

Hospital Community Benefit Funds: Resources for the HCH Community

May 2016

To qualify for tax exemptions as charitable organizations, not-for-profit hospitals are required to engage in activities that benefit their communities, often known as “hospital community benefit.” Numerous changes have impacted how these benefits have been defined and reported over the past 50 years, but provisions of the Affordable Care Act provide new opportunities to look more holistically at community needs and consider how best to meet them. This policy brief will give an overview of hospital community benefit requirements, illustrate the difference between two types of benefits, describe how community benefit funds are currently distributed, discuss additional state requirements, consider hospital perspectives, provide examples of successful partnerships currently in practice, and share advice for maximizing hospital partnerships with the Health Care for the Homeless (HCH) community. Hospitals share an interest in improving the health of people without homes given that this population has high emergency department and inpatient utilization, and hospital community benefit funds can be a valuable source for growing effective programs and services to not only reduce avoidable hospital care, but also to increase positive health outcomes for a vulnerable group.

History

The definition and scope of hospital community benefit has significantly evolved since its inception in 1956 when an Internal Revenue Service (IRS) ruling stated that hospitals “qualifying as 501(c)(3) charitable organizations were expected to provide charity care, namely, free health services to the poor who were unable to afford their care, to the best of the hospital’s financial ability.”¹ In 1969, the definition and scope was broadened, requiring nonprofit hospitals to demonstrate how they “reduced governmental burden and promoted general welfare.”² Unfortunately, wide variability of implementation, vague definitions and a lack of detailed guidelines around data collection and reporting methods made it difficult for the IRS to quantify whether hospitals were meeting their obligations as non-profit entities. To address these concerns, the IRS introduced Schedule H in 2007, a special tax form that hospitals file along with their annual Form 990 filings (a required filing for all federally tax-exempt corporations), making it mandatory for all nonprofit hospitals in 2009.³ Schedule H standardizes the definition of a community benefit, streamlines reporting requirements across all nonprofit hospitals, and provides additional guidelines on ways to satisfy community benefit requirements.⁴

Affordable Care Act Requirements

The Affordable Care Act contains many provisions to help improve community health. One such provision, Section 9007, requires non-profit hospitals to meet four provisions as part of their community benefit obligations.⁵

- **Community health needs assessment (CHNA):** conduct a CHNA at least every three years and adopt an implementation strategy to meet the needs identified. Of note, the law requires the assessment to “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” and to make the CHNA publicly available.
- **Financial assistance policy:** develop a policy that includes the eligibility criteria for financial assistance, and whether such assistance includes free or discounted care; the basis for calculating amounts charged to patients; the method for applying for financial assistance; in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment, including collections action and reporting to credit agencies; and measures to widely publicize the policy within the community to be served by the organization. This subsection requires the hospital to have a policy to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the financial assistance policy.

- **Limit hospital charges:** develop requirements to limit charges for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy to not more than the lowest amounts charged to individuals who have insurance covering such care, and prohibits the use of gross charges.^a
- **Extraordinary collection actions:** prohibit making collections before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy.^b

While the latter three provisions to improve fiscal aspects related to patient use of the hospital are important protections for very low-income patients, the requirement to regularly conduct a CHNA offers an important opportunity for the broader community to participate in evaluating ongoing needs and be involved in hospital decision-making related to meeting those needs. In other words, the new requirement to conduct a CHNA and the prior requirement to provide community benefit resources are now linked activities. Schedule H now requires hospitals to attest to all four of these requirements and provide details behind how they fulfill each component. The law further requires the Secretary of the Treasury to review the community benefit activities of every hospital at least once every three years.

Community Benefit v. Community Building

The ACA's requirements, coupled with prior clarification of what constitutes a "community benefit," have yielded a much more detailed Schedule H form.^{6 7} There are now multiple sections to Schedule H, which makes an important distinction between those activities that count as community benefit (Part 1) and those that are considered "community building" (Part 2). Because community benefit activities are required and serve as the basis for justifying tax exemptions (while community building activities are optional), there is a vested interest for the hospital to include as many of its activities on Part 1, rather than Part 2. This section describes each Part in greater detail.

