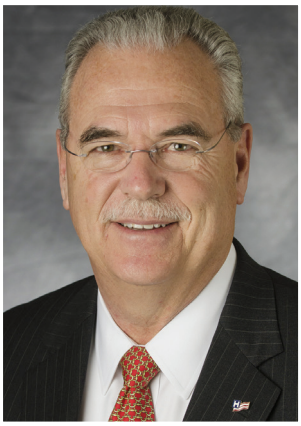


Ernst & Young Schedule H Benchmark Report for the American Hospital Association Tax Year 2012

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

For four 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 has asked Ernst & Young to analyze and report on it. Schedule H forms were obtained directly from hospitals that filed them with the IRS.

Data from over 1,100 hospitals around the nation shows that tax-exempt hospitals provided benefits to the community valued at an average of 12.3 percent of their total expenses in 2012.

Direct benefits to patients, which include financial assistance and spending to fill gaps in Medicaid underpayments, averaged 6.1 percent of total expenses in 2012. This means that a hospital that reported $100 million in total expenses to the IRS spent an average of more than $12 million on benefits to the community, approximately $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 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. With that in mind, we encourage hospitals to share this information, especially the community benefit information, with their local communities and continue to regularly communicate their great stories of service.

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

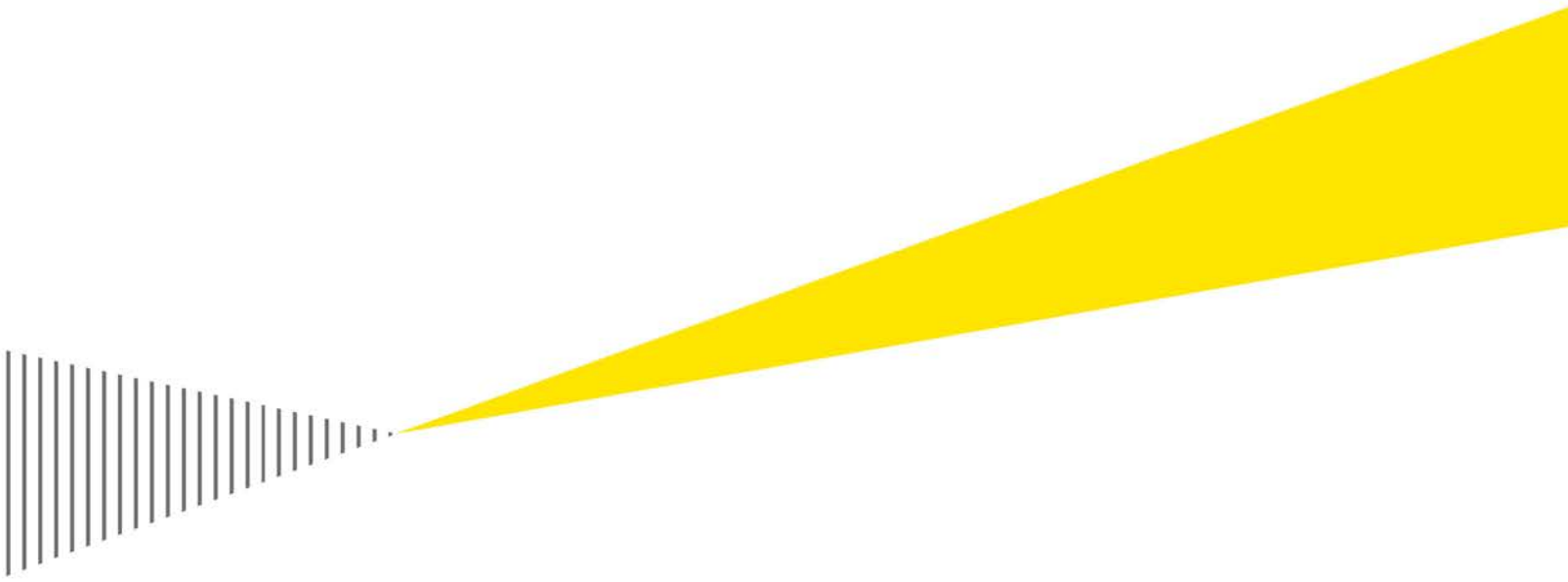
Rich Umbdenstock
President & CEO
American Hospital Association

