

Revealing Ambiguities and Faults: Understanding Nonprofit Hospitals and Their Community Benefits

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Abstract:

Nonprofit hospitals are required to provide community benefits, which are defined as benefits that will serve their greater communities, in return for tax-exemption status by the Internal Revenue Service (IRS). Important documentations such as community benefit reports, community health needs assessments (CHNAs), and implementation strategy reports are released on behalf of nonprofit hospitals to assess accountability and effectiveness of community benefit programs in addressing population health.

This research seeks to conduct a qualitative analysis of the ambiguities within the language of the community benefits policy at large in comparison to the language within community benefit documents provided by nonprofit hospitals in an attempt to discover what other elements and factors are needed to address the policy's vagueness and strengthen the role of the different agencies that are involved in overseeing community benefits. Community benefit reports, community health needs assessments, and implementation strategy reports were analyzed using the online data software Dedoose for significant terms and concepts and for most commonly used community benefit programs. By strengthening structural guidelines and addressing ambiguities in the policy, we can improve the programming and reporting processes of nonprofit hospitals' community benefit works, ensure the faults in current community benefits reporting documents are reduced, and assure the successfulness and effectiveness of community benefit programs in the future.

Introduction:

In 2018, healthcare is an ongoing debate. House and Senate Republicans are trying tirelessly to pass bills that will cut funding for Medicaid expansion and repeal the Affordable Care Act (ACA) passed under Obama's administration. The Congressional Budget Office has repeatedly released reports that state the Republican's efforts on healthcare reform will result in millions of more uninsured people, increase healthcare coverage costs, and eliminate certain healthcare services for vulnerable populations such as women, children, seniors, and the disabled. Concerns about healthcare accessibility, insurance plans and coverage, and service affordability are amongst the most popular aspects of healthcare discussed amongst the American people ("Affordable Care Act" 2018.). In this research paper, I focus on another important aspect of healthcare: the community benefits standard to which tax-exempted, nonprofit hospitals are subjected to follow. Under the community benefits standard, nonprofit hospital organizations can qualify for tax-exemption if they engage in activities and/or programs that will provide benefits to the community(s) that they serve in addition to their traditional medical care and treatment responsibilities.

The community benefits standard signals key implications not just to the American healthcare system but also to the way hospitals have traditionally been seen. First, the inclusion of the community benefits requirement proposed under the ACA aims to change the American healthcare system from a reactive, medical system to being a prevention-based, population-health driven, public health system (Leider et al. 2017; Cramer et al. 2017). The policy shifts the healthcare framework from emphasizing treatment and medical care of the patient to include strategies to address the underlying conditions that contribute to the growing poor health outcomes and disparities across vulnerable local communities (Rosenbaum 2016; Pennel et al.

2015). Second, the policy and its regulations are ways in which the government begins to highlight the importance of community input and the recognition of social determinants as part of hospitals' efforts to start addressing upstream determinants of health (Crossley, Tobin Tyler, and Herbst 2016). Lastly, this policy seeks to increase political engagement and social empowerment by supporting broader health activities and interventions that can foster leadership and a stronger public health perspective at the local level. This comprehensive approach intends to make better healthcare and better population health an inclusive mission for every individual, governmental agency, and nongovernmental institution (Cramer et al. 2017; Rosenbaum 2016).

It is unclear how the community benefits standard will move forward during Trump's administration. Attempts to defund the healthcare system will create financial burdens on hospitals, especially nonprofit hospitals that rely on federal dollars to support their operations, which may weaken hospitals' incentives to providing community benefits. Nevertheless, the importance of this community benefits standard makes it necessary for us to find ways to strengthen its guidelines and eliminate areas of ambiguities. Doing so will help us create a far-reaching health policy that enables America's healthcare system to produce sustainable alternatives that will protect people's well-being and address population health at large.

Through analyzing community benefit documents such as community health needs assessments, community benefit reports, and implementation reports provided by nonprofit hospitals for the usage of key terms, concepts, and types of community benefit programs, this project explores alternative elements and factors that can be incorporated to the community benefits standard in hopes of addressing the policy's vagueness and strengthening the role of the different agencies that are involved in overseeing community benefits.

Background:

The historical context of community engagement-based tax exemption code for nonprofit hospitals helps to account for the progress made to U.S. healthcare system, strengths and weaknesses of the policy that were demonstrated over time, and what changes are needed in order to better permit nonprofit hospitals to serving community health needs in the future.

In 1956, the Internal Revenue Service (IRS) included in the Section 501(c)(3) a policy standard that will provide federal tax exemption status to hospitals that operate under religious, charitable, scientific, or educational purposes, meaning they will not be subjected to federal income taxation, property land taxation, and sales taxation if applicable (Rubin, Singh, and Jacobson 2013). In other words, as long as hospital organizations were nonprofits, they can receive tax-exemption status by the federal government without providing anything in return. However, in 1969, the IRS revised their nonprofit tax-exemption criteria. The IRS would no longer grant tax-exemption status to nonprofit hospitals unless nonprofit hospitals satisfied the community benefits standard, meaning nonprofit hospitals must now give back to their community(s) in exchange for receiving tax-exemption benefits (“Nonprofit Hospitals’ Community Benefit Requirements” 2018.). In 2002, the value in tax exemption to nonprofit hospitals was \$12.6 billion dollars (Hellinger 2009).

In 2008, the IRS incorporated Schedule H in its Form 990 which will require hospitals to disclose information on the community benefits that they provide (Rubin, Singh, and Jacobson 2013). The IRS Schedule H categorized community benefits into eight areas: financial assistance or charity care, Medicaid, cost of other in means-tested government programs, community health improvement services and operations, health profession education programs, subsidized health

services, health research, and cash or in-kind contributions to local community groups (Leider et al. 2017).

In 2009, reported nonprofit hospital spending on community benefits was roughly 7.5 percent of the total amount received from their federal benefits (Young et al. 2013). The majority of community benefit spending, roughly at 85 percent, was allocated to patient care services (“Nonprofit Hospitals’ Community Benefit Requirements” 2018), and the remaining 15 percent was allocated to community health improvement activities, health professions education and medical research (Rubin, Singh, and Young 2015). Nationwide, community benefit spending reached \$50 billion (Leider et al. 2017).

