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Fiscal Research Center

Tax Incentive Evaluation: Non-profit Hospital Exemptions

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For:

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Table of Contents

1. Executive Summary

Private non-profit hospitals (NPH) account for nearly half of all hospitals in the United States. To maintain tax-exempt status at the federal level, hospitals must provide recognized benefits to their community, such as offering charity care, community health improvements, professional education, subsidized health services, and research. In Georgia, NPH are exempt from state income tax, state sales and use taxes, and property tax to incentivize similar community benefits (CB). Of Georgia's four types of hospital ownership, three are tax exempt: government, hospital authorities, and private non-profit. The first two are tax-exempt through their function as a local government, while private NPH are qualified 501(c)(3) tax-exempt entities by the U.S. Internal Revenue Service (IRS), whose charitable nature exempts them from federal income taxation.

Numerous studies have examined CB in relation to the federal income tax benefit, which is not considered in this report. The purpose of this report more narrowly evaluates state-level non-profit hospital exemptions in accordance with the provisions of O.C.G.A. § 28-5-41.1 (2021 Senate Bill 6), in terms of its fiscal and economic effects, as well as its public benefits. In particular, this report assesses the difference in CB between NPH and their for-profit hospital (FPH) counterparts. NPH in Georgia receive exemptions from state and local taxes under the following codes sections: O.C.G.A. § 48-7-1(a)(1), § 48-8-3(7), and § 48-5-41(a)(5)(A).

This report was prepared under a contract with the Georgia Department of Audits and Accounts (GDAA). Some administrative tax data was obtained from the Georgia Department of Revenue (DOR). Additional tax estimation data was obtained from IRS data (Form 990) and the Health Planning Annual Survey datasets collected and maintained by the Georgia Department of Community Health (DCH).

Table E1 summarizes the primary findings of this report. State and local exempted tax revenues are estimated to be $264 million in fiscal year (FY) 2024, increasing to $352 million in FY 2028. Total CB are estimated at $3.7 billion in FY 2024 and $5.4 billion in FY 2028. Charity care (the primary component of total CB) is estimated at $1.4 billion in FY 2024, rising to $2.1 billion in FY 2028. NPH provide more CB and charity care in Georgia than FPH, and Table E1 illustrates the estimated portion of charity care attributable to the non-profit status of these hospitals (i.e., their incremental benefits). The estimate of incremental benefits is derived from the hospital-type difference between the average amount of community benefits provided, as a share of total revenue. This is expected to be $1.1 billion in FY 2024 and to grow to $1.5 billion in FY 2028.

Table E1. Summary of Tax Expenditures and Community Benefits

($ in millions)	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**
Total State and Local Expenditures*	$263.6	$283.1	$304.2	$327.0	$352.0
Total Community Benefits	$3,699.0	$4,072.0	$4,482.0	$4,933.0	$5,430.0
Charity Care – Total	$1,430.7	$1,574.8	$1,733.5	$1,908.1	$2,100.3
Charity Care – Incremental	$1,053.1	$1,159.2	$1,276.0	$1,404.5	$1,546.0

* Though not included here, NPH are also exempt from federal income taxes.

During FY 2021, the average total expenditure for a NPH was $243.4 million. For the same year, average CB are estimated at $64.5 million (26.5 percent of expenses) and charity care at $25.0 million (10.3 percent of expenses). As in Table E1, roughly 74 percent of all charity care can be attributed the tax-exempt status of these hospitals. Table E2 details the average amounts of Georgia's NPH state and local tax exemptions, along with CB and charity care.

Table E2. Average NPH State and Local Tax Expenditures and Community Benefits

($ in millions)	**FY 2021**
Total Expenses	$243.4
Corporate Income Tax Exemption	$2.9
State Sate Tax Expenditure	$1.3
Local Sales Tax Expenditure	$1.3
Property Tax Exemptions*	$0.6
Community Benefits (CB)**	$64.5
Charity Care	$25.0

* Total school, county and city property taxes exempted

** The CB categories estimated from the IRS 990 data are from 2021, or the most recently available year.

2. Introduction

Georgia laws exempt non-profit hospitals (NPH) from state income tax, state sales and use taxes, and property tax. These exemptions are justified on the premise that they incentivize investment (by tax-exempt hospitals) in the healthcare needs of low-income individuals. In this report, we estimate the economic magnitude of such health and community benefits (CB) and compare them to the cost of Georgia's associated tax exemptions. In accordance with the provisions of O.C.G.A. § 28-5-41.1 (2021 Senate Bill 6), the evaluation of these exemptions includes estimates of fiscal and economic effects as well as public benefits. Private NPH in Georgia receive exemptions from state and local taxes under O.C.G.A. § 48-7-1(a)(1), O.C.G.A. §48-8-3(7), and §48-5-41(a)(5)(A).

This report was prepared under a contract with the Georgia Department of Audits and Accounts (GDAA). Some administrative tax data was obtained from the Georgia Department of Revenue (DOR). Additional tax estimation data was obtained from IRS data (Form 990) and the Health Planning Annual Survey datasets, collected and maintained by the Georgia Department of Community Health (DCH).

Private NPH in Georgia provide important public services within their communities. As qualified charitable non-profits, their net income is exempt from taxation, along with the state sales tax, local sales taxes, and property tax exemptions. As part of IRS reporting through Schedule H of Form 990, non-profits must describe and quantify the value of the CB they provide through their provision of charity and indigent care.

Additionally, DCH requires the reporting of certain types of CB across all hospitals, regardless of tax-exempt status. We combine and analyze data from these sources and find that the CB of these hospitals are larger than the amount of state and local revenues foregone through these tax exemptions. Additionally, NPH provide more CB in Georgia than their for-profit hospital (FPH) counterparts. Note the purpose of this report is to compare FPH and NPH based on tax expenditures *controlled by the State of Georgia*—thus the impact of the large federal income tax exemptions that NPH also receive is not included here.

The report proceeds as follows. Section 3 provides an overview of NPH in Georgia, including relevant laws and regulations. Section 4 discusses the main policy debates surrounding the tax-exempt status of private NPH, while Section 5 looks at charity care. Section 6 estimates the costs of these exemptions for Georgia and its local governments. Section 7 discusses the CB investment requirements and provides benefit estimates. In Section 8, we discuss the fiscal impact through a comparison of the comprehensive tax exemption costs and benefits for the tax-exempt hospitals of interest. In Section 9, the economic impact is assessed, as we compare the CB contributions made by private tax-exempt and non-exempt hospitals in aggregate as well as estimate the marginal CB attributable to the tax-exemption status in Georgia. Section 10 looks at ownership changes, mergers, and acquisitions. Section 11 concludes.

3. Overview of Non-profit Hospitals in Georgia

Tax-exemption Eligibility

Section 5 of the 1931 federal income tax bill exempted from taxation any corporation that was "organized for religious, charitable, scientific, or educational purpose." NPH are eligible for tax-exempt status as charitable organizations under Internal Revenue Code (IRC) Section 501(c)(3), provided they meet certain requirements. According to the IRC definition, an eligible

organization must be exclusively organized and operated for exempt purposes, as defined in §501(c)(3), with none of its earnings benefiting any private shareholders or individuals.[1]

NPH must explicitly meet both general requirements—organizational and operational tests—for tax exemption.[2] Additionally, they must satisfy four other requirements under more recently implemented under IRC Section 501(r)(1).[3]

IRC Section 501(c)(3) was initially enacted as part of the Revenue Act of 1954, while IRC Section 501(r)(1) was added with the passage of the Affordable Care Act (ACA) in 2010. One of the requirements under this newer section is a federal mandate for the completion of a community health needs assessment (CHNA) every three years, beginning in 2012. The development of an implementation strategy to address the identified community health needs is also required.

In Georgia, 1947 legislation exempted non-profit hospitals from property taxation in the state if the property is used to provide health care services. In 1971, further legislation exempted all tangible personal property or services when sold to a NPH, as long as the goods are used for health care services.

Community Benefits

According to the American Hospital Association, private NPH make up about half (49 percent) of the hospitals in the country.[4] NPH are expected to make substantive contributions to the health needs of their community in exchange for the tax exemptions they receive. Given this and a need for greater transparency, in 2009 the IRS introduced a Schedule H worksheet filing requirement for hospitals, as a part of its major redesign effort of Form 990.[5] In accordance with Schedule H, NPH are required to report specific CB levels, activities, and policies annually as a part of their Form 990 filing, unless the organization's gross receipts are $50,000 or less.[6] Part I of Schedule H introduced reporting of eight distinct categories of CB; these are explained in detail in Table 1 below.

Table 1. Community Benefits, Part I of IRS Schedule H Form

Type of Community Benefits	IRS Schedule H Definitions
Charity care (financial assistance at cost)	Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of services. This does not include bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay.
Unreimbursed Medicaid costs	Difference between the hospital's costs incurred for treating Medicaid patients and the payment received

[1] www.irs.gov/charities-non-profits/charitable-organizations/exemption-requirements-501c3-organizations.
[2] Under Internal Revenue Code (IRC) Section 501(c)(3) and Revenue Ruling 69-545, there are seven organizational and four operational criteria that must be fulfilled. For details: www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3.
[3] For these detailed requirements, see: www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r.
[4] Fast Facts on U.S. Hospitals, AHA, 2023.
[5] See the summary of Form 990 Redesign Process, August 19, 2008, IRS.
[6] https://www.irs.gov/charities-non-profits/exempt-organization-annual-filing-requirements-overview.

Costs of other means tested government programs	Difference between the hospital's costs incurred for treating patients and the payment received from other means-tested government programs
Community health improvement services and operations	Activities or programs subsidized by the hospital that aim to improve community health
Health professions education	Costs incurred on training programs that contribute to the education of health professionals
Subsidized health services	Clinical services provided to patients despite causing a financial loss to the hospital, after incorporating the payments received
Research	A study or investigation with a goal of generating knowledge to the public
Cash and in-kind contributions for CB	Donations to other organizations to provide any of the seven aforementioned CB

Notes: Sources include 2022 IRS instructions for Schedule H in 990 Form, and Herring et al. (2018). Concise definitions of each Community Benefit are adopted from Herring et al. (2018).

Although Schedule H requires hospitals to report their contributions across eight distinct types of CB, it does not impose a minimum benefit level. As such, in the last two decades the substantive tax exemption policies towards NPH have been the subject of much analysis and debate (e.g., Rubin et al., 2015; Herring et al., 2018). Essentially, NPH are required to go beyond the basic charity care spending offered, to some extent, by all types of hospitals.[7] Furthermore, a U.S. Government Accountability Office report (2020) emphasizes the need for specificity and clarity on existing laws for better accountability and enforcement of legal requirements.

In addition to the above information on eight distinct CB, hospital organizations report on Schedule H, Part II, their spending on community building activities, such as expenses on economic development, environmental improvements, and workforce development, following a description of how these expenses contributed to the health of their communities.

Hospital Types

Georgia has four hospital ownership designations for the purpose of state and local taxation. The first is FPH, which have owners or shareholders who receive income dependent on the direct profit or loss of the hospital. FPH pay property, sales, and income taxes in the same manner as other for-profit businesses.

The other three types of hospitals are tax-exempt: government, hospital authorities, and private non-profits. The former two are tax-exempt through their function as a local government and are, therefore, tax exempt in the same way as a city or county government. Private NPH are qualified 501(c)(3) tax-exempt non-profits by the U.S. Internal Revenue Service (IRS), whose profits are not subject to federal income taxation due to their charitable nature. Multiple provisions in the O.C.G.A. further exempt NPH from the state income tax, state and local sales taxes, and all levels of local property taxation.

Hospitals affiliated with hospital authorities and local governments are often managed by non-profit companies, thus appearing like NPH, and they sometimes file a Schedule H with Form 990

[7] FPH provide financial assistance to those in need as well because every hospital has a financial assistance policy (also referred to as a charity care policy), and FPH can claim tax deductions against such expenses.

—a requirement reserved for private NPH. Hospital systems can include both private NPH and those owned by hospital authorities.[8] Both types are effectively exempt from taxation, but the codified source and purpose of their exemptions differ. The focus of this study is on the first type of hospital facilities discussed above, those receiving exemption due to ownership status as private non-profit.

4. Comparison of State-level Tax Exemptions and Community Benefit Standards

State-level Tax Exemption Policies

The following are the tax policy exemptions currently in place in U.S. states that have an income, property, and sales tax, per the Hilltop Institute Report (2016).

- 30 states including Georgia offer income tax, property tax and sales tax exemptions.
- Seven states (Alabama, California, Louisiana, North Carolina, Oklahoma, Rhode Island and West Virginia) offer two of the three exemptions.
- Washington State offers only a property tax exemption.
- Every state allows at least one of the three types of tax exemptions.

In summary, below are exemption policies for Georgia and neighboring states:

State	Income Tax Exemption	Property Tax Exemption	Sales Tax Exemption
Georgia	Yes	Yes	Yes
Alabama	Yes	Yes	**No**
Tennessee	**No**	Yes	Yes
North Carolina	Yes	Yes	**No**
South Carolina	Yes	Yes	Yes
Florida	Yes	Yes	Yes

State-level Community Benefit Policies

As mentioned above, the IRS implemented Schedule H of Form 990 in 2009, which collects information on specific types of CB and community building activities, substantially helping to set a uniform reporting standard for certain CB. Additionally, the ACA reforms of 2010 and 2012 established additional legal requirements to retain tax-exempt status, such as establishing a financial assistance policy (FAP). These federal efforts have attempted to improve accountability for NPH contributions to their communities in exchange for tax exemptions.

