Community Benefit Expenditures at Nonprofit Hospitals

2025 Evaluation Report

Program Evaluation Division

Office of the Legislative Auditor

State of Minnesota

Program Evaluation Division

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Judy Randall, Legislative Auditor
State of Minnesota

February 2025

Members of the Legislative Audit Commission:

Minnesota has 104 nonprofit general hospitals that are exempt from paying most federal, state, and local taxes. The Internal Revenue Service (IRS) and Minnesota law require nonprofit hospitals to publicly report the amounts they spend on "community benefits"—uncompensated services that benefit the public.

We found that most nonprofit hospitals appear to spend more to benefit their communities than they receive in tax benefits. However, limited data and competing definitions made it difficult to accurately quantify either community benefits or tax benefits. Using different definitions of community benefits led to different conclusions. We do not make legislative recommendations, but we offer some observations for the Legislature to consider.

Our evaluation was conducted by David Kirchner (project manager), Scott Fusco, and Kyle Malone. The Minnesota Department of Health and the Minnesota Department of Revenue provided valuable assistance with this evaluation.

Sincerely,

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Summary February 2025

Community Benefit Expenditures at Nonprofit Hospitals

Most nonprofit hospitals appear to spend more to benefit their communities than they receive in tax benefits. However, limited data and competing definitions make it difficult to accurately quantify either community benefits or tax benefits.

Report Summary

Tax Benefits

Nonprofit hospitals in Minnesota benefit from multiple tax exemptions at the federal, state, and local levels. However, estimating exactly how much hospitals benefit is challenging.

- It is necessary to make numerous assumptions in order to calculate nonprofit hospitals' tax benefits, creating uncertainty in those estimates. (pp. 18-19)
- Although estimates are imprecise, nonprofit hospitals received a substantial amount in tax benefits from 2019 through 2023. (p. 21)
- Tax benefits varied substantially from year to year and from hospital to hospital. (pp. 21-22)

Community Benefits

Differences of opinion exist about what types of hospital spending actually benefit communities. We thus developed three definitions of community benefit expenditures: a moderate definition matching Minnesota's reporting requirement, a more limited definition, and a more expansive one.

- The choice of definitions mattered. In the years we analyzed, reported community benefit spending was between seven and ten times as much under the expansive definition as under the limited definition. (p. 29)
- Hospitals reported that most community benefit spending has been directed toward care for hospital patients. (pp. 30-31)
- Reported community benefit spending varied more widely across hospitals when using the moderate and expansive definitions than when using the limited definition. (p. 32)
- Some nonprofit hospitals reported community benefit spending differently to the IRS and the state. (p. 28)

Background

Nearly all of Minnesota's 135 hospitals are nonprofit or government-owned. The vast majority of these are small (30 to 74 beds) or very small (fewer than 30 beds).

The federal Internal Revenue Service (IRS) and Minnesota law require nonprofit hospitals to publicly report the amounts they spend on "community benefits"—uncompensated services that benefit the public.

The IRS requires nonprofit hospitals to provide some benefits to their communities as a condition of receiving tax exemptions, but it does not require any minimum spending by hospitals. Minnesota law sets no conditions on nonprofit hospitals' tax exemptions.

Some policy advocates have argued that hospitals' community benefit spending should be commensurate with the value of their tax exemptions. However, neither the federal government nor Minnesota has such a requirement.

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Comparing Community Benefits to Tax Benefits

Because of the lack of consensus around defining community benefits and the challenges to accurately estimating tax benefits, comparing the two is tenuous.

- Using a moderate definition of community benefit expenditures, total reported community benefits exceeded estimated total tax benefits from 2019 through 2023. (p. 37)

- Using limited or expansive definitions of community benefit expenditures changed our estimates of the number of hospitals receiving more in estimated tax benefits than they provided in community benefit spending. (pp. 39-40)

- The extent to which reported community benefit spending exceeded estimated tax benefits varied among hospitals and over time. (p. 38)

Legislative Considerations

We do not make specific legislative recommendations, but we offer the following observations:

- The Minnesota Constitution prevents the Legislature from requiring community benefit expenditures as a condition of exempting hospitals from corporate income tax or sales and use taxes. (p. 42)

- Possible legislative actions would have varying effects depending on how tax benefits and community benefits are defined. (p. 43)

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Introduction

Most hospitals in Minnesota are private, nonprofit institutions. Federal and state laws exempt nonprofit hospitals from federal, state, and local taxes.[1]

As part of the broader national conversation about health care costs and potential reforms, there has been considerable interest in the tax benefits that nonprofit hospitals receive in comparison to the benefits they provide to their surrounding communities. Specifically, a number of academic authors and policy advocates have sought to compare the value of tax benefits hospitals receive to their community benefit expenditures, the amount that they spend to benefit the public.

In April 2024, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate nonprofit hospitals' spending on community benefits and compare those amounts to the tax benefits hospitals receive. Our evaluation addressed the following questions:

- **How does nonprofit hospitals' spending on community benefits compare to the tax exemptions they receive?**
- **What percentage of community benefit spending is dedicated to charity care, and how is charity care defined?**

To address these questions, we reviewed relevant state and federal laws and administrative rules. We reviewed nonprofit hospitals' financial assistance policies to determine the varying levels of assistance that hospitals provide to patients who cannot afford to pay for services. We compared Minnesota's community benefit requirements with those of other states.

To learn more about nonprofit hospitals' community benefit activities and how they report them to state and federal agencies, we interviewed administrators at seven nonprofit hospitals throughout the state. We also interviewed agency staff at the Minnesota Department of Health (MDH).

To analyze community benefit spending and tax benefits, we obtained and analyzed data from several sources, including the Minnesota Department of Health, the Minnesota Department of Revenue, the Internal Revenue Service, and the Centers for Medicare and Medicaid Services.

We focused our analysis of nonprofit hospitals' tax benefits on federal and state income tax, property tax, and sales and use tax. We did not analyze other financial benefits hospitals may receive as a result of being tax exempt, such as the ability to receive tax-deductible contributions.

We limited our analysis to the five-year period from 2019 through 2023. We acknowledge that the COVID-19 pandemic affected nonprofit hospitals' spending and tax benefits during this period. However, our findings are generally consistent with an analysis of 2019 data alone, and are also consistent with the findings of other studies that analyzed earlier time periods.

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[1] 26 *U.S. Code*, secs. 501(c)(3) and 501(r) (2023); *Minnesota Constitution*, Article X, sec. 1; and *Minnesota Statutes* 2024, 272.02, subd. 4; 297A.70, subd. 7; and 290.05, subd. 2.

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Chapter 1: Background

Hospitals serve their communities in a variety of ways. Most importantly, they provide health care to individuals. But they also promote public health, serve as centers of research, educate health professionals, and support external community organizations and events. Activities that support communities but do not generate enough income for a hospital to cover its costs are labeled *community benefits*. The extent to which nonprofit hospitals provide such benefits, and the extent to which governments should monitor or regulate how hospitals provide them, has been a policy debate for many years.

Key Findings in This Chapter

- Federal tax exemptions for nonprofit hospitals are based on their broad value to the communities they serve.
- The federal government has never fully defined what community benefits are, how they should be measured, or the extent to which hospitals should provide them.
- Minnesota law has few requirements related to hospitals' community benefits.

In this chapter, we provide key background information to put that policy debate in context. First, we describe hospitals in Minnesota, providing information about their characteristics and services. Second, we discuss the federal community benefit standard and federal reporting requirements. Third, we examine Minnesota's minimal laws surrounding community benefits.

Hospitals in Minnesota

A hospital is defined in state regulations as an institution "providing services, facilities, and beds for the reception and care for a continuous period longer than 12 hours for...persons requiring diagnosis, treatment, or care for illness, injury, or pregnancy."[1] Hospitals must be licensed by the Minnesota Department of Health (MDH).[2] Because hospitals offer around-the-clock care, a common measurement of the size of a hospital is the number of beds, which is an approximation of the number of patients that a hospital can simultaneously accommodate and treat. Hospital licenses specify the maximum number of beds a hospital may operate.

[1] *Minnesota Rules* 4640.0100, subp. 5, https://www.revisor.mn.gov/rules/4640/, accessed December 26, 2024. The definition further states a hospital should offer "clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent." *Minnesota Statutes* 2024, 144.50, subd. 3, specifies a continuous period of longer than 24 hours.

[2] *Minnesota Statutes* 2024, 144.50, subd. 1. There are a few exceptions; U.S. Department of Veterans Affairs hospitals are federally licensed, and tribal hospitals operating on tribal land do not require a state license. We exclude these hospitals in the remainder of this report.

Exhibit 1.1

Health Care Systems with the Most Hospital Beds, 2023

System	Number of Hospitals	Number of Beds	Location of Largest Hospital
Allina Health	8	1,814	Minneapolis
M Health Fairview	10	1,712	Minneapolis
Mayo Clinic	10	1,682	Rochester
HealthPartners – Park Nicollet	6	1,044	St. Paul
Essentia Health	12	829	Duluth
CentraCare	9	667	St. Cloud
North Memorial Health Care	2	458	Robbinsdale
Sanford Health	16	422	Bemidji
Children's Hospitals and Clinics	1	301	Minneapolis
Aspirus Health	2	283	Duluth

Notes: Numbers include only hospitals and beds in Minnesota. The number of hospitals refers to the number of licenses. Some licenses cover multiple locations (for example, Children's Minneapolis and Children's St. Paul operate under one license).

Source: Office of the Legislative Auditor, analysis of MDH data.

As of January 2024, there were 135 state-licensed hospitals in Minnesota, with a total capacity of over 11,000 beds, according to data from MDH.[3] The great majority of these (91 percent) were general hospitals, meaning that they served patients with a variety of conditions and were designed primarily for short-term stays. The remaining 9 percent were specialized hospitals that treated patients with specific health care needs.[4]

Most of the hospitals in Minnesota (73 percent) are part of larger integrated health care systems that comprise a variety of health care facilities, such as clinics, hospitals, dental clinics, optical shops, pharmacies, physical therapy centers, nursing homes, assisted living facilities, hospices, ambulance services, or mental health treatment centers.[5] Health care systems typically centralize administrative functions like purchasing, billing, contract negotiation, and reporting. As a result, it can sometimes be challenging to clearly distinguish the activities of individual hospitals from the activities of larger health care systems.

In some instances, health care systems stretch across state borders. For example, Sanford Health, which is affiliated with 16 Minnesota hospitals, is headquartered in Sioux Falls, South Dakota, and has facilities in Iowa, Minnesota, Nebraska, North Dakota, Oregon, and South Dakota.

Most Minnesota hospitals are small and have limited services, while most hospital beds are in large urban hospitals.

The majority of the state's 135 hospitals are very small hospitals that have fewer than 30 beds, mostly in rural areas.[6] In contrast, 15 large hospitals account for over 60 percent of the state's total hospital beds. These large hospitals with 175 or more beds are

[3] This figure is available bed capacity; some hospitals are licensed for more beds than they have available for patient use. Here and elsewhere in this report, we exclude St. Joseph's Hospital in St. Paul, which was still licensed at the beginning of 2024 but was no longer operating.

[4] Ten specialized hospitals provided only mental health care—all but two of them were state-operated. There were also two specialized hospitals that treated patients with chronic conditions or that otherwise required long-term hospital stays.

[5] Some independent hospitals (those not in a health care system) also operate smaller satellite facilities like clinics and pharmacies.

[6] Our size categories are based on those used by the Healthcare Cost and Utilization Project of the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality. For "rural areas," we use the definition used by MDH's Division of Health Policy.

concentrated in metropolitan areas—11 are in the Twin Cities metropolitan area, 2 are in Duluth, and there is 1 each in Rochester and St. Cloud.[7]

Very small hospitals in rural areas typically provide a limited range of services, concentrating on care that is financially sustainable in the communities they serve. Specialized care, such as obstetric, oncology, orthopedic, and psychiatric services, is less likely to be available at rural hospitals than at urban hospitals. In many parts of the state, Minnesotans who need more complex care cannot obtain that care at their local hospital; they must instead travel to a medium or large hospital in a regional population center. In 2023, the average length of stay at hospitals in urban areas was 5.6 days; in rural areas, it was 3.6 days.

Exhibit 1.2
Hospitals by Size, 2023

Size	Number of Beds	Number of Hospitals	Percentage of Total Beds
Very small	1 – 29	81	13%
Small	30 – 74	24	10%
Medium	75 – 174	15	14%
Large	175 or more	15	63%

Source: Office of the Legislative Auditor, analysis of MDH data.

Nearly all Minnesota hospitals are nonprofit or government-owned.

More than 75 percent of Minnesota hospitals are private, nonprofit entities. Nearly all the remaining hospitals are owned by local or state governments. Some government-owned hospitals, such as Ortonville Hospital (Sanford) and Pipestone County Medical Center (Avera), are hybrids that are owned by a local government but affiliated with a private health care system.

Only 2 of Minnesota's 135 hospitals are for-profit hospitals.[8] Both are specialty hospitals that serve specific populations.[9]

The information and data in the remainder of this report focus on the 104 nonprofit general hospitals in Minnesota (there are two nonprofit specialty hospitals).

Exhibit 1.3
Hospitals by Ownership, 2023

Ownership	Number of Hospitals	Percentage of Total Beds
Nonprofit	106	89%
Government	27	10%
For-profit	2	1%

Source: Office of the Legislative Auditor, analysis of MDH data.