In 2010, due to the enactment of the Affordable Care Act (ACA), a new section called Section 501(r) added four new requirements that hospitals must satisfy for tax exemption status: create a financial assistance policy, create standards to determine an individual’s eligibility for financial assistance under the hospital’s policy, limit amount of hospital billings, charges, and collection to individuals eligible for assistance under the hospital’s policy, and conduct a community health needs assessment and implementation strategy at least every 3 years (“New Requirements for 501c3 Hospitals Under the Affordable Care Act | Internal Revenue Service” 2018). The requirement that will be the focus of this research is the standard in which nonprofit hospitals must conduct a community health needs assessment (CHNA) and an implementation strategy. The CHNA is a written report, which hospitals are required to make widely public, detailing community health needs, financial and other challenges to addressing those needs, promotion of health, and addressing social, behavioral, and environmental conditions of the community. The implementation strategy report includes tools and strategies that would be used to meet those needs and the impacts of the community benefit efforts such as who benefitted

from the efforts and the total community benefit expenses. Hospitals are then required to compile a community benefits plan in addition to federal tax forms to submit to the state as part of the tax-exemption process. This requirement became effective in fiscal years after 2012.

Literature Review:

Current Debate:

In 2018, approximately 58.5 percent of nongovernment hospitals in the United States are nonprofit hospitals (“Fast Facts on US Hospitals” 2018). Over the years, nonprofit hospitals have saved millions to billions of dollars from tax-exemption; it was estimated in 2014 that the annual financial benefit in tax exemption to nonprofits exceeds \$13 billion (Burke et al. 2014). Moreover, in 2011 alone, hospitals nationwide saved approximately \$24.6 billion in tax exemption (Cramer et al. 2017). Community benefit expenses on the national level also increased from \$50 billion in 2009 to nearly \$62.5 billion in 2011. However, the amount spent by nonprofits on community health improvements decreased significantly from 15 percent of the \$50 billion back in 2009 to just a little more than 4.3 percent of the \$62.5 billion spending in 2011 (Rosenbaum 2016). This indicates that while nonprofit hospitals have been experiencing an increase in tax-exemption benefits, the resources directed towards larger community-based improvement efforts have been decreasing significantly.

Additional research indicates that the amount spent by nonprofit hospitals on community benefits is still less than the overall amount they received from tax exemption (Rubin, Singh, and Young 2015). Moreover, research has shown that the amount spent on community benefits by nonprofit hospitals is nearly the same as the amount spent on community benefits by for-profit hospitals (Pennel et al. 2015), which leads to questions about the value of community benefits

provided by nonprofit hospitals and their qualifications for exemption from local, state, and federal taxes (Hellinger 2009). Should nonprofit hospitals be granted tax-exempt status even when they are spending less on their community benefit programs than the amount they receive in tax-exemption? Should nonprofit hospitals be given tax exemption in the first place (Rubin, Singh, and Young 2015; Seay et al. 1989)? To understand this political and health discussion, we need to go back and trace the problem to its root.

Fundamentally, the language of the community benefits requirement standard to receive tax exemption is insufficient. First, the IRS does not have a clear definition of community benefit in its language. Community benefit is defined at the discretion of the nonprofit hospitals in their assessment reports, which can cause variation across all government levels in what community benefits look like and what they provide to communities. Moreover, this feeds into the debate about nonprofit versus for-profit hospitals (McGregor 2007). For example, if a nonprofit hospital and a for-profit hospital both provide a free health education program to promote awareness of health services available to the community, why should the nonprofit hospital be granted tax exemption status if there is no clear IRS definition that would distinguish the work provided by the nonprofits from that provided by the for-profits. Additionally, the nonprofit hospital can define what the term community means as well in terms of geographical boundaries and target populations, which further complicates the problem of what it means to provide benefits to a community and what counts as benefits (Singh et al. 2015).

Second, the IRS neither defines the structure of community benefit programs and activities nor does it define the structure of how CHNAs should be conducted (Pennel et al. 2015). Again, nonprofit hospitals are able to organize and structure their community benefit programs and efforts according to their discretion and their definition of community benefits,

which, as long as it contributes to the overall goal of bettering the community and promoting population health, can qualify them for tax exemption. This freedom causes variation amongst nonprofit hospitals. This variation is both positive and negative. Positively, this variation allows nonprofit hospitals to serve their specific community populations and specific community health conditions. Negatively, the lack of structural guidelines in reporting allows nonprofit hospitals to leave out as much information as they want regarding quality of community benefits, responses from community members toward the hospitals' efforts, and community conditions that may or may not be improved as a result of community benefits programming, which is why this variation needs to be addressed.

Third, the IRS does not have a set minimum value for which hospitals must provide community benefits in order to qualify for tax exemption. This becomes problematic because nonprofit hospitals can choose to spend as little as they want on giving back to the community and still maintain their tax exemption status, thereby saving much more than they give in return (McGregor 2007). In the end, nonprofit hospitals will still receive federal benefits but, in reality, the impacts to providing community benefit are undermined and contribute little to addressing population health of the greater community.

Fourth, the federal tax form 990 nonprofit hospitals use to apply for exemption is inadequate. The inclusion of Schedule H on form 990 allows nonprofit hospitals to provide supplemental information on needs assessment, patient education on eligibility for assistance, community information, promotion of community health, affiliated health care systems, and filing of a community benefit plan beyond what is included in their community benefit reports already ("About Schedule H Form 990 | Internal Revenue Service" 2018), which helps federal and state governments properly assess exemption status for hospitals and conduct examination of

the policy as a whole. However, Schedule H focuses on using expenditures as indicators for providing community benefits and improvements of community health (Rubin, Singh, and Jacobson 2013). This indirectly defines benefits as expenditures by the hospitals rather than as welfare given to better the community and undermines the causal relationships and impacts of community benefit programs and activities on the community (Byrd and Landry 2012)

Finally, the most problematic challenge to the community benefits policy as a whole is that the IRS can sometimes determine satisfaction for exemption by a case-by-case basis (Rubin, Singh, and Jacobson 2013). This is the compilation of the issues mentioned above on why the community benefits policy is complicated and controversial to groups. Because there are no firm definitions for what community benefits are, what they look like, how they should be structured, how much should be spent on them, and how much benefit should be provided, the IRS could end up just giving tax exemption status to nonprofit hospitals that might not have truly satisfied the standard and reject those that qualified.

Between the years 2011 and 2013, numerous community benefit needs assessments were conducted by nonprofit hospitals. Despite having the potential to improve community and population health, the broad scope and loosely defined guidelines of the standard as a whole have resulted in variations in assessment methods, public reporting, and program quality amongst nonprofits (Carroll-Scott et al. 2017). In sum, in order to better serve the underserved, poor, and vulnerable populations that are in need of community benefits the most and tackle issues of population health from the community levels, there is a need for the IRS and the federal government to address the gaps in the language and strengthen the guidelines in regards to conducting needs assessments, structuring community benefit activities and programs, evaluating

implementation and assessment reports, and, overall, defining the framework at which the standard is operating under.