However, as outlined above, there are no standardized levels of CB that hospitals must provide to maintain tax-exempt status, nor are there any imposed mandates. Given the absence of clear federal minimum standards, state governments have taken the initiative to set their own CB policies, though they vary widely across states.[9]

[8] Northside Hospital, located in Atlanta near the intersection of Georgia S.R. 400 and I-285 (right), is one such example because it is run by Northside Hospital Inc., a non-profit operator, but is owned by the Hospital Authority of Fulton County. Two other Northside Hospitals located are owned and run as NPH. Emory and WellStar hospitals also include multiple owner-operator type combinations within their hospitals.

[9] Kaiser Family Foundation, Health News Report, 2023.

The following briefly summarizes the variation in the CB policies across states[10]:

- Five states (Utah, Texas, Pennsylvania, Nevada, and Illinois) impose minimum CB levels NPH must provide.
- Sixteen states including Georgia enforce some form of CB requirement, such as the provision of charity care or other health services to low-income or underserved individuals.
- Nine states impose some form of CB requirement for both NPH and FPH.
- Thirty-one states including Georgia impose one or more types of CB reporting requirements. For example, Georgia requires nonprofit hospitals to report charity care expenses.
- The ACA requires all states to conduct a community health needs assessment (CHNA) every three years and to adopt an implementation strategy to address those needs. Such assessments require hospitals to fill out detailed CHNAs. There is considerable variation across states in how vigorously these implementation strategies are pursued. That said Georgia has completed at least two rounds of CHNAs and those have been reviewed by Georgia Watch group.
- States have issued their own rules for the FAP. Twenty states have some type of FAP in place, but they vary widely. Georgia does not have a FAP, according to the Hilltop Institute Report.
- Finally, many states limit hospital billing and charging practices for the welfare of the low-income individuals. Again, wide variation exists. For instance, California limits the amounts hospitals may charge patients whose income does not exceed 350 percent of the federal poverty line. Overall, 24 states impose such limitation laws, not including Georgia.

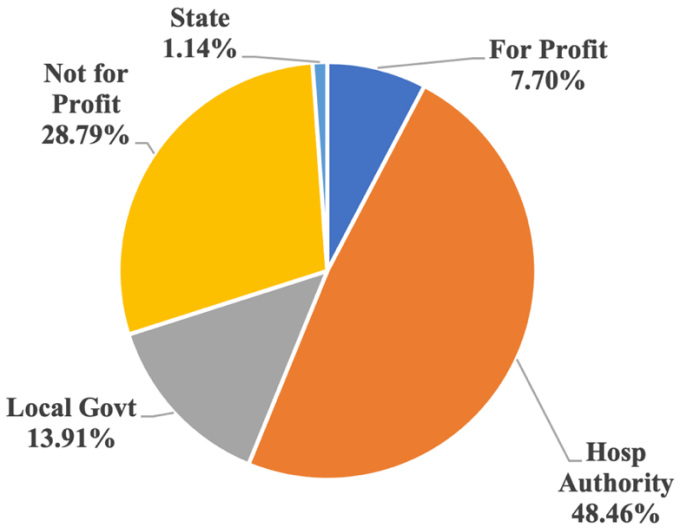
In summary, below are CB policies for Georgia and neighboring states:

State	CB Reporting Requirement	FAP Dissemination	Billing Limits
Georgia	Yes	**No**	**No**
Alabama	**No**	Yes	**No**
Tennessee	Yes	Yes	Yes
North Carolina	Yes	Yes	Yes
South Carolina	Yes	**No**	**No**
Florida	**No**	Yes	Yes

According to DCH, 45 of the 172 operating hospital facilities in 2021 were NPH and accounted for 29 percent of licensed beds in Georgia, after excluding state and federal hospitals in which the number of beds was not reported. All hospital facilities report certain CB to DCH, and Figure 1 summarizes the shares of statewide CB (with community benefits defined as indigent care plus charity care) for each ownership type. NPH account for roughly 29 percent of CB in Georgia. Note the combined 78 local government hospitals and hospital authorities contribute 62 percent of statewide CB.

[10] Community Benefit State Law Profiles, Hilltop Institute Report, 2016.

Figure 1. Statewide Community Benefits, by Hospital Ownership Type



5. Policy Considerations around Charity Care

Importance of Charity Care

Approximately 10 percent of adults in the United States lack insurance, resulting in burdensome medical debts.[11] The sources of high medical debt appear to include a significant proportion of the population without insurance and substantial cost burdens that end up falling on the patients.[12] The uninsured rate in Georgia is 13.7 percent—the third highest in the country—potentially reaching 26 percent for rural Georgia by 2026.[13]

One policy mechanism to counter these healthcare affordability challenges has been to incentivize hospital financial assistance spending of NPH in the form of charity and indigent care (i.e., free or subsidized care for low-income individuals) through various tax exemptions available under IRC Section 501(c)(3) from all levels of governments. One popular idea is that charity care spending by hospitals can serve as a critical safety net for numerous uninsured and underinsured patients across the country, and most hospitals have a FAP to help those in need. As recent research details, FPH dedicate a meaningful share of their expenses to charity care and in some instances even more than the NPH (Bai et al., 2021). FPH are not required to make charity care contributions, but they can claim tax deductions against such expenses. By contrast, NPH receive extensive tax exemptions with the expectation that they will not only make healthcare more affordable and accessible for low-income individuals, but also will extensively invest in the healthcare needs and benefits of their local communities through community building activities and supporting Medicaid cost shortfalls (see, e.g., Part II, Schedule H of Form 990).[14]

[11] Commonwealth Fund Health Care Survey, 2021.
[12] AHA, June 2023.
[13] GBPI, 2020.
[14] CFBP (2022) defines these financial efforts as required financial assistance, one of the main forms of assistance hospitals offer to low-income consumers to help cover the cost of medical treatment.

Current Policy Debates

Extensive policy research consistently shows that NPH spending on charity care and CB are insufficient and fall significantly short in comparison to the foregone taxes—at all levels of government[15]—despite the IRS efforts to monitor CB levels of NPH through detailed reporting and the introduction of additional tax exemption requirements under the ACA.

For example, the Lown Institute Hospital Index (2023), utilizing Form 990 data for fiscal year (FY) 2020, finds that over three-quarters of the 1,773 NPH in their nationwide sample allocates less to charity care and community investment than the estimated value of their tax exemptions. They call these shortfalls "fair share deficits," and in 41 states including Georgia, such deficits are substantial enough to cover the net losses of all rural hospitals in those states in 2020. The fair share estimate involves a comparison of incremental charity care (and some other CB) in Schedule H with the estimated value of tax exemptions, along with the setting of a threshold for detecting a fair share, following the insights from Zare et al. (2022).

Additional national reports put forth similar evidence. A report by the Kaiser Family Foundation (2022) indicates that approximately one half of all hospitals report allocating 1.4 percent of their operating expenses to charity care in 2020, although with considerable variation across facilities. A more recent Kaiser report from 2023 estimates the total value of tax exemptions for NPH at approximately $28 billion in 2020, while the total estimated charity care costs of the NPH are estimated at $16 billion, highlighting a significant shortfall. The report further emphasizes that the value of tax exemptions for NPH has surged considerably, up by 45 percent from 2011 to 2020.

Recent academic findings based on national data have similar results. For example, Bai et al. (2021) use 2018 Medicare Hospital Cost Reports data to compare charity care provision across a national sample of 1,024 government, 2,709 NPH, and 930 FPH. They show that, in aggregate, NPH spend $2.3 of every $100 in total expenses on charity care, which is less than government ($4.1) and FPH ($3.8) hospitals. They also find that the provision of charity care by individual hospitals of the same ownership type varies widely, with the most significant variation among government hospitals. Furthermore, 54 percent of government hospitals, 36 percent of nonprofit hospitals, and 43 percent of FPH provide less than $1 of charity care per $100 of expenses. They found no statistically significant association between hospital ownership type and charity-care-to-expense ratio. The authors conclude that government or NPH contribute a lower charity-care-to-expense ratio than FPH in 46 percent of hospital service areas.

The deficiencies in CB spending of NPH, as highlighted above, have sparked debates and discussions regarding the need for reforms among policymakers at both federal and state levels.

6. Tax Expenditure Estimates and Administrative Costs

Income Tax Exemption Estimate

The cost of this tax expenditure is understood as the amount of corporate income tax revenue generated from private NPH, absent their current exemptions. Used here is the DCH Hospital Financial Survey, which collects data for all hospitals operating in Georgia annually. Hospitals

[15] This research all includes the federal income tax deductions, which makes up a substantial portion of the total tax benefits that the NPH receive.

designated as having private non-profit ownership for 2000–21 were used to estimate the amount of corporate income tax that is currently exempted due to status as 501(c)(3) NPH.

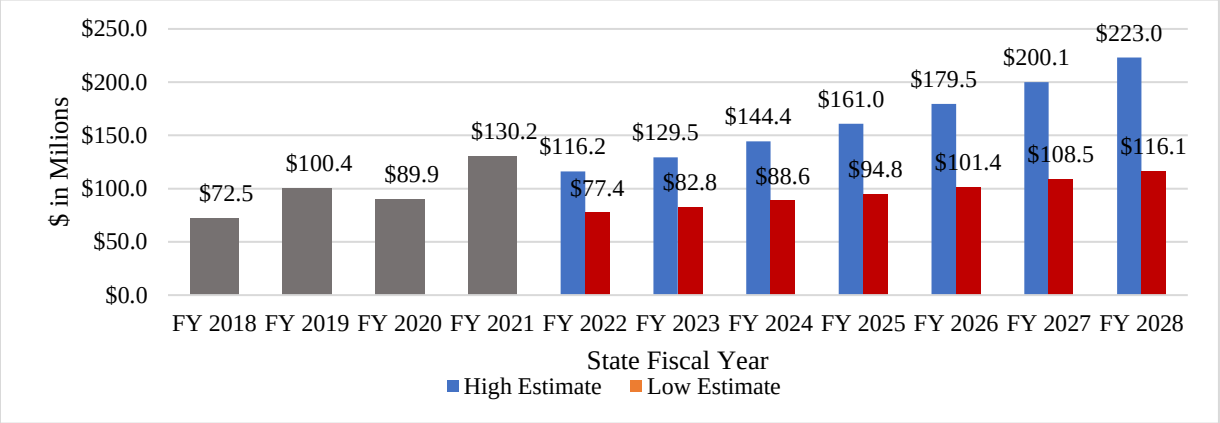
Corporations pay tax on net revenues at a statutory rate of 5.75 percent, and they deduct net operating losses against future net revenues. Net revenues from DCH data were calculated as inpatient and outpatient revenue, less all contractual or regulatory deductions from revenue. Total expenses were assumed to be the operating expenses of the hospital facility, and net revenues minus expenses were used as the net operating revenues for a given year. Net Operating Losses (NOLs) were calculated by observing a hospital facility over time and establishing an NOL deduction against future years, subject to an 80 percent of net revenue maximum. In aggregate, NPH would have deducted 6.5 percent of net revenues based on the NOL of previous years over the period.

Between 2000–21, net revenues for NPH increased rapidly due to high inflation, population growth, and a recent trend for hospitals to change ownership type to non-profit (covered extensively in Section 10). This trend had large variation year to year; in one year, aggregate net revenues were 40 percent below the previous year, and in another year, net revenues were 84 percent above the previous year. The lingering impacts of the COVID-19 pandemic may have led to a large peak in hospital margins observed in the DCH data for 2021, the last year of available data. This peak was expected to sharply decline in future years, according to the American Hospital Association (AHA), driven largely by inflationary pressure increasing costs while pandemic-related demand slows. The Centers for Medicare and Medicaid Services (CMS) provide projections for expenditures at hospitals through 2030. Both of these sources were used to project net revenues in Georgia declining in 2022 but increasing through FY 2028.

The high and low corporate income tax exemptions were based on the following data and assumptions.

- Based on DCH net patient revenues, expenses, and historic NOL deduction behavior, taxable income for these hospitals is estimated to have been between $2.32 and $2.61 billion in FY 2021.
- AHA models predicted margins to decline by 37–133 percent in 2022 over 2019 because their pessimistic models assumed future waves of COVID-19, a scenario known not to have occurred during 2022. The high estimate assumes average margins in 2022 to be 25 percent below 2019, while the low estimate assumes average margins 45 percent below 2019. High and low net revenues for 2022 are 13 and 39 percent below 2021, respectively, modeled using these high and low margin assumptions. These form the basis for the declines in high-low estimate off the 2021 peak shown in Figure 2, which are also in line with the average and trends in aggregate taxable net revenues for NPH pre-pandemic.
- Based on the existing trend in net revenues and CMS projections, the high estimates increase at 11 percent per year after 2022, and the low estimates increase at 7 percent per year.

Figure 2. Estimate of Corporate Income Tax Expenditure for Private Non-Profit Hospitals ($ *millions*)



State and Local Sales Tax Exemption Estimates

The tax expenditure cost of the sales tax exemptions for NPH was estimated for the forthcoming FY 2025 Georgia Tax Expenditure Report, as shown in Figure 3 below. These costs are understood in terms of forgone state sales tax revenue, meaning the state sales tax base, absent this exemption, would apply to these hospitals' purchases and would be expected to generate the tax amounts shown.

The detailed breakdown of operating expenses is from Form 990 returns in 2021, which included the categories: office, information technology, repairs and maintenance, medical supplies, and miscellaneous. The categories include some percentage of sales tax-eligible expenses, absent the exemption, but the share is unknown. Based on the share of total expenses that these categories represent and the likely amount of sales tax-eligible purchase that could be included, the low estimate is based on 11 percent of functional expenses captured by the exemption, and the high estimate is based on 16 percent. Each hospital's local sales tax rate, along with the state rate of 4 percent, is the basis for the estimates detailed in Figures 3 and 4.