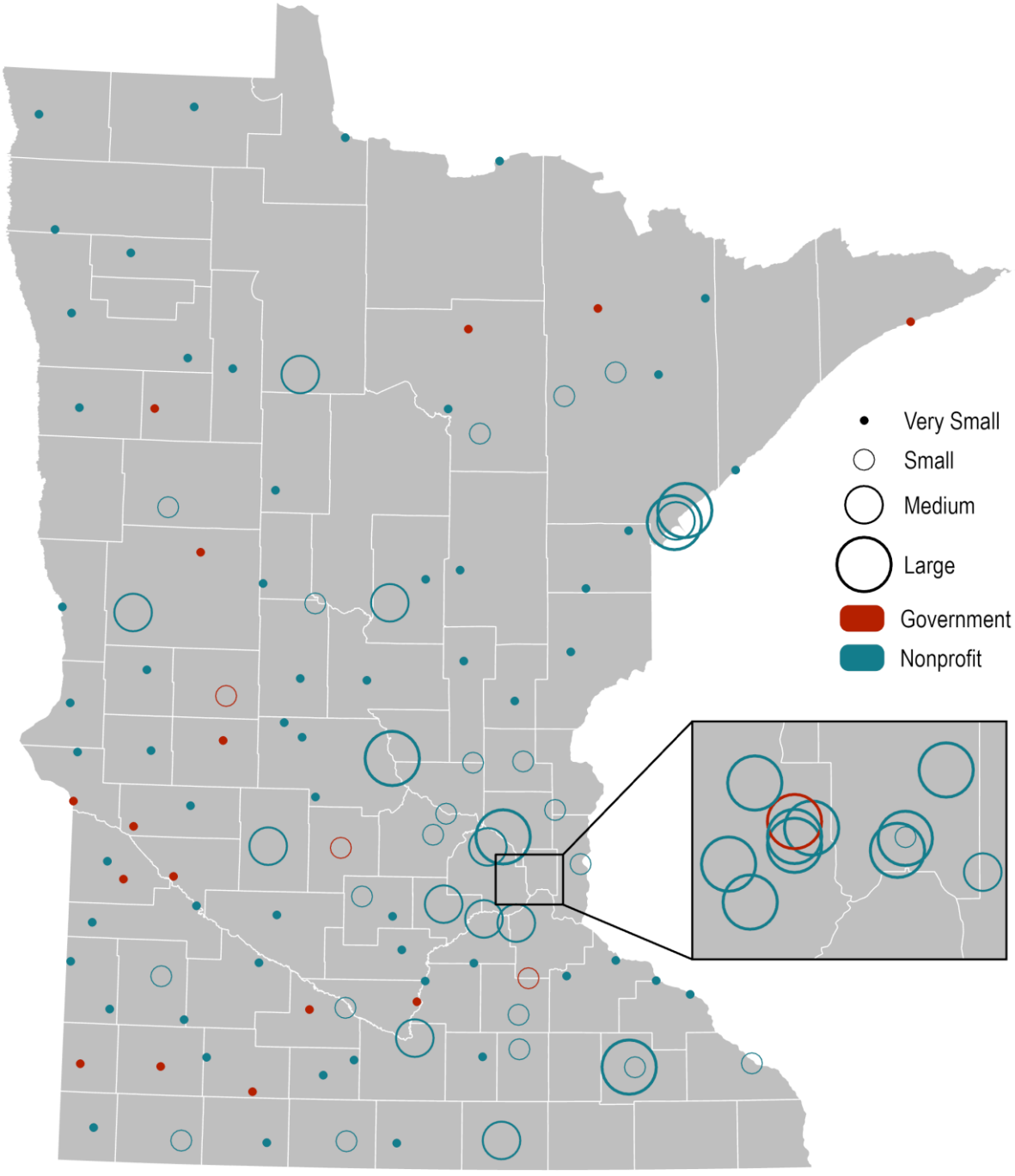
[7] Large hospitals in Fargo and Grand Forks, North Dakota; Sioux Falls, South Dakota; and La Crosse, Wisconsin also serve many Minnesotans.

[8] For-profit hospitals are uncommon in the upper Midwest. According to 2022 data gathered by the Kaiser Family Foundation, fewer than 10 percent of the hospitals in Illinois, Iowa, Minnesota, North Dakota, and Wisconsin were for-profit hospitals. By contrast, more than one-third of hospitals in many southern and southwestern states were operated on a for-profit basis.

[9] PrairieCare in Brooklyn Park is a psychiatric hospital that specializes in treating children, adolescents, and young adults. Regency Hospital in Golden Valley is a rehabilitation hospital that serves patients with chronic or critical conditions that require long-term hospital stays.

Exhibit 1.4

Minnesota Hospital Locations



Notes: This map excludes long-term care and specialty psychiatric hospitals (and therefore excludes both of Minnesota's for-profit hospitals). For hospitals with multiple campuses operated under a single license, only one location is shown.

Source: Office of the Legislative Auditor.

Federal Community Benefit Requirements

As stated above, community benefits are services that a hospital provides to its community without recovering the associated costs. At the federal level, the concept of community benefits is closely tied to tax exemptions for nonprofit hospitals.

Businesses in Minnesota pay a variety of taxes, including income taxes at the federal and state level, and property, sales, and use taxes at the state and local levels. Both the federal and state governments have long exempted charitable institutions from paying such taxes.[10]

History

Hospitals initially provided free care to nearly all patients, and were first granted federal tax exemptions as charitable institutions.

In the 19th and early 20th centuries, hospitals generally offered their services free of charge ("charity care") and primarily served patients who could not afford to pay for medical care. Wealthier individuals who could afford to pay for care were typically treated in their homes or in small physician-owned clinics and hospitals. As a result, hospitals for the general public were viewed as fundamentally charitable institutions and were first granted federal tax exemptions on that basis.[11]

Societal and health care changes in the 20th century transformed the role of hospitals. Advances in medical care introduced many diagnostic techniques and treatments that required specialized resources only available at hospitals. Income from self-paying patients gradually became an important part of hospital revenues. Later, the widespread adoption of private health insurance, followed by the creation of the Medicaid and Medicare public insurance programs, enabled hospitals to receive payments for the vast majority of patients they served.

Charity Care

Charity care is patient care provided by hospitals free of charge or at a discounted rate. The term "financial assistance" may be used interchangeably with charity care.

As a result of these changes, by the mid-20th century, hospitals were no longer institutions that typically provided charity care to most patients. Instead, they had become facilities that provided the most complex forms of health care, and they treated individuals from all economic backgrounds. Hospitals typically billed for their services, and most of their revenues came from patient fees.

[10] Charitable institutions may be subject to other taxes, such as those paid by employers.

[11] The principal federal taxes originally were tariffs; charitable exemptions were created for the federal corporate income tax when it was introduced. At the state and local levels, exemptions originally applied primarily to property tax, and were later extended to state corporate income tax and sales and use taxes.

The Internal Revenue Service now bases tax exemptions for nonprofit hospitals on their broad value to the communities they serve.

Recognizing that hospitals were no longer typically institutions that provided mostly free care, the Internal Revenue Service (IRS) issued rulings reconceptualizing the basis for hospitals' tax exemptions in 1956 and 1969.[12] Under the new philosophy, nonprofit hospitals were tax-exempt because they broadly benefited their communities by providing needed health services. The 1969 ruling explicitly stated that hospitals could qualify for tax exemptions even if they did not provide any free health care, as long as their overall activities served public—and not private—interests.[13]

Unclear Definition

The IRS has stated that a hospital seeking a federal tax exemption must (1) be a nonprofit organization promoting health that does not inappropriately direct funds or profits to any private interest, and (2) benefit the community in which it operates.[14] The second of these requirements has been criticized for decades as vague and open to multiple interpretations.[15]

The federal government has never fully defined what community benefits are, how they should be measured, or the extent to which hospitals should provide them.

The federal government has created two sets of community benefit expectations, both of which apply to hospitals seeking a federal tax exemption—one set created administratively

[12] Internal Revenue Service, Revenue Ruling 56-185, 1956-1 C.B. 202, https://www.irs.gov/pub/irs-tege/rr56-185.pdf, accessed November 27, 2024; and Revenue Ruling 69-545, 1969-2 C.B. 117, https://www.irs.gov/pub/irs-tege/rr69-545.pdf, accessed May 23, 2024.

[13] Internal Revenue Service, Revenue Ruling 69-545.

[14] These two criteria are simplified and do not encompass all requirements; however, a full discussion of the extensive law surrounding tax exemptions for nonprofit organizations (and nonprofit hospitals in particular) is beyond the scope of this report. For an introduction, see Nina J. Crimm, "Evolutionary Forces: Changes in For-Profit and Not-For-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards," *Boston College Law Review* 37, no. 1 (1995): 1-117; or Cecilia M. Jardon McGregor, "The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?", *Journal of Contemporary Health Law and Policy* 23, no. 2 (2007): 302-340.

[15] For example, General Accounting Office, *Nonprofit Hospitals: Better Standards Needed For Tax Exemption*, GAO/HRD-90-84 (Washington, DC: General Accounting Office, 1990); John D. Columbo, "The Failure of Community Benefit," *Health Matrix: The Journal of Law-Medicine* 15, no. 1 (2005): 29-65; David M. Studdert, Michelle M. Mello, Christopher M. Jedrey, and Troyen A. Brennan, "Regulatory and Judicial Oversight of Nonprofit Hospitals," *New England Journal of Medicine* 356, no. 6 (2007): 625-631; Government Accountability Office, *Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements*, GAO-08-880 (Washington, DC: Government Accountability Office, 2008); Government Accountability Office, *Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status*, GAO-20-679 (Washington, DC: Government Accountability Office, 2020); and Daniel G. Bird and Eric J. Maier, "Wayward Samaritans: 'Nonprofit' Hospitals and Their Tax-Exempt Status," *University of Pittsburgh Law Review* 85 (2023): 81-144.

by the IRS in 1956 and 1969, and another established statutorily by Congress in 2010.[16] Both consist of components framed as binary yes/no outcomes; either a hospital conducts an activity or it does not.

As we discuss below, neither set of expectations indicate how *much* a hospital should do for its community in order to be tax-exempt. Neither establishes a minimum level of activity or spending on behalf of the community that hospitals should adopt. Instead, both give hospitals a great deal of discretion in determining what they should do, how many resources they should expend, and what community health outcomes they should attempt to achieve. As a federal appeals court commented,

> In sum, no clear test has emerged to apply to nonprofit hospitals seeking tax exemptions…. For the most part…hospitals must meet a flexible 'community benefit' test based on a variety of indicia.[17]

The 1969 IRS administrative ruling (expanding on a 1956 ruling) gave examples of characteristics that could demonstrate that a nonprofit hospital serves the public interest and thus qualifies as a charitable institution.[18] These characteristics, listed in the box on the next page, have remained in use since that time.[19] Although the IRS now refers to this list of characteristics as the "community benefit standard," it does not require hospitals to implement them as a condition of receiving tax exemptions. Instead, the IRS has stated that it considers all of a hospital's facts and circumstances, and the absence or presence of any of the characteristics does not necessarily lead to granting or rejecting an exemption.[20]

In 2010, Congress created four requirements that nonprofit hospitals must meet in order to claim federal tax exemptions.[21] Unlike the characteristics listed in the 1969 IRS ruling, these requirements are mandatory for all tax-exempt nonprofit hospitals. Two of the requirements mandate that hospitals develop and publicly share certain documents about their community benefit activities, and the other two prohibit hospitals from taking certain actions. The requirements do not clarify the existing IRS standard, nor do they set minimum expectations for activities or spending.

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[16] Internal Revenue Service, Revenue Rulings 56-185 and 69-545; and Patient Protection and Affordable Care Act, Public Law No. 111-148, title IX, subtitle A, sec. 9007(a) (2010), codified in 26 *U.S. Code*, sec. 501(r) (2024).

[17] *Geisinger Health Plan v. Commissioner of Internal Revenue*, 985 F.2d 1210, 1217 (3d Cir. 1993).

[18] Internal Revenue Service, Revenue Ruling 69-545. Although this administrative ruling is the basis for the "community benefit standard," the ruling itself did not use that term.

[19] See Internal Revenue Service, "Charitable Hospitals—General Requirements for Tax-Exemption Under Section 501(c)(3)," https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3, accessed December 2, 2024.

[20] For example, a 1983 IRS administrative ruling explicitly stated that it was possible for a hospital that did not have an emergency room to obtain a federal tax exemption, as long as it benefited its community in other ways. Internal Revenue Service, Revenue Ruling 83-157, 1983-2 C.B. 94.

[21] Patient Protection and Affordable Care Act, sec. 9007(a).

IRS Community Benefit Characteristics

The IRS has stated that the following actions could indicate that a nonprofit hospital merits a federal tax exemption:

- Operate an emergency room open to all, regardless of ability to pay
- Maintain a board of directors drawn from the community
- Offer admitting privileges widely to physicians in the community
- Provide care to patients covered by Medicaid or Medicare, or with no resources to pay for care
- Use surplus funds for medical training, education, research, or improving patient care

Congressional Tax-Exemption Requirements

Federal law requires that nonprofit hospitals receiving federal tax exemptions take the following actions:

- Conduct a community health needs assessment every three years
- Maintain a written financial assistance policy
- Avoid charging patients receiving financial assistance more than patients with insurance coverage
- Avoid taking collection actions against patients before determining their eligibility for financial assistance

However, Congress did require nonprofit hospitals to evaluate the health needs of their local communities through a "community health needs assessment" and adopt strategies to meet those needs.[22] In passing this requirement, Congress essentially agreed with the IRS's existing policy that tax-exempt hospitals should serve their communities.

Reporting

The IRS has required nonprofit hospitals to report certain financial information as part of their tax filings.

The Internal Revenue Service requires nonprofit hospitals to report spending on activities it labels "community benefits," but it does not use most of the reported data when making tax-exemption decisions.

Since 2009, the IRS has required nonprofit hospitals to report certain types of spending on Schedule H—a hospital-specific schedule attached to the Form 990 financial report that most nonprofit organizations submit.[23] The schedule labels certain categories of spending as community benefits, including charity care, the costs of caring for patients covered by Medicaid or similar programs, and efforts to promote public health, among others (see box on the next page).

[22] 26 *U.S. Code*, sec. 501(r)(3) (2024).

[23] 26 *U.S. Code*, sec. 6033, requires most nonprofit organizations to file a tax return with the IRS, even if they are tax-exempt. The IRS uses Forms 990 and 990-EZ to gather this information.

Schedule H Reporting Requirements

Nonprofit hospitals receiving federal tax exemptions must report net spending on the following IRS-labeled community benefits:

- Charity care (labeled "financial assistance" by the IRS)
- Unreimbursed care for Medicaid patients
- Unreimbursed care for patients using other means-tested government programs
- Community health improvement activities and associated administrative costs
- Education of health professionals
- Health services subsidized by the hospital (services that lose money but meet a community need)
- Research
- Contributions to health-related community organizations and activities

Nonprofit hospitals also report spending in the following categories, which the IRS does not label as community benefits:

- Community-building activities (not health-related)
- Bad debt (unpaid patient debts for which there was an expectation of payment at the time of service)
- Unreimbursed care for Medicare patients

Because of this labeling, Schedule H seems to define what activities the IRS considers a benefit to communities, and how the IRS measures the extent of those activities. Many academic studies and advocacy articles have used the categories on Schedule H to identify and measure community benefit spending.

However, as we discuss further in Chapter 3, other formulations of community benefits also appear in the academic and policy literature (and in some other states' laws). Some of these formulations are more restrictive than the IRS labeling, while some are more expansive. The more expansive definitions often include one or more of the categories for which the IRS collects spending data without labeling those categories community benefits.

Despite the Schedule H labeling, the IRS has continued to base its tax-exemption decisions on its 1969 standard outlined in the previous section and the mandatory requirements of the Patient Protection and Affordable Care Act, according to a recent Government Accountability Office report.[24] The IRS only uses the Schedule H information for evaluating hospitals' tax-exempt status to the extent that the information enables the agency to apply those standards. When Schedule H was introduced, a senior IRS administrator stated that the purpose of the form was to increase transparency, not to determine whether reporting hospitals were tax-exempt.[25]

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[24] Government Accountability Office, *Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status*.

[25] Stephen T. Miller, "Charitable Hospitals: Modern Trends, Obligations and Challenges," speech to the Office of the Attorney General of Texas, January 12, 2009, https://www.irs.gov/pub/irs-tege/miller_speech_011209.pdf, accessed April 23, 2024, 10.

Minnesota Community Benefit Requirements

Like the federal government, Minnesota has distinctly different requirements regarding the community benefits that hospitals must *provide* and the benefits they must *report*.

Minnesota law has few requirements related to hospitals' community benefits.

