

# Form NHCT31, Community Benefits Reporting

version 1.14

(Submission #: HPM-G90S-AANWG, version 1)

## Details

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**Submitted** 1/12/2023 (48 days ago) by Courtney Stryke

**Alternate Identifier** Riverbend Community Mental Health, Inc.

**Submission ID** HPM-G90S-AANWG

**Status** Submitted

## Form Input

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### Section 1: Organizational Information

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**For Fiscal Year Beginning**

07/01/2021

**Organization Name**

Riverbend Community Mental Health, Inc.

**Street Address**

PO Box 2032

Concord, NH 03302-2032

**Federal ID #**

02-0264383

**State Registration #**

1433

**Website address (must have a prefix such as "http://www.")**

http://www.riverbendcmhc.org

**Is the organization's community benefit plan on the organization's website?**

Yes

**Chief Executive**

**First Name**

Lisa

**Last Name**

Madden

**Phone Type**

Business

**Number**

[REDACTED]

**Extension**

[REDACTED]

**Email**

[REDACTED]

**Board Chair**

<b>First Name</b>	<b>Last Name</b>	
John	<i>Barthelmes</i>	
<b>Phone Type</b>	<b>Number</b>	<b>Extension</b>
Mobile	[REDACTED]	
<b>Email</b>	[REDACTED]	

**Community Benefits Plan Contact**

<b>First Name</b>	<b>Last Name</b>	
Crystal	<i>Welch</i>	
<b>Title</b>		
CFO		
<b>Phone Type</b>	<b>Number</b>	<b>Extension</b>
Business	[REDACTED]	[REDACTED]
<b>Email</b>	[REDACTED]	

**Does this report include community benefit information for affiliated or subsidiary organizations?**

No

**Section 2: Mission & Community Served**

**Mission Statement**

We care for the behavioral health of our community.

**Has the Mission Statement been reaffirmed in the Past Year (RSA 7:32e-I)?**

Yes

**Service Area**

Community may be defined as a geographic service area comprised of the locations from which most service recipients come (primary service area) or a subset of the general population that share certain characteristics such as age range, health condition, or socioeconomic resources. For some trusts, the definition of community may be a combination of geographic service area and a subset of the population within that area. Please include information from the drop down lists and narrative field as applicable to sufficiently describe the community served.

**Did the primary service area cover ALL of New Hampshire?**

No

**Please select service area Counties (NH), if applicable**

Hillsborough  
Merrimack

**Please select service area municipalities (NH), if applicable**

ALLENSTOWN  
ANDOVER  
BOSCAWEN  
BOW  
BRADFORD  
CANTERBURY  
CHICHESTER  
CONCORD  
DANVILLE  
DEERING  
DUNBARTON  
EPSOM  
FRANKLIN  
HENNIKER  
HILL  
HILLSBOROUGH  
HOPKINTON  
LOUDON  
NEW LONDON  
NEWBURY  
NORTHFIELD  
PEMBROKE  
PITTSFIELD  
SALISBURY  
SUTTON  
WARNER  
WEARE  
WEBSTER  
WILMOT  
WINDSOR

**Service Population Description**

Riverbend Community Mental Health consumers are adults, children and families of all ages who experience a range of mental health illnesses and life changes.

The majority of our work involves treatment of mental health/behavioral health concerns: life threatening severe mental illness such as psychosis, schizophrenia and bipolar disorder a forms of addiction; as we as anxiety, depression, divorce or relationship related stress, and other impairing, but highly treatable conditions. We work with consumers in schools, outpatient clinics, homes, jails, facilities serving the elderly, health care settings and residential supported living programs, offering a broad variety of counseling, psychiatric services, case management and emergency consultations.