Part 1 of Schedule H now consists of seven distinct categories that hospitals use to calculate the value of their contribution to the community benefit requirement. Activities under this Part must assess that value under one or more of the following categories:⁸

1. **Financial assistance:** free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services.
2. **Hospital participation in Medicaid and other means-tested public insurance programs:** the cost of Medicaid and other government health programs for which eligibility depends on the recipient's income or asset level.
3. **Community health improvement services:** activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health.
4. **Health professions education:** educational programs that result in a degree, certificate, or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty.
5. **Subsidized health services:** clinical services provided despite a financial loss to the organization and needed by the community. The financial loss is measured after removing losses associated with bad debt, financial assistance, Medicaid, and other means-tested government programs.

^a "Gross patient charges" means the total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

^b "Extraordinary collection actions" means any actions that the hospital facility (or other authorized party) may take related to obtaining payment of a bill for medical care, including, but not limited to, reporting to credit agency(ies), selling an individual's debt to another party, actions that require a legal or judicial process, etc.

6. **Research:** any study or investigation the goal of which is to generate increased generalizable knowledge made available to the public.
7. **Cash and in-kind contributions for community benefit:** contributions made by the organization to health care organizations and other community groups restricted to one or more of the community benefit activities.

Separate from community benefit activities, Part 2 of Schedule H requires hospitals to report on “community building” activities. The value of contributions to these activities fall under the following categories:⁹

1. **Physical improvements and housing:** to include, but are not limited to, the provision or rehabilitation of housing for vulnerable populations, such as removing building materials that harm the health of the residents, neighborhood improvement or revitalization projects, provision of housing for vulnerable patients upon discharge from an inpatient facility, housing for low-income seniors, and the development or maintenance of parks and playgrounds to promote physical activity.
2. **Economic development:** to include, but is not limited to, assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness.
3. **Community support:** to include, but is not limited to, child care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.
4. **Environmental improvements:** to include, but are not limited to, activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards.
5. **Leadership development and training for community members:** to include, but is not limited to, training in conflict resolution; civic, cultural, or language skills; and medical interpreter skills for community residents.
6. **Coalition building:** to include, but is not limited to, participation in community coalitions and other collaborative efforts with the community to address health and safety issues.
7. **Community health improvement advocacy:** to include, but is not limited to, efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation.
8. **Workforce development:** to include, but is not limited to, recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved, and collaboration with educational institutions to train and recruit health professionals needed in the community (other than the health professions education activities reported in Part 1).

Elements of both Part 1 (community benefit) and Part 2 (community building) could apply to assistance, programs, or services targeted to the needs of people who are homeless. Of particular interest to both hospitals and community stakeholders has been how to categorize housing, which traditionally has been included under “physical improvements and housing” in Part 2. While the Schedule H instructions clearly state that “some community building activities may also meet the definition of community benefit,” there was no clear guidance that allowed housing to be an allowable expense under Part 1.

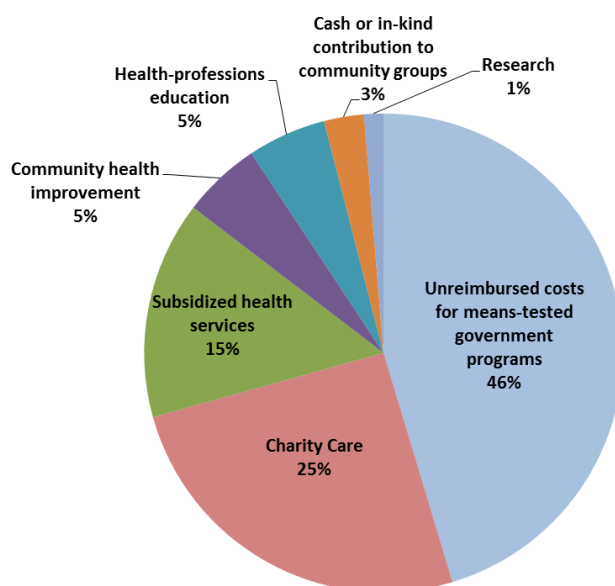
Recently, a number of hospital associations requested the IRS consider allowing housing to be an approved activity under Part 1¹⁰ and after meeting with IRS officials, provided a public health rationale for considering housing as a valid community benefit. In it, these organizations make an argument that “moving the reporting of housing activities to Schedule H, Part 1 not only will align the incentives with population health findings and the efforts of other federal agencies, but also will provide a clearer picture of how hospitals are contributing to the

health of their communities.”¹¹ In December 2015, the IRS issued an update to Schedule H, indicating that “some housing improvements and other spending on social determinants of health that meet a documented community need may qualify as community benefit for the purposes of meeting the community benefit standard.”¹² Hence, hospitals may now count certain investments in housing as allowable community benefit expenditures.