Minnesota has a number of requirements related to the provision of charity care, but otherwise does not require hospitals to provide any other type of community benefit or to meet a minimum spending level.

Charity Care

Minnesota's few requirements for the provision of community benefits focus on charity care—free or discounted care that hospitals provide to individuals who could not otherwise afford to pay for services.

State statutes require Minnesota hospitals to have policies for providing charity care to patients who cannot afford to pay for care.[26] State law requires hospitals to publicly advertise the availability of charity care, screen any uninsured patient to determine if the patient is eligible for charity care, and assist potentially eligible patients to apply for charity care.[27] MDH has adopted rules that set guidelines around the use and reporting of charity care (for example, a hospital cannot count unpaid patient debt as charity care in its state reporting).[28]

Other than the charity care requirements outlined above, Minnesota law does not require hospitals to provide other community benefits, nor does it tie tax exemptions to hospitals' community benefits activities or reporting. The state does have a few other requirements related to how hospitals serve their communities. However, those requirements prohibit hospitals from taking potentially harmful actions—particularly with regard to patient billing and debt collection—rather than requiring hospitals to take beneficial actions. For example, a hospital may not take certain debt collection actions until it determines that a patient is ineligible for charity care.[29]

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[26] Minnesota law does not explicitly require hospitals to have charity care policies, but it implicitly requires them by mandating that hospitals post their charity care policies on their web sites and screen all uninsured patients for charity care eligibility. The law also does not directly require hospitals to provide charity care, just to set a policy and follow it. The charity care law applies to all state-licensed hospitals, not just nonprofit hospitals. *Minnesota Statutes* 2024, 144.587.

[27] *Minnesota Statutes* 2024, 144.587, subds. 2, 3, and 5.

[28] *Minnesota Rules* 4650.0115, subp. 2F, https://www.revisor.mn.gov/rules/4650/, accessed December 26, 2024.

[29] *Minnesota Statutes* 2024, 144.587, subd. 4. A more detailed set of hospital billing and debt collection requirements is contained in longstanding agreements between all of the state's nonprofit hospitals and the Minnesota Attorney General's Office. First signed in 2005, the agreements have been renewed several times, most recently in 2022. See "Attorney General Ellison Protects Minnesotans From Unfair Billing and Collections with Extension of Hospital Agreement," July 27, 2021, https://www.ag.state.mn.us/Office/Communications/2022/07/27_HospitalAgreement.asp, accessed February 3, 2025.

Reporting

Minnesota has required hospitals to publicly report information about some community benefits since the 1980s.[30] The Legislature expanded reporting requirements in 2007 and 2024.[31]

Minnesota law requires hospitals to report information on community benefit spending, but the state does not use that information for decision-making.

Minnesota law requires hospitals to annually report to MDH information on community benefit expenditures. Minnesota's reporting categories mostly mirror the categories labeled as community benefits on the federal Schedule H.[32] However, no tax exemptions nor any other state actions are based upon the community benefit information that hospitals report.[33] Minnesota law merely requires MDH to collect the data and summarize it annually.[34]

In 2024, the Legislature passed additional requirements that amplify and strengthen the existing federal requirement that nonprofit hospitals create publicly available community health needs assessments at least once every three years.[35] Specifically, hospitals must:

- Provide details about each separate "community health improvement service" they offer (rather than lumping them together into larger community benefit spending categories).[36]
- Consult with local stakeholders and use evidence-based methods when developing the federally required community benefit implementation strategies to address the needs identified in their community health needs assessments.[37]

Because the law will not take effect until 2026, we were unable to draw from reports meeting these new requirements in conducting our evaluation.

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[30] *Laws of Minnesota* 1989, chapter 282, art. 2, sec. 11, codified as *Minnesota Statutes* 2024, 144.698, subd. 1.

[31] *Laws of Minnesota* 2007, chapter 147, art. 9, sec. 21; and *Laws of Minnesota* 2024, chapter 127, art. 59, sec. 32, codified as *Minnesota Statutes* 2024, 144.699, subd. 5, and 144.6985, respectively.

[32] *Minnesota Statutes* 2024, 144.699, subd. 5. Minnesota requires hospitals to report their spending on community building activities as a community benefit. The Schedule H requires hospitals to report such spending, but does not label it as a community benefit—nonetheless, the IRS encourages hospitals to describe how those activities promote health in their communities.

[33] MDH must consider the ability of an existing hospital to maintain its current level of community benefit work when considering an application from that hospital to construct a new hospital. However, Minnesota has a statutory moratorium on the construction of new hospitals. *Minnesota Statutes* 2024, 144.552(d); 144.553, subd. 3(c); and 144.551.

[34] *Minnesota Statutes* 2024, 144.699, subd. 5.

[35] *Laws of Minnesota* 2024, chapter 127, art. 59, sec. 32, codified as *Minnesota Statutes* 2024, 144.6985.

[36] The law requires certain hospitals (including most very small hospitals) to provide details on their ten highest-cost activities. All other hospitals must provide details on any activity costing at least $5,000.

[37] *Laws of Minnesota* 2024, chapter 127, art. 59, sec. 32, codified as *Minnesota Statutes* 2024, 144.6985. We list here the key provisions of the 2024 law that expanded upon federal requirements. The law also contained several provisions codifying existing federal requirements into state statutes. For example, it required hospitals to define the communities they serve as part of the community health needs assessment process, which was already a federal requirement. See 26 *CFR*, sec. 1.501(r)-3(b)(1) (2024).

OLA

Chapter 2: Tax Benefits

As we discussed in Chapter 1, nonprofit hospitals have long been exempted from paying taxes. As part of the broader national conversation about health care costs and potential reforms, there has been considerable interest in the value of tax benefits that nonprofit hospitals receive.[1]

Key Findings in This Chapter

- It is necessary to make numerous assumptions in order to calculate hospitals' tax benefits, creating uncertainty in those estimates.
- Hospitals received a substantial amount in tax benefits from 2019 through 2023.

In this chapter, we explore several taxes that nonprofit hospitals are exempt from paying. We then discuss the substantial challenges that arise when estimating hospitals' tax benefits, due to the limitations of available data and the assumptions needed to reach conclusions about hypothetical scenarios. Nonetheless, we estimate the overall tax benefits that Minnesota hospitals received from 2019 through 2023, while cautioning that the estimates contain a high level of uncertainty.

Types of Tax Benefits

Organizations pay income tax at both the federal and state levels; they pay property and sales and use taxes at the state and local levels. Each level of government defines its own tax exemptions; an entity may be tax-exempt at the federal level but taxable at the state level, or vice versa.

Nonprofit hospitals in Minnesota benefit from tax exemptions at the federal, state, and local levels.

Determining the total tax benefits that nonprofit hospitals receive requires calculating and combining multiple taxes that they would pay if their tax exemptions were removed. As we discuss further in Chapter 4, removing all state and local tax exemptions from nonprofit hospitals would require either a state constitutional amendment or a reinterpretation of the state constitution by Minnesota courts.[2]

Income Tax

Organizations pay federal and state taxes on corporate income. Corporate income taxes are levied against corporations' net incomes after subtracting certain deductions.

As we discussed in Chapter 1, the federal government exempts hospitals from federal corporate income taxes if they do not benefit private interests and if they provide community benefits.

[1] We use "tax benefits" to refer to the combined monetary amount that hospitals do not pay in taxes.

[2] *Minnesota Constitution*, art. X, sec. 1; and *State v. Browning*, 192 Minn. 25, 255 N.W. 254 (1934).

Minnesota statutes exempt from state corporate income taxes organizations that are exempt from paying federal corporate income taxes.[3] Thus, all nonprofit hospitals exempt from federal taxation are also exempt from state corporate income taxes by statute, in addition to the constitutional provision cited above.

Property Tax

Property owners pay state and local taxes on their property.[4] The property tax amount is based on the assessed value of the property as determined by county assessors. County auditors then apply state and local tax rates to the assessed value.

Minnesota statutes exempt from taxation property owned by federally tax-exempt organizations, including nonprofit hospitals, as long as the organizations also meet state statutory requirements to be considered charitable institutions.[5] Hospitals may, however, owe taxes on property they own that is not used exclusively for public purposes. For example, the Minnesota Supreme Court has ruled that hospital-owned clinics can be subject to property taxes.[6]

Sales and Use Taxes

Purchasers of goods and services pay sales and use taxes for each taxable transaction. Sales taxes apply to most purchases of goods, while use taxes apply to certain purchases that are taxable, but for which the seller does not collect sales taxes.[7] The seller of the goods or services collects the taxes and transfers the funds to the Department of Revenue for distribution to applicable state and local governments.

Both state and local governments levy sales and use taxes. A statewide sales and use tax applies throughout Minnesota (6.875 percent as of December 2024). Various local tax rates may also apply, depending on where the purchase occurs. In some locations, local governments do not impose any additional sales and use taxes, and the only tax charged is the statewide tax. In others, local taxing jurisdictions charge not only an additional sales and use tax, but also levy special taxes that apply solely to specific sales or services, such as liquor or lodging.

Sales and use tax exemptions may be based on (1) the type of entity making the purchase, or (2) the type of goods or services purchased. Minnesota hospitals are exempt from paying sales and use taxes on their purchases because they meet the first criterion.[8]

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[3] *Minnesota Statutes* 2024, 290.05, subd. 2. There are several exceptions listed in the law, but none of them apply to hospitals.

[4] State property tax (formally, state general tax) applies only to certain properties, including commercial property.

[5] *Minnesota Statutes* 2024, 272.02, subds. 4 and 7(a).

[6] *City of Springfield v. Commissioner of Revenue*, 380 N.W.2d 802, 805-806 (Minn. 1986).

[7] Sales and use taxes are mutually exclusive. A purchaser may pay sales tax or use tax, but never both on the same purchase.

[8] *Minnesota Statutes* 2024, 297A.70, subd. 7; and 297A.99, subd. 7.

However, Minnesota also exempts certain goods, such as most food and clothing, from sales tax under the second criterion.[9] Even if hospitals became subject to sales tax, they would not pay taxes on transactions involving these goods because the goods are tax-exempt, regardless of the purchaser. For example, drugs and certain medical devices—including over-the-counter drugs, prescription drugs, and prosthetics—are exempt from sales taxes.[10] In addition, Minnesota law exempts from sales tax any item purchased in a transaction covered by Medical Assistance (the state's Medicaid program) or Medicare.[11]

Examples of Health-Care Related Tax-Exempt Sales

- Durable medical equipment for home use
- Insulin and medical oxygen
- Items purchased in transactions covered by Medicare or Medicaid
- Medical supplies that are used on a patient for treatment
- Pharmaceutical drugs
- Food and prepared meals for patients

— *Minnesota Statutes* 2024, 297A.67; and 297A.68, subd. 28

Indirect Benefits

In addition to the tax exemptions provided directly to nonprofit hospitals, they also financially benefit from certain tax exemptions and deductions provided to others.[12] For example, contributions to nonprofit charitable institutions are tax-deductible at the federal and state levels. Although this is a tax benefit provided to the contributors and not to the hospitals, hospitals benefit because they may receive more contributions than they would if those deductions did not exist.

Nonprofit hospitals also have the ability to use bonds that are tax-exempt, meaning that the bondholders do not have to pay taxes on the interest payments they receive as the bonds are paid off. As a result, hospitals' costs of borrowing money are reduced, because investors are willing to pay more for tax-exempt bonds than for similar taxable bonds.

We did not attempt to estimate these indirect benefits, because they involve not only hospital decisions, but also decisions by third parties. For example, we observed that most hospitals have affiliated charitable foundations; we think that if hospitals were to become taxable, third parties wishing to contribute funds to hospitals would shift to doing so through those foundations, which we assume would remain tax-exempt. We do not know how third-party investors would change their willingness to buy hospital bonds if hospitals could no longer make them tax-exempt for the purpose of state taxes.

The majority of third-party taxpayers' benefits from charitable contributions and tax-exempt bond income derives from federal tax law, which the state does not have the ability to change.

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[9] *Minnesota Statutes* 2024, 297A.67, subds. 2 and 8.

[10] *Minnesota Statutes* 2024, 297A.67, subd. 7(a).

[11] *Minnesota Statutes* 2024, 297A.67, subd. 7(b).

[12] Government policies or actions may provide nonprofit hospitals with other financial benefits that are unrelated to taxes. See, for example, Minnesota Department of Health, "340B Covered Entity Report," November 25, 2024, https://www.health.state.mn.us/data/340b/docs/2024report.pdf, accessed January 6, 2025.

Estimation Challenges

Estimating hospitals' tax benefits is inherently difficult.

It is necessary to make numerous assumptions in order to calculate nonprofit hospitals' tax benefits, creating uncertainty in those estimates.

Estimating the amounts nonprofit hospitals received in tax benefits requires an analyst to make many assumptions—most importantly, that hospitals would have made the same financial decisions and taken the same actions knowing that they would be subject to taxation. As we discuss below, this assumption is unrealistic. Further, some important data are missing or incomplete. In addition, the time period we analyzed overlapped with the COVID-19 pandemic, which had substantial effects on the operations and finances of health care organizations.

Income Tax. Income tax is based on a corporation's taxable income—that is, its net income after deductions are subtracted. However, nonprofit hospitals do not list deductions to their income in their income tax filings as for-profit corporations do. Although we could identify significant deductions that hospitals would likely claim if they were taxed—notably the deductions for business losses in the previous year and for payment of other taxes—we could not determine what other deductions hospitals might have been eligible to claim. We assumed they would have made no other deductions from their net income.

Further, companies' financial decisions may be influenced by their potential tax liability. For example, a company may choose whether to make a major expenditure before or after the start of a calendar or fiscal year based upon which date is more advantageous from a tax standpoint. Some hospital officials we interviewed agreed that if their hospitals were no longer tax-exempt, they would adjust how they operate. We did not have information that would enable us to model such changes, and thus we assumed that hospitals would have operated no differently had they been taxable.

Lastly, by developing estimates on a per-hospital basis, we assumed that corporations would file separate income tax returns for each hospital. However, if hospitals were taxable, health systems like Allina Health or Mayo Clinic could elect to file a single corporate tax return covering multiple hospital and nonhospital operations, calculating their overall revenue and tax liability on a combined basis. Doing so would likely change systems' tax liabilities in ways that are not predictable given the data available to us.

Property Tax. Property taxes are based on a property's assessed value. County assessors develop property assessments for every parcel—including tax-exempt parcels—enabling us to calculate property tax amounts.

However, assessments of tax-exempt parcels are less consequential than other assessments. No taxes are owed, so it is less important for assessors to make accurate assessments—and hospitals are also unlikely to challenge assessments with which they disagree. Further, to make assessments, county assessors typically rely on comparable

sales of similar properties. However, hospitals are rarely sold, and thus assessors may have little basis for comparison.

In addition, hospitals may own properties that have a variety of uses. Some uses may enable hospitals to claim that all or a portion of those properties are tax-exempt under other provisions of law. For example, a building used as a nursing home that is now treated as tax-exempt hospital property could instead be treated as a tax-exempt nursing facility. A free community health clinic could be treated as a charitable institution. We did not attempt to determine any other potentially tax-exempt uses of each tax parcel currently coded as hospital property.

