**SCHEDULE H (Form 990)**

Department of the Treasury
Internal Revenue Service

# Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

**2018**

**Open to Public Inspection**

**Name of the organization**: Walnut Hospital Inc

**Employer identification number**: 00 9000001

## Part I Financial Assistance and Certain Other Community Benefits at Cost

| | | | Yes | No |
|---|---|---|---|---|
| 1a | Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a | ✔ | |
| b | If "Yes," was it a written policy? | 1b | ✔ | |
| 2 | If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. | | | |
| | ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☑ Generally tailored to individual hospital facilities | | | |
| 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. | | | |
| a | Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☑ 200% ☐ Other _____ % | 3a | ✔ | |
| b | Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☑ 400% ☐ Other _____ % | 3b | ✔ | |
| c | If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. | | | |
| 4 | Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | 4 | ✔ | |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | ✔ | |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | ✔ | |
| c | If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | 5c | | ✔ |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | ✔ | |
| b | If "Yes," did the organization make it available to the public? | 6b | ✔ | |
| | Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H. | | | |

**7** Financial Assistance and Certain Other Community Benefits at Cost

| | Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|---|
| a | Financial Assistance at cost (from Worksheet 1) | 6 | 9,000 | 2,500,000 | 500,000 | 2,000,000 | 7.8% |
| b | Medicaid (from Worksheet 3, column a) | | | | | | |
| c | Costs of other means-tested government programs (from Worksheet 3, column b) | | | 300,000 | 100,000 | 200,000 | .8% |
| d | **Total.** Financial Assistance and Means-Tested Government Programs | 6 | 9,000 | 2,800,000 | 600,000 | 2,200,000 | 8.6% |
| | **Other Benefits** | | | | | | |
| e | Community health improvement services and community benefit operations (from Worksheet 4) | | | 1,000,000 | 100,000 | 900,000 | 3.5% |
| f | Health professions education (from Worksheet 5) | | | 2,000,000 | 200,000 | 1,800,000 | 7% |
| g | Subsidized health services (from Worksheet 6) | | | 1,000,000 | 500,000 | 500,000 | 1.9% |
| h | Research (from Worksheet 7) | | | 1,500,000 | 750,000 | 750,000 | 2.9% |
| i | Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 1,000,000 | | 1,000,000 | 3.9% |
| j | **Total.** Other Benefits | | | 6,500,000 | 1,550,00 | 4,950,000 | 19.2% |
| k | **Total.** Add lines 7d and 7j | 6 | 9,000 | 9,300,000 | 2,150,000 | 7,150,000 | 27.8% |

**Part II** **Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

| | | (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 | (f) Percent of total expense |
|---|---|---|---|---|---|---|---|
| 1 | Physical improvements and housing | | | | | | |
| 2 | Economic development | | | | | | |
| 3 | Community support | | | | | | |
| 4 | Environmental improvements | | | | | | |
| 5 | Leadership development and training for community members | | | | | | |
| 6 | Coalition building | | | | | | |
| 7 | Community health improvement advocacy | | | | | | |
| 8 | Workforce development | | | | | | |
| 9 | Other | | | | | | |
| 10 | **Total** | | | | | | |

**Part III** **Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1 | Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | | 1 | | ✔ |
| 2 | Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount | 2 | 1,237,605 | | |
| 3 | Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. | 3 | 123,760 | | |
| 4 | Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements. | | | | |

**Section B. Medicare**

| | | | |
|---|---|---|---|
| 5 | Enter total revenue received from Medicare (including DSH and IME) | 5 | 9,999,999 |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 8,888,888 |
| 7 | Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 | 1,111,111 |

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:

☑ Cost accounting system ☐ Cost to charge ratio ☐ Other

**Section C. Collection Practices**

| | | | Yes | No |
|---|---|---|---|---|
| 9a | Did the organization have a written debt collection policy during the tax year? | 9a | | ✔ |
| b | If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI | 9b | | |