American Hospital Association®

Results from 2012 Tax-Exempt Hospitals' Schedule H Community Benefit Reporting

May 2015

Prepared by Ernst & Young LLP for the
American Hospital Association



EY
Building a better working world

Introduction

Hospitals provide benefits to their communities in a multitude of ways, a portion of which is captured by the IRS Form 990 Schedule H. 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 financial assistance. In addition, they offer programs and activities to:

- Improve community and population health
- Underwrite medical research and health professions education
- Subsidize high cost essential health services

Ernst & Young LLP (EY) assisted the American Hospital Association (AHA) in reviewing over 1,100 member hospitals' Form 990 Schedule Hs for tax year 2012. This is the fourth year for which EY assisted the AHA in reviewing member hospitals' Form 990 Schedule Hs. This report presents information for 2010, 2011, and 2012 tax years.

Table 1 shows selected community benefit items for 2010 to 2012. In 2012, the hospitals' and systems' reported total community benefits of 12.3 percent of their total hospital expenses, 6.1 percentage points of which resulted from expenditures for financial assistance and absorbing losses from Medicaid and other means-tested programs.[1]

Table 1. Financial assistance and community benefit, 2010 – 2012
(average percent of total expense)

Type of Benefit	2010	2011	2012
Financial assistance, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs	5.7	6.1	6.1
Total Benefits to the Community	11.6	12.3	12.3

Source: EY calculations.

This summary of 2012 Schedule Hs reports the financial costs incurred by hospitals and systems in providing these community benefits, but does not 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

In 2012, EY collected 2010 Schedule H forms and in 2014, AHA repeated this request to their members for their filed 2011 and 2012 Schedule Hs. These data allow EY to analyze the ways in which hospitals and systems benefit their communities.

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, 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:[3]

- Part I on financial assistance and certain other community benefits
- Part II on community building activities
- Part III on bad debt and Medicare

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

- **Systems** (Schedule H with more than one licensed hospital)[4]
- **Single Hospitals** (Schedule H with a single licensed hospital)
    - **Size** – *based on total hospital expense*[5]
        - Small – *less than $100M total hospital expense*
        - Medium – *$100M to $299M total hospital expense*
        - Large – *$300M or more 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 to the IRS 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.[6]
- 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

740 Schedule H's were received for tax year 2012 for 1,177 hospitals, representing about 40 percent of the hospitals required to file a Schedule H in 2012. [7]

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

Table 2. Responding Schedule Hs, with individual hospitals by size, location, and type[8]

Size	2010	2011	2012
Small	188	205	257
Medium	121	152	193
Large	97	133	140
System	118	97	150
Location			
Urban/Suburban	258	308	383
Rural	148	182	207
Type			
General Medical	374	403	499
Children's	25	18	18
Teaching	97	99	110
Critical Access	91	98	118

Source: EY calculations.

A description for each category is provided below.

Size

There were 740 Schedule Hs submitted by individual hospitals and hospital systems for tax year 2012 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 the 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 did not 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/suburban and rural locations.

Type

Individual hospitals identified up to three hospital types in which to classify themselves. A hospital could indicate that they qualify for multiple types (e.g., general medical, teaching, and critical access) and therefore be included in results for more than one type. Again, system respondents were not included, as they might include a mix of hospital types on their Schedule H.

Comparison to AHA Annual Survey of Hospitals

Table 3 shows a comparison of Schedule H respondents with AHA's 2012 Annual Survey of Hospitals.[9] Based on this comparison, 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 2012 AHA Annual Survey of Hospitals. Individual responding hospitals are 20 percent of total hospitals in the field, while responding systems make up 20 percent of total hospitals in the field.

Table 3. Responding individual hospitals compared to AHA Survey of Hospitals, 2012
(percent of respondents)

Hospital Type	Sch H Participants	AHA Hospital Survey
General Medical	92	93
Children's	3	2
Teaching	19	25
Critical Access	20	31
Location	**Sch H Participants**	**AHA Hospital Survey**
Urban/Suburban	65	56
Rural	35	44
Bed Size Category	**Sch H Participants**	**AHA Hospital Survey**
99 or less	35	51
100-199	21	19
200-299	15	12
300 or more	29	18

Source: AHA 2012 Annual Survey of Hospitals and EY calculations.

