American Hospital Association™

Advancing Health in America

Tax-exempt Hospitals Provided Nearly $130 Billion in Total Benefits to their Communities

Every hospital and health system's mission is to always care for their patients and communities. Even during a once-in-a-century pandemic, hospitals continued to provide a comprehensive range of benefits, programs and essential services. Tax-exempt hospitals provided nearly **$130 billion in total benefits to their communities** in 2020 alone — the most recent year for which comprehensive data is available. This new report demonstrates that hospitals never retrenched during the pandemic, and, in fact, the amount of community benefit exceeded prior years by nearly $20 billion.

In addition to providing financial assistance to those in need, hospitals and health systems' community benefit activities include programs and services that are responsive and designed to meet the current and future health needs of the specific communities they serve. They tailor programs aimed at keeping their communities healthy and productive, helping with housing, accessing healthy food, health education, health screenings, transportation, vaccination clinics and other programs to address the needs that affect their community's health and well-being.

Hospitals annually report the comprehensive ways in which they benefit their communities. Nearly **7% of not-for-profit hospitals' total expenses — amounting to $57 billion — was for financial assistance** for patients in need, including absorbing underpayments from Medicaid and other government programs for the poor. Hospitals strive to help patients without insurance transition to programs that can provide them with coverage for regular preventive and restorative care. In addition, hospitals and health systems offer a range of programs and services that focus on their community's health and wellbeing, including programs that address some of the most persistent drivers of illness and accident. This is on top of funds invested in lifesaving research and medical innovation, training health professionals and subsidizing vital health services such as burn and neonatal units.

Executive Summary

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

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 2020.*

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 health by addressing pressing health and wellness needs
- Underwrite medical research and health professions education
- Subsidize many high-cost, essential health services

In addition, they provide financial assistance and absorb underpayments from means-tested government programs to aid those in need, 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. Financial Assistance and other benefits to the community (average percent of total expense)

Type of Benefit	2020
Financial Assistance, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs	6.9%
Total Benefits to the Community	15.5%
Note: Percentages are based on actual reported costs, not charges. (2,790 Hospitals)	

Table 1 shows a snapshot of the benefits tax-exempt hospitals provide to their communities. In 2020, these hospitals and health systems reported total community benefits of over $129 billion, or 15.5% percent of total expenses, half of which resulted from expenditures for financial assistance for patients and absorbing losses from Medicaid and other means-tested government program underpayments. It is of particular note that the amount of community benefit increased from that reported the previous year by almost $20 billion, despite hospitals battling an unprecedented national pandemic.

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. They also engage in a regularly scheduled process, in conjunction with their communities, to develop a plan to tackle the greatest health and wellness needs culminating in a formal Community Health Needs Assessment.

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

Methodology

The AHA, assisted by Ernst & Young (EY) LLP, has since 2012 reviewed and analyzed Schedule H tax filings. In 2023, AHA contracted with Candid to create a file of all electronically submitted Schedule H forms for the most recently completed tax year, 2020. Using the Schedule H community benefit data and total expense data from the 2020 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 2020 file contains 2,288 Schedules. Upon review, AHA identified 2,790 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 2020 AHA Annual Survey. For purposes of the IRS Form 990 Schedule H, the tax year is equivalent to the calendar year in which the reporting year begins (e.g., a fiscal year beginning October 1, 2020 would report under tax year 2020, not under the fiscal year end of September 30, 2021). There may be timing differences for tax year 2020 and AHA Survey and AHA membership database fiscal year reporting. The calculation of community benefits for exempt hospitals in aggregate includes all data from both individual Schedules and group Schedules. 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 (1,849). 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 2020 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 2020, exempt hospitals spent on average 15.5% 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
All Filed Schedule Hs (2,790 hospitals)	11.3%	0.1%	3.9%	0.3%	15.5%
DEMOGRAPHIC COMPARISONS (1,849 individual hospitals)					
Size					
Small	9.0%	0.1%	1.7%	0.8%	11.7%
Medium	9.2%	0.1%	3.7%	0.5%	13.5%
Large	12.3%	0.1%	3.6%	0.3%	16.2%
Location					
Rural	8.1%	0.1%	1.4%	0.6%	10.2%
Urban/Suburban	11.6%	0.1%	3.5%	0.3%	15.5%
Type**					
General Medical	11.1%	0.1%	3.7%	0.4%	15.2%
Children's	17.1%	0.1%	0.2%	0.1%	17.6%
Teaching Hospital	12.0%	0.1%	3.4%	0.3%	15.7%
Critical Access Hospital Status	8.7%	0.1%	0.7%	0.5%	10.0%
System-Affiliation					
Affiliated	10.9%	0.0%	3.5%	0.3%	14.8%

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 2020, financial assistance and unreimbursed costs from Medicaid and means-tested government programs were 6.9% 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 11.3% of expenses in 2020.

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
All Filed Schedule Hs (2,790 hospitals)	6.9%	1.7%	0.5%	0.3%	1.8%	11.3%
DEMOGRAPHIC COMPARISONS (1,849 individual hospitals)						
Size						
Small	6.1%	0.2%	0.1%	0.1%	2.5%	9.0%
Medium	6.5%	0.5%	0.0%	0.2%	2.1%	9.2%
Large	7.1%	2.3%	0.7%	0.2%	2.0%	12.3%
Location						
Rural	5.0%	0.1%	0.0%	0.1%	2.9%	8.1%
Urban/Suburban	6.9%	1.9%	0.5%	0.2%	2.0%	11.6%
Type**						
General Medical	6.8%	1.8%	0.3%	0.2%	2.1%	11.1%
Children's	9.9%	2.1%	2.1%	0.5%	2.5%	17.1%
Teaching Hospital	6.9%	2.1%	0.6%	0.2%	2.1%	12.0%
Critical Access Hospital Status	5.2%	0.2%	0.0%	0.1%	3.2%	8.7%
System-Affiliation						
Affiliated	6.6%	1.9%	0.2%	0.2%	1.9%	10.9%

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

Bad Debt Expenses: In 2020, 42.9% of the 1,849 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 0.3% of total expenses in 2020.

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, the following is an 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 2020, 70.0% 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:

- *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.*
- *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 – a tax exempt purpose.*

Community Building Activities: In 2020, hospital systems and individual hospitals spent on average 0.1% 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 department activities and neighborhood community relations committees, and with university and other school partnerships.*
- *Environmental improvements*
- *Workforce and jobs development*

These activities often promote community 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.

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]

Appendix B
Demographic Definitions and Data Source

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 2020 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 2020 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 2020 Annual Survey*

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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*