**Part IV** **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

| | (a) Name of entity | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | | | | | |
| 11 | | | | | |
| 12 | | | | | |
| 13 | | | | | |

## Part V Facility Information

**Section A. Hospital Facilities**

(list in order of size, from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year? 2

| Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility) | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER–24 hours | ER–other | Other (describe) | Facility reporting group |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 Walnut Medical Center<br>655 Bradford St.<br>Nixon, NV 89424<br>0003392 | ✔ | ✔ | ✔ | ✔ | | ✔ | ✔ | | | A |
| 2 Walnut Urgent Care Center<br>850 Bradford St.<br>Nixon, NV 89424 | | ✔ | | | | | | | non-emergency care facility | A |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

**Part V Facility Information** *(continued)*

**Section B. Facility Policies and Practices**

(complete 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** A

**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

| | | | Yes | No |
|---|---|---|---|---|
| | **Community Health Needs Assessment** | | | |
| 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 two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 | 3 | ✔ | ☐ |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ 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(s) | | | |
| j | ☐ Other (describe in Section C) | | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA: 20 16 | | | |
| 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 | ✔ | ☐ |
| 6 a | 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 | ✔ | ☐ |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.walnuthospital.com | | | |
| 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 | ☐ | ☐ |
| a | If "Yes," (list url): | | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | ☐ | ☐ |
| 11 | 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. | | | |
| 12 a | 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 | ☐ | ✔ |
| b | If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | ☐ | ☐ |
| c | If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $ | | | |

**Part V Facility Information** *(continued)*

**Financial Assistance Policy (FAP)**

**Name of hospital facility or letter of facility reporting group** A

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? | 13 | ✔ | |
| | If "Yes," indicate the eligibility criteria explained in the FAP: | | | |
| a | ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300 % and FPG family income limit for eligibility for discounted care of 150 % | | | |
| b | ☐ Income level other than FPG (describe in Section C) | | | |
| c | ☐ Asset level | | | |
| d | ☐ Medical indigency | | | |
| e | ☐ Insurance status | | | |
| f | ☐ Underinsurance status | | | |
| g | ☐ Residency | | | |
| h | ☐ Other (describe in Section C) | | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | ✔ | |
| 15 | 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): | | | |
| a | ☑ Described the information the hospital facility may require an individual to provide as part of his or her application | | | |
| b | ☐ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | | |
| c | ☐ Provided the contact information of hospital facility staff who can provide an individual with information 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 | | | |
| e | ☐ Other (describe in Section C) | | | |
| 16 | Was widely publicized within the community served by the hospital facility? | 16 | | ✔ |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | ☐ The FAP was widely available on a website (list url): | | | |
| b | ☐ The FAP application form was widely available on a website (list url): | | | |
| c | ☐ A plain language summary of the FAP was widely available on a website (list url): | | | |
| d | ☐ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| e | ☐ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| f | ☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | | |
| g | ☐ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of 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 | | | |
| h | ☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP | | | |
| i | ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations | | | |
| j | ☐ Other (describe in Section C) | | | |

**Part V Facility Information** *(continued)*

**Billing and Collections**

**Name of hospital facility or letter of facility reporting group** A

| | | | Yes | No |
|---|---|---|---|---|
| 17 | Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (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: | | | |
| a | ☑ Reporting to credit agency(ies) | | | |
| b | ☐ Selling an individual's debt to another party | | | |
| c | ☐ 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 | | | |
| e | ☐ 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: | | | |
| a | ☑ Reporting to credit agency(ies) | | | |
| b | ☐ Selling an individual's debt to another party | | | |
| c | ☐ 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 | | | |
| e | ☐ 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 listed (whether or not checked) in line 19 (check all that apply):

- a ☑ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)
- b ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)
- d ☑ Made presumptive eligibility determinations (if not, describe in Section C)
- e ☐ Other (describe in Section C)
- f ☐ None of these efforts were made

