Community Benefit Under Heightened Scrutiny:

Advanced Reporting, § 501(r) Compliance, and Risk Management Strategies for Tax-Exempt Hospitals

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Learning Objectives & Agenda

Learning Objectives

- Identify how Schedule H, CHNAs, FAPs, and implementation strategies are being evaluated by regulators and stakeholders;
- Assess how Missouri hospitals compare on selected community benefit and uncompensated care measures; and
- Recognize practical steps to strengthen documentation, reporting consistency, and readiness for IRS or stakeholder review.

Agenda

1. Tax-exempt hospital framework
2. Ongoing scrutiny of charitable hospitals; federal and state proposed legislation
3. Schedule H community benefit reporting and Missouri benchmarking
4. ACA §9007, §501(r), and mandatory IRS reviews
5. CHNA and implementation-strategy readiness
6. FAP, AGB, billing, and collection readiness

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Presenters

Brian Todd

Partner

Brian is a tax specialist in the Healthcare Practice. He joined Forvis Mazars in 1999 and has experience providing tax services to both for-profit and nonprofit healthcare organizations. He regularly assists hospitals, senior living organizations, home health agencies, CHCs, colleges and universities, and other nonprofit agencies with navigating complex tax issues. He consults with nonprofit organizations on unrelated business income issues, Section 501(r) compliance, fringe benefit reporting, exemption applications, and alternative investment reporting. He has represented both for-profit and nonprofit organizations in IRS examinations and assisted both with joint venture tax considerations.

Garrett Gluth

Managing Director

Garrett Gluth is an Attorney, CPA, and former IRS Senior Executive with 20 years of legal, tax, financial, and regulatory experience. He drafted and reviewed statutory text that became ACA § 9007, which added §501(r) to the Internal Revenue Code and created mandatory recurring IRS reviews of tax-exempt hospitals. While at the IRS, he worked on publicly released tax-exempt hospital guidance, Form 990/Schedule H revisions and instructions, and tax-exempt hospital training and implementation efforts. His comments today are based on public law, regulations, IRS guidance, publicly available IRS procedures, published oversight reports, and professional experience.

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Tax-Exempt Hospital Framework

Key point: tax-exempt hospital compliance is both an exemption issue and an ongoing operational/documentation issue.

IRC § 501(c)(3) baseline: organized and operated for charitable purposes, with no private inurement or impermissible private benefit.

Promotion of health: nonprofit hospitals may qualify as charitable organizations when they operate to promote health for the benefit of the community.

Community benefit standard: hospital exemption is evaluated under a facts-and-circumstances framework focused on whether the hospital benefits the community.

IRC § 501(r) overlay: ACA § 9007 added hospital facility-level requirements for CHNAs, financial assistance, limitation on charges, and billing/collection practices.

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Promotion of Health - Community Benefit Standard (1969 -)

Readiness point: There is no federal minimum percentage required for a nonprofit hospital's community benefit spending. However, hospitals are well-served to adopt a reporting strategy.

Rev. Rul. 69-545 moved hospital exemption from a charity-care-focused standard to a broader community-benefit framework. Relevant factors may include:

- Operating an ER open to all, regardless of ability to pay;
- Community board;
- Open medical staff;
- Providing hospital care for all patients able to pay, including Medicaid and Medicare; and
- Using surplus funds to improve care, facilities, training, education, and research.

No single factor controls—the IRS evaluates all relevant facts and circumstances.

Why it matters: ACA § 9007 added on top of this framework.

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Section 501(r) - Additional Requirements for Charitable Hospitals

- **IRC § 501(r) added requirements that apply on a facility-by-facility basis:**
  - Community Health Needs Assessment (CHNA) – IRC § 501(r)(3),
  - Financial Assistance Policy and Emergency Medical Care Policy – IRC § 501(r)(4),
  - Limitation on Charges – IRC § 501(r)(5), and
  - Billing and Collections – IRC § 501(r)(6).
- A hospital organization reports related policies, practices, and community benefit information on **Form 990, Schedule H.**

Why it matters: A failure at one hospital facility can have facility-level tax consequences and, in significant cases, may put the organization's federal tax exemption at risk.

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Ongoing Scrutiny of Charitable Hospitals

Tax-exempt hospitals face scrutiny from multiple directions:

- **IRS:** mandatory ACA reviews, tax-exempt hospital examinations, and data-driven compliance priorities.
- **Congress:** hearings and correspondence focused on community benefit, charity care, and financial assistance.
- **Public reports:** TIGTA, CRS, GAO, Lown, and academic studies questioning transparency and consistency in community-benefit reporting.
- **State lawmakers:** expanding financial-assistance, billing, collection, and nonprofit-accountability requirements.

Readiness point: IRC § 501(r) compliance, Schedule H reporting, and state-law obligations should be reviewed together — not in silos.

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Proposed Federal Legislation: Continued Focus on § 501(r)

The Holding Nonprofit Hospitals Accountable Act (H.R. 3019, 2025), would amend IRC § 501(r) to establish more specific community-benefit standards for tax-exempt hospital organizations.

The proposal would generally require hospitals to spend an amount tied to the value of their tax exemptions on qualifying activities, including:

- training, education, or research designed to improve patient care;
- certain facility and equipment improvements; and
- free or discounted care under a financial assistance policy.

Status: Proposed legislation; not current law.

Key point: Regardless of whether the bill advances, it reflects continued federal attention on whether tax-exempt hospitals can demonstrate measurable community benefit, charity care, financial assistance, and transparency.

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Proposed Federal Legislation: Continued Focus on § 501(r)

The Tax Exempt Hospital Transparency Act (H.R. 9504), introduced June 29, 2026, would add new IRC § 6033A and create a hospital-specific reporting regime that builds on and expands the existing § 501(r) framework and Form 990 Schedule H.

The proposal would require tax-exempt hospital organizations to provide significantly more granular reporting, including:

- Community Health Needs Assessment (CHNA) implementation details (§ 501(r)(3));
- Financial assistance applications received, granted, and denied;
- Financial assistance provided at cost under the FAP (§ 501(r)(4));
- Facility-level reporting (for multi-hospital systems);
- Health-service-line revenue and costs (using a new standardized federal taxonomy);
- Advertising costs; and
- 340B program information (for applicable organizations).

Additional enhanced reporting would apply to “large tax-exempt hospital organizations” and “high revenue tax-exempt hospital organizations.”

Status: Referred to the House Committee on Ways and Means and subsequently advanced on July 1, 2026

Key point: H.R. 9504, together with H.R. 3019, reflects continued congressional focus on tax-exempt hospital transparency, community benefit measurement, financial assistance reporting, and facility-level accountability. Hospitals should assess whether their current data systems, CHNA tracking, financial assistance processes, service-line accounting, and 340B controls can support this expanded reporting.

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State Law Overlay: States Are Building on IRC § 501(r)

Readiness point: As a best practice, § 501(r) compliance should not be treated as a standalone federal tax exercise; it is increasingly part of broader federal/state hospital accountability.

IRC § 501(r) is increasingly serving as a baseline for state hospital financial-assistance, billing, collection, and accountability requirements.

- **Some states expressly incorporate IRC § 501(r) concepts** into state financial-assistance or billing/collection laws.
- **States are adding more specific operational requirements**, such as presumptive eligibility screening, uniform applications, expanded eligibility thresholds, refund rules, debt-sale restrictions, credit-reporting limits, lawsuit restrictions, and interest caps.
- **Requirements can vary significantly by state** (and may apply more broadly).
- **Operational impact:** multistate systems may need to align IRC § 501(r), state-law requirements, FAPs, billing/collection workflows, vendor contracts, patient communications, and Schedule H reporting.

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Schedule H Community Benefit Reporting

Form 990, Schedule H, Part I, Line 7

7 Financial Assistance and Certain Other Community Benefits at Cost

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

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What Goes into IRS Form 990, Schedule H, Line 7?

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance & Means-Tested Programs

Schedule H, Part I — Lines 7a–7d

Financial Assistance at Cost

Free/discounted care under the FAP

Medicaid

Cost less revenue received

Costs of Other Means-Tested Government Programs

Unreimbursed cost, non-Medicaid

Other Community Benefits

Schedule H, Part I — Lines 7e–7i

Community Health Improvement Services and Community Benefit Operations

Consolidates two primary categories of community benefit.

Health Professions Education

Training current & future providers

Subsidized Health Services

Needed services operating at a loss

Research

Studies to generate medical knowledge

Cash and In-Kind Contributions for Community Benefit

Gifts & grants for community benefit

Line 7d (Financial Assistance & Means-Tested Programs) + Line 7j (Other Benefits) = Line 7k, Total Community Benefit

Source: 2025 Instructions for Schedule H (Form 990), Part I, Line 7

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Line 7a, Financial Assistance at Cost

✓ What's Reported

- **Gross patient charges** written off under the organization's FAP, converted to cost using the most accurate costing methodology.
- Medicaid provider taxes, fees, and assessments — **only the portion reasonably allocable to financial assistance**
- **Direct offsetting revenue:** payments from uncompensated care pools or programs intended primarily to offset financial assistance, plus restricted grants used to fund financial assistance.

✗ What NOT to Report

- **Bad debt** or uncollectible charges written off due to a patient's failure to pay.
- **Shortfalls on Medicaid**, other means-tested programs, or Medicare.
- **Self-pay/prompt-pay discounts** or contractual adjustments with any third-party payer.
- **Unrestricted grants** or contributions the organization chooses to apply toward financial assistance — only grantor-restricted funds offset.

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Line 7a, Financial Assistance at Cost

Commonly Underreported/Potential Opportunities

- **Full entity and facility coverage**. Cover every FAP location — EDs, urgent care, clinics — plus disregarded entities and joint-venture shares, not just the main hospital.
- **Presumptive eligibility**. Non-applying FAP-eligible patients get booked as bad debt, off Line 7a. Add presumptive determinations to the FAP and screen to recover them.
- **Costing granularity**. A blended cost-to-charge ratio understates high-acuity units (ED, ICU). Use department-level ratios or true cost accounting for a defensible figure.

Commonly Misclassified

- State pool / UPL / DSH allocation. Revenue meant to offset FA belongs on Line 7a, not defaulted to Medicaid (7b). The 7d subtotal is unchanged; accuracy and audit defensibility improve.
- Restricted grants for FA. Grantor-restricted funds belong in offsetting revenue (column (d)); omitting them overstates net benefit expense (column (e)).

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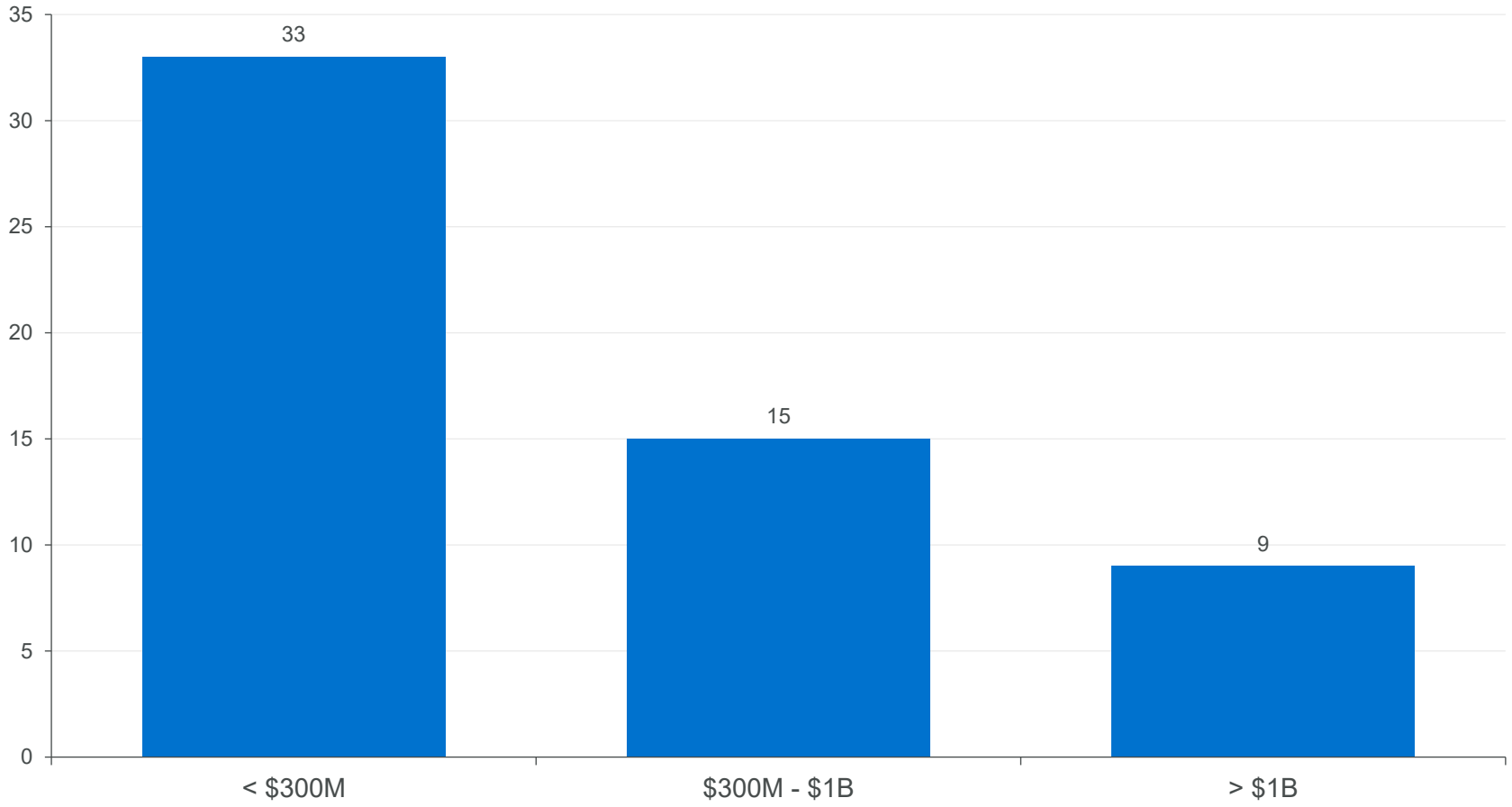
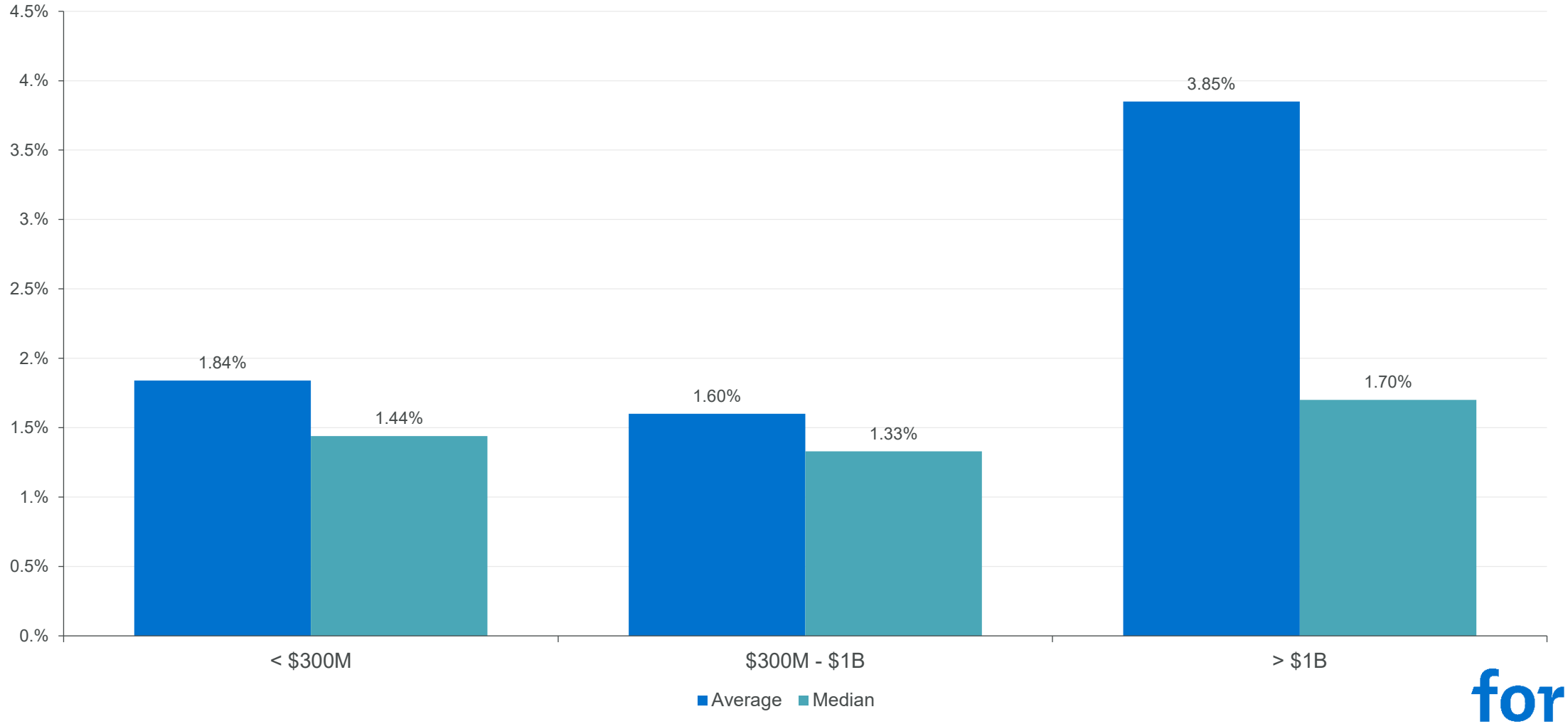
Benchmarking Overview