Hospitals' benefits to the community

In 2012, participating hospitals and systems reported an average of 12.3 percent of their total annual expense as providing benefits to the community. Benefits to the community include financial assistance, Medicaid and other means-tested government program underpayments, community health improvement services, research, health professions education, subsidized services, bad debt expense attributable to financial assistance, 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 financial assistance and certain other community benefits
- Part II on community building activities
- Part III on bad debt and Medicare

Table 4. Hospitals' benefit to the community, by type of benefit
(average percent of total expense)

Hospital Category	Total Financial Assistance, Unreimbursed Means-Tested Government Programs and Other Benefits			Community Building Activities			Medicare Shortfall**			Bad Debt Expense Attributable to Financial Assistance			Total Benefits to the Community		
	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012
Overall*	**8.2**	**8.9**	**8.8**	**0.1**	**0.2**	**0.1**	**2.8**	**2.7**	**2.8**	**0.5**	**1.0**	**1.0**	**11.6**	**12.3**	**12.3**
System	8.1	9.0	9.1	0.1	0.1	0.1	2.9	3.3	2.6	0.5	1.1	0.9	11.6	13.2	12.4
Individual Hospitals: Size															
Small	7.3	8.5	8.6	0.1	0.1	0.1	2.9	2.3	2.4	0.8	0.9	1.2	11.1	11.4	11.8
Medium	7.5	8.5	8.0	0.1	0.3	0.1	2.6	3.1	4.0	0.5	1.1	1.0	10.8	12.7	12.8
Large	9.2	9.8	9.6	0.1	0.1	0.1	2.6	2.1	2.2	0.3	0.8	0.7	12.2	12.4	12.3
Individual Hospitals: Location															
Urban/Suburban	8.2	9.1	8.7	0.1	0.2	0.1	2.9	2.9	3.4	0.6	0.9	0.9	11.7	12.8	12.7
Rural	7.2	8.4	8.6	0.1	0.1	0.2	2.6	1.8	1.9	0.6	0.9	1.2	10.5	10.9	11.3
Individual Hospitals: Type															
General Medical	7.7	8.7	8.5	0.1	0.2	0.1	2.9	3.1	3.1	0.6	0.9	1.0	11.3	12.5	12.3
Children's	12.6	15.5	12.7	0.1	0.1	0.1	2.1	0.3	1.4	0.2	1.0	0.9	15.0	16.3	14.4
Teaching	9.7	10.2	9.4	0.1	0.1	0.1	1.7	1.5	1.5	0.4	0.9	0.9	12.0	12.3	11.5
Critical Access	8.1	9.3	9.6	0.1	0.2	0.2	0.6	0.4	1.0	0.8	0.9	1.1	9.7	10.4	11.3

Note: Total averages may not sum due to rounding.
*Overall averages include hospital system and individual hospital results.
**Net shortfall (gross shortfall less surplus).
Source: EY calculations.

Financial assistance, means-tested programs, and other benefits

In addition to providing financial assistance and subsidizing Medicaid underpayments, hospitals fund community health improvement services, underwrite health professions education, fund health research, subsidize certain health services, and make cash and in-kind contributions for community benefit.

Table 5 shows the overall average for hospital systems and individual hospitals' financial assistance and unreimbursed expenses by Medicaid and other means-tested government programs, as well as other benefits to the community. In 2012, financial assistance and unreimbursed costs from Medicaid and means-tested government programs were 6.1 percent of total hospital expenses. Combined with expenditures for health professions education, medical research, cash and in-kind contributions and other benefits, this value amounts to 8.8 percent of expenses in 2012.

