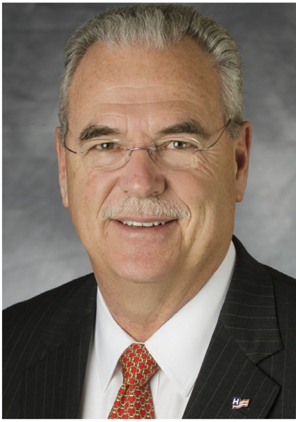


Ernst & Young Schedule H Benchmark Report for the American Hospital Association Tax Years 2009 & 2010

Improving the health of their communities is at the heart of every hospital's mission.

For two consecutive years, the American Hospital Association (AHA) has collected the community benefit information that tax-exempt hospitals file with the Internal Revenue Service (IRS) in a form called "Schedule H," and asked Ernst & Young to analyze and report on it. Schedule H forms were obtained directly from hospitals that filed them with IRS.

Data from more than 900 hospitals around the nation shows that tax-exempt hospitals consistently provided benefits to the community valued at more than 11 percent of their total expenses, averaging 11.6 percent in 2010 and 11.3 percent in 2009. Direct benefits to patients, which include free care, financial assistance and spending to fill gaps in Medicaid underpayments, averaged 5.7 percent of expenses in both 2010 and 2009.

This means that a hospital that reported $100 million in total expenses to the IRS spent an average of more than $11 million on benefits to the community, nearly $6 million of which was devoted to patients in financial need.

The report demonstrates that, measured in dollars alone, hospitals of every size, type and general location are not only meeting, but are exceeding, the community benefit obligations conferred by their tax-exempt status.

A form filed with the IRS – even one as complicated as Schedule H – can never convey the full measure of the benefits a hospital provides to its community. *That is why AHA believes that communities themselves are in the best position to determine whether the benefits provided by their local hospital match their needs and aspirations.*

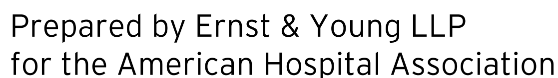
We look forward to continuing our support for hospitals' mission of caring for their communities.

Richard (Rich) Umbdenstock is president and chief executive officer of the American Hospital Association.

American Hospital Association®

Results from 2009 & 2010 Tax-Exempt Hospitals' Schedule H Community Benefit Reporting

April 2013



Prepared by Ernst & Young LLP
for the American Hospital Association

Ernst & Young
Quality In Everything We Do

Introduction

Hospitals provide benefits to their communities in a multitude of ways. They not only provide financial assistance and absorb underpayments from means-tested government programs such as Medicaid, but also incur losses due to unreimbursed Medicare expenses and bad debt expenses that are attributable to charity care. In addition, they offer programs and activities to:

- improve community health,
- underwrite medical research and health professions education, and
- subsidize high cost health services.

Ernst & Young LLP (EY) assisted the American Hospital Association (AHA) in reviewing over 900 member hospitals' Form 990 Schedule Hs from tax years 2009 and 2010. In 2010, the hospitals and systems' reported total community benefits of 11.6 percent of their total hospital expenses, 5.7 percentage points of which resulted from expenditures for charity care and absorbing losses from Medicaid and other means-tested programs.[1] In 2009, total community benefits were reported as 11.3 percent of total hospital expenses, 5.7 percentage points of which resulted from expenditures for charity care and absorbing losses from Medicaid and other means-tested programs.

Table 1. Charity Care and Community Benefit as Percent of Total Hospital Expense, 2009 and 2010

Type of Benefit	2010	2009
Charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs	5.7	5.7
Total Benefits to the Community	11.6	11.3

This summary and comparison of the 2009 and 2010 Schedule Hs reports the financial costs incurred by hospitals in providing these community benefits, but doesn't measure the overall tangible and intangible benefits of improving their communities' health and economic well-being. Hospitals provided the Internal Revenue Service (IRS) with detailed descriptions of their community benefit programs as part of their filing. These descriptions often tell the hospitals' story beyond what can be found from the financial information alone.

