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SCHEDULE H (Form 990)

Hospitals

TREASURY/IRS AND OMB USE ONLY DRAFT

Complete if the organization answered "Yes" on Form 990, Part IV, question 20a. Attach to Form 990.

OMB No. 1545-0047

Open to Public Inspection

Department of the Treasury Internal Revenue Service Name of the organization

Go to www.irs.gov/Form990 for instructions and the latest information. Employer identification number

Par	t I Financial Assistance and Ce	rtain Other (Community I	Benefits at C	ost				
								Yes	No
1a	Did the organization have a financial assistance			=		<u> </u>	1a		
b	If "Yes," was it a written policy?					1b			
2	the FAP to its various hospital facilities during the tax year:								
	Applied uniformly to all hospital facilit		Applied ι	uniformly to m	ost hospital fac	cilities			
•	Generally tailored to individual hospita								
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.								
а	Did the organization use federal poverty free care? If "Yes," indicate which of the						3a		
	☐ 100% ☐ 150% ☐ 200%	☐ Other _	%						
b	Did the organization use FPG as a factorindicate which of the following was the factorindicate which of the following was the factoring was the factoring with the factoring was the factoring w					e? If "Yes,"	3b		
	☐ 200% ☐ 250% ☐ 300%	□ 350%	☐ 400%	☐ Other _	%				
С	If the organization used factors other that for determining eligibility for free or discount asset test or other threshold, regarding a vertex of the same of the	unted care. Ind	clude in the de	scription whet	her the organiz	zation used			
4	discounted care. Did the organization's FAP that applied								
	free or discounted care to the "medically	•				<u> </u>	4		
5a	Did the organization budget amounts for				_		5a		
b	If "Yes," did the organization's financial a						5b		
С	If "Yes" to line 5b, as a result of budg discounted care to a patient who was eliq				inable to prov		5с		
6a	Did the organization prepare a communit		_	-		-	6a		
b	If "Yes," did the organization make it avail						6b		
	Complete the following table using the values worksheets with the Schedule H.	worksneets pro	ovided in the S	schedule H ins	structions. Do	not submit			
7		'ammunity Pan	ofite at Coat						
	Financial Assistance and Certain Other C	(a) Number of	(b) Persons	(c) Total	(d) Direct	(e) Net	(f) Percer	nt of
	Financial Assistance and Means-Tested Government Programs	activities or	served (optional)	community benefit expense	offsetting revenue		to	tal expe	
а	Financial assistance at cost (from Worksheet 1)								
b	Medicaid (from Worksheet 3, column a)								
С	Costs of other means-tested government programs (from Worksheet 3, column b)								
d	Total. Financial assistance and means-tested government programs.								
	Other Benefits						+		
е	Community health improvement services and community benefit operations (from Worksheet 4)								
f	Health professions education (from Worksheet 5)								
~	Subsidized health services (from						+-		
g	Worksheet 6)								
h	Research (from Worksheet 7)						\perp		
i	Cash and in-kind contributions for community benefit (from Worksheet 8)								
j	Total. Other benefits						\perp		
k	Total. Add lines 7d and 7j		1	1					

TREASURY/IRS	AND OMB	USE ONL	Y DRAFT
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Par	activities during the	g Activities. Complete tax year and describe							
	health of the commu	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	tot	Percer al expe	
1	Physical improvements and ho	ousing							
2	Economic development								
3	Community support								
4	Environmental improvements								
5	Leadership development and t	training							
	for community members								
6	Coalition building								
7	Community health improvement a	dvocacy							
8	Workforce development	·							
9	Other								
10	Total								
Par	Bad Debt, Medicar	e, & Collection Praction	ces				•		
Section	on A. Bad Debt Expense							Yes	No
1	Did the organization report bad debt	expense in accordance with F	Healthcare Financi	al Management A	Association Stater	nent No. 15?	1		
2	Enter the amount of the or	ganization's bad debt	expense. Expl	ain in Part V	'I the				
	methodology used by the orga	anization to estimate this	amount		2				
3	Enter the estimated amount	of the organization's b	ad debt expe	nse attributab	ole to				
	patients eligible under the org								
	by the organization to estima	te this amount and the	rationale, if an	y, for including	g this				
	portion of bad debt as commu	ınity benefit			3				
4	Provide in Part VI the text of t expense or the page number of								
Section	on B. Medicare								
5	Enter total revenue received fr	om Medicare (including D	SH and IME)		5				
6	Enter Medicare allowable cost	s of care relating to paym	nents on line 5		6				
7	Subtract line 6 from line 5. This	s is the surplus (or shortfa	all)		7				
8	Describe in Part VI the exten	t to which any shortfall	reported on li	ne 7 should b	e treated as	community			
	benefit. Also describe in Part	VI the costing methodolo	ogy or source ι	used to determ	nine the amou	nt reported			
	on line 6. Check the box that o								
	☐ Cost accounting system	Cost to charge ratio	o ∐ Oth	er					
Section	on C. Collection Practices					J			
9a	3						9a		
b	If "Yes," did the organization's collec-								
	on the collection practices to be for	•					9b		
Part		panies and Joint Vent		10% or more	by officers,	directors, tru	ustee	s, ke	y
	. , ,	sicians-see instructio							
	(a) Name of entity	(b) Description of activity of en		(c) Organi profit % o ownersl	or stock hip % director or key profit	Officers', s', trustees', employees' % or stock ership %	profit 9	nysiciar % or st ership (ock
1									
2									
3									
4									
5									
6									

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	ownership %	profit % or stock ownership %	ownership %
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
		Sched	ule H (Form 990) 2025

