibility criteria that are used by the hospital which has the most patient contacts during the taxable year.

Line 3a. "Federal Poverty Guidelines" (FPG) are the Federal Poverty Guidelines established by the U.S. Department of Health and Human Services. If the facility has established a family or household income threshold that a patient must meet or fall below to qualify for free medical care, check the box in the "Yes" column and indicate the specific threshold by checking the appropriate box. For instance, if a patient's family or household income must be less than 250% of FPG for the patient to qualify for free care, then check the box marked, "Other" and write in "250%."

Line 3b. If the facility has established a family or household income threshold that a patient must meet or fall below to qualify for discounted medical care, check the box in the "Yes" column and indicate the specific threshold by checking the appropriate box.

Line 3c. If applicable, describe the other income-based criteria, asset test, or other means test or threshold for free or discounted care in Part VI, Question 1 of this Schedule H. An "asset test" includes (i) a limit on the amount of total or liquid assets that a patient or the patient's family may own for the patient to qualify for free or discounted care, and/or (ii) a criterion for determining the level of discounted medical care patients may receive, depending on the amount of assets that they and/or their families own.

Line 4. "Medically indigent" means persons whom the organization has determined are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income and/or assets (*e.g.,* due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the generally applicable eligibility requirements for free or discounted care under the organization's charity care policy.

Line 5a. Answer "yes" if the organization establishes an annual or periodic budgeted amount of free or discounted care to be provided under its charity care policy. If "no" skip to line 6a.

Line 5b. Answer "yes" if the free or discounted care the organization provided in the applicable year exceeded the budgeted amount (of costs or charges) for that year. If "no" skip to line 6a.

Line 5c. Answer "yes" if the organization denied financial assistance to any patient eligible for free or discounted care under the charity care policy solely because the organization's charity care budget was exceeded.

Line 6a. Answer "yes" if the organization prepared an annual written report that describes the organization's programs and services that promote the health of the community or communities served by the organization. If the organization's community benefit report is contained in a report prepared by a related organization, answer "yes" and identify the related organization in Part VI. If "no" skip to line 7.

Line 6b. Some of the ways in which an organization can make its community benefit report available to the public are to post the report on the organization's website, to publish and distribute the report to the public by mail or at its facilities, or to submit the report to a state agency or other organization that makes the report available to the public.

Lines 7a-7k. Report the organization's charity care and certain other community benefits at cost in the Table (lines 7a-7k). To calculate the amounts to be reported in the Table, use the Worksheets below or other equivalent documentation that substantiates the information reported consistent with the methodology required in the Worksheets. If the organization includes information with respect to services provided by facilities other than the hospital, pursuant to the aggregation rule described above, it may complete separate Worksheets for each facility. The organization should aggregate all information from these Worksheets for purposes of reporting amounts in the Table. Note that only the portion of each joint venture or partnership that represents the organization's capital interest may be reported on Lines 7a-7k (see aggregation instruction above).

Use the organization's most accurate costing methodology (cost accounting system, cost to charge ratio, or other) to calculate the amounts reported in the Table. If the organization uses a cost to charge ratio, it may use *Worksheet 2, Ratio of Patient Care Cost to Charges*, for this purpose. See the instructions to Part VI, line 1, regarding an explanation of the costing methodology used to calculate the amounts reported in the Table.

Bad debt expense is not to be reported in the Table under any circumstances.

The following are descriptions of the type of information to be reported in each column of the table in Part I of Schedule H:

Column (a). "Number of activities or programs" means the number of the organization's activities or programs conducted during the year that involve the community benefit reported on the line. An activity or program must be reported on only one line so that it is not counted more than once. Reporting in this column is optional.

Column (b). "Persons served" means the number of patient contacts or encounters, in accordance with the filing organization's records. Persons served may be reported in multiple rows, as services across different categories may be provided to the same patient. Reporting in this column is optional.

Column (c). "Total community benefit expense" means the total gross expense of the activity incurred during the year, calculated by using the pertinent worksheets for each line item. "Total community benefit expense" includes both "direct costs" and "indirect costs". "Direct costs" means salaries and benefits, supplies, and other expenses directly related to the actual conduct of each activity or program. "Indirect costs" means facilities and administration costs related to the organization's infrastructure (*e.g.,* space, utilities, custodial services, security, information systems, administration, materials management, and others) that are shared by multiple activities or programs.

Column (d). "Direct offsetting revenue" means revenue from the activity during the year that offsets the total community benefit expense of that activity, as calculated on the worksheets for each line item. "Direct offsetting revenue" includes any revenue generated by the activity or program, such as reimbursement for services provided to program patients. Direct offsetting revenue does not include restricted or unrestricted grants or contributions that the organization uses to provide community benefit.