Figure 3. State Sales Tax Expenditure Estimate – Exemption of Purchases by Private Non-Profit Hospitals ($ *millions*)

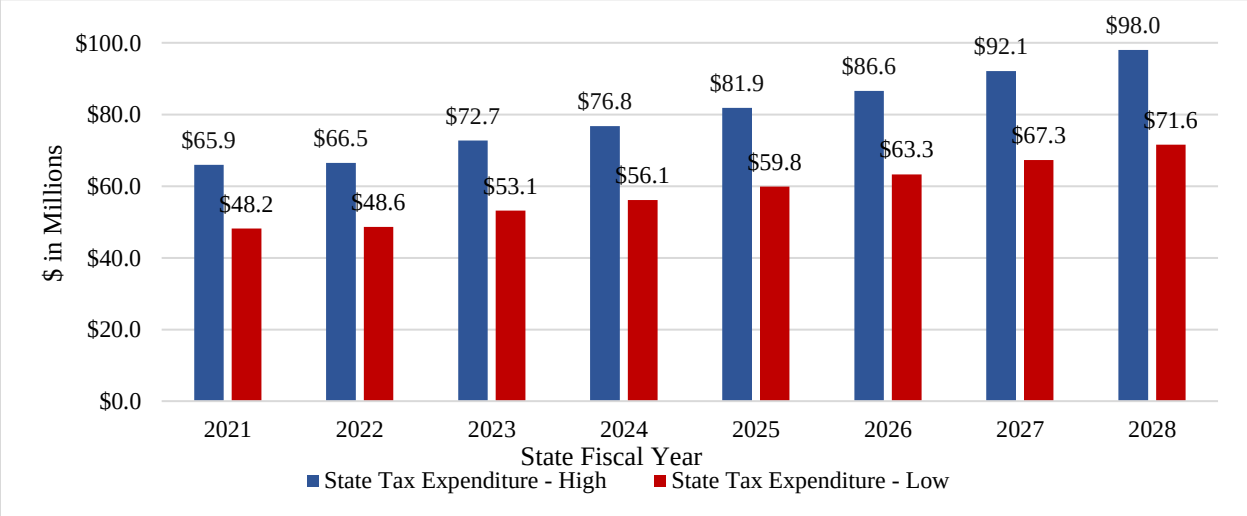
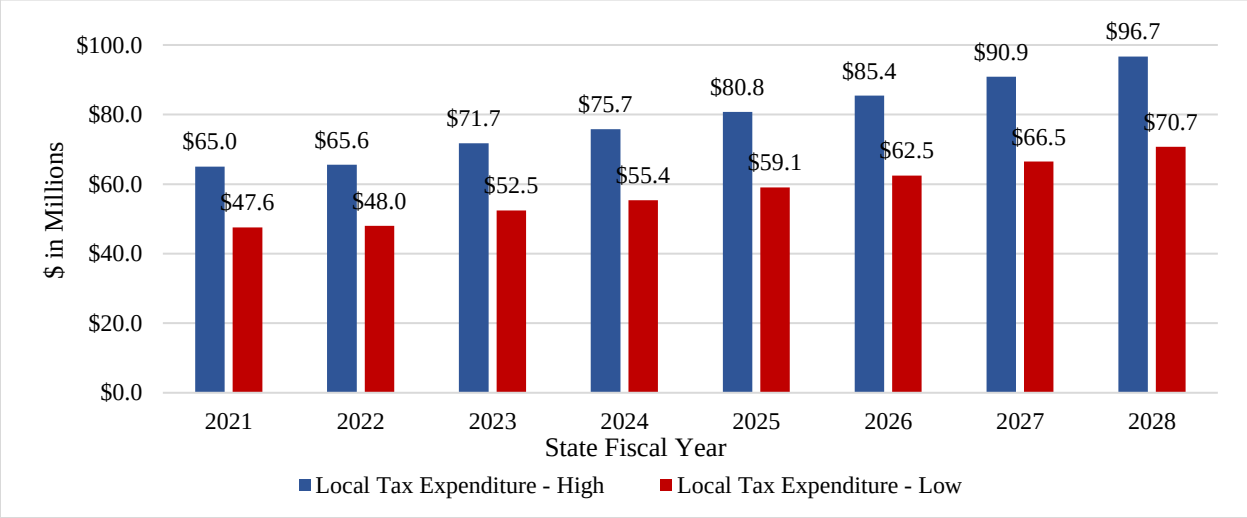


Figure 4. Local Sales Tax Expenditure Estimate – Exemption of Purchases by Private Non-Profit Hospitals ($ *millions*)

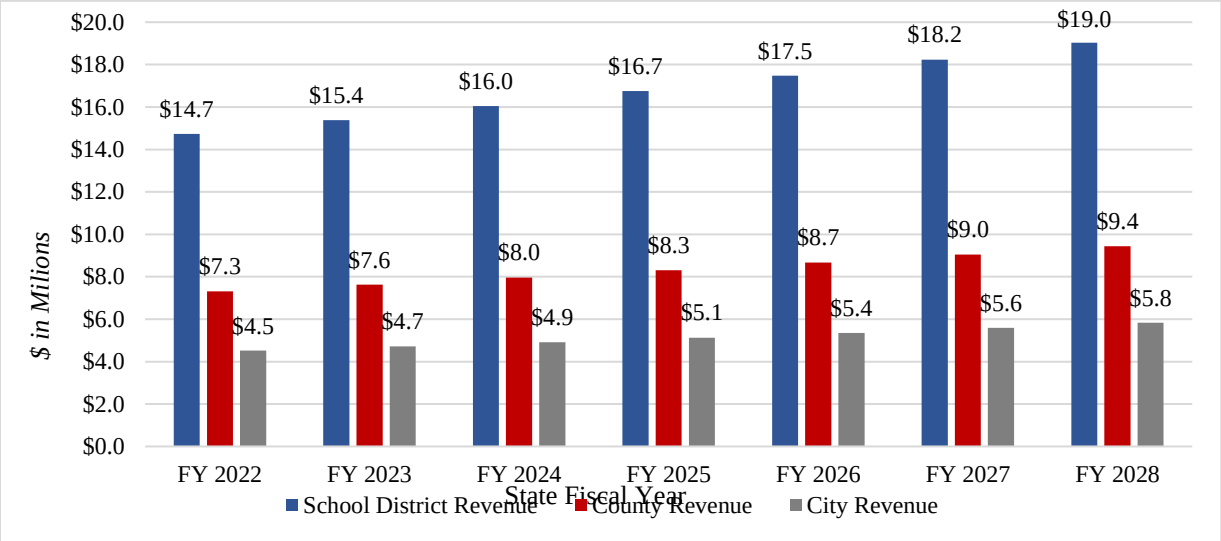


Property Tax Exemption Estimates

The cost of the local property tax expenditure is understood as the amount of property tax revenues that school districts, county governments, and local municipalities (cities) would collect if NPH real property were subject to local property taxes. HB 321 (2019) required that hospitals provide listings of all property holding for the purpose of transparency. These and parcel-level exempt digests were used to identify all the parcels associated with the 47 NPH facilities operating in 2021. Exemption status was confirmed through their presence in the exempt digests, and ownership was verified through the HB 319 reporting, or by address and name. ArcGIS software identified each parcel's school district, county, and municipality, if the parcel was within an incorporated city. Based on 2021 millage rates, these parcels had a 40-percent valuation of $831 million, representing $14.8 million in forgone school district revenue, $7.3 in county revenue, and $4.5 million in city revenue.

Statewide consolidation tax digest sheet data from DOR for 2014–21 were used to establish the trend in assessment in hospital-owned exempt property. Over this period, the hospital-owned exempt parcels, in aggregate, grew in value at 4.3 percent annually, which was used to project assessments for NPH-owned property assessment through FY 2028. Based on the timing of property tax collection, one half of the revenue from a given tax year was assumed to impact the following fiscal year's revenues, and the other half was assumed to impact the subsequent fiscal year. Figure 5 details school, county, and city expenditure estimates through FY 2028, assuming constant millage rates.

Figure 5. School, County, and City Property Tax Expenditure Estimates (*$ millions*)



The tax exemption estimates corresponding to the three types of tax exemptions are presented in Table 2 below, separately and in total. For corporate income and sales tax exemptions, the mid-points between the high and low estimates are presented for simplicity.

Table 2. Summary of State and Local Tax Expenditures (*$ millions*)

	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028
State Tax Expenditures					
Corporate Income Tax Exemption	$106.2	$116.5	$127.9	$140.5	$154.3
State Sales Tax Exemption	$64.7	$68.7	$72.9	$77.3	$82.3
Local Tax Expenditures					
Local Sales Tax	$63.8	$67.7	$71.9	$76.3	$81.2
Local Property Taxes	$28.9	$30.2	$31.5	$32.9	$34.3
Total State and Local	$263.6	$283.1	$304.2	$327.0	$352.0

Administrative Costs

Georgia DOR is responsible for administering the sales and income tax exemptions for NPH, while property tax exemptions are primarily administered at the county level. DOR verifies both the sales and income tax exemption based on the hospital's 501(c)(3) determination letter from the federal IRS. Georgia DCH monitors, licenses, and surveys hospital facilities in Georgia but does so for all hospitals, FPH and NPH. Because of the reliance on the federal determination of non-profit status, the administrative costs associated with these exemptions are assumed to be negligible.

State-level Economic Impact Assumptions

This report addresses the question of economic impact in a different way than previous tax credit evaluations. The focus of this analysis is to compare the total amount of CB provided by NPH versus FPH. In addition, the incremental benefits provided by NPH versus FPH are estimated.

This analysis assumes the existence of the tax credit at the hospital level does not have an impact on the demand for medical care. Rather, the credit is intended to incentivize NPH to offer charity care. Providing reduced-price or free medical care to patients in need is a valuable service and has economic benefits to the individual receiving it. It is beyond the scope of this project to quantify economic benefits received by patients, but we acknowledge they exist. Thus, no IMPLAN analysis is included to quantify these economic benefits. Similarly, as the metric of interest is comparing NPH to FPH in the provision of charity care, an alternative use scenario of the tax credit modeled in IMPLAN is not included.

7. Methods and Estimation of Gross Community Benefits

We identify the list of NPH in our sample from DCH in order to collect data on them from the eight CB reported in Part I on Schedule H in the Form 990. We combine the Form 990 numbers with the specific CB measures that DCH requires in their annual Hospital Financial Survey (explained below). We generate our CB estimates using these two data sources.

DCH Reporting Requirements and Definitions of Community Benefits

Under O.C.G.A. § 31-6-70, all hospitals report information on the measures (related to CB, free care, and bad debt) in Table 3 on Georgia's Division of Health Planning surveys. We present the definitions of these variables in Table 3 below. The primary variables of interest in terms of CB contributions of the Georgia's hospitals are indigent care and charity care expenses reported to the DCH. We use DCH's measure of charity care expense instead of the charity care recorded in IRS Schedule H in our data.

We use the DCH charity care measure in this section (and a few other CB measures in Section 9) for several reasons. First, CB data available from DCH is more complete for NPH as well as our comparison group—FPH, government, and hospital authorities. By contrast, Schedule H data from Form 990 is only available for NPH. Second, even within the NPH category, data from Form 990 is sometimes unavailable because the hospital is small in size or the Form 990 data is reported at the system instead of the hospital-facility level. Previous studies done at the national level have used the charity care expense from IRS 990 because it is the only reliable data source for national studies. Third, the charity care expense data from DCH is expressed at the full retail price, whereas the charity care estimate reported in the Schedule H, Part I of Form 990 is the expense reported at the cost to the hospital. Consequently, DCH charity care estimates are bigger than those reported on Form 990.

The remainder of the seven CB measures reported by the NPH come from IRS data. When comparing CB across NPH and FPH, we use indigent and charity care expenses, bad debt, and free care. As explained in the table below, bad debt is different from charity care; however, part of a patient's care covered under these expenses may be eligible for charity care under a hospital's charity care policy—of which the patient may not be aware. Finally, we are also able to look at uncompensated care (the sum of charity care and bad debt), as past researchers have looked at this measure in their analysis of CB.

Table 3. Community Benefits Information, DCH Annual Survey

Community Benefit Measure	DCH Definitions and Instructions
Indigent Care	Unpaid charges for services to patients whose family income is less than or equal to 125% of the federal poverty guidelines. This does not include unpaid charges for patients who were eligible for Medicare, Medicaid, or third party, or for patients provided other free care.
Charity Care	Unpaid charges for services to patients whose family income is greater than 125% of the federal poverty guidelines, if in accordance with the agency's *formal written charity care policy*. Charity care represents that portion of health care services that are provided but payment is not expected. Charity care is provided to a patient with demonstrated inability to pay for some or all of the service. Only the portion of a patient's account that meets the organization's charity care criteria is recognized as charity.
Bad Debt	An amount that a party has an obligation to pay but is considered uncollectible. Bad debt represents the portion of a patient's account not expected to be collected from the patient or another responsible party. The patient's portion of a bill should not be categorized as a bad debt for patients whose income is less than or equal to 125% of the federal poverty guidelines. *Bad debt must be differentiated from charity services.*
Other Free Care	Uncompensated care provided as a result of employee discounts, administrative adjustments, courtesy discounts, small bill write-offs, or other similar write-offs *and are not based on a patient's inability to pay.*

Community Benefit Data Sources, Methods, and Estimates

We identify our primary sample of NPH using the DCH list of NPH in 2021, from which we find 45 NPH in Georgia. For our estimate of total CB contributions for our primary sample (i.e., NPH), we collect data from Schedule H, Part I of Form 990 (for the most recently available year, which is most frequently 2020 or 2021), and we combine that with data from the 2021 DCH Annual Survey. We estimate the total CB at the hospital level for our base year 2021, inclusive of charity care expense. We must note three points about the data compilation and methods.