Further, the large size of some hospitals relative to other property has important implications for the local property tax rate itself, especially in small communities. If hospitals were taxed, the overall tax base of some local areas could dramatically increase. In that event, we cannot predict whether local jurisdictions would set their property tax levies so that taxpayers would pay the same rates (leading to significantly more total revenue) or set their levies to collect the same amount of revenue they were collecting before hospitals become taxable (thus reducing property tax rates for others).

We assumed that all assessments were accurate, that all property currently tax-exempt as hospital property would become taxable, and that local governments would have left the property tax rates for individual taxpayers unchanged.[13]

Sales and Use Taxes. Sales and use tax benefits are the most challenging to estimate. Unlike net incomes and property values, for which there is reported data, hospitals do not report their purchases of otherwise taxable goods. Hospitals do report to the Minnesota Department of Health (MDH) a total amount spent on "supplies." We used this amount in the absence of a better alternative, but we could not know how well this amount represented the total purchases a hospital made over the course of a year. MDH's reporting form offers no definition of supplies, so hospitals have discretion to decide what expenses to include. Also, reported supplies spending likely excludes services for which a hospital would pay taxes, such as cleaning, maintenance, landscaping, and laundry services.

Further, the amount that hospitals report spending on supplies is a single lump sum; they do not provide any information about where those supplies were bought (which would affect the sales tax rate) nor are those amounts disaggregated into taxable and nontaxable goods. It also seems likely that hospitals would adjust their purchasing decisions if they were subject to paying Minnesota sales and use taxes.

We assumed that the amount hospitals spent on supplies represented their total purchases and that all purchases were made where the hospital was located. Drawing from analyses of other data, we also estimated and subtracted a percentage of purchases that would have been tax-exempt for other reasons. However, we cannot assess the validity of these adjustments. Given these challenges, sales and use tax estimates may only be accurate to an order of magnitude.

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[13] In a few instances, hospitals do not own the property they occupy. We assumed that in such cases, hospitals would end up paying an equivalent of the property tax amount through lease arrangements.

Tax Estimates

Despite the challenges described in the last section, we estimated tax benefits that nonprofit hospitals received during 2019 through 2023.[14] We summarize our methodology in Exhibit 2.1. Estimates for individual hospitals appear in Appendix A.

Exhibit 2.1

Tax Estimation Methods and Assumptions

Tax Type	Methodology	Assumptions
Income	*Base data:* Hospitals' net incomes, as reported to MDH *Adjustments:* Applied deductions for net operating losses and for payment of other taxes *Rate:* Applied federal and state corporate tax rates (21 percent and 9.8 percent, respectively)	• Nonprofit hospitals would not change their behavior if they knew they were taxable • Nonprofit hospitals would file as C corporations • Hospitals would not claim deductions other than the adjustments we made • Individual hospitals within a system would file separate tax returns • Hospitals provided all of their services within Minnesota (and thus did not receive any of their taxable income in another state)
Property	*Base data:* Assessments of tax-exempt hospital property by county assessors, as reported to the Department of Revenue *Adjustments:* Removed government-owned parcels not used by hospitals included in the data *Rate:* Combined and applied state and local property tax rates (varied by jurisdiction)	• Nonprofit hospitals would not change their behavior if they knew they were taxable • All currently exempt property would become taxable, unless owned and used by a government entity • Local tax rates would not change
Sales and Use	*Base data:* Annual spending on supplies, as reported to MDH *Adjustments:* Subtracted estimated amounts that hospitals spent on tax-exempt goods, based on analysis of data from Centers for Medicare and Medicaid Services (CMS) hospital cost reports; Subtracted estimated amounts that hospitals spent on tax-exempt Medicare and Medicaid transactions, based on how many Medicare and Medicaid patients the hospital served and the lengths of their stays *Rate:* Combined and applied state and local sales and use tax rates (varied by jurisdiction)	• Nonprofit hospitals would not change their behavior if they knew they were taxable • Reported supply expenditures reasonably represented hospitals' total purchases • All hospitals reported supply costs similarly, and hospitals spent similar proportions of their total supply amounts on tax-exempt goods • All purchases were taxed at the applicable rates for the hospitals' locations • Subtractions were correctly calculated, even though they were based on unrelated data and we could not assess their validity

Source: Office of the Legislative Auditor.

[14] Each hospital reports financial information based on its own fiscal year. For simplicity, we have ignored these differences. Thus, 2023 totals combine together data from all hospitals' 2023 reports, regardless of the exact dates of the fiscal years being reported.

Although the unrealistic assumptions necessary to create tax estimates created uncertainty in our calculations, we drew a few broad conclusions.

Nonprofit hospitals received a substantial amount in tax benefits from 2019 through 2023.

Even given the uncertainties of estimation and the effects of the COVID-19 pandemic on hospital finances, it is clear that state and local governments have provided a large amount of combined tax benefits to nonprofit hospitals. We estimated hospitals received approximately $2 billion in total state and local tax benefits from 2019 through 2023, as shown in Exhibit 2.2. We estimated that nearly all nonprofit hospitals received at least $1 million in tax benefits over the course of the five-year period; a few large hospitals received more than $100 million. We provide estimates of tax benefits for individual hospitals in Appendix A.

Exhibit 2.2

Estimated State and Local Tax Benefits for Nonprofit Hospitals

In Millions

Tax	2019	2020	2021	2022	2023
Income	$159	$121	$228	$128	$159
Sales and Use	77	74	84	84	84
Property	168	157	161	168	161
Total	$404	$352	$473	$380	$405

Notes: Estimates in this table are based on many assumptions. Sales and use tax estimates are particularly imprecise. Totals may not add up due to rounding.

Source: Office of the Legislative Auditor.

Property tax and corporate income tax exemptions contributed the largest shares to nonprofit hospitals' tax benefits. Property tax benefits accounted for 40 percent of total state and local tax benefits over the five-year period, slightly more than corporate income tax benefits, which accounted for 39 percent. Sales and use tax benefits accounted for 20 percent of total estimated state and local tax benefits.[15] When examining only 2019, the last full year prior to the COVID-19 pandemic, property tax benefits also accounted for the largest share (42 percent) of state and local tax benefits.

If we include estimated federal corporate income tax benefits as well, combined federal and state income taxes would represent a clear majority (67 percent) of nonprofit hospitals' total tax benefits over the five-year period.[16] Total estimated tax benefits from 2019 through 2023 would increase to approximately $3.7 billion. When examining only 2019, income tax benefits accounted for the same share (67 percent) of tax benefits as the total five-year period.

Tax benefits varied substantially from year to year and from hospital to hospital.

The COVID-19 pandemic's effect on public health and the funding response by federal and state governments likely affected hospitals' net incomes in multiple ways during the time period we examined. Hospitals reported significant variation in net income from year to year. As a result, the estimates of corporate income tax benefits—and thus total tax benefits—also fluctuated over the five-year period.

[15] The total does not add to 100 percent due to rounding.

[16] Property taxes would represent 22 percent of hospitals' tax benefits, and sales and use taxes would represent the remaining 11 percent.

For many hospitals, estimated corporate income tax benefits dropped to zero in some years because they reported operating losses. More than one-half of hospitals reported an operating loss at least once during 2019 through 2023.

There was also substantial variation in estimated tax benefits from hospital to hospital. As is shown in Appendix A, we estimated that over 30 hospitals received less than $20,000 per bed in tax benefits for 2023, while a similar number received more than $40,000 per bed. Substantial variation across hospitals existed in all hospital size categories.

Variation in hospitals' incomes—and thus tax benefits—can be caused by many factors, including patient volumes, operational costs, and investment incomes. Although the COVID-19 pandemic likely affected hospitals' net incomes during the time period we examined, other studies covering different time periods have also found wide variation in the value of hospitals' tax benefits.[17]

[17] For example, Bradley Herring, Darrell Gaskin, Hossein Zare, and Gerard Anderson, "Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 55 (2018): 1–11; Legislative Audit Division, Montana Legislature, *Community Benefit and Charity Care Obligations at Montana Nonprofit Hospitals* (Helena: September 2020); Sara Rosenbaum, David A. Kindig, Jie Bao, Maureen K. Byrnes, and Colin O'Laughlin, "The Value Of The Nonprofit Hospital Tax Exemption Was $24.6 Billion In 2011," *Health Affairs* 34, no. 7 (July 2015): 1225-1233; and Hossein Zare and Gerard Anderson, "Beyond the Bottom Line: Assessing Charity Care, Community Benefits, and Tax Exemptions in Nonprofit Hospitals," *Journal of Healthcare Management* 69, no. 6 (2024): 439-454.

Chapter 3: Community Benefit Spending

Hospitals provide important benefits to their communities, including access to critical health care services, investments in community health, and the provision of free care to the uninsured. According to longstanding legal precedent at both the state and federal levels, providing these services promotes the public interest, and nonprofit hospitals are therefore exempt from taxation.[1]

Key Findings in This Chapter

- Hospitals report that most community benefit spending has been directed toward care for hospital patients.
- Reported community benefit spending varied more widely across hospitals under some definitions than others.
- While every nonprofit hospital provided some charity care, the level of spending varied widely among hospitals.

However, the question of just how much nonprofit hospitals benefit the public is a subject of considerable debate. Critics have argued that some nonprofit hospitals operate much like their for-profit counterparts, providing relatively few benefits—yet they receive substantial tax benefits due to their nonprofit status.[2] Conversely, hospitals themselves have argued that they provide extensive community benefits that far outweigh the monetary value of the tax benefits they receive.[3]

In this chapter, we begin by exploring how to define community benefits and provide an overview of the different types of spending that could be combined to create an overall amount of community benefit expenditures. We develop three definitions of community benefit expenditures and discuss how much nonprofit hospitals in Minnesota report spending on community benefits using each definition. Finally, we provide an overview of nonprofit hospitals' charity care spending and policies.

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[1] *State v. Browning*, 192 Minn. 25, 255 N.W. 254 (1934); *Village of Hibbing v. Commissioner of Taxation*, 217 Minn. 528, 14 N.W.2d 923 (1944); Internal Revenue Service, Revenue Ruling 56-185, 1956-1 C.B. 202, https://www.irs.gov/pub/irs-tege/rr56-185.pdf, accessed November 27, 2024; and Internal Revenue Service, Revenue Ruling 69-545, 1969-2 C.B. 117, https://www.irs.gov/pub/irs-tege/rr69-545.pdf, accessed April 24, 2024.

[2] For example, Daniel G. Bird and Eric J. Maier, "Wayward Samaritans: 'Nonprofit' Hospitals and Their Tax-Exempt Status," *University of Pittsburgh Law Review* 85 (2023): 81-144; John D. Colombo, "The Role of Access in Charitable Tax Exemption," *Washington University Law Quarterly* 82 (2004): 343-387; Meredith Gingold, "Using Community Benefit To Bridge the Divide Between Minnesota's Nonprofit Hospitals and Their Communities," *Minnesota Law Review* 105 (2021): 2505-2550; Cecilia M. Jardon McGregor, "The Community Benefit Standard for Non-Profit Hospitals: Which Community, and For Whose Benefit?", *Journal of Contemporary Health Law & Policy* 23, no. 2 (2007): 302-340; Theodore J. Patton, "The Calamity of Community Benefit: Redefining the Scope and Increasing the Accountability of Minnesota's Nonprofit Hospitals," *Hamline Law Review* 37, no. 1 (2014): 1-18; and James Earl Goodpasture, "Calculation of Foregone Taxes and Community Benefit for Florida Not-For-Profit Hospitals," *International Journal of Healthcare Management* 12, no. 2 (2019): 137–140.

[3] For example, EY, *Estimates of the Value of Federal Tax Exemption and Community Benefits Provided by Nonprofit Hospitals, 2020*, report prepared for the American Hospital Association, September 2024, https://www.aha.org/2024-09-23-estimates-value-federal-tax-exemption-and-community-benefits-provided-nonprofit-hospitals-2020, accessed December 11, 2024.

Defining and Measuring Community Benefits

A key element of the ongoing debate regarding the value of hospitals to their local communities is defining what activities actually benefit communities.

Assessments of hospital community benefit activity often focus on how much hospitals spend, not on how effectively they improve public health.

Measuring how much the health of a community is improved by the activities of a single hospital is a very challenging task, and is probably impossible in practical terms in urban settings. There is no obvious way to disentangle the effects of one hospital's activities from the work of other health care providers, social service agencies, insurance carriers, public health authorities, public safety departments, and myriad other organizations whose activities could affect public health.

Instead, federal and state reporting requirements—and numerous analyses based on the reported data—use hospitals' spending on certain activities as a proxy for their community impact. Using hospital spending has numerous practical advantages: it is easily countable, it isolates the activities of each hospital from other organizations, it uses a single unit of analysis (money) that is comparable across hospitals and communities, and it is readily understandable to the general public.

Despite these advantages, using spending alone to assess community impact is an imperfect approach. Some research suggests that hospitals' spending on community benefits does not necessarily lead to improved health outcomes.[4] Evaluations based solely on spending could even encourage hospitals to prioritize ineffective, costly interventions over more effective but less expensive ones.

Further, without any measurable connection between hospital spending and community health outcomes, there are no clear criteria for deciding which expenditures should be counted as benefiting a community. As we discuss in the next section, analysts seeking to assess how much hospitals spend on community benefits have made different choices about which expenditures to include.

[4] Legislative Audit Division, Montana Legislature, *Community Benefit and Charity Care Obligations at Montana Nonprofit Hospitals* (Helena: September 2020), 27-28; Simone R. Singh, Erik Bakken, David A. Kindig, and Gary J. Young, "Hospital Community Benefit in the Context of the Larger Public Health System," *Journal of Public Health Management and Practice* 22, no. 2 (March/April 2016): 164-174; and Grant Wen, Hossein Zare, Matthew D. Eisenberg, and Gerard Anderson, "Association Between Non-Profit Hospital Community Benefit Spending and Health Outcomes," *Health Services Research* 58 (2023): 107-115.

Community Benefit Expenditure Definitions

As we discussed in Chapter 1, the Internal Revenue Service (IRS) and Minnesota have very similar community benefit reporting requirements. Both require hospitals to report on spending in the same nine categories, though the IRS treats one of those categories (community building) as distinct from other community benefit spending. The IRS also allows hospitals to report two additional categories that some hospitals have argued should count as community benefits, though neither the IRS nor Minnesota labels them as such.

Based on our review of the academic and policy literature and the state and federal reporting guidelines, we developed three different definitions for community benefit expenditures: a limited, a moderate, and an expansive definition. The moderate definition closely aligns with the Minnesota reporting requirements and to the items labeled "community benefits" on the IRS Schedule H (see Chapter 1). The limited and expansive definitions reflect departures from that moderate definition in both directions. Exhibit 3.1 provides a brief description of the spending categories we used.

- **Limited.** Includes charity care, subsidizing health services operated at a financial loss, community health services, contributions to other organizations, community building activities, and community benefit administrative overhead. Certain advocates prefer limited definitions like this one.[5]

- **Moderate.** Includes all categories in the limited definition plus education, research, and absorbing underpayments for state health insurance programs (i.e., Medical Assistance and MinnesotaCare).[6] These are the categories of community benefits listed in Minnesota's reporting law.[7] However, as we discussed in Chapter 1, state statutes do not require hospitals to provide these benefits, only to report their expenditures.

