

# Results from 2016

## Tax-Exempt Hospitals' Schedule H Community Benefit Reports

### Executive Summary

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

For example, tax-exempt hospitals annually demonstrate accountability to the communities they serve by reporting to Internal Revenue Service (IRS) on the benefits they provide to their community using the IRS Form 990 Schedule H and making it publicly available. This report summarizes such community benefit information for the tax year 2016.\*

Tax-exempt hospitals provide benefits to their communities in a multitude of ways, only some of which is captured by the IRS Form 990 Schedule H. They offer programs and activities to:

- Improve community and population health by addressing social determinants of health
- Underwrite medical research and health professions education
- Subsidize high-cost, essential health services

In addition, they provide financial assistance and absorb underpayments from means-tested government programs, such as Medicaid, as well as incur losses due to unreimbursed Medicare expenses and bad debt expenses that are attributable to financial assistance.

Table 1 shows a snapshot of the benefits tax-exempt hospitals provide to their communities. In 2016, these hospitals and health systems reported total community benefits of 13.7 percent of their total hospital expenses, half of which resulted from expenditures for financial assistance for patients and absorbing losses from Medicaid and other means-tested government program underpayments.

This report presents the financial costs incurred by tax-exempt hospitals and health systems in providing community benefits. IRS requires such hospitals to report community benefit as a percent of hospital expenses. These numbers alone, however, do not measure the value of the overall tangible and intangible benefits hospitals provide by improving their communities' health and economic well-being. Tax-exempt hospitals also provide the IRS descriptions of their community benefit programs as part of their filing that begin to tell the hospital's story beyond what can be learned from the financial information alone.

*\*(Tax year for which the most recent comprehensive filed information is available.)*

**Table 1. Table 1. Financial Assistance and other benefits to the community (average percent of total expense)**

Type of Benefit	2016
Financial Assistance, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs	6.4
<b>Total Benefits to the Community</b>	<b>13.7</b>

**Note:** Percentages are based on actual reported costs, not charges.

## Methodology

The AHA, assisted by Ernst & Young LLP, has since 2012 reviewed and analyzed Schedule H tax filings. In 2019, AHA contracted with Guidestar to create a file of all electronically submitted Schedule H forms for the most recently completed tax year, 2016. Using the Schedule H community benefit data and total expense data from the 2016 AHA Annual Survey database, AHA calculated the percent of total hospital expenses spent on benefits to the community.

**Individual and Group Schedule Hs:** Hospitals submit a Schedule H for a single hospital (individual Schedule) or as part of a combined Schedule that includes other hospitals (group Schedule), depending on their organizational structure. The 2016 file contains 2,398 Schedules. Upon review, AHA identified 2,733 total hospitals in the Schedule H data file and matched these records with the AHA Annual Survey database.

**Community Benefit Calculation:** The community benefit expenses used for this report are those reported to the IRS net of any offsetting revenue. Net community benefit expenditures were summed across hospitals and expressed as a percentage of the total hospital expenses reported by the same hospitals on the 2016 AHA Annual Survey. The calculation of community benefits for exempt hospitals in aggregate includes all data from both individual Schedules and group Schedules. Ernst & Young (EY) confirmed that “[t]he methodology described above is consistent with the approach used by EY in our prior analyses of the Form 990 Schedule H.”

**Demographic Calculation:** The calculation of community benefits based on demographic characteristics (e.g., type, size) requires individual hospital community benefits information. Since a group Schedule does not specify the amount of community benefit expense attributed to individual hospitals and the hospitals on a group Schedule may have very different demographic characteristics, comparison groups were developed using only the Schedule Hs filed for single hospitals (1,922). Although a significant portion of system-affiliated hospitals submitted a single-hospital Schedule H, the comparison data slightly underrepresents the community benefit expenditures of system-affiliated hospitals reporting as a group.

**Schedule H Data:** Data was extracted from the following sections of the 2016 990 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

See Appendix A for a detailed list of Schedule H data elements used in this report.

**Hospital Segments:** Results are presented for the following segments of hospitals:

- Size
- Location
- Type

See Appendix B for a detailed description of the comparison groups.

