Results from 2013 Tax-Exempt Hospitals' Schedule H Community Benefit Reporting

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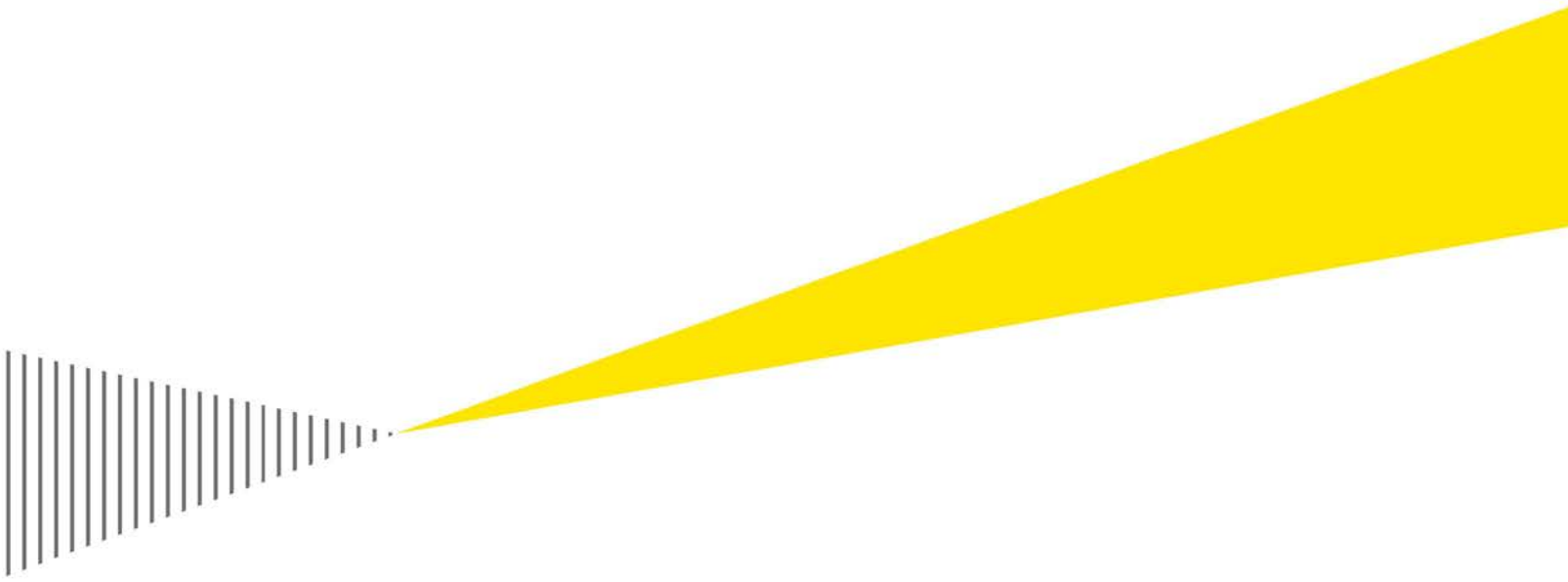
Prepared by Ernst & Young LLP for the
American Hospital Association



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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 1,300 member hospitals' Form 990 Schedule Hs for tax year 2013. This is the fifth year for which EY assisted the AHA in reviewing member hospitals' Form 990 Schedule Hs. This report presents information for the 2013 tax year.

Table 1 shows selected community benefit items. In 2013, the hospitals' and systems' reported total community benefits of 11.7 percent of their total hospital expenses, 6.0 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
(average percent of total expense)

Type of Benefit	2013
Financial assistance, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs	6.0
Total Benefits to the Community	11.7

Source: EY calculations.

This summary of 2013 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 2016, AHA requested that their members share their filed 2013 Schedule Hs with EY. 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.

Methodology

Data was collected and tabulated for the following sections of the Schedule H form: [2]

- 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) [3]
- **Single Hospitals** (Schedule H with a single licensed hospital)
    - **Size** – *based on total hospital expense* [4]
        - 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. [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

788 Schedule H's were received for tax year 2013 for 1,324 hospitals, representing about 45 percent of the hospitals required to file a Schedule H in 2013. [6]

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 [7]

Size	2013
Small	280
Medium	193
Large	153
System	162
Location	
Urban/Suburban	409
Rural	217
Type	
General Medical	416
Children's	19
Teaching	99
Critical Access	144

Source: EY calculations.

A description for each category is provided below.

Size

There were 788 Schedule Hs submitted by individual hospitals and hospital systems for tax year 2013 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 2013 Annual Survey of Hospitals. [8] 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 2013 AHA Annual Survey of Hospitals.