Background

Beginning in January of 2011, AHA requested that their members provide EY with a copy of their filed 2009 Schedule H. In 2012, AHA repeated this request to their members for their filed 2010 Schedule H. In addition, EY invited its clients to submit their Schedule H forms.

As part of the Form 990 filing requirement, tax-exempt hospitals complete the Schedule H form. The form reports hospitals' benefit to the community through questions on free or discounted care; Medicaid underpayments, health research, education, bad debt expense attributable to patients eligible for financial assistance, and Medicare shortfalls; and other community benefits and building activities.[2]

Methodology

Data was collected and tabulated for the following sections of the Schedule H form:

- Part I on charity care and certain other community benefits
- Part II on community building activities
- Part III on bad debts and Medicare.

Based on the participating hospitals, the results are presented by the following segments of respondents:

- **Systems**[3] (A Schedule H with more than one licensed hospital)
- **Single Hospitals** (Schedule H with a single licensed hospital)
    - **Size** – *based on total hospital expense*[4]
        - Small – *less than $100M of total hospital expense*
        - Medium – *$100M to $299M of total hospital expense*
        - Large – *$300M or more of total hospital expense*
    - **Location** – *based on hospital zip code*
        - Urban and Suburban
        - Rural
    - **Hospital Type** – *based on facility response*
        - General Medical and Surgical
        - Children's
        - Teaching
        - Critical Access

Parts I, II, and III responses are reported as a percent of hospitals' or systems' total annual expenses.

- Average responses were calculated for all hospital systems, as well as for individual hospitals by their size, location, and type.
- Calculations made are simple averages of the Schedule Hs received. No weighting was applied for size of the hospitals.[5]
- Overall averages represent the average of results from both hospital systems (multiple hospitals responding on a consolidated basis on a single Schedule H) and individual hospitals.

Results

524 Schedule H's were received for fiscal year 2010 representing 972 hospitals or one-third of the hospitals required to file a Schedule H in 2010.[6] In the previous year, 571 Schedule Hs were received, representing nearly 900 hospitals or 30 percent of the hospitals required to file Schedule H.

Table 2 below shows the number of respondent hospitals' Schedule Hs based on size, location, and type categories.

Table 2. Responding Hospitals by Size, Location, and Type

Size	2010	2009
Small	188	172
Medium	121	185
Large	97	120
System	118	94
Location[7]		
Urban/Suburban	258	298
Rural	148	159
Type[8]		
General Medical	374	375
Children's	25	26
Teaching	97	107
Critical Access	91	85

Details of the breakout for each category are included below, along with a comparison of the respondents to the field using the American Hospital Association's 2009 and 2010 Survey of Hospitals.

Size

There were 524 individual hospitals and hospital systems in 2010 and 571 individual hospitals and hospital systems in 2009 that reported enough information to estimate total annual expense, and were therefore included in all the tabulations. "System" respondents were Schedule Hs that included more than one hospital reporting on a consolidated basis. System respondents were not included in other size calculations, as their response may include a mix of hospitals of different sizes.

Location

Individual hospitals were divided into urban/suburban and rural locations by matching zip codes to Census Bureau data on metropolitan areas. If a hospital chose not to include its zip code in its submission, the hospital was excluded from the tabulations by location. System respondents were not included in these calculations, as their response may contain both urban and rural locations.

Type

Individual hospitals identified up to three hospital types under which to classify themselves. For example, a hospital could indicate they qualify as general medical, teaching, and critical access categories, and therefore be included in results for each of the three types. Again, system respondents were not included, as they might include a mix of hospital types on their Schedule H.