- **Expansive.** Includes all categories in the moderate definition plus absorbing bad debt and underpayments for Medicare. The Minnesota Hospital Association and the American Hospital Association have used this definition.[8] Some other states have also adopted more expansive interpretations of community benefit spending.[9]

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[5] For example, Lown Institute, "2024 Fair Share Spending Report: Are Hospitals Giving Back As Much As They Take?", https://lownhospitalsindex.org/hospital-fair-share-spending-2024/, accessed April 29, 2024.

[6] Medical Assistance is Minnesota's Medicaid program for people with low incomes.

[7] *Minnesota Statutes* 2024, 144.699, subd. 5. These categories also align with those used in Catholic Health Association, *A Guide to Planning and Reporting Community Benefit* (St. Louis: Catholic Health Association of the United States, 2022), 49-65.

[8] EY, *Estimates of the Value of Federal Tax Exemption and Community Benefits*; and Minnesota Hospital Association, "Community Benefit Report: Aug. 2023," https://www.mnhospitals.org/wp-content/uploads/2024/05/2023-Community-Benefit-Report.pdf, accessed December 13, 2024.

[9] See *California Health and Safety Code*, sec. 127345(d) (West 2024); *Idaho Code*, sec. 63-602D(7) (West 2024); *Wilson Area School District v. Easton Hospital*, 747 A.2d 877, 878 (Pa. 2000); and Utah State Tax Commission, Property Tax Division, *Property Tax Exemptions: Standards of Practice* (Salt Lake City: August 2024), https://propertytax.utah.gov/standards/standard02.pdf, accessed September 19, 2024, Appendix 2B.

Exhibit 3.1

Spending Categories for Limited, Moderate, and Expansive Community Benefit Definitions

Definition	Category	Description
Limited	Charity care	Free or discounted medical care for patients who are unable to pay
Limited	Subsidized services	Health care services that are operated at a significant financial loss and that are otherwise unavailable in the area (e.g., neonatal intensive care)
Limited	Community health services	Community health education, community-based clinic services, and other health care support services that improve community health
Limited	Contributions	Cash and in-kind contributions to health care organizations and community groups to improve the health of a community
Limited	Community building activities	Programs and activities that are not directly related to providing health care but may have indirect effects on community health (e.g., affordable housing)
Limited	Overhead	Administrative overhead costs associated with operating community benefit programs
Moderate	Underpayments for state health care programs	Difference between the cost of providing services to patients enrolled in Medical Assistance and MinnesotaCare and the payments received for those services
Moderate	Education	Professional education, training programs, and financial assistance for medical students, nursing students, and other health professionals
Moderate	Research	Research that benefits the public
Expansive	Underpayments for Medicare	Difference between the cost of providing services to patients enrolled in Medicare and the payments received for those services
Expansive	Bad debt	Unpaid patient debts for which there was an expectation of payment at the time of service

Source: Office of the Legislative Auditor.

The lack of consensus about how to define community benefit spending has led researchers to reach different conclusions based on data from the same source.

We created multiple definitions because other studies have used different definitions when analyzing hospitals' community benefit spending. Some studies have focused on the spending categories that the IRS labels as community benefit spending.[10] Others have taken a narrower view of community benefit expenditures, opting to include fewer spending categories than the IRS does.[11] Still others have taken a more expansive view, opting to include unreimbursed spending on Medicare patients or the cost of caring for patients who are billed but do not pay (i.e., bad debt).[12]

Academic authors have found that different definitions of community benefits can lead to very different conclusions regarding hospitals' community benefit spending.[13] Policy advocates have also come to different conclusions based on their choice of definition, even when those studies utilize data from the same IRS source. One study using a more conservative definition compared community benefit spending to the estimated value of tax exemptions across more than 2,400 nonprofit hospitals and found that the hospitals spent nearly $26 billion less on community benefits than they received in tax benefits in 2021.[14] In contrast, a consulting firm working on behalf of the American Hospital Association used a more expansive definition to estimate that nonprofit hospitals nationwide provided nearly $129 billion in benefits to their communities in 2020, nearly ten times their estimated tax benefits.[15]

[10] Krisda H. Chaiyachati, Mingyu Qi, and Rachel M. Werner, "Non-Profit Hospital Community Benefit Spending Based On Local Sociodemographics," *Journal of Health Care for the Poor and Underserved* 29, no. 4 (2018): 1259-1268; Hossein Zare, Matthew Eisenberg, and Gerard Anderson, "Charity Care and Community Benefit in Non-Profit Hospitals: Definition and Requirements," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 58 (2021): 1-8; and Susannah Camic Tahk, "Tax-Exempt Hospitals and Their Communities," *Columbia Journal of Tax Law* 6 (2014): 33-85.

[11] Lown Institute, "2024 Fair Share Spending Report"; and Bradley Herring, Darrell Gaskin, Hossein Zare, and Gerard Anderson, "Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 55 (2018): 1–11.

[12] EY, *Estimates of the Value of Federal Tax Exemption and Community Benefits*; and Gloria J. Bazzoli, Jan P. Clement, and Hui-Min Hsieh, "Community Benefit Activities of Private, Nonprofit Hospitals," *Journal of Health Politics, Policy and Law* 35, no. 6 (December 2010): 999-1026.

[13] Simone Rauscher Singh, "Community Benefit in Exchange for Non-Profit Hospital Tax Exemption: Current Trends and Future Outlook," *Journal of Health Care Finance* 39, no. 3 (2013): 32-41; Hossein Zare, Matthew D. Eisenberg, and Gerard Anderson, "Comparing the Value of Community Benefit and Tax-Exemption in Non-profit Hospitals," *Health Services Research* 57, no. 2 (2022): 270-284; and Herring et al., "Comparing the Value of Nonprofit Hospitals' Tax Exemption."

[14] Lown Institute, "2024 Fair Share Spending Report."

[15] EY, *Estimates of the Value of Federal Tax Exemption and Community Benefits*.

Some nonprofit hospitals reported community benefit spending differently to the IRS and the state.

As we have described above, the IRS and Minnesota have very similar reporting requirements; however, not all hospitals report consistent numbers to the two agencies.

We compared 63 nonprofit hospitals that both reported community benefit expenditures to the Minnesota Department of Health (MDH) and filled out an individual Schedule H with the IRS in 2023.[16] For 27 of those hospitals, reported community benefit spending to one agency exceeded reported spending to the other agency by at least 50 percent.[17]

Based on our interviews with hospital representatives, some nonprofit hospitals place a higher priority on accurately reporting community benefit expenditures to the IRS than accurately reporting to MDH. While some hospitals do not differentiate between the federal and state processes when reporting their community benefit spending, others have different staff prepare separate reports that may draw on different data sources.

Adjustments made by the IRS and MDH, rather than differences in hospital reporting, may also account for some of the variation between the two sources. Both the IRS and MDH require adjustments to hospitals' reported charity care spending to reflect the actual cost of care, rather than the amount billed to patients, but the two agencies have different methodologies for doing so. Nonetheless, 11 of the 27 hospitals noted above reported community benefit spending figures to the IRS and MDH that differed by at least 50 percent even after excluding charity care costs.[18]

The inconsistent reporting raised some concerns regarding data accuracy.[19] We opted to use MDH data for our analyses of nonprofit hospitals' community benefit reporting for several reasons. First, unlike the federal community benefit reports—in which large systems may file a single report for dozens of hospitals—each hospital reports data to MDH individually, even if it is part of a larger hospital system.[20] We can thus compare community benefit spending across hospitals, even if some systemwide spending is not captured in the MDH data. Second, hospitals' community benefit reporting to MDH is folded into a larger report that contains information on finances, staffing, services, equipment, and patient population. As a result, it is easier to examine community benefits in the context of other information, such as the proportion of a hospital's patients enrolled in Medicare or state health insurance programs. Lastly, if the Legislature decides to take action related to community benefit spending (a possibility we discuss further in Chapter 4), we assume that it would rely upon the spending reported to MDH.

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[16] The IRS allows health care systems to report community benefit spending for multiple hospitals on a single Schedule H form.

[17] These numbers were calculated using the limited definition of community benefit expenditures.

[18] For the other 16 hospitals, we were unable to determine the extent to which the differences we observed were due to the different adjustment methods.

[19] In our listing of individual hospital data in Appendix B, we note when hospitals reported dramatically different spending numbers to the IRS.

[20] MDH allows a hospital to file one report for multiple locations if they operate under a single license. For example, Allina Health files a single report that covers both its St. Paul and Hastings campuses. Prior to 2022, the Hastings campus operated under its own license and thus filed an independent report.

Analyzing Community Benefit Expenditures

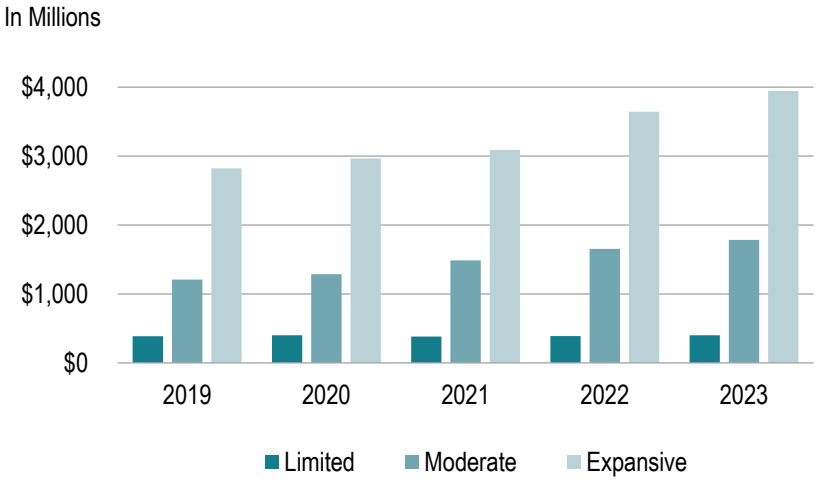
Appendix B lists reported community benefit spending for each nonprofit hospital under the three definitions. Below, we discuss community benefit expenditures across all hospitals.

Choosing which definition of community benefit expenditures to use is consequential.

Definitions matter. As shown in Figure 3.2, nonprofit hospitals reported spending between seven and ten times as much under the expansive definition as they did under the limited definition.[21] While reported community benefit spending under the limited definition was stagnant between 2019 and 2023, spending under the moderate and expansive definitions increased by at least 40 percent over the same five-year period.

Exhibit 3.2

Total Reported Community Benefit Spending Using Three Alternative Definitions



Source: Office of the Legislative Auditor, analysis of MDH data.

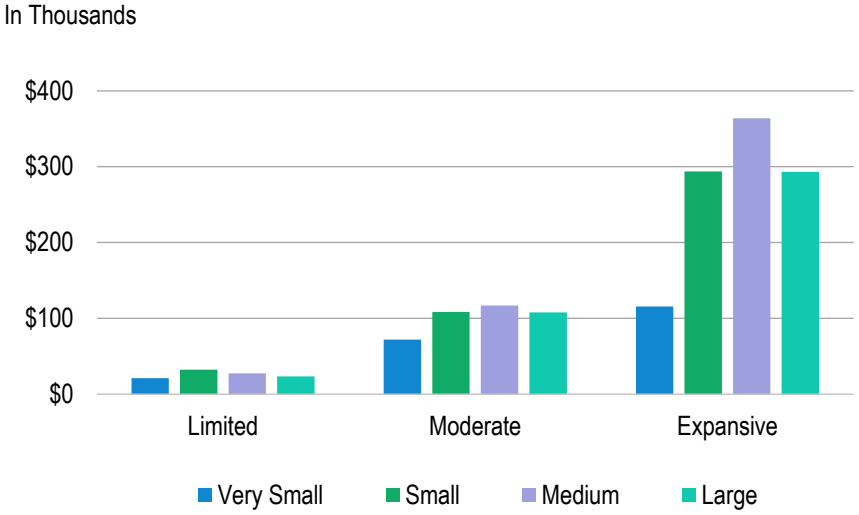
The growth in reported community benefit spending under the moderate and expansive definitions was driven largely by increases in spending on education, Medicare underpayments, and state health insurance underpayments. Other spending categories—including charity care, subsidized services, overhead, and bad debt—fluctuated year to year but remained largely unchanged between 2019 and 2023.

The importance of definitions is also apparent when comparing hospitals of different sizes. As shown in Exhibit 3.3, under the limited definition of community benefits, the median hospital of each size spent about the same amount per bed. However, under the expansive definition, the median very small hospital (fewer than 30 beds) spent substantially less than the median hospitals in the other size categories.

[21] As we noted in Chapter 2, each hospital reports financial information based on its own fiscal year. For simplicity, we have ignored these differences. Thus, 2023 totals combine together data from all hospitals' 2023 reports, regardless of the exact dates of the fiscal years being reported.

Exhibit 3.3

Under the expansive definition, the median very small hospital spent substantially less per bed on community benefits compared to median hospitals of larger sizes.



Note: See Chapter 1 for an explanation of the hospital size categories.

Source: Office of the Legislative Auditor, analysis of MDH data.

These spending differences are largely due to differences in Medicare underpayments.[22] More than one-third of very small hospitals reported no Medicare underpayments, suggesting that program reimbursements were sufficient to offset their costs for caring for Medicare patients. Another 40 percent of very small hospitals spent less than $50,000 per bed on unreimbursed Medicare costs; only one large hospital and one medium-sized hospital reported a similarly low level of unreimbursed Medicare costs. These discrepancies may be a product of different reimbursement rates for certain hospital types. All but one of the very small hospitals were critical access hospitals, which are reimbursed for the cost of caring for Medicare patients at a higher rate than other hospitals.[23]

Hospitals reported that most community benefit spending has been directed toward care for hospital patients.

In each of our definitions, community benefit spending can be broadly divided into two types: patient care and public-focused spending. Patient care is spending specifically for hospital patients through charity care, subsidized services, absorbing bad debt, and covering the difference between payments from Medicaid and Medicare and the actual costs of the services. Conversely, public-focused spending involves benefiting the public at large through community health activities, contributions to community organizations, community building activities, and education and research.

[22] MDH staff noted that recent legislative changes may also increase the amount of bad debt hospitals report in future years.

[23] "Critical access hospital" is a federal designation for hospitals with no more than 25 beds that are at least 35 miles from another hospital and meet other criteria.

As Exhibit 3.4 shows, nonprofit hospitals reported their community benefit expenditures were primarily focused on patient care. Public-focused spending made up less than 21 percent of total spending under all three definitions, and less than 10 percent of total spending under the most expansive definition.