Distribution of Community Benefit Spending

Knowing how hospitals typically target community benefit might help inform current and future initiatives that can aid local needs. The most recent data from tax year 2011 indicated that non-profit hospitals spent nearly 10% of their expenditures on community benefit activities, constituting \$62 billion.¹³ The vast majority of community benefit expenses were dedicated to charity care and filling budget gaps created by low reimbursements from Medicaid and Medicare; only 5% of expenditures were devoted to community health improvements and 3% given as cash or in-kind contributions to community groups (see figure 1).¹⁴

Figure 1. Distribution of Community Benefit Expenditures



Source: Young, 2013.

There is no federal standard that specifies the level of community benefits that a non-profit hospital must provide.¹⁵ The way hospitals distribute community benefit resources may begin to change, however, because of the ACA’s health insurance expansions that went into effect in 2014. This change increased the percentage of people who have health coverage, especially among the lowest income residents who now have access to Medicaid (in states that opted into the expansion). In these Medicaid expansion states, the need for charity care should begin to decrease as health insurance coverage increases. While this may result in shifting more resources into covering the shortfall in reimbursements from Medicaid and other means-tested programs, it does represent an opportunity to make new investments in the other categories, such as community health improvement.

The ACA puts a greater emphasis on achieving improved health outcomes, implementing more integrated, high-quality care, and placing a larger focus on population health. Hospitals are increasingly at the center of new health care delivery models (e.g., Accountable Care Organizations) and as the system shifts away from a fee-for-service model towards value-based care, population health management is driving improved care coordination efforts. Likewise, insurance programs such as Medicare are incentivizing reductions in hospital lengths of stay and/or readmissions by withholding reimbursements, so there is a growing focus on the social determinants of health and community factors that cause poor health and high hospital utilization.

State Requirements

States can add their own requirements to hospitals for community benefits, often tied to state tax exemptions, hospital licensure and/or certificates of need. A few states require specific minimum amounts (e.g., at least that equivalent to a tax exemption), others have various reporting requirements using different types of data, while still others require consideration of additional factors in the community health needs assessment process/report. Financial assistance policies can also range widely based on eligibility factors, sliding fee scales, and/or mandating some portion of free care.¹⁶ For more information on any individual state, The Hilltop Institute maintains profiles of each state's community benefit requirements and has analyzed recent legislative initiatives.^{17 18}

Hospital Perspectives for the HCH Community

Many non-profit hospitals are under tremendous budget pressures and are navigating numerous changes in the health care environment. Just as every community is different, so is every hospital, and each finds unique ways to allocate resources to address identified needs. Community benefit funds often go toward charity care and to offset short-falls on Medicaid reimbursements; this is a fiscal reality that hospitals have to accommodate (especially as more people seek care in Medicaid expansion states, and many of the lowest income people in non-Medicaid expansion states remain uninsured). Common projects in the community that are frequently supported include street outreach/medicine teams, mobile medical vans, shelter-based clinics, and medical respite care programs.^c Also, because "health" is defined broadly and there is now a more formal process for evaluating community needs, there is also increased competition for these resources that are both internal and external to the hospital setting. Finally, while more attention is being given to how social determinants of health (such as housing status) impact cost, service utilization and health outcomes, it will take time to change a hospital culture that is still focused on providing acute care and transitioning to a value-based payment model.

Successful Partnerships Benefiting Homeless Populations

A number of existing community benefit projects address the needs of people who are homeless. The following examples may provide models for those who are looking to initiate new or expand current partnerships:

- *LifeLong Medical Care, Berkeley, CA:* LifeLong Medical Care partners with Sutter Hospital to improve post-discharge care for patients in need of recuperative or rehabilitative services following admission. Under LifeLong's contract, Sutter provides community benefit funding for 10 low-acuity medical respite care beds. Sutter also provides a nurse to handle discharge referrals and determine the eligibility of patients needing medical respite care. LifeLong uses the hospital funding to arrange for beds with three separate entities. A LifeLong case manager coordinates transitional care and housing services for the patients.
- *Mercy Care, Atlanta, GA:* Mercy Care receives community benefit financial support from one neighboring hospital to support its 19-bed respite care program. Hospital funding helps Mercy provide high quality respite care to underserved patients, including those who are homeless, following inpatient discharges. These services help patients who are still in need of recuperative care following a hospital admission. In return, Mercy agrees to accept respite care referrals from supporting hospitals. This system benefits participating hospitals by reducing the length of stay of often costly homeless and underserved patients. In addition, Mercy

^c Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. More information on medical respite is available at <https://www.nhchc.org/resources/clinical/medical-respite/>.