Column (e). "Net community benefit expense" -- for each line item this equals "Total community benefit expense" (column c) minus "Direct offsetting revenue" (column d). If the calculated amount is less than zero, report such amount as a negative number.

Column (f). "Percent of total expense" – for each line item divide the "net community benefit expense" in column (e) by the amount in Part IX, line 25(A), of the Form 990, or use the percentages from the applicable worksheets. Report the percentage to two decimal places (x.xx). Any bad debt included in the denominator should be removed prior to calculation, and an explanation of the amount of bad debt that was included in line 25(A) but removed from this figure should be provided in Part VI.

NOTE: Organizations that report amounts of direct offsetting revenue also might wish to report gross expenses (column d) as a percentage of total expenses. This percentage may not be reported in column (f), but may be described and reported in Part VI of Schedule H.

Worksheets for Part I, Line 7 ("Charity Care and Certain Other Community Benefits At Cost")

Worksheets 1 through 8 are intended to assist the organization in completing Schedule H, Part I, lines 7a-7k. Use of the Worksheets is not required, and they should not be filed with the Form 990. The organization may use alternative, equivalent documentation, provided that the methodology described in these instructions (including the instructions to the Worksheets) is followed. Regardless of whether the Worksheets or alternative, equivalent documentation is utilized to compile and report the required information, such documentation must be retained by the organization to substantiate the information reported on Schedule H. Each of the Worksheets is to be completed using the organization's most accurate costing methodology, which may include a cost accounting system, cost to charge ratios, or some other method.

If the organization is filing a group return or has a disregarded entity or an ownership interest in one or more joint ventures, the organization may find it helpful to complete the Worksheets for the organization and also separate Worksheets for each disregarded entity, group affiliate, and joint venture in which the organization participated during the filing period. Complete Schedule H, Part I, lines 7a-7k by aggregating (1) amounts from the organization's Worksheets, (2) amounts from the disregarded entity and/or group affiliate, and/or (3) amounts from the joint venture that are attributable to the organization's proportionate ownership interest in each joint venture, pursuant to the aggregation instructions above.

See below for Worksheets 1-8 and specific instructions to these Worksheets.

Part II -- Community Building Activities (OPTIONAL FOR 2008)

An organization that reports information in this section must describe, in Part VI, question 5, how its community building activities provide community benefit and promote the health of the communities it serves.

Line 1. "Physical improvements and housing" may include, but is not limited to, the provision or rehabilitation of housing for vulnerable populations, such as removing building materials that harm the health of the residents; neighborhood improvement or revitalization projects; provision of housing for vulnerable patients upon discharge from an inpatient facility; housing for low-income seniors; and the development or maintenance of parks and playgrounds to promote physical activity.

Line 2. "Economic development" may include, but is not limited to, assisting small business development in neighborhoods with vulnerable populations, and creating new employment opportunities in areas with high rates of joblessness.

Line 3. "Community support" may include, but is not limited to, child care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.

Line 4. "Environmental improvements" may include, but are not limited to, activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards.

Line 5. "Leadership development and training for community members" may include, but is not limited to, training in conflict resolution, civic, cultural or language skills, and medical interpreter skills for community residents.

Line 6. "Coalition building" may include, but is not limited to, participation in community coalitions and other collaborative efforts with the community to address health and safety issues.

Line 7. "Community health improvement advocacy" may include, but is not limited to, efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation.

Line 8. "Workforce development" may include, but is not limited to, recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved, collaboration with educational institutions to train and recruit health professionals needed in the community (other than the health professions education activities reported in Part I, Line 7f).

Line 9. "Other" refers to community building activities that protect or improve the community's health or safety that are not captured in the categories listed in Lines 1-8 above

Refer to the instructions to Part I, columns (a) through (f) for descriptions of the type of information that should be reported in each column of Part II:

Part III -- Bad Debt, Medicare, & Collection Practices (OPTIONAL FOR 2008)

Part III requires a hospital to report aggregate bad debt expense, at cost, provide an estimate of how much bad debt expense, if any, is attributable to persons who qualify for financial assistance under its charity care policy, and provide a rationale for what portion of bad debt it believes should constitute community benefit. In addition, the organization must report whether it has adopted Healthcare Financial Management Association ("HFMA") Statement No. 15, and provide the text of its footnote to its audited financial statements that describes bad debt expense.

Part III also requires reporting of aggregate Medicare reimbursements, and the aggregate allowable costs to deliver care reimbursed by Medicare, in order to report aggregate Medicare surpluses or shortfalls. In addition, the organization should describe what portion of its Medicare shortfall beyond any amounts permitted to be reported in Part I, if any, it believes should constitute community benefit, and explain its rationale for its position in Part VI.