Exhibit 3.4

Percentage of Reported Community Benefit Spending by Category, 2019-2023

Category	Limited	Moderate	Expansive
Patient Care			
Charity care	37.1%	9.8%	4.4%
Subsidized services	43.6	11.5	5.2
Underpayments for state health care programs	–	57.9	26.1
Underpayments for Medicare	–	–	50.0
Bad debt	–	–	5.0
Subtotal	**80.7%**	**79.2%**	**90.7%**
Public-Focused			
Community health services	9.3%	2.4%	1.1%
Contributions	3.2	0.9	0.4
Community building activities	1.6	0.4	0.2
Community benefit overhead	5.1	1.3	0.6
Education	–	14.9	6.7
Research	–	0.7	0.3
Subtotal	**19.2%**	**20.6%**	**9.3%**
Total	**100%**	**100%**	**100%**

Note: Individual categories may not sum to 100 percent due to rounding.

Source: Office of the Legislative Auditor, analysis of MDH data.

The COVID-19 pandemic appeared to have had a significant impact on the distribution of reported community benefit spending. Using the moderate definition, charity care expenses fell from 12.6 percent of reported community benefit spending in 2019 to 8.4 percent in 2022, while underpayments for state health care programs rose from 51.5 percent to 62.9 percent.[24] A representative from one hospital told us that because more patients became eligible for Medical Assistance during the pandemic, the number of patients qualifying for charity care declined.[25]

[24] The increase in spending on underpayments may be partly due to reporting changes. During the five-year period we reviewed, one health system stopped reporting their own calculations for state health program underpayments and switched to using standard MDH calculations. Among that system's hospitals, underpayments for state health programs rose from $30 million in 2020 to $186 million in 2022.

[25] Between 2020 and 2023, the federal government prohibited states from removing most recipients from their Medicaid rolls, including those who would have lost their eligibility prior to the pandemic (due to a change in income, for instance). According to the Minnesota Department of Human Services, enrollment in Medical Assistance and MinnesotaCare grew by more than 30 percent during the period.

Reported community benefit spending varied more widely across hospitals when using the moderate and expansive definitions.

As other studies have also found, reported community benefit expenditures varied widely across hospitals.[26] The differences among hospitals increased when using more expansive definitions of community benefit spending. Using the limited definition, hospitals were closely grouped together: more than three-quarters of hospitals reported average annual spending of less than $50,000 per bed, and another 16 percent reported spending between $50,000 and $100,000.[27] Two hospitals reported spending more than $300,000 per bed.

Under the moderate definition, hospitals were distributed more widely, with 19 percent of hospitals reporting expenditures of less than $50,000 per bed and 25 percent reporting expenditures between $100,000 and $150,000 per bed. About 4 percent of hospitals reported spending at least $500,000 per bed. Hospitals were even more widely distributed under the expansive definition: reported spending ranged from $500 per bed to $1.4 million per bed. About 12 percent of hospitals reported spending less than $50,000 per bed while 13 percent reported spending more than $500,000.

Charity Care

As we discussed in Chapter 1, hospitals were once primarily charitable entities that provided free care to most patients. However, the widespread adoption of health insurance in the 20th century and the creation of Medicare and Medicaid drastically reduced the need for free or discounted charity care.

The provision of charity care is widely considered an important community benefit that nonprofit hospitals provide, even among those who adopt limited definitions of community benefit spending.[28] We therefore included it in all three of our definitions. In this section, we examine how Minnesota hospitals have provided this key benefit.

[26] Bazzoli et al., "Community Benefit Activities"; Herring et al., "Comparing the Value of Nonprofit Hospitals' Tax Exemption"; Young et al., "Provision of Community Benefits"; Zare et al., "Charity Care and Community Benefit"; and Hossein Zare and Patricia Gabow, "Influence of Not-For-Profit Hospital Ownership Type on Community Benefit and Charity Care," *Journal of Community Health* 48 (2023): 199-209.

[27] We present five-year averages throughout this section. Although the numbers differ slightly, the same trends were present when looking at only 2019 data.

[28] For example, Jamie Godwin, Zachary Levinson, and Scott Hulver, "The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020," (San Francisco: Kaiser Family Foundation, March 2023), https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/, accessed July 15, 2024; Goodpasture, "Calculation of Foregone Taxes and Community Benefit," (2019); and Lown Institute, "2024 Fair Share Spending Report."

While every nonprofit hospital provided some charity care, the level of spending varied widely among hospitals.

Charity care spending varied widely across hospitals. Average annual spending on charity care ranged from a low of $300 per bed to a high of $48,000 per bed. About 43 percent of hospitals spent less than $10,000 annually per bed on charity care, while another 31 percent spent between $10,000 and $20,000 per bed.

As with community benefit spending overall, there were also differences across hospitals of different sizes, with the smallest hospitals spending less on charity care compared to other hospitals. More than half of very small hospitals spent less than $10,000 per bed on charity care, compared to 33 percent of large hospitals, 31 percent of medium-sized hospitals, and 17 percent of small hospitals.

Hospitals have considerable discretion in creating their charity care policies.

As we discussed in Chapter 1, state law requires Minnesota hospitals to have policies for providing charity care to patients who cannot afford to pay for care.[29] However, each hospital (or hospital system) sets its own charity care policy, including the eligibility criteria and the extent of discounts provided. State law sets no minimum requirements for eligibility or amount of discount. As a result, hospitals' charity care policies vary considerably. As shown in Exhibit 3.7, the maximum income at which a patient could qualify for fully discounted (i.e., free) care in fall 2024 ranged from 100 to 300 percent of the Federal Poverty Guidelines, with 200 percent the most common limit.[30] Some hospitals focus almost entirely on income to determine charity care eligibility, while others also consider other factors such as a patient's assets. Some hospitals require patients applying for charity care to first apply for public assistance programs such as Medicaid.

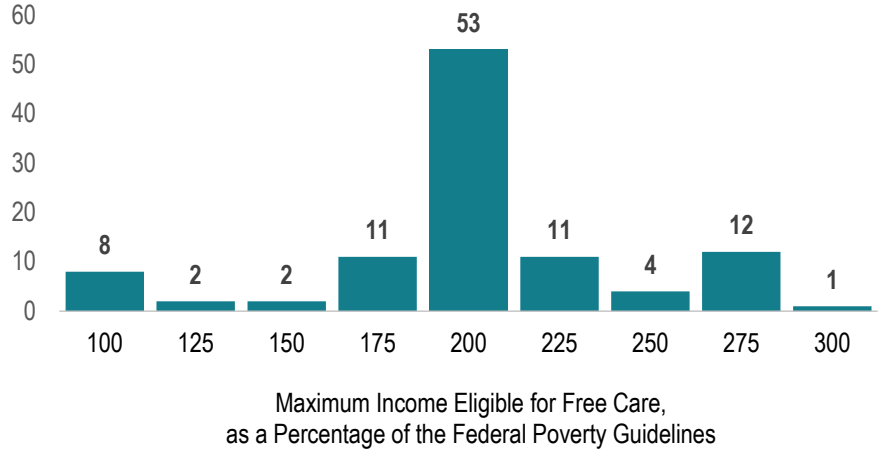
These differences may have a substantial impact on individual patients; someone who is eligible for entirely free care at one hospital may not qualify for any assistance at another. However, determining how hospital policies affected overall charity care spending was beyond the scope of this evaluation.

[29] *Minnesota Statutes* 2024, 144.587, subd. 5(b).

[30] The Federal Poverty Guidelines are a measure of income set by the U.S. Department of Health and Human Services to determine eligibility for certain programs and benefits. The guidelines are based on family or household size; for instance, the poverty guideline for a family of four in 2024 was about $31,000 across most of the U.S. The Federal Poverty Guidelines are distinct from the poverty thresholds established by the U.S. Census Bureau, which are primarily used for statistical purposes.

Exhibit 3.7

The majority of Minnesota's nonprofit hospitals set the maximum income for patients to receive free care at between 175 percent and 225 percent of the federal poverty guidelines.



Notes: The chart displays the income limits for receiving fully discounted or free care. One hospital that sets its threshold at 160 percent of the federal poverty guidelines is included in the 150 percent category.

Source: Office of the Legislative Auditor, analysis of hospitals' charity care policies.

Chapter 4: Comparing Community Benefits to Tax Benefits

Federal and state laws have long treated nonprofit entities differently from for-profit entities. Most notably, nonprofit charitable institutions are generally exempt from taxation. This exemption is rooted in the philosophy that charitable institutions benefit the public at large. As the U.S. Supreme Court noted in a 1983 decision:

> Charitable exemptions are justified on the basis that the exempt entity confers a public benefit—a benefit which the society or the community may not itself choose or be able to provide, or which supplements and advances the work of public institutions already supported by tax revenues.[1]

Key Findings in This Chapter

- Using a moderate definition of community benefit expenditures, total reported community benefits exceeded estimated total tax benefits from 2019 through 2023.
- The extent to which reported community benefit spending exceeded estimated tax benefits varied among hospitals and over time.
- A handful of states require hospitals to make minimum community benefit expenditures, usually as a condition of providing tax exemptions.

Because of their care for the sick and injured, nonprofit hospitals have long been considered organizations deserving of tax exemptions. For example, the Minnesota Constitution of 1858 exempted "public hospitals" from taxation, and an 1877 U.S. Supreme Court decision commented that hospitals were one of the "commonest forms" of charitable uses.[2] However, in more recent decades, public policy advocates have questioned whether nonprofit hospitals provide enough public benefit to justify the tax exemptions they receive.[3] In several cases in other states, courts have found that nonprofit hospitals were not acting as charitable institutions and limited their state or

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[1] *Bob Jones University v. United States*, 461 U.S. 574, 591 (1983).

[2] *Minnesota Constitution*, article IX, sec. 3 (1858), currently codified in *Minnesota Constitution*, article X, sec. 1 (2024); and *Ould v. Washington Hospital for Foundlings*, 95 U.S. 303, 311 (1877).

[3] See, for example, Douglas M. Mancino, "Income Tax Exemption of the Contemporary Nonprofit Hospital," *St. Louis University Law Journal* 32 (1988): 1015-1074; Edward C. Liu, *501(c)(3) Hospitals and the Community Benefits Standard*, Report RL34605 (Washington, DC: Congressional Research Service, 2010), https://crsreports.congress.gov/product/pdf/RL/RL34605, accessed April 25, 2024; Lown Institute, "2024 Fair Share Spending Report: Are Hospitals Giving Back As Much As They Take?", https://lownhospitalsindex.org/hospital-fair-share-spending-2024/, accessed April 29, 2024; Daniel G. Bird and Eric J. Maier, "Wayward Samaritans: 'Nonprofit' Hospitals and Their Tax-Exempt Status," *University of Pittsburgh Law Review* 85 (2023): 81-144; and U.S. Senators Elizabeth Warren, Raphael Warnock, Bill Cassidy, M.D., and Charles E. Grassley, letter to Daniel Werfel, Commissioner, Internal Revenue Service, and Edward T. Killen, Commissioner, Tax Exempt and Government Entities Division, August 7, 2023, https://www.warren.senate.gov/imo/media/doc/Letters%20on%20Nonprofit%20Hospitals.pdf, accessed July 15, 2024.

local tax exemptions.[4] As we discuss below, Minnesota courts have reached different conclusions.

In this chapter, we draw together information from the preceding chapters to compare the community benefit expenditures that Minnesota nonprofit hospitals report with the tax benefits they receive. We then review the actions taken by some other states, and discuss considerations for the Legislature if it wishes to emulate those states by requiring a minimum level of hospital community benefit spending.

Community Benefits and Tax Benefits

As we discussed in Chapter 1, there is no law, rule, or policy at either the federal or state level that requires Minnesota nonprofit hospitals to spend a minimum amount on community benefits in order to receive a tax exemption. Nonetheless, many policy advocates have pointed to the "public benefit" basis for exempting charitable institutions from taxation and argued that a hospital's community benefit expenditures should be commensurate with the value of its tax exemptions.[5]

However, it is difficult to compare tax benefits to community benefit spending. First, as we discussed in Chapter 2, there are significant challenges to accurately estimating hospitals' tax benefits due to the limited information available and the assumptions required. Although we provided estimates in that chapter, there is a high level of uncertainty in those estimates. Second, as we discussed in Chapter 3, there is no consensus on what expenditures should be counted as community benefit spending.

Different Definitions of Community Benefit Spending

Limited. Includes charity care, subsidizing health services operated at a financial loss, community health services, contributions to other organizations, community building activities, and community benefit administrative overhead.

Moderate. Includes all categories in the limited definition plus education, research, and absorbing underpayments for state health insurance programs (i.e., Medical Assistance and MinnesotaCare).

Expansive. Includes all categories in the limited and moderate definitions plus absorbing bad debt and underpayments for Medicare.

[4] *Provena Covenant Medical Center v. Department of Revenue*, 925 N.E.2d 1131 (Ill. 2010) [Illinois]; *AHS Hospital Corporation v. Town of Morristown*, 28 N.J. Tax 456 (N.J. Tax 2015) [New Jersey]; *Pottstown School District v. Montgomery County Board of Assessment Appeals*, 289 A.3d 1142 (Pa. Commw. Ct. 2023) [Pennsylvania]; and *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985) [Utah].

[5] Meredith Gingold, "Using Community Benefits To Bridge the Divide Between Minnesota's Nonprofit Hospitals and Their Communities," *Minnesota Law Review* 107 (2021): 2505-2550; James Earl Goodpasture, "Calculation of Foregone Taxes and Community Benefit For Florida Not-For-Profit Hospitals," *International Journal of Healthcare Management* 12, no. 2 (2019): 137–140; Cecilia M. Jardin McGregor, "The Community Benefit Standard for Nonprofit Hospitals: Which Community, and For Whose Benefit," *Journal of Contemporary Health Law and Policy* 23, no. 2 (2007): 302-340; and U.S. Senate Health, Education, Labor, and Pensions Committee, "Executive Charity: Major Non-Profit Hospitals Take Advantage of Tax Breaks and Prioritize CEO Pay Over Helping Patients Afford Medical Care," Majority Staff Report, October 10, 2023, https://www.sanders.senate.gov/wp-content/uploads/Executive-Charity-HELP-Committee-Majority-Staff-Report-Final.pdf, accessed May 7, 2024.

Lastly, hospitals' exemptions from federal corporate income taxes make up an important component of their total tax benefits. Because the state does not have the ability to change federal tax policy, examining the size of the federal tax benefit seemed beyond the scope of our evaluation. On the other hand, ignoring federal tax benefits and considering only state and local tax benefits dramatically lowers the threshold at which community benefit spending would exceed tax benefits.

Despite these challenges, we compare hospitals' community benefit spending to the value of their estimated tax benefits below. We provide multiple analyses based on the different definitions of community benefit spending we outlined in Chapter 3 and whether estimated federal tax benefits are included.

Using a moderate definition of community benefit expenditures, total reported community benefits exceeded estimated total tax benefits from 2019 through 2023.

The moderate definition of community benefit expenditures we introduced in Chapter 3 is the definition used in the state's reporting law (see the box on the previous page).[6]

Using this definition, Minnesota nonprofit hospitals reported $7.4 billion in community benefit expenditures from 2019 through 2023.[7] That amount was far larger than the $2.0 billion in state and local taxes that we estimated those hospitals did not pay due to their tax-exempt status. It is also larger than the $3.7 billion that we estimated hospitals would have paid when also including federal taxes. As shown in Exhibit 4.1, reported community benefit expenditures were larger than estimated taxes for hospitals of all sizes.[8]

Examining only 2019 data, the last full year prior to the COVID-19 pandemic's impact on hospitals and health care, showed a similar story. The total amount of reported community benefit spending using the moderate definition, $1.2 billion, exceeded the $404 million we estimated that hospitals would have paid in state and local taxes had they been taxable.

