# Annual Non Profit Hospital Community Benefits Plan Report

<table>
<thead>
<tr>
<th>Hospital or Hospital System:</th>
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<tbody>
<tr>
<td><strong>Mailing Address:</strong></td>
<td></td>
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<tr>
<td>(Street Address/P.O. Box)</td>
<td>(City, State, Zip)</td>
</tr>
<tr>
<td><strong>Physical Address (if different than mailing address):</strong></td>
<td></td>
</tr>
<tr>
<td>(Street Address/P.O. Box)</td>
<td>(City, State, Zip)</td>
</tr>
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</table>

**Reporting Period:** __ / __ / __ through __ / __ / __  
Taxpayer Number: ________________

If filing a consolidated financial report for a health system, list below the Illinois hospitals included in the consolidated report.  
**Hospital Name** | **Address** | **FEIN #**  
___________________ | ___________________ | _________  
___________________ | ___________________ | _________  
___________________ | ___________________ | _________  
___________________ | ___________________ | _________  
___________________ | ___________________ | _________  

1. **ATTACH Mission Statement:**  
The reporting entity must provide an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community and the date it was adopted.

2. **ATTACH Community Benefits Plan:**  
The reporting entity must provide its most recent Community Benefits Plan and specify the date it was adopted. The plan should be an operational plan for serving health care needs of the community. The plan must:  
   1. Set out goals and objectives for providing community benefits including charity care and government-sponsored indigent health care.  
   2. Identify the populations and communities served by the hospital.  
   3. Disclose health care needs that were considered in developing the plan.

3. **REPORT Charity Care:**  
Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. Charity care does not include bad debt. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital’s Medicare cost report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), not the charges for the services.  

Charity Care: ____________________________ $ __________________

**ATTACH Charity Care Policy:**  
Reporting entity must attach a copy of its current charity care policy and specify the date it was adopted.
4. **REPORT Community Benefits** actually provided other than charity care:
See instructions for completing Section 4 of the Annual Non Profit Hospital Community Benefits Plan Report.

**Community Benefit Type**

Language Assistant Services ...............................................................$_______
Government Sponsored Indigent Health Care ...........................................$_______
Donations .........................................................................................$_______

Volunteer Services
   a) Employee Volunteer Services ..................................................$_______
   b) Non-Employee Volunteer Services .............................................$_______
   c) Total (add lines a and b) ..............................................................$_______

Education .........................................................................................$_______

Government-sponsored program services .............................................$_______

Research ..........................................................................................$_______

Subsidized health services .................................................................$_______

Bad debts .........................................................................................$_______

Other Community Benefits ..................................................................$_______

Attach a schedule for any additional community benefits not detailed above.

5. **ATTACH Audited Financial Statements for the reporting period.**

Under penalty of perjury, I the undersigned declare and certify that I have examined this Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto. I further declare and certify that the Plan and the Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto are true and complete.

Name / Title (Please Print) ................................................................. Phone: Area Code / Telephone No.

Signature.............................................................................................. Date.

Name of Person Completing Form .................................................. Phone: Area Code / Telephone No.

Electronic / Internet Mail Address ................................................. FAX: Area Code / FAX No.