Some might argue that having more defined guidelines and regulations would constrain and hinder the efforts of nonprofit hospitals in providing community benefits and that these hospitals should know best where to dedicate resources to address their community(s) health conditions. Yet, it is important to consider that without clear boundaries and guidelines, it would be harder to evaluate community benefits programming and draw conclusions on whether or not community benefits are needed, whether or not community benefits are making impact, and whether or not local community members are truly the ones receiving the most benefits. Even though nonprofit hospitals have expertise in knowing about their local community(s) and approaches to serve the people, properly addressing the ambiguities in the community benefits standard will over time help the hospitals develop more comprehensive reports and understanding on how to further improve their community benefits and their scope of work.

Gaps in Research:

Many studies (Burke et al. 2014; Rubin, Singh, and Young 2015; Rosenbaum 2016; Pennel et al. 2015) agree that the IRS should play a greater role in clarifying the ambiguities in the law in order to have community benefit programs and activities better serve the health needs of their targeted communities. Some research focuses on using a policy framework to analyze the implications of the new standards and requirements by the IRS. Some research focus on using a public health framework to address the clarification needed in the policy in order to serve local communities and find public health approaches that can be used to bring upon changes. Other research studies conduct reviews and evaluations of needs assessments, reports, and plans

released by nonprofit hospitals to address issues such as accountability and the role of nonprofits, challenges within the policy, the role of the healthcare system, new approaches to conducting needs assessments, and new approaches to fulfilling the community benefits standard. However, despite existing research that accounts for analysis of needs assessments and reports, the focus has been on examining and dissecting quantitative data instead. Few studies have actually used the language within the assessments, reports, and plans themselves to evaluate, improve, and strengthen the policy.

This type of qualitative research is important because hospitals have been using predominately quantitative methodologies with minimal community input in their assessments. The reliance on quantitative research alone approach is problematic because it minimizes the potential for creating partnerships with the community and reduces the benefits that can result from proper collection of community input, including greater success in outreach, generating reliable and valid data, enhancing community capacity, greater sustainability of programs in the long term, and accurate reflection of community conditions over time (Santilli, Carroll-Scott, and Ickovics 2016; Ainsworth, Diaz, and Schmidlein 2013).

It is essential to have strong policy guidelines to ensure nonprofit hospitals are properly providing community benefits that their communities need. Without being complemented with significant data on community input, hospitals will be generating CHNAs that fail to meet the policy's goals of creating impactful benefits that address population health and increasing sustainable collaboration between ordinary people and different institutions (Rubin, Singh, and Jacobson 2013). Furthermore, without proper community input and participation, hospitals' efforts to better community conditions may even take the opposite direction, by addressing

health needs that are less prioritized by the community, or producing minimal outcomes where the efforts are simply short-term strategies for addressing community needs.

In this research paper, I analyze the language of the federal community benefits policy itself and the community benefits plans released by three different non-profit hospitals/medical centers in the Los Angeles area: City of Hope, Huntington Memorial Hospital, and Glendale Memorial Hospital. I examine the reports released by the nonprofits from the years 2011 to 2015. Moreover, I add onto recommendations made by other literature and studies by incorporating specific elements, factors, and criteria that help answer some of the policy's ambiguities. The final analysis includes specific methods and approaches for changes; however, these are not specific to any one community or any particular state. The analysis generates a flexible yet targeted discussion framed around the policy even though my case studies are focused on the Los Angeles geographical area.

Methodology:

Data Source and Sample:

Community benefit plans were required to be released online on the hospitals' websites and be made available on the webpage of the California Office of Statewide Health Planning and Development. I evaluated the community benefit reports released by City of Hope, Huntington Memorial Hospital, and Glendale Memorial Hospital from the years 2011 to 2015. City of Hope is a private, nonprofit clinical research center, hospital and graduate medical school located in Duarte. Huntington Memorial Hospital is a nonprofit, community-focused regional medical center located in Pasadena. Glendale Memorial Hospital is a nonprofit, acute care community hospital located in Glendale. These three nonprofit hospitals were specifically chosen because

they were located in the greater Los Angeles area and all have a community benefits review board or council as their main entity for supervising their organizations' community benefits, which made researching their programs and documents more available and accessible.

Additionally, CHNAs and implementation strategy plans that were published by the nonprofit hospitals were included in the analysis. Analyzing the content of CHNAs and their trends over time was an important research method because changes in how the hospitals prioritize their community benefits, their implementation strategies, and their evaluation for success helped answer how different definitions, criteria, and implementation processes are set across different nonprofit levels and what additional factors or elements can be used to create more specific and concise language for the community benefits standard.

Initial research included an interview component. However, I was unable to secure any interviews during the research process, which led to the removal of this research method from the project. This will be further discussed in the limitations section.

Coding Structure:

Specific key terms and concepts were taken from the IRS community benefits standard and from the IRS Schedule H Instruction Guide, which were then used as codes for analysis. Using Dedoose, an online data analysis software, these codes were measured in reports released by nonprofit hospitals for their frequency of mention. Codes used for analyzing the community benefit reports included the following: health, benefit, community-identified issues/needs, and community. The IRS did not have a clear definition for community but included descriptive terms such as low income, vulnerable, and underserved to describe community conditions. These descriptive terms were used for coding as well. Additional term minority was added since many

of the community benefit reports contained demographic information to illustrate a disparity amongst served community members.

Codes were context-based. Health was coded for when it defined or described the work that the non-profit hospital does. Variations of the term included healthy, healthier, unhealthy, well-being, and quality of life. Community was coded for when it defined or described the target community the hospital works for and the current conditions or environment of said community. Issues and needs that were defined by the nonprofit hospital or identified by community participants were coded for. Benefit was coded for similarly as well when it answers the question of how the nonprofit situates and defines its own benefits. On the other hand, sub-codes including low income, vulnerable, minority, and underserved used to describe the hospitals' service communities or their target communities were not analyzed based on context, which means that these terms were coded for every time they were mentioned.

Key Terms and Concepts	
Health	
Community	<ul style="list-style-type: none"> • Low Income • Minority • Underserved • Vulnerable
Issue/Need	
Benefit	

Moreover, different types of community benefit programs were used as codes to see which types of community benefits were most prevalent or most often provided. The frequency at which these codes were mentioned was measured as the dependent variable. The higher the

frequency value meant that the specific type of community benefit program was more likely to be mentioned by the hospitals as being used. As for types of community benefits programs, to organize information in a more understandable and concise fashion, I placed Medicaid and subsidized health services under one category since the goal of both is to provide medical services. I also separated community health improvement services and community benefit operations into two categories, and combined community health improvement services with community building activities instead since the two are very similar in terms of the type of services that qualifies as community building and the types that qualifies as community health improvement. Additionally, cash or in-kind contribution was grouped with community building and community health improvement as well. Lastly, I decided to remove costs of other means-tested government programs since the prevalence of this code would be close to zero in the community benefit reports.