Comparison to AHA Survey of Hospitals

Table 3. Responding Individual Hospitals Compared to AHA Survey of Hospitals, 2010

Hospital Type	Sch H Participants	AHA Hospital Survey
General Medical	92%	94%
Children's	6%	2%
Teaching	24%	26%
Critical Access	22%	33%
Location	**Sch H Participants**	**AHA Hospital Survey**
Urban/Suburban	64%	53%
Rural	37%	47%
Bed Size Category	**Sch H Participants**	**AHA Hospital Survey**
99 or less	38%	54%
100-199	21%	18%
200-299	13%	11%
300 or more	28%	17%

Source: American Hospital Association 2011 Annual Survey of Hospitals and EY calculations

Based on a comparison with AHA's 2011 Annual Survey of Hospitals, the responding hospitals are representative of the field. The participants included tax-exempt hospitals located in thirty-five states throughout the country. Hospital types were compared to the 2011 AHA Hospital Survey. Individual responding hospitals are 14 percent of total hospitals in the field, while responding systems make up 20 percent of total hospitals in the field.

Hospitals' benefits to the community

In 2010, participating hospitals and systems reported an average of 11.6 percent of their total annual expense as providing benefits to the community. In 2009, participating hospitals and systems reported 11.3 percent of their total annual expense as providing benefits to the community.

Benefits to the community include charity care, Medicaid underpayments, community health improvement programs, health research and education, subsidized services, bad debt expense attributable to charity care, Medicare shortfall, and other community benefits and building activities. These are the financial costs incurred by hospitals in providing these community benefits, but do not include all the tangible and intangible benefits of improving their communities' health and well-being

Table 4 shows the average percent of total expense broken down to correspond to Parts I, II and III of the Schedule H form:

- Part I on charity care and certain other community benefits
- Part II on community building activities
- Part III on bad debts and Medicare.

Table 4. Hospitals' Benefit to the Community, by Type of Benefit
Average percent of total expense.

Hospital Category	Total Charity Care, Unreimbursed Means-Tested Government Programs and Other Benefits		Community Building Activities		Medicare Shortfall**		Bad Debt Expense Attributable to Charity Care		Total Benefits to the Community	
	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009
Overall*	8.2	8.4	0.1	0.1	2.8	2.4	0.5	0.4	11.6	11.3
System	8.1	9.3	0.1	0.1	2.9	3.8	0.5	0.5	11.6	13.7
Individual Hospitals: Size										
Small	7.3	7.3	0.1	0.1	2.9	2.0	0.8	0.5	11.1	9.9
Medium	7.5	8.0	0.1	0.2	2.6	3.6	0.5	0.5	10.8	12.3
Large	9.2	9.8	0.1	0.2	2.6	2.6	0.3	0.3	12.2	12.8
Individual Hospitals: Location										
Urban/Suburban	8.2	8.3	0.1	0.2	2.9	3.0	0.6	0.4	11.7	11.9
Rural	7.2	8.1	0.1	0.2	2.6	2.7	0.6	0.5	10.5	11.5
Individual Hospitals: Type										
General Medical	7.7	7.9	0.1	0.2	2.9	3.2	0.6	0.4	11.3	11.7
Children's	12.6	14.1	0.1	0.4	2.1	0.5	0.2	0.2	15.0	15.2
Teaching	9.7	10.1	0.1	0.2	1.7	1.8	0.4	0.3	12.0	12.4
Critical Access	8.1	8.3	0.1	0.1	0.6	1.0	0.8	0.5	9.7	10.0

*Overall averages include hospital system and individual hospital results.
**Net shortfall (gross shortfall less surplus).

Charity care, means-tested programs, and other benefits

In addition to providing charity care and subsidizing Medicaid underpayments, hospitals fund community health improvement programs, underwrite health professions education, conduct medical research, subsidize certain health services, and make cash and in-kind contributions to community groups.

Table 5 shows the overall average for hospital systems and individual hospitals' charity care and unreimbursed means-tested government programs for 2009 and 2010, as well as other benefits to the community. In 2009 and 2010, charity care and unreimbursed costs from Medicaid and means-tested government programs were 5.7 percent of total hospital expenses. Adding this amount to expenditures for health professions education, medical research, cash and in-kind contribution and other benefits amounts to 8.2 percent of expenses in 2010 and 8.4 percent of expenses in 2009.

Table 5. Charity care, means-tested programs, and other benefits
Average percent of total expense.