First, a fair number of hospitals in the non-profit category (about 34 percent of the 45 NPH in our sample) report CB to the IRS in Schedule H at the system level. Consequently, we disaggregate the system-level CB values reported to IRS into hospital-level estimates using a methodology commonly adopted by previous research (e.g., Herring et al., 2018). Specifically, using hospital-level charity care expenses from the DCH data as our main measure of charity care contributions in our sample, we can trace this measure for 43 of 45 hospitals. We then use the distribution of this variable from the DCH data for a given facility within a system of hospitals to disaggregate the IRS values of seven other CB to obtain these at the hospital level.

Second, Schedule H data from Form 990 is available for 35 out of the 45 NPH in our sample. In terms of the total hospital expenses, these 10 missing hospitals represent about 5.5 percent of the total hospital expenses of the NPH in Georgia in 2021. We imputed the missing CB for hospitals with no Form 990 by using the size of CB predicted by their DCH charity care and total expenses.

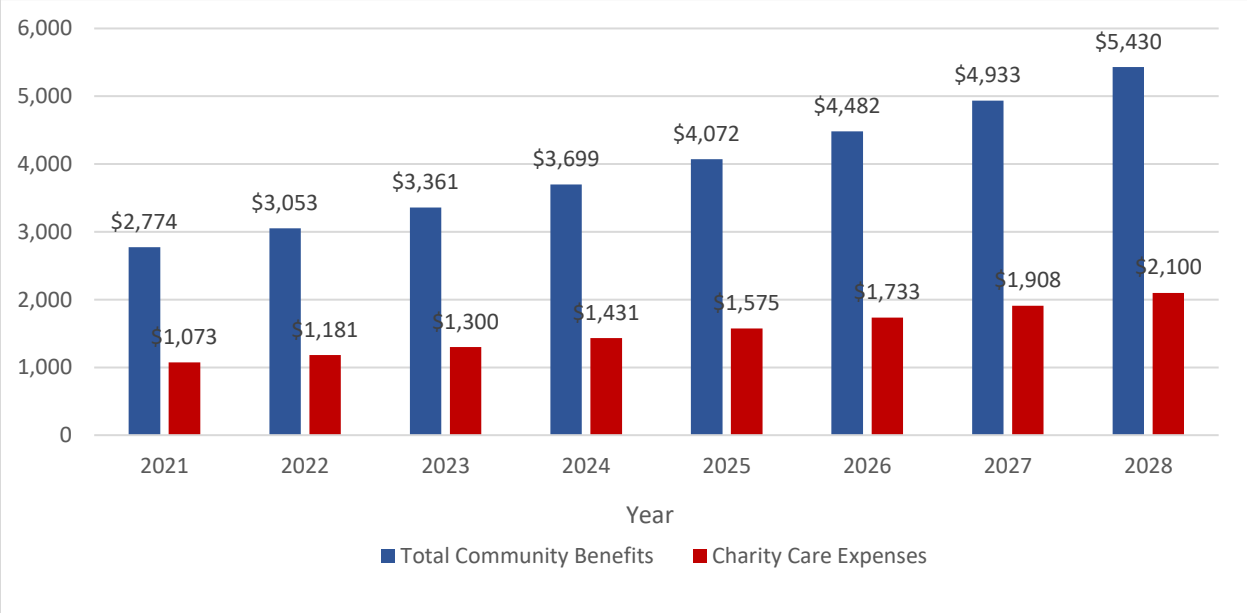
Finally, out of the 35 NPH hospitals for which Form 990 data is available, we collect the most recent year available from either GuideStar or DCH. About 63 percent of the hospitals have data available for 2021, and the rest come from either 2020 (31 percent) or 2019 (6 percent).

With the estimation of total CB for the NPH sample in the base year, we project these benefits through 2028—illustrated in Figure 6 below. To estimate a reliable growth rate for CB, we use panel data from DCH for 2010–21 to identify a combined compound annual growth rate for indigent and charity care expenses. This approach yields an annual growth rate of 10.1 percent, which we use to project charity care as well as the other seven CB values in the next few years.[16]

In the figure below, we show the trend in total CB, inclusive of the eight distinct types as outlined by the IRS (from Table 1, page 4), along with separate illustrations of charity care expenses. Following Herring et al. (2018), we regard the total CB estimates as the upper bound and charity care estimates as the lower bound of the level of CB provided by NPH. The authors argue that it is important to consider whether all eight categories on the IRS list should be compared against the tax exemptions received. For instance, it is not clear if unreimbursed Medicaid and other means-tested program costs should be included as CB, particularly when unreimbursed Medicaid costs are not regarded as CB by the IRS. Furthermore, Herring et al. assert that ambiguity exists around which services should be included in the IRS category of subsidized health services. Finally, they point out that some of the eight benefits may be somewhat self-serving to hospitals by advancing their marketing efforts.

Given its definition and purpose, charity care contributions are regarded as one of the most important CB and are the most frequently tracked component of CB for both NPH and FPH. Additionally, in our sample, charity care expenses comprise about 39 percent of the total CB in the base year 2021—the largest portion of CB.

Figure 6. Community Benefit Estimates of Non-profit Hospitals, 2021–31 (*$ millions*)



[16] We acknowledge that this is a substantial annual rate of growth. It is, however, beyond the scope of this analysis to offer objective reasons as to why this estimate, based on historical data from 2010-21, should be changed.

Geographic Distribution of Community Benefits

Because health care is a fundamental need for all communities in Georgia and is an immobile service, most areas have a hospital, even rural ones. A trend of rural hospital closures is currently being aggressively addressed through DCH and its State Office of Rural Health as well as the Rural Hospital Tax Credit Program. Figure 7 shows the distribution of rural and urban hospitals in Georgia. The marker shape defines the hospital type: a diamond for FPH, plus sign for NPH, triangle for hospital authorities, and star for local governments. The color of the symbol indicates the share of their total spending in 2021 dedicated to charity care, with yellow representing a low percentage, red a high percentage, and orange an intermediate percentage. Figure 8 presents the same information in a detailed view of the Atlanta Metro region.

As the figures illustrate, hospital facilities are clustered in urban areas, particularly central Atlanta. These urban clusters include hospitals of multiple ownership types, while rural areas typically have one facility. Areas of higher incomes are roughly correlated with lower percentages of charity care. Section 9 presents statistical analyses on the predictors of a higher percentage of expenses on charity care across hospital ownership type and tax-exempt status.

Figure 7. Hospital Location by Ownership Type and Percentage of Total Expenses on Charity Care

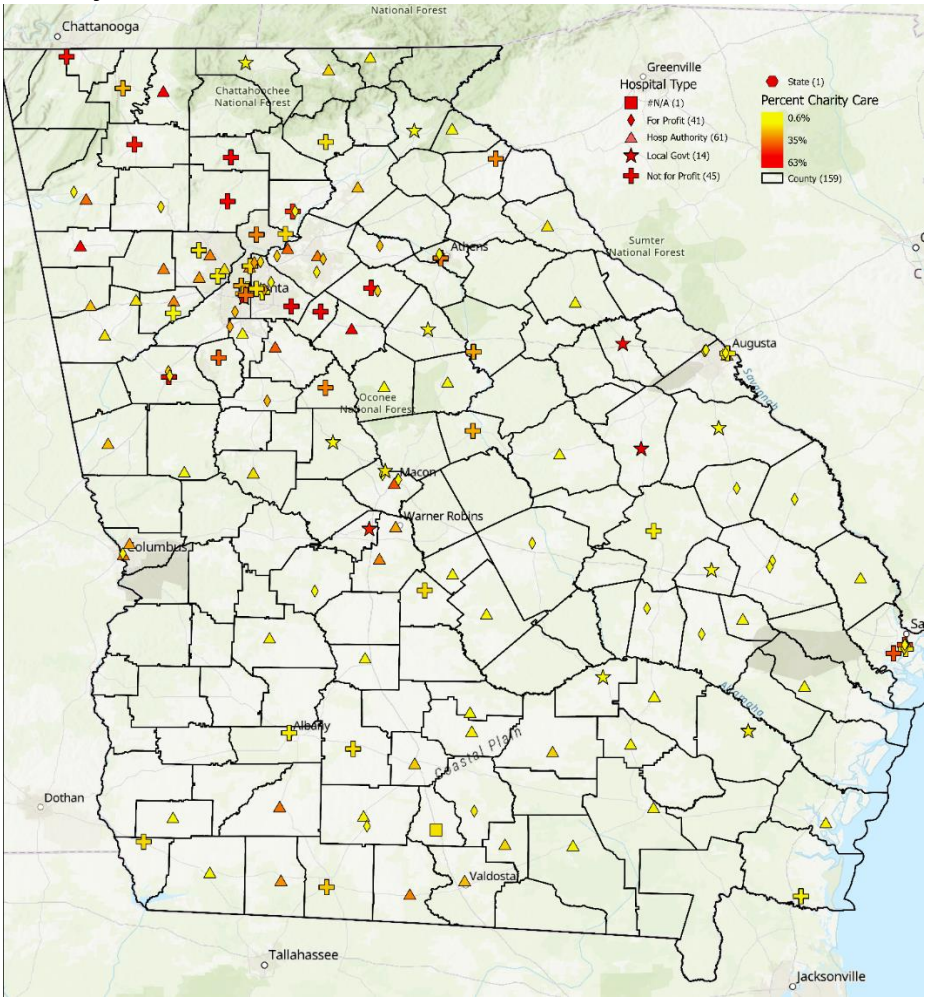
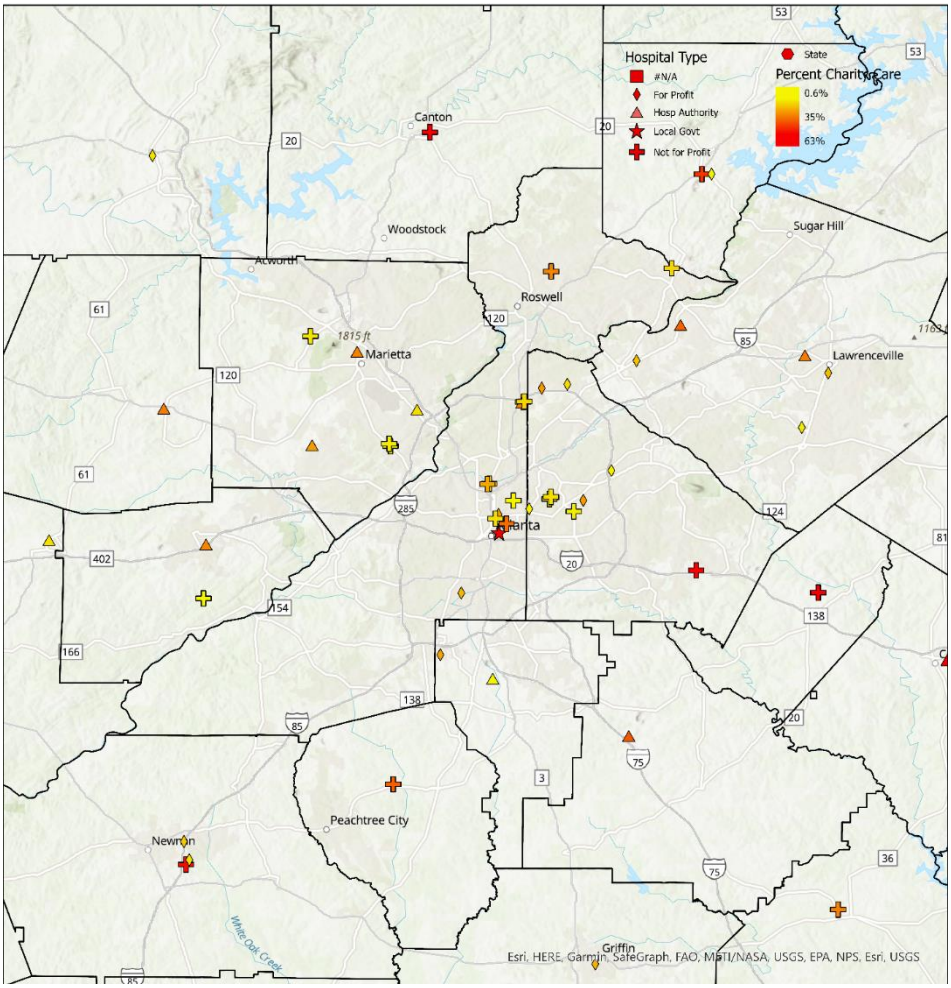


Figure 8. Atlanta Metro Hospital Location by Ownership Type and Percentage of Total Expenses on Charity Care



8. Fiscal Impact: Comparison of Community Benefits and Tax Benefit Costs

We next compare total CB and charity care estimates for NPH to those of FPH to assess the additional amount of CB attributed to hospitals' tax-exempt status. All hospitals provide some amount of CB, but the rationale of comparing CB and tax expenditures rests in the logic that, absent the exemption, hospitals would have less resources to provide CB.

Table 4. Total Community Benefits, Charity Care, and State and Local Tax Exemptions

($ millions)	**Total Community Benefits**	**Total Charity Care**	**Total Tax Exemptions**
2024	$3,699.00	$1,430.70	$263.60
2025	$4,072.00	$1,574.80	$283.10
2026	$4,482.00	$1,733.50	$304.20
2027	$4,933.00	$1,908.10	$327.00
2028	$5,430.00	$2,100.30	$352.00

Notes: These are forecasted values, based on the estimation methodologies adopted in this report.

It is important to note that the cost-benefit analysis conducted here provides net benefit estimates based on only the three types of tax exemptions that exist at the state and local levels (given the focus on a state-level analysis), excluding federal income tax exemptions.