Thus, I looked into six categorizations: community building activities and improvement programs, community building operations, financial assistance, health profession education, medical service, and health research. For each of these community benefit programs, their descriptions such as goals and outcomes and their implementations strategies were coded for. The criteria for what qualifies for each category were aligned with IRS Schedule H standards.

Types of Community Benefit Programs
Community Building Activities and Community Improvement Services
Medical Service <ul style="list-style-type: none"> • Medicaid • Medi-Cal • Subsidized medical services
Health Profession Education

Financial Assistance
Health Research
Community Benefit Operations

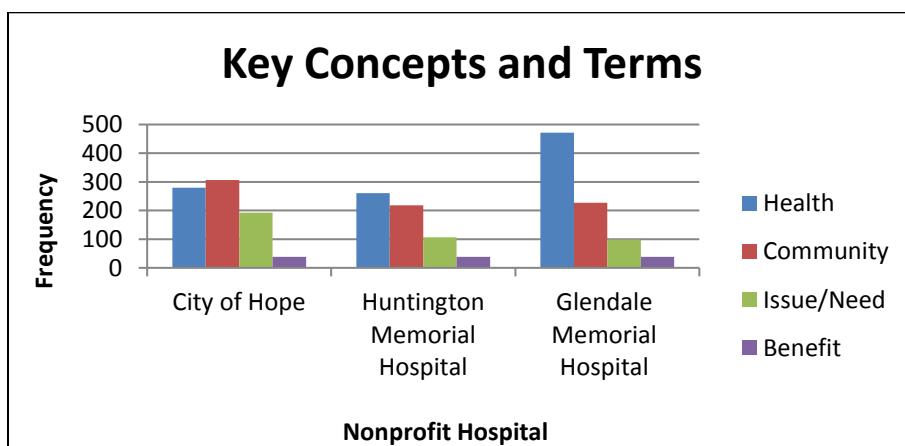
Data Results:

The table of analytic codes in Appendix 1 represented the frequency at which all codes were mentioned in the community benefit reports released by the three nonprofit hospitals. Codes that have empty value cells meant that the key term or concept was either not mentioned or it did not fit into the research context.

Codes- Key Terms and Concepts:

The following table encompassed the instances at which key terms and concepts were coded for when they satisfied the research context. Overall, “health” and “community” were key terms heavily used. Low income, vulnerable, and underserved were used infrequently, and minority was rarely used. “Benefit” and “issue/need” were used less loosely compared to “community” and “health” and were better explained.

Table 1: Frequency of Key Terms and Concepts



Only a chosen subset of said key terms and concepts had further analytical purposes. The reasoning behind this was because the terms “health” and “community” in the reports mostly served as semantic satiation, which is the state where repetition causes a word or phrase to lose its meaning over time. They either did not contribute to further analytical discussion, only served for listing and/or naming purposes, or were used to stand in for concepts that were not explicitly defined in the community benefit reports but were generalized for basic understanding.

City of Hope gave a definition for health in the beginning of their community benefit reports, which set the context for how the word would be used later and defined its organizational context within the realm of cancer-related issues. Glendale Memorial Hospital and Huntington Memorial Hospital, on the other hand, were less clear for how their organizations defined health, and there was no specific realm of work for which the two organizations define their community benefits in like City of Hope. Huntington Memorial Hospital and Glendale Memorial Hospital focused on a wider range of health issues that largely ranged from physical health to behavioral health needs.

As for the key concepts benefit and issue/need, City of Hope defined their benefits based on their mission statement and their expenses/cost. Huntington Memorial Hospital and Glendale Memorial Hospital defined their benefits based on the types of programs and activities they provided and which categorization those programs and activities satisfied. Issues and needs that were identified and being addressed by the hospitals were outlined clearly and concisely.

Codes- Community Benefit Programs:

Community benefit programs were ranked based on highest to lowest frequency of mention. Looking at the community benefit programs provided by all three nonprofit hospitals, community building and improvement programs and medical service programs were ranked the highest in terms of being most frequently mentioned in the community benefit reports as the type of programming being used.

Table 2: Types of Community Benefits and Their Rankings

Types of Community Benefit Program	Frequency of Mention	Rank
Community Building and Improvement	674	1
Medical Service	202	2
Health Profession Education	80	3
Financial Assistance	71	4
Health Research	27	5
Community Benefit Operations	10	6

The community building and improvement programs provided by Glendale Memorial Hospital were broken down into several activities. The most frequent types of activities were community health education (classes, lectures, and workshops) and community outreach-based or awareness-based efforts. Other types of activities included community support groups, workforce development (recruitment), and coalition building (partnerships, collaborations, or grant funding).

For Huntington Memorial Hospital, subsidized medical health service, and health profession education (educational program required for licensed health professional) were the types of community benefit programs most frequently mentioned. Community health education

was another community benefit program that was mentioned a few times as well. The most common community benefit activity that the nonprofit hospitals employs to further their community benefit programs is community outreach efforts.

As for City of Hope, most frequently mentioned activities were coalition building, community health education (patient self-advocacy classes and workshops), workforce development (science and health fair recruitments), and community support groups, which all fell under community building and improvement programming. Two other types of programming that were closely mentioned were health profession education and medical service.

Data Analysis:

Finding 1:

Through coding for key terms and concepts, it was clear which terms and concepts were most popularly used. It seemed that the language in nonprofit hospitals contained in their community benefit reports paralleled the language published by the IRS. Key terms and concepts such as health, community, low income, vulnerable, and underserved that were popular in the IRS Schedule H language were just as likely if not more likely to be used in the nonprofits' community benefit reports. As previously established already, a fault in the community benefits standard was the lack of structural guidelines for creating community benefit reports and assessment plans. The constant repetition and restatement present in the nonprofits' reporting of community benefits demonstrated the significance of this fault. The vagueness of the policy as whole most likely led nonprofits to communicate their reports and plans in the same way as the IRS to avoid making language or conceptual mistakes, which may unintentionally led to the development of reports that contain less substance and more repeated, surface-level information.

