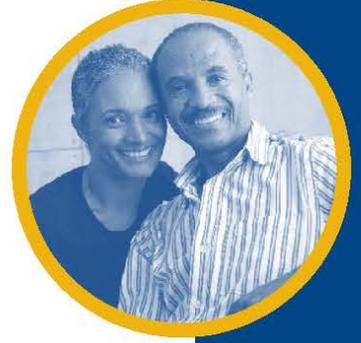


Community Benefits



Reporting Guide



DECEMBER 2020



Community Benefits Reporting Guide

Office of the New Hampshire Attorney General
Charitable Trusts Unit
Concord, NH

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Introduction

Health care charitable trusts in New Hampshire provide many benefits to the communities they serve in keeping with the charitable purposes for which the trusts were established. New Hampshire law requires that health care charitable trusts develop plans and make publicly available reports on their community benefit activities each year. See RSA 7:32-c, I (attached as an Appendix at the end of this guide).

As each community or region of the state may have particular health care needs and concerns specific to that community or region, health care needs should be examined in that context, and the benefits provided by health care charitable trusts in

“Health care charitable trust” means a charitable trust organized to directly provide health care services, including, but not limited to, hospitals, nursing homes, community health services, and medical-surgical or other diagnostic or therapeutic facilities or services. RSA 7:32-d, V.

response should be directed toward addressing the particular issues and concerns identified in the community or population served. This guide and the online New Hampshire Community Benefits Reporting Form introduced in 2020 are intended to provide a consistent framework for describing and quantifying the range of potential community benefit activities among the varied health care charitable trusts in our state.

This guide and online the community benefits reporting form were developed with input from a Community Benefits Advisory Committee convened by the Charitable Trusts Unit of the Office of the New Hampshire Attorney General and comprised of representatives from a variety of organizational types included within the definition of health care charitable trusts. The goals of the Advisory Committee were to simplify and ensure consistency in community benefits reporting and provide an opportunity for the description of important community benefit activities in order to enhance qualitative information provided to the general public. This guide and the community benefits reporting form incorporate categories and definitions developed at the national level, while also reflecting the statutory requirements and other circumstances specific to the New Hampshire experience. For example, the guide draws substantially on the work of the Catholic Health Association (CHA)¹ and incorporates cost reporting elements modeled after federal Community Benefit reporting requirements for hospital corporations found in IRS section 501(r) and Schedule H, Form 990.²

The Charitable Trusts Unit is grateful to the members of the Advisory Committee and the Community Health Institute for their important work in the development of this guide and the online Community Benefits Reporting Tool. The Charitable Trusts Unit is also grateful to the Endowment for Health for its support of this project.

¹ *A Guide for Planning and Reporting Community Benefit*, Catholic Health Association of the United States; 2020.

² <https://www.irs.gov/forms-pubs/about-schedule-h-form-990>

Guide to Reporting

The following pages are intended to provide additional information and guidance for each section of the Community Benefits Reporting Form accessible on the Charitable Trusts Unit website.³ Definitions and additional descriptions to assist in report preparation are included where applicable. The organization of this document corresponds sequentially to the sections contained in the revised form.

The screenshot shows the 'Department of Justice Office of the Attorney General' reporting form. The left sidebar lists sections: Section 1: Organizational Information (highlighted in red), Section 2: Mission & Community Servod (highlighted in red), Section 3: Community Needs Assessment, Section 3.1: Community Needs Assessment, and Section 4: Community Benefit Activities. The main content area is 'Section 1: Organizational Information' with fields for 'For Fiscal Year beginning' (2020), 'Organization Name' (NH Health Care Charitable Trust), and 'Street Address' (Address Line 1 and 2). A 'SAVE PROGRESS' button is in the top right, and a 'CLEAR SECTION' button is in the top right of the form area. A 'Tips / help tool' icon is next to the 'For Fiscal Year beginning' field.

Navigation: Sections will highlight in red until all required fields (*) are complete.

Save Progress button. Information will also save automatically when moving between sections.

Tips / help tool available for many data fields.

³ <https://www.doj.nh.gov/charitable-trusts/forms.htm>

Section 1 ORGANIZATIONAL INFORMATION

The form requires descriptive and contact information for each separately incorporated/organized health care charitable trust. Please include the health care charitable trust's website address, if any, and indicate whether its community benefits plan is posted on the site.

New Hampshire law allows multiple health care charitable trusts to work collaboratively on their community needs assessments, benefit planning, and reporting, provided that cost information is reported specifically for each health care charitable trust. See RSA 7:32-I (Appendix C). In most instances, independent health care charitable trusts will file separate annual reports of community benefits activities and costs. NH health care charitable trusts that are part of a health care system comprised of multiple entities under common governance or control may report combined community benefits,⁴ provided that: a) such affiliates are under common governance or control; and b) such affiliates are themselves considered health care charitable trusts subject to the NH community benefits law. See RSA 7:32-d, V ("Health care charitable trust" means a charitable trust organized to *directly provide* health care services) (emphasis supplied).

Section 1: Organizational Information

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

Yes
 No
 N/A

If YES, please provide the following information on affiliated or subsidiary organizations included in this report. For the purpose of this section, affiliated or subsidiary organizations are: a) under common governance or control; and b) themselves considered health care charitable trusts subject to the NH community benefit law.

Affiliated or Subsidiary Organizations

ORGANIZATION NAME	FEDERAL ID #	STATE REGISTRATION #

ADD ROW

NEXT SECTION
Section 2: Mission & Community Served

Add row to enter information on multiple affiliated or subsidiary organizations.

⁴ Note that this option may vary from federal IRS hospital community benefit reporting. The IRS instructs hospital organizations to refrain from reporting on Schedule H (Form 990) information from an entity organized as a separate legal entity from the organization and treated as a corporation for federal income tax purposes (except for members of a group exemption included in a group return filed by the organization), even if such entity is affiliated with or otherwise related to the organization (for example, part of an affiliated health care system). Consequently, NH health care charitable trusts that are part of an affiliated system may continue to file separate, individual community benefit reports with the NH Charitable Trusts Unit.

Section 2 MISSION & COMMUNITY SERVED

Health care charitable trusts are required to include their **mission statements** in their community benefits plans and are required to reaffirm their mission statements on an annual basis. See RSA 7:32-e. Annual reaffirmation can be accomplished by vote of the Board at an annual meeting.

Health care charitable trusts must **describe the communities** they serve. “Community” may be defined as a geographic service area defined by 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 to describe the community served.

Section 1: Organizational Information

Section 2: Mission & Community Served

Section 3: Community Needs Assessment

Section 3.1: Community Needs Assessment

Section 4: Community Benefit Activities

Section 5: Community Building

Did the primary service area cover ALL of New Hampshire?

Yes

No

Please select service area Counties (NH), if applicable

Please select service area municipalities (NH), if applicable

Service Population Description

<Serve the general population>

Select information from the drop down lists and / or use the narrative field as applicable to describe the community served.

Sections 3.1 and 3.2 COMMUNITY NEEDS ASSESSMENT

The Community Needs Assessment portion of the revised form has two parts. **Section 3.1** requires that health care charitable trusts identify the year of the most recent community health needs assessment. If a new or updated community needs assessment was completed in the past year, a copy of the needs assessment can be uploaded as a file attachment to the community benefits report.