Schedule H (Form 990) 2025 Page 3 Part V **Facility Information** Section A. Hospital Facilities ER-24 hours General medical & surgica Children's hospital Critical access hospita Licensed hospital Teaching hospital Research facility (list in order of size, from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? Name, address, primary website address, and state license number Facility (and if a group return, the name and EIN of the subordinate hospital reporting organization that operates the hospital facility): Other (describe) group 1 10

Schedu	alle H (Form 990) 2025		F	⊃age 4
Par	t V Facility Information (continued)		•	
	on B. Facility Policies and Practices			
(compl	lete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)			
Name	of hospital facility or letter of facility reporting group:			
	number of hospital facility or line numbers of hospital			
	ies in a facility reporting group (from Part V, Section A):			
	<u> </u>		Yes	No
Comn	nunity Health Needs Assessment (CHNA)			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		
3	During the tax year or either of the 2 immediately preceding tax years, did the hospital facility conduct a CHNA? If "No," skip to line 12	3		
	If "Yes," indicate what the CHNA report describes (check all that apply):			
а	A definition of the community served by the hospital facility			
b	Demographics of the community			
С	Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	How data was obtained			
e	The significant health needs of the community			
f	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	The process for consulting with persons representing the community's interests			
i	The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA			
j	Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5		
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		
7	Did the hospital facility make its CHNA report widely available to the public?	7		
а	Hospital facility's website (list url):			
b	Other website (list url):			
C	Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8		
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		
а	If "Yes," list url:			
b 11	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.	10b		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		

If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . .

4720 for all of its hospital facilities? \$

If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form

12b

TREASURY/IRS AND OMB USE ONLY DRAFT Schedule H (Form 990) 2025 Part V Facility Information (continued) **Financial Assistance Policy (FAP)** Name of hospital facility or letter of facility reporting group: Yes No Did the hospital facility have in place during the tax year a written FAP that: Explained eligibility criteria for financial assistance and whether such assistance included free or discounted care? 13 13 If "Yes," indicate the eligibility criteria explained in the FAP: FPG, with FPG family income limit for eligibility for free care of and FPG family income limit for eligibility for discounted care of Income level other than FPG (describe in Section C) b c Asset level d Medical indigency Insurance status Underinsurance status f g Residency h П Other (describe in Section C) Explained the basis for calculating amounts charged to patients? 14 14 Explained the method for applying for financial assistance? 15 If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply): Described the information the hospital facility may require an individual to provide as part of their application Described the supporting documentation the hospital facility may require an individual to submit as part b of their application Provided the contact information of hospital facility staff who can provide an individual with information С about the FAP and FAP application process d Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications Other (describe in Section C) 16 If "Yes," indicate how the hospital facility publicized the policy (check all that apply): The FAP was widely available on a website (list url): The FAP application form was widely available on a website (list url): b A plain language summary of the FAP was widely available on a website (list url): C d The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) Individuals were notified about the FAP by being offered a paper copy of the plain language summary of g

the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention

Notified members of the community who are most likely to require financial assistance about availability

The FAP application form, and plain language summary of the FAP were translated into the

primary language(s) spoken by limited-English proficiency (LEP) populations

h

of the FAP

Other (describe in Section C)

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Part	V Facility Information (continued)		-	
Billing	g and Collections			
Name	of hospital facility or letter of facility reporting group:			
			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written FAP that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17		
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
а	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
С	Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	Actions that require a legal or judicial process			
е	Other similar actions (describe in Section C)			
f	☐ None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year			
	before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
а	Reporting to credit agency(ies)			
b	Selling an individual's debt to another party			
С	Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	Actions that require a legal or judicial process			
е	Other similar actions (describe in Section C)			
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions line to checked) on line 19 (check all that apply):	sted (wheth	ner or
а	Provided a written notice about upcoming extraordinary collection actions (ECAs) and a plain language FAP at least 30 days before initiating those ECAs (if not, describe in Section C)	sumn	nary o	of the
b	☐ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, descri	ibe in	Section	on C)
С	☐ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d	☐ Made presumptive eligibility determinations (if not, describe in Section C)			
е	☐ Other (describe in Section C)			
f	☐ None of these efforts were made			
Policy	Relating to Emergency Medical Care			
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care			
	that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's FAP?	21		
	If "No," indicate why:			
а	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
С	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
Ы	Other (describe in Section C)			

Schedule H (Form 990) 2025 Page 7 Facility Information (continued) Part V Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals) Name of hospital facility or letter of facility reporting group: Yes No Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged 22 to FAP-eligible individuals for emergency or other medically necessary care: The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service а during a prior 12-month period The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and b all private health insurers that pay claims to the hospital facility during a prior 12-month period The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in С combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period The hospital facility used a prospective Medicare or Medicaid method d During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility 23 provided emergency or other medically necessary services more than the amounts generally billed to 23 If "Yes," explain in Section C. During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross 24 If "Yes," explain in Section C.

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Schedule H (Form 990) 2025 Page 8 Part V Facility Information (continued) Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Schedule H (Form 990) 2025 Page **9**

Part V Facility Information (continued)	
Section D. Other Health Care Facilities That Are Not Licensed, Reg (list in order of size, from largest to smallest)	jistered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)	
How many non-hospital health care facilities did the organization operate of	during the tax year?
Name and address	Type of facility (describe)
1	Type of Identity (describe)
2	
3	
4	
5	
6	
7	
8	
9	
10	
IV	

Schedule H (Form 990) 2025 Page **10**

Part VI Supplemental Information

Provide the following information.

7

1 Required descriptions. Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II, and Part III, lines 2, 3, 4, 8, and 9b.

- 2 Needs assessment. Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance. Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's FAP.
- **4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (for example, open medical staff, community board, use of surplus funds, etc.).
- Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

State filing of community benefit report. If applicable, identify all states with which the organization, or a related organization.

files a community benefit report.	,	,	,	,