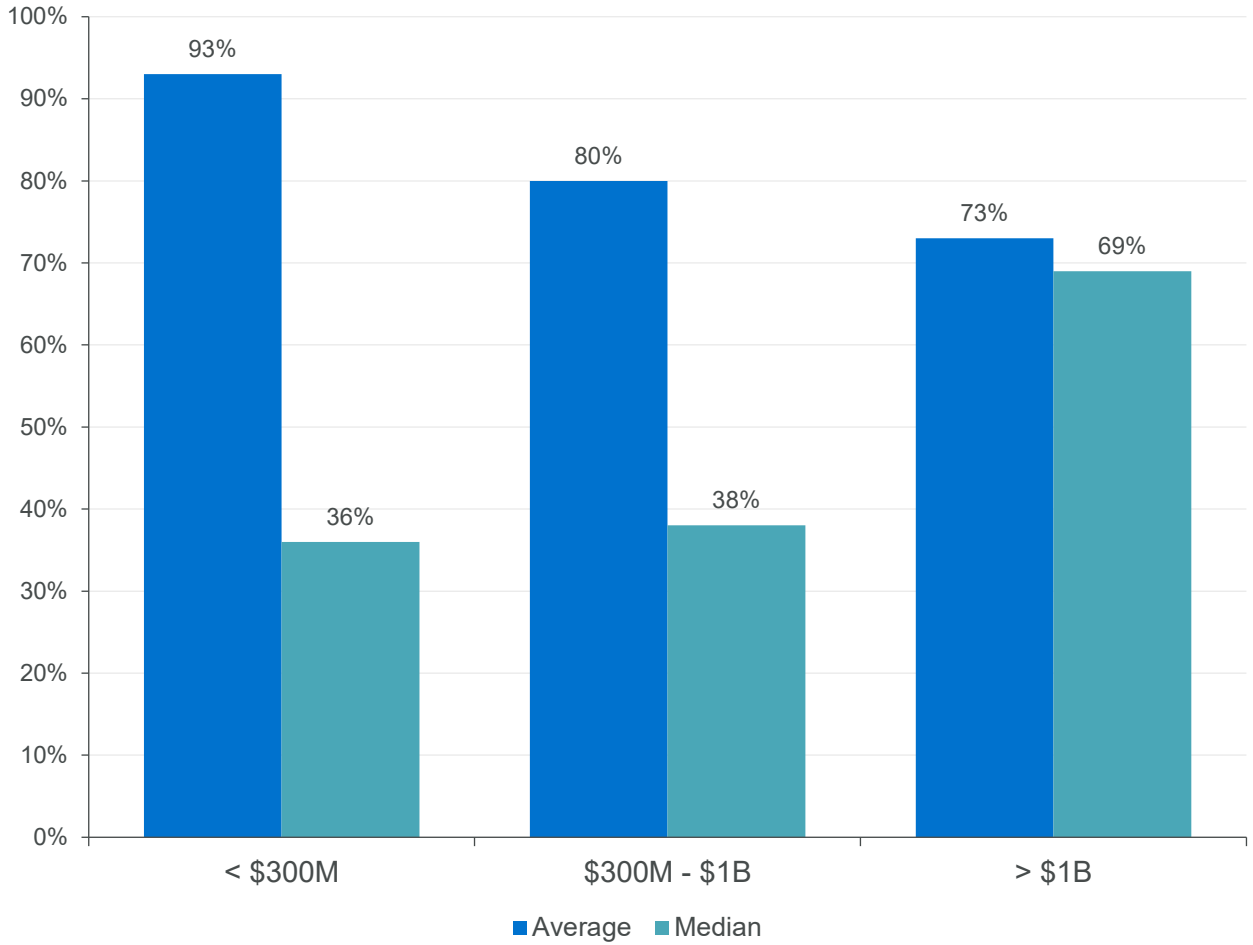
57 Missouri hospitals · CauseIQ data from most recently filed Form 990s (a range of year-ends, most commonly 2024).



Schedule H, Part I, Line 7a – Financial Assistance



Schedule H, Part III, Section A – Bad Debt vs Charity Care



Percentage = charity care ÷ bad debt.

An informal indicator of:

- How much uncompensated care is proactively classified as charity care versus ending up as bad debt.
- Whether there is room to improve FAP screening, presumptive charity determinations, or financial counseling before accounts become uncollectible.

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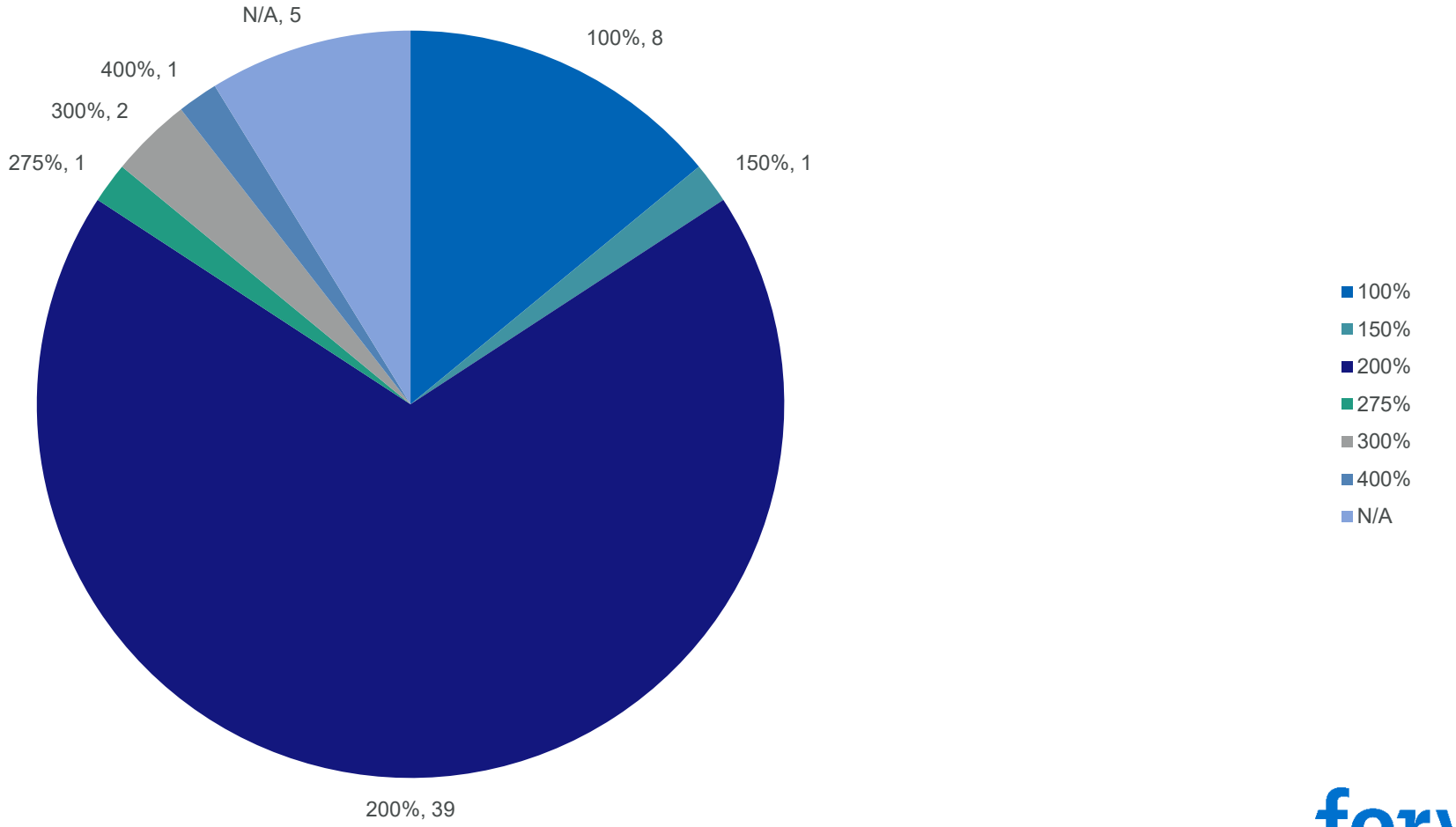
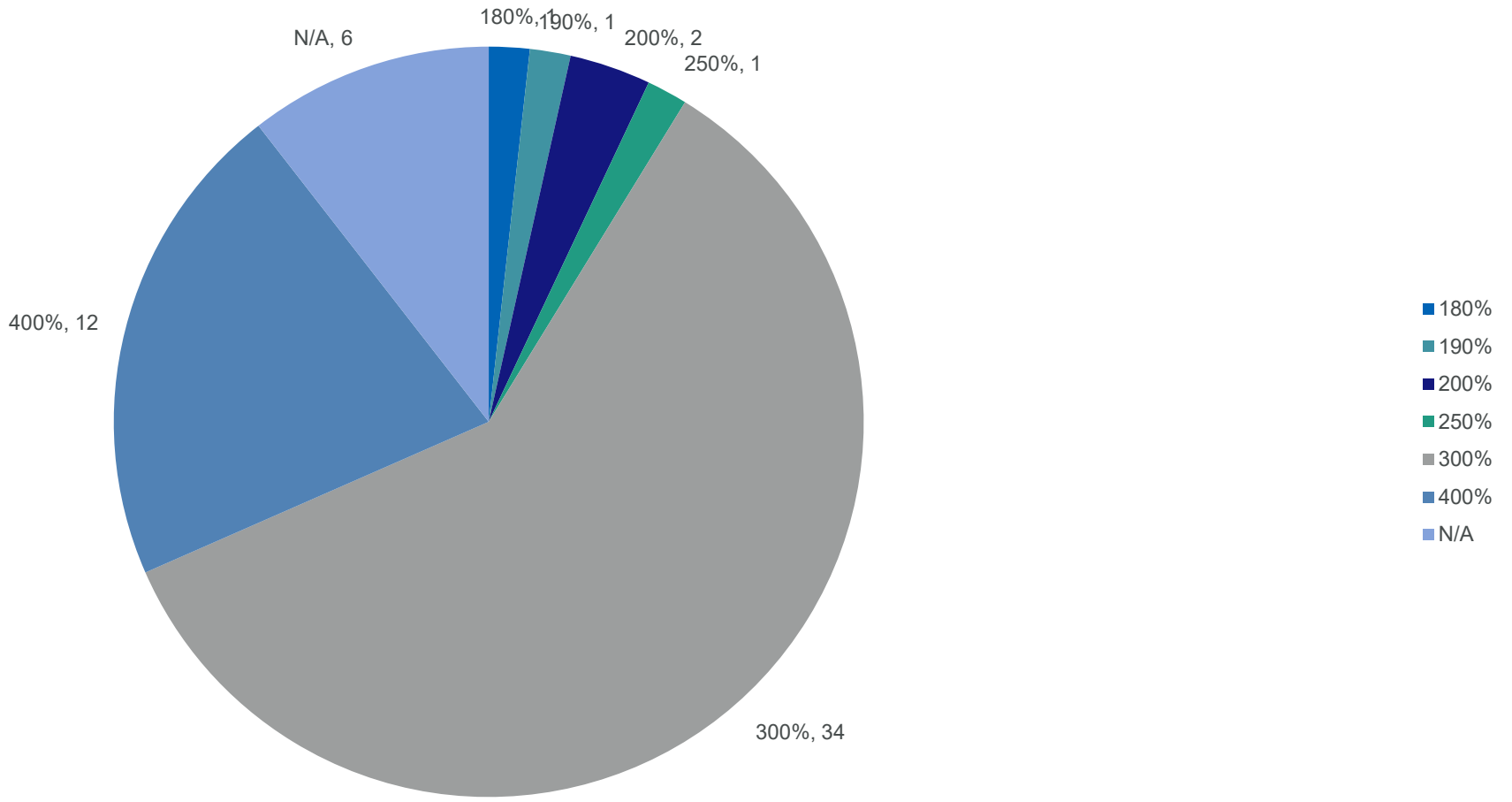
Schedule H, Part I, Line 3a – Free Care FPG (All MO Hospitals)



Schedule H, Part I, Line 3a – Discounted Care FPG (All MO Hospitals)



Line 7b, Medicaid, and Line 7c, Costs of Other Means-tested Government Programs

✓ What's Reported

- **Medicaid (7b) & other means-tested programs (7c)** — e.g., CHIP, income/asset-based programs; converted to cost like 7a, revenue at actual.
- **Net Medicaid patient revenue** — managed care Medicaid, DSH, UPL, and indirect GME (IME); excludes direct GME reimbursement (goes to 7f).
- **Medicaid-allocable provider taxes, fees, assessments** (FA-allocable portion goes to 7a).
- **All states** where the organization operates, not just the home state.

✗ What NOT to Report

- **Direct GME** costs or Medicaid reimbursement (Worksheet 5 / Line 7f).
- **Costs or revenue already in other Line 7 categories** — subsidized health, community health improvement, research; avoid double-counting.
- **Medicare shortfalls** or Medicare patients (Part III, Section B).

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Line 7b, Medicaid, and Line 7c, Costs of Other Means-tested Government Programs

Commonly Underreported/Potential Opportunities

- **Provider taxes and assessments**. Book the Medicaid-allocable portion as 7b cost — often the largest single omission.
- **Managed Medicaid**. Capture below-cost managed Medicaid volume — it materially raises 7b cost and net benefit.
- **Multi-state activity.** Report all states, not just the home state, where programs pay below cost.

Commonly Misclassified

- Indirect GME (IME) revenue. IME stays on 7b; only direct GME moves to 7f. Misrouting shifts the 7d/7j split and weakens defensibility.
- DSH / UPL / pool revenue allocation. The state's FA-offset portion belongs on 7a, not 7b; defaulting all to 7b misstates both.