The screenshot shows a web form titled "Section 3.1: Community Needs Assessment". On the left is a navigation sidebar with sections: Information, Section 2: Mission & Community Served, Section 3.1: Community Needs Assessment (highlighted), Section 3.2: Community Needs Assessment, Section 4: Community Benefit Activities, and Section 5: Community Building Activities. The main content area asks: "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)". Below this is a dropdown menu showing "2020". Underneath is a dashed box for file upload with the text "Please attach a copy of the needs assessment if completed in the past year", "Drop files here to upload", a file icon, "OR", and a "CHOOSE FILE" button. A callout box points to the upload area with the text: "Attach a copy of the community needs assessment if new or updated in the past year."

The first item in **Section 3.2** is a drop down list of 35 potential community health needs or concerns. The list in the reporting form was developed from a review of the most commonly reported needs across all organizational types, review of other typologies such as National Health Promotion and Disease Prevention Objectives, and Advisory Committee review and input. The full list is included as Appendix B of this document.

The form requires that health care charitable trusts use this list to report the priority community needs as determined in the most recent community health needs assessment or through other methods and sources. For each identified need, health care charitable trusts indicate if the need was identified in the Community Needs Assessment and if the need is included in the Community Benefits Plan.

The purpose of the needs assessment process is to assist health care charitable trusts in determining activities to be included in their community benefits

plans. Some important activities of health care charitable trusts that provide community benefits may not be reflected in a public community needs assessment process, however. It is not the intent of the community benefits process to redirect health care charitable trusts away from their primary missions such that the consequence would be to create a need in the community where one did not previously exist.

For example, an agency with the primary mission of providing long-term care may not find that mission well reflected in a broad, periodic community needs assessment that ranks maternal and

Every health care charitable trust shall, either alone or in conjunction with other health care charitable trusts in its community, conduct a community needs assessment to assist in determining the activities to be included in its community benefits plan. RSA 7:32-f

child health issues as high priorities. In spite of the community needs assessment, such an agency likely would conclude that its primary community benefit is to provide long-term care and aging-related services to the community consistent with its charitable purpose. Similarly, some services are provided by health care charitable trusts despite an ongoing financial loss because they are essential services that would not otherwise be available to the community (e.g., trauma services, intensive care, hospice care). Such services may not show up as a need in a public community assessment process until they became unavailable or inaccessible.

Considering these and other similar scenarios, it is possible that a health care charitable trust may report a priority community need that is not addressed in the Community Benefits Plan of that particular organization or may report a community benefits activity that was not identified as a priority in the most recent community-wide needs assessment. Broad-based community assessments may be supplemented by focused assessment and engagement of current and potential recipients of the health care charitable trust’s services, as well as an examination of other factors, including waiting lists for services and applications for financial relief. The open field on the form may be used to describe strategies and activities and briefly describe information sources and processes for identifying these additional community needs.

The image shows a screenshot of a web-based form titled "Section 3.2: Community Needs Assessment". On the left, a vertical navigation menu lists sections from 7 to 11, with "Section 10: Certification Contact" highlighted. The main form area contains the following fields and options:

- Area of Community Need / Concern:** A dropdown menu with "1. Financial Barriers to Care, Cost of Care / Insurance" selected. A callout box points to this field with the text: "Select identified need from the dropdown list".
- Is the need identified in the Community Needs Assessment?** Radio buttons for "Yes" (selected) and "No". A callout box points to these buttons with the text: "Indicate if the need was identified in the most recent Community Needs Assessment and if the need is addressed in the Community Benefits Plan."
- Is the need addressed in the Health Care Charitable Trusts Community Benefit Plan?** Radio buttons for "Yes" (selected) and "No". A callout box points to these buttons with the text: "Indicate the Community Benefit Category or Categories (see next page of this guide) included in the Community Benefits Plan to address the need (including N/A)".
- Please select the applicable Category or Categories of Community Benefit included in your plan associated with this need.** A dropdown menu with "1: Financial Assistance" selected. A callout box points to this field with the text: "Indicate the Community Benefit Category or Categories (see next page of this guide) included in the Community Benefits Plan to address the need (including N/A)".
- Brief description of major strategies or activities to address this need (optional):** A text area containing "Sliding fee scale offered based household income", "Case workers provide eligibility / enrollment assistance", "Operational support of free clinic", and "Financial support of community health center". A callout box points to this text area with the text: "Optional section for brief narrative description of strategies and activities".

At the bottom of the form, there are two buttons: "DUPLICATE SECTION 3.2: COMMUNITY NEEDS ASSESSMENT" and "ADD NEW SECTION 3.2: COMMUNITY NEEDS ASSESSMENT". A callout box points to these buttons with the text: "For each additional area of need, select either 'Add New Section' or 'Duplicate Section' to create additional rows for entering information on that need."

Section 3.2 (continued)

COMMUNITY BENEFIT CATEGORIES

This section addresses what counts as a community benefit activity and how to report the associated costs. The section is organized into three main categories of community benefit with further categorization of the third category: Community Benefit Services. These categories are listed below and described on the following pages of this guide.

Category 1: Financial Assistance

Category 2: Government Sponsored Health Care

Category 3: Community Benefit Services

- A. Community Health Improvement Services and Community Benefit Operations
- B. Health Professions Education
- C. Subsidized Health Services
- D. Research
- E. Financial Contributions
- F. Community Building Activities

The plan shall identify the activities the trust expects to undertake or support which address the needs determined through the community needs assessment process or which otherwise qualify as community benefits and shall include all charity care in a discrete category. RSA 7:32-e, III

Category 1: Financial Assistance. Financial assistance, also referred to as charity care, is free or discounted care provided to persons deemed unable to pay based on formal financial assistance policies established by the organization. Charity care is financial assistance that is provided without expectation of payment and therefore does not include “bad debt.” The term likewise does not include discounts not resulting from a determination of financial need or contractual allowances. Financial

assistance should be reported in terms of costs, not charges, for providing care to uninsured patients who qualify for free or discounted care as well as for under-insured patients who qualify for discounted or forgiven charges for amounts that are the patient’s responsibility.

“Charity care” means health care services provided by a health care charitable trust for which the trust does not expect and has not expected payment. Such services are not and have not been recognized as either a receivable or as revenue in the trust’s financial statements. Charity care is not bad debt. RSA 7:32-d, I and 7:32-h, I

Category 2: Government-Sponsored Health Care. Health care charitable trusts can report payment shortfalls incurred as a result of caring for patients with Medicaid (Category 2.1) and other public insurance programs⁵ with an income eligibility requirement, provided that the amount reported is the difference between actual reimbursement and the cost of care. Payment shortfalls are not synonymous with contractual allowances (the difference between full charges and actual payments). Please see Section 4: Community Benefit Activities for additional information on reporting community benefit costs including guidance on reporting Medicaid Enhancement Tax expenses and Disproportionate Share revenue.

Medicare shortfall (Category 2.3) is also included on the list of community benefit categories in Section 3.2 of the reporting form. Note that the IRS does not consider Medicare shortfall as a community benefit and that as Medicare is not a means-tested program, the Catholic Health Association recommends against inclusion of Medicare shortfall in community benefit reporting. Given the diversity of filing organizations in New Hampshire, it is, however, possible that Medicare shortfall could be the result of insufficient payment rates. Therefore, while the Medicare shortfall is not included in the calculation of community benefit (section 7), charitable trusts in New Hampshire may record this information in an optional section of the form (Section 6).