Table 3. Responding individual hospitals compared to AHA Survey of Hospitals, 2013
(percent of respondents)

Hospital Type	Sch H Participants	AHA Hospital Survey
General Medical	90	93
Children's	2	2
Teaching	8	30
Critical Access	19	31
Location	**Sch H Participants**	**AHA Hospital Survey**
Urban/Suburban	65	58
Rural	35	42
Bed Size Category	**Sch H Participants**	**AHA Hospital Survey**
99 or less	45	52
100-199	19	19
200-299	13	11
300 or more	22	17

Source: AHA 2013 Annual Survey of Hospitals and EY calculations.

Hospitals' benefits to the community

In 2013, participating hospitals and systems reported an average of 11.7 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
Overall*	**8.6**	**0.1**	**2.5**	**1.1**	**11.7**
System	8.4	0.1	2.9	1.1	12.0
Individual Hospitals: Size					
Small	8.3	0.2	1.9	1.2	11.0
Medium	8.6	0.1	3.2	1.1	12.4
Large	9.2	0.1	2.5	0.6	12.0
Individual Hospitals: Location					
Urban/Suburban	8.9	0.2	2.8	0.9	12.3
Rural	8.0	0.2	1.7	1.3	10.5
Individual Hospitals: Type					
General Medical	8.7	0.2	3.4	0.9	12.8
Children's	12.3	0.1	0.6	0.8	13.3
Teaching	9.3	0.1	1.7	0.6	11.3
Critical Access	7.6	0.3	0.9	1.1	9.3

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. These numbers correspond to Part I, Line 7 of the Schedule H form.

In 2013, financial assistance and unreimbursed costs from Medicaid and means-tested government programs were 6.0 percent of total hospital expenses. When combined with expenditures for health professions education, medical research, cash and in-kind contributions and other benefits, this value amounts to 8.6 percent of expenses in 2013.

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*
Overall	**6.0**	**0.7**	**0.1**	**0.2**	**1.4**	**8.6**
System	5.8	0.9	0.2	0.5	1.1	8.4
Individual Hospitals: Size						
Small	6.2	0.2	0.0	0.1	1.8	8.3
Medium	6.3	0.6	0.0	0.2	1.3	8.6
Large	5.6	1.7	0.3	0.2	1.4	9.2
Individual Hospitals: Location						
Urban/Suburban	6.4	0.9	0.1	0.2	1.3	8.9
Rural	5.6	0.2	0.0	0.1	1.9	8.0
Individual Hospitals: Type						
General Medical	6.4	0.7	0.1	0.2	1.3	8.7
Children's	7.2	2.1	0.7	0.1	2.1	12.3
Teaching	5.7	2.2	0.3	0.1	1.1	9.3
Critical Access	5.5	0.5	0.1	0.1	1.5	7.6

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 2013, 99 percent of hospitals in each of the size and location categories used FPG to determine eligibility for free care. [9]

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 2013, more than 90 percent of hospitals in each of the size and location categories used FPG to determine eligibility for discounted care.
- In 2013, 91 percent of small hospitals used FPG for discounted care eligibility, 93 percent of medium-sized hospitals, 93 percent of large hospitals, and 90 percent of systems. 91 percent of urban/suburban hospitals, as well as 95 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)

	Overall	Size				Location		Type			
Use FPG for:		Small	Medium	Large	System	Urban/ Suburban	Rural	General Medical	Children's	Teaching	Critical Access
Free Care	99	100	99	99	99	100	100	100	100	100	99
Discounted Care	92	91	93	93	90	91	95	92	100	97	97

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 2013, 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
Less than 100%	0	0	0	0	0	0	0	0	0	0	0
100-200%	87	90	89	85	82	87	92	86	74	87	92
More than 200%	13	10	11	15	18	13	8	14	26	13	8

Discounted Care Threshold	Overall	Size				Location		Type			
		Small	Medium	Large	System	Urban/Suburban	Rural	General Medical	Children's	Teaching	Critical Access
200% and lower	7	9	8	3	5	6	10	7	6	10	7
201-300%	34	38	32	33	33	32	40	30	31	27	40
301-400%	50	47	54	50	49	51	47	52	50	45	46
More than 400%	9	6	6	14	13	11	3	11	13	18	7

Note: Total averages may not sum due to rounding.
Source: EY calculations.

Bad debt expense

In 2013, 56 percent of the 788 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 1.1 percent of total expenses in 2013. 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:

> 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 2013, 73 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.[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

In 2013, hospital systems and individual hospitals spent on average 0.14 percent of their total expenses on community building activities. Critical access hospitals reported the largest spending by hospital type at 0.35 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:

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- Ken Nagle (Ernst & Young) 202.327.6409

Endnotes

[1] The percentages are based on the hospitals' actual reported costs, not charges.
[2] The detail of each of these Parts is available on the Form 990 Schedule H 2013 located: http://www.irs.gov/pub/irs-prior/f990sh--2013.pdf
[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 788 Schedule Hs received in 2013. A large system's Schedule H has the same weight as a small individual hospital's Schedule H.
[6] The 162 systems for 2013 represent 707 individual hospitals. In 2013, three 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.
[7] 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.
[8] 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.
[9] 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.
[10] IRS Notice 2011-20.