Table 5. Financial assistance, means-tested programs, and other benefits
(average percent of total expense)

Hospital Category	Financial assistance, 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 financial assistance, means-tested government programs, and other benefits*		
	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012
Overall	5.7	6.1	6.1	0.9	0.7	0.7	0.6	0.3	0.2	0.3	0.3	0.3	1.0	1.5	1.5	8.2	8.9	8.8
System	5.2	6.5	6.1	1.1	0.9	1.0	0.2	0.3	0.2	0.5	0.2	0.6	1.0	1.2	1.1	8.1	9.0	9.1
Individual Hospitals: Size																		
Small	5.9	6.3	6.6	0.1	0.2	0.2	0.0	0.0	0.0	0.2	0.2	0.2	1.1	1.7	1.7	7.3	8.5	8.6
Medium	5.5	6.1	5.9	0.4	0.4	0.6	0.0	0.0	0.0	0.3	0.2	0.2	1.3	1.7	1.6	7.5	8.5	8.0
Large	5.5	5.5	5.5	1.6	1.6	1.7	1.1	0.9	1.0	0.2	0.5	0.2	0.9	1.3	1.2	9.2	9.8	9.6
Individual Hospitals: Location																		
Urban/Suburban	5.7	6.1	6.1	0.8	0.9	0.9	0.4	0.4	0.4	0.2	0.4	0.2	1.1	1.4	1.3	8.2	9.1	8.7
Rural	5.6	6.0	6.2	0.2	0.2	0.2	0.0	0.0	0.0	0.1	0.2	0.2	1.2	1.9	2.0	7.2	8.4	8.6
Individual Hospitals: Type																		
General Medical	5.7	6.1	6.1	0.6	0.6	0.7	0.2	0.2	0.2	0.2	0.3	0.2	1.0	1.5	1.3	7.7	8.7	8.5
Children's	6.7	7.7	6.4	1.8	2.5	1.9	1.8	1.9	1.3	0.2	0.6	0.3	2.1	2.6	2.8	12.6	15.5	12.7
Teaching	5.7	5.6	5.1	1.7	2.1	2.2	1.1	0.8	0.9	0.1	0.2	0.1	1.1	1.5	1.1	9.7	10.2	9.4
Critical Access	6.5	6.0	6.3	0.3	0.3	0.4	0.0	0.0	0.2	0.1	0.2	0.1	1.1	2.5	2.5	8.1	9.3	9.6

Note: Total averages may not sum due to rounding.
*Does not include Medicare shortfall, bad debt expense attributable to financial assistance, or community building activities.
Source: EY calculations.

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 in poverty. The Schedule H form asks hospitals about their use of FPG to determine eligibility for free and discounted care.

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

- In 2012, 99 percent of hospitals in each of the size and location categories used FPG to determine eligibility for free care.[10]

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

- In 2012, more than 86 percent of hospitals in each of the size and location categories used FPG to determine eligibility for discounted care.
- In 2012, 88 percent of small hospitals used FPG for discounted care eligibility, 94 percent of medium-sized hospitals, 91 percent of large hospitals, and 86 percent of systems. 90 percent of urban/suburban hospitals, as well as 91 percent of rural hospitals, used 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 FPG for free or discounted care.

Table 6. Respondents using Federal Poverty Guidelines to determine free and discounted care

(percent of respondents)

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
2011	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	98	97	98	98	99	100	100	96
Discounted Care	87	87	89	90	77	89	89	87	100	95	91
2012	Overall	Size				Location		Type			
Use FPG for:		Small	Medium	Large	System	Urban/ Suburban	Rural	General Medical	Children's	Teaching	Critical Access
Free Care	99	99	99	99	99	99	99	99	100	99	98
Discounted Care	90	88	94	91	86	90	91	89	89	94	92

Source: EY calculations.

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 2012, 100 percent of hospitals provided free care for those patients below 100 percent of FPG, while 93 percent of hospitals provided discounted care for those below 200 percent of FPG.

Table 7. Respondents using Federal Poverty Guidelines to determine free and discounted care by FPG threshold

(percent of respondents)

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
2011	0	0	0	0	0	0	0	0	0	0	0
Less than 100%	0	0	0	0	0	0	0	0	0	0	0
100-200%	87	93	90	82	78	87	93	89	56	83	94
More than 200%	13	7	10	18	22	13	7	11	44	17	6
2012	0	0	0	0	0	0	0	0	0	0	0
Less than 100%	0	0	0	0	0	0	0	0	0	0	0
100-200%	86	91	89	81	80	85	94	87	83	87	95
More than 200%	14	9	11	19	20	15	6	13	17	13	5