Category 3: Community Benefit Services. In addition to financial assistance to individuals and shortfall from government programs for reimbursable health care services, community benefits can include a broad set of programs and activities intended to address identified community health needs and to promote overall community health improvement including underlying determinants of health. Community Benefit Services are organized conceptually in six areas with subcategories as described below. Some health care charitable trusts may not conduct or report activities in all of these areas.

A. Community Health Improvement Services and Community Benefit Operations: Community health improvement services include activities carried out to improve community health that extend beyond patient care activities and are subsidized by the health care organization. Community services do not generate inpatient or outpatient bills, although there may be a nominal fee. Sub-categories of community health services can include:

A1 - Community Health Education includes presentations and other educational programs and activities provided to groups that do not include the provision of clinical or diagnostic services. Examples include caregiver training for persons caring for family members at home, education on specific disease conditions (e.g. diabetes, heart disease), health promotion and wellness programs, support groups, and the communication of public health messages. Community health education activities designed primarily to increase market share should not be included.

⁵ An example of an ‘other public insurance program’ is the Children’s Health Insurance Program (CHIP). In New Hampshire, the entire CHIP program is now part of Medicaid including Expanded Children's Medicaid.

A2 - Community-Based Clinical Services include clinical services to the community on an occasional or one-time basis designed to meet an identified community need. Examples include community-based screenings and health risk appraisals, one-time or occasionally held clinics, and free clinics providing health services through the use of donated staff time. Do not count services that primarily are promotional or intended to generate referrals, and do not count the value of volunteer time.

A3 - Health Care Support Services are services intended to assist community members in accessing information and services. Examples include enrollment assistance in public programs, assistance in obtaining free or reduced cost medications, information and referral to community services, telephone information services (e.g., hotlines, poison control centers), and transportation programs to enhance access to care. Do not count care management or discharge planning services that are considered routine aspects of the clinical care process and typically are factored into reimbursable costs. Do not count the value of medications accessed through medication assistance programs beyond the cost of medications directly purchased and donated by the organization.

A4 - Other Community Health Improvement Services can include programs or policy initiatives where the *primary purpose* is to improve access to health services, improve public health, increase health knowledge and awareness, or address underlying determinants of health including the social, economic, and physical environment. These activities may be related to Community Building Activities (Category F). The difference between the two terms is that the term “Community health improvement activities” means those activities “provided to *improve the health of individuals and populations* in the community” while “community building activities” are those activities “provided to *strengthen the community’s capacity* to promote the health and well-being of its residents.”⁶ (Note: the New Hampshire Community Benefits form includes unreimbursed costs for community health improvement and for community building in the community benefit total.)

A5, A6, A7 - Community Benefit Operations: Community benefit operations include costs associated with staff dedicated to administering benefit programs, community health needs assessment costs, and other costs associated with community benefit planning and operations. **Dedicated Staff Costs (A5)** include staff costs of management of community benefit program activities and coordination of community benefit-related volunteer programs that are not included in other community services categories. **Cost of Needs Assessment Activities (A6)** include surveys, forums, and staff and contract costs for data collection and analysis. Do not count costs of marketing and image assessment activities. **Other Community Benefit Operations (A7)** can include costs of fundraising for organization-sponsored community benefit programs including grant writing and other fundraising costs, costs associated with community benefits reporting, and office and indirect expenses associated with community benefits operations. Do not count fundraising costs or

⁶ *Community Benefit and Community Building*, Catholic Health Association (March 2015) (available at www.chausa.org/docs/default-source/community-benefit/guidance_for_determining-march25_2015.pdf).

organizational projects that are not directly associated with community benefit programs.

- B. **Health Professions Education:** Health professions education activities that count as community benefits include unreimbursed, unsubsidized provision of clinical settings for undergraduate training, internships, and residency education programs. Financial assistance for continuing health professional education may also be counted when the educational purpose is to increase capacity for community health improvement including expanding access and availability of needed services for underserved communities.

B1 - Provision of Clinical Setting for Undergraduate Education includes unsubsidized costs of providing or sponsoring clinical settings for undergraduate/vocational training of physicians, dentists, advance practice providers, nurses, counselors, therapists, technicians, and other health care professionals.

B2 - Intern/Residency Education includes unsubsidized costs of providing or sponsoring clinical settings for advanced practice training of physicians, dentists, advance practice providers, nurses, counselors, therapists, technicians, and other health care professionals including internships, clerkships, and residencies.

B3: Scholarships/Funding for Health Professions Education includes registration, fees, travel, and incidental expenses for staff education linked to community benefit services and health improvement. This category can also include scholarships or tuition payments for professional education to non-employees and volunteers. Do not count standard orientation, in-service training, continuing education activities required for licensure, or other continuing education expenses provided as a benefit of employment.

B4: Other Health Professions Educational Support may include internships for pastoral education, social service, dietary, and other professional/instructional internships, medical translator training, job shadowing and mentoring projects, recruitment/retention of under-represented populations, scholarships to community members (i.e. not employees), and in-service/video conferencing programs made available to professionals in the community.

- C. **Subsidized Health Services:** Subsidized health services are services provided despite a significant and ongoing financial loss because they meet an essential community need and would not otherwise be available unless the responsibility was assumed by government. “Subsidized health services” do not include services that are operated at a loss due to inefficiency. The costs of subsidized health services (which generate a claim or bill) are separate from charity care (does not generate a claim or bill, although it will generate a charge before adjustment) and Medicaid or Medicare shortfalls. The costs of charity care and public insurance programs are included in other categories of community benefit. Health care charitable trusts should subtract revenues and costs associated with Medicaid and financial assistance from values reported for subsidized health services to avoid double counting the community benefit.

In order to determine whether a particular subsidized service should be considered a community benefit, consider the following test:

“Is it reasonable to conclude that if the organization no longer offered the service, the service would be unavailable in the community, the community’s capacity to provide the services would be below the community’s need, or the service would become the responsibility of government or another tax-exempt organization?”⁷

Examples of subsidized health services may include:

- Emergency and Trauma Services (C1)
- Neonatal Intensive Care (C2)
- Hospital Outpatient Services (C3)
- Burn Units (C4)
- Women’s and Children’s Services (C5)
- Renal Dialysis Services (C6)
- Subsidized Continuing Care (C7)
- Behavioral Health Services (C8)
- Palliative Care (C9)
- Other Subsidized Health Services (C10)

Some organizations, such as community health centers, provide discounted health services that may not otherwise be available. To the extent that such services are provided as free or discounted care to individuals where no bill is generated for the full or partial charge, these costs should be reported as charity care (Category 1: Financial Assistance). Subsidized health services are distinct from free or discounted care in that the former is a set of health services operated at an ongoing loss *subsidized by other areas of operation* in order to meet an essential community need.

In some cases, subsidized health services or discounted health services are reimbursed by federal and state grants to eligible organizations that serve vulnerable and underserved populations. In these instances, the amount of external funds leveraged through grants and other sources that make it possible to provide subsidized services or charity care as a benefit to the community should be reported as “Leveraged Revenue” in Section 7: Summary Financial Measures.