Federal tax exemptions have a substantial impact on hospital budgets and weigh heavily when comparing total hospital taxes exempted and their CB. The focus of our study is the comparison between the fiscal impacts of Georgia's tax treatment of NPH and the CB of those hospitals, which necessarily excludes the impact of federal tax policy. Therefore, any net-benefit findings using data from Table 4 must be interpreted and compared with the previous results with this in mind.

Second, as noted above, investor-owned FPH also provide CB. Therefore, to evaluate the *real economic impact* of these tax exemption policies, we must not only compare levels by tax-exempt status, but also investigate "how much more" CB do NPH provide beyond that provided by FPH. Past literature calls this latter difference incremental non-profit CB (e.g., Herring et al., 2018). Essentially, the difference is attributable to the tax-exempt status of the NPH and warrants comparison against the tax benefits received. We discuss this comparison in detail in the following section.

9. Economic Impact: Comparison of Community Benefits between Non-profit and For-profit Hospitals

The compelling policy question regarding the tax exemption policies granted to NPH is essentially whether tax-exempt hospitals sufficiently contribute to CB and charity care. There are several ways to analyze this. One approach, shown in Section 8, compares total direct costs against benefits of state- and local-level tax exemptions. This method is illustrative of the state and local tax contributions but not overly satisfying, as the large federal income tax exemption is not a part of this analysis. A second approach is to compare "how much more" CB do NPH contribute compared to FPH, estimating the incremental CB attributable to the tax-exempt status (e.g., Herring et al., 2018). To that end, in the manner of prior literature, we do the following here:

A. First, we compare the overall means of CB provisions across hospital ownership types.
B. We then estimate the *incremental* CB for NPH versus FPH, to capture a marginal effect (if any) attributable to the tax-exemptions policies.
C. Next, we compare the CB means by certain hospital characteristics across hospital ownership types.
D. Finally, we empirically explore whether CB expenses differ statistically significantly between NPH and FPH. We examine this while statistically controlling for conventional hospital characteristics commonly found in previous literature to be associated with CB levels.

Average Community Benefits across Hospital Types

We report means across various CB measures specifically available from the DCH data across four hospital types: NPH, FPH, hospital authorities, and government owned. These measures are defined and explained above (see Table 3) and include charity care expenses, indigent care expenses, bad debt, and other free care. When comparing the means of CB reported in this section (and the appendix) with the past literature, two points must be noted. First, past literature

dominantly analyzes the federal-level charity care expense reported in Schedule H of Form 990, while we use more complete, state-level charity care estimates from DCH. The charity care expense from DCH is reported at the full price (i.e., retail price)—in contrast to Form 990 charity care expense, reported at the cost of providing care. Therefore, the former is noticeably bigger in magnitude. Second, the seminal work on the CB contributions of NPH has not been updated since the COVID-19 pandemic. For example, Herring et. al. 2018 analyses charity care and other CB data for 2012. In this report, we analyze data for 2021, and charity care and other CB (like indigent care) measures have grown rapidly since 2012, particularly post-pandemic.[17]

We generate an additional estimate—uncompensated care—that is defined as the sum of charity care and bad debt expenses. Some prior research has emphasized that actual charity care expenses for a hospital tend to be a function of the hospital's own charity care policy and, therefore, a patient's expense may qualify as charity care in one hospital but as bad debt in another (e.g., Valdovinos et al., 2015). Consequently, some researchers have attested that the distinction between charity care and bad debt is contingent on individual hospital charity care policies. With this complementary relationship between charity care and bad debt, it may be insightful to compare an aggregate measure (uncompensated care) that likely captures more comprehensively the amount spent on the low-income and uninsured individuals.

Table 5 below presents the overall means of specific CB measures as a percentage of total expenses for four types of hospitals. We include all the measures available from the DCH data for each hospital type and report the means for base year 2021. Within the measures discussed, charity and uncompensated care have often been the focus of comparisons in previous literature, which has extensively concentrated on the national sample.

For 2021, we have a total of 172 hospital facilities that fall under one of the four ownership types, as outlined in Table 5. More specifically, in this sample we have 45 NPH and FPH each, along with 19 government owned (4 state and 15 local) and 63 hospital authorities. As is evident in the second column of the table, all of the CB and the total expense numbers are missing for two NPH and two FPH in the DCH list of hospitals from FY 2021.

In Table 5, we observe the average charity care expense is highest for NPH and lowest for FPH. This observation is reversed for the other free care expenses. According to relevant research and as argued above, the two most important CB measures—in terms of support for a local community's health care—are charity and indigent care expenses. Comparison of uncompensated care is also meaningful, and the overall mean for charity and uncompensated care is higher for NPH than FPH.

[17] Average charity care expense for NPH in the DCH data grew from 5.4 to 11.14 percent from 2012–21.

Table 5. Average Community Benefits as a Percentage of Total Expense (by Ownership Type)

Ownership Type	Count	Uncompensated Care			Indigent Care	Other Free Care
		Charity Care	Bad Debt	Total		
Non-profit (NPH)	43	11.14	10.9	22.04	8.52	1.51
For-profit (FPH)	43	2.95	10.98	13.93	7.97	10.84
Government (Govt)	19	6.19	22.66	28.84	8.21	2.69
Hospital Authority (HA)	63	7.81	19.86	27.67	10.07	3.64

Note: Total Uncompensated Care = Charity Care + Bad Debt; source: DCH 2021 data for all hospitals

Incremental Community Benefit Estimates

We next estimate the additional contribution that NPH make toward charity care compared to FPH, referred to in the literature as the incremental benefit. As was shown in Table 5, NPH spend 11.14 percent of total expenses on charity care, while FPH spend 2.95 percent. Thus, NPH spend 8.19 percent more as a share of total expenses than the FPH. This percentage represents the incremental amount of charity care provided by NPH and is 73.6 percent of the total NPH average share of 11.14 percent. Consistent with the empirical literature, we deem this incremental amount as the portion of total charity care attributable to the tax-exempt status of NPH.

Table 6 below illustrates total charity care and incremental charity care expense across all hospitals in the state of Georgia. We estimate the incremental charity care for FY 2024 by applying the 73.6 percent to total charity care of $1.43 billion.

Table 6. Incremental Charity Care Attributed to Non-Profit Hospital Status, FY 2024 *($ millions*)

Charity Care – Total	Incremental Charity Care Share	Charity Care – Incremental
$1,430.7	73.6 precent	$1,053.10

Source: DCH data and authors' calculations
Note: Values in nominal dollars

This estimate of the incremental benefit of charity care provided by NPH relies on the difference in means estimated from 43 NPH hospitals and 43 FPH, as shown in Table 5. This methodology assumes that the means for both groups of hospitals are representative of the population and that any variance in hospital characteristics—such as size, location, or type—is distributed in such a way as not to create bias. (Statistically, we assume a normal distribution of these characteristics.) In the next section, we offer additional statistical analyses based on the empirical literature to test for potential biases in the data and confirm whether the use of the differences in means shown Table 6 is appropriate.

Average Community Benefits by Hospital Characteristics

To better understand the characteristics of NPH and FPH, we examine different measures of CB found in the DCH data for three attributes. Table 7 below presents the means of CB broken out by these three attributes, found to be relevant in the academic literature:

A. *Size* (measured by the number of beds)

B. *Region* (urban versus rural county)

C. *Hospital Category* (general versus other—where other includes general cancer hospital, psychiatric, psychiatric extended care, specialty, and state specialty—as classified by DCH)

For instance, Brusch and Bellamy (2021) empirically compare the community levels of NPH versus FPH using a 2018 national sample of hospitals from CMS. Their results demonstrate the sole instance in which the mean percentage of charity care significantly differs between FPH and NPH occurs within the large-sized hospital category, with FPH surpassing their non-profit counterparts by 1.11 percentage points. Similarly, Zare et al. (2022), also based on a national sample, explores numerous hospital characteristics that could relate to CB levels. Among other things, they identify size (based on hospital beds), region as indicative of poverty-level, and system affiliation to be statistically relevant.

Table 7. Average Community Benefits (as a Percentage of Total Expense)

	Count	Charity Care	Indigent Care	Bad Debt	Other Free Care	Uncompen-sated care
Size: Small (Beds 0 to 49)						
NPH	3	8.18	30.47	16.29	2.27	24.47
FPH	8	0.95	0.72	10.73	15.1	11.68
Government	7	8.03	5.98	20.33	0.31	28.36
Hospital Authority	17	7.05	4.48	21.05	3.41	28.09
Size: Medium (Beds 50 to 199)						
NPH	22	12.61	3.92	11.63	1.61	24.24
FPH	28	3.35	8.53	9.63	7.99	12.98
Government	9	1.76	7.55	22.83	3.43	24.59
Hospital Authority	27	6.34	10.19	21.43	3.97	27.77
Size: Large (Beds 200+)						
NPH	18	9.85	10.47	9.11	1.26	18.95
FPH	6	4.23	16.2	14.04	19.03	18.27
Government	2	22.36	19.29	22.02	8.99	44.38
Hospital Authority	19	10.59	14.9	16.55	3.36	27.15
Region: Rural						
NPH	10	9.52	14	17.49	3.06	27.01
FPH	8	0.44	5.74	19.99	7.51	20.43
Government	15	4.69	6.86	25.31	2.17	30
Hospital Authority	36	5.34	6.68	22.66	4.49	27.99
Region: Urban						
NPH	33	11.64	6.85	8.9	1.04	20.54
FPH	35	3.52	8.48	8.92	11.61	12.44

Government	4	11.82	13.3	12.7	4.6	24.52
Hospital Authority	27	11.12	14.59	16.12	2.49	27.24
Category: General						
NPH	34	13.61	10.46	12.71	1.53	26.32
FPH	19	2.36	14.36	19.77	18.09	22.13
Government	16	6.79	9.62	26.72	3.18	33.51
Hospital Authority	62	7.89	10.19	20.12	3.7	28
Category: Other						
NPH	9	1.82	1.18	4.06	1.42	5.87
FPH	24	3.41	2.91	4.03	5.1	7.43
Government	3	2.96	0.73	0.97	0.04	3.93
Hospital Authority	1	3.43	2.92	3.73	0	7.16

We examine means stratified by size, urban vs. rural region, and general vs. other hospital type, primarily looking at the relationship to charity and uncompensated care. In our discussion of the means across these characteristics, we focus on comparing NPH and FPH, as it is the key area of interest here.

We note that while there is a great deal of variation in the share of indigent care provided, it appears to be more related to local economic factors as opposed to hospital policy. Table 5 above supports this, suggesting that in aggregate the share of indigent care across hospital types is similar.

Hospital Size

Starting with the hospital size, it appears to be a key indicator of charity care provision for FPH. While there are eight small FPH and only three small NPH, the small FPH provide only 1 percent of total expenses as charity care, compared to 8 percent in NPH. For uncompensated care, NPH, government, and hospital authority hospitals have similar shares, ranging from 25–29 percent, but the FPH share of uncompensated care is considerably smaller, at about 12 percent.

Among the medium sized hospitals, the distribution of charity care for NPH and FPH is similar to that of small hospitals—NPH at about 13 percent and FPH at about 3 percent. Note there are 28 medium size FPH and 22 NPH in this category. The percentage of uncompensated care shares for medium hospitals are also similar to small hospitals.

With regard to large hospitals (200+ beds), considerable variation is seen across hospital types. Eighteen NPH provide on average a roughly 10-percent share of expenses to charity care. By contrast, six FPH of this size use 4 percent of expenses for charity care. Despite a smaller share of charity care, FPH and NPH provide about the same level of uncompensated care, about 19 percent. Government hospitals, on the other hand, provide a tremendous amount of uncompensated care—a 44-percent share of total expenses; however, there are only two such hospitals in the state. Note most of the large hospitals in the state are in the Atlanta Metro area (see Figures 7 and 8).

Urban vs. Rural

Examining urban versus rural regions further illustrates the differences in charity care and uncompensated care shares provided by FPH and NPH. Because urban hospitals are more likely to be large hospitals, the urban-rural data falls along similar lines. Rural FPH provide 0.4 percent of total expenses to charity care, compared to almost 10 percent for rural NPH.

General vs. Other Hospital Services

Perhaps the biggest distinction amongst hospitals in terms of charity care and uncompensated care is that of category, general versus other. In the general category, NPH provide the highest levels of charity and uncompensated care at 14 and 26 percent, respectively. General FPH also provide relatively high levels of uncompensated care (22 percent). Another point to note is that most NPH, government, and hospital authorities tend to be general hospitals. Specifically, from Table 2 these account for 90 percent of the total. FPH meanwhile have a larger number of non-general, or other, type, with 55 percent of all FPH falling in this category. Other-type hospitals provide low levels of uncompensated care in the range of 4 to 7 percent, with the FPH at the top of this range. The type and nature of care that general hospitals provide, however, naturally necessitates providing more uncompensated care (see Figures 7 and 8 for hospital locations).

FPH also provide substantially more other free care than NPH. This type of uncompensated care is a result of employee discounts, administrative adjustments, courtesy discounts, and small bills or other similar write-offs. None of the above are based on a patient's ability to pay and thus are not a good proxy for a hospital's effort to help lower-income individuals pay for medical care.

Finally, outside of charity and uncompensated care, it is also informative to consider average bad debt (as a percentage of total expense), particularly with respect to rural hospitals, which have the highest shares of bad debt—between 18 and 20 percent for NPH and FPH, respectively. Bad debt levels are also high for hospital authorities and government hospitals at 27 and 25 percent, respectively. Moreover, rural areas have fewer hospitals compared to urban areas, with 10 NPH in rural areas versus 33 in urban areas, similar to the distribution of FPH that have eight in a rural setting and 35 in urban areas. As the final point regarding the bad debt metric, the distribution of uncompensated care in urban hospitals is similar to that of medium-size hospitals, with FPH at about a 12-percent share and the three other hospital types ranging from 20 to 27 percent.

