Community Benefits Reporting Guide

November 2008
# Contents

**Introduction** ........................................................................................................ 1

Guide to Reporting .................................................................................................. 2

**Section 1**  
ORGANIZATIONAL INFORMATION .................................................................... 2

**Section 2**  
MISSION & COMMUNITY SERVED ...................................................................... 2

**Section 3**  
COMMUNITY NEEDS ASSESSMENT ................................................................... 3

**Section 4**  
COMMUNITY BENEFIT ACTIVITIES ................................................................... 4

**Section 5**  
SUMMARY FINANCIAL MEASURES ...................................................................... 10

**Section 6**  
COMMUNITY ENGAGEMENT .............................................................................. 11

**Section 7**  
CHARITY CARE COMPLIANCE .......................................................................... 11

**Worksheet 1**  
Charity Care .......................................................................................................... 12

**Worksheet 2**  
Unpaid Costs of Medicaid and Other Public Programs .......................................... 13

**Worksheet 3**  
Ratio of Costs to Charges .................................................................................... 14

**Appendix A**  
Community Benefits Reporting Form ..................................................................... 15

**Appendix B**  
Initial Filing Form .................................................................................................. 28

**Appendix C**  
RSA7:32-c-l ............................................................................................................. 33
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 Statutes require health care charitable trusts to develop a plan and make publicly available a report on their community activities each year (refer to RSA 7:32c-l, attached as an Appendix at the end of this guide).

It is acknowledged that each community or region of the state may have particular health care problems and needs specific to that community or region. Health care needs should therefore be examined in that context and the benefits provided by health care charitable trusts in response should be directed toward addressing the issues and concerns identified in the specific community or population served. While some variation in community need and response is expected, a consistent framework describing and quantifying the range of potential community benefit activities can and should be articulated. The purpose of this guide and revised Community Benefit Reporting Form is to provide that consistent framework.

The guidance and revised reporting form draw on several key resources. In particular, the categories and definitions in this guidance draw substantially on the work of the Catholic Health Association (CHA) and VHA in developing the Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability¹, as well as the Advancing the State of the Art of Community Benefit Demonstration Project². This information was reviewed, revised and adapted to the New Hampshire context by a Community Benefits Advisory Committee with input from community forums held around the state in 2006. More recently, the Office of the New Hampshire Attorney General, Division of Charitable Trusts has been monitoring work at the federal level including revisions to IRS Form 990 that include a schedule for reporting community benefits (Schedule H). The revisions to the community benefit reporting process in New Hampshire described in this guide are intended to incorporate the categories and definitions that have been developed at the national level, while also reflecting the statutory requirements and other circumstances specific to the New Hampshire experience.

Guide to Reporting

The following pages are intended to provide additional information and guidance for each section of the Community Benefit Reporting Form – 2008 Revision (included as Attachment A). Definitions and additional worksheets to assist in report preparation are included where applicable. The document is organized by section corresponding to those sections contained in the form.

Section 1
ORGANIZATIONAL INFORMATION

Descriptive and contact information is requested for each separately incorporated/organized health care charitable trust. As part of this information, please include the website address for the organization as applicable and indicate whether your community benefit plan is posted on the site.

An initial filing information form (Attachment B) asks for information that includes articles of incorporation, a complete list of officers and directors, and any structural relationships to parent or subsidiary organizations. The initial filing form and related information only needs to be submitted once unless there are changes or information updates during the reporting period.

New Hampshire Statute allows multiple health care charitable trusts to work collaboratively on the community needs assessment, benefit planning and reporting. If a common community benefit report is filed for more than one organization, all of the organizational information for each participating trust should be included. In addition, a collaborative report must include information on current and projected community benefit costs for each participating trust (Sections 4 and 5 of the reporting form; also refer to RSA 7:32-l).

Section 2
MISSION & COMMUNITY SERVED

Health care charitable trusts are required by New Hampshire Statute to include their mission statement in the community benefit plan and are required to reaffirm the mission statement on an annual basis - by vote of the Board, for example, at the annual meeting.