Exhibit 4.1

Total Reported Community Benefit Expenditures and Estimated Tax Benefits, 2019-2023 (Moderate Definition)

In Millions

Size	Community Benefit Expenditures	Estimated State/Local Tax Benefits	Estimated Federal Tax Benefits
Very small	$ 553	$ 195	$ 193
Small	966	171	84
Medium	1,051	216	125
Large	4,853	1,433	1,301
Total	$7,423	$2,014	$1,702

Source: Office of the Legislative Auditor, analysis of MDH and Department of Revenue data.

[6] *Minnesota Statutes* 2024, 144.699, subd 5. For definitions of these categories, see Chapter 3, especially Exhibit 3.1.

[7] As we noted in previous chapters, each hospital reports financial information based on its own fiscal year. For simplicity, we have ignored these differences. Thus, 2023 totals combine together data from all hospitals' 2023 reports, regardless of the exact dates of the fiscal years being reported.

[8] See Chapter 1 for definitions of the hospital size categories.

The extent to which reported community benefit spending exceeded estimated tax benefits varied among hospitals and over time.

A review of reported community benefit expenditures and tax benefits for individual hospitals showed that most nonprofit hospitals' reported community benefit expenditures exceeded their estimated state and local tax benefits. However, there were some hospitals for which estimated tax benefits were larger. Not surprisingly, the number of hospitals for which estimated tax benefits exceeded reported community benefit expenditures was higher when also taking federal tax benefits into account.

For many hospitals, whether estimated tax benefits exceeded reported community benefit expenditures varied from year to year. During the five-year period we examined, 33 percent of nonprofit hospitals shifted at least once between reported community benefit expenditures being the larger value and estimated tax benefits being the larger value. If we include federal tax benefits, 45 percent of hospitals experienced such shifts.

Very small hospitals were much more likely to have estimated tax benefits exceed their reported community benefit expenditures. In 2020, 2021, and 2022, the percentage of very small hospitals having estimated tax benefits exceeding reported community benefit spending under the moderate definition was more than double the percentage in any other size category.

Exhibit 4.2

Number of Nonprofit Hospitals with Estimated Tax Benefits Exceeding Reported Community Benefit Expenditures (Moderate Definition)

State and Local Tax Benefits Only

Size	2019	2020	2021	2022	2023
Very small	3	9	18	18	10
Small	1	0	1	2	0
Medium	1	0	0	1	0
Large	2	1	1	1	2
Total	7	10	20	22	12

Federal, State, and Local Tax Benefits

Size	2019	2020	2021	2022	2023
Very small	14	21	33	22	21
Small	4	3	4	3	4
Medium	1	1	2	2	1
Large	2	2	4	1	2
Total	21	27	43	28	28

Note: The total number of nonprofit hospitals each year varied from 102 to 104 due to closures and government hospitals converting to nonprofit hospitals.

Source: Office of the Legislative Auditor, analysis of MDH and Department of Revenue data.

However, rural hospitals may provide important community benefits that cannot be measured through expenditures. Most very small hospitals in Minnesota are federally designated critical access hospitals, which are usually at least 35 miles from another hospital. Many community members likely believe that the only hospital in a 35-mile radius provides an important, unquantifiable benefit simply by existing.

Using limited or expansive definitions of community benefit expenditures changed how many hospitals received more in estimated tax benefits than they provided in community benefit spending.

As we discussed in Chapter 3, some policy advocates have criticized the IRS-labeled categories of community benefit spending—which closely mirror those used by Minnesota for reporting purposes—as being overly broad.[9] Thus, we created a limited definition of community benefits that does not include research, education, or unreimbursed costs for treating Medical Assistance and MinnesotaCare patients.

When using the limited definition described in Chapter 3, the large margin by which community benefit spending exceeded tax benefits disappeared. Instead of totaling $7.4 billion over five years, community benefit expenditures under the limited definition totaled only $1.96 billion. That amount is approximately the same as the $2.01 billion in state and local tax benefits, and is considerably less than the $3.7 billion in tax benefits when federal tax is included.

Similarly, under the limited definition, many individual hospitals received estimated tax benefits that exceeded their reported spending on community benefits (see Exhibit 4.3). For every year we analyzed, over 40 percent of Minnesota's nonprofit hospitals received more in estimated state and local tax benefits than their reported community benefit spending under the limited definition. If federal tax benefits are included, the proportion was over one-half in every year.

Exhibit 4.3

Number of Nonprofit Hospitals with Estimated Tax Benefits Exceeding Reported Community Benefit Expenditures (Limited Definition)

State and Local Tax Benefits Only

Size	2019	2020	2021	2022	2023
Very small	24	28	36	32	36
Small	9	8	10	10	10
Medium	7	2	7	6	7
Large	8	4	7	4	5
Total	48	42	60	52	58

Federal, State, and Local Tax Benefits

Size	2019	2020	2021	2022	2023
Very small	31	37	44	39	39
Small	11	8	14	10	10
Medium	12	6	7	7	8
Large	9	5	9	4	5
Total	63	56	74	60	62

Note: The total number of nonprofit hospitals each year varied from 102 to 104 due to closures and government hospitals converting to nonprofit hospitals.

Source: Office of the Legislative Auditor, analysis of MDH and Department of Revenue data.

[9] For example, see Lown Institute, "2024 Fair Share Spending Report: Are Hospitals Giving Back As Much As They Take?"

The expansive definition of community benefits we presented in Chapter 3 takes the moderate definition and adds unrecovered medical debt and underpayments for Medicare patients. It reflects the definition used by the Minnesota Hospital Association and the American Hospital Association.[10]

Under this definition, Minnesota hospitals' reported community benefit expenditures totaled $16.5 billion, more than eight times the amount of state and local tax benefits we estimated. As shown in Exhibit 4.4, using the expansive definition reduced the number of hospitals that had larger estimated tax benefits than reported community benefit spending from the number using the moderate definition. However, there were still hospitals, especially very small ones, that had higher estimated tax benefits than reported community benefit spending.

Exhibit 4.4

Number of Nonprofit Hospitals with Estimated Tax Benefits Exceeding Reported Community Benefit Expenditures (Expansive Definition)

State and Local Tax Benefits Only

Size	2019	2020	2021	2022	2023
Very small	1	3	11	6	7
Small	0	0	0	0	0
Medium	0	0	0	0	0
Large	0	0	0	0	0
Total	1	3	11	6	7

Federal, State, and Local Tax Benefits

Size	2019	2020	2021	2022	2023
Very small	7	15	27	17	14
Small	0	0	1	1	0
Medium	1	0	1	1	0
Large	2	1	3	1	2
Total	10	16	32	20	16

Note: The total number of nonprofit hospitals each year varied from 102 to 104 due to closures and government hospitals converting to nonprofit hospitals.

Source: Office of the Legislative Auditor, analysis of MDH and Department of Revenue data.

Other States

Other states have varied widely in actions they have taken with regard to nonprofit hospitals' community benefits. In Appendix C, we provide a summary of community benefit requirements that other states have implemented. Most states with community benefit laws have (1) broad requirements that hospitals provide community benefits without requiring minimum expenditures, (2) reporting requirements that either duplicate or add to the federal reporting requirements, or (3) both. Minnesota falls in the second category.

[10] Minnesota Hospital Association, "Community Benefit Report: Aug. 2023," https://www.mnhospitals.org/wp-content/uploads/2024/05/2023-Community-Benefit-Report.pdf, accessed December 13, 2024; and American Hospital Association, *Tax-Exempt Hospitals Provided Nearly $130 Billion in Total Benefits to their Communities*, https://www.aha.org/system/files/media/file/2023/10/Results-from-2020-Tax-Exempt-Hospitals-Schedule-H-Community-Benefit-Reports.pdf, accessed December 4, 2024, Appendix A.

A handful of states require nonprofit hospitals to make minimum community benefit expenditures, often as a condition of providing tax exemptions.

A few states require nonprofit hospitals to demonstrate that their community benefit spending meets a minimum standard. In some instances, these requirements were prompted by state court decisions finding that nonprofit hospitals were not tax-exempt unless they demonstrated a certain level of public benefit.

- **Illinois** and **Utah** require that hospitals demonstrate their community benefit expenditures are greater than their estimated property tax liability in order to receive a property tax exemption.[11]

- **Nevada** requires hospitals with more than 100 beds in counties with more than one hospital to annually spend at least 0.6 percent of their net revenue for the preceding year on charity care.[12]

- **New Jersey** requires nonspecialized hospitals exempt from property taxes to make a "community service contribution" based on hospital size to the municipalities in which they are located. Hospitals are only excluded from this requirement if they do not bill patients and meet a minimum community benefit spending requirement.[13]

- **Oregon** requires hospitals to demonstrate their community benefit expenditures are greater than a minimum amount set individually for each hospital by the state's health agency.[14]

- **Pennsylvania** requires that organizations providing direct services that qualify for tax purposes as charitable institutions (including hospitals) meet any one of several criteria for donating services to others. The criteria are based on either the percentage of recipients that are given discounted or free services, or the percentage of net income devoted to providing free goods or services.[15]

- **Texas** requires hospitals qualifying as charitable organizations to meet any one of four community benefit spending criteria. Three of the criteria are based on demonstrating sufficient charity care spending; the fourth is based on exceeding a minimum threshold for overall community benefit expenditures.[16]

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[11] 35 *Illinois Compiled Statutes Annotated*, secs. 105/3-8, 120/2-9, and 200/15-86 (West 2024); *Utah County v. Intermountain Health Care*; and Utah State Tax Commission, Property Tax Division, *Property Tax Exemptions: Standards of Practice* (Salt Lake City: August 2024), https://propertytax.utah.gov/standards/standard02.pdf, accessed September 19, 2024, Appendix 2B. (The Utah requirement is not in statute; the state revenue agency implemented the court decision administratively.)

[12] *Nevada Revised Statutes Annotated*, 439B.320 (West 2024).

[13] *New Jersey Statutes Annotated*, sec. 40:48J-1 (West 2024).

[14] *Oregon Revised Statutes*, sec. 442.624 (West 2024).

[15] 10 *Pennsylvania Statutes*, sec. 375 (West 2024).

[16] *Texas Tax Code Annotated*, sec. 11.1801 (West 2024).

Policy Considerations

We do not make any recommendations regarding whether the Minnesota Legislature should follow the lead of the states listed in the previous section. We view that decision as a policy question for elected legislators to decide. However, for the information of interested legislators and others, we offer the following observations.

The Minnesota Constitution prevents the Legislature from requiring community benefit expenditures as a condition of exempting hospitals from corporate income tax or sales and use taxes.

Since it was first written, the Minnesota Constitution has specifically exempted public hospitals from taxation:

> Taxes shall be uniform upon the same class of subjects and shall be levied and collected for public purposes, but public burying grounds, public school houses, *public hospitals*, academies, colleges, universities, all seminaries of learning, all churches, church property, houses of worship, institutions of purely public charity, and public property used exclusively for any public purpose, shall be exempt from taxation except as provided in this section.[17]

Since the 1930s, Minnesota courts have interpreted "public hospitals" as including all nonprofit hospitals, as long as they are accessible to the general public.[18] The key case addressing this issue is *State v. Browning*, decided by the Minnesota Supreme Court in 1934. Chief Justice Devaney wrote for the court:

> We hold here only that at least two elements must be present before an institution is a public hospital. It must be open to the public generally, and it must be operated for the benefit of the public, and thus without a private profit.[19]

In other words, unless state courts revisit this interpretation, the Legislature may not place conditions on hospitals' tax-exempt status (with the possible exception of property tax, as discussed below).

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[17] *Minnesota Constitution*, article X, sec. 1, emphasis added.

[18] *State v. Browning*, 192 Minn. 25, 255 N.W. 254 (1934); *State v. H. Longstreet Taylor Foundation* 198 Minn. 263, 269 N.W. 469 (1936); and *Village of Hibbing v. Commissioner of Taxation*, 217 Minn. 528, 14 N.W.2d 923 (1944). For a recent case citing these precedents, see *Welia Health v. County of Pine*, No. 58-CV-22-196, 2023 WL 4917278, at *4 (Minn. Tax Aug. 1, 2023).

[19] *State v. Browning*, 192 Minn. 25, 30, 255 N.W. 254, 256.

The Legislature could require minimum community benefit expenditures as a condition of property tax exemptions or hospital licensure.

The last sentence of the constitutional section exempting hospitals from taxation gives the Legislature some powers with regard to taxation of property held by hospitals.

> The legislature by law may define or limit the property exempt under this section other than churches, houses of worship, and property solely used for educational purposes by academies, colleges, universities and seminaries of learning.[20]

We have not identified a Minnesota court decision interpreting this sentence with regard to hospitals. However, we believe this clause allows the Legislature to statutorily place conditions—such as community benefit spending requirements—on hospitals' property tax exemptions.

Further, hospitals cannot operate in Minnesota unless they have a license issued by the state.[21] Instead of focusing on tax exemptions as the means of enforcing community benefit spending requirements, the Legislature could instead make licensing conditional on meeting community benefit spending targets.

Possible legislative actions would have varying effects, depending on how tax benefits and community benefits are defined.

Our detailed examinations of tax benefits in Chapter 2 and community benefit expenditures in Chapter 3 highlight the importance of clearly defining terms in order to fully realize legislative intent.

As we explain in Chapter 2, it is difficult to pinpoint what a hospital's tax liability would be if it were taxable. Any law that attempts to define a minimum level of community benefit expenditures in terms of forgone tax payments would need to provide guidance to taxpayers and the implementing agency on how the Legislature expects hospitals to calculate the amount of taxes they do not pay.

Similarly, our findings in Chapter 3 demonstrate that the Legislature's decisions regarding what hospitals can count as community benefit expenditures would have important impacts. The difference in reported community benefits between using the most limited and most expansive definitions we presented in Chapter 3 was over $14 billion across all Minnesota nonprofit hospitals over a five-year period. As with the overall question of whether to set a minimum threshold for community benefit expenditures, we view the definition of community benefit expenditures as a policy question and make no recommendation.

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[20] *Minnesota Constitution*, article X, sec. 1.

[21] *Minnesota Statutes* 2024, 144.50, subd. 1. As we noted in Chapter 1, certain federal- and tribal-operated hospitals do not require a state license.

Any legislation affecting all nonprofit hospitals could create additional challenges for small, independent rural hospitals.

As we discussed in Chapter 1, the great majority of hospitals in the state are very small, having fewer than 30 beds. Such hospitals—especially independent hospitals not affiliated with a larger health care system—may have limited administrative staffing and resources to meet regulatory requirements. Larger hospitals and hospitals that are part of larger health care systems could have greater flexibility to allocate administrative resources to address any new requirements the Legislature introduces.