**Section 3.1: Community Needs Assessment**

**In what year was the last community needs assessment conducted to assist in determining the activities to be included in the community benefit plan? (Please attach a copy of the needs assessment below if completed in the past year)**

2018

**Please attach a copy of the needs assessment if completed in the past year**

NONE PROVIDED  
**Comment**  
NONE PROVIDED

**Was the assessment conducted in conjunction with other health care charitable trusts in your community?**

Yes

**Section 3.2: Community Needs Assessment (1 of 12)**

**Area of Community Need / Concern**

22. Access to Mental Health Services

**Is the need identified in the Community Needs Assessment?**

Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

1: Financial Assistance

C3: Hospital Outpatient Services

C1: Emergency and Trauma Services

E3: In-Kind Assistance

F6: Coalition Building

E4: Resource Development Assistance

A6: Community Needs/Asset Assessment

**Brief description of major strategies or activities to address this need (optional)**

NONE PROVIDED

### **Section 3.2: Community Needs Assessment (2 of 12)**

**Area of Community Need / Concern**

23. Dementia, including Alzheimer's Disease

**Is the need identified in the Community Needs Assessment?**

Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

A3: Health Care Support Services

**Brief description of major strategies or activities to address this need (optional)**

NONE PROVIDED

### **Section 3.2: Community Needs Assessment (3 of 12)**

**Area of Community Need / Concern**

25. Access to Substance Use Disorder Services

**Is the need identified in the Community Needs Assessment?**

Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

C8: Behavioral Health Services

**Brief description of major strategies or activities to address this need (optional)**

NONE PROVIDED

### **Section 3.2: Community Needs Assessment (4 of 12)**

**Area of Community Need / Concern**

31. Transportation Services

**Is the need identified in the Community Needs Assessment?**

Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

A2: Community-Based Clinical Services  
A3: Health Care Support Services

**Brief description of major strategies or activities to address this need (optional)**  
NONE PROVIDED

### **Section 3.2: Community Needs Assessment (5 of 12)**

**Area of Community Need / Concern**  
21. Suicide Prevention

**Is the need identified in the Community Needs Assessment?**  
Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**  
Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

A1: Community Health Education  
C1: Emergency and Trauma Services  
F7: Community Health Advocacy

**Brief description of major strategies or activities to address this need (optional)**  
NONE PROVIDED

### **Section 3.2: Community Needs Assessment (6 of 12)**

**Area of Community Need / Concern**  
36. Other Community Health Need

**If "Other" please describe here:**  
Serious Mental Health

**Is the need identified in the Community Needs Assessment?**  
Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**  
Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

C3: Hospital Outpatient Services  
C1: Emergency and Trauma Services  
C7: Subsidized Continuing Care