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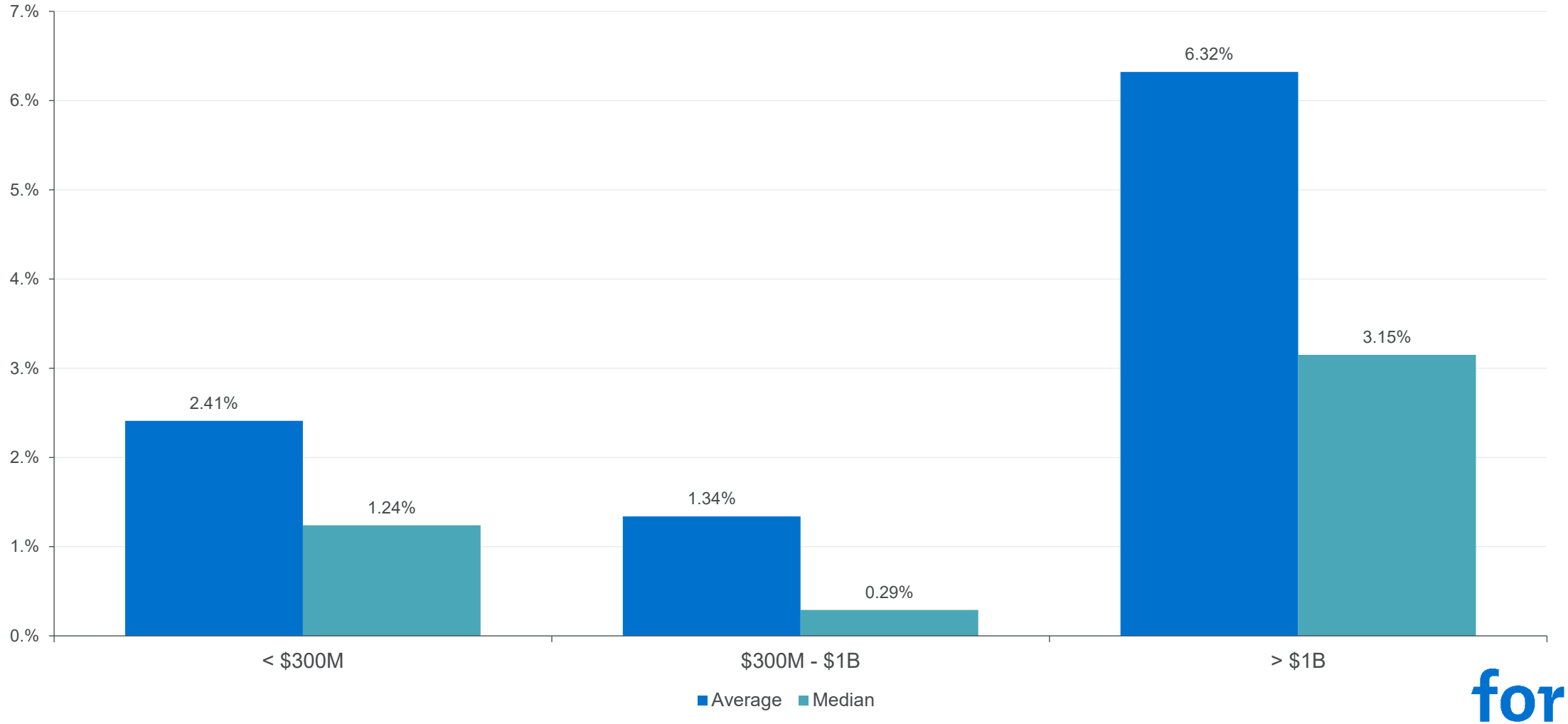
Schedule H, Part I, Line 7b – Medicaid



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Line 7e, Key Definitions and Requirements

- **“Community health improvement services”**: Subsidized programs that improve community health and generate no patient revenue (nominal/sliding-scale fee OK).
- **“Community benefit operations”**: CHNA work, program administration, and grant-writing/fundraising for community benefit.
- **Community need must be demonstrated:** via the CHNA, an agency/community request, or partnership with an unrelated exempt/government organization.
- **Community benefit objectives include:**
  - Improving access to health services
  - Enhancing public health
  - Advancing general knowledge (education or research for the public)
  - Relief of a government burden to improve health

Best Practice: Document need (link to CHNA), track direct and indirect costs, and tie activities to the implementation strategy.

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Line 7e, Community Health Improvement Services and Community Benefit Operations

✓ What's Reported

- **Community health improvement services** — subsidized programs to improve community health that generate no patient revenue (nominal/sliding-scale fee OK).
- **Health care support services** — Medicaid/CHIP/marketplace enrollment help, transportation, and similar access services.
- **Community benefit operations** — CHNA activities, program administration, and fundraising/grant-writing for community benefit.
- **Total expense (direct + indirect)**, net of offsetting revenue.
- **Demonstrated community need** — via CHNA, an agency/community request, or collaboration with an unrelated exempt/government org.

✗ What NOT to Report

- **Marketing-driven activities.**
- **Licensure/accreditation activities** — unless they independently address a demonstrated need.
- **Programs limited to employees or physicians.**
- **Activities without a demonstrated community need.**
- **Community building** (housing, economic/workforce development, environment) — unless it meets the Worksheet 4 definition; not double-entered in Part II.

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Line 7e, Community Health Improvement Services and Community Benefit Operations

Commonly Underreported/Potential Opportunities (verify against program documentation and the organization's CHNA)

- **Re-examine Part II**. Community building tied to a documented health need may qualify as a 7e service (food security, housing, SDOH).
- **Community benefit operations**. CHNA time, program administration, and grant-writing are reportable but rarely tracked — try an annual time study.
- **Enrollment assistance**. Financial-counselor enrollment time (Medicaid, CHIP, marketplace) is reportable, often missed in the revenue-cycle budget.
- **Indirect cost allocation**. Apply a consistent indirect rate (facilities, IT, HR, admin) — expressly allowed but often skipped for smaller programs.
- Programs excluded for "no demonstrated need" may qualify once need is documented (CHNA, written request, or exempt/government partner).

Commonly Misclassified

- **In-kind support**: 7e vs. 7i. Support through your own programs (at cost, not FMV) is 7e; in-kind gifts to other organizations are 7i. Never both.
- **7e vs. Part II**. One activity, one place: if it's a community health improvement service, report on 7e, not Part II.

Key Takeaway: Capturing operations costs and indirect allocations can meaningfully raise reported 7e.

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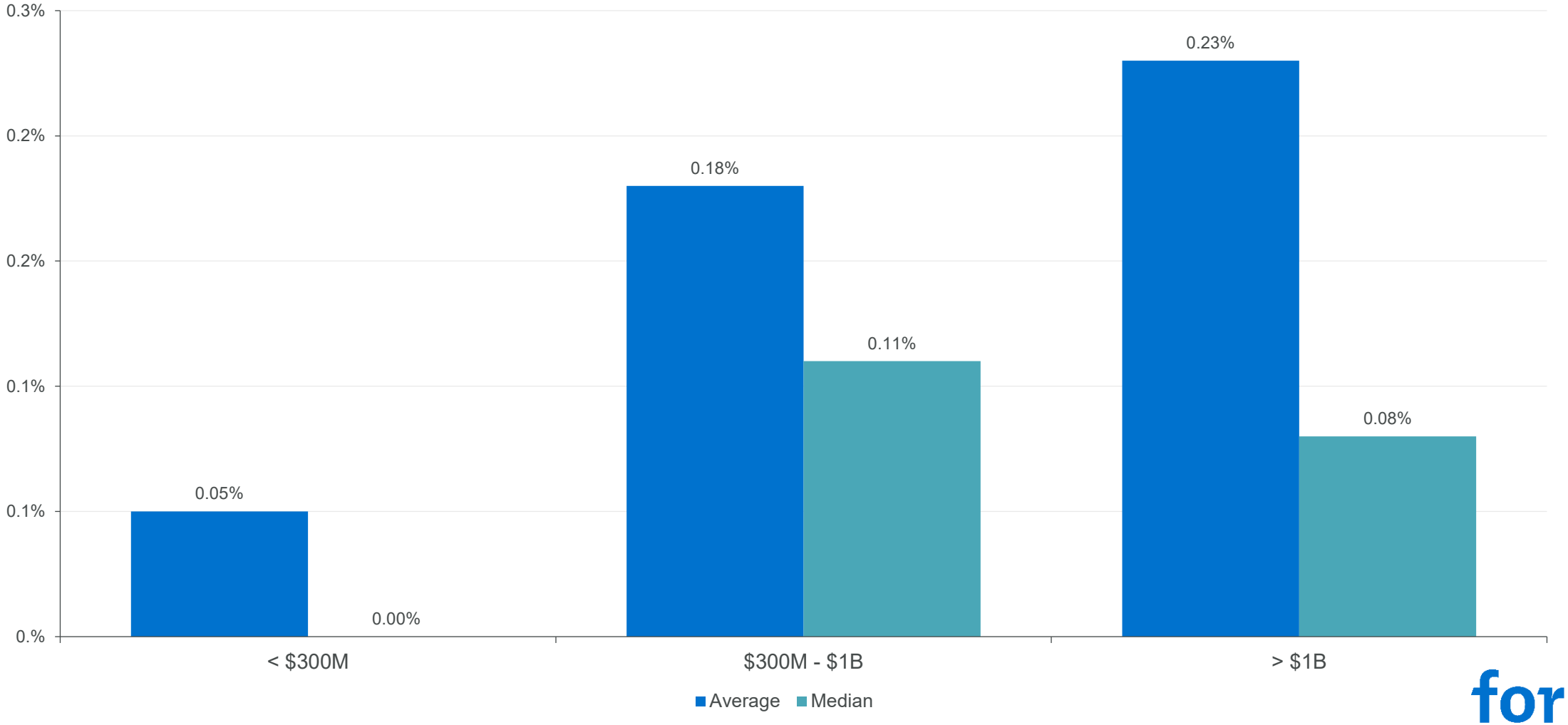
Schedule H, Part I, Line 7e – Community Health Improvement Services & Operations



Line 7f, Health Professions Education

✓ What's Reported

- **Education for a degree, certificate, or training needed to be licensed or certified**, or CE needed to retain licensure — including direct GME for residents.
- **Total cost (direct + indirect)**, net of offsetting revenue; Medicare/Medicaid direct GME payments, tuition, and fees received.
- **Scholarships and financial support** for students and community members in health professions education (not just own staff).

✗ What NOT to Report

- **Orientation, on-the-job/in-service, and internal workforce training** (EHR, compliance) — operating costs, not education.
- **Indirect GME** costs or reimbursement — stay in Medicaid (Worksheet 3) or Medicare Part III, not 7f.
- **Workforce development** — recruiting physicians to shortage areas, or recruiting (vs. educating), belongs in Part II, Line 8.

Commonly Underreported / Potential Opportunities

- **Clinical rotations & preceptor time** — staff hours supervising outside nursing, NP/PA, pharmacy, and allied health students; rarely time-tracked.
- **Non-employee training / licensure-linked CE** for community providers, EMS, and others outside staff.
- **Scholarship & tuition support** for community members (often in a foundation's books, missed at consolidation).
- **Indirect costs** (facilities, IT, admin) allocable to education programs.

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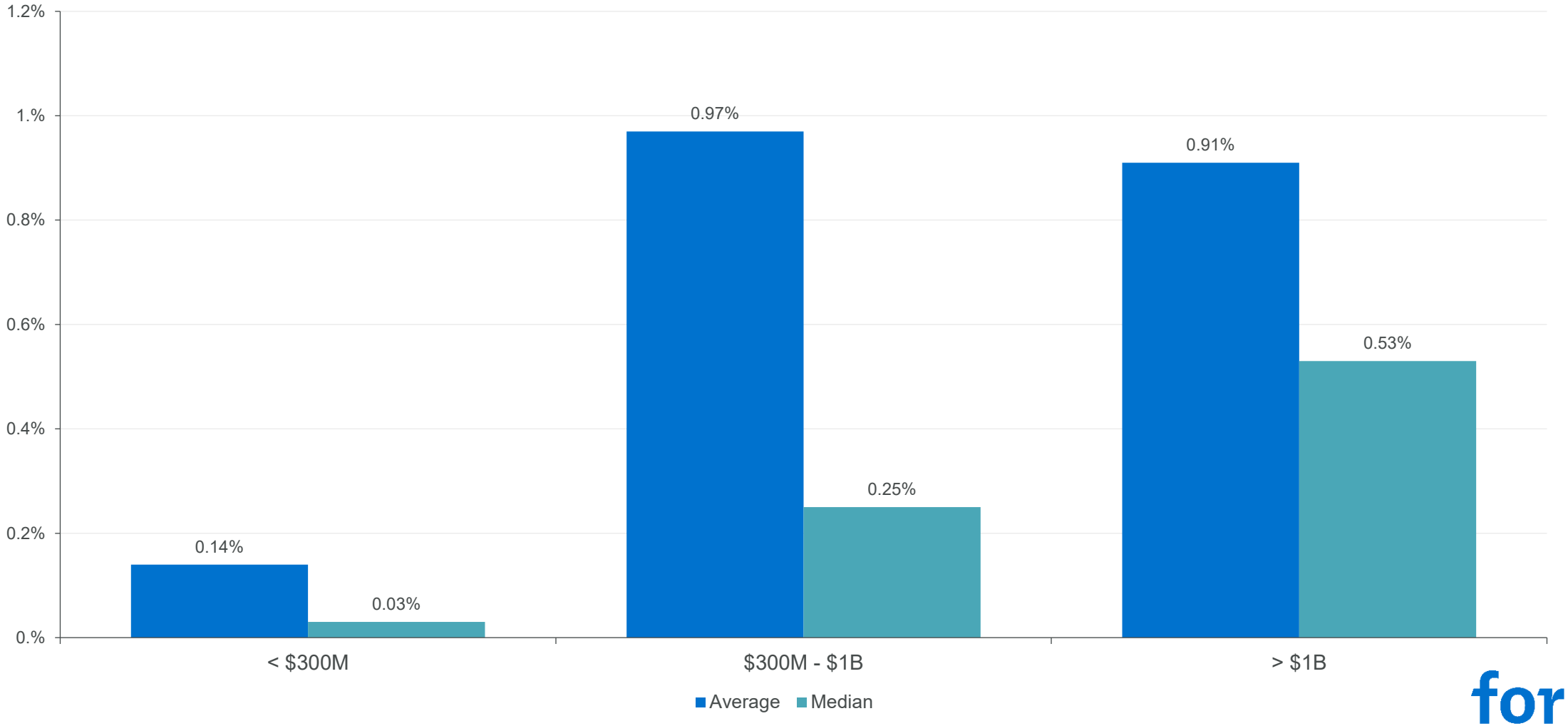
Schedule H, Part I, Line 7f – Health Professions Education



Line 7g, Subsidized Health Services

✓ What's Reported

- **Clinical services run at a loss** where both hold: the loss remains **after carving out** FA, Medicaid/means-tested shortfalls, and bad debt; and the service meets an **identified community need** (its loss would leave the community without it, below capacity, or shift it to government/another nonprofit).
- **Residual net loss**, computed **service line by service line** on a fully loaded basis (direct + indirect), net of that line's revenue.
- **Physician clinic losses** may qualify, but the costs must be disclosed in Part VI, line 1.

✗ What NOT to Report

- **Losses from FA, Medicaid/means-tested, or bad debt** — those belong on 7a–7c or are excluded; 7g reports only the residual.
- **A service that loses money overall but profits once carve-outs are removed.**
- **A money-losing service with no documented need** — need must be established for the specific service.
- **A needed service that doesn't actually operate at a loss.**

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Line 7g, Subsidized Health Services

Commonly Underreported/Potential Opportunities (confirm against service-line cost accounting and the org's CHNA)

- **Run an annual service-line screen.** Screen ED/trauma, NICU, burn, behavioral health, rural OB, dialysis, palliative care — any needed service losing money after carve-outs is a 7g candidate.
- **Physician practice subsidies.** Loss-making employed-physician practices serving an unmet need can support 7g reporting, with the Part VI, line 1 disclosure.
- **Fully loaded costing, consistently applied.** The loss test uses direct **and** indirect costs. Apply the allocation consistently across service lines.
- **Document the need prong.** Tie each service to the three-part need test using CHNA, market, or payer-mix evidence.

Commonly Misclassified

- **7g vs. 7a–7c double-counting.** A shortfall can't sit in both 7g and 7a–7c; Worksheet 6 carve-outs prevent it.
- **Physician clinics without the Part VI disclosure.** Permitted, but if clinics are in 7g the Part VI narrative is not optional.