Hospital Category	Charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs		Health professions education		Medical research		Cash and in-kind contributions to community groups		Other benefits		Total charity care, means-tested government programs, and other benefits*	
	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009
Overall	5.7	5.7	0.9	0.8	0.6	0.3	0.3	0.3	1.0	0.8	8.2	8.4
System	5.2	5.8	1.1	1.2	0.2	0.5	0.5	0.6	1.0	0.7	8.1	9.3
Individual Hospitals: Size												
Small	5.9	5.7	0.1	0.2	0.0	0.0	0.2	0.1	1.1	1.0	7.3	7.3
Medium	5.5	5.8	0.4	0.6	0.0	0.1	0.3	0.2	1.3	0.9	7.5	8.0
Large	5.5	5.7	1.6	1.6	1.1	0.9	0.2	0.4	0.9	0.7	9.2	9.8
Individual Hospitals: Location												
Urban/Suburban	5.7	5.5	0.8	0.9	0.4	0.4	0.2	0.2	1.1	0.7	8.2	8.3
Rural	5.6	6.1	0.2	0.2	0.0	0.0	0.1	0.1	1.2	1.2	7.2	8.1
Individual Hospitals: Type												
General Medical	5.7	5.7	0.6	0.6	0.2	0.1	0.2	0.2	1.0	0.8	7.7	7.9
Children's	6.7	6.7	1.8	2.0	1.8	2.4	0.2	0.8	2.1	1.2	12.6	14.1
Teaching	5.7	5.9	1.7	1.9	1.1	0.7	0.1	0.2	1.1	1.1	9.7	10.1
Critical Access	6.5	6.1	0.3	0.3	0.0	0.0	0.1	0.1	1.1	1.4	8.1	8.3

*Does not include Medicare shortfall, bad debt expense attributable to charity care, or community building activities

Federal Poverty Guidelines to Determine Free and Discounted Care

Hospitals generally use Federal Poverty Guidelines (FPG) to determine free and discounted care to patients. The Department of Health and Human Services issues FPG annually. The FPG is based on the Census Bureau's federal poverty threshold, the income level at which an individual or family unit is considered to be poor. The Schedule H form asks hospitals about their use of FPG to determine eligibility for free or discounted care.

The 2009 and 2010 Schedule H provided checkboxes for free care in the amounts of 100%, 150%, 200% of FPG and an open field for "Other %".

- In 2010, more than 97 percent of hospitals in each of the size and location categories use FPG to determine eligibility for free care while more than 96 percent used FPG to determine eligibility in 2009.[9]

The Schedule H also provided checkboxes for discounted care in the amounts of 200%, 250%, 300%, 350%, 400% of FPG, and an open field for "Other %".

- In 2009 and 2010, more than 87 percent of hospitals in each of the size and location categories use FPG to determine eligibility for discounted care.
- In 2010, 87 percent of small hospitals use FPG for discounted care eligibility compared to 89 percent of systems, 91 percent of medium-sized hospitals, and 94 percent of large hospitals. 90 percent of urban/suburban and 89 percent of rural hospitals use FPG for discounted care eligibility.
- In 2009, 88 percent of small hospitals use FPG for discounted care eligibility compared to 91 percent of systems, 92 percent of medium-sized hospitals, and 97 percent of large hospitals. 94 percent of urban/suburban and 87 percent of rural hospitals use FPG for discounted care eligibility.

Amounts listed as greater than 200% for free care and greater than 400% for discounted care were based on open field ("Other %") responses.

Table 6 details the percentage of respondents who indicated they used the Federal Poverty Guidelines for free or discounted care.