**Brief description of major strategies or activities to address this need (optional)**  
NONE PROVIDED

### **Section 3.2: Community Needs Assessment (7 of 12)**

**Area of Community Need / Concern**  
36. Other Community Health Need

**If "Other" please describe here:**  
Depression

**Is the need identified in the Community Needs Assessment?**  
Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

C1: Emergency and Trauma Services

C3: Hospital Outpatient Services

C7: Subsidized Continuing Care

**Brief description of major strategies or activities to address this need (optional)**

NONE PROVIDED

### **Section 3.2: Community Needs Assessment (8 of 12)**

**Area of Community Need / Concern**

2. Access to Prescription Medications / Prescription Assistance

**Is the need identified in the Community Needs Assessment?**

Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

1: Financial Assistance

**Brief description of major strategies or activities to address this need (optional)**

NONE PROVIDED

### **Section 3.2: Community Needs Assessment (9 of 12)**

**Area of Community Need / Concern**

34. Education / Job Training

**Is the need identified in the Community Needs Assessment?**

Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

A2: Community-Based Clinical Services

**Brief description of major strategies or activities to address this need (optional)**

NONE PROVIDED

### **Section 3.2: Community Needs Assessment (10 of 12)**

**Area of Community Need / Concern**

15. Information & Referral Services

**Is the need identified in the Community Needs Assessment?**

Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

A1: Community Health Education

A6: Community Needs/Asset Assessment

F7: Community Health Advocacy

**Brief description of major strategies or activities to address this need (optional)**

NONE PROVIDED

## **Section 3.2: Community Needs Assessment (11 of 12)**

**Area of Community Need / Concern**

29. Workforce Development

**Is the need identified in the Community Needs Assessment?**

Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

B1: Provision of Clinical Setting for Undergraduate Education

B2: Intern/Residency Education

B3: Scholarships/Funding for Health Professions Education

B4: Other Health Professions Education Support

**Brief description of major strategies or activities to address this need (optional)**

NONE PROVIDED

## **Section 3.2: Community Needs Assessment (12 of 12)**

**Area of Community Need / Concern**

1. Financial Barriers to Care; Cost of Care / Insurance

**Is the need identified in the Community Needs Assessment?**

Yes

**Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?**

Yes

**Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.**

E1: Cash Donations

E2: Grants

E3: In-Kind Assistance

**Brief description of major strategies or activities to address this need (optional)**

NONE PROVIDED

## **Section 4: Community Benefit Activities**

**Optional Section 4 completion tool**

An optional MS Excel tool can be used to aid completion of this Section offline. Please click on the "Community Benefits Reporting Tool" link below, this will download the file to a suitable location. Once opened, refer to the "Worksheets" sheet at the bottom of the form. Numbers/dollar amounts can be calculated and will automatically populate into the appropriate fields of the "Section 4" sheet. These numbers can then be entered manually by you in the appropriate fields of this Section 4, below.

[Community Benefits Reporting Worksheets](#)

**Financial Assistance, Means-Tested Government Programs and Community Benefit Services**

**Total Functional Expenses for the Reporting Year (\$)**

34012118

**(1) Financial Assistance at cost (if using the optional Excel tool, refer to Worksheet 1)**

(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 (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
NONE PROVIDED	NONE PROVIDED	968854	0	968854	2.8%	1063467

**(2) Medicaid (if using the optional Excel tool, refer to Worksheet 3, column A)**

(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 (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
NONE PROVIDED	NONE PROVIDED	23798937	23450000	348937	1%	500000

**(3) Costs of other means-tested government programs (if using the optional Excel tool, refer to Worksheet 3, column B)**

(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 (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
NONE PROVIDED	NONE PROVIDED	772645	742644	30001	0.1%	30000

**(4) Total Financial Assistance and Means-Tested Government Programs**

(a) Number of activities or programs	(b) Persons served	(c) Total community benefit expense (\$)	(d) Direct offsetting revenue (\$)	(e) Net community benefit expense (\$)	(f) Percent of total expense (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
0	0	25540436	24192644	1347792	4%	1593467

**Community Benefit Services**

**(5) Community health improvement services and community benefit operations (if using the optional Excel tool, refer to Worksheet 4)**

(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 (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
NONE PROVIDED	NONE PROVIDED	86958	18475	68483	0.2%	91306

**(6) Health professions education (if using the optional Excel tool, refer to Worksheet 5)**

(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 (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
NONE PROVIDED	NONE PROVIDED	103355	0	103355	0.3%	108522

**(7) Subsidized health services (if using the optional Excel tool, refer to Worksheet 6)**



(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 (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
NONE PROVIDED	NONE PROVIDED	1193716	1001023	192693	0.6%	1207641

**(8) Research (if using the optional Excel tool, refer to Worksheet 7)**

(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 (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
NONE PROVIDED	NONE PROVIDED	156083	0	156083	0.5%	163887

**(9) Cash and in-kind contributions for community benefit (if using the optional Excel tool, refer to Worksheet 8)**

(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 (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
NONE PROVIDED	NONE PROVIDED	165584	0	165584	0.5%	150000

**(10) Total Other Benefits**

(a) Number of activities or programs	(b) Persons served	(c) Total community benefit expense (\$)	(d) Direct offsetting revenue (\$)	(e) Net community benefit expense (\$)	(f) Percent of total expense (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
0	0	1705696	1019498	686198	2%	1721356

Total

**(11) Totals**

(a) Number of activities or programs	(b) Persons served	(c) Total community benefit expense (\$)	(d) Direct offsetting revenue (\$)	(e) Net community benefit expense (\$)	(f) Percent of total expense (%)	Estimated expense of activities projected for the next Fiscal Year (\$)
0	0	27246132	25212142	2033990	6%	\$3314823

**Section 5: Community Building Activities**

Total expense (\$; entered at top of Section 4)

34012118

**(1) Physical improvements and housing**

(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 (%)
NONE PROVIDED	NONE PROVIDED	0	0	0	0%

**(2) Economic development**

(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 (%)
NONE PROVIDED	NONE PROVIDED	0	0	0	0%

**(3) Community support**

(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 (%)
NONE PROVIDED	NONE PROVIDED	0	0	0	0%