Section A – Bad Debt Expense

Line 1. The HFMA "Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers" has not been adopted by the

AICPA, and the IRS does not require hospitals to adopt or rely on it. However, some hospitals rely on Statement 15 in reporting bad debt expense and charity care in their audited financial statements. Statement 15 provides instructions for recordkeeping, valuation, and disclosure for bad debts.

Line 2. Report bad debt expense at cost. If using a cost accounting system or other costing methodology, enter the estimated cost of patient care services attributable to charges written off to bad debt. If using a cost to charge ratio methodology, filers may use Worksheet A (optional). If only a portion of a patient's bill for services is written off as bad debt, include only the proportionate amount of the cost of providing those services that is attributable to bad debt.

Line 3. Provide an estimate of the amount of cost reported in Line 2 that reasonably could be attributable to patients who would likely qualify for financial assistance under the hospital's charity care policy as reported in Part I, lines 1-4, but for whom sufficient information was not obtained to make a determination of their eligibility. DO NOT INCLUDE THIS AMOUNT IN PART I, LINE 7. Organizations may use any reasonable methodology to estimate this amount, such as record reviews, an assessment of charity care applications that were denied due to incomplete documentation, analysis of demographics, or other analytical methods. If, in using that methodology, the organization determines that a patient would have been eligible for discounted care, but not free care, only include the costs of treating that patient less the amount of the discount.

Line 4. In Part VI, provide the rationale and the costing methodology used for calculating the amount reported in line 3 as community benefit. Also, provide the footnote from the organization's audited financial statements on bad debt expense, if applicable, or the footnotes related to "accounts receivable," "allowance for doubtful accounts" or similar designations. If the footnote or footnotes address only the filing organization's bad debt expense or "accounts receivable," "allowance for doubtful accounts," or similar designations, provide the footnote or footnotes verbatim. If the organization is a member of a group with consolidated financial statements, the organization may summarize that portion, if any, of the footnote or footnotes that apply to the organization.

Worksheet A (optional)
Estimated Bad Debt Expense (at Cost)

This worksheet may be used to estimate the bad debt expense reported in Part III, line 2 using one of the cost accounting methods identified in the organization's response to Part III, line 4.

1. Bad debt attributable to patient accounts **$**_____

2. Ratio of cost to charges (from worksheet 2 line 10) **$**_____

3. Estimated cost of bad debt attributable to patient accounts (line 1 X line 2) **$**_____

Enter value from Worksheet A, line 3 in Part III, line 2.

Section B – Medicare

Line 5. Enter all net patient service revenue from payments that the organization received or accrued for Medicare services performed during the year related to Medicare patients, except for revenue related to subsidized health services as reported in Part I, Line 7(g) (see Worksheet 6) and direct Graduate Medical Education ("GME") as reported in Part I, line 7(f) (see Worksheet 5). Include only revenue related to services provided under Medicare Part A (inpatient hospital services) and Medicare Part B (outpatient hospital, home health, and physician services).

Include all payments as reported including payments for IME, DSH, Outliers, Capital, Bad Debt, and any other amounts paid to the hospital on the basis of the Medicare Cost Report. In addition, for Part B, include revenues for employed and/or contracted physicians when such payments are billed and retained by the hospital.

Line 6. Enter all Medicare allowable costs associated with services to Medicare beneficiaries billed under Part A and Part B except those already reported in Part I, Line 7g (subsidized health services) and costs associated with direct GME that is already reported in Part I, Line 7f (health professions education). This can be determined using Worksheet B below. If worksheet B is not used, the organization still must subtract the costs attributable to subsidized health services and direct GME from the amount of Medicare allowable costs that it enters in line 6.

Line 7. Subtract the amount in line 6 from the amount in line 5. If the amount in line 6 exceeds the amount in line 5, report the excess amount (the shortfall) as a negative number.

Line 8. The information requested should be provided in Part VI. The organization must provide its rationale for treating the amount reported in Part III, line 7, or any portion of it, as community benefit. An organization's rationale must have a reasonable basis. DO NOT INCLUDE THIS AMOUNT IN PART I, LINE 7. Accordingly, do not include any amount of Medicare-related expenses or revenue properly reported in Part 1, line 7g (subsidized health services) or any amount of Medicare-related expanses or revenue reported in Part 1, line 7f (health professions education) in this Part III(B).

Worksheet B (optional)

1. Total Medicare allowable costs (from Medicare Cost Report) $_____

2. Total Medicare allowable costs (from line 1) included in Worksheet 6 (Subsidized Health Services), Line 3A $_____

3. Total Medicare allowable costs (from line 1) included in Worksheet 5 (Health Professions Education), line 8 (direct GME) $_____

4 Total adjustments to Medicare allowable costs (line 2 plus line 3) $_____

5. Total Medicare allowable costs (line 1 minus line 4) $_____

Enter value from Worksheet B, Line 5 in Part III, Line 6.