Table 6. Percent of Respondents Using Federal Poverty Guidelines to Determine Free and Discounted Care

2010	Overall	Size				Location		Type			
Use FPG for:		Small	Medium	Large	System	Urban/ Suburban	Rural	General Medical	Children's	Teaching	Critical Access
Free Care	98%	98%	98%	100%	97%	99%	97%	99%	100%	98%	98%
Discounted Care	90%	87%	91%	94%	89%	90%	89%	90%	92%	91%	92%
2009	Overall	Size				Location		Type			
Use FPG for:		Small	Medium	Large	System	Urban/ Suburban	Rural	General Medical	Children's	Teaching	Critical Access
Free Care	97%	98%	96%	99%	98%	97%	97%	97%	100%	98%	96%
Discounted Care	92%	88%	92%	97%	91%	94%	87%	92%	96%	94%	93%

Table 7 shows the percent of FPG used by those hospitals to determine free and discounted care, with breakouts by hospital size and location. In 2010, 100 percent of hospitals provided free care for those below 100 percent of FPG, while 91 percent of hospitals provided discounted care for those below 200 percent of FPG.

Table 7. Use of Federal Poverty Guidelines to Determine Free and Discounted Care

Free Care Threshold	Overall	Size				Location		Type			
		Small	Medium	Large	System	Urban/Suburban	Rural	General Medical	Children's	Teaching	Critical Access
2010											
Less than 100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
100-200%	91%	96%	91%	83%	89%	88%	97%	91%	88%	85%	95%
More than 200%	9%	4%	9%	17%	11%	12%	3%	9%	12%	15%	5%
2009											
Less than 100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
100-200%	81%	92%	82%	69%	75%	78%	91%	84%	50%	77%	91%
More than 200%	19%	8%	18%	31%	25%	22%	9%	16%	50%	23%	9%
Discounted Care Threshold	**Overall**	**Size**				**Location**		**Type**			
		Small	Medium	Large	System	Urban/Suburban	Rural	General Medical	Children's	Teaching	Critical Access
2010											
200% and lower	10%	13%	10%	8%	6%	5%	21%	10%	9%	8%	21%
201-300%	31%	35%	33%	30%	22%	33%	34%	33%	26%	30%	32%
301-400%	47%	44%	46%	45%	54%	50%	36%	46%	57%	51%	40%
More than 400%	13%	9%	10%	17%	18%	13%	9%	12%	9%	11%	7%
2009											
200% and lower	14%	23%	16%	6%	5%	10%	29%	15%	0%	5%	25%
201-300%	28%	33%	27%	25%	29%	25%	36%	29%	21%	24%	39%
301-400%	42%	35%	42%	42%	52%	44%	28%	42%	71%	52%	28%
More than 400%	16%	9%	16%	28%	14%	21%	8%	14%	8%	19%	7%

Bad debt expense

In 2010, more than 80% of the 524 responding hospitals and systems reported bad debt expense attributable to charity care on their Schedule H submissions. For 2009, approximately 70% of the 571 respondents had bad debt attributable to charity care. Although the IRS provides minimal instruction on how to calculate this amount, the average bad debt expense attributable to charity care reported was 0.5 percent of total expenses in 2010 and 0.4 percent in 2009, or an average $1.8 million and $1.6 million per respondent respectively. Some patients unable to pay for their medical care do not complete hospitals' financial assistance processes. Consequently, hospitals classify unreimbursed care for those patients as bad debt expense. Most hospitals and systems report that some portion of their bad debt expense would qualify as a benefit to the community as charity care due to the low income of the patients.

One of the respondents, who indicated that about 5% of their bad debt expense would be attributable to charity care, provided the following explanation to the Schedule H question about the rationale for including bad debts amounts in community benefit:

> The Hospital provides an allowance for doubtful accounts based upon a review of outstanding receivables, historical collection information and existing economic conditions…. The Hospital believes that this cost is a community benefit because patients, who would likely qualify for assistance under the Hospital's Charity Care policy, do not or are unwilling to provide documentation of their eligibility for charity care, and are therefore classified as bad debt. The Hospital is very willing to work out payment arrangements and discounted fees: however, those patients who do not respond to repeated offers of assistance are categorized as bad debt expense. Had information been made available to make a determination of their eligibility, the Hospital believes that many of the patients classified as bad debt, would qualify for charity care. This judgment is based on the economic conditions of our area and specific knowledge of the patients involved.

Medicare surplus and shortfall

In 2010, 74 percent of participating hospitals and systems reported having Medicare shortfalls, which compares with 75 percent in 2009. Medicare reimbursement shortfalls occur when the Federal government reimburses the hospitals less than their costs for treating Medicare patients.