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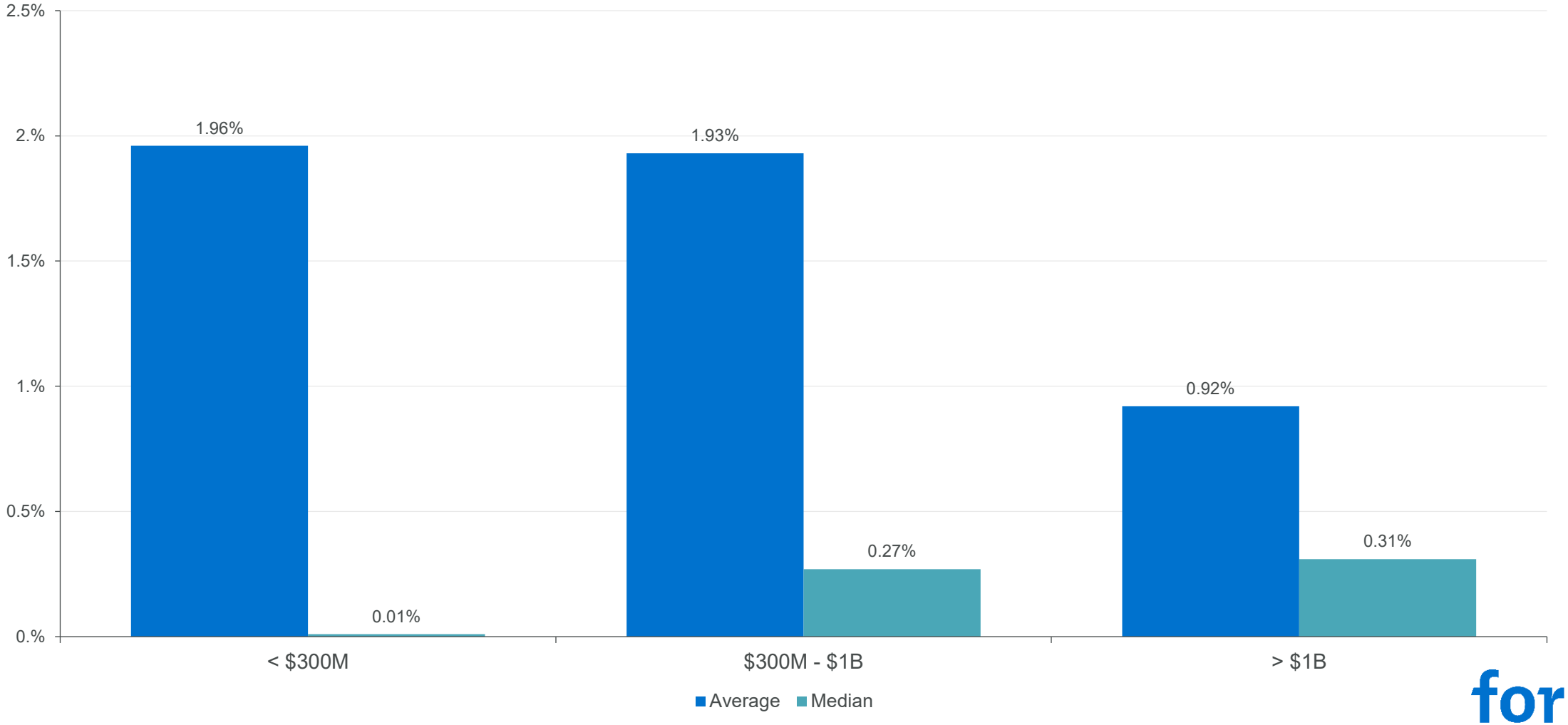
Schedule H, Part I, Line 7g – Subsidized Health Services



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Line 7h, Research

✓ What's Reported

- **Studies producing (1) generalizable knowledge (2) made available to the public** — both required, regardless of funding source.
- **Internally funded/unfunded research, and research funded by tax-exempt or government entities**, reported gross: total cost (direct + indirect) in column (c), restricted grants as offsetting revenue in column (d).
- **Indirect/overhead costs** (facilities, IT, admin, research compliance) allocable to qualifying research.

✗ What NOT to Report

- **Research funded by for-profit/industry sponsors** — qualifying funded research is limited to tax-exempt/government funders.
- **Studies whose results aren't made public** — don't qualify, regardless of funder.
- **QI/operational studies used only internally** (not generalizable) — unless published or publicly disseminated.
- **Research of separately filing affiliates** — only the filer's own activity, including its share of consolidated JVs.

Commonly Underreported / Potential Opportunities

- **Internally funded pilots, unfunded investigator-initiated research, and projects with no grant number** — missed by systems tracking only “sponsored” research.
- **Fully grant-funded qualifying research** — nets to zero in column (e), but gross cost, offsetting revenue, and counts still belong on the return.
- **Indirect costs** when research runs through a separate institute or foundation (check consolidation).
- **Full program costing**, including open-access fees, data repositories, and community dissemination.

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Line 7i, Cash and in-kind Contributions for Community Benefit

✓ What's Reported

- **Cash/in-kind contributions or grants restricted in writing** to Line 7a–7h activities, made to other organizations that carry them out.
- **In-kind donations** — supplies, space, depreciated equipment, and staff time on payroll, valued at book value/cost, **not fair market value**.
- **Grants to joint ventures** the organization holds an interest in — a special Worksheet 8 rule prevents double-counting.

✗ What NOT to Report

- **Contributions funding the organization's own 7a–7h activities** — support through its own programs is 7e, not 7i.
- **Employee volunteering on personal time**, and unrestricted contributions (no written restriction, no 7i).
- **Grants restricted to community building** (housing, economic development) — follow the activity to Part II unless it's a community health improvement service.
- **In-kind valued at FMV** rather than cost/book value (a common overstatement error).

Commonly Underreported / Potential Opportunities

- **Sponsorships/donations with a clear health purpose but no written restriction** — a grant letter tying the gift to a 7a–7h activity makes it reportable.
- **In-kind donations generally** — donated space, surplus equipment, and lent staff time go untracked; capture at full cost, including coordination time.
- **Grants through a hospital-affiliated foundation** for 7a–7h purposes (missed when the foundation files separately).

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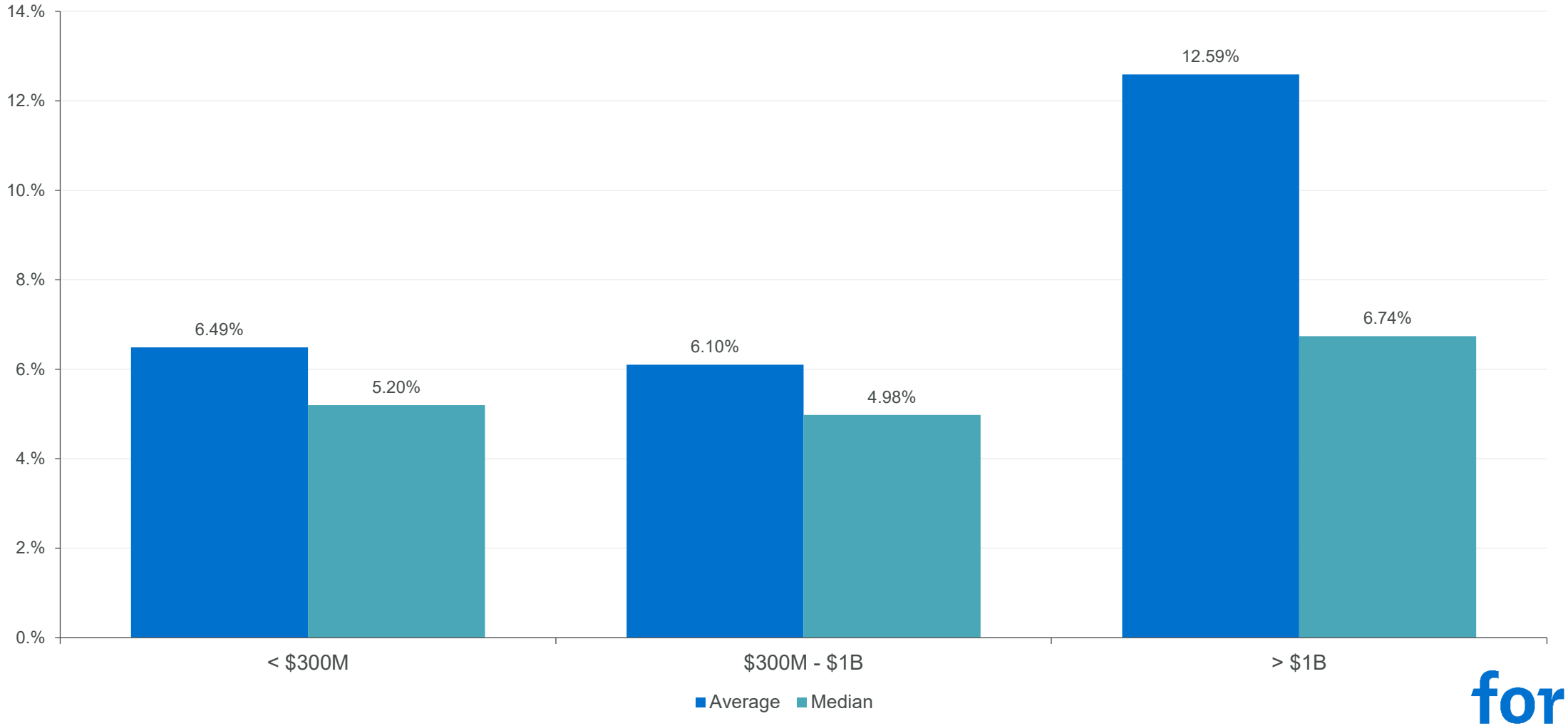
Schedule H, Part I, Line 7k – Total Community Benefits



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Cross-Cutting Rules (Apply Across Lines 7a–7i)

These rules apply across every Worksheet 1–8 category, regardless of which line an amount lands on:

- **Bad debt and uncollectible charges** are never in Line 7 — report in Part III, Section A.
- **Medicare** is excluded from Line 7 (except indirect GME). Shortfall goes to Part III, Section B, which invites a **Part VI narrative** on why it's community benefit.
- **Self-pay/prompt-pay discounts** and third-party contractual adjustments are never community benefit.
- **Unrestricted grants or contributions** are not "direct offsetting revenue" — only grants restricted **in writing** by the grantor offset.
- **Community building activities** (housing, economic development, etc.) generally belong in **Part II,** *unless* it meets the Worksheet 4 community health improvement definition, then on **7e** (Line 7k). Never both.
- **Double-counting is prohibited** — e.g., 7a–7c losses inside a 7g loss, or the same support on 7e *and* a contribution on 7i.

Closing checklist: For every Line 7 amount: any bad debt, Medicare, or contractual adjustment? Every offsetting grant and outbound gift restricted in writing? Same dollar on two lines? Anything in Part II that belongs on 7e?

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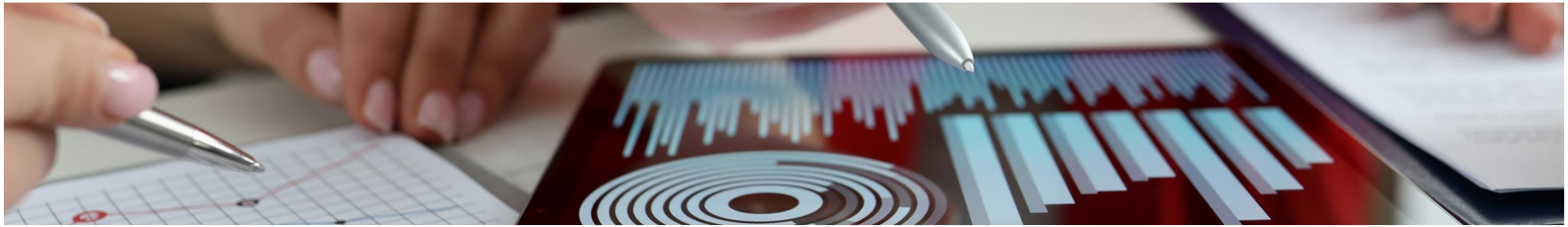
Readiness Opportunity: Benchmarking and Reporting



- Form 990, Schedule H, CHNAs, FAPs, implementation strategies, and financial statements are publicly available and easily compared.
- Tax-exempt hospital leaders should ask:
  - How does our **Schedule H reporting** compare to peer hospitals and similarly situated systems?
  - Are all reportable community-benefit activities being captured, documented, and reported consistently?
  - Do our costs, narratives, CHNA priorities, implementation strategy, and financial statements tell the same story?
  - Could underreporting make our community benefit appear lower than our actual investment?
  - Are there opportunities to strengthen programs, documentation, reporting, and public-facing narratives?
  - **Key point:** Hospitals should be able to explain not only **what** they provide, but **how they measured, documented, and reported it.**

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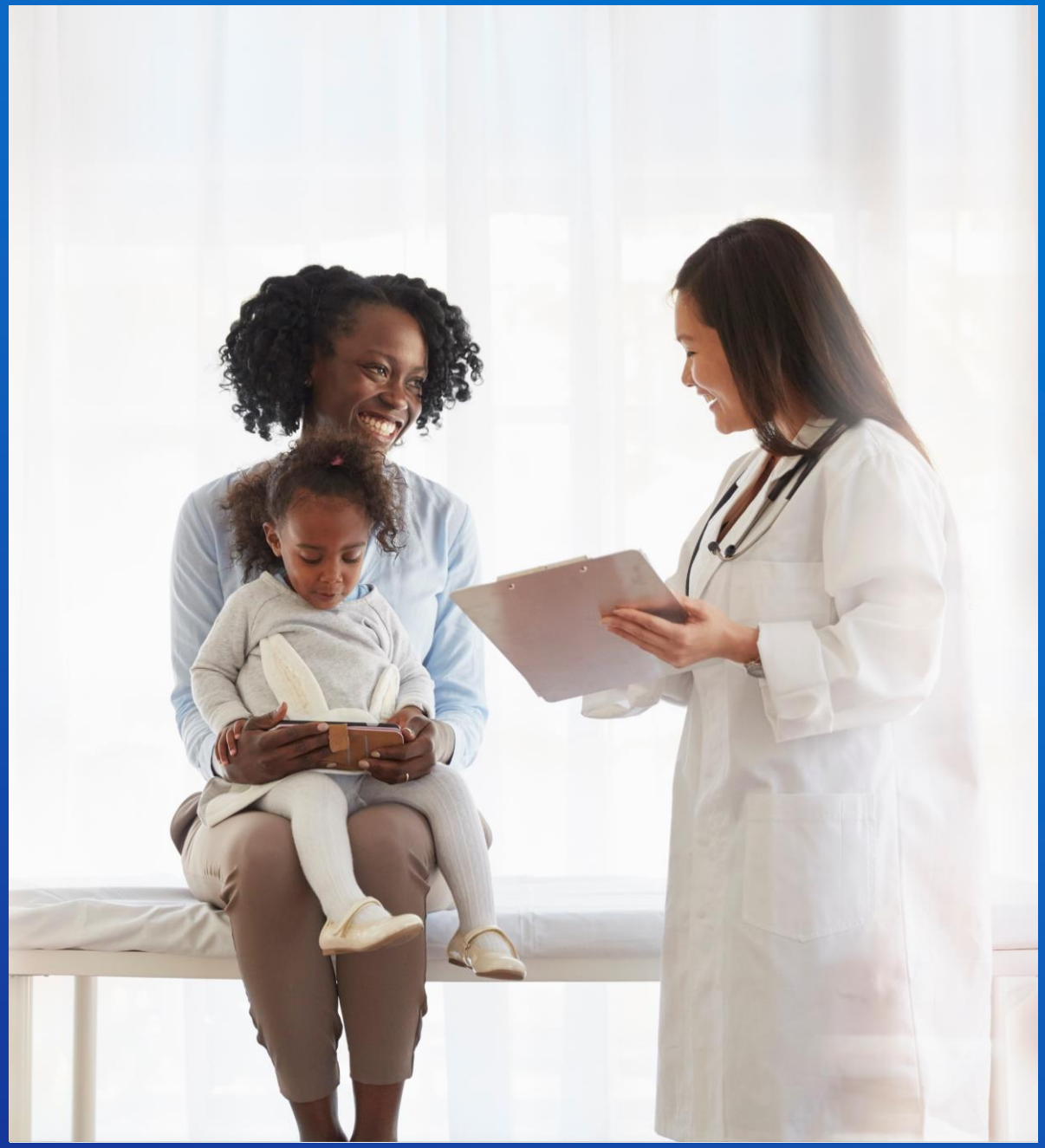
Patient Protection and Affordable Care Act Enacted in 2010

- **Section 9007** of the Patient Protection and Affordable Care Act (ACA), Public Law 111-148 (124 Stat. 119 (2010)), significantly transformed the landscape for tax-exempt hospitals.
  - **Section 9007(a)** added IRC § 501(r) to the Internal Revenue Code.
  - **Section 9007(b)** added IRC § 4959 to the Internal Revenue Code.
  - **Section 9007(c)** requires the IRS to review the community benefit activities of each hospital organization described in §501(r) at least once every three years.
  - **Section 9007(d)** imposes additional reporting requirements.
  - **Section 9007(e)** requires reports on the levels of charity care and trends.