Finding 2:

Additionally, through analyzing and ranking coded community benefit programs, not only was I able to identify which programs and activities were most prevalent amongst the nonprofit hospitals, I was also able to identify a few other areas that too were resulted from insufficient guidelines of the community benefits policy. For one, some programs and services including their implementation strategies satisfied the criteria of multiple community benefit and improvement activities outlined by the IRS, which made the boundaries between how to categorize the nonprofit hospitals' community benefit programs and activities unclear. The lack of clarification could potentially lead to some programs and activities being misclassified or being double-counted, which is problematic to understanding which types of community benefits are most efficient to addressing community health conditions and which are most often provided.

Finding 3:

There was a lack of explanation amongst all three hospitals as to why they have chosen to use the implementation strategies and community benefit programs and activities that they had. Thus, I was unable to further observe whether certain programs, activities, or strategies were more effective than others or whether or not certain approaches were inexpensive and more cost-efficient than others. Providing information to answer those questions would be beneficial to evaluating the effectiveness of community benefits.

Finding 4:

The last area worthy of attention was regarding the type of information these three nonprofits chose to report on. From the ranking of community benefit programs in Table 2, community building and improvement programs and medical services were ranked the highest in

terms of the types of community benefits most frequently mentioned as being used. Yet, from the executive summary of all three nonprofits' reporting, it was obvious that the expenses contributed to medical care services (Medicaid and Medi-Cal) and financial assistance far exceeded the amount of expenses contributed to community building and improvement programs and activities. This was not surprising because the first and foremost responsibility of these nonprofit hospitals is to provide medical care and treatment in their local communities. However, this did bring up the question of why these nonprofit hospitals chose to focus on reporting their broader community benefits such as community building and improvement rather than on their financial assistance programs and medical care services, which were in reality more heavily prioritized by the hospitals. Information regarding medical services was sufficient in the community benefits reports, but there was a lack of substantial information regarding financial assistance, or free or no-cost programs, amongst all three nonprofit hospitals. Choosing to focus their reporting on their broader community benefit efforts created a misleading impression where broader community building and improvement programs were thought to be the efforts most emphasized by the hospitals. Future research studies evaluating community benefit programs should take into account the difference between the amount of information reported on certain programs and the amount of financial support that those same programs or perhaps other programs actually received.

In conclusion, from the nonprofits' repeated usage of blanket terms to their lack of clear definitions and explanations for their community benefits, it was evident that the absence of standards and guidelines in the community benefits policy greatly impacted how community benefit reports are structured, organized, and examined. Larger implications of such ambiguities in the policy include misleading conclusions about how community benefits are serving the

population, false recognition of how nonprofit hospitals should continue developing their community benefit reports, and inadequate understanding for how public health issues should be tackled in the future.

Limitations:

Limitations
<ul style="list-style-type: none">• Context based coding• Lack of comparability• Lack of informal interviews

One of the limitations in this paper was context-based data coding. Despite explaining the criteria at which key terms and concepts were coded in, there could be instances where, for example, terms that satisfied the research context but were not included in the analysis and terms that did not satisfy the research context but were mistakenly accounted for. This was due to the different structures and context in which community benefit reports by the nonprofit hospitals were written in that led to inconsistencies between codes. Furthermore, key terms and concepts that were selected based on context for this research project may differ from another researcher who has chosen other key terms and concepts for data coding. Results generated by different context-based key terms and concepts for different researchers simply indicate there is a difference in what each researcher identifies as significant.

Another limitation to the research was the lack of comparability. Only three private/public tax-exempted nonprofit hospitals were included in the research due to the lack of time and resources. Therefore, the data collected from analysis of the three chosen nonprofit hospitals was

not statistically significant. A greater pool of hospitals that are diverse in terms of location, size, and service demographics would generate more insightful analysis and policy recommendations applicable towards a wider population of nonprofit hospitals. Moreover, there is a lack of distinction between private and public nonprofit hospitals. This caused some differences in structure, organization, and functions, which may or may not help explain the differences in provided community benefits, of the three nonprofit hospitals to be overlooked. Future research studies would need to pay attention to this area.

Lastly, a limitation, which also resulted from a lack of time and resources, was the lack of a multi-perspective interview component in the data collection/analysis process. Due to the inconvenient scheduling between the researcher and potential interview participants, the informal interview research element was removed from the research. Thus, supplementary evidences and interpretations were missing from this research paper to illustrate the positions which nonprofit hospitals internally take on in view of the ambiguities of the community benefits standard and the recommendations that they felt are most needed.

Discussion:

Recommendations for policy and structural changes for agencies involved in community benefits were developed through research findings and through review of scholarly research literature that also seek to address loopholes in the community benefits standard.

Recommendations	
Nonprofit Level	<ul style="list-style-type: none"> • Create an internal organizational structure to oversee the community benefit works • Conduct CHNAs using their own organizational or departmental staff rather than hiring an outside agency • Reference advantages seen in community benefit reports released by City of Hope, Huntington Memorial Hospital, and Glendale Memorial Hospital • Have an appropriate or conventional definition to establish the foundation and legitimacy of their community benefits
State Government	<ul style="list-style-type: none"> • Define the expectations for tax-exemption hospitals based on the unique health needs of their populations and community benefit reports submitted by their local nonprofit hospitals • Establish a criterion for tax-exemption and report such criterion and the qualified nonprofit hospitals to the IRS • Provide an incentive for nonprofit hospitals to seek input from governmental health departments or public health agencies either on the state level or city level
Federal Government	<ul style="list-style-type: none"> • Integrate outcome-based measurements into the tax form 990 • Incorporate community building activities to be under the same section as financial assistance and community benefits at cost • Require nonprofit hospitals to conduct a comprehensive evaluation method to assess their community benefits • Require the publication of hospitals' financial assistance policies and their implementation strategy reports

Recommendations for Nonprofit Hospitals: *nonprofit hospitals can adopt such recommendations in order to improve the structure and organization of their community benefits and their community benefit reports.*

Recommendation 1:

Firstly, in order to create consistent and effective community benefit works, nonprofit hospitals should have an organizational structure within themselvesthat oversees work on community benefits where there are full time-paid community members and other partner organizations in the community (Alexander, Weiner, and Succi 2000). Creating alliances promote the performance of wider-range community benefits developed by other organizations while still retaining the legal independence of individual organizations (CenterMerger, Populations, and Medicine 2012). Alliances and partnerships are also positively associated with having more community health orientation (Ginn and Moseley 2006) that result in increasing community participation for more upstream health equity solutions (Carroll-Scott et al. 2017). Moreover, having local staff members to coordinate and supervise community benefit activities increases communication, accountability, and transparency between the different agencies that are involved in and committed to ensuring that community members take full advantage of the benefits provided by the hospitals.