## Results

**Hospitals' Total Benefits to the Community:** In tax year 2016, exempt hospitals spent on average 13.7 percent of their total annual expense on benefits to the community. Benefits 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 hospitals incurred in providing particular benefits to their community, but do not reflect all the tangible and intangible benefits of improving their communities' health and well-being.

Table 2 shows the average percent of total expense corresponding to the Schedule H form:

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

**Table 2. Hospitals' total benefit to the community** (Percent of expense)

Hospital Category	Financial Assistance And Certain Other Community Benefits	Community Building Activity	Medicare Shortfall*	Bad Debt Expense Attributable To Financial Assistance	Total Benefits To The Community
<b>All Filed Schedule Hs</b> (2,733 hospitals)	10.0%	0.1%	3.3%	0.4%	13.7%
<b>DEMOGRAPHIC COMPARISONS</b> (1,922 single-hospitals)					
<b>Size</b>					
Small	8.7%	0.1%	2.0%	0.8%	11.7%
Medium	8.4%	0.1%	3.2%	0.6%	12.2%
Large	11.0%	0.1%	2.9%	0.3%	14.3%
<b>Location</b>					
Rural	8.4%	0.1%	2.8%	0.6%	12.0%
Urban/Suburban	10.4%	0.1%	2.9%	0.4%	13.8%
<b>Type**</b>					
General Medical	9.8%	0.1%	3.1%	0.5%	13.4%
Children's	15.6%	0.1%	0.1%	0.1%	16.0%
Teaching Hospital	10.7%	0.1%	2.7%	0.4%	13.8%
Critical Access Hospital Status	8.2%	0.1%	0.9%	0.6%	9.9%
<b>System-Affiliation</b>					
Affiliated	9.7%	0.0%	3.0%	0.4%	13.2%

**Note:** Total percent may not sum due to rounding.

\* Net shortfall (gross shortfall less surplus)

\*\* A single hospital can be in more than one TYPE category

**Hospitals' Financial Assistance, Means-tested Programs, and Certain 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 3 shows the average percent of total expense corresponding to the types of community benefit reported on Schedule H form Part I. In 2016, financial assistance and unreimbursed costs from Medicaid and means-tested government programs were 6.4 percent of total tax-exempt hospital expenses. When combined with expenditures for health professions education, medical research, cash and in-kind contributions and other benefits, this value amounts to 10.0 percent of expenses in 2016.

**Table 3. Financial assistance, means-tested programs and certain other benefits**  
(Percent of total expense)

Hospital Category	Financial Assistance, Unreimbursed Medicaid, Unreimbursed Costs From Means-Tested Government Programs	Health Professions Education	Medical Research	Cash And In-Kind Contributions To Community Groups	Other *	Total Financial Assistance And Other Community Benefits
<b>All Filed Schedule Hs</b> (2,733 hospitals)	6.4%	1.6%	0.4%	0.3%	1.3%	10.0%
<b>DEMOGRAPHIC COMPARISONS</b> (1,922 single-hospitals)						
<b>Size</b>						
Small	6.0%	0.3%	0.0%	0.1%	2.2%	8.7%
Medium	5.9%	0.5%	0.1%	0.2%	1.6%	8.4%
Large	6.4%	2.4%	0.7%	0.2%	1.3%	11.0%
<b>Location</b>						
Rural	5.6%	0.4%	0.0%	0.1%	2.2%	8.4%
Urban/Suburban	6.4%	1.9%	0.5%	0.2%	1.4%	10.4%
<b>Type**</b>						
General Medical	6.2%	1.7%	0.3%	0.2%	1.4%	9.8%
Children's	8.9%	2.1%	2.0%	0.4%	2.2%	15.6%
Teaching Hospital	6.2%	2.2%	0.6%	0.2%	1.4%	10.7%
Critical Access Hospital Status	5.0%	0.2%	0.0%	0.1%	2.9%	8.2%
<b>System Affiliation</b>						
Affiliated	6.2%	1.8%	0.3%	0.3%	1.2%	9.7%

**Note:** Total percent may not sum due to rounding.

\*Other Benefits include community health improvement services and subsidized health services

\*\*A single hospital can be in more than one TYPE category

**Bad Debt Expenses:** In 2016, 52 percent of the 1,922 individual hospital 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 0.4 percent of total expenses in 2016. However, 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.