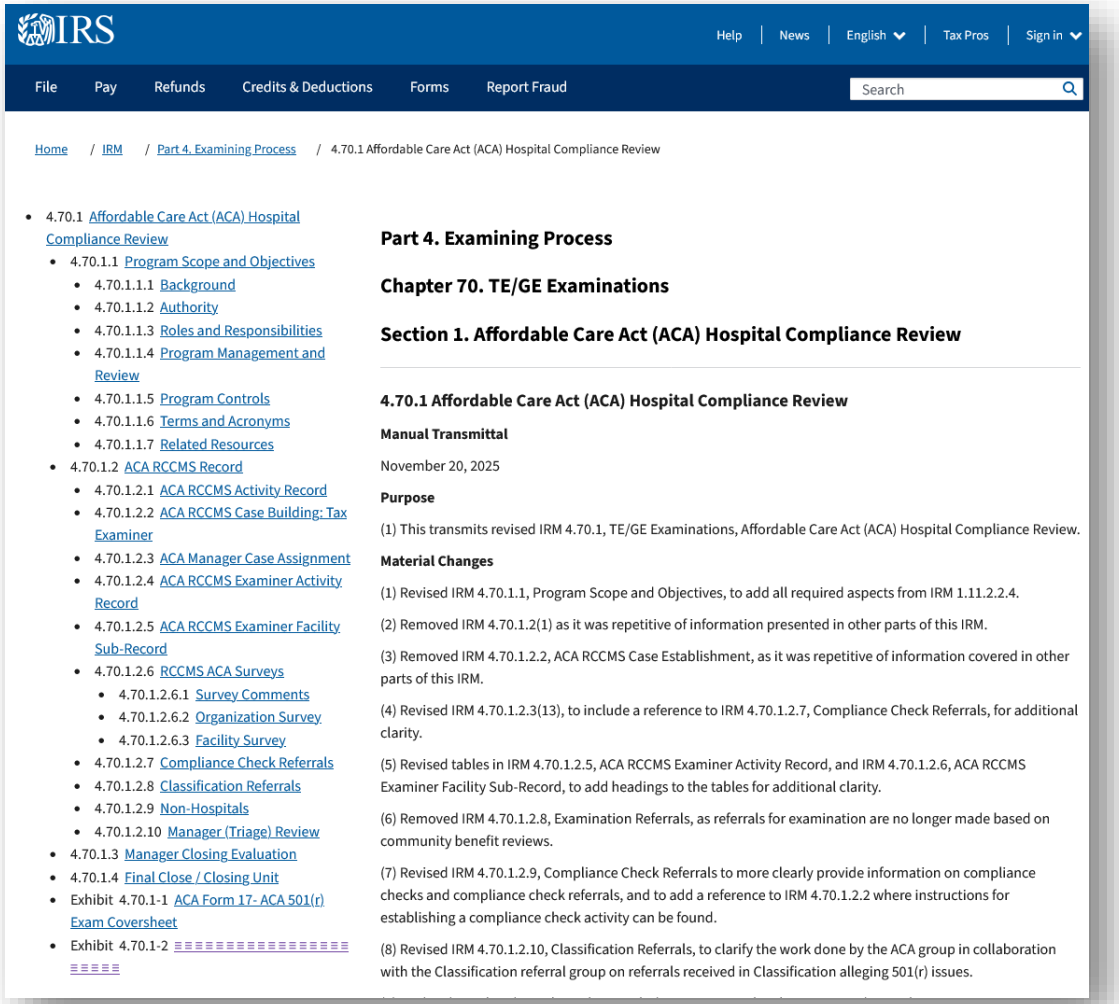


Mandatory Review of Tax Exemption for Hospitals

- Section 9007(c) of the ACA requires Treasury/IRS to review, at least once every three years, the community benefit activities of each hospital organization subject to IRC § 501(r).
- The Internal Revenue Manual (4.70.1 Affordable Care Act (ACA) Hospital Compliance Review) provides additional information on the process.
- The review is focused on community benefit activities and § 501(r)-related compliance using IRS-filed and publicly available information.

- **Key point:** IRS reviews are mandatory recurring statutory reviews, not optional or complaint-driven.

- **Readiness point:** A hospital should be able to support its community benefit, FAP, CHNA, billing/collection, and Schedule H positions before questions arise.



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Part 4. Examining Process

Chapter 70. TE/GE Examinations

Section 1. Affordable Care Act (ACA) Hospital Compliance Review

4.70.1 Affordable Care Act (ACA) Hospital Compliance Review

Manual Transmittal

November 20, 2025

Purpose

(1) This transmits revised IRM 4.70.1, TE/GE Examinations, Affordable Care Act (ACA) Hospital Compliance Review.

Material Changes

(1) Revised IRM 4.70.1.1, Program Scope and Objectives, to add all required aspects from IRM 1.11.2.2.4.

(2) Removed IRM 4.70.1.2(1) as it was repetitive of information presented in other parts of this IRM.

(3) Removed IRM 4.70.1.2.2, ACA RCCMS Case Establishment, as it was repetitive of information covered in other parts of this IRM.

(4) Revised IRM 4.70.1.2.3(13), to include a reference to IRM 4.70.1.2.7, Compliance Check Referrals, for additional clarity.

(5) Revised tables in IRM 4.70.1.2.5, ACA RCCMS Examiner Activity Record, and IRM 4.70.1.2.6, ACA RCCMS Examiner Facility Sub-Record, to add headings to the tables for additional clarity.

(6) Removed IRM 4.70.1.2.8, Examination Referrals, as referrals for examination are no longer made based on community benefit reviews.

(7) Revised IRM 4.70.1.2.9, Compliance Check Referrals to more clearly provide information on compliance checks and compliance check referrals, and to add a reference to IRM 4.70.1.2.2 where instructions for establishing a compliance check activity can be found.

(8) Revised IRM 4.70.1.2.10, Classification Referrals, to clarify the work done by the ACA group in collaboration with the Classification referral group on referrals received in Classification alleging 501(r) issues.

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TIGTA Follow-Up and IRS Examination Strategy

TIGTA reported (Report Number 2025-100-019) that CBAR referrals resulted in compliance checks and examinations, including:

- **FY 2023:** 64 compliance checks from CBAR referrals; a majority resulted in agreed corrective action.
- **FY 2024:** 75 compliance checks from CBAR referrals; 85% closed with agreed corrective action.
- **FY 2023:** 22 examinations completed after CBAR referrals.
- **FY 2024:** 9 examinations completed based on CBAR referrals.

- Separately, IRS's CP&C function built a data-driven § 501(r) examination strategy, flagging 45 “at-risk” organizations for examination.

Readiness point: Even where no formal action results, avoiding documentation and reporting issues is a best practice that can reduce follow-up questions, corrective-action requests, and avoidable demands on tax, legal, compliance, revenue-cycle, and community-benefit teams.

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Section 501(r) - Additional Requirements for Charitable Hospitals

- **IRC § 501(r) added requirements that apply on a facility-by-facility basis:**
  - Community Health Needs Assessment (CHNA) – IRC § 501(r)(3),
  - Financial Assistance Policy and Emergency Medical Care Policy – IRC § 501(r)(4),
  - Limitation on Charges – IRC § 501(r)(5), and
  - Billing and Collections – IRC § 501(r)(6).
- A hospital organization reports related policies, practices, and community benefit information on **Form 990, Schedule H.**

Why it matters: A failure at one hospital facility can have facility-level tax consequences and, in significant cases, may put the organization's federal tax exemption at risk.

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Section 501(r)(3) – Community Health Needs Assessment (CHNA)

- A hospital facility must, at least once every three years:
  - Conduct a CHNA;
  - Take into account input from persons representing the broad interests of the community, including public health expertise;
  - Make the CHNA report widely available to the public; and
  - Adopt an implementation strategy to address identified health needs.
- Failure to satisfy section 501(r)(3) may result in a $50,000 excise tax under IRC §4959, in addition to other potential §501(r) consequences.

Readiness point: The CHNA, implementation strategy, and Schedule H should tell a consistent story. Approach § 501(r)(3) compliance strategically, not as a check-the-box exercise.

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Assessing & Documenting the CHNA Regulatory Requirements (26 CFR § 1.501(r)-3(b)(4) & (b)(6))

Assess needs (identify → prioritize → resources), then document the CHNA report:

COMMUNITY SERVED:

definition of the community and how it was determined

PROCESS AND METHODS:

data sources, analysis, collaborators, and externally sourced information

COMMUNITY INPUT:

who was solicited, how input was received, what was heard, and how **required** sources were addressed

SIGNIFICANT NEEDS AND PRIORITIES:

identified health needs, prioritization criteria, and reasons for prioritizing certain needs.

RESOURCES AND IMPACT:

resources available to address identified needs and evaluation of the impact of actions taken since the prior CHNA.

Readiness point: Show not just what needs were identified, but why they were prioritized and what resources were considered — the report should tell a clear story from **data and input** → **identified needs** → **priorities** → **implementation strategy.**

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Implementation Strategy

26 CFR § 1.501(r)-3(c).

For each significant health need identified in the CHNA, the implementation strategy should:

DESCRIBE

How the hospital plans to address the health need, including planned actions, anticipated impact, resources, and collaborations; or

EXPLAIN

Why the hospital does not intend to address the need, such as resource constraints, lower priority, existing community resources, or lack of effective interventions.

TIMING

An authorized body of the hospital facility must adopt the implementation strategy by the 15th day of the 5th month after the end of the tax year in which the CHNA was conducted.

Readiness point: The implementation strategy should connect directly back to the CHNA's prioritized needs.

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Section 501(r)(3) – Readiness Questions

- Is the current CHNA timely, adopted by an authorized body, posted online and easy to find?
- Is a free paper copy available upon request at the hospital facility?
- Is the community definition clear, supported, and inclusive of required populations?
- Is required community input documented, including how considered?
- Are significant health needs prioritized using stated criteria?
- Does the implementation strategy address each prioritized need or explain why not?
- Was the implementation strategy adopted on time by an authorized body?
- Can a reviewer follow the story from **data and input** → **identified needs** → **priorities** → **implementation strategy**?

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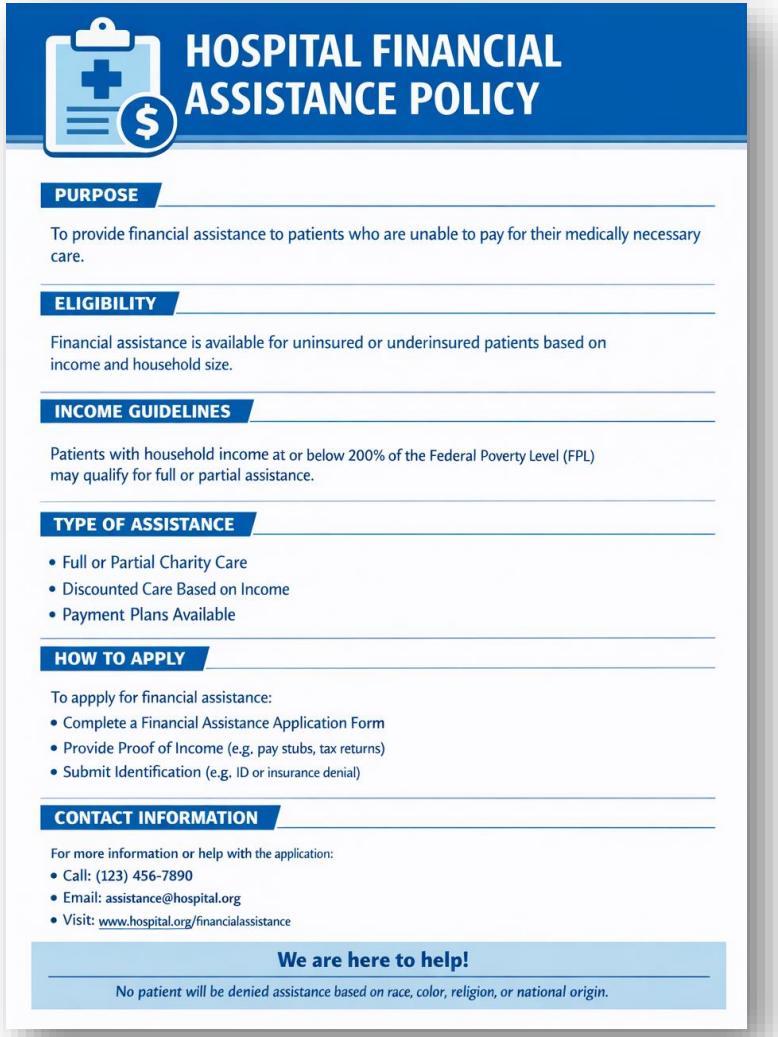
Section 501(r)(4) – Financial Assistance Policy

A hospital facility must establish a:

- **Financial Assistance Policy (FAP)**
  - Addresses eligibility, free or discounted care, how amounts are calculated, how patients apply, collection actions, and publicity.
- **Emergency Medical Care Policy**
  - Requires emergency medical care without discrimination, regardless of FAP eligibility.

Readiness point: The written policy, plain-language summary, application, website, signage, billing statements, and revenue-cycle practices should tell the same story.



HOSPITAL FINANCIAL ASSISTANCE POLICY

PURPOSE

To provide financial assistance to patients who are unable to pay for their medically necessary care.

ELIGIBILITY

Financial assistance is available for uninsured or underinsured patients based on income and household size.

INCOME GUIDELINES

Patients with household income at or below 200% of the Federal Poverty Level (FPL) may qualify for full or partial assistance.

TYPE OF ASSISTANCE

- Full or Partial Charity Care
- Discounted Care Based on Income
- Payment Plans Available

HOW TO APPLY

To appply for financial assistance:

- Complete a Financial Assistance Application Form
- Provide Proof of Income (e.g. pay stubs, tax returns)
- Submit Identification (e.g. ID or insurance denial)

CONTACT INFORMATION

For more information or help with the application:

- Call: (123) 456-7890
- Email: assistance@hospital.org
- Visit: www.hospital.org/financialassistance

We are here to help!

No patient will be denied assistance based on race, color, religion, or national origin.