In summary, it appears from Table 6 that NPH provide, on average, more charity and uncompensated care than FPH—with the exception in the other hospital category, in which FPH provide more charity and uncompensated care than NPH. However, the shares provided are low, and there are only a few NPH in the other hospital category.

Empirical Analysis of Community Benefits and Hospital Ownership Type

Overall, Table 7 shows intuitively the distributions in important categories of hospitals and how NPH versus FPH differ in the provision of certain CB based on similar attributes. It is still possible, though, that various confounding factors related to size, region, and hospital type are influencing these observations. To better isolate the influence of these various factors, we use more robust statistical techniques.

We estimate hospital-level ordinary least squares (OLS) regression results for NPH and FPH hospitals, as well as the three notable characteristics from the academic literature: size, location, and the hospital category. Using the OLS regression, we can focus on the impact of each characteristic, holding the others constant. We illustrate these OLS regressions for three outcome variables from Table 5. It is important to note that these results must be interpreted cautiously, given the limited amount of data in our statistical analysis. We analyze a single year of data (2021), which limits the number of hospital-level observations and limits how broadly we can apply these results. Thus, we think of the results presented in Table 7 as additional evidence to support the other pieces of analysis above (for a complete discussion of our regressions, see Table A1 in the Appendix).

Table 8 shows a summary of these regressions focusing on variables that are statistically significant across the different specifications. The table shows the results for the regressions with charity care, indigent care, and bad debt as our dependent variables—all measured as the percentage of total expenses. The first coefficient on the NPH versus FPH variable in Table 8 illustrates the relationship of NPH to FPH. For instance, examining NPH versus FPH shows that NPH on average provide 6.7 percent more charity care (as a proportion of total expense) than FPH. This coefficient is statistically significant at the 99-percent level, so we can have high confidence in the point value of this estimate.

Table 8. Summary of Regression Analysis of Community Benefit Levels and Tax-exempt Status

	Dependent Variables		
Variables	**Charity Care only**	**Indigent Care only**	**Bad Debt**
NPH vs. FPH	6.7***	NS	-4.2*
Large vs. Small Size	NS	NS	NS
Urban	7.1***	NS	-5.7**
General Category	6.9***	11.5***	13.1***

Stata levels of statistical significance: * 90%; ** 95%; *** 99%; NS (not significant)

We also include the hospital size variable (large versus small), as Table 7 showed differences in the provision of charity care depending on size. The size of the hospital does not appear to play a role independent of other elements—in the level of provision of charity care or any other measures of interest.

The urban and rural distinction appears important in the provision of charity care, as well as bad debt. Urban hospitals on average provide 7 percent more charity care as a percentage of total expense than rural hospitals, and they have less bad debt—about 5.7 percent lower as a share of expenses than rural hospitals.

The variable with the largest and most consistent effects is hospital category or type. General hospitals, as one would expect due to the nature of the medical care they provide, spend a considerably higher share of their expenses in all metrics for CB. Note that all coefficients shown here are statistically significant and range from 7 to 13 percent. This is the only variable in Table 8 that has an impact on the provision of indigent care. As noted earlier, the amount of indigent care provided is likely determined by factors outside of the hospital's control, with an exception of being a general services hospital. We discuss these factors further in the Appendix.

There are several reasons why urban-based and the general-category hospitals may have a large impact on the provision of charity care per expenditure. Urban area hospitals see more patients than rural hospitals, and the likelihood of seeing a patient without insurance is also greater in urban areas. Moreover, insurance likely plays a key role in the need to provide charity care. For general-purpose hospitals, the presence of an emergency room (ER) and the number of visits it receives is likely to impact charity care. ER care is quite expensive, and in many cases those who end up in the ER do not have insurance.

To test these intuitions, we run another OLS specification that includes variables for insurance status, ER visits, and Medicaid enrollment, as well as other control variables from literature that

have been shown to be relevant. These results are provided and discussed in the Appendix (see Table A2), and they support the intuitions above.

In summary, even though our regression specifications are mostly suggestive in nature, our findings from Table 8 and the Appendix provide support for the means calculated in Table 5. In general, Table 5 shows that NPH provide, on average, roughly 8 percent more charity care as a share of expenses than FPH. Our regression results, using various specifications, show approximately 7 percent.

10. Ownership Changes, Mergers, and Acquisitions

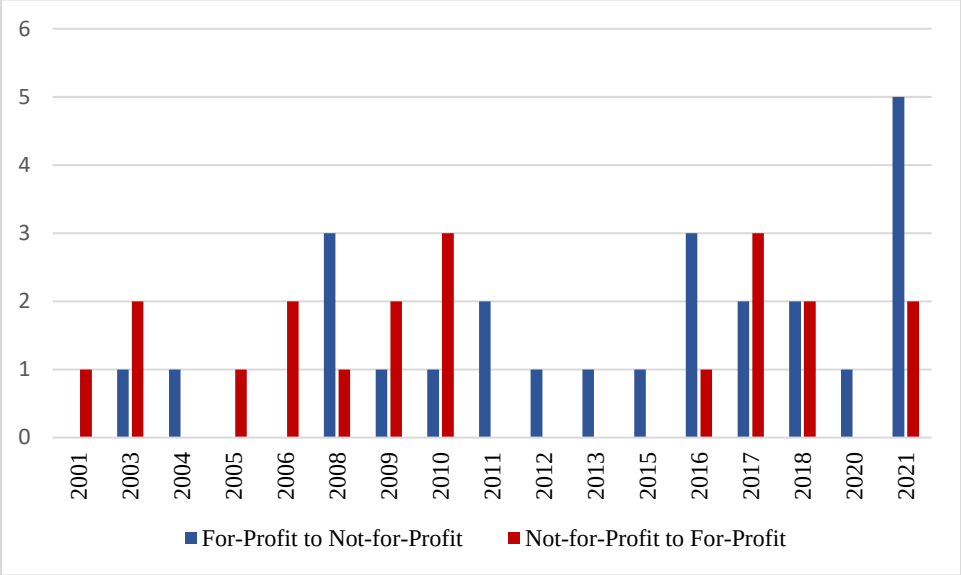
Changes in the type of ownership of a hospital have implications for state and local taxation. When a hospital's ownership changes from a FPH with shareholders to a NPH, a formerly taxable business becomes exempt, with implications for tax revenues. The history of hospitals in Georgia includes many changes in ownership type, with hospitals changing into and out of tax-exempt status. These transitions could also impact the provision of CB, as new NPH could use additional resources towards CB. After verifying their federal income tax exemption with DOR, hospitals transitioning into non-profit status gain exemption from property taxes via § 48-5-41(5), income tax via § 48-7-25(a), and state and local sales taxes via § 48-8-3(7).

Over the past two decades, and especially since the passing of the ACA, hospital merger and acquisition activity has significantly increased.[18] This consolidation is driven by the pursuit of economies of scale. This trend is important for two reasons: first, a variety of empirical evidence has shown consolidation in the healthcare market to be associated with increased prices but no corresponding increase in quality.[19] Second, when these mergers take place between hospitals with different tax treatment, there may be a large effect on the local tax base (see, e.g., Bell, 2020). For example, if a FPH, subject to local property tax, becomes a NPH and gains tax exempt status, the associated local government will no longer be able to collect tax on the hospital's property value. This has become a topic of increased importance at both the federal and state levels. In 2018, a Philadelphia area hospital was converted from FPH to NPH following a merger. This change in tax status lowered a local school district's operating budget by $900,000.[20] The school system appealed the hospital's nonprofit status and had it overturned.

This larger trend of hospital consolidation is present in Georgia as well. The DCH annual survey covers ownership and ownership type and can be used to catalogue year-over-year changes impacting tax revenues. Based on these data, there have been 25 instances of a FPH facility changing ownership into a tax-exempt NPH or hospital authority-owned hospital. These were more likely to occur since 2010 and peaked with five such changes between 2020 and 2021. There were 20 instances where a NPH or hospital authority-owned hospital changed ownership into a FPH—more common before 2011 with a peak of three such changes between 2009 and 2010 (see Figure 9).

[18] Press, 2023.
[19] Godwin et al., 2023.
[20] Miller & Hawryluk, 2023.

Figure 9. Number of Hospital Ownership Changes that Impacted State and Local Revenues



Some notable examples include an August 2023 transaction in which the University Health System signed a letter of intent to join the Marietta-based non-profit WellStar Health System. Following the acquisition, WellStar assumed control of the 478-bed Augusta University Medical Center and 154-bed Children's Hospital of Georgia, as well as the rights to build a 100-bed hospital in suburban Augusta.[21] WellStar also took over Roosevelt Warm Springs Rehabilitation and Specialty Hospitals.

In 2021, the for-profit, Nashville-based Hospital Corporation of America (HCA) sold four Georgia Hospitals to the non-profit Piedmont Healthcare: the Eastside Medical Center in Snellville; the Cartersville Medical Center; and the two-hospital Coliseum Health System in Macon, including the Coliseum Medical Centers and Coliseum Northside.[22] Following the merger, these hospitals were renamed Piedmont Eastside Medical Center, Piedmont Cartersville Medical Center, Piedmont Macon Medical Center, and Piedmont Macon North Hospital, respectively.

In 2015, non-profit WellStar purchased five metro Atlanta hospitals from for-profit Tenet Healthcare for $575 million. In this deal, WellStar acquired North Fulton Hospital in Roswell, Spalding Regional Hospital in Griffin, Sylvan Grove Hospital in Jackson, Atlanta Medical Center and its South Campus, and Tenet's physician practices in Atlanta. These acquisitions resulted in WellStar becoming the largest health system in Georgia at the time.[23]

The state and local tax implications of such deals are complex. For property and sales tax exemptions, transitions would be immediately effective, though the applicability of exemptions for individual hospitals has been challenged in court. For the state income tax, the transition would be less clear and would depend on the ownership structure involved before and after the sale, as well as the hospital margins involved. Our estimates suggest the average NPH would

[21] Amy, 2023b.
[22] Paavola, 2021.
[23] Miller, 2015.

have spent about 2 percent of its total expenses on state and local taxes in Georgia, absent its current exempt status. In each of these instances of a tax-impactful ownership change, it can be assumed that approximately the relevant share of a NPH total expenses were either added to the state and local tax rolls or exempted from it.

11. Conclusion

Our primary objective is to assess the cost-effectiveness of the tax exemptions granted to private NPH at both the state and local levels within the State of Georgia, in relation to their CB contributions. To accomplish this, we consolidate data extracted from IRS Form 990 and DCH data to calculate the net direct CB provided by these NPH.

Furthermore, in alignment with previous research, we compare the CB levels of NPH to those of FPH and examine whether any observed differences hold statistical significance. Moreover, we calculate the incremental CB provided by NPH to illustrate the extent to which they offer additional benefits beyond what FPH provide. This analysis is also valuable, considering that FPH have economic tax policy incentives to provide CB, as these are fully tax deductible.

We find that, on average, NPH provide more charity care and uncompensated care as a percentage of total expenses than FPH. In terms of the incremental CB, about 74 percent of NPH charity care can be deemed incremental, due to the nonprofit designation. Because the data used to estimate these effects are limited to one year and roughly 86 total hospitals, we are cautious in making broad conclusions. However, for 2021 the data and our analysis support a finding that, on average, NPH provide enough additional CB as compared to FPH, supporting the intended policy goal of helping low-income Georgians access health care.

Appendix

In this appendix, we discuss in greater detail the hospital-level ordinary least squares (OLS) regression results for the four hospital types, as well as the three notable characteristics from the literature: size, location, and the hospital category. Using the OLS regression, we can focus on the impact of each characteristic, holding the others constant. Again, these results must be taken cautiously, given the data limitations in that we analyze a single year of data (2021), which limits the number of hospital-level observations and thus the power of our inference and how generalizable the results might be.

As Table A1 shows, we ran regressions with charity care, indigent care, bad debt, and uncompensated care as our dependent variables—all measured as the percentage of total expenses. The charity and uncompensated care results (columns 1 and 4) are ones typically found in prior research and are therefore readily comparable to other studies.

The first three coefficients on the variables in Table A1 illustrate the relationship of NPH, government hospitals, and health authorities relative to FPH. For instance, examining NPH versus FPH shows that NPH on average provide 6.7 percent more charity care (as a proportion of total expense) than FPH. This coefficient is statistically significant at the 99-percent level, so we can have high confidence in this estimate.

Next, comparing government and hospital authorities to FPH, the point estimates are not statistically significant at traditional levels. However, using standard errors, we can conclude that the coefficients are very likely positive, our expected sign. This appears to show that government hospitals and hospital authorities provide more charity care than FPH, holding many other hospital characteristics and admission data constant.

The size of the hospital does not appear to play a role independent of other elements, in the level of provision of charity care, or any of the other care measures of interest.

The urban and rural distinction appears important in the provision of charity care as well as bad debt. Urban hospitals on average provide 7 percent more charity care as a percentage of total expense than rural hospitals, and their bad debt is 5.7 percent lower.