Section C – Collection Practices

Line 9a. Answer "yes" if the organization has a written debt collection policy on the collection of amounts owed by patients.

Line 9b. Answer "yes" if the organization's written debt collection policy contains provisions for collecting amounts due from patients, including those patients who likely would qualify under the organization's charity care or financial assistance policies. These include provisions such as procedures for internal review of accounts prior to initiating legal actions or prior to initiating or continuing a collection action undertaken by an outside agency.

Part IV -- Management Companies & Joint Ventures (OPTIONAL FOR 2008)

List any joint venture or other separate entity (whether taxed as a partnership or a corporation) of which the organization is a partner or shareholder, or any management company (1) for which current officers, directors, trustees, or key employees of the organization, and physicians who have staff privileges with one or more of the organization's hospitals, own in the aggregate more than 10% of the share of profits of such partnership or stock of such corporation, and (2) that either (a) provides management services used by the organization in its provision of medical care, or (b) provides medical care, or owns or provides real, tangible personal, or intangible property used by the organization or by others to provide medical care. Examples of such entities include an ancillary joint venture formed by the organization and its officers or physicians to conduct an exempt or unrelated business activity, a company owned by the organization's officers or physicians that owns and leases to the organization a hospital or other medical care facility, and a company that owns and leases to entities other than the organization diagnostic equipment or intellectual property used to provide medical care. Do not include publicly traded entities or entities whose sole income is passive investment income from interest or dividends.

For purposes of Part IV, the percentage share of profits or stock ownership percentage of officers, directors, trustees, key employees, and physicians who are employees practicing as physicians or who have staff privileges with one or more of the organization's hospitals are measured as of the close of the taxable year of the organization. All stock, whether common or preferred, is considered stock for purposes of determining the stock ownership percentage. Provide all the information requested in the table for each such entity.

Column (a). Name of Entity. State the full legal name of the entity.

Column (b). Description of primary activity of entity. Describe the primary business activity or activities conducted by the management company, joint venture or separate entity.

Column (c). Organization's profit % or stock ownership %. State the organization's percentage share of profits in the partnership or stock in the entity that is owned by the organization.

Column (d). Officers, directors, trustees, or key employees' profit % or stock ownership %. State the percentage share of profits or stock in the entity owned by all of the organization's current officers, directors, trustees, or key employees.

Column (e). Physician's Profit % or Stock Ownership %. State the percentage share of profits or stock in the entity owned by all physicians who are employees practicing as a physician or who have staff privileges with one or more of the organization's hospitals.

If a physician described above is also a current officer, director, trustee or key employee of the organization, include his or her profits or stock percentage in column (d) and omit it from column (e).

Part V -- Facility Information (REQUIRED FOR 2008)

Any facility whose information is reported or included elsewhere in Schedule H must be separately listed in Part V. A facility is defined for Part V to include a campus (or component thereof), building, structure, or other physical location or address at which the organization provides medical or hospital care, including a hospital, outpatient facility, surgery center, urgent care clinic, or rehabilitation facility, whether operated directly by the filing organization or indirectly through a disregarded entity or joint venture taxed as a partnership.

Provide the name and address of each facility operated directly by the organization, or indirectly through a disregarded entity or joint venture taxed as a partnership, in the left hand column of the chart in Part V. In the row for each facility, check all boxes that are applicable to that facility. More than one box may be checked for each facility.

“Licensed hospital” is a facility that is licensed or certified in its state as a hospital.

“General medical and surgical” refers to a hospital that is primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with a wide variety of medical conditions, and that may provide outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services for a variety of procedures, and pharmacy services.

“Children’s hospital” is a center for provision of health care to children, and includes independent acute care children’s hospitals, children’s hospitals within larger medical centers, and independent children’s specialty and rehabilitation hospitals.

“Teaching hospital” is a hospital that provides training to medical students, interns, residents, fellows, nurses, and/or other health professionals and providers, provided that such educational programs are accredited by the appropriate national accrediting body.

“Critical access hospital” (“CAH”) is a hospital that is designated as a CAH by a state that has established a State Medicare Rural Hospital Flexibility Program in accordance with Medicare rules.

“Research facility” is a facility that conducts research.

“Research” means any study or investigation that receives funding from a tax-exempt or governmental entity of which the goal is to generate generalizable knowledge that is made available to the public, such as about underlying biological mechanisms of health and disease, natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal).

"ER—24 hours" refers to a facility that operates an emergency room 24 hours a day, 365 days a year.

"ER—other" refers to a facility that operates an emergency room for periods other than 24 hours a day, 365 days a year.

Complete the "Other (Describe)" column for each type of facility (*e.g.,* outpatient clinic, long-term acute care facility) the organization owns or operates that is not described in the other columns of Part V.