**(4) Environmental improvements**

(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 (%)
NONE PROVIDED	NONE PROVIDED	0	0	0	0%

**(5) Leadership development and training for community members**

(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 (%)
NONE PROVIDED	NONE PROVIDED	0	0	0	0%

**(6) Coalition building**

(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 (%)
NONE PROVIDED	NONE PROVIDED	0	0	0	0%

**(7) Community health improvement advocacy**

(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 (%)
NONE PROVIDED	NONE PROVIDED	93438	0	93438	0.3%

**(8) Workforce development**

(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 (%)
NONE PROVIDED	NONE PROVIDED	0	0	0	0%

**(9) Other**

(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 (%)
NONE PROVIDED	NONE PROVIDED	0	0	0	0%

**Total****(10) Totals**

(a) Number of activities or programs	(b) Persons served	(c) Total community benefit expense (\$)	(d) Direct offsetting revenue (\$)	(e) Net community benefit expense (\$)	(f) Percent of total expense (%)
0	0	93438	0	93438	0.3%

## **Section 6: Medicare**

**Enter total revenue received from Medicare (\$ -- including DSH and IME)**

742644

**Enter Medicare allowable costs of care relating to payments specified above (\$)**

772645

**Medicare surplus (shortfall)**

\$-30001

**Describe the extent to which any shortfall reported above should be treated as community benefit. Please also describe the costing methodology or source used to determine the amount reported above.**

Costs are calculated as Medicare percentage of revenue multiplied by total costs

**Describe the costing methodology or source used to determine the amount reported above. Please check the boxes below that describe the method used:**

Cost to charge ratio

## **Section 7: Summary Financial Measures**

**Gross Receipts from Operations (\$)**

36801937

**Net operating costs (\$)**

34012118

**Ratio of gross receipts from operations to net operating costs**

1.082

**Unreimbursed Community Benefit Costs**

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**Financial Assistance and Means-Tested Government Programs (\$)**

1347792

**Other Community Benefit Costs (\$)**

686198

**Community Building Activities (\$)**

93438

**Total Unreimbursed Community Benefit Expenses (\$)**

2127428

**Net community benefit costs as a percent of net operating costs (%)**

6.25%

**Other Community Benefits (optional)**

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**Leveraged Revenue for Community Benefit Activities (\$)**

NONE PROVIDED

**Medicare Shortfall (\$)**

\$-30001

## **Section 8: Community Engagement in the Community Benefits Process**

**Please list below**

<b>Community Organizations, Local Government Officials and other Representatives of the Public:</b>	<b>Identification of Need</b>	<b>Prioritization of Need</b>	<b>Development of the Plan</b>	<b>Commented on Proposed Plan</b>
Consumer Empowerment Team	No	No	Yes	Yes
DHHS Bureau of Behavioral Health	No	No	Yes	Yes
Family HealthCenter	No	No	Yes	Yes
DHHS Div of Children Youth and Families	No	No	Yes	Yes
Juvenile Justice	No	No	Yes	Yes
Child and Family Services	No	No	Yes	Yes
NH Mediation	No	No	Yes	Yes
Community Bridges	No	No	Yes	Yes
Variety of Public Schools	No	No	Yes	Yes
Concord Boys and Girls Club	No	No	Yes	Yes
Police Department	No	No	Yes	Yes

**Please provide a description of the methods used to solicit community input on community needs:**

Community Meetings were held and compiled into a planning process for the Community Support Programs that provide services to adults and the other for children and adolescents and their families.

**Section 9: Charity Care Compliance**

**The valuation of charity does not include any bad debt, receivables or revenue.**

Yes

**A written charity care policy is available to the public.**

Yes

**Any individual can apply for charity care.**

Yes

**Any applicant will receive a prompt decision on eligibility and amount of charity care offered.**

Yes

**Notice of the charity care policy is posted in lobbies.**

Yes

**Notice of the policy is posted in waiting rooms.**

Yes

**Notice of the policy is posted in other public areas of our facilities.**

Yes

**Notice of the charity care policy is given to recipients who are served in their home.**

Yes

**Section 10: Certification Contact**

**Name of Person Submitting the Community Benefits Report**

**First Name      Last Name**

Crystal              WELCH

**Title**

CFO

**Email**

[REDACTED]