- D. **Research:** Research includes [clinical research \(D1\)](#) or [community health, public or population health, and health services research \(D2\)](#) on topics impacting community need such as cost, access, and quality where the findings are made available outside the organization. In this category, count as a community benefit only the difference between external subsidies (such as grants) and operating costs for research.

⁷ A Guide for Planning and Reporting Community Benefit, The Catholic Health Association of the United States; 2015 edition.

E. **Financial Contributions:** This category includes funds and in-kind services donated by the health care charitable trust to individuals, other organizations, or the community-at-large. In-kind services include hours donated by staff to the community while on health care organization work time, overhead expenses of space donated for use by community groups, and donations of food, equipment, and supplies. Sub-categories of financial contributions include:

E1: Cash Donations including contributions or matching funds provided to community organizations, event sponsorships and contributions to charity events, contributions provided to individuals for emergency assistance, and scholarships to community members not specific to health care professions. *Do not count as a community benefit of the organization funds donated by employees.*

E2: Grants made to not-for-profit community organizations, projects, and initiatives including program grants, operating grants, education and training grants, and matching grants.

E3: In-Kind Assistance including donations of space for community groups; donations of equipment, food and supplies; costs of coordinating community events not sponsored by the health care organization; employee costs associated with board and community involvement on paid time; and donations of technical assistance to community organizations, such as information technology, accounting, human resources, planning, and marketing. *Do not count costs or value of volunteer time of employees engaged in board and community involvement on their own time.*

E4: Resource Development Assistance such as grant writing and other fundraising costs specific to community programs and resource development assistance not captured under Other Community Benefit Operations (A7).

F. **Community Building Activities:** As noted in section A4, Community Building Activities are provided to strengthen the community's capacity to promote the health and well-being of its residents. Community building activities can include expenditures and in-kind donations by the health care charitable trust for the development of programs, policies, and partnerships intended to address physical, social, and economic determinants of health. Sub-categories in this area include:

F1: Physical Infrastructure Improvement including community revitalization projects; housing rehabilitation; public works; contributions to community-based assisted living, senior and low-income housing projects; and home safety assessment and installations. *Do not count the costs for renovations or improvements to the health care charitable trust's own infrastructure.*

F2: Economic development such as small business development and participation in economic development councils and chambers of commerce.

F3: Support Systems Enhancement efforts such as child care for community residents with qualified need; mentoring programs and youth development initiatives; emergency preparedness activities such as community disease surveillance and reporting infrastructure; costs of stockpiling medical, surgical, and pharmaceutical supplies including personal protective equipment; costs associated with new or expanded training, task force participation, and drills; and mental health resource costs associated with training, community partnerships, and outreach planning.

F4: Environmental Improvements such as efforts to reduce environmental hazards in the air, water, and ground including lead detection and remediation; radon detection and remediation; community waste reduction and sharps disposal programs; health care facility waste and mercury reduction.

F5: Leadership Development; Training for Community Members including cultural skills training, language skills development, life skills training programs, medical interpreter training for community members, and community leadership training and development. *Do not count interpreter training programs for hospital staff required by law.*

F6: Coalition Building such as organizational representation on community coalitions; collaborative partnerships with community groups to improve community health; and costs for community coalition meetings, visioning sessions, community health improvement task force meetings, and task force projects and initiatives.

F7: Community Health Advocacy at the local, state, or national level for community members and groups relative to policies and funding for identified community and public health improvement needs including the social and economic determinants of health.

F8: Workforce Development connected to community needs and priorities including recruitment of physicians and other health professionals for government-designated medically underserved areas; recruitment of under-represented populations; job creation and training programs; participation in community workforce boards and workforce initiatives; partnerships to address health care workforce shortages; and school and community-based programs on health care careers. *Do not count routine staff recruitment and retention initiatives and in-service education and tuition reimbursement programs for current employees.*

Section 4 COMMUNITY BENEFIT ACTIVITIES

In Section 4, health care charitable trusts report the unreimbursed costs associated with Community Benefits Activities described in the preceding section (Section 3.2) except for Community Building Activities which are addressed in Section 5. The format of Section 4 of the New Hampshire Community Benefits Reporting Form is substantially modeled on IRS Schedule H, Form 990. This format was chosen to more consistently align Community Benefit Reporting with federal guidelines. Health care charitable trusts are not expected to report Community Benefit costs or revenue in every category.

One variation between the New Hampshire form and the federal reporting form, IRS Form 990, Schedule H, is that the state form includes an additional column for reporting estimated expenses of activities projected for the next fiscal year as required by New Hampshire law.

To the extent practicable, the plan shall include:
(1) An estimate of the cost of each activity expected to be undertaken or supported in the ensuing year;
and (2) a report on the unreimbursed cost of each activity undertaken in the preceding year.
RSA 7:32-e, V

In order to improve the consistency and comparability of expense information reported on NH Community Benefit Reports, the form adopts the IRS instructions for reporting total expenses. For purposes of community benefit reporting and calculations, the IRS defines total expenses as the organization's Total Functional Expenses excluding bad debt reported on Form 990 (specifically "the amount reported on Form 990, Part IX, line 25, column (A) including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25"). The first data entry field in Section 4 requires that health care charitable trusts report Total Functional Expenses for the Reporting Year.

Required fields in Section 4 for each community benefit category are Total Community Benefit Expense, Direct Offsetting Revenue, Net Community Benefit Expense, and Estimated Expense of Activities Projected for the Next Fiscal Year. As the form requires data entry in each of those fields, **organizations that do not have any activity in a particular category must enter zeros** in the applicable fields to complete the section. Optional fields are included for reporting Number of Activities or Programs and Persons Served for each category.

Financial Assistance should be reported in terms of costs, not charges. Do not include bad debt, discounts not resulting from a determination of financial need, or contractual allowances. Means-tested public program revenues and costs are reported in terms of total and net expense (with "net community benefit expense" determined by subtracting net patient revenue from total expense). These programs, like financial assistance, are reported in terms of total and net cost.

The Medicaid Enhancement Tax (MET) and Disproportionate Share Hospital (DSH) Payment Program in New Hampshire historically have been used to offset uncompensated care costs for both Medicaid and Financial Assistance to uninsured individuals. Organizations subject to the Medicaid Enhancement Tax can: a) allocate the tax expense proportionately between Financial Assistance and Medicaid based on a reasonable estimate of which portions are intended for each category of community benefit; and b) allocate Disproportionate Share revenue proportionately between Financial Assistance and Medicaid based on a reasonable estimate of which portions are intended for each category of uncompensated care.

The screenshot shows a reporting form with a sidebar on the left containing sections: Information, Section 2: Mission & Community Served, Section 3.1: Community Needs Assessment, Section 3.2: Community Needs Assessment, Section 4: Community Benefit Activities (selected), Section 5: Community Building Activities, Section 6: Medicare, and Section 7: Summary Financial Measures.

Total Functional Expenses for the Reporting Year (\$)
 1000000

(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 (\$)
	500	200000	0	200000	2%	200000

(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 (\$)
		1000000	500000	500000	5%	1000000

(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 (\$)
		0	0	0	0%	0

Callout 1: Total Functional Expenses are the amount reported on Form 990, Part IX, line 25, column (A) including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25

Callout 2: Note: The form does not accept comma separators. Please double check data entry, particularly for large numbers.

Callout 3: Enter zero (0) values for categories where the organization has no activities or costs.

