Form AG-CBP-1
Rev 01/19

KWAME RAOUL
ATTORNEY GENERAL

Annual Non Profit Hospital Community Benefits Plan Report

Hospital or Hospital System: _____

Mailing Address: _____
(Street Address/P.O. Box) (City, State, Zip)

Physical Address (if different than mailing address):

_____
(Street Address/P.O. Box) (City, State, Zip)

Reporting Period: ____/____/____ **through** ____/____/____ **Taxpayer Number:** _____
Month Day Year Month Day Year

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 it's 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.