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Schedule H, Part V, Section B

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

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group:

		Yes	No
	Did the hospital facility have in place during the tax year a written FAP that:		
13	Explained eligibility criteria for financial assistance and whether such assistance included free or discounted care?		
	If "Yes," indicate the eligibility criteria explained in the FAP:		
a	☐ FPG, with FPG family income limit for eligibility for free care of ___ % and FPG family income limit for eligibility for discounted care of ___ %		
b	☐ Income level other than FPG (describe in Section C)		
c	☐ Asset level		
d	☐ Medical indigency		
e	☐ Insurance status		
f	☐ Underinsurance status		
g	☐ Residency		
h	☐ Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?		
15	Explained the method for applying for financial assistance?		
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a	☐ Described the information the hospital facility may require an individual to provide as part of their application		
b	☐ Described the supporting documentation the hospital facility may require an individual to submit as part of their application		
c	☐ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	☐ Other (describe in Section C)		

		Yes	No
16	Was widely publicized within the community served by the hospital facility?		
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a	☐ The FAP was widely available on a website (list url):		
b	☐ The FAP application form was widely available on a website (list url):		
c	☐ A plain language summary of the FAP was widely available on a website (list url):		
d	☐ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	☐ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	☐ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by limited-English proficiency (LEP) populations		
j	☐ Other (describe in Section C)		

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FAP Readiness: Where Gaps Commonly Appear

Hospitals should periodically test whether the FAP is aligned across:

- **Policy documents:** FAP, plain-language summary, application, emergency medical care policy, and billing/collection policy.
- **Public access:** website postings, translations, physical-location notices, and patient-facing materials.
- **State-law overlays:** eligibility thresholds, presumptive eligibility, collection restrictions, refund rules, and required notices.
- **Revenue-cycle operations:** billing statements, call-center scripts, vendor notices, collection workflows, and account holds.
- **Governance and accountability:** approval history, periodic updates, monitoring, and documentation that practices match the written policy.

Readiness point: The risk is often not the FAP itself — it is whether the FAP, patient communications, vendors, systems, and actual workflows tell the same story.

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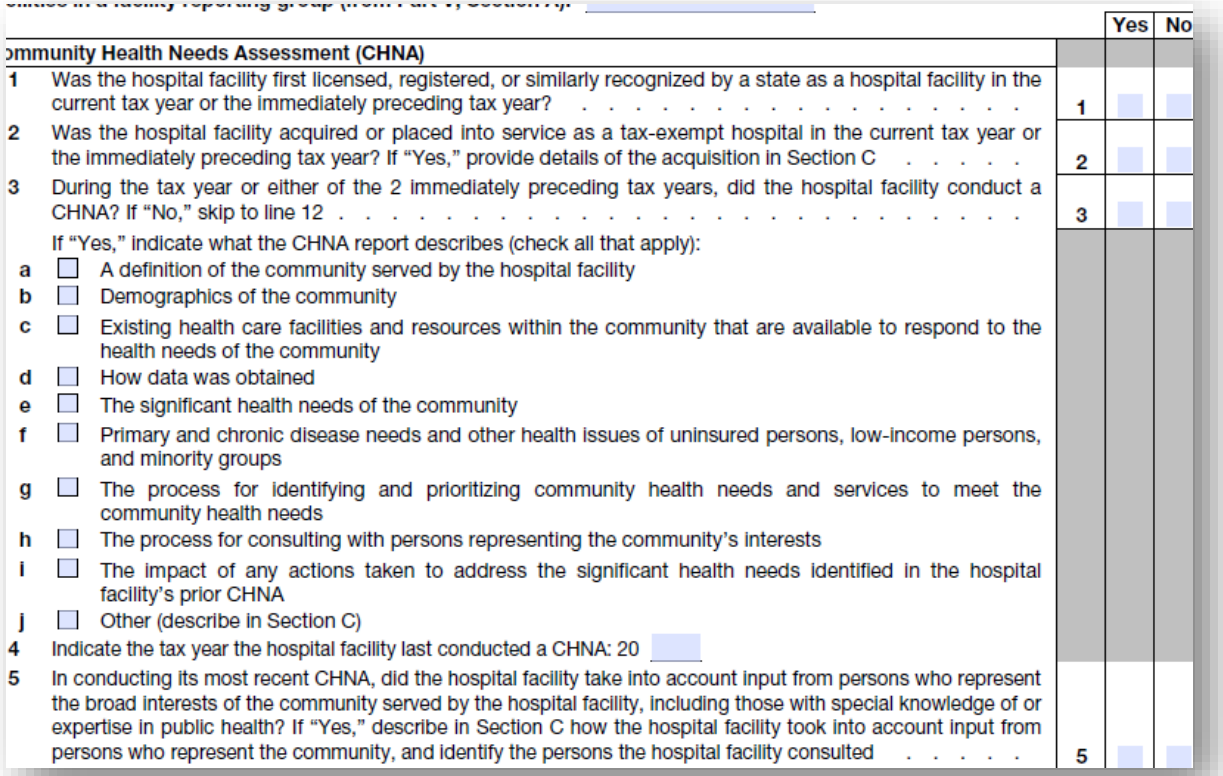
Schedule H, Part V, Section B



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

Schedule H (Form 990) 2025

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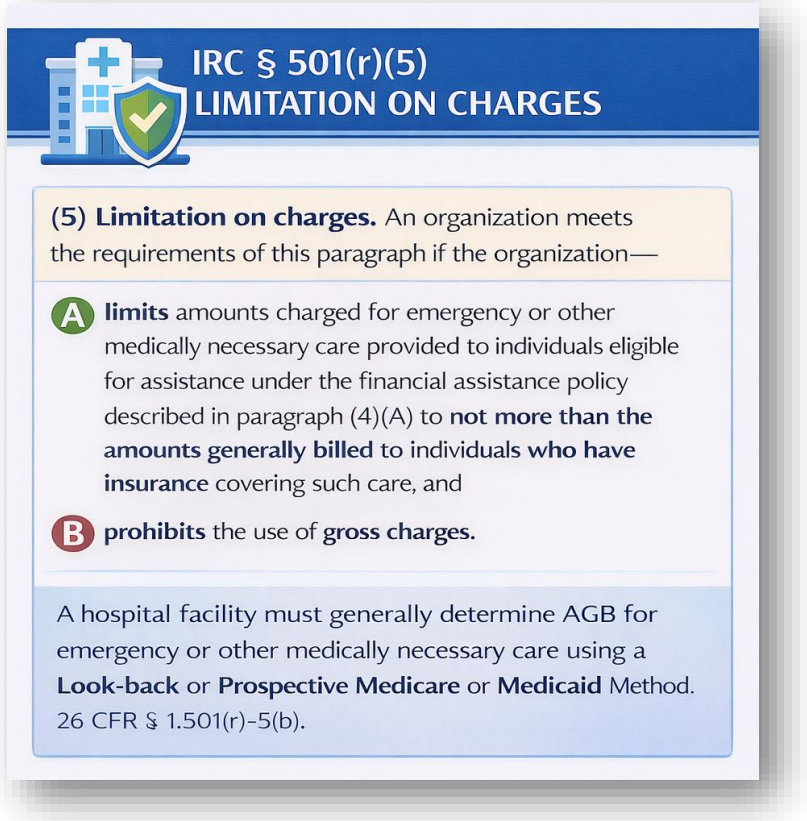
Section 501(r)(5) – Limitation on Charges

A hospital facility must:

- **Limit amounts charged** for emergency or other medically necessary care provided to FAP-eligible individuals to no more than **amounts generally billed (AGB)** to insured patients.
- **Prohibit the use of gross charges** for FAP-eligible individuals receiving emergency or other medically necessary care.

Hospitals generally determine AGB using one of two permitted methods:

- **Look-back method:** based on allowed claims during a prior 12-month period.
- **Prospective method:** based on the amount Medicare or Medicaid would allow for the care.



Readiness point: The selected AGB method should be documented, updated timely, reflected in the FAP, and consistently applied in billing operations.

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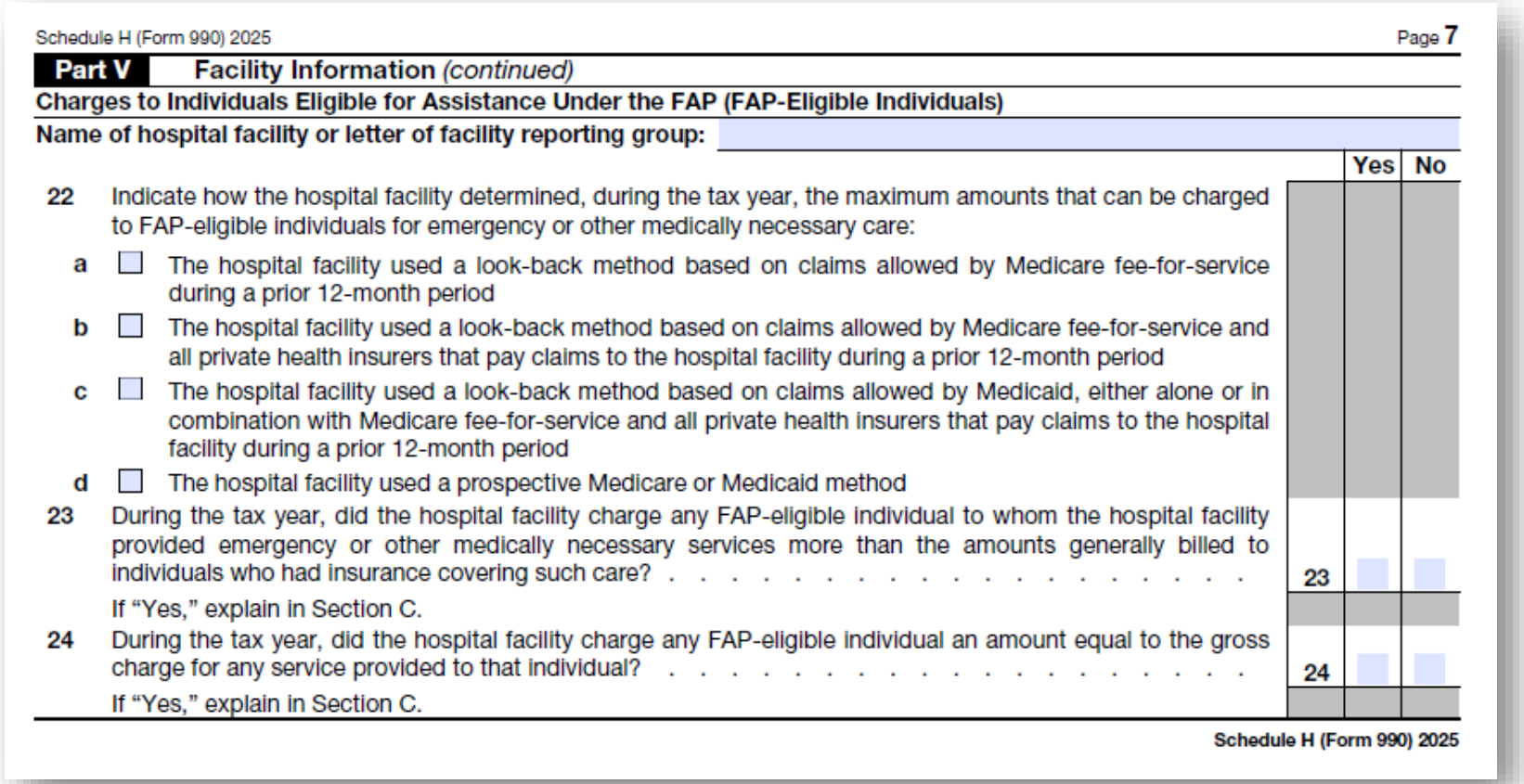
Schedule H, Part V, Section B



Schedule H (Form 990) 2025 Page 7

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

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

Name of hospital facility or letter of facility reporting group:

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:		
a	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	☐ The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? 23		
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? 24		
	If "Yes," explain in Section C.		

Schedule H (Form 990) 2025

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Section 501(r)(5) — Readiness Questions

- Does the FAP clearly describe the AGB method used?
- Is the AGB percentage calculated and updated on schedule?
- Are FAP-eligible patients protected from charges above AGB?
- Do billing systems apply the correct discounts automatically?
- Are gross charges prohibited for FAP-eligible emergency or medically necessary care?
- Are patient statements, estimates, vendor scripts, and collection workflows consistent with the FAP and AGB methodology?
- Can the hospital reconcile its AGB calculation to supporting data?

Section 501(r)(6) – Billing and Collection

- A hospital facility may not engage in **extraordinary collection actions (ECAs)** before making reasonable efforts to determine whether an individual is eligible for financial assistance.
- ECAs may include: lawsuits; credit reporting; liens, garnishments, and deferring or denying medically necessary care because of prior unpaid bills.
- Reasonable efforts generally include: FAP notice, application access, time to apply, consistent application processing, and vendor coordination.

Readiness point: Billing and collection workflows should show that patients had a meaningful opportunity to apply for assistance before any ECA.

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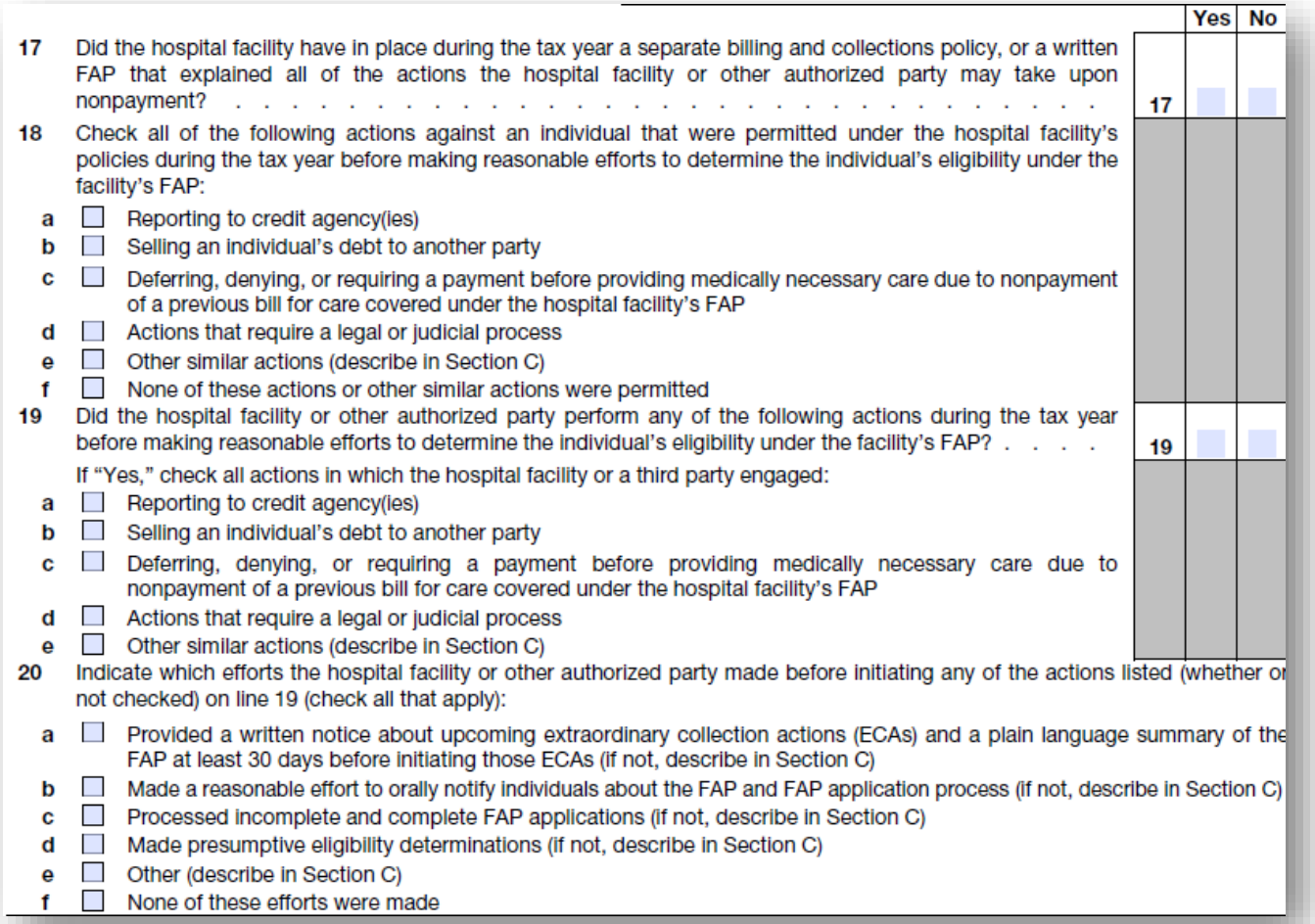
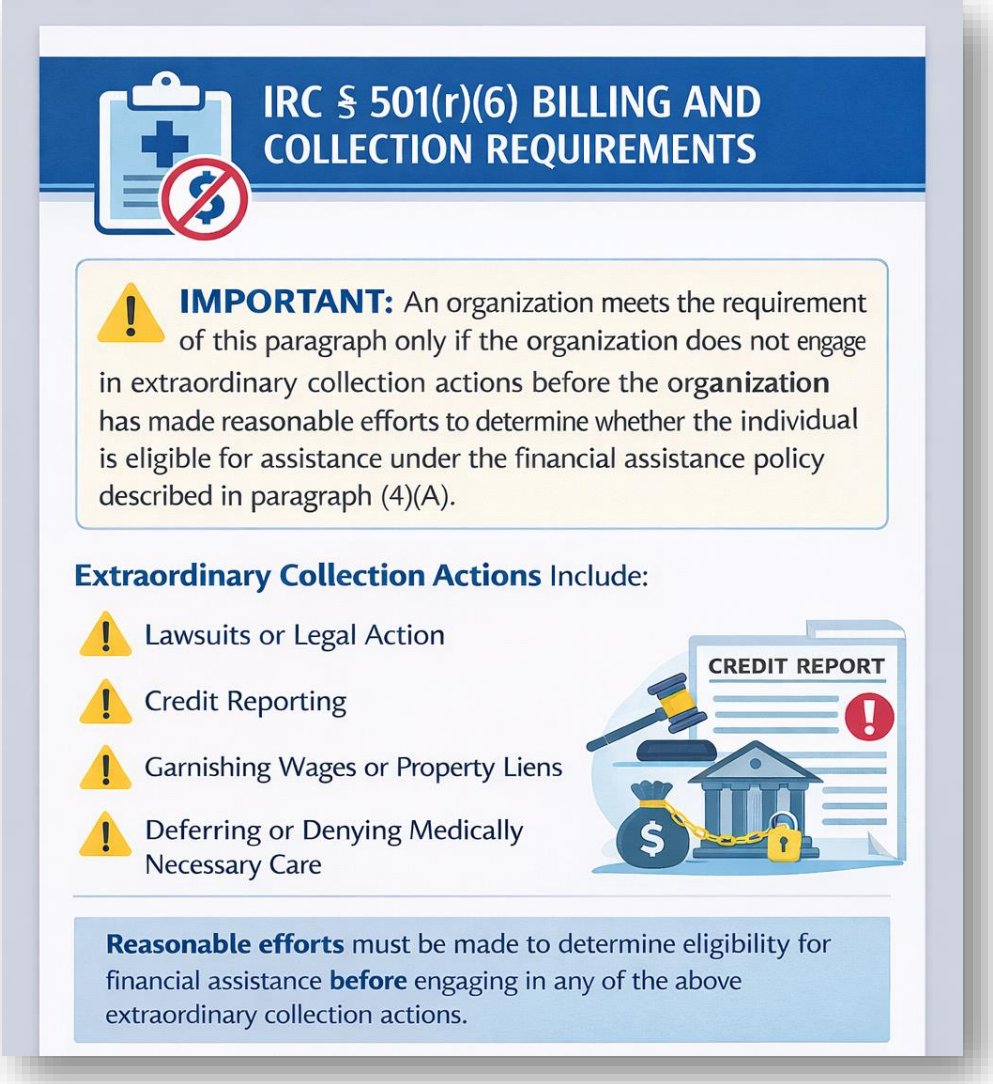
Schedule H, Part V, Section B



		Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written FAP that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?		
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	☐ Actions that require a legal or judicial process		
e	☐ Other similar actions (describe in Section C)		
f	☐ None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		
	If "Yes," check all actions in which the hospital facility or a third party engaged:		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	☐ Actions that require a legal or judicial process		
e	☐ Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) on line 19 (check all that apply):		
a	☐ Provided a written notice about upcoming extraordinary collection actions (ECAs) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
b	☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
c	☐ Processed incomplete and complete FAP applications (if not, describe in Section C)		
d	☐ Made presumptive eligibility determinations (if not, describe in Section C)		
e	☐ Other (describe in Section C)		
f	☐ None of these efforts were made		

Section 501(r)(6) — Readiness Questions

- Do billing statements, notices, and call-center scripts clearly direct patients to financial assistance?
- Is the FAP application period tracked before accounts are referred to collections?
- Are collection agencies and other vendors contractually required to follow the hospital's FAP and § 501(r)(6) procedures?
- Are ECAs identified, approved, suspended, and reversed consistently?
- Are lawsuits, credit reporting, liens, garnishments, and care-deferral practices reviewed for compliance before use?
- Do revenue-cycle practices align with the written FAP and billing/collections policy?
- Can the hospital document reasonable efforts before any ECA?



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Questions?

Appendix

Line 7e Examples: Community Health Improvement Services

Reportable Examples

- Free/low-cost health screenings or education sessions in underserved areas tied to CHNA priorities (**addresses identified community health needs**)
- Community-based diabetes, hypertension, or nutrition programs open to the public (**improves community health and serves low-income consumers**)
- Transportation assistance (e.g., ride-share vouchers or shuttle services) for low-income patients (**reduces financial and geographic barriers to care**)
- Enrollment assistance — helping patients enroll in Medicaid, CHIP, or marketplace coverage (**improves access to health services;** commonly missed because it sits in the revenue cycle budget)
- Outreach programs supporting senior independence or behavioral health in the community (**enhances public health / improves access to health services**)
- Immunization or maternal/child health initiatives in partnership with public health departments (**addresses public health priorities and relieves government burden**)
- In-kind support such as meeting space, staff time (while on hospital payroll), or surplus supplies used directly in the organization's own or jointly operated community health improvement programs (**net community benefit expense subsidized by the organization; in-kind donations *to other organizations* go to Line 7i**)

Non-Reportable Examples

- Health fairs, screenings, or programs designed primarily for marketing or to drive insured referrals (**more beneficial to the organization than the community**)
- Employee-only wellness programs or flu shots for staff (**restricted to individuals affiliated with the organization**)
- Routine discharge planning or care coordination for the hospital's own patients (**part of patient care operations; required for licensure and doesn't independently address a community need**)
- Community programs with no documented need basis (**no CHNA link, public health agency or community group request, or unrelated exempt/government partner**)

Readiness Tip: For each program on your community benefit inventory, ask three questions: Which objective does it advance? Where is the need documented (CHNA or public health request)? Does it generate inpatient/outpatient revenue? Track both direct and indirect costs.

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Line 7e Examples: Community Benefit Operations

Reportable Examples

- Staff time dedicated to conducting or updating the CHNA (**core community benefit operations — CHNA-related activities**)
- Development, adoption, and updating of the implementation strategy and staff time executing its community benefit programming (**part of the CHNA cycle; commonly captured only through the assessment itself**)
- Consultant fees for conducting community assessments (**directly supports CHNA compliance**)
- Community benefit program administration and coordination (**enumerated community benefit operations category**)
- Grant-writing or fundraising activities specifically for community benefit programs (**the costs of raising restricted community benefit funds, not the amounts raised**)
- Consultant or evaluation costs directly supporting community health improvement programs (**program-attributable cost of a reportable activity**)

Non-Reportable Examples

- General administrative or marketing costs not tied to community benefit (**more beneficial to the organization than the community**)
- Staff time spent volunteering on personal time, not on hospital payroll (**benefit provided by the individual, not the organization**)
- General fundraising for the organization's operations, capital, technology, or equipment (**not restricted to a community benefit activity**)
- Feasibility studies for new service lines or internal operational improvements (**relates to internal operations rather than community need**)
- Costs of preparing Schedule H and other tax/compliance reporting (**a compliance cost of the organization, not community benefit program administration**)

Readiness Tip: Capture indirect/allocated costs (facilities, IT, HR) on community benefit operations, and time-track the full CHNA cycle (assessment, implementation strategy, and execution) not just the assessment consultant's invoice.

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Line 7f Examples: Health Professions Education

Reportable Examples (generally)

- Residency and fellowship programs — direct GME costs, net of Medicare/Medicaid direct GME payments received (**degree/training necessary for licensure; report cost net of direct offsetting revenue**)
- Hospital-operated or hospital-sponsored nursing, allied health, or technician training programs leading to a degree, certificate, or licensure (**within the Worksheet 5 definition of health professions education**)
- Continuing education open to community-based physicians, nurses, EMS personnel, or other professionals beyond the organization's own staff (**CE necessary to retain licensure/certification; not restricted to the organization's workforce**)
- Clinical rotations and preceptorships for students from outside colleges/universities where the hospital bears unreimbursed cost (**training necessary for licensure; supervision time is reportable cost**)
- Scholarships or tuition support for students and community members pursuing health professions degrees, not restricted to the organization's own staff (**financial support for licensure-track education**)

Non-Reportable Examples (generally)

- Orientation, in-service, on-the-job, and internal operational training (EHR systems, annual compliance modules) (**operating cost of the workforce, not education leading to a degree, certificate, or licensure**)
- Training or CE programs restricted exclusively to the organization's own employees or medical staff (**available exclusively to the organization's workforce**)
- Workforce recruitment — job fairs, relocation incentives, recruiting physicians to shortage areas, or collaborating with schools to *recruit* rather than educate (**workforce development; belongs in Part II, Line 8**)
- Industry-sponsored education conducted primarily for marketing or proprietary product purposes (**primarily for the benefit of the sponsor, not the community**)
- Fully reimbursed training programs (**no net community benefit expense after offsetting revenue**)

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Line 7g Examples: Subsidized Health Services

Reportable Examples (if meet two-prong test)

- **Emergency and trauma services** maintained despite a residual loss (**community capacity would fall below need if discontinued**)
- **Inpatient behavioral health / substance use disorder programs** with a documented need and a loss remaining after the Medicaid carve-out (**often the only such capacity in the service area**)
- **Neonatal intensive care and burn units** (**regional sole-provider services; residual loss after carve-outs**) **OB / labor & delivery in underserved areas** where the loss survives the Medicaid carve-out and discontinuation would leave the community without the service (**unavailable in the community if dropped**)
- **Palliative care / hospice and renal dialysis programs** operating at a residual loss against documented need (**would become a government or other nonprofit's responsibility**)
- **Primary care clinics in medically underserved communities**, including subsidized physician clinics (**permitted, but clinic costs must be disclosed in Part VI, line 1**)

Non-Reportable Examples (generally)

- Losses attributable to **financial assistance, Medicaid/means-tested programs, or bad debt** within the service line (**already reported on 7a–7c or excluded — 7g reports only the residual**)
- A service that loses money overall but is **profitable after the carve-outs** (**no residual subsidized loss**) Services operated **primarily for marketing purposes** (**excluded regardless of profitability**)
- Cosmetic or elective service lines without demonstrated community need (**fails the need prong**)
- Services profitable on a fully loaded basis (**fails the loss prong**)

Key Tip: Evaluate each service line individually on fully loaded costs (direct + indirect), **remove the 7a–7c components from both sides**, and document the residual loss and the specific need (sole provider, capacity below need, or government/nonprofit fallback) tied to the CHNA or market data.

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Line 7h Examples: Research

Reportable Examples (generally)

- An unfunded, investigator-initiated pilot study on reducing health disparities, with results submitted for publication (**increases generalizable knowledge made available to the public, no grant number required**)
- A CDC- or University-funded community health study with publicly available results (**qualifying funder, report gross cost with the grant as offsetting revenue, even though it nets to zero**)
- Translational research on local disease patterns or prevention strategies shared with the community (**generalizable knowledge addressing community health needs**)
- A hospital-led community health study published open-access and presented to local health departments — including the publication and dissemination costs in the program's cost (**public availability is part of what qualifies the research**)

Non-Reportable Examples (generally)

- A pharma-sponsored Phase III drug trial run at the hospital under a commercial contract (**for-profit funder, outside the definition regardless of scientific value**)
- A study whose results are kept confidential or never disseminated (whoever funds it, including internal studies) (**fails the public-availability prong of the definition**)
- An internal sepsis-protocol improvement study used only to change hospital workflows (**not generalizable, but the same study, published in a journal, can qualify**)
- Research conducted by a related research institute or foundation that files its own return (**a separately filing affiliate reports its own activity, only the filing organization's costs, including its share of consolidated JV activity, belong on its Schedule H**)

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Line 7i Examples: Cash and In-Kind Contributions for Community Benefit

Reportable Examples (generally)

- Cash grants restricted in writing to community benefit activities (e.g., financial assistance, health education, CHNA implementation) made to other organizations (**restricted to Line 7a–7h purposes**)
- An annual community sponsorship converted to reportable by adding a grant letter restricting the funds to a health program (**the written restriction is what qualifies it, review existing giving**)
- In-kind donations of meeting space, surplus supplies, or depreciated equipment to community clinics or nonprofits (**valued at cost, allocated occupancy cost per hour for space, carrying/book value for supplies and equipment, not market rates**)
- Staff time lent to a community organization's health education or outreach program (**loaded payroll cost — salary plus benefits — while on the organization's payroll**)
- Grants made through the hospital's affiliated foundation to community organizations for 7a–7h purposes (**captured at consolidation or reported by whichever entity files the Schedule H**)

Non-Reportable Examples (generally)

- Contributions funding the organization's own activities already reported on Lines 7a–7h (**avoid double-counting**)
- A health fair the hospital runs itself using its own space and staff (**that's the organization's own program — Line 7e, not 7i**)
- Unrestricted grants or contributions where the recipient decides how to spend the funds (**no written restriction, consider a grant-letter**)
- A grant restricted to a housing or economic development project (**follows the activity to Part II unless the funded activity qualifies as a community health improvement service**)
- Staff volunteering on personal time, not on hospital payroll (**benefit provided by the individual, not the organization**)
- In-kind donations valued at fair market value rather than cost/book value (**common overstatement error**)