For categories that are programmatic in nature such as Community Health Services, direct costs may include salaries, benefits, supplies, equipment, travel, cash contributions, tuition, fees, and other costs that are directly attributable to the activity or program. In recognition of the fact that community benefit programs require the attention and support of senior administration and administrative support systems, health care charitable trusts may also elect to apply an indirect cost rate consistent with their general accounting practices. Report indirect costs only if they have not already been included in calculating costs. For example, the cost of administrative staff involvement in community benefit-related assessment, planning, or programming should not be included as both direct and indirect costs. Similarly, an indirect cost rate should not be applied to the valuation of charity care or other direct patient care subsidies

that are based on unit of service costs that already factor in the indirect costs of patient care operations.

Section 5 COMMUNITY BUILDING ACTIVITIES

Section 5 provides a separate table for reporting costs for Community Building Activities. Community Building Activities (i.e., activities intended to strengthen the community’s capacity to promote the health and well-being of its residents) are counted as a community benefit in the New Hampshire equivalent to other categories of community benefit. The NH Community Benefit Reporting Form separates cost reporting of these activities only to facilitate ease of reporting by aligning the table formats with Schedule H of IRS Form 990.

The structure of Section 5 is similar to Section 4 with required fields for each community building category for Total Community Benefit Expense, Direct Offsetting Revenue, and Net Community Benefit Expense. Organizations that do not have any activity in a particular category must enter zeros in the applicable fields to complete the section. Optional fields are included for reporting Number of Activities or Programs and Persons Served for each category. As with Section 4, there should be some correlation in reporting between Section 5 and the Community Benefit categories identified in Section 3.2.

Section 5: Community Building Activities

Complete this table if the organization conducted community building activities during the reporting year. Information provided on this table should align with the information provided in Section 3.2: Community Needs Assessment with respect to Community Benefit Subcategories F1 to F7 (Community building Activities).

Total expense (\$, entered at top of Section 4)
100000.00

(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 (%)
(1) Physical improvements and housing					
		10000	0	10000	0.1%
(2) Economic development					
		0	0	0	0%
(3) Community support					
		6000	0	6000	0.1%
(4) Environmental improvements					
		0	0	0	0%
(5) Leadership development and training for community members					
		2000	0	2000	0%
(6) Coalition building					
		2000	0	2000	0%
(7) Community health improvement advocacy					
		0	0	0	0%

Section 6 MEDICARE

Section 6 on the NH Community Benefits Reporting Form provides an opportunity for reporting Medicare shortfall in a manner that is consistent with IRS instructions. Section 6 also provides a comment field to enable organizations to describe how this shortfall is a community benefit. The net expense from Medicare shortfall is shown separately in the Financial Summary section (Section 7).

Section 6 is OPTIONAL, meaning that health care charitable trusts can choose to leave this section blank, and the system will not generate an error message. Because Medicare is not considered a means-tested program (i.e., does not have eligibility criteria based on income or assets), deficits or shortfall from serving Medicare recipients are not typically considered to be a community benefit.

Nevertheless, Section 6 provides the opportunity for health care charitable trusts to report and comment on Medicare shortfall, if they wish to do so.

Section 7 SUMMARY FINANCIAL MEASURES

The Summary Financial Measures section of the revised NH Community Benefit Reporting Form largely is pre-populated with values entered in Sections 4 and 5. There are two additional data entry fields in this section. The first is a field for entering “Gross Receipts from Operations,”

which is the terminology used in the NH Community Benefits statute. In order to ensure consistency in how health care charitable trusts are defining or perceiving that terminology for community benefit reporting, health care charitable trusts should use IRS Form 990 as a source document. Specifically, the first field in Section 7: “Summary Financial Measures” requires that health care charitable trusts enter the

Enter the amounts (\$) from Form 990, Part I, line 8 (Program Service Revenue) plus line 9 (Contributions and Grants)

amounts (\$) from Form 990, Part I, line 8 (Program Service Revenue) plus line 9 (Contributions and Grants). The sum of these two amounts provides a consistent basis for reporting revenue from operations across organizations and organizational types.

The second open field for additional data entry in Section 7 is “Leveraged Revenue for Community Benefit Activities,” an OPTIONAL field (meaning that it can be left blank). The field is included in order to allow health care charitable trusts to report leveraged revenue (e.g., grants, donations) for community benefit activities as a net benefit, as such leveraged revenue may be the primary community benefit of organizations with low operating margins and limited means for direct expenditures in support of community benefit activities. For example, the community may benefit from revenue received by a federally qualified health center in the form of a federal grant that subsidizes discounted services for individuals with low income.

Section 8

COMMUNITY ENGAGEMENT IN THE COMMUNITY BENEFITS PROCESS

New Hampshire law, RSA 7:32, requires that in developing their community benefits plans, health care charitable trusts consult with members of the public, community organizations, service providers, and local government officials in their service areas in order to identify community assets, build strong community partnerships, and ensure that the plans are responsive to emerging community needs. The law requires that the process for development of the plan include an opportunity for members of the public in the trust’s service area to provide input into development of the plan and comment upon the trust’s proposed plan for each reporting year. Many health care organizations across New Hampshire regularly engage with community leaders, recipients of services, and other health and non-health care organizations in their service areas in order to assess needs and develop collaborative plans for community health improvement.

Section 8 of the form requires health care charitable trusts to identify their partners in the assessment and planning process. In addition to identifying assessment and planning participants, Section 8 of the form requires organizations to report the role of each participant in the process with respect to the identification of need, prioritization of need, development of the plan, or plan comment.

Section 8: Community Engagement in the Community Benefits Process CLEAR SECTION

List the Community Organizations, Local Government Officials and other Representatives of the Public consulted in the community benefits planning process. Indicate the role of each in the process.

Please list below

SPECIFY COMMUNITY ORGANIZATIONS, LOCAL GOVERNMENT OFFICIALS AND OTHER REPRESENTATIVES OF THE PUBLIC:	IDENTIFICATION OF NEED	PRIORITIZATION OF NEED	DEVELOPMENT OF THE PLAN	COMMENTED ON PROPOSED PLAN	
Agency 1	Yes -	Yes -	Yes -	Yes -	X
Community Group 1	Yes -	Yes -	No -	Yes -	X
Civic Leader 1	Yes -	No -	No -	Yes -	X

ADD ROW

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

Add as many additional rows as needed to list partners and other participants in the community benefits assessment and planning process.

Section 9 CHARITY CARE COMPLIANCE

This section addresses formal documentation and public notice of charity care policies. For many health care charitable trusts, charity care will be the largest form of community benefit in financial terms. New Hampshire RSA 7:32 specifies that bad debt is not included in the definition of charity care and requires that charity care be reported as a discrete category.

Each health care charitable trust will adopt its own policies regarding charity care. Such policies should be in writing and available to the public. Notice of the charity care policy should be displayed in publicly accessible areas of the facility such as lobbies and waiting rooms. Individuals who receive services outside of the trust’s facilities, such as in the home, should also receive notification of the policy.

Section 10 CERTIFICATION CONTACT; REVIEW, CERTIFY AND SUBMIT

Section 10 requires that the health care charitable trust provide the name and title of the individual who will be certifying the accuracy of the health care charitable trusts’ annual Community Benefits Report. After submitting the individual’s name and title, the trust will have the opportunity to print and review the full report and to make any additional changes prior to the final certification and submission step. At the final certification and submission step, the application will display an error if any required fields are incomplete. The incomplete sections and fields will also be highlighted in red.