Health care charitable trusts are asked to describe the community they serve. Community may be defined as a geographic service area defined by the locations from which most service recipients come 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 in the narrative fields provided on the form sufficient to describe the community served by the organization. Either or both fields (geography, population) may be used as indicated.
Section 3
COMMUNITY NEEDS ASSESSMENT

This section requires health care charitable trusts to identify the priority community needs identified by a periodic community needs assessment. It also provides the opportunity to indicate other important activities of health care charitable trusts that provide community benefits that may not be reflected by information gathered through a community assessment process. New Hampshire Statute requires trusts to update their community needs assessment at least every five years. The first table in this section asks trusts to report identified needs from the community assessment according to their priority rank. The assessment and prioritization process may be done in conjunction with other health care charitable trusts and must involve engagement of the community (see section 6) served by the Trust.

Trusts are asked to use a coding typology included as an attachment to the reporting form for identifying community need categories. The purpose of the coding typology is to provide common terminology that will allow aggregation of priority needs identified across the state. In completing this section, trusts are asked to list the high priority needs determined through the assessment and prioritization process. While the table shows a numbered list (i.e. 1, 2, 3, etc.), the numbering of needs is primarily intended to facilitate the process of linking needs to activities on subsequent tables. It is recognized that some identified needs may simultaneously have equal priority in a community.

The purpose of the needs assessment process is to assist health care charitable trusts in determining activities to be included in their community benefits plan. It is recognized, however, that 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 mission such that the consequence would be to create a need in the community where one did not previously exist. For example, an agency whose primary mission is to provide long-term care may not see that mission well reflected in a broad, periodic community needs assessment that ranks maternal and child health issues as high priorities. Such an agency would likely continue to determine 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.

The second table in this section provides an opportunity for trusts to specify these other important health care needs or community characteristics identified in the development of the current community benefits plan. While a health care charity is not expected to divert resources to activities unrelated to that organization’s mission as discussed above, the charity should be able to demonstrate the existence of those needs on which the community benefit plan is based.

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
Health care charitable trusts may choose to focus on demographic, socioeconomic and health status data that objectively demonstrates need in their community. Broad-based community assessments may also be supplemented by focused assessment and engagement of current and potential recipients of the trust’s services, as well as an examination of other factors including waiting lists for services and applications for financial relief. Trusts may wish to use the open field at the end of this section to describe information sources and processes for identifying these additional community needs.

In completing the second table in this section, trusts are asked to use the same coding typology used for the first table. If a health care charitable trust has questions about which codes best apply or if the Trust identifies additional types of need that should be included in a future, expanded list of potential community needs, please contact the Division of Charitable Trusts.

Section 4
COMMUNITY BENEFIT ACTIVITIES

This section addresses what counts as a community benefit activity and how to report the associated costs. The section is organized according to categories of community benefit activities.

Community benefit activities can be classified in nine broad categories. These categories are:

A. Community health services
B. Health professions education
C. Subsidized health services
D. Research
E. Financial contributions
F. Community building activities
G. Community benefit operations
H. Charity care
I. Government-sponsored health care

Within each category are several sub-categories or activity areas. The categories and activity areas are described in more detail beginning on the next page. For each area of activity in which the health care charitable trust provides a community benefit, reporting organizations are asked to indicate the need (from Section 3) that is addressed by the activity. Reporting organizations are then asked to record the unreimbursed costs associated with each activity for the preceding year (if applicable) and make a projection of the expected unreimbursed costs for the coming year (if applicable).

Individual health care charitable trusts are not expected to provide activities in each category. Please leave blank those parts of Section 4 that do not apply to your organization. This section also allows for reporting “other” needs and “other” activities that may not be reflected by the available category descriptions. Please attach additional pages as necessary to describe other community benefit needs and activities.
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.

A. Community Health Services

Community health services include activities carried out to improve community health. They extend beyond patient care activities and are usually 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 to quantify include:

**Community Health Education:** Lectures, presentations, and other programs and activities provided to groups, without providing clinical or diagnostic services. Examples include caregiver training for persons caring for family members at home, education on specific disease conditions (diabetes, heart disease, etc.), health promotion and wellness programs, prenatal classes serving at-risk populations, support groups and communication of public health messages. Community health education activities designed primarily to increase market share should not be included.

**Community-Based Clinical Services:** Clinical services provided (e.g., free clinics, screenings) to the community on an occasional or one-time basis. 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 community-based clinical services in which a fee is charged and a profit is realized. Do not count services which are primarily promotional or intended to generate referrals. Also, do not count the value of volunteers donating services on their own time.

**Health Care Support Services:** Services given 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 (hotlines, poison control centers), and transportation programs to enhance access to care. Do not count care management or discharge planning services which are considered routine aspects of the clinical care process and are typically 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.

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 increased capacity for community health improvement including expanding access and availability of needed services for underserved communities.