Recommendation 2:

Secondly, nonprofits should conduct CHNAs using a community-based participatory approach themselves rather than hiring an outside agency to create the CHNAs (Ainsworth, Diaz, and Schmidlein 2013; Bias et al. 2017). The CHNAs themselves are community-based research reports generated through community participation. However, due to possible reasons such as limited resources, staff, and time, nonprofit hospitals would employ an external organization to conduct CHNAs on their own communities instead. An outside entity may overlook important

findings and community input due to lack of knowledge of community conditions. If nonprofit hospitals were to take upon themselves the responsibility of conducting CHNAs using their own staff, which should also be made up of local community members as suggested before, greater collaboration and community leadership could be fostered. Other benefits include appropriate communication and collection of data and support in implementation for future potential community benefits. Furthermore, this contributes to greater community growth and development amongst the different stakeholders in the community itself, which leads to an increase in community engagement.

Recommendation 3:

Thirdly, despite the lack of structural guidelines for the organization of community benefit reports and plans, there were advantages in the different community benefit reports provided by the three hospitals that can be used for reference. A strength that nonprofits should incorporate would be Glendale Memorial Hospital's example of including in the reports a specific section on which community benefit category the program satisfies and the expenses that the program consisted of. In the reports provided by City of Hope, a strength that the other nonprofit hospitals can integrate was the clear definition of health and the type of field or realm that the community benefits are operating under, which clarified why some public issues were chosen over others to be addressed by the hospital's community benefit efforts. Even though Glendale Memorial Hospital and Huntington Memorial Hospital focused on general care and a wide range of health issues, it would be beneficial to define a narrow scope of work which can be used to help situate their community benefit works. Finally, the strength of Huntington Memorial Hospital lies in the way it summarizes the outcomes of its community benefit programs by organizing information into tables and charts so that details and data were clear and

concise. Some of these approaches can be used by any other nonprofit hospital to create stronger and more comprehensive community benefit reports that are more straightforward in discussing its community benefits and how the hospital fulfills its tax-exemption requirement.

Recommendation 4:

Lastly, although it is understandable why nonprofit hospitals employ an abundant use of key terms and concepts that were also used in the national policy language as their structural foundation for reporting, without properly defining or explaining the context for these terms or concepts, the audience of their reports would simply see a lack of analytic significance and informational significance. Therefore, particularly when it comes to using abstract terms and concepts, it is crucial that nonprofit hospitals have an appropriate or conventional definition either created by their own organization or an outside organization to establish the foundation and legitimacy of their community benefits. Similarly, in addition to providing context to abstract concepts and terms used in nonprofit hospitals' reporting of community benefits, it is equally important and beneficial to provide an explanation for the usage of different types of community benefit programs and activities.

Another reason why it is important to properly define concepts such as "community" and "health" and explain certain programming decisions is because the way nonprofit hospitals respond to community benefit programs and activities and their financial assistance policy already differs based on their own community standards (Tahk 2017; Bazzoli, Clement, and Hsieh 2010). So, by offering the general public a scope of either a narrowly defined community region or a larger broad implication of community (including the term health as well), nonprofit hospitals can design better evaluation measurements considering the difference in community

population between nonprofits, and researchers and government agencies may be able to look into and understand why certain community benefits may or may not be more effective compared to others when it comes to addressing population health issues. Properly stating the significance of certain community benefits over others help contextualize each nonprofit hospital's community benefit works as a whole.

Recommendations for State Governments: *recommendations the state governments can adopt in order to help guarantee and better evaluate the quality of community benefit programs provided by the nonprofit hospitals in their respective states.*

Recommendation 1 and 2:

An approach state governments can consider is defining the expectations for tax-exemption hospitals based on the unique health needs of their populations and community benefit reports submitted by their local nonprofit hospitals (Rubin, Singh, and Young 2015; Carroll-Scott et al. 2017; Principe et al. 2012). From there, state revenue agencies will integrate the information to create a criterion for tax-exemption and report such criterion and the qualified nonprofit hospitals to the IRS. The IRS will then examine whether the list of qualified nonprofit hospitals selected by the state agencies satisfies the community benefits standard on the national level by reviewing their reported Schedule H Form 990 and proceed to assign tax-exemption status accordingly. For example, a nonprofit hospital that has been expanding the amount of funding for a community benefit program, receiving positive input from the community regarding its impacts, and addressing a unique health need or needs that have been indicated by its state should obtain tax-exemption status compared to a nonprofit hospital that has been providing a community benefit that qualifies for the federal standard but is not beneficial, applicable, or supported by the community at large in any way. In this way, state agencies can help the IRS distinguish true and false nonprofit community benefits and ensure proper

compensation for those nonprofits that do provide quality community benefits (Hellinger 2009).

In addition, a research study indicates focusing on accountability, equity in results, and public value, performance in a government funding model will increase as well (Lee and Nowell 2015).

In other words, to ensure the performance of nonprofit hospitals that secure government funding, or in this case tax exemption status, attention should also be drawn to how nonprofit hospitals achieve equity and foster public input. Not only are state agencies more accessible to holding nonprofit hospitals accountable to these factors than the IRS, but they can include equity in outcomes and intensive public input as part of the criterion for tax-exemption status for their particular state, thus, making this recommendation much suited at the state level.

Recommendation 3:

Likewise, another approach suitable for state governments to lead is creating an incentive for nonprofit hospitals to seek input from governmental health departments or public health agencies either on the state level or city level (Crossley, Tobin Tyler, and Herbst 2016). This would allow the government sector and private/public nonprofit sectors to pool together resources and provide feedback to each other since the IRS is slow in providing feedback. Promoting the cooperation of various institutions could also lead to greater partnerships or collaborations for future community projects (Skinner, Franz, and Kelleher 2017). City of Hope, Glendale Memorial Hospital, and Huntington Memorial Hospital all supply a list of partner organizations, groups, and individuals that were a part of their community benefit programming, designing, and reporting processes. However, from those lists, less than a handful of partnerships and collaborations are with government agencies. By encouraging nonprofit hospitals to work together with public health practitioners outside of their organizations and with technical experts on needs assessments and community benefits program compliance from within the government,

ambiguities and confusions regarding community benefit structure and reporting can be addressed at earlier stages, efficient community benefit programs and activities can be implemented with greater support, and state governments can play a larger role in overseeing and assisting their nonprofit hospitals to tackle pressing public health issues in their individual states.