Section 10: Certification Contact CLEAR SECTION

By typing my name below, I certify that this Community Benefits Report is true and complete.

Please note: You will have an opportunity to review and print your complete report in the next section. You will then have an opportunity to make any necessary edits before the final submission step in the last section.

Name of Person Submitting the Community Benefits Report

First Name: Last Name:

Title: CEO:

Email: hqdt@gmail.com

↓ NEXT SECTION Review

The Review section includes a print form function to facilitate final review before submission.

Certify & Submit

This step allows you to certify the form as complete and accurate and to submit the form to State of New Hampshire for review and processing.

Please note: Any work you perform filling out a form will not be accessible by State of New Hampshire staff or the public until you actually submit the form in the 'Certify & Submit' step. At the time of submission, it will be securely transmitted to State of New Hampshire

Please review the complete report prior to certification and submission.

You must address all errors before your form can be submitted.

✓ FINALIZE SUBMISSION Submit Form 🔄 FINISH LATER Save and Exit

All required fields must be complete before the system will allow the form to be submitted. Work in progress can be saved and returned to at another point in time.

Appendix A

TITLE I THE STATE AND ITS GOVERNMENT

CHAPTER 7 ATTORNEYS GENERAL, DIRECTOR OF CHARITABLE TRUSTS, AND COUNTY ATTORNEYS

Community Benefits

RSA7:32-c-1

Community Benefits

Purpose **Section 7:32-c**

7:32-c Purpose. – The purpose of this subdivision is to ensure that health care charitable trusts provide the communities they serve with benefits in keeping with the charitable purposes for which the trusts were established and in recognition of the advantages the trusts enjoy. It acknowledges that each community is unique and its particular health care problems and needs should be examined and the community benefits provided by health care charitable trusts which serve it should be directed toward addressing the issues and concerns of that community. Community involvement in the development of community benefits plans is necessary to make the health care charitable trusts more responsive to the true needs of the community. State oversight of the planning process and public access to the community benefits plans will assure appropriate use of the resources of health care charitable trusts.

Source. 1999, 312:1, eff. Jan. 1, 2000.

Community Benefits

Definitions Section 7:32-d

7:32-d Definitions. –

In this subdivision:

I. "Charity care" means health care services provided by a health care charitable trust for which the trust does not expect and has not expected payment and which health care services are not recognized as either a receivable or as revenue in the trust's financial statements.

II. "Community" means the service area or patient population for which a health care charitable trust provides services.

III. "Community benefits" means a health care charitable trust's activities that are intended to address community health care needs including, but not limited to, any of the following:

(a) Charity care.

(b) Financial or in-kind support of public health programs even if the programs extend beyond the trust's service area, including support of recommendations in any state health plan developed by the department of health and human services.

(c) Allocation of funds, property, services, or other resources that contribute to community health care needs identified in a community benefits plan.

(d) Donation of funds, property, services, or other resources which promote or support a healthier community, enhanced access to health care or related services, health education and prevention activities, or services to a vulnerable population.

(e) Support of medical research and education and training of health care practitioners, including the pooling of funds by different health care charitable trusts for this purpose.

IV. "Community benefits plan" means a written document prepared by a health care charitable trust which identifies health care needs in the area served by the trust and describes the activities the trust has undertaken and will undertake to address the identified needs.

V. "Health care charitable trust" means a charitable trust organized to directly provide health care services, including, but not limited to, hospitals, nursing homes, community health services, and medical-surgical or other diagnostic or therapeutic facilities or services. "Health care charitable trust" shall not include any testamentary or inter vivos trust which is not organized to provide health care services.

VI. "Vulnerable population" means any population that is at risk of not receiving health services due to medical, financial, or other barriers.

Source. 1999, 312:1. 2003, 232:1, eff. Sept. 5, 2003.

Community Benefits

Community Benefits Plans

Section 7:32-e

7:32-e Community Benefits Plans. –

Within 90 days of the start of its fiscal year every health care charitable trust shall develop a community benefits plan. The plan shall be developed in accordance with the following criteria on forms supplied by the attorney general:

I. The trust shall adopt a mission statement which shall be included in its plan and which shall be reaffirmed by the trust on an annual basis.

II. The plan shall take into consideration a community needs assessment conducted in accordance with RSA 7:32-f and shall identify the health care needs that were considered in development of the plan.

III. The plan shall identify the activities the trust expects to undertake or support which address the needs determined through the community needs assessment process or which otherwise qualify as community benefits and shall include all charity care in a discrete category.

IV. The plan shall include a report on the community benefit activities undertaken by the trust in the preceding year and information describing the results or outcomes of the trust's community benefit activities. The report shall also include the means used to solicit the views of the community served by the trust, identification of community groups, members of the public, and local government officials consulted on the development of the plan, and an evaluation of the plan's effectiveness.

V. (a) To the extent practicable, the plan shall include:

(1) An estimate of the cost of each activity expected to be undertaken or supported in the ensuing year; and

(2) A report on the unreimbursed cost of each activity undertaken in the preceding year.

(b) For reporting purposes, the cost of contributed services shall be determined in accordance with the rates, costs, units of service, or other statistical measures used for general accounting purposes by the health care charitable trust. In addition, each charitable trust shall include in its report the ratio of its gross receipts from operations to its net operating costs, as shown in its final statement of accounts for the preceding fiscal year.

VI. The process for development of the plan shall include an opportunity for members of the public in the trust's service area to provide input into development of the plan and comment upon the trust's proposed plan.

Source. 1999, 312:1, eff. Jan. 1, 2000.

Community Benefits

Community Needs Assessment Section 7:32-f

7:32-f Community Needs Assessment. – Every health care charitable trust shall, either alone or in conjunction with other health care charitable trusts in its community, conduct a community needs assessment to assist in determining the activities to be included in its community benefits plan. The needs assessment process shall include consultation with members of the public, community organizations, service providers, and local government officials in the trust's service area, in the identification and prioritization of community needs that the health care charitable trust can address directly, or in collaboration with others. The community needs assessment shall be updated at least every 5 years.

Source. 1999, 312:1. 2004, 213:2, eff. Aug. 10, 2004.

Community Benefits

Notice to Director of Charitable Trusts and Public Section 7:32-g

7:32-g Notice to Director of Charitable Trusts and Public; Administrative Fine. –

- I. Every health care charitable trust shall submit its community benefits plan to the director of charitable trusts on an annual basis no later than 90 days after the start of the trust's fiscal year. The trust and the director of charitable trusts shall make all community benefits plans available to the public and, where practicable, shall place the reports on an internet site or web page. Every health care charitable trust shall at least annually provide notice to the public of the availability and process for obtaining a copy of its community benefits plan and shall prominently display such notice in its lobby, waiting rooms, or other area of public access.
- II. An extension of time for filing the community benefits plan may be granted by the director, for a period of time not to exceed 12 months.
- III. The director may impose an administrative fine upon a charitable organization that violates any provision of RSA 7:32-g, I, in an amount not to exceed \$1,000 plus attorneys fees and costs for each such violation.

Source. 1999, 312:1. 2001, 205:1, eff. July 11, 2001.