Sub-categories of health professions education include:

**Provision of Clinical Settings for Undergraduate Training:** Unsubsidized costs of providing or sponsoring clinical settings for undergraduate/vocational training of physicians, nurses, therapists, technicians and other health care professionals.

**Intern/Residency Education:** Unsubsidized costs of providing or sponsoring clinical settings for advanced practice training of physicians, nurses, therapists, technicians and other health care professionals including internships, clerkships and residencies.

**Scholarships/Funding for Professional Education:** Funding, including registrations, fees, travel, and incidental expenses for staff education linked to community services and health improvement. Also includes 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.

**Other Health Professions Education:** 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 minorities, scholarships to community members (i.e. not employees), in-service/video conferencing programs made available to professionals in the community.

C. Subsidized Health Services

Subsidized health services are services that are provided despite a significant and ongoing financial loss, but are continued anyway because they meet an essential community need and would not otherwise be available unless the responsibility was assumed by government. 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 Medicare/Medicaid shortfalls. The costs of charity care and public insurance programs are included in other categories of community benefit. Subsidized health services are also not services that are operated at a loss due to inefficiency.

Examples of subsidized health services may include, but are not limited to:

- Emergency and Trauma Services
- Neonatal Intensive Care
- Burn Unit
- Mobile Health Units
- Primary Care (Including OB) and Behavioral Health Services/Centers for Underserved areas/populations
- Renal Dialysis Services
- Home Care/Hospice/Adult Day Care
- Inpatient Behavioral Health Services
- Detox/Substance Abuse Treatment
Some organizations, such as community health centers, provide discounted health services that may not otherwise be available except for the existence of that organization. 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 (section H). 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, reporting organizations are asked to record in Section 5—Financial Indicators—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.

D. Research

Research includes clinical research, community and public health research, and health services research of cost, access and quality where the findings are made available external to the organization. In this category, count as a community benefit only the difference between external subsidies such as grants and operating costs for research (i.e. the difference results in a negative margin or internal subsidy).

E. Financial Contributions

This category includes funds and in-kind services donated to individuals, other organizations or the community-at-large by the Trust. 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:

**Cash Donations**: 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 funds donated by employees as a community benefit of the organization.*

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

**In-Kind Donations**: Includes in-kind 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.*

**Cost of Fund-Raising for Community Programs**: Grant writing and other fund-raising costs specific to community programs and resource development assistance not captured under category G – Community Benefit Operations.
F. Community-Building Activities

Community-building activities include cash, in-kind donations, and budgeted expenditures by the Trust for the development of programs and partnerships intended to address social and economic determinants of health. Sub-categories in this area include:

**Physical Improvements/Housing:** Community improvement and revitalization projects; housing rehabilitation; public works; contributions to community-based assisted living, senior and low-income housing projects; home safety assessment and installations.

**Economic Development:** Small business development; participation in economic development council, chamber of commerce.

**Support System Enhancements:** Adopt-a-school efforts, child care for community residents with qualified need; mentoring programs; youth development initiatives, including categories of caring adults, safe places, emergency preparedness; community disease surveillance and reporting infrastructure, costs of stockpiling medical, surgical, and pharmaceutical supplies, including barriers, respirators, clothing, IV pumps and poles, IV fluids, suction machines, stretchers, wheelchairs, linens, bandages, and dressings, personal protective equipment; costs associated with new or expanded training, task force participation, and drills; mental health resource costs associated with training, community partnerships, and outreach planning.

**Environmental Improvements:** 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.

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

**Coalition Building:** Organizational representation on community coalitions; collaborative partnerships with community groups to improve community health; community coalition meeting costs, visioning sessions, task force meetings, etc. and costs for task force–specific projects and initiatives.

**Community Health Improvement Advocacy:** Local, state, and/or national advocacy for community members and groups relative to policies and funding to improve community and public health including the social and economic determinants of health.

**Workforce Enhancement:** Recruitment of physicians and other health professionals for government–designated medically underserved areas; recruitment of underrepresented minorities; job creation and training programs; participation in community workforce boards, workforce partnerships, and welfare–to–work initiatives; partnerships to address the health care workforce shortage; 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.*
G. 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:** Includes staff costs of management/oversight of community benefit program activities and staff costs to coordinate community benefit-related volunteer programs that are not included in other community services categories.