Part VI -- Supplemental Information (OPTIONAL FOR 2008)

Question 1

Provide the description called for in Part I, line 3c. Specifically, describe the income based criteria for determining eligibility for free or discounted care under the organization's charity care policy. Also describe whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.

Provide the description called for in Part III, line 4. Specifically, provide the text of the footnote to the organization's financial statements that describes bad debt expense. Also, describe the costing methodology used in determining the amounts reported on lines 2 and 3 of Part III, and the organization's rationale and position regarding whether any portion of its bad debt expense should be regarded as community benefit.

Provide the description called for in Part III, line 8. Specifically, describe the extent to which any shortfall reported in Part III, line 7 should be treated as community benefit, and the rationale for your position (note that this may not include any amounts that were already included in Part I, line 7g under "subsidized health services" or Part I, line 7f under "health professions education").

If the organization has a written debt collection policy and answered 'Yes' to Part III, Line 9b, describe the collection practices set forth in the policy for patients who are known to qualify for financial assistance under the organization's charity care policy.

In addition, provide an explanation of the costing methodology used to calculate the amounts reported in the Table in Part I, line 7 ("Charity Care and Certain Other Community Benefits at Cost"). If a cost accounting system was utilized, indicate whether the cost accounting system addresses all patient segments (*e.g.,* inpatient, outpatient, emergency room, private insurance, Medicaid, Medicare, uninsured or self pay). Also, indicate whether a cost to charge ratio was used for any of the figures reported in the Table. If a combination of a cost accounting system and a cost to charge ratio was used, explain this combined method. Describe whether this cost to charge ratio was derived from the attached *Worksheet 2, Ratio of Patient Care Cost to Charges*, and, if not, what kind of cost to charge ratio was used and how it was derived. If a combination of a cost accounting system and a cost to charge ratio was used, explain this combined method. If some other costing methodology was utilized besides a cost accounting system, cost to charge ratio, or a combination of the two, describe the method used.

Question 2

Needs Assessment: Describe whether, and if so how, the organization assesses the health care needs of the community or communities it serves.

Question 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 charity care policy. For example, state whether the organization (1) posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of the organization's facilities in which eligible patients are likely to be present; (2) provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients as part of the intake process; (3) provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients with discharge materials; (4) includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; and/or (5) 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.

Question 4
Community Information: Describe the community or communities the organization serves, taking into account the geographic service area(s) (*e.g.,* urban, suburban, rural), the demographics of the community or communities (*e.g.,* population, average income, percentages of community residents with incomes below the federal poverty guideline, percentage of the hospital's and community's patients who are uninsured or Medicaid recipients), the number of other hospitals serving the community or communities, and whether one or more federally-designated medically underserved areas or populations are present in the community.

Question 5
Community Building Activities: Describe how the organization's community building activities, as reported in Part II, promote the health of the community or communities the organization serves.

Question 6
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 contractors of the organization, nor family members thereof;

- whether the organization extends medical staff privileges to all qualified physicians in its community for some or all of its departments; and

- whether and how the organization applies surplus funds to improvements in patient care, medical education, and research.

Question 7
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 that are under common governance or control, or that cooperate in providing health care services to their community or communities.

Question 8

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. For purposes of this question, a 'related organization' is related either as a parent, subsidiary, brother/sister (*i.e.,* controlled by the same person or persons that control the organization), or as a supporting or supported organization.

Worksheet 1: Charity Care at Cost (Part I, Line 7a)

"Charity care" – refer to instructions to Part I for the definition of charity care.

Line 1. Enter the amount of gross patient charges written off to charity care pursuant to the organization's charity care policies. "Gross patient charges" means the total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Line 3. Multiply line 1 by line 2, or enter estimated cost based on the organization's cost accounting. Organizations with a cost accounting system or a cost accounting method more accurate than the ratio of patient care cost to charges from Worksheet 2 may rely on that system or method to estimate charity care cost.

Line 4. Enter the amount of Medicaid or provider taxes paid by the organization, if payments received from an uncompensated care pool or Medicaid Disproportionate Share Hospital ("DSH") program in the organization's home state are intended primarily to offset the cost of charity care. If such payments are primarily intended to offset the cost of Medicaid services, then report this amount in Worksheet 3, line 4(A). "Medicaid or provider taxes" means amounts paid or transferred by the organization to one or more states as a mechanism to generate federal Medicaid DSH funds. In a majority of cases, the cost of the tax is promised back to organizations either through an increase in the Medicaid reimbursement rate or through direct appropriation.

Line 6. "Revenue from uncompensated care pools or programs" means payments received from a state, including Medicaid DSH funds, as direct offsetting revenue for charity care or to enhance Medicaid reimbursement rates for DSH providers. If such payments are primarily intended to offset the cost of Medicaid services, then report this amount in Worksheet 3, line 7(A).