**Policy Relating to Emergency Medical Care**

| | | | Yes | No |
|---|---|---|---|---|
| 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 financial assistance policy? | 21 | ✔ | |
| | If "No," indicate why: | | | |
| a | ☐ The hospital facility did not provide care for any emergency medical conditions | | | |
| b | ☐ The hospital facility's policy was not in writing | | | |
| c | ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | |
| d | ☐ Other (describe in Section C) | | | |

**Part V** **Facility Information** *(continued)*

**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

**Name of hospital facility or letter of facility reporting group** A

| | | | Yes | No |
|---|---|---|---|---|
| **22** | Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care. | | | |
| **a** | ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period | | | |
| **b** | ☑ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period | | | |
| **c** | ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period | | | |
| **d** | ☐ The hospital facility used a prospective Medicare or Medicaid method | | | |
| **23** | During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? | **23** | ☐ | ✔ |
| | If "Yes," explain in Section C. | | | |
| **24** | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? | **24** | ☐ | ✔ |
| | If "Yes," explain in Section C. | | | |

**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.

#1: FormAndLineReferenceDesc: Facility 1 - Walnut Medical Center. Part V, Section B, Line 5

ExplanationTxt: The facility consulted with members of the greater Nixon community through meetings, focus groups, interviews, surveys, and written correspondence in conducting its community health needs assessment. In particular, the facility consulted with the Nixon Health Department, the Colson County Health Department, Nixon Social Services Systems Department, Greater Nixon Regional Health Information Organizations, Hazelnut Health Systems Agency, Lesser Colson Regional Health Center, Colson Professional Standards Review Organization, Federation Pharmacy Services, Peachnut Health Insurance Coalition, Citizens for a Healthier Nixon, Nixon Inter-Faith Coalition, the Nixon Coroner's office, and the Colson County Nurses Auxiliary in determining the health needs of the community.

#2: FormAndLineReferenceDesc: Facility 1 - Walnut Medical Center. Part V, Section B, Line 11

ExplanationTxt: The facility is in the final stages of adopting an implementation strategy to meet the community health needs identified in the latest CHNA.

#3: FormAndLineReferenceDesc: Facility 2 - Walnut Urgent Care Center. Part V, Section B, Line 5

ExplanationTxt: The facility consulted with members of the greater Nixon Community through meetings, focus groups, interviews, surveys, and written correspondence in conducting its community health needs assessment. In particular, the facility consulted with the Acorn Urgent Care Center, Nixon Health Department, Nixon Chamber of Commerce, Colson County Health Department, Citizens for a Safer Colson, Colson Emergency Care Coalition, Nixon Social Services Department, Nixon Inter-Faith Health Coalition, and Nurses for a Safer Nixon in determining the health needs of the community.

#4: FormAndLineReferenceDesc: Facility 2 - Walnut Urgent Care Center. Part V, Section B, Line 11

ExplanationTxt: The facility is in the final stages of adopting an implementation strategy to meet the community health needs identified in the latest CHNA.

**Part V** **Facility Information** *(continued)*

**Section D. Other Health Care Facilities That Are Not Licensed, Registered, 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 during the tax year? _____

| Name and address | Type of Facility (describe) |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| 10 | |

## Part VI Supplemental Information

Provide the following information.

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 financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **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 (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **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.

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

| FormAndLineReferenceDesc | ExplanationTxt |
|---|---|
| 1 Part I, Line 7 | Costing methodology sample text |
| 2 Part III, Lines 2, 3 & 4 | Bad debt expense estimation methodology explanation and financial statement footnote reference sample text |
| 3 Part III, Line 8 | Medicare costing methodology sample text |
| 4 Part VI, Line 2 | Community needs assessment sample text |
| 5 Part VI, Line 3 | Patient education sample text |
| 6 Part VI, Line 4 | Community information sample text |
| 7 Part VI, Line 5 | Community building activities sample text |
| 8 Part VI, Line 6 | Other exempt purpose sample text |
| 9 Part VI, Line 7 | Nevada |