**Community Health Needs/Health Assets Assessment:** Costs of assessment activities including surveys, forums, staff and contract costs for data collection and analysis. *Do not count costs of marketing and image assessment activities.*

**Other Resources:** Includes cost of fund-raising for organization-sponsored community benefit programs, including grant writing and other fund-raising costs, costs associated with community benefit reporting, and office or indirect expenses associated with community benefit operations. *Do not count fund-raising costs of organizational projects (such as capital funding of buildings and equipment) that are not associated with community benefit programs.*

H. Charity Care

Charity Care is free or discounted care given to persons deemed unable to pay based on formal financial assistance policies established by the organization. Charity care is provided without expectation of payment and is therefore not bad debt. Charity care 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.

*Worksheet 1, located after Section 7 in this document, is a worksheet adapted from the draft IRS 990, Schedule H for calculating charity care costs.*

I. Government-Sponsored Health Care

Health care charitable trusts can report payment shortfalls incurred from caring for patients with Medicaid, Medicare, and other public insurance programs (e.g. SCHIP) 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). It should also be noted that the IRS does not consider Medicare shortfall as a community benefit and the CHA also recommends against inclusion of Medicare shortfall in community benefit reporting. Given the diversity of filing organizations in New Hampshire, it is possible that Medicare shortfall could be the result of insufficient payment rates and not due to inefficiency. Charitable trusts in New Hampshire are thus provided the opportunity to record this information in their filing.

*Worksheet 2, located after Section 7 in this document, is a worksheet adapted from the draft IRS 990, Schedule H for calculating the unpaid costs of government-sponsored health insurance programs.*
Section 5  
SUMMARY FINANCIAL MEASURES  

This section asks charitable trusts to report information on a set of financial measures of the organization overall and of community benefits in particular. These measures include the following:

**Gross Receipts from Operations:** Gross receipts from operations include net revenue from patient services and other operating revenue related to health care operations, but not from patient care services. Examples include non-patient food sales, gift shop sales, and supplies and medications sold to non-patients.

**Net Revenue from Patient Services:** Total charges for the provision of health care services less related deductions such as contractual allowances.

**Total Operating Expenses:** Total cost incurred to maintain and develop the operation of the organization during the reporting period. It includes health care service delivery costs, research, education, general services, fiscal services, administrative services, and other operating costs. It excludes non-operating expenses and taxes.

**Net Medicare Revenue:** Total charges for the provision of health care services to Medicare patients less related deductions such as contractual allowances.

**Medicare Costs:** Operating expenses associated with provision of care to Medicare patients; obtained from the cost report, cost accounting system or calculated ratio of cost to charges.

**Net Medicaid Revenue:** Total charges for the provision of health care services to Medicaid patients less related deductions such as contractual allowances.

**Medicaid Costs:** Operating expenses associated with provision of care to Medicare patients; obtained from the cost report, cost accounting system or calculated ratio of cost to charges.

**Unreimbursed Charity Care Expenses:** The total unreimbursed costs for free and discounted care reported in part H of Section 4.

**Unreimbursed Expenses of Other Community Benefits:** The total of unreimbursed costs for community benefit activities reported in all other parts of Section 4.

**Total Unreimbursed Community Benefit Expenses:** Total unreimbursed community benefits are the sum of unreimbursed charity care expenses and the unreimbursed expenses of other community benefits activities reported in Section 4 including Medicaid and other public insurance shortfalls.

**Leveraged Revenue for Community Benefit Activities:** Leveraged revenue includes all grants, contracts, and donations acquired by the organization from external sources to support free or discounted care and other community benefit-related activities of the organization.

**Total Community Benefits including Leveraged Revenue for Community Benefit Activities:** Total community benefits including leveraged revenue for community benefits includes the total unreimbursed community benefit expenses and revenue leveraged by the organization from external sources to support charity care and other community-benefit related activities.

---

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. RSA 7:32-e V (b)
Section 6
COMMUNITY ENGAGEMENT

Community involvement in the development of community benefits plans is required under NH law in assisting health care charitable trusts to be responsive to emerging community needs, as well as for identifying community assets and building strong community partnerships. Many health care organizations across New Hampshire regularly engage with other health and non-health care organizations in their service area, community leaders, and recipients of services to assess needs and develop collaborative plans for community health improvement.