Care receives pro bono radiology technical services from a local healthcare system which includes the professional reading of both x-rays and ultrasounds.

- *Mission Health System Community Benefit – North Carolina:* Within Mission Health System, Mission Hospital uses community benefit funding to improve medical and behavioral health access to those who are homeless and vulnerable in Western North Carolina. In the last few years, Mission has funded a hospital-embedded nurse-case manager and a Homeless Outreach Team (HOT) to identify frequent users of the emergency department and transition them to other community health care providers and social services agencies within the Continuum of Care. The nurse-case manager supports monthly case conferences with all community agencies involved to create patient-centered treatment plans to ensure that high-needs patients receive the maximum amount of support in an efficient manner.

Mission Health also invests additional community benefit resources into homeless service programs, such as providing \$85,000 in 2016 for Homeward Bound, an organization that provides day shelter, case management and housing for some chronically homeless individuals. Furthermore, Mission Health contributed funds to an eight-bed medical respite program, donated renovation and site space for a new health center (with HCH designation) that opened early this year, and a community walk in center for uninsured individuals in need of behavioral health crisis services.

- *Mount Carmel Health System—Street Medicine, Columbus, OH –* The health system includes five hospitals, where community benefit funds are combined. Since 1998, the hospital system has used a portion of these funds to support a mobile coach with medical and support staff who provide free urgent medical services to those not able to access traditional care, to include many people who are homeless. The street medicine team is an extension of the mobile coach, where clinicians can achieve greater reach into encampments and provide basic care, connecting individuals back to the mobile clinic and other area services. A patient advocate follows up with homeless patients to assist with overcoming barriers to accessing resources (e.g., birth certificate, identification, housing appointments, etc.). The faith-based system views serving homeless populations as part of its mission, and allocates nearly \$ 1 million annually for this project, which covers the operating costs of the mobile coach plus staff.
- *Catholic Medical Center (CMC) and the Health Care for the Homeless Program of the City of Manchester, NH –* Manchester Health Department (MHD) is the public entity grantee for this HCH program. In a true public/private partnership since 1994, CMC has provided generous in-kind contributions to cover needed services such as office space and administrative support for the entire HCH team. CMC also provides a full continuum of uncompensated medical care, specialty care, dental care, and diagnostics for all uninsured HCH patients. The missions of MHD, HCH and CMC align well together. The 2016 CHNA is currently underway, and HCH Manchester staff are participating in this process.
- *Our Lady of Lourdes Regional Medical Center – St. Bernadette Clinic – Lafayette, LA:* Community benefit resources from a faith-based hospital support seven full-time staff at a free clinic (plus supplies), located in a church-owned facility near a food pantry and a men’s shelter. The clinic provides medical and preventive care as well as case management, prescriptions, vision and dental services for people who are homeless. The most recent CHNA found needs around cancer, mental health, diabetes, substance abuse, and general access to care, so there is a renewed focus on these issues, with grants funding a dietician/cook to help plan healthier meals and purchase food items. Because of constraints on space, the clinic hopes to expand to larger space in the future.

Advice for the HCH Community

To maximize the likelihood that community benefit resources are used to meet the needs of homeless populations, consider the following suggestions for implementation into any approach:

Understand the local process: Find out how needs assessments are conducted in your community, and who is in the lead. In some areas, several hospitals conduct a joint assessment, others are led by the United Way or the local health department, or it might be a stand-alone effort at each hospital (or some other process). Knowing this will help guide how an HCH project can join the effort.

Know hospitals' current priorities: Become familiar with the current needs assessment and implementation plan before approaching hospital partners with new ideas. Address homeless population-specific needs in the context of any established priorities. The ultimate goal is to create ongoing changes to meet community needs, so the activities will likely be longer-term initiatives rather than one-time grants or sponsorships.

Participate in CHNA development process: Participating in the community health needs assessment process will strengthen an organization's position to leverage community benefit resources. There is often a committee that organizes the CHNA so it might be possible for a key staff person or consumer leader to get nominated to serve as a member, which could have numerous advantages beyond the immediate CHNA. As an example, the Illumination Foundation (IF) of Orange County, CA has a dedicated nurse to exclusively work with local hospitals during their CHNA process. As a result, IF is able to ensure that its voice is heard at the outset of the community benefit conversation. IRS rules require hospitals consider any written comments on previous CHNA reports and respond in the next assessment, so interviewing clients and/or staff and providing written feedback may be another way to participate. Consider maximizing the health center requirement to conduct needs assessments by partnering with other hospitals so that a final product could be more comprehensive than one done solely by the health center.