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

- *The portion of bad debt expense that reasonably could be attributable to patients who may qualify for financial assistance under the hospital's charity care program (reported in Part III line 3) was calculated by applying the percentage of bad debts by zip code (for which the average household income for each zip code is less than 200% of the federal poverty level) to bad debt expense reported in Part III line 2. Since this portion of bad debt is attributable to patients residing in an area where the average income is less than 200% of the Federal poverty level, it is highly likely these patients would have qualified for Hospital's charity care program had they applied. For this reason, we believe the amount should be treated as community benefit expense in Part I.*

**Medicare Surplus and Shortfall:** In 2016, 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.*
- *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 2016, hospital systems and individual hospitals spent on average 0.1 percent of their total expenses on community building activities. 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 absorb underpayments by Medicaid and other means-tested government programs, but also absorb 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 [help@aha.org](mailto:help@aha.org).

**Financial Assistance and Certain other Benefits:** Sum of the following

- Financial assistance and means-tested government programs: Part I, line 7d(e)
- Community health improvement services: Part I, line 7e(e)
- Health professions education: Part I, line 7f(e)
- Subsidized health services: Part I, line 7g(e)
- Medical research: Part I, line 7h(e)
- Cash and in-kind contributions to community groups: Part I, line 7i(e)

**Community Building Activities:** Part II, line 10[e]

**Medicare Shortfall:** Part III, Section B, line 7

**Bad debt expense attributable to financial assistance:** Part III, Section A, 3

**Total benefits to community:** Sum of [Financial Assistance and Certain Other Benefits]+[Community Building Activities]+[Medicare Shortfall]+[Bad Debt Expense Attributable to Financial Assistance]

## Size

**Definition:** Categories based on total hospital expenses.

- “Small” is less than \$100M;
- “Medium” is \$100M - \$299M; and
- “Large” is \$300M or more.

**Source:** AHA 2016 Annual Survey

## Location

**Definition:** Categories are based on core-based statistical areas (CBSA). A CBSA is a U.S. geographic area defined by the Office of Management and Budget (OMB) that consists of one or more counties (or equivalents) anchored by an urban center of at least 10,000 people plus adjacent counties that are socioeconomically tied to the urban center by commuting. Hospitals located in a CBSA are categorized as “Urban/Suburban”. Hospitals not located in a CBSA are categorized as ‘Rural’.

**Source:** US Census

## Type

### Critical Access Hospital

**Definition:** A critical access hospital (CAH) is a hospital designated as a CAH by a state that has established a State Medicare Rural Hospital Flexibility Program in accordance with Medicare rules.

**Source:** The national CAH database is maintained by a consortium of the Rural Health Research Centers at the Universities of Minnesota, North Carolina-Chapel Hill, and Southern Maine, and funded by the Federal Office of Rural Health Policy. The list contains the most current information and is updated regularly based on CMS reports, information provided by state Flex Coordinators, and data collected by the NC Rural Health Research Program on hospital closures.

### General Medical Hospital

**Definition:** A general medical hospital is a hospital primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with a wide variety of medical conditions, and that may provide outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services, and pharmacy services.

**Source:** AHA 2016 Annual Survey



## Children's Hospital

**Definition:** A children's hospital is a center for provision of health care to children, and includes independent acute care children's hospitals, children's hospitals within larger medical centers, and independent children's specialty and rehabilitation hospitals.

**Source:** AHA 2016 Annual Survey

## Teaching Hospital

**Definition:** A teaching hospital is a hospital that provides training to medical students, interns, residents, fellows, nurses, or other health professionals and providers, provided that such educational programs are accredited by the appropriate national accrediting body.

**Source:** AHA Membership Database. To be identified as a teaching hospital, the hospital site must meet at least one of the following criteria: be recognized for one or more Accreditation Council for Graduate Medical Education accredited programs; have a medical school affiliation reported to the American Medical Association; be a COTH member; have internships approved by the American Osteopathic Association (AOA); or have residencies approved by AOA.

## System Affiliation

**Definition:** A hospital is considered "affiliated" if it is owned, leased, or managed by a health care system. Unaffiliated hospitals are called "independent" or "stand-alone".

**Source:** AHA Membership Database