This section of the reporting form requires health care charitable trusts to identify their partners in the assessment and planning process. In addition to identifying assessment and planning participants, the form asks reporting organizations to indicate the role of each in the process including participation in identification of need; prioritization of need; plan development; or plan comment. New Hampshire RSA 7:32 provides direction on the needs assessment process including requirements for consultation with members of the public, community organizations, service providers, and local government officials in the trust’s service area. Such consultation includes participation in the identification and prioritization of community needs that the health care charitable trust can address directly, or in collaboration with others. The RSA further specifies that 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 for each reporting year.

Section 7
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. The law also requires charity care to be reported as a discrete category.

Each 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.

“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)
Worksheet 1  
Charity Care

Use this worksheet to calculate the cost of charity care.

Total number of persons served: _______________

Calculation of the net cost of charity care

<table>
<thead>
<tr>
<th>Method 1: Ratio of cost to charges</th>
<th>Method 2: Cost accounting system</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Charges forgiven for charity</td>
<td></td>
</tr>
<tr>
<td>2. Inpatient charges</td>
<td></td>
</tr>
<tr>
<td>3. Outpatient/Ambulatory charges</td>
<td></td>
</tr>
<tr>
<td>4. Long-term care charges</td>
<td></td>
</tr>
<tr>
<td>5. Home care charges</td>
<td></td>
</tr>
<tr>
<td>6. Other patient care charges</td>
<td></td>
</tr>
<tr>
<td>7. Total charges</td>
<td></td>
</tr>
<tr>
<td>8. Cost of charity care</td>
<td></td>
</tr>
<tr>
<td>9. Ratio of cost to charges (from Worksheet 3)</td>
<td>$</td>
</tr>
<tr>
<td>10. Estimated cost</td>
<td></td>
</tr>
<tr>
<td>11. Any other direct contributions to charity care programs</td>
<td>$</td>
</tr>
<tr>
<td>12. Total charity care costs (add lines 10 and 11)</td>
<td>$</td>
</tr>
<tr>
<td>13. Revenue received to support charity</td>
<td></td>
</tr>
<tr>
<td>14. Grants and contracts to provide free and discounted services</td>
<td>$</td>
</tr>
<tr>
<td>15. Payments from uncompensated care pools or programs</td>
<td>$</td>
</tr>
<tr>
<td>16. Philanthropy received and/or used to support charity*</td>
<td>$</td>
</tr>
<tr>
<td>17. All other sources of funding</td>
<td>$</td>
</tr>
<tr>
<td>18. Total offsetting revenue (add lines 14-17)</td>
<td>$</td>
</tr>
<tr>
<td>19. Net traditional charity care (line 12 minus line 18)</td>
<td>$</td>
</tr>
</tbody>
</table>

*Excludes resources received from foundations or other entities that are related parties and share common governance.
Worksheet 2
Unpaid Costs of Medicaid and Other Public Programs

Use this worksheet to determine the unpaid costs of Medicaid and other public insurance programs.

<table>
<thead>
<tr>
<th>Unpaid Costs of Public Programs</th>
<th>(a) Medicaid</th>
<th>(b) Medicare</th>
<th>(c) Other public programs</th>
<th>(d) Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Persons served</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Total expenses (Choose A, B or C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. From cost accounting system, or</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>B. From program cost report, or</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>C. Use Ratio of Cost to Charges</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3. Expenses before Medicaid taxes (from 2A, 2B or 2C)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4. Taxes or assessment used as matching funds*</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5. Total expenses (add lines 3 and 4)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6. Reimbursement and other support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Inpatient reimbursement</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>8. Outpatient/Ambulatory reimbursement</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>9. Long-term care reimbursement</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10. Home care reimbursement</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>11. Other patient care reimbursement</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>12. Medicaid disproportionate share funds</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>13. Total reimbursement and other support</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>14. Net costs of public programs (line 5 minus line 13)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

*Included to assure that provider taxes or assessments used as matching funds for federal resources are included in the costs of services for Medicaid or other public insurance programs.
Worksheet 3
Ratio of Costs to Charges

Use the recommended formula below to calculate a ratio of costs to charges if cost report or cost accounting system is not available or applicable.