Involve consumers in assessing needs: The CHNA will likely have a process for obtaining community input and/or periodic focus groups. Given that the ACA requires hospitals to "take into account input from persons who represent the broad interests of the community served by the hospital," arrange for consumers to speak at meetings and/or provide feedback or ideas in other ways. HCH clients have a vested interest in the ACA's requirements that hospitals have a clear policy on financial assistance, limit hospital charges and protect consumers from extraordinary collection practices, and clients may wish to address this as well as broader concerns that ultimately impact them.

Establish community-wide support: Approach the hospital as a coalition of community partners, rather than as a separate entity, especially if there is already an established hospital relationship with one or more providers. This could be a more efficient way to share information with hospital staff, minimize competition among community providers, and focus on working together to build a broader community network of care and support. This will in turn yield greater influence on hospital decision makers, who are often eager to have partners engaged in the process and providing helpful information and perspectives. Hospitals could feel more confident about their decisions after working with a comprehensive, community-wide request for resources. For example, Mercy Care is an active member of the Atlanta Regional Collaborative on Health Improvement (ARCHI). This partnership unites local hospitals and health organizations to perform the CHNA process collectively and ensure that community benefit dollars are spent where the need is greatest.

Invest in relationships and speak the language: Fostering continual relationships with hospital leadership and the staff who lead the CHNA will keep an HCH project on the hospital's radar as a (potential) community benefit recipient. Contact information for CHNA leads should be on the hospital's website alongside the most recent assessment. HCH organizations find that demonstrating knowledge of hospital budgetary challenges and interests will expand current and future opportunities for partnerships. Speaking their language is likely to improve hospital

perceptions of HCH organizations as true partners. This means understanding their budget constraints and connecting community needs to acute/episodic hospital care. Hospitals are consequently more prone to seeing community benefit requests as investments that will benefit both parties rather than simply being requests for donations. HCH perspectives on larger hospitals goals, such as reducing readmissions, could also help develop new initiatives and further shared objectives.

Conduct community research: HCH due diligence in researching existing community benefit programs will avoid redundant requests for services that are already being funded. Robust research efforts will also help HCH organizations develop a comprehensive gap analysis that will in turn present a stronger message to local hospitals.

Conclusion

Hospital community benefit funds serve not only as tangible resources to help meet the needs of people who are homeless (and the providers who serve them), but the partnerships established through these initiatives can serve to strengthen broader community systems to improve health outcomes. Recent changes in how hospitals conduct needs assessments and report on their activities offer a renewed opportunity for HCH projects to engage with hospitals to fill gaps in care and identify how to better meet the needs of vulnerable populations. Knowing the current identified priorities, participating in the CHNA process, involving key staff and consumers, establishing community support, and being a helpful resource for information will help position the HCH community more strongly to target these funds towards the needs of people who are homeless.

Additional Resources

- Centers for Disease Control and Prevention (CDC), Community Health Improvement Navigator. Available at: <http://www.cdc.gov/chinav/index.html>.
- Catholic Health Association of the United States, broad range of community benefit resources. Available at: <https://www.chausa.org/communitybenefit/community-benefit>.
- IRS Instructions for Schedule H: Available at: <https://www.irs.gov/pub/irs-pdf/i990sh.pdf>
- The Hilltop Institute, Hospital Community Benefit Program, Community Benefit State Law Profiles: A 50-State Survey of State Community Benefit Laws through the Lens of the ACA. Available at: http://www.hilltopinstitute.org/hcbp_cbl.cfm

Suggested Citation for this Policy Brief: National Health Care for the Homeless Council. (May 2016.) *Hospital Community Benefit: Resources for the HCH Community*. (Authors: Barbara DiPietro, Senior Director of Policy, and Eli Simons, Intern for National HCH Council Board of Directors and Vanderbilt University MBA Candidate 2016.) Available at: <https://www.nhchc.org/policy-advocacy/reform/nhchc-health-reform-materials/>

Acknowledgements: We offer our sincere appreciation to the many hospital and HCH community members who spoke to us about community benefit, and how these resources can be maximized for people experiencing homelessness. Thank you for your time and expertise.

Funding: This project was also supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09746, a National Training and Technical Assistance Cooperative Agreement for \$1,625,741, with 0% match from nongovernmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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