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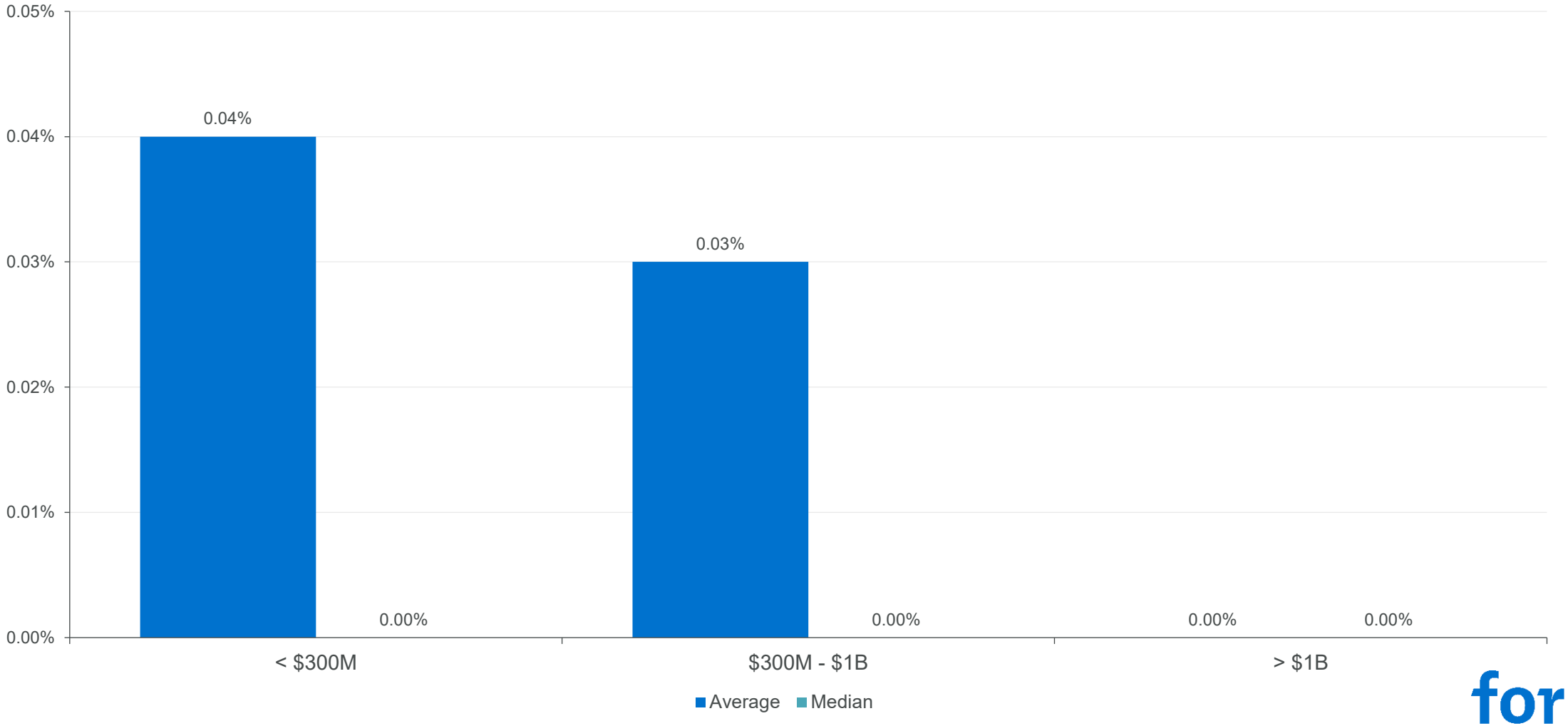
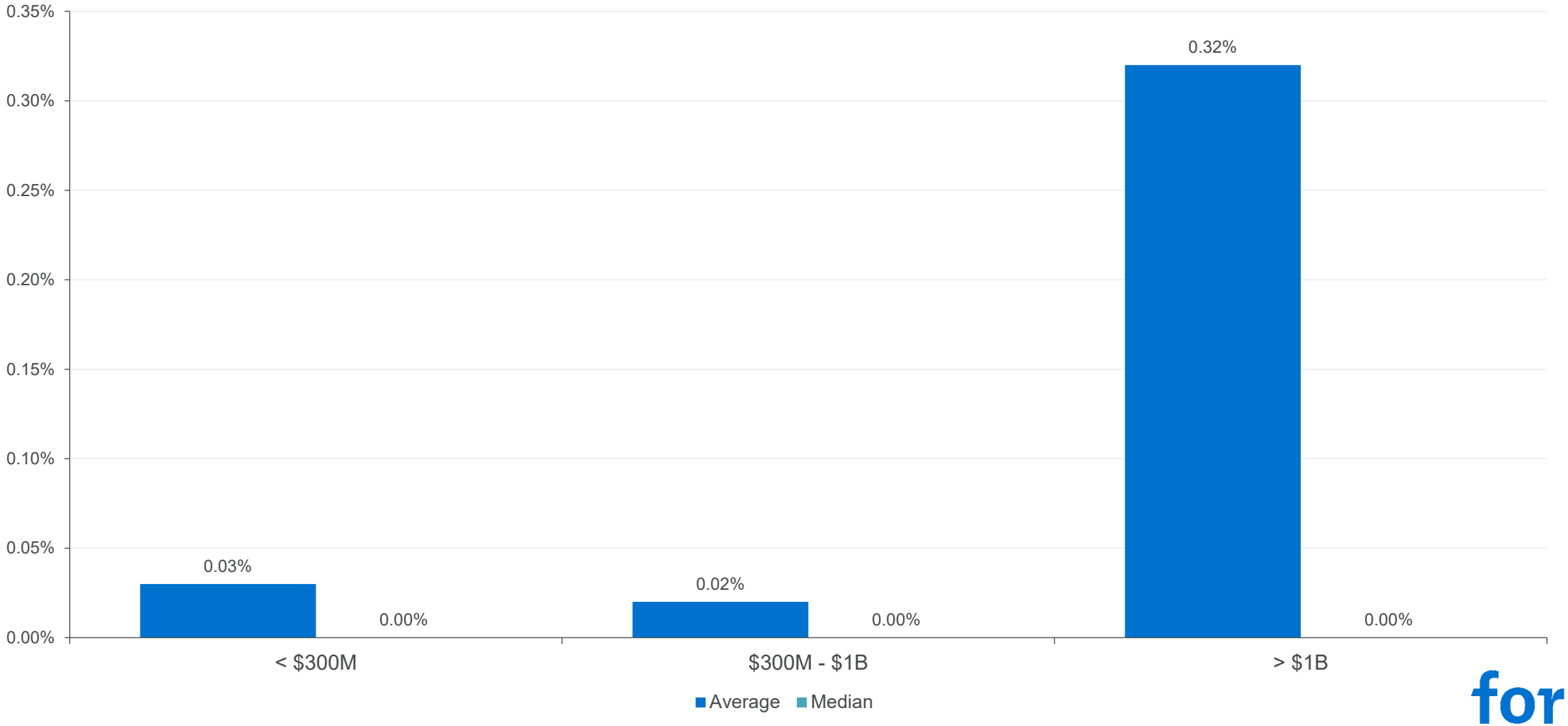
Additional Schedule H Benchmarking

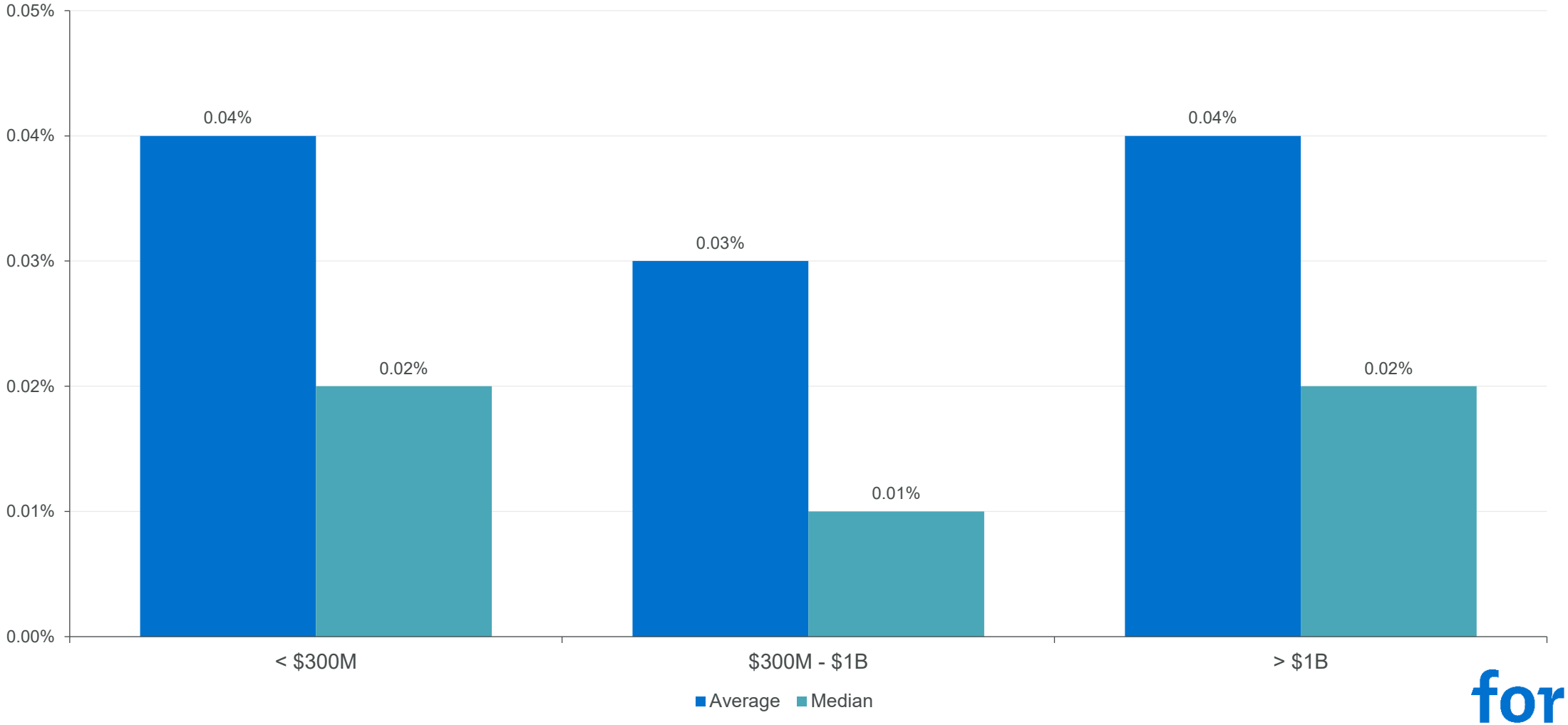
Schedule H, Part I, Line 7c – Costs of Other Means-Tested Programs



Schedule H, Part I, Line 7h – Research



Schedule H, Part I, Line 7i – Cash and In-Kind Contributions



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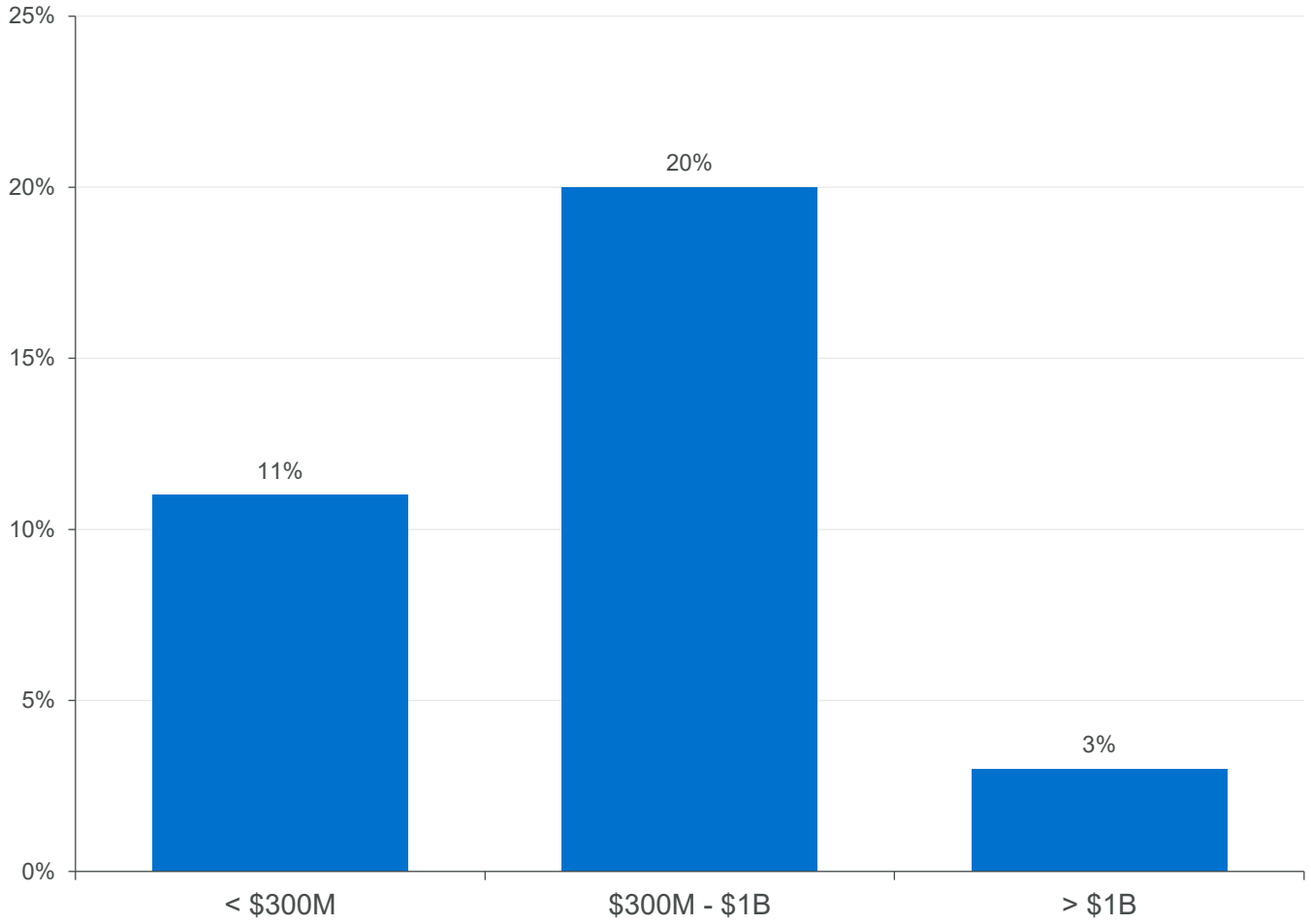
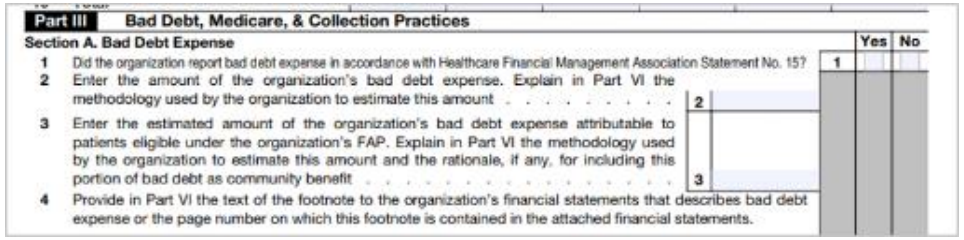
Schedule H, Part III, Section A – Bad Debt





Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Only 25 of 57 MO hospitals

reported bad debt attributable to financial-assistance-eligible patients.

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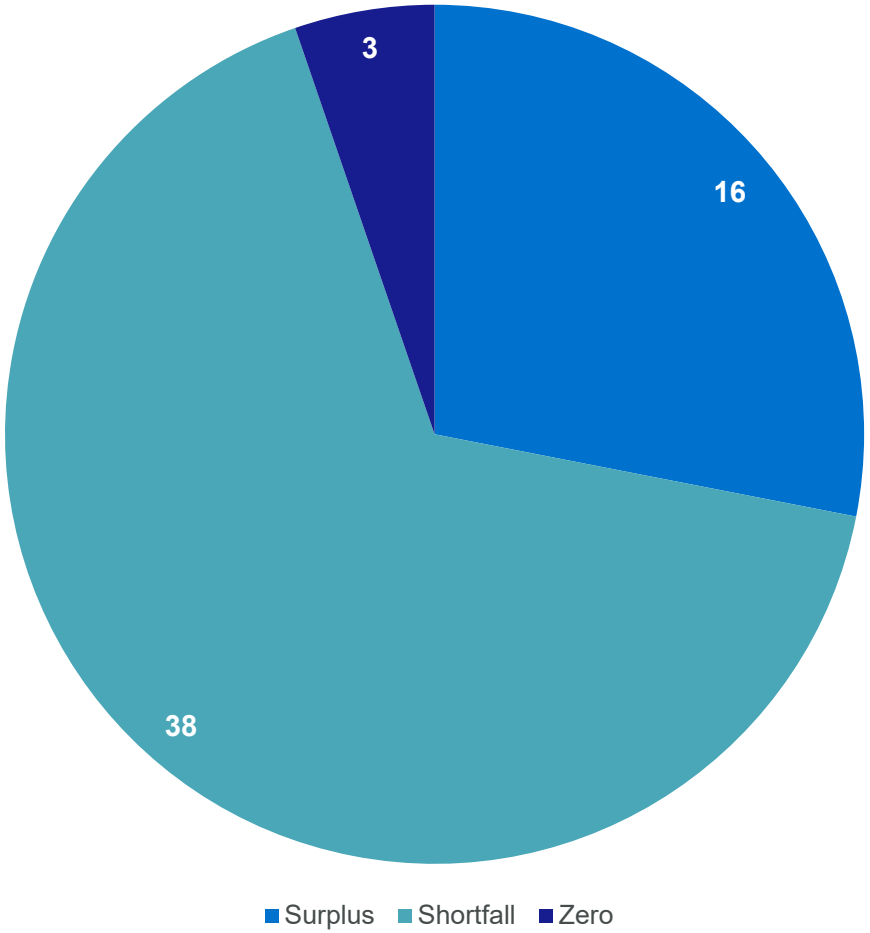
Schedule H, Part III, Section B – Medicare Surplus or Shortfall



Shortfall

Average – $(22,131,546)

Median – $(3,550,218)

Surplus

Average – $8,222,128

Median – $4,938,702