1. **Adjusted total operating expenses**
2. Total operating expenses (including bad debt expenses) $ 
3. **Less: Adjustments**
4. Other operating revenue $ 
5. Medicaid taxes $ 
6. *Operating expenses for subsidized health services (if applicable)* $ 
7. Expenses for other programs for persons qualifying for charity care $ 
8. Other community benefit-related expenses $ 
9. Total adjustments $ 
10. Adjusted total operating expenses (line 2 - line 9) $ 
11. **Adjusted total gross charges**
12. Total gross charges (including bad debt charges) $ 
13. **Less: Adjustments**
14. *Gross charges for subsidized health services* $ 
15. Total adjustments $ 
16. Adjusted total gross charges (line 12 – line 15) $ 
17. **Ratio calculation**
18. A. Adjusted total operating expense (from line 10) $ 
19. B. Adjusted total gross charges (from line 16) $ 
20. Calculated patient cost-to-charge ratio: $ \frac{A}{B} = $ 

*Reduce operating expenses for the amount of other operating revenue that has an associated operating expense. Some operating revenue or income (e.g., from joint ventures) should not be included in the adjustment.

**Note:** Operating expenses and gross charges for subsidized health services should be excluded from the formula (as shown in italics) if your organization has a cost accounting system to measure those services.
Appendix A

Community Benefits Reporting Form
COMMUNITY BENEFITS REPORTING FORM
Pursuant to RSA 7:32-c-1
FOR FISCAL YEAR BEGINNING 01/01/2009

to be filed with:
Office of the Attorney General
Charitable Trusts Unit
33 Capitol Street, Concord, NH 03301-6397
603-271-3591

Section 1: ORGANIZATIONAL INFORMATION

Organization Name

Street Address

City                  County --                State NH Zip Code

Federal ID #                State Registration #

Website Address:
Is the organization’s community benefit plan on the organization’s website? Yes

Has the organization filed its Community Benefits Plan Initial Filing Information form? Yes

IF NO, please complete and attach the Initial Filing Information Form.
IF YES, has any of the initial filing information changed since the date of submission?
   No    IF YES, please attach the updated information.

Chief Executive: Name Telephone # email address
Board Chair: Name Telephone # email address
Community Benefits Plan Contact: Name Telephone # email address

Is this report being filed on behalf of more than one health care charitable trust? No

IF YES, please complete a copy of this page for each individual organization included in this filing.
Section 2: MISSION & COMMUNITY SERVED

Mission Statement:
Has the Mission Statement been reaffirmed in the past year (RSA 7:32e-I)? Yes

Please describe the community served by the health care charitable trust. “Community” may be defined as a geographic service area and/or a population segment.

Service Area (Identify Towns or Region describing the trust’s primary service area):
All New Hampshire

Service Population (Describe demographic or other characteristics if the trust primarily serves a population other than the general population):
Serve the General Population
Section 3: 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?
2005 (Please attach a copy of the needs assessment if completed in the past year)

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

Based on the needs assessment and community engagement process, what are the priority needs and health concerns of your community?

<table>
<thead>
<tr>
<th>NEED (Please enter code # from attached list of community needs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
</tbody>
</table>

What other important health care needs or community characteristics were considered in the development of the current community benefits plan (e.g. essential needs or services not specifically identified in the community needs assessment)?

<table>
<thead>
<tr>
<th>NEED (Please enter code # from attached list of community needs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>E</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>G</td>
</tr>
</tbody>
</table>

Please provide additional description or comments on community needs including description of “other” needs (code 999) if applicable. Attach additional pages if necessary:
**Section 4: COMMUNITY BENEFIT ACTIVITIES**

Identify the categories of Community Benefit activities provided in the preceding year and planned for the upcoming year (note: some categories may be blank). For each area where your organization has activities, report the past and/or projected unreimbursed costs for all community benefit activities in that category. For each category, also indicate the primary community needs that are addressed by these activities by referring to the applicable number or letter from the lists on the previous page (i.e. the listed needs may relate to only a subset of the total reported costs in some categories).