Worksheet 2: Ratio of Patient Care Cost to Charges

Worksheet 2 may be used to calculate the organization's ratio of patient care cost to charges.

Line 1. Enter the organization's total operating expenses (excluding bad debt expense) from its most recent audited financial statement, Statement of Revenues and Expenses.

Line 2. Enter the cost of non-patient care activities. "Non-patient care activities" include health care operations that generate "other operating revenue" such as non-patient food sales, supplies sold to non-patients, and medical records abstracting. The cost of non-patient care

activities does not include any total community benefit expense reported on Worksheets 1 through 8.

If the organization is unable to establish the cost associated with non-patient care activities, the organization can use "other operating revenue" from its most recent audited financial statement as a proxy for these costs. This proxy assumes no markup exists for other operating revenue compared to the cost of non-patient care activities. Alternatively, if other operating revenue provides a markup compared to the cost of non-patient care activities, the organization can assume such a markup exists when completing line 2.

Line 3. Enter the amount of Medicaid or provider taxes paid by the organization that are included in line 1, so this expenditure is not double counted when the ratio of patient care cost to charges is applied.

Line 4. Enter the sum of the total community benefit expenses reported by the organization on Part I, Question 7, column (c), rows e, f, h, and i, so that these expenses are not double counted when the ratio of patient care cost to charges is applied.

Also include in line 4 the total community benefit expense reported on Part I, Question 7, column (c), rows a, b, c, and g, if the organization has not relied on the ratio of patient care cost to charges from this Worksheet to determine these expenses, but rather has relied on a cost accounting system or other cost accounting method to estimate costs of charity care, Medicaid or other means-tested government programs, or subsidized health services.

Line 8. Enter the amount of gross patient charges for any community benefit activities or programs for which the organization has not relied on the ratio of patient care cost to charges from this Worksheet to determine these expenses. For example, if the organization uses a cost accounting system or another cost accounting method to estimate total community benefit expense for Medicaid or any other means tested government programs, enter gross charges for those programs in Line 8.

Worksheet 3: Unreimbursed Medicaid and Other Means Tested Government Programs (Part I, lines 7b and 7c)

Use Worksheet 3 to report the net cost of Medicaid and other means tested government programs. A "means tested government program" is a program for which eligibility depends on the recipient's income and/or asset level.

"Medicaid" means the United States health program for individuals and families with low incomes and resources. "Other Means Tested Government Programs" means government-sponsored health programs where eligibility for benefits or coverage is determined by income and/or assets. Examples include:

- The State Children's Health Insurance Program (SCHIP), a United States federal government program that gives funds to states in order to provide health insurance to families with children; and

- Other federal, state, or local health care programs.

Line 1, column (A). Enter the amount of gross patient charges for Medicaid services. Include gross patient charges for all Medicaid recipients, including those enrolled in managed care

plans. In certain states, SCHIP functions as an expansion of the Medicaid program, and reimbursements from SCHIP are not distinguishable from regular Medicaid reimbursements. Hospitals that cannot distinguish their SCHIP reimbursements from their Medicaid reimbursements may report SCHIP charges, costs and offsetting revenue under column A.

Line 1, column (B). Enter the amount of gross patient charges for other means tested public programs.

Line 3, column (A). Enter the estimated cost for Medicaid services. Multiply line 1, column (A) by line 2, column (A), or enter estimated cost based on the organization's cost accounting. Organizations with a cost accounting system or a cost accounting method more accurate than the ratio of patient care cost to charges from Worksheet 2 may rely on that system or method to estimate the cost of Medicaid services.

Line 3, column (B). Enter the estimated cost for services provided to patients who receive health benefits from other means tested public programs.

Line 4, column (A). Enter the amount of Medicaid or provider taxes paid by the organization, if payments received from an uncompensated care pool or Medicaid DSH program in the organization's home state are intended primarily to offset the cost of Medicaid services. If such payments are primarily intended to offset the cost of charity care, then report this amount in Worksheet 1, line 4.

Line 6, column (A). Enter all costs associated with Medicare direct GME that are already reported in Part I, Line 7f (health professions education).

Line 8, column (A). Enter the amount of "Net patient service revenue" for Medicaid services, including revenue associated with Medicaid recipients enrolled in managed care plans. Do not include Medicaid reimbursement for *direct* Graduate Medical Education (GME) costs, which should be reported on Worksheet 5, line 9. Include Medicaid reimbursement for *indirect* GME costs, including the indirect (IME) portion of children's health GME (the direct portion of children's health GME should be reported on line 10 of Worksheet 5). "Net patient service revenue" means payments expected to be received from patients or third-party payers for patient services performed during the year.

Amounts received from the Medicaid program as "reimbursement for direct GME" or "indirect medical education reimbursement" (IME) should be considered as either direct GME or IME consistent with the way the Medicaid program in the hospital's home state classifies the funds.