Most hospitals described why their Medicare shortfall should be treated as community benefit:

- They explained on their Schedule H forms that non-negotiable Medicare rates are sometimes out-of-line with the true costs of treating Medicare patients.
- By continuing to treat patients eligible for Medicare, hospitals alleviate the federal government's burden for directly providing medical services. The IRS recently acknowledged that lessening the government burden associated with providing Medicare benefits is a charitable purpose.[10]
- Additionally, many hospitals pointed to IRS Rev. Rul. 69-545 in their explanation of Medicare shortfall as a community benefit. IRS Rev. Rul. 69-545 states that if a hospital serves patients with government health benefits, including Medicare, then this is an indication that the hospital operates to promote the health of the community.

Community Building Activities

For 2009 and 2010, hospital systems and individual hospitals spent on average 0.1 percent of their total expenses on community building activities. Children's hospitals report the largest spending at 0.4 percent. Community building activities take many forms:

- Hospital employees report participating on the state Board of Health, in regional health departments and neighborhood community relations committees, and with university and other school partnerships.
- Many hospitals donate cash or in-kind to programs that address health problems in their surrounding communities.

These activities often promote regional health by offering direct and indirect support to communities with unmet health needs. These include patients who are indigent, uninsured, underprovided for, or geographically isolated from healthcare facilities.

Conclusion

Hospitals provide benefits to the communities in a multitude of ways. They not only provide charity care and make up for underpayments by Medicaid and other means-tested government programs, but also cover for losses due to unreimbursed Medicare and bad debt expense attributable to charity care. In addition, they offer programs and activities to improve community health, underwrite medical research and health professions education, and subsidize high cost health services.

Follow-up

Questions about this report can be addressed to:

- Howard Levenson (Ernst & Young) 202.327.8811
- Kathy Pitts (Ernst & Young) 205.254.1608
- Ken Nagle (Ernst & Young) 202.327.6409
- Ambar La Forgia (Ernst & Young) 202.327.6299

A copy of the tax year 2009 and 2010 Schedule H form is available online at
<http://www.irs.gov/pub/irs-prior/f990sh--2009.pdf>
<http://www.irs.gov/pub/irs-prior/f990sh--2010.pdf>

Endnotes

[1] The percentages are based on the hospitals' actual reported costs, not charges.
[2] Links to the Form 990 Schedule H for 2009 and 2010 are included on the last page.
[3] For purposes of this study, "System" is used to identify Schedule Hs with more than one hospital filing on a combined tax return. Systems filing separately for each hospital are reported by individual hospital.
[4] Total hospital expense is reduced by bad debt expense for Schedule H calculations.
[5] The responses reported are simple averages of the 524 Schedule Hs received in 2010. A large system's Schedule H has the same weight as a small individual hospital's Schedule H. When the overall responses were weighted by total hospital expense, the average total benefit to the community was 12.2 percent, compared to 11.6 percent for the simple average in 2010.
[6] The 118 systems for 2010 represent 565 individual hospitals. The 94 system responses for 2009 represent 400 individual hospitals. In 2010, two hospitals of all responding hospitals and systems reported insufficient information on their Schedule H forms to estimate total annual expenses. In 2009, eight hospitals had insufficient information. These hospitals and systems are excluded from the tabulations in this report.
[7] Location does not include system respondents, as system responses may contain both urban and rural locations.
[8] Hospital type is provided only for individual hospital responses. Hospitals could identify up to three different categories that applied to their hospital. For example, a hospital could identify itself as both a children's and teaching hospital. Hospital type does not include system respondents, as system responses may contain a mix of hospital types.
[9] Of the hospitals that indicated they did not use FPG to determine free or discounted care, most used low income housing guidelines from the Department of Housing and Urban Development. One indicated they also used an asset test, one used their state's food stamp eligibility guidelines, one used an internally developed "ability-to-pay" model, and two did not provide additional details to their response.
[10] IRS Notice 2011-20