Federal Level Recommendations: *recommendations the federal government can adopt in order to reduce some of the policy ambiguities and help define the scope of work for nonprofit hospitals.*

Recommendation 1:

There should be changes made to the Schedule H Form 990 as a whole. For one, the federal government needs to focus less on expenses as measurements for the effectiveness of community benefits. The federal government should integrate outcome-based measurements into their tax-exemption determining process (Rubin, Singh, and Jacobson 2013; Rubin, Singh, and Young 2015). The reason behind this recommendation is to ensure critical evaluation of nonprofit hospitals' work and assure that local community members are the ones benefitting the most. One type of outcome-based measurements would be including section in Form 990 Schedule H where nonprofit hospitals provide a consolidation of public comments that reflect what community members think about the hospitals' work on community benefits before and after certain programs were put into place. Another type of outcome-based measurement can be including, which was covered in City of Hope's reports, a ranking component where the nonprofit hospitals ask local community members to rank the different types of available community benefits and then combine the information onto the tax form to show which programs or activities were most supported and most effective.

Recommendation 2:

Another change that should be made to the IRS Schedule H form is incorporating community building activities to be under the same section as financial assistance and community benefits at cost instead of having its own separate section or establish certain community building activities under the category of community health improvements. The boundaries that differentiate community benefits and community building activities are vague and ill defined by the IRS in the first place. Certain programs and activities throughout the research process reveal that multiple programs and their implementation methods are very closely aligned with each other but have to be classified as either a community benefit program or a community building activity. Community building activities encompass similar goals and outcomes as other community benefits, so it seems unreasonable and redundant to have the two categories to be separate sections.

Recommendation 3:

On a different note, IRS should include in the community benefits policy the requirement to have nonprofits also conduct a comprehensive evaluation method to assess the effectiveness and sustainability of their community benefit programs in order to qualify for tax-exemption (Burke et al. 2014). This recommendation is different from the previous recommendation to have the IRS include in its Schedule H tax form outcome-based evaluation methods. The goal of incorporating outcome-based measurements to Schedule H is to change the way we currently analyze the success of community benefits whereas the goal of requiring nonprofit hospitals to include a comprehensive evaluation method to their reporting if they are not already doing so is to have nonprofit hospitals analyze underlying or overlooked aspects of their community benefits and come up with new methodologies and techniques to which they can use to address the issues/needs of their communities. Similar outcome-based approaches listed previously can be

used by nonprofit hospitals to assess their own programs and activities; however, nonprofit hospitals should additionally highlight either in their community benefit reports or in a completely separate report the findings, patterns, causal relationships, and evaluation goals disclosed by their community members after benefits were served. Attention should also be drawn to whether or not there are varying experiences and perceptions between community members that may differ in terms of ethnicity, age, gender, or other socio-demographic factors on how they view the success and impact of said community benefits. Not only does requiring the incorporation of a comprehensive evaluation method generate greater accountability on behalf of the nonprofit hospitals to the national government and the general public, but such a requirement can further encourage nonprofit hospitals to review the approaches and strategies that have been overused or outdated and begin to develop alternative measures that may be more applicable and advantageous to serving their community needs.

Recommendation 4:

Furthermore, the IRS should incorporate in the community benefits policy that other than requiring nonprofit hospitals to publish their CHNAs on their websites, it is equally important to require the publication of their financial assistance policy and their implementation strategy report so that these documents can also be widely accessible to the public. Establishing a financial assistance policy and developing an implementation strategy are already included in the community benefits requirement. Nonetheless, there is no language that states the publication of either of those documents is required for wide accessibility in the same way as CHNAs. One important finding by a research study reveals that requiring the reporting of stand-alone documents have led stakeholders to see the CHNAs as an continuous dialogue for long term accountability in evaluation (Franz, Skinner, and Kelleher 2017). City of Hope, Glendale

Memorial Hospital, and Huntington Memorial Hospital all made their CHNAs, community benefit reports, and implementation strategies available on their websites. As for the financial assistance document, only City of Hope inserts this document as a supplement in their community benefit reports. Nonprofits do not have to submit these documents along with their community benefit reports to their state offices, but by requiring the publication of such documents on the hospitals' websites, the public can gain a greater sense for how their local nonprofit hospitals are planning to deliver community benefits to them and decide for themselves whether or not certain programs, strategies, or financial assistance criteria are applicable to their and their community needs.

Conclusion:

Ambiguities in the community benefits standard create many loopholes and confusions leading to many faults that we have seen reflected in three nonprofit hospitals' reporting documents. These ambiguities and faults ultimately undermine the impacts and significances of community benefits on improving greater population health. Strengthening structural guidelines and addressing ambiguities of the policy would not only improve the programming and reporting processes of nonprofit hospitals' community benefit works, the successfulness and effectiveness of community benefit programs in the future can also be assured as well. This paper serves as a stepping stone for critical thinking and analysis on how to further improve current standards of monitoring and evaluating the efforts of nonprofit hospitals in addressing population health issues from local perspectives.

In order to create far-reaching health policies with sustainable alternatives protecting and serving the underserved, poor, and vulnerable populations at large, we need to properly remove

the ambiguities and mend the faults. We need to push forth more effective policy changes and structural changes for community benefits standard. We need to have better measurements to qualitatively assess the success and impacts of community benefit programs. We need to encourage greater community participation and input. We still need to do much more work.

Appendix 1: All Analytic Codes

Media	Codes		Benefit	Community	Health	Low-Income	Minority	Underserved	Vulnerable	Community Benefit Operations	Community Building and	Financial Assistance	Health Profession Education	Health Research	Issue/Need	Medical Service	Totals	
HMH CHNA2013.pdf	4	50	4	2				1	2		12					27	4	106
HMH CB Report 2015.pdf	7	34	39	2				1	3		26	2	14	2	15	12	157	
HMH CB Report 2014.pdf	7	38	36	2				3	3		23	1	13	3	15	11	155	
HMH CB Report 2013.pdf	7	35	74	1				1	1		17	1	15	3	17	12	184	
HMH CB Report 2012.pdf	7	32	56	1				1	1		12	1	13	3	16	10	153	
HMH CB Report 2011.pdf	7	29	52	2				2	1	2	21	1	7	2	16	8	150	
GMH CB Report 2015.pdf	7	58	109	6				9	1		63	7				18	15	293
GMH CB Report 2014.pdf	9	53	95	4				5	1		64	15	1			21	23	291
GMH CB Report 2013.pdf	9	49	96	4				3	2	3	55	13	1	1	1	24	35	295
GMH CB Report 2012.pdf	10	57	91	4				3	1	4	66	11	1			18	43	309
GMH CB Report 2011.pdf	3	60	81	6				5	1		77	11				18	29	291
COH CHNA2013.pdf	1	15	36	7	3				2							20		84
COH CB Report 2015.pdf	8	71	67	16	11	3	14	1	27	1						46		265
COH CB Report 2014.pdf	10	47	39	14	10	4	9			27	1					42		203
COH CB Report 2013.pdf	9	69	52	15	7	2	2			76	4	6	2	2	40			284
COH CB Report 2012.pdf	8	66	44	12	7	2	2			73	2	6	3	3	42			267
COH CB Implementation	2	38	41		1	8	17			35		3	8	3				156
Totals	115	801	1012	98	39	53	63	10	674	71	80	27	398	202				