Line 9, column (A). Enter revenue received from uncompensated care pools or programs if payments received from an uncompensated care pool or Medicaid DSH program in the organization's home state are intended primarily to offset the cost of Medicaid services. If such payments are primarily intended to offset the cost of charity care, then report this amount in Worksheet 1, line 6.

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

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

"Community health improvement services" means activities or programs carried out or supported for the express purpose of improving community health that are subsidized by the health care organization. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services.

"Community benefit operations" means activities associated with community health needs assessments as well as community benefit planning and administration. Community benefit operations also include the organization's activities associated with fund raising or grant-writing for community benefit programs.

Activities or programs may not be reported if they are provided primarily for marketing purposes and the program is more beneficial to the organization than to the community; for instance, if the activity or program is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization.

To be reported, community need for the activity or program must be established. Community need may be demonstrated through:

- A community needs assessment developed or accessed by the organization,
- Documentation that demonstrated community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program, or
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program.

Community benefit activities or programs also seek to achieve objectives, including: improving access to health services, enhancing public health, advancing generalizable knowledge, and relief of government burden. This includes activities or programs that:

- Are available broadly to the public and serve low-income consumers,
- Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (*e.g.*, longer wait times or increased travel distances),
- Address federal, state or local public health priorities (such as eliminating disparities in health care among different populations),
- Leverage or enhance public health department activities (such as childhood immunization efforts),
- Otherwise would become the responsibility of government or another tax-exempt organization, or
- Advance generalizable knowledge through education or research that benefits the public.

Line 1, rows a through j, column (A). Enter the name of each reported community health improvement activity or program and total community benefit expense for each. Include both direct costs and indirect costs in total community benefit expense. Use additional worksheets if the organization reports more than 10 community health improvement activities or programs.

Line 3, rows a through d, column (A). Enter the name of each reported community benefit operations activity or program and total community benefit expense for each. Include both

direct costs and indirect costs in total community benefit expense. Use additional worksheets if the organization reports more than four community benefit operations activities or programs.

Report total community benefit expense, direct offsetting revenue, and net community benefit expense for each line item.

Worksheet 5: Health Professions Education (Part I, line 7f)

Use Worksheet 5 to report the net cost of health professions education.

"Health professions education" means educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law; or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education or training programs available only to the organization's employees and medical staff or scholarships provided to those individuals. If education and training is not restricted to the organization's employees and medical staff, use a reasonable allocation to report only the expenses related to providing the education or training to persons who are not employees of the organization or not on the organization's medical staff.

Examples of health professions education activities or programs that should and should not be reported are as follows.

Activity or Program	Report	Example Rationale
Scholarships for community members	Yes	More benefit to community than organization
Scholarships for staff members	No	More benefit to organization than community
Continuing medical education for community physicians	Yes but only to the extent provided to doctors not on the hospital's own medical staff	Accessible to all qualified physicians
Continuing medical education for own medical staff	No	Restricted to own medical staff members
Nurse education if graduates are free to seek employment at any organization	Yes	More benefit to community than organization
Nurse education if graduates are required to become the organization's employees	No	Program designed primarily to benefit the organization

Line 1 through line 6. Include both direct and indirect costs.

Direct costs of health professions education include:

- Stipends, fringe benefits of interns, residents, and fellows in accredited graduate medical education programs; salaries and fringe benefits of faculty directly related to intern and resident education

- Salaries and fringe benefits of faculty directly related to teaching of medical students

- Salaries and fringe benefits of faculty directly related to teaching of students enrolled in nursing programs that are licensed by state law or, if licensing is not required, accredited by the recognized national professional organization for the particular activity.

- Salaries and fringe benefits of faculty directly related to teaching of students enrolled in allied health professions education programs, that are licensed by state law or, if licensing is not required, accredited by the recognized national professional organization for the particular activity, including, but not limited to programs in pharmacy, occupational therapy, dietetics, and pastoral care.

- For continuing health professions education open to all qualified individuals in the community, the salaries and fringe benefits of faculty for teaching continuing health professions education, including payment for development of on-line or other computer-based training that is accepted as continuing health professions education by the relevant professional organization

- Grants made by the hospital to support health professions education programs run by other tax-exempt entities

- Scholarships provided by the organization to community members

Direct costs of health professions education do not include costs related to Ph.D. students and post-doctoral students, which are to be reported on *Worksheet 7, Research*.

Line 8. Enter Medicare reimbursement for direct GME, including reimbursement for approved nursing and allied health education activities. For a children's hospital that receives Children's GME payments from HRSA, count that portion of the payment that is equivalent to Medicare direct GME. Do not include indirect GME reimbursement provided by Medicare.