<table>
<thead>
<tr>
<th><strong>A. Community Health Services</strong></th>
<th>Community Need Addressed</th>
<th>Unreimbursed Costs (preceding year)</th>
<th>Unreimbursed Costs (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Education</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-based Clinical Services</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Support Services</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>B. Health Professions Education</strong></th>
<th>Community Need Addressed</th>
<th>Unreimbursed Costs (preceding year)</th>
<th>Unreimbursed Costs (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of Clinical Settings for Undergraduate Training</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intern/Residency Education</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scholarships/Funding for Health Professions Ed.</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>C. Subsidized Health Services</strong></th>
<th>Community Need Addressed</th>
<th>Unreimbursed Costs (preceding year)</th>
<th>Unreimbursed Costs (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Service:</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Service:</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Service:</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Service:</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Service:</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Research</td>
<td>Community Need Addressed</td>
<td>Unreimbursed Costs (preceding year)</td>
<td>Unreimbursed Costs (projected)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Clinical Research</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Research</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. Financial Contributions</th>
<th>Community Need Addressed</th>
<th>Unreimbursed Costs (preceding year)</th>
<th>Unreimbursed Costs (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Donations</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Kind Assistance</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource Development Assistance</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F. Community Building Activities</th>
<th>Community Need Addressed</th>
<th>Unreimbursed Costs (preceding year)</th>
<th>Unreimbursed Costs (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Infrastructure Improvement</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Development</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Systems Enhancement</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Improvements</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership Development; Training for Community Members</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coalition Building</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Advocacy</td>
<td>-- -- --</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>G. Community Benefit Operations</strong></td>
<td>Community Need Addressed</td>
<td>Unreimbursed Costs (preceding year)</td>
<td>Unreimbursed Costs (projected)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Dedicated Staff Costs</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Community Needs/Asset Assessment</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Other Operations</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>H. Charity Care</strong></th>
<th>Community Need Addressed</th>
<th>Unreimbursed Costs (preceding year)</th>
<th>Unreimbursed Costs (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free &amp; Discounted Health Care Services</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>I. Government-Sponsored Health Care</strong></th>
<th>Community Need Addressed</th>
<th>Unreimbursed Costs (preceding year)</th>
<th>Unreimbursed Costs (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Costs exceeding reimbursement</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Medicaid Costs exceeding reimbursement</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Other Publicly-funded health care costs exceeding reimbursement</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
## Section 5: SUMMARY FINANCIAL MEASURES

<table>
<thead>
<tr>
<th>Financial Information for Most Recent Fiscal Year</th>
<th>Dollar Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Receipts from Operations</td>
<td></td>
</tr>
<tr>
<td>Net Revenue from Patient Services</td>
<td></td>
</tr>
<tr>
<td>Total Operating Expenses</td>
<td></td>
</tr>
<tr>
<td>Net Medicare Revenue</td>
<td></td>
</tr>
<tr>
<td>Medicare Costs</td>
<td></td>
</tr>
<tr>
<td>Net Medicaid Revenue</td>
<td></td>
</tr>
<tr>
<td>Medicaid Costs</td>
<td></td>
</tr>
<tr>
<td>Unreimbursed Charity Care Expenses</td>
<td></td>
</tr>
<tr>
<td>Unreimbursed Expenses of Other Community Benefits</td>
<td></td>
</tr>
<tr>
<td>Total Unreimbursed Community Benefit Expenses</td>
<td></td>
</tr>
<tr>
<td>Leveraged Revenue for Community Benefit Activities</td>
<td></td>
</tr>
<tr>
<td>Total Community Benefits including Leveraged Revenue for Community Benefit Activities</td>
<td></td>
</tr>
</tbody>
</table>
Section 6: COMMUNITY ENGAGEMENT in the Community Benefits Process

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.

<table>
<thead>
<tr>
<th>Identification of Need</th>
<th>Prioritization of Need</th>
<th>Development of the Plan</th>
<th>Commented on Proposed Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide a description of the methods used to solicit community input on community needs (attach additional pages if necessary):
### Section 7: CHARITY CARE COMPLIANCE

Please characterize the charity care policies and procedures of your organization according to the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>YES</th>
<th>NO</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>The valuation of charity does not include any bad debt, receivables or revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written charity care policy available to the public</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any individual can apply for charity care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any applicant will receive a prompt decision on eligibility and amount of charity care offered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notices of policy in lobbies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notice of policy in waiting rooms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notice of policy in other public areas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notice given to recipients who are served in their home</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
List of Potential Community Needs for Use on Section 3

100 - Access to Care; General
101 - Access to Care; Financial Barriers
102 - Access to Care; Geographic Barriers
103 - Access to Care; Language/Cultural Barriers to Care
120 - Availability of Primary Care
121 - Availability of Dental/Oral Health Care
122 - Availability of Behavioral Health Care
123 - Availability of Other Medical Specialties
124 - Availability of Home Health Care
125 - Availability of Long Term Care or Assisted Living
126 - Availability of Physical/Occupational Therapy
127 - Availability of Other Health Professionals/Services
128 - Availability of Prescription Medications

200 - Maternal & Child Health; General
201 - Perinatal Care Access
202 - Infant Mortality
203 - Teen Pregnancy
204 - Access/Availability of Family Planning Services
206 - Infant & Child Nutrition
220 - School Health Services