Table A1. Regression Analysis of Community Benefit Levels and Tax-exempt Status

	Dependent Variable			
Variables	**(1) Charity Care only**	**(2) Indigent Care only**	**(3) Bad Debt**	**(4) Uncompensated Care**
NPH vs FPH	6.5728***	-4.5091	-4.2219*	2.3509
	(2.1982)	(2.97)	(2.4895)	(3.50)
Govt vs FPH	4.6066	-1.7476	3.1247	7.7313*
	(2.8838)	(3.90)	(3.2660)	(4.60)
HA vs FPH	3.9104*	-3.1376	0.5444	4.4547
	(2.2314)	(3.02)	(2.5272)	(3.56)
Medium size vs. small	-0.7299	2.5116	2.8615	2.1317
	(1.9978)	(2.70)	(2.2626)	(3.18)
Large size vs. small	-2.7918	4.6431	0.3919	-2.3999
	(2.6495)	(3.58)	(3.0007)	(4.22)
Urban	7.0702***	3.7895	-5.7227**	1.3476
	(2.0705)	(2.80)	(2.3449)	(3.30)
General Category	6.9311***	11.4794***	13.1058***	20.0370***
	(2.2699)	(3.07)	(2.5708)	(3.62)

Constant	-4.7925*	-2.1890	7.5211**	2.7286
	(2.7834)	(3.76)	(3.1523)	(4.44)
Observations	**166**	**166**	**166**	**166**
R-squared	**0.175**	**0.129**	**0.347**	**0.273**

Stata levels of Statistical significance: * 90% ** 95% *** 99%

Notes: Standard errors are in parentheses. We also ran regressions with and without the inclusion of the teaching status of the hospital as a predictor, given its importance in previous literature (e.g., Brusch and Bellamy, 2021; Zare et al., 2022). The results do not change across the two specifications. Source: DCH data from 2021 annual questionnaire. NPH: Non-profit; FPH: is For-profit; Govt: Government owned; HA: Hospital Authority.

The category with the largest and most consistent effects is hospital category. General hospitals, as one would expect due to the nature of the medical care they provide, spend a considerably higher share of their expenses in all four metrics for CB. Note all of these coefficients are statistically significant and range from 7 to 20 percent.

This is the only variable in Table A1 that has an impact on the provision of indigent care. As we noted earlier, the amount of indigent care provided is likely determined by factors outside of the hospital's control, with the exception of being a general services hospital. The fact that all the other various control variables when considered together are not statistically significant supports this claim. As we show in Table A2, the only factor that has an impact on indigent care spending is the share of ER visits relative to total admissions.

There are several reasons why urban-based and the general-category hospitals may have a large impact on the provision of charity care per expenditure. Urban area hospitals see more patients than rural hospitals, and the likelihood of seeing a patient without insurance is also greater in urban areas. Moreover, insurance likely plays a key role in the need to provide charity care. For general-purpose hospitals, the presence of an ER and the number of visits it receives is likely to impact charity care. ER care is quite expensive, and in many cases those who end up in the ER do not have insurance.

To test these intuitions, we run another OLS specification that includes variables for insurance status, ER visits, and Medicaid enrollment, as well as other control variables from the academic literature that have been shown to be relevant. These results are provided in the Table A2. Briefly, we find that the coefficients of ER visits, percentage of uninsured patients, and percentage of Medicaid admissions are statistically significant and have the appropriate signs, providing some empirical evidence to support our intuition on the factors behind the importance of urban versus rural and general hospital category.

Table A2. Regression Analysis of Community Benefit Levels and Tax-exempt Status

	Dependent Variable				
	(1)	(2)	(3)	(4)	(5)
Variables	**Charity Care only**	**Indigent Care only**	**Charity and Indigent Care**	**Bad Debt**	**Uncompensated Care**
NPH vs FP	**6.7140*** **	**-2.6116**	**4.0799**	**-3.1074**	**3.6067**
	(2.2050)	**(2.83)**	**(3.42)**	**(2.53)**	**(3.42)**
Govt vs FP	3.7743	-4.4540	-0.4753	1.5820	5.3563
	(2.8819)	(3.70)	(4.53)	(3.30)	(4.48)
HA vs FP	2.5977	-4.5837	-1.9857	-0.1695	2.4281
	(2.1883)	(2.81)	(3.39)	(2.51)	(3.40)
Medium vs. small size	-1.6743	0.2998	-1.2590	2.8232	1.1489
	(1.9938)	(2.56)	(3.12)	(2.29)	(3.10)
Large vs. small size	-5.5047*	-1.0276	-6.4158	1.5569	-3.9478
	(3.0630)	(3.93)	(4.76)	(3.51)	(4.76)
Urban	3.2999	-1.5612	1.7300	-5.3065*	-2.0065
	(2.3889)	(3.07)	(3.70)	(2.74)	(3.71)
General Category	-2.1760	2.2683	0.2741	7.4812**	5.3052
	(3.1651)	(4.06)	(4.95)	(3.63)	(4.92)
System Affiliated	2.9783	-4.3187	-1.3507	-1.3835	1.5948
	(2.1302)	(2.73)	(3.30)	(2.44)	(3.31)
If there is an OB	-0.3934	-0.0693	-0.4884	-1.5139	-1.9073
	(2.0389)	(2.62)	(3.16)	(2.34)	(3.17)
If Open	-4.1124	-4.0269	-8.1472*	-3.1457	-7.2581
Heart Procedures	(2.9085)	(3.73)	(4.50)	(3.33)	(4.52)
Percent Minority	-0.0966**	0.0085	-0.0849	0.0345	-0.0621
Admissions	(0.0462)	(0.06)	(0.07)	(0.05)	(0.07)
Percent Medicaid	-0.0922*	-0.0539	-0.1472*	-0.1207**	-0.2129***
Admissions	(0.0519)	(0.07)	(0.08)	(0.06)	(0.08)
ER Visits	0.0002***	0.0002***	0.0004***	-0.0000	0.0002*
	(0.0001)	(0.00)	(0.00)	(0.00)	(0.00)
Percent Uninsured	0.4535**	0.4556	0.8983***	1.0869***	1.5404***
Admissions	(0.2169)	(0.28)	(0.34)	(0.25)	(0.34)
Constant	3.5794	3.6833	7.0766	7.1601*	10.7395*
	(3.5328)	(4.53)	(5.52)	(4.05)	(5.49)
Observations	**159**	**159**	**158**	**159**	**159**
R-squared	**0.303**	**0.269**	**0.408**	**0.412**	**0.393**

Notes: Standard errors are in parentheses

Stata levels of Statistical significance: * 90% ** 95% *** 99%

In summary, even though our regression results are mostly suggestive in nature, our findings from Tables A1 and A2 provide additional evidence to support the difference in means used to estimate the amount of incremental care due to a hospitals nonprofit status. These results are also in line with the only similar state-level study in the literature discussed (i.e., Valdovinos et al., 2015). Recall, this study compares charity and uncompensated care spending of NPH versus FPH using aggregate measures on general acute care hospitals in California over 2011–13. They find a statistically significant difference in the mean charity care spending as a percentage of

total operating expenses, with NPH outperforming FPH. In addition, they find the presence of an ER and higher admission rates of uninsured and minority patients to be significantly correlated to charity and uncompensated care provision. These are the primary predictors that prove significant in our analysis as well (see Table A2).

Next, we present hospital-level data for each of the 172 hospitals in our sample in the year 2021, as identified from DCH data. We illustrate the hospital-level information across two appendix tables—A3 and A4—depending on whether CB data is available for them from Schedule H in the IRS Form 990.

Our sample consists of 45 NPH, and we find CB data from Schedule H (for a recent year) for 35 of these hospitals. Appendix Table A3 below presents hospital-level data for these NPH with IRS 990 data availability. Additionally, we have a total of 63 hospital authorities (Has) in our sample. These hospital types are not required to file Schedule H in Form 990 to the IRS, but they frequently do so. We find Schedule H data for 39 out of the 63 HAs and report data for these hospitals in Appendix Table A3.

The first data column of total CB (as a percentage of the hospital's total expenses) identifies the sum of CB across the eight distinct types outlined in Schedule H of IRS Form 990. Charity care (as defined in the main report) is one of the eight components of CB, and data corresponding to it is obtained from Georgia's Department of Community Health (DCH) for 2021. The remaining seven CB values come from IRS Form 990. These eight CB are the reporting standards that NPH must follow and report annually to the IRS through Schedule H, Part I of Form 990.

In addition to data on total CB, we report information on each hospital's size (following the size criteria from Table 6, where we use the information on the number of hospital beds from the DCH data to classify a hospital as small, medium, or large), whether the hospital is in an urban or rural region, ownership type, whether the hospital category is general or other (again following Table 6 in the report), and finally, state and local tax expenditure as a percentage of the total expense of the hospital. The latter number is reported if the ownership type is NPH.

Table A3. Data for Hospitals with Availability of Schedule H, IRS Form 990

Hospital Name	Total CB	Size	Urban/ Rural	Ownership Type	Category	Tax Exp
Advent Health Gordon	32.10	Medium	Urban	NPH	General	2.08
Advent Health Murray	76.22	Small	Rural	HA	General	
Bacon County Hospital	2.26	Small	Rural	HA	General	
Brooks County Hospital	33.38	Small	Rural	HA	General	
Candler Hospital	22.90	Large	Urban	NPH	General	2.48
Chatuge Regional Hospital	1.36	Small	Rural	HA	General	
CHI Memorial Hospital Georgia	29.78	Medium	Urban	NPH	General	1.27
Children's Healthcare of Atlanta at Egleston	27.94	Large	Urban	NPH	General	3.33
Children's Healthcare of Atlanta at Scottish Rite	23.55	Large	Urban	NPH	General	3.20
Coffee Regional Medical Center	6.39	Medium	Rural	HA	General	
Crisp Regional Hospital	18.33	Medium	Rural	HA	General	

Donalsonville Hospital, Inc.	4.45	Medium	Rural	NPH	General	1.76
Effingham Health System	4.19	Small	Urban	HA	General	
Emory Hillandale Hospital	87.21	Medium	Urban	NPH	General	1.32
Emory Johns Creek Hospital	11.11	Medium	Urban	NPH	General	3.15
Emory Long Term Acute Care	3.80	Medium	Urban	NPH	Other	1.79
Emory Saint Joseph's Hospital of Atlanta	10.75	Large	Urban	NPH	General	1.52
Emory University Hospital	48.56	Large	Urban	NPH	General	1.75
Emory University Hospital Midtown	41.60	Large	Urban	NPH	General	1.88
Emory University Hospital Smyrna	20.69	Medium	Urban	NPH	General	5.82
Evans Memorial Hospital	5.73	Small	Rural	HA	General	
Floyd Medical Center	18.92	Large	Urban	HA	General	
Grady General Hospital	28.65	Medium	Rural	HA	General	
Gwinnett Medical Center - Duluth	20.92	Medium	Urban	HA	General	
Hamilton Medical Center	12.44	Large	Urban	NPH	General	2.43
Hillside, Inc.	3.59	Medium	Urban	NPH	Other	2.37
Houston Medical Center	13.29	Large	Urban	HA	General	
Jasper Memorial Hospital	6.58	Small	Rural	HA	General	
John D. Archbold Memorial Hospital	14.96	Large	Rural	NPH	General	3.09
Medical Center, Navicent Health, The	19.36	Large	Urban	HA	General	
Mitchell County Hospital	37.34	Small	Rural	HA	General	
Navicent Health Baldwin	11.45	Medium	Rural	HA	General	
Northeast Georgia Medical Center Lumpkin	5.77	Medium	Rural	NPH	General	1.23
Northside Hospital	17.44	Large	Urban	HA	General	
Northside Hospital Cherokee	35.10	Large	Urban	NPH	General	1.92
Northside Hospital Forsyth	27.53	Large	Urban	NPH	General	2.13
Northside Hospital Gwinnett	17.45	Large	Urban	HA	General	
Perry Hospital	18.54	Small	Urban	HA	General	
Phoebe Putney Memorial Hospital	6.76	Large	Urban	NPH	General	1.32
Phoebe Sumter Medical Center	8.47	Medium	Rural	HA	General	
Piedmont Athens Regional Medical Center	31.24	Large	Urban	HA	General	
Piedmont Columbus Regional Midtown	16.97	Large	Urban	HA	General	
Piedmont Columbus Regional Northside	11.41	Medium	Urban	HA	General	
Piedmont Fayette Hospital	19.15	Large	Urban	NPH	General	2.40
Piedmont Henry Hospital, Inc	19.87	Large	Urban	HA	General	
Piedmont Hospital	11.07	Large	Urban	NPH	General	2.84
Piedmont Mountainside Medical Center	39.81	Medium	Rural	NPH	General	1.57
Piedmont Newnan Hospital	28.84	Medium	Urban	NPH	General	2.30
Piedmont Newton Hospital	31.38	Medium	Urban	HA	General	
Piedmont Rockdale Hospital	30.10	Medium	Urban	NPH	General	0.84
Piedmont Walton Hospital	39.07	Medium	Urban	NPH	General	1.81
Polk Medical Center	40.09	Medium	Rural	HA	General	

Saint Joseph's Hospital	22.59	Large	Urban	NPH	General	1.85
Shepherd Center	6.63	Medium	Urban	NPH	Other	3.09
Southeast Georgia Health System - Camden Campus	4.22	Small	Rural	NPH	General	1.38
Southeast Georgia Health System-Brunswick Campus	4.92	Large	Urban	HA	General	
St Mary's Hospital	17.50	Medium	Urban	NPH	General	1.94
St. Mary's Good Samaritan Hospital	9.73	Small	Rural	NPH	General	2.35
St. Mary's Sacred Heart Hospital	14.10	Medium	Rural	NPH	General	2.24
Stephens County Hospital	0.55	Medium	Rural	HA	General	
Tanner Medical Center-Carrollton	10.53	Medium	Urban	HA	General	
Taylor Regional Hospital	5.68	Medium	Rural	NPH	General	2.64
Tift Regional Medical Center	7.85	Large	Rural	HA	General	
Union General Hospital	4.73	Small	Rural	HA	General	
University Hospital	13.59	Large	Urban	HA	General	
Upson Regional Medical Center	14.64	Medium	Rural	HA	General	
Warm Springs Medical Center	0.05	Small	Rural	HA	General	
Wellstar Cobb Hospital	14.58	Large	Urban	HA	General	
Wellstar Douglas Hospital	16.62	Medium	Urban	HA	General	
Wellstar Kennestone Hospital	18.12	Large	Urban	HA	General	
Wellstar North Fulton Hospital	17.69	Large	Urban	NPH	General	2.09
Wellstar Paulding Hospital	18.42	Medium	Urban	HA	General	
Wellstar Sylvan Grove Hospital	21.54	Small	Rural	NPH	General	1.05
Wellstar West Georgia Medical Center	12.67	Large	Urban	HA	General	

Notes: Total CB number in the table is the sum across the eight distinct CB that are reported in the Schedule H of Form 990. Charity care is one of the components of these eight CB and its value is sourced from DCH data. Data for the rest of the columns are sourced from DCH. Total expenses numbers are also sourced from DCH.