Legend:

- City of Hope (COH)
- Glendale Memorial Hospital (GMH)
- Huntington Memorial Hospital (HMH)
- Community Benefit (CB)
- Community Health Needs Assessment (CHNA)

Appendix 2: IRS Community Benefits Policy

New Requirements for Charitable 501(c)(3) Hospitals

Section 501(r), added to the Code by the ACA, imposes new requirements on 501(c)(3) organizations that operate one or more hospital facilities (hospital organizations). Each 501(c)(3) hospital organization is required to meet four general requirements on a facility-by-facility basis:

- establish written financial assistance and emergency medical care policies,
- limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy,
- make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy before engaging in extraordinary collection actions against the individual, and
- conduct a CHNA and adopt an implementation strategy at least once every three years. (These CHNA requirements are effective for tax years beginning after March 23, 2012).

The ACA also added new section 4959, which imposes an excise tax for failure to meet the CHNA requirements, and added reporting requirements under section 6033(b) related to sections 501(r) and 4959.

Notice 2010-39, 2010 IRB 24 (June 14, 2010) described the new requirements and solicited public comments.

Requirements Related to Financial Assistance and Emergency Medical Care

The IRS issued proposed regulations, which were published on June 26, 2012. These regulations provide information on the requirements for charitable hospitals relating to financial assistance and emergency medical care policies, charges for emergency or medically necessary care provided to individuals eligible for financial assistance, and billing and collections. A public hearing on these proposed regulations was held on December 5, 2012.

CHNA Requirements

Notice 2011-52, addresses the CHNA requirements. Hospital organizations may continue to rely on the guidance provided in Notice 2011-52 for CHNAs conducted and implementation strategies adopted up to 6 months after April 5, 2013.

On April 3, 2013, the IRS issued proposed regulations on the CHNA requirements (formal publication on April 5, 2013). The proposed regulations also discuss the related excise tax and reporting requirements for charitable hospitals and the consequences for failure to satisfy the section 501(r) requirements.

On August 15, 2013, the IRS issued temporary regulations and proposed regulations under sections 6011 and 6071 on how to report any section 4959 excise tax owed for failing to meet the CHNA requirements. The temporary regulations provide that a charitable hospital organization liable for the section 4959 excise tax must file a return on Form 4720, *Return of Certain Excise Taxes Under Chapters 41 and 42 of the Internal Revenue Code*. The form must be filed by the

15th day of the fifth month after the end of the charitable hospital's tax year during which the liability under section 4959 was incurred.

Notice 2014-2 confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012 and April 5, 2013, pending the publication of final regulations or other applicable guidance.

On December 30, 2013 the IRS issued Notice 2014-3 which contains a proposed revenue procedure that provides correction and disclosure procedures under which certain failures to meet the requirements of § 501(r) of the Internal Revenue Code will be excused for purposes of § 501(r)(1) and 501(r)(2)(B). This notice invites comments regarding the procedures set forth in the proposed revenue procedure, including what additional examples, if any, would be helpful and whether hospitals should be required to make additional disclosures.

On December 31, 2014, the IRS issued final regulations under the heading Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return. With respect to the requirements under section 501(r), the final regulations are effective for tax years beginning after December 29, 2015.

Core Form 990 and Schedule H Revisions for Tax Years 2010 and 2011

Form 990, *Return of Organization Exempt From Tax*, was redesigned for tax years beginning in 2008 after significant and continued input from the tax-exempt sector, including the tax-exempt healthcare community. Schedule H was developed as part of the redesign of the form.

Form 990, Schedule H, Part V, Section B was added for tax years beginning in 2010. It is intended to provide hospitals with ample opportunities to describe their policies and activities related to compliance with ACA requirements and to explain how they are complying with the new requirements. Further revisions were made in 2011 after public input was considered.

New Questions on Section 501(r) Requirements in Part V, Section B, in general

Form 990, Schedule H, Part V, Section B was revised for tax years beginning in 2010 and 2011 to include new questions relating to the new section 501(r) requirements, and asks for information concerning each hospital facility's financial assistance, emergency medical care, and billing and collection policies.

New questions relating to CHNAs were also added to Schedule H, Part V, Section B. These questions were optional for tax years 2010 and 2011 because the CHNA requirements of section 501(r) only became effective for tax years beginning after March 23, 2012.

New Questions on 501(r) Requirements on a Facility-by-Facility Basis

Hospital organizations file a single Schedule H with the organization's Form 990. Schedule H, Part V, Facility Information has been expanded to include:

- Section A: The filer will list the hospital facilities it operated during the tax year.

- Section B: The filer will report separately on the activities, policies and practices of each of its hospital facilities listed in Section A by filing a separate Section B for each of its hospital facilities listed in Section A. Since non-hospital healthcare facilities are not required to meet the requirements of section 501(r), hospital organizations do not need to complete Section B for any of its non-hospital health care facilities listed in Part V, Section C.
- Section C: The filer will list its non-hospital health care facilities that it operated during the tax year.

Note: Only Part V, Section B of the Form 990 Schedule H requires separate reporting for each individual hospital facility. All other portions of Schedule H will be completed on an organization-wide basis.

TY 2011, Part 5, Section B - Section B is Required

The IRS considered public input on Part V, Section B and made revisions to Part V, Section B for the 2011 tax year. Notice 2012-4 notifies hospital organizations that are required to file Form 990 for tax year 2011 that they will be required to complete all parts and sections of the Schedule H (except for lines one through seven of Part V, Section B relating to CHNAs, as these are optional for tax year 2011). The IRS anticipates making further revisions in future tax years and welcomes public input as described below.

TY 2012, Part 5, Section B - CHNA Questions May Be Required

Hospital organizations whose 2012 tax years began after March 23, 2012 are required to complete all questions on their 2012 Form 990, Schedule H. Hospital organizations whose 2012 tax years began on or before March 23, 2012 are required to complete all parts and sections of Schedule H for tax year 2012, with the exception of Part V, Section B, lines 1-8 regarding CHNAs.

TY 2013 and beyond, Section B

Completion of all questions contained in Schedule H, Part V is required for all years after 2012

Audited Financial Statements

If a hospital organization is required to file Form 990 Schedule H, the organization is required to attach a copy of its most recent audited financial statements to its return for tax years beginning after March 23, 2010. Organizations that file electronically are requested to submit their financial statements in Adobe PDF format.

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