Charity Care Section 7:32-h

7:32-h Charity Care. –

The provision of charity care may be included in a community benefits plan by a health care charitable trust only to the extent that it:

- I. Does not include any sums identified as bad debt, a receivable, or revenue by the trust in accordance with generally accepted accounting principles.
- II. Is provided in accordance with a written policy which is available to the public, which allows any individual to make application and receive a prompt decision on eligibility for and the amount of charity care, and notice of which is prominently displayed in the trust's lobby, waiting rooms, or other area of public access or otherwise is provided to service applicants and recipients who are served in their own homes or in locations other than a facility of the trust.

Source. 1999, 312:1, eff. Jan. 1, 2000.

Community Benefits

Enforcement

Section 7:32-i

7:32-i Enforcement. – Nothing in this subdivision shall derogate from authority of the attorney general, or the rights of others, provided by common law or other statute.

Source. 1999, 312:1, eff. Jan. 1, 2000.

Exemption

Section 7:32-j

7:32-j Exemption. – If the total value of the fund balances of a health care charitable trust do not exceed \$100,000, the trust shall have no obligation to comply with the provisions of this subdivision. In addition, those health care charitable trusts for which compliance would be a financial or administrative burden, according to criteria established and administered by the director of charitable trusts, may request an exemption from the provisions of this subdivision. An exemption, if granted, shall be valid for 3 years from the date of issuance unless it is revoked by the director of charitable trusts and written notice of such revocation is provided to the health care charitable trust.

Source. 1999, 312:1, 2, eff. Jan. 1, 2001.

Effect on Eligibility for Property Tax Exemption

Section 7:32-k

7:32-k Effect on Eligibility for Property Tax Exemption. – Compliance with this subdivision shall not establish eligibility for a property tax exemption under RSA 72:23, V, but may be considered if relevant to the criteria established in RSA 72:23, RSA 72:23-I, and at common law.

Source. 1999, 312:1, eff. Jan. 1, 2000.

Combined Needs Assessments, Planning, Reporting

Section 7:32-l

7:32-l Combined Needs Assessments, Planning, Reporting. – Health care charitable trusts may satisfy the requirements of RSA 7:32-e, RSA 7:32-f, and RSA 7:32-g, individually or in a combination with other health care charitable trusts, provided that information required to be reported under RSA 7:32-e, V(a) and (b) shall be specifically reported for each health care charitable trust participating in a combined plan or report.

Source. 1999, 312:1, eff. Jan. 1, 2000.

Appendix B

List of Potential Community Needs

Community Benefits Reporting Form, Section 3.2

1. Financial Barriers to Care; Cost of Care / Insurance
2. Access to Prescription Medications / Prescription Assistance
3. Access to Primary Care
4. Oral Health
5. Cancer Prevention / Treatment
6. Heart Disease and Stroke
7. Diabetes
8. COPD
9. Congestive Heart Failure
10. Asthma
11. Obesity
12. Family / Parent Support Services
13. Injury Prevention / Safety
14. Domestic Abuse / Child Abuse
15. Information & Referral Services
16. Aging Population / Senior Services
17. Access to Home Health Care
18. Access to Long Term Care or Assisted Living
19. Palliative Care / Hospice
20. Mental Health
21. Suicide Prevention
22. Access to Mental Health Services
23. Dementia, including Alzheimer's Disease
24. Substance Use
25. Access to Substance Use Disorder Services
26. Tobacco Use
27. Healthy Eating / Nutrition / Food Insecurity
28. Physical Activity / Active Living
29. Workforce Development
30. Cultural / Language Barriers to Care
31. Transportation Services
32. Economic Development / Poverty
33. Affordable Housing
34. Education / Job Training
35. Other Social Determinants of Health
36. Other Community Health Need

Appendix C

FREQUENTLY ASKED QUESTIONS

Where did the list of Community Needs come from?

The list of potential community needs in the reporting form was developed by a subgroup of the Community Benefits Advisory Group who reviewed the most frequently identified needs in past community benefit filings, along with information from other sources, such as the national Healthy People 2020 topics and priorities. The list represents the most commonly identified needs across different agency types.

What if our organization has identified a need that is not on the list?

The list of needs in Section 3.2 of the reporting form includes an “Other Community Health Need” choice that will allow the health care charitable trust to add a need in the open text field. The Charitable Trusts Unit periodically will review the needs most frequently mentioned in community benefit reports. If there are other or emerging needs that are frequently mentioned over time, the Charitable Trusts Unit will modify the choices in the list of needs to reflect those community needs.

What if our organization is addressing a need not identified in periodic Community Health Needs Assessments conducted in collaboration with other organizations for our service area or population?

Questions arise from time to time on how to address important activities that provide a community benefit that are not directly linked to priority needs identified by periodic Community Health Needs Assessments required of Health Care Charitable Trusts. Some important activities of health care charitable trusts that provide community benefit may not be reflected in a public community needs assessment process. It is not the intent of the community benefits process to redirect health care charitable trusts away from their primary missions such that the consequence would be to create a need in the community where one did not previously exist. In Section 3.2 of the online reporting form, organizations can select from a Yes/No drop-down menu to indicate whether a particular need was identified in the most recent Community Health Needs Assessment and can report in the open text field community activities associated with the need, information on how the need was identified, and strategies and activities associated with that need.

Why do Sections 4 and 5 of the reporting form look like Schedule H, Form 990 that hospitals file with the IRS?

The federal Affordable Care Act includes a provision requiring hospital organizations to provide information to the IRS on community benefit activities and policies using Schedule H (Form 990). Sections 4 and 5 of the New Hampshire form are intended to be consistent with Schedule H to the extent possible under current New Hampshire law in order to ease the burden of hospitals in having to report community benefits in two different ways.

Our health care charitable trust is not a hospital. Why should we have to use a form that aligns with the IRS reporting format for hospitals?

The interests and circumstances of non-hospital organizations required to report community benefits in NH were considered in the development of the form. With respect to reporting community benefit expense information, the primary variation between hospitals and non-hospitals is in the variety of different types of community benefit expense other than financial assistance (charity care) and Medicaid shortfall. Non-hospitals (as well as some hospitals) may enter zero values for many of the community benefit expense types. One advantage of aligning NH reporting guidance with IRS guidelines is consistency of definitions for reporting total revenue and total expenses based on the Form 990, which all NH health care charitable trusts have in common as a federal reporting requirement.

Why is Medicare shortfall not included in the community benefit total?

Medicare is not a means-tested program (i.e., does not have eligibility criteria based on income or assets). Deficits or shortfall from serving Medicare recipients thus are not considered to be a charitable contribution or community benefit. Historically, some health care charitable trusts in New Hampshire, particularly non-hospital organizations, have expressed support for the position that Medicare shortfall should be counted as a component of community benefit resulting from insufficient reimbursement rates. Section 6 on the NH Community Benefit Reporting Form provides an opportunity for reporting Medicare shortfall in a manner that is consistent with IRS instructions along with a comment field, enabling organizations to describe how this shortfall is a community benefit. The net expense from Medicare shortfall is reflected separately in the Financial Summary section (Section 7).

Are Community Building Activities counted as a community benefit?