300 - Chronic Disease – Prevention and Care; General
301 - Breast Cancer
302 - Cervical Cancer
303 - Colorectal Cancer
304 - Lung Cancer
305 - Prostate Cancer
319 - Other Cancer
320 - Hypertension/HBP
321 - Coronary Heart Disease
322 - Cerebrovascular Disease/Stroke
330 - Diabetes
340 - Asthma
341 - Chronic Obstructive Pulmonary Disease
350 - Access/Availability of Chronic Disease Screening Services

360 - Infectious Disease – Prevention and Care; General
361 - Immunization Rates
362 - STDs/HIV
363 - Influenza/Pneumonia
364 - Food borne disease
365 - Vector borne disease
370 - Mental Health/Psychiatric Disorders – Prevention and Care; General
371 - Suicide Prevention
372 - Child and adolescent mental health
372 - Alzheimer’s/Dementia
373 - Depression
374 - Serious Mental Illness

400 - Substance Use; Lifestyle Issues
401 - Youth Alcohol Use
402 - Adult Alcohol Use
403 - Youth Drug Use
404 - Adult Drug Use
405 - Youth Tobacco Use
406 - Adult Tobacco Use
407 - Access/Availability of Alcohol/Drug Treatment

420 - Obesity
421 - Physical Activity
422 - Nutrition Education
430 - Family/Parent Support Services

500 – Socioeconomic Issues; General
501 - Aging Population
502 - Immigrants/Refugees
503 - Poverty
504 - Unemployment
505 - Homelessness
506 - Economic Development
507 - Educational Attainment
508 - High School Completion
509 - Housing Adequacy

520 - Community Safety & Injury; General
521 - Availability of Emergency Medical Services
522 - Local Emergency Readiness & Response
523 - Motor Vehicle-related Injury/Mortality
524 - Driving Under Influence
525 - Vandalism/Crime
526 - Domestic Abuse
527 - Child Abuse/Neglect
528 - Lead Poisoning
529 - Work-related injury
530 - Fall Injuries
531 - Brain Injury
532 - Other Unintentional Injury
533 - Air Quality
534 - Water Quality

600 - Community Supports; General
601 - Transportation Services
602 - Information & Referral Services
603 - Senior Services
604 - Prescription Assistance
605 - Medical Interpretation
606 - Services for Physical & Developmental Disabilities
607 - Housing Assistance
608 - Fuel Assistance
609 - Food Assistance
610 - Child Care Assistance
611 - Respite Care

999 – Other Community Need
Appendix B

Initial Filing Form
COMMUNITY BENEFITS PLAN

INITIAL FILING INFORMATION

Pursuant to RSA 7:32-c – l

to be filed with:

Office of the Attorney General
Charitable Trusts Unit
33 Capitol Street, Concord, NH 03301-6397
603-271-3591
http://doj.nh.gov/charitable/index.html

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Federal Tax Identification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>State Registration Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following information and attachments must be included with the initial community benefits plan filed with the Attorney General:

I. a. General Background Information:

   Name and Address of the chief executive officer and board chair:

b. Organizational Structure:

   Please attach:

   • A copy of the charitable trust’s articles of incorporation, constitution, and by-laws, or other instrument of creation.

   • A list of the names and addresses of the officers and directors of the organization.

   • A brief description of the governance and administrative structure of the health care charitable trust, its parent and subsidiary entities, if any.
II. Program Information

Does your health care charitable trust have a strategic plan that addresses community benefits?

Yes _______ No _______

If yes, please attach a copy of the plan or section(s) of the plan pertaining to community benefits.

PLEASE NOTE: It will not be necessary to resubmit the information requested in I and II unless changes or amendments occur. Any updated information or amended organizational documents must be submitted to the Attorney General at the time the community benefits plan is filed.
Appendix C

RSA7:32-c-l
TITLE I
THE STATE AND ITS GOVERNMENT
CHAPTER 7
ATTORNEYS GENERAL, DIRECTOR OF CHARITABLE TRUSTS, AND COUNTY ATTORNEYS

Community Benefits

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.

TITLE I
THE STATE AND ITS GOVERNMENT
CHAPTER 7
ATTORNEYS GENERAL, DIRECTOR OF CHARITABLE TRUSTS, AND COUNTY ATTORNEYS

Community Benefits
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.

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.

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.

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.

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.

Community Benefits  
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.

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.

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-l, and at common law.

7:32-1 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.