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	7	13	10	8	6	5	21	10	9	8	21
201-300%	32	35	33	30	22	33	34	33	26	30	32
301-400%	46	44	46	45	54	50	36	46	57	51	40
More than 400%	16	9	10	17	18	13	9	12	9	11	7
2011	0	0	0	0	0	0	0	0	0	0	0
200% and lower	11	14	10	4	17	6	17	8	0	11	18
201-300%	33	38	37	28	20	32	40	36	17	31	36
301-400%	42	40	43	47	37	48	35	43	56	40	35
More than 400%	14	8	10	21	25	14	9	12	28	18	10
2012	0	0	0	0	0	0	0	0	0	0	0
200% and lower	7	8	7	4	6	4	11	6	6	8	11
201-300%	32	38	36	26	20	31	42	35	25	30	34
301-400%	46	47	42	44	50	45	43	45	38	36	47
More than 400%	16	7	15	25	23	20	3	14	31	25	8

Source: EY calculations.

Bad debt expense

In 2012, 64 percent of the 740 Schedule Hs reported bad debt expense attributable to financial assistance. Although the IRS provides minimal instruction on how to calculate this amount, the average bad debt expense attributable to financial assistance reported was 1.0 percent of total expenses in 2012 or an average $4.0 million. 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 financial assistance due to the low income of the patients.

One of the respondents provided the following explanation to the Schedule H question about the rationale for including bad debt amounts in community benefit:

> Although our financial assistance policies and procedures make every effort to identify those patients who are eligible for financial assistance before the billing process begins, often it is not possible to make an appropriate determination until after the billing and collection cycle has commenced. The rationale for including bad debt amounts in community benefits would be to account for those patients who were classified as bad debt expense, but would have qualified for financial assistance if sufficient information had been available to make a determination of their eligibility.

Medicare surplus and shortfall

In 2012, 71 percent of participating hospitals and systems reported having Medicare shortfalls. 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 has acknowledged that lessening the government burden associated with providing Medicare benefits is a charitable purpose.[11]
- 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

In 2012, hospital systems and individual hospitals spent on average 0.12 percent of their total expenses on community building activities. Critical access hospitals reported the largest spending by hospital type at 0.2 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.
- Environmental improvements
- Workforce development

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 health care facilities.

Conclusion

Hospitals provide benefits to the communities they serve in a multitude of ways. They not only provide financial assistance and make up for underpayments by Medicaid and other means-tested government programs, but also cover losses due to unreimbursed Medicare and bad debt expense attributable to financial assistance. 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:

- Kathy Pitts (Ernst & Young) 205.254.1608
- Ken Nagle (Ernst & Young) 202.327.6409

A copy of the tax year 2010, 2011, and 2012 Schedule H forms are available online at:

<http://www.irs.gov/pub/irs-prior/f990sh--2010.pdf>

<http://www.irs.gov/pub/irs-prior/f990sh--2011.pdf>

<http://www.irs.gov/pub/irs-prior/f990sh--2012.pdf>

Endnotes

[1] The percentages are based on the hospitals' actual reported costs, not charges.
[2] Links to the Form 990 Schedule H for 2010, 2011, and 2012 are included on the last page.
[3] The detail of each of these Parts is available on the Form 990 Schedule H 2012 located: http://www.irs.gov/pub/irs-prior/f990sh--2012.pdf
[4] 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.
[5] Total hospital expense is reduced by bad debt expense for Schedule H calculations.
[6] The responses reported are simple averages of the 740 Schedule Hs received in 2012. A large system's Schedule H has the same weight as a small individual hospital's Schedule H.
[7] The 150 systems for 2012 represent 587 individual hospitals. In 2012, five hospitals of all responding hospitals and systems reported insufficient information on their Schedule H forms to estimate total annual expenses. These hospitals and systems are excluded from the tabulations in this report.
[8] Responding individual hospitals can be identified as more than one hospital type. As a result, the sum of these categories is greater than the number of responding individual hospitals.
[9] The American Hospital Association conducts an annual survey of hospitals in the United States. AHA Annual Survey of Hospitals generates data on utilization, personnel, revenue, expenses, managed care contracts, community health indicators, and physician models.
[10] Hospitals also report using asset tests, food stamp eligibility guidelines, and internally developed "ability-to-pay" models, and two did not provide additional details to their response.
[11] IRS Notice 2011-20.