Line 9. Enter Medicaid reimbursement for direct GME, including only that portion of Medicaid GME payment that is equivalent to Medicare GME. Do not include indirect GME reimbursement provided by Medicaid, which is to be reported on *Worksheet 3: Unreimbursed Medicaid and Other Means Tested Government Programs*.

Line 10. Enter the direct portion of Children's Hospital GME revenue (CHGME). CHEGME revenue includes both a direct and an indirect component. The indirect component should be reported on Worksheet 3, line 6.

Line 11. Enter revenue received for continuing health professions education reimbursement or tuition.

Worksheet 6: Subsidized Health Services (Part I, line 7g)

Use Worksheet 6 to report the net cost of subsidized health services. Complete Worksheet 6 for each subsidized health service and report on Part I the total amount for all subsidized health services combined.

"Subsidized health services" means clinical services provided despite a financial loss to the organization. The financial loss is measured after removing losses, measured by cost,

associated with bad debt, charity care, Medicaid and other means tested government programs. Losses attributable to these items are not included when determining which clinical services are subsidized health services because they are reported as community benefit elsewhere in Part I or as bad debt in Part III. Losses attributable to these items are also excluded when measuring the losses generated by the subsidized health services. In addition, in order to qualify as a subsidized health service, the organization must provide the service because it meets an identified community need. If the organization no longer offered the service, it would be unavailable in the community, the community's capacity to provide the service would be below the community's need, or the service would become the responsibility of government or another tax-exempt organization.

Subsidized health services generally include qualifying inpatient programs (such as neonatal intensive care, addiction recovery and inpatient psychiatric units) and ambulatory programs (such as emergency services, satellite clinics designed to serve low-income communities, and home health programs). Subsidized health services generally exclude ancillary services (that support inpatient and ambulatory programs) such as anesthesiology, radiology, laboratory departments , physician clinic services, and skilled nursing facility services.

Line 3, column (A), column (B), column (C), and column (D). Enter the estimated cost for each subsidized health service. For column B, enter bad debt amounts attributable to the subsidized health service measured by cost. For column C, enter amounts attributable to the subsidized health service for patients who are recipients of Medicaid and other means tested government programs measured by cost. For column D, enter charity care amounts attributable to the subsidized health service measured by cost. Multiply line 1 by line 2 or enter estimated cost based on the organization's cost accounting. Organizations with a cost accounting system or a cost accounting method more accurate than the ratio of patient care cost to charges from Worksheet 2 may rely on that system or method to estimate the cost of each subsidized health service.

Worksheet 7: Research (Part I, line 7h)

Use Worksheet 7 to report the net cost of research.

"Research" means any study or investigation that receives funding from a tax-exempt or governmental entity of which the goal is to generate generalizable knowledge that is made available to the public, such as about underlying biological mechanisms of health and disease, natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal).

Examples of costs of research include, but are not limited to: Salaries and benefits of researchers and staff (including stipends for research trainees: either Ph.D. candidates or fellows); Facilities (including research, data, and sample collection and storage; animal facilities); Equipment; Supplies; Tests conducted for research rather than patient care; Statistical and computer support; Compliance (*e.g.,* accreditation for human subjects protection; biosafety; HIPAA); and dissemination of research results.

Line 1. For Worksheet 7, organizations should define “direct costs” pursuant to guidelines and definitions published by the National Institutes of Health. Count only direct costs of research funded by a tax-exempt or governmental entity.

Line 2. For Worksheet 7, organizations should define “indirect costs” pursuant to guidelines and definitions published by the National Institutes of Health.

Worksheet 8: Cash and In-Kind Contributions to Community Groups (Part I, line 7i)

Use Worksheet 8 to report cash contributions and the cost of in-kind contributions. Do not include any contributions that were funded in whole or in part by a restricted grant, to the extent that such grant was funded by a related organization. For purposes of this question, a 'related organization' is related either as a parent, subsidiary, brother/sister (*i.e.*, controlled by the same person or persons that control the organization), or as a supporting or supported organization.

“Cash and in-kind contributions” means contributions made by the organization to health care organizations and other community groups that are restricted to one or more of the community benefit activities described in the Table in Part I, line 7 (or the Worksheets thereto). “In-kind contributions” include the cost of hours donated by staff to the community while on the organization’s payroll, indirect cost of space donated to tax-exempt community groups (such as for meetings), and the financial value (generally measured at cost) of donated food, equipment, and supplies.

Report cash contributions and grants made by the organization to entities and community groups that share the organization’s goals and mission. Do not report (a) cash or in-kind contributions contributed by employees, or emergency funds provided by the organization to the organization’s employees; (b) loans, advances, or contributions to the capital of another organization; or (c) unrestricted grants or gifts to another organization that may, at the discretion of the grantee organization, be used other than to provide the type of community benefit described in the Table in Part 1, line 7.