Community Building Activities (i.e., activities intended to strengthen the community’s capacity to promote the health and well-being of its residents) are counted as community benefits in the New Hampshire form. On the New Hampshire form, Community Benefit Activities (Section 4) are separately reported from Community Building Activities (Section 5) in order to facilitate ease of reporting by aligning the table formats with Schedule H. The net expense for Community Building Activities is included in the community benefit expense total in the Financial Summary section and the calculation of total community benefit expense to total expense ratio.

Can subsidies of physician practices be counted as a community benefit?

The category of subsidized health services is a common area where questions arise about what can be counted as a community benefit and, in particular, with regard to physician practice subsidies. The following IRS instructions for Schedule H should be used as guidance in reporting subsidized health services as a community benefit.

“Subsidized health services” means clinical services provided despite a financial loss to the organization. The financial loss is measured after removing losses associated with bad debt,

financial assistance, Medicaid, and other means-tested government programs In addition, in order to qualify as a subsidized health service, the organization must provide the service because it meets an identified community need. A service meets an identified community need if it is reasonable to conclude that if the organization no longer offered the service:

- The service would be unavailable in the community,
- The community's capacity to provide the service would be below the community's need, or
- The service would become the responsibility of government or another tax-exempt organization. . . .

Subsidized health services generally exclude ancillary services that support inpatient and ambulatory programs such as anesthesiology, radiology, and laboratory departments. Subsidized health services include services or care provided at physician clinics and skilled nursing facilities if such clinics or facilities satisfy the general criteria for subsidized health services. . . . The organization can report a physician clinic as a subsidized health service only if the organization operated the clinic and *associated hospital services* (emphasis added) at a financial loss to the organization during the year.”

Can we file a community benefit report jointly with subsidiaries / affiliates?

Some health care charitable trusts have an interest in being able to report combined community benefits of a health care system comprised of multiple entities to more accurately reflect the community benefits provided by a health system.

The NH community benefits law allows combined reporting “provided that information required to be reported under RSA 7:32-e, V(a) and (b) shall be specifically reported for each health care charitable trust participating in a combined plan or report.”

The NH Community Benefit Reporting Form includes the capability to add lines for subsidiary organizations included in the community benefit report. It does not currently include a mechanism for separate, specific reports other than filing a complete, separate report for each legal entity. NH health care charitable trusts should take into account the IRS instructions for Schedule H of Form 990 and current NH law in determining how best to reflect the combined community benefit activities of multiple entities within an affiliated health care system under common governance or control.

How should we report community benefit activities of affiliated foundations?

Some health care charitable trusts maintain separate charitable foundations in support of the mission of the trust including its capital improvement and programmatic activities. Similar to the questions around joint reporting of health care system affiliates, questions arise about inclusion of the activities of foundations for which the health care charitable trust is the controlling member.

Unless a charitable foundation is itself a health care charitable trust (meaning a charitable trust organized to *directly provide* health care services) subject to the NH community benefit law, the

activities of the charitable foundation are not directly reportable. However, funds transferred from the foundation to the health care charitable trust explicitly in support of an identified community benefit activity can be reported as community benefit revenue and expense by the health care charitable trust.

How should Medicaid Enhancement Tax (MET) and Disproportionate Share Hospital (DSH) Payment Program revenue be reported?

For guidance with respect to Medicaid taxes, fees, and assessments, refer to the IRS instructions for filing Schedule H (Form 990):

- ◇ Medicaid taxes are reported as a Financial Assistance community benefit expense if payments received from an uncompensated care pool or DSH program are intended primarily to offset the cost of financial assistance;
- ◇ If DSH payments are primarily intended to offset the cost of Medicaid services, then Medicaid taxes are reported as a Medicaid community benefit expense;
- ◇ If the primary purpose of the taxes or payments has not been made clear by state regulation or law, then organizations can allocate the taxes or payments proportionately between Financial Assistance and Medicaid based on a reasonable estimate of which portions are intended for financial assistance and Medicaid, respectively.

For guidance in addressing uncompensated care pools such as DSH funds, refer to IRS instructions with respect to treatment of such revenue:

- ◇ Report DSH payments as Financial Assistance revenue if such payments are primarily intended to offset the cost of charity care;
- ◇ If such payments are primarily to offset the cost of Medicaid services, then report the revenue is reported as Medicaid revenue on Schedule H;
- ◇ If the primary purpose of the payments has not been made clear by state regulation or law, then the organization can allocate the payments proportionately between Financial Assistance and Medicaid based on a reasonable estimate of which portions are intended for financial assistance and Medicaid, respectively.

The Medicaid Enhancement Tax (MET) and Disproportionate Share Hospital (DSH) Payment Program in New Hampshire historically have been used to offset uncompensated care costs for both Medicaid and Financial Assistance to uninsured individuals. Organizations subject to the Medicaid Enhancement Tax should: a) allocate the tax expense proportionately between Financial Assistance and Medicaid based on a reasonable estimate of which portions are intended for each category of community benefit; and b) allocate Disproportionate Share revenue proportionately between Financial Assistance and Medicaid based on a reasonable estimate of which portions are intended for each category of uncompensated care.

How do we report revenue our organization receives for activities that provide a community benefit?

Some health care charitable trusts in New Hampshire have expressed an interest in the ability to report leveraged revenue (e.g. grants, donations) for community benefit activities as a net benefit. For example, an argument could be made that if not for the existence of a particular organization, such as a federally qualified health center, the community would not benefit from revenue in the form of a federal grant that subsidizes discounted services for individuals with low income. In some cases, such leveraged revenue may be the primary community benefit of organizations with low operating margins and limited means for direct expenditures in support of community benefit activities.

The NH Community Benefit Reporting Form includes fields for reporting offsetting revenue for each community benefit category. Revenue such as grants and donations to support community benefit activities should be reported as offsetting revenue in Sections 4 and 5. A field is also available in Financial Summary (Section 7) where health care charitable trusts can report revenue leveraged for the primary purpose of supporting community benefit activities. Leveraged revenue reported in that section is not included directly in the calculation of Total Community Benefit Expense.

How are “gross receipts from operations” and “net operating costs” defined?

In addition to reporting unreimbursed costs of community benefit activities, RSA 7:32-especificies that “each charitable trust shall include in its report the ratio of its gross receipts from operations to its net operating costs reporting.”

All health care charitable trusts with few exceptions have Form 990 in common as a potential source document for consistent revenue and expense information. In order to improve the consistency and comparability of expense information reported on NH Community Benefit Reports, the New Hampshire form adopts the IRS instructions for reporting total expenses. For purposes of community benefit reporting and calculations, the IRS defines total expenses as the organization’s Total Functional Expenses excluding bad debt reported on Form 990 (specifically “the amount reported on Form 990, Part IX, line 25, column (A) including the organization's share of joint venture expenses, and excluding any bad debt expense included in Part IX, line 25”).

With respect to the definition of “gross receipts from operations,” the NH Community Benefit Reporting Form draws on Form 990 as a source document. Specifically, the first field in Section 7: Summary Financial Measures asks trusts to enter the amounts (\$) from Form 990, Part I, line 8 (Program Service Revenue) plus line 9 (Contributions and Grants). The sum of these two amounts together provide a consistent basis for reporting revenue from operations across organizations and organizational types including organizations that receive relatively significant operational support through grants, such as federally qualified health centers, and leaves out revenue from such sources as investment income or unrelated business revenue.