Appendix Table 4 reports hospital-level data for the remaining hospitals in our sample. This includes NPH and HAs that do not have Schedule H, IRS Form 990 data, along with FPH and government-owned hospitals. Column one outlines the charity care measure as a percentage of the hospital's total expenses, as obtained from the DCH data (when available). The remaining columns identify the same information presented in Appendix Table 3.

Table A4. Data for Hospitals without Availability of Schedule H, IRS Form 990

Hospital Name	Charity Care	Size	Urban	Ownership Type	Category
Appling Hospital	0.53	Medium	Rural	HA	General
AU Medical Center	4.08	Large	Urban	Govt	General
Bleckley Memorial Hospital	0.05	Medium	Rural	HA	General
Burke Medical Center	0.00	Small	Rural	Govt	General
Candler County Hospital	0.41	Medium	Rural	Govt	General
Cartersville Medical Center	2.90	Medium	Urban	FPH	General

Children's Healthcare of Atlanta at Hughes Spalding	0.23	Small	Urban	Govt	General
Clinch Memorial Hospital	0.30	Small	Rural	HA	General
Coastal Behavioral Health	4.56	Medium	Urban	FPH	Other
Coastal Harbor Treatment Center	0.26	Medium	Urban	FPH	Other
Coliseum Medical Centers	0.90	Large	Urban	FPH	General
Coliseum Northside Hospital	0.34	Medium	Urban	FPH	General
Colquitt Regional Medical Center	1.19	Medium	Rural	HA	General
Columbus Specialty Hospital	0.00	Medium	Urban	FPH	Other
Devereux Georgia Treatment Network	2.44	Medium	Urban	NPH	Other
Doctor's Hospital of Augusta	7.30	Large	Urban	FPH	General
Dodge County Hospital	0.19	Medium	Rural	HA	General
Dorminy Medical Center	0.71	Medium	Rural	HA	General
East Georgia Regional Medical Center	0.00	Medium	Urban	FPH	General
Eastside Medical Center	1.50	Large	Urban	FPH	General
Elbert Memorial Hospital	2.30	Medium	Rural	HA	General
Emanuel Medical Center	1.58	Medium	Rural	NPH	General
Emory Decatur Hospital	10.82	Large	Urban	FPH	General
Emory Rehabilitation Hospital	3.25	Medium	Urban	NPH	Other
Emory University Orthopaedics & Spine Hospital	1.19	Medium	Urban	FPH	General
Encompass Health Rehab Hospital of Savannah	2.79	Medium	Urban	NPH	Other
Encompass Health Rehabilitation Hospital of Newnan	2.33	Medium	Urban	FPH	Other
Fairview Park Hospital	1.55	Medium	Rural	FPH	General
Fannin Regional Hospital	1.15	Medium	Rural	Govt	General
Flint River Community Hospital	0.07	Medium	Rural	FPH	General
Grady Memorial Hospital	40.64	Large	Urban	Govt	General
Greenleaf Center	.	Medium	Urban	FPH	Other
Habersham County Medical Center	0.51	Medium	Rural	Govt	General
HealthSouth Rehabilitation Hospital of Forsyth County	0.71	Medium	Urban	FPH	Other
Higgins General Hospital	6.22	Medium	Rural	HA	General
Irwin County Hospital	1.81	Small	Rural	HA	General
Jeff Davis Hospital	0.07	Medium	Rural	Govt	General
Jefferson Hospital	0.02	Medium	Rural	Govt	General
Jenkins County Medical Center	0.00	Small	Rural	FPH	General
Lakeview Behavioral Health System	6.10	Medium	Urban	FPH	Other
Landmark Hospital of Athens	0.00	Small	Urban	FPH	Other
Landmark Hospital of Savannah	0.02	Medium	Urban	FPH	Other
Laurel Heights Hospital	1.59	Medium	Urban	FPH	Other
Liberty Regional Medical Center	0.80	Small	Rural	HA	General
LifeBrite Community Hospital of Early	.	Small	Rural	FPH	General

Lighthouse Care Center of Augusta	0.93	Medium	Urban	FPH	Other
Meadows Regional Medical Center	0.81	Medium	Rural	HA	General
Medical Center of Peach County, Navicent Health	24.78	Small	Rural	Govt	General
Memorial Health University Medical Center	1.11	Large	Urban	HA	General
Memorial Hospital of Bainbridge	0.00	Medium	Rural	HA	General
Memorial Satilla Health	1.42	Large	Rural	HA	General
Miller County Hospital	0.00	Small	Rural	HA	General
Monroe County Hospital	0.27	Small	Rural	Govt	General
Morgan Memorial Hospital	1.37	Small	Rural	Govt	General
Mountain Lakes Medical Center	0.00	Small	Rural	FPH	General
Northeast Georgia Medical Center	7.03	Large	Urban	HA	General
Northeast Georgia Medical Center Barrow	7.18	Medium	Urban	FPH	General
Northridge Medical Center	0.00		Urban	FPH	General
Optim Medical Center - Screven	0.04	Small	Rural	FPH	General
Optim Medical Center - Tattnall	0.01	Small	Rural	FPH	General
Peachford Behavioral Health System of Atlanta	3.80	Large	Urban	FPH	Other
Phoebe Worth Medical Center	3.45	Medium	Rural	Govt	General
Putnam General Hospital	0.08	Medium	Rural	HA	General
Redmond Regional Medical Center	1.04	Large	Urban	FPH	General
Regency Hospital Company of Macon	0.00	Medium	Urban	FPH	Other
Regency Hospital of South Atlanta	7.55	Small	Urban	FPH	Other
Rehabilitation Hospital, Navicent Health	2.32	Medium	Urban	Govt	Other
Ridgeview Institute	1.28	Large	Urban	NPH	Other
Ridgeview Institute Monroe	5.28	Medium	Urban	FPH	Other
Riverwoods Behavioral Health System	.	Medium	Urban	NPH	Other
Roosevelt Long Term Acute Care Hospital	0.00	Small	Rural	Govt	Other
Roosevelt Warm Springs Institute for Rehabilitation	6.57	Medium	Rural	Govt	Other
Saint Francis Hospital	.	Large	Urban	NPH	General
Select Specialty Hospital - Midtown Atlanta, LLC	9.78	Medium	Urban	FPH	Other
Select Specialty Hospital - Savannah	0.00	Small	Urban	FPH	Other
Select Specialty Hospital of Augusta	0.00	Medium	Urban	FPH	Other
South Georgia Medical Center	7.04	Large	Urban	HA	General
South Georgia Medical Center - Berrien Campus	1.89	Medium	Rural	FPH	General
South Georgia Medical Center Lanier Campus	4.20	Small	Rural	HA	General
Southeastern Regional Medical Center, LLC	5.40	Medium	Urban	FPH	Other
Southern Crescent Behavioral Health System-Anchor Hospital Campus	9.75	Medium	Urban	FPH	Other
Southern Regional Medical Center	0.22	Large	Urban	HA	General
Southwest Georgia Regional Medical Center	0.82		Rural	Govt	General

St. Simons-By-The-Sea	5.92	Medium	Urban	FPH	Other
SummitRidge Center - Psychiatry & Addictive Medicine	7.01	Medium	Urban	FPH	Other
Tanner Medical Center Villa Rica	2.77	Medium	Urban	HA	General
Turning Point Care Center, LLC	0.00	Medium	Rural	FPH	Other
University Hospital McDuffie	29.58	Small	Rural	Govt	General
Veritas Collaborative Georgia	10.76	Medium	Urban	FPH	Other
Walton Rehab Hospital, Affiliate of Encompass Health	2.46	Medium	Urban	NPH	Other
Washington County Regional Medical Center	0.00	Medium	Rural	HA	General
Wayne Memorial Hospital	1.31	Medium	Rural	Govt	General
Wellstar Atlanta Medical Center	15.95	Large	Urban	NPH	General
Wellstar Spalding Regional Hospital	8.19	Medium	Urban	FPH	General
Wellstar Windy Hill Hospital	3.43	Medium	Urban	HA	Other
Willingway Hospital	0.00	Small	Urban	FPH	Other
Wills Memorial Hospital	0.50	Small	Rural	HA	General
Youth Villages - Inner Harbour Campus	0.00	Large	Urban	NPH	Other

Notes: Total CB number in the table is the sum across the eight distinct CB that are reported in Schedule H of Form 990. Charity care is one of the components of these eight CB, and its value is sourced from DCH data. Numbers for the rest of the columns are sourced from DCH. Total expenses numbers are also sourced from DCH.

References

Amy, J. (2023a, March 8). *Atlanta Hospital Closure Inquiry sought by Georgia Democrats*. AP News. https://apnews.com/article/wellstar-atlanta-hospital-closed-discriminate-black-9d1eb5705bed8f3bd36ff92da89ea4ca

Amy, J. (2023b, August 30). *An Atlanta-area hospital system has completed its takeover of Augusta University's hospitals*. AP News. https://apnews.com/article/wellstar-takeover-augusta-university-hospitals-georgia-c70aa774f94d13b3329fa366cdbe2476

Bai, G., Zare, H., Eisenberg, M. D., Polsky, D., & Anderson, G. F. (2021). Analysis Suggests Government And Nonprofit Hospitals' Charity Care Is Not Aligned With Their Favorable Tax Treatment: Study examines government and nonprofit hospital charity care expenses compared to charity care obligations arising from the organizations' favorable tax treatment. *Health Affairs*, *40*(4), 629-636.

Bell, J. (2020). The Impact of Hospital Concentration on Municipal Finances. The Yale Undergraduate Research Journal, 1(1), 46.

Bruch, J. D., & Bellamy, D. (2021). Charity care: do nonprofit hospitals give more than for-profit hospitals? *Journal of general internal medicine*, *36*(10), 3279-3280.

Collins, S.R. Gabriella N. Aboulafia, and Munira Z. Gunja, As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021 (Commonwealth Fund, July 2021).

Fact Sheet: Medical Debt, American Hospital Association. (June 2023). https://www.aha.org/fact-sheets/2023-06-12-fact-sheet-medical-debt

Fast Facts on Medicaid Expansion, GBPI. (2020). https://gbpi.org/fast-facts-on-medicaid-expansion/

Fast Facts on U.S. Hospitals, AHA. (2023). https://www.aha.org/statistics/fast-facts-us-hospitals

Hilltop Institute. (2016). Community Benefit State Law Profiles: A 50-State Survey of State Community Benefit Laws through the Lens of the ACA June 2015. Report link: https://hilltopinstitute.org/publication/community-benefit-state-law-profiles-a-50-state-survey-of-state-community-benefit-laws-through-the-lens-of-the-aca/

Hilltop Institute. Online resource link: https://hilltopinstitute.org/our-work/hospital-community-benefit/hcbp-state-comparison/

KFF. (2022, November). Hospital Charity Care: How It Works and Why It Matters. https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/#endnote_link_569639-2

KFF. (2023). The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020. https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/

KFF Health News. (2023). As Nonprofit Hospitals Reap Big Tax Breaks, States Scrutinize Their Required Charity Spending, https://kffhealthnews.org/news/article/nonprofit-hospitals-tax-breaks-community-benefit/

Levinson, Z., Holver, S., & Godwin, J. (2023, August 22). Understanding mergers between hospitals and health systems in different markets. KFF. https://www.kff.org/health-costs/issue-brief/understanding-mergers-between-hospitals-and-health-systems-in-different-markets/

Lown Institute Hospital Index. (2023, April). Fair Share Spending. https://lownhospitalsindex.org/2023-fair-share-spending

Lown Institute Hospital Index (2023). Are nonprofit hospitals earning their tax breaks? https://lownhospitalsindex.org/2023-fair-share-spending/

Miller, A. (2015, December 2). *Wellstar oks $575m deal for Tenet Hospitals*. AJC. https://www.ajc.com/business/wellstar-oks-575m-deal-for-tenet-hospitals/gQ2e8RP22LSv8E6XTnwuTM/

Miller, A., & Hawryluk, M. (2023, July 10). *Nonprofit hospitals under growing scrutiny over how they justify billions in tax breaks*. CNN. https://www.cnn.com/2023/07/10/health/nonprofit-hospitals-community-benefits-kff-health-news/index.html

Paavola, A. (2021, August 3). *HCA sells 4 hospitals to Piedmont*. Becker's Hospital Review. https://www.beckershospitalreview.com/hospital-transactions-and-valuation/hca-sells-4-hospitals-to-piedmont.html

Press, A. (2023, January 3). *Action in Georgia reflects continuing hospital mergers*. The Journal Record. https://journalrecord.com/2023/01/03/action-in-georgia-reflects-continuing-hospital-mergers/

Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status, GAO, 2020. https://www.gao.gov/products/gao-20-679

Understanding Required Financial Assistance in Medical Care, CPPB. (2022). https://www.consumerfinance.gov/data-research/research-reports/understanding-required-financial-assistance-in-medical-care/

Zare, H., Eisenberg, M.D. and Anderson, G. (2022). "Comparing the value of community benefit and Tax-Exemption in non-profit hospitals." *Health Services Research, 57*(2), pp.270–284.