The Legislature may wish to consider whether to apply the same standards to all hospitals. The 2024 legislation expanding community benefits reporting we discussed in Chapter 1 set different requirements for hospitals meeting certain specifications in law, which included nearly all very small rural hospitals.[22] We also observe that the Texas law discussed above excludes some small rural hospitals, and Illinois's reporting law applies only to hospitals with more than 100 beds located in a metropolitan statistical area.[23]

[22] *Laws of Minnesota* 2024, chapter 127, art. 59, sec. 32, codified as *Minnesota Statutes* 2024, 144.6985, subds. 3(a) and 3(b). The law has different provisions for hospitals that are designated by federal or state law as critical access hospitals, sole community hospitals, or rural emergency hospitals.

[23] *Texas Tax Code Annotated*, sec. 11.1801 (West 2024); and 210 *Illinois Compiled Statutes Annotated*, sec. 76/5 (West 2024).

Appendix A: Tax Benefit Estimates

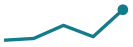
As we discussed in Chapter 2, estimating the value of tax benefits that nonprofit hospitals receive requires making many assumptions, leading to highly uncertain results. Most importantly, we assumed that hospitals would not have altered their behavior had they been subject to taxation. In addition, important data are missing or incomplete, particularly with regard to sales and use taxes. The estimates below allow for broad comparisons across hospitals, but the accuracy of any individual hospital's estimate is questionable. For a summary of our methodology, see Exhibit 2.1.

For each hospital listed below, we estimated combined state and local tax benefits per bed and federal corporate income tax benefits per bed for 2023. The table includes nonprofit general hospitals only, and thus excludes government-owned hospitals and specialty hospitals (such as mental health hospitals). To the left of each estimate is a small line graph to show the year-to-year variation from 2019 to 2023. Data for years in which a hospital was a government-owned entity are excluded (a few hospitals converted from government-owned to nonprofit organizations during this time period), and hospitals with only a single year of available data are omitted entirely.

Estimated Total Tax Benefits per Bed, 2019-2023

		State and Local		Federal	
Hospital	County	5-Year Line	2023	5-Year Line	2023
Allina Health					
Abbott Northwestern Hospital	Hennepin		$15,000		$0
Buffalo Hospital	Wright		$56,000		$59,000
Cambridge Medical Center	Isanti		$33,000		$4,000
Faribault Medical Center	Rice		$24,000		$1,000
Mercy Hospital	Anoka		$16,000		$0
New Ulm Medical Center	Brown		$70,000		$78,000
Owatonna Hospital	Steele		$23,000		$0
United Hospital	Ramsey		$20,000		$0
Allina Health – Health Partners/Park Nicollet – Essentia Health					
St. Francis Regional Medical Center	Scott		$27,000		$1,000
Aspirus Health					
Lake View Hospital	Lake		$40,000		$16,000
St. Luke's Hospital	St. Louis		$15,000		$0

Estimated Total Tax Benefits per Bed, 2019-2023 (continued)

Hospital	County	State and Local		Federal	
		5-Year Line	2023	5-Year Line	2023
Avera Health					
Granite Falls Health Center[a]	Yellow Medicine		$14,000		$0
Marshall Regional Medical Center	Lyon		$51,000		$41,000
Tyler Hospital	Lincoln		$5,000		$10,000
Catholic Health Initiatives					
LakeWood Health	Lake of the Woods		$18,000		$0
St. Francis Health	Wilkin		$13,000		$4,000
St. Gabriel's Hospital	Morrison		$28,000		$0
St. Joseph's Health	Hubbard		$26,000		$27,000
CentraCare					
Long Prairie Hospital	Todd		$57,000		$56,000
Melrose Hospital	Stearns		$93,000		$129,000
Monticello Hospital	Wright		$45,000		$49,000
Paynesville Hospital	Stearns		$51,000		$75,000
Redwood Hospital	Redwood		$108,000		$16,000
Rice Memorial Hospital	Kandiyohi		$26,000		$14,000
Sauk Centre Hospital	Stearns		$37,000		$66,000
St. Cloud Hospital	Stearns		$18,000		$5,000
Children's Hospitals and Clinics					
Children's Minnesota	Hennepin		$42,000		$11,000
Essentia Health					
Ada	Norman		$27,000		$18,000
Deer River	Itasca		$41,000		$18,000

Estimated Total Tax Benefits per Bed, 2019-2023 (continued)

Hospital	County	State and Local		Federal	
		5-Year Line	2023	5-Year Line	2023
Essentia Health (continued)					
Duluth	St. Louis		$31,000		$0
Fosston	Polk		$6,000		$2,000
Holy Trinity Hospital	Big Stone		$4,000		$0
Moose Lake[a]	Carlton		$27,000		$0
Northern Pines	St. Louis		$14,000		$5,000
Sandstone	Pine		$42,000		$30,000
St. Joseph's Medical Center	Crow Wing		$33,000		$34,000
St. Mary's – Detroit Lakes Hospital	Becker		$41,000		$28,000
St. Mary's Medical Center	St. Louis		$22,000		$1,000
Virginia	St. Louis		$5,000		$0
Gundersen Health System					
Saint Elizabeth's Hospital	Wabasha		$19,000		$4,000
HealthPartners – Park Nicollet					
Glencoe Regional Health	McLeod		$32,000		$9,000
Hutchinson Health	McLeod		$44,000		$5,000
Lakeview Hospital	Washington		$48,000		$28,000
Methodist Hospital	Hennepin		$79,000		$86,000
Olivia Hospital and Clinic[a]	Renville		$92,000		$130,000
Regions Hospital	Ramsey		$43,000		$14,000
Lake Region Healthcare					
Elbow Lake Medical Center	Grant		$23,000		$0
Fergus Falls Hospital	Otter Tail		$10,000		$0

Estimated Total Tax Benefits per Bed, 2019-2023 (continued)

		State and Local		Federal	
Hospital	County	5-Year Line	2023	5-Year Line	2023
M Health Fairview					
Fairview Range	St. Louis		$16,000		$0
Grand Itasca Clinic and Hospital	Itasca		$22,000		$0
Lakes Medical Center	Chisago		$41,000		$34,000
Northland Medical Center	Sherburne		$28,000		$1,000
Ridges Hospital	Dakota		$22,000		$16,000
Southdale Hospital	Hennepin		$27,000		$0
St. John's Hospital	Ramsey		$28,000		$0
University of Minnesota Medical Center	Hennepin		$27,000		$0
Woodwinds Hospital	Washington		$41,000		$0
Mayo Clinic					
Albert Lea and Austin	Freeborn		$29,000		$0
Cannon Falls	Goodhue		$65,000		$75,000
Fairmont	Martin		$18,000		$0
Lake City	Goodhue		$2,000		$3,000
Mankato	Blue Earth		$22,000		$0
New Prague	Scott		$66,000		$117,000
Red Wing	Goodhue		$27,000		$5,000
Rochester	Olmsted		$110,000		$175,000
St. James	Watonwan		$31,000		$39,000
Waseca	Waseca		$30,000		$48,000
North Memorial Health Care					
Maple Grove Hospital	Hennepin		$60,000		$55,000
Robbinsdale Hospital	Hennepin		$10,000		$1,000

Estimated Total Tax Benefits per Bed, 2019-2023 (continued)

		State and Local		Federal	
Hospital	County	5-Year Line	2023	5-Year Line	2023
Ridgeview Medical Center					
Le Sueur Medical Center	Le Sueur		$32,000		$30,000
Ridgeview Medical Center	Carver		$15,000		$0
Sibley Medical Center	Sibley		$27,000		$47,000
Sanford Health					
Bagley Medical Center	Clearwater		$51,000		$85,000
Bemidji Medical Center	Beltrami		$35,000		$14,000
Canby Medical Center	Yellow Medicine		$23,000		$20,000
Jackson Medical Center	Jackson		$35,000		$65,000
Luverne Medical Center	Rock		$25,000		$25,000
Thief River Falls Medical Center	Pennington		$88,000		$92,000
Tracy Medical Center	Lyon		$13,000		$19,000
Westbrook Medical Center	Cottonwood		$18,000		$23,000
Wheaton Medical Center	Traverse		$17,000		$18,000
Worthington Medical Center	Nobles		$14,000		$2,000
No Affiliation					
Astera Health	Wadena		$72,000		$125,000
Community Memorial Hospital	Carlton		$33,000		$0
Cuyuna Regional Medical Center	Crow Wing		$40,000		$25,000
Ely-Bloomenson Community Hospital	St. Louis		$20,000		$3,000
Gillette Children's Hospital	Ramsey		$44,000		$5,000
Hendricks Community Hospital Association	Lincoln		$61,000		$85,000
Kittson Healthcare	Kittson		$13,000		$0

Estimated Total Tax Benefits per Bed, 2019-2023 (continued)

		State and Local		Federal	
Hospital	County	5-Year Line	2023	5-Year Line	2023
No Affiliation (continued)					
Lakewood Health System	Todd		$22,000		$4,000
LifeCare Medical Center	Roseau		$63,000		$45,000
Madelia Health	Watonwan		$7,000		$0
Madison Hospital	Lac Qui Parle		$9,000		$0
Mille Lacs Health System	Mille Lacs		$13,000		$0
North Valley Health Center	Marshall		$15,000		$0
Olmsted Medical Center	Olmsted		$52,000		$36,000
Rainy Lake Medical Center	Koochiching		$18,000		$0
RiverView Health	Polk		$50,000		$0
Riverwood Healthcare Center	Aitkin		$40,000		$10,000
Stevens Community Medical Center	Stevens		$34,000		$40,000
United Hospital District	Faribault		$23,000		$15,000
Welia Health[b]	Kanabec		$124,000		$121,000
Winona Health Services	Winona		$43,000		$0

Notes: Prior to 2022, Regina Hospital in Hastings operated under its own license and reported separately to the Minnesota Department of Health. Beginning that year, Regina Hospital and United Hospital in St. Paul began reporting under the same license. Regina Hospital is excluded from this Appendix.

[a] Excludes 2019 data.

[b] Excludes 2019 and 2020 data.

Source: Office of the Legislative Auditor, analysis of Centers for Medicare and Medicaid Services, Minnesota Department of Health, and Minnesota Department of Revenue data.

Appendix B: Community Benefit Spending Estimates

In Chapter 3, we introduced three definitions of community benefit spending:

- **Limited.** Includes charity care, subsidizing health services operated at a financial loss, community health services, contributions to other organizations, community building activities, and community benefit administrative overhead.

- **Moderate.** Includes all categories in the limited definition plus education, research, and absorbing underpayments for state health insurance programs (i.e., Medical Assistance and MinnesotaCare).

- **Expansive.** Includes all categories in the limited and moderate definitions plus absorbing bad debt and underpayments for Medicare.

For a full explanation of each category, see Exhibit 3.1 in Chapter 3.

Below, we present estimates of per-bed community benefit spending in 2023 for each Minnesota nonprofit hospital under all three definitions. The table includes nonprofit general hospitals only, and thus excludes government-owned hospitals and specialty hospitals (such as mental health hospitals). To the left of each estimate is a small line graph to show the year-to-year variation from 2019 to 2023. Hospitals that were nonprofit entities for only a single year over that time period are omitted from the table.

As we discussed in Chapter 3, some hospitals have reported different community benefit spending numbers to the Internal Revenue Service (IRS) than they have reported to the Minnesota Department of Health (MDH). The data below are based on reporting to MDH. We have marked with an asterisk hospitals whose reported community benefit spending to MDH and the IRS differed by at least 50 percent under the limited definition; two asterisks indicate a difference of at least 100 percent.

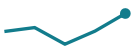
Reported Community Benefit Spending per Bed, 2019-2023

		Limited		Moderate		Expansive	
Hospital	County	5-Year Line	2023	5-Year Line	2023	5-Year Line	2023
Allina Health							
Abbott Northwestern Hospital	Hennepin		$22,000		$164,000		$551,000
Buffalo Hospital	Wright		$31,000		$105,000		$322,000
Cambridge Medical Center	Isanti		$40,000		$156,000		$467,000
Faribault Medical Center	Rice		$33,000		$178,000		$382,000
Mercy Hospital	Anoka		$36,000		$117,000		$381,000
New Ulm Medical Center	Brown		$44,000		$148,000		$301,000
Owatonna Hospital	Steele		$27,000		$152,000		$364,000
United Hospital	Ramsey		$22,000		$133,000		$465,000
Allina Health – Health Partners/Park Nicollet – Essentia Health							
St. Francis Regional Medical Center*	Scott		$30,000		$167,000		$483,000
Aspirus Health							
Lake View Hospital**	Lake		$21,000		$95,000		$107,000
St. Luke's Hospital	St. Louis		$78,000		$141,000		$499,000
Avera Health							
Granite Falls Health Center**	Yellow Medicine		< $1,000		$46,000		$149,000
Marshall Regional Medical Center**	Lyon		$9,000		$92,000		$285,000
Tyler Hospital**	Lincoln		$3,000		$10,000		$22,000
Catholic Health Initiatives							
LakeWood Health	Lake of the Woods		$25,000		$83,000		$138,000
St. Francis Health	Wilkin		$23,000		$55,000		$116,000
St. Gabriel's Hospital**	Morrison		$30,000		$174,000		$495,000
St. Joseph's Health	Hubbard		$66,000		$156,000		$309,000

Reported Community Benefit Spending per Bed, 2019-2023 (continued)

		Limited		Moderate		Expansive	
Hospital	County	5-Year Line	2023	5-Year Line	2023	5-Year Line	2023
CentraCare							
Long Prairie Hospital*	Todd		$21,000		$60,000		$101,000
Melrose Hospital*	Stearns		$8,000		$9,000		$27,000
Monticello Hospital	Wright		$5,000		$51,000		$167,000
Paynesville Hospital	Stearns		$2,000		$8,000		$22,000
Redwood Hospital	Redwood		$42,000		$47,000		$182,000
Rice Memorial Hospital	Kandiyohi		$2,000		$97,000		$273,000
Sauk Centre Hospital	Stearns		$6,000		$7,000		$18,000
St. Cloud Hospital	Stearns		$9,000		$119,000		$282,000
Children's Hospitals and Clinics							
Children's Minnesota	Hennepin		$118,000		$745,000		$775,000
Essentia Health							
Ada	Norman		$6,000		$32,000		$42,000
Deer River	Itasca		$13,000		$81,000		$95,000
Duluth	St. Louis		$18,000		$248,000		$817,000
Fosston	Polk		$17,000		$71,000		$81,000
Holy Trinity Hospital	Big Stone		$3,000		$15,000		$65,000
Moose Lake	Carlton		$0		$112,000		$136,000
Northern Pines	St. Louis		$9,000		$43,000		$55,000
Sandstone	Pine		$27,000		$150,000		$197,000
St. Joseph's Medical Center	Crow Wing		$12,000		$77,000		$295,000
St. Mary's – Detroit Lakes Hospital	Becker		$24,000		$153,000		$375,000
St. Mary's Medical Center	St. Louis		$14,000		$115,000		$315,000
Virginia	St. Louis		$16,000		$173,000		$571,000

Reported Community Benefit Spending per Bed, 2019-2023 (continued)

Hospital	County	Limited		Moderate		Expansive	
		5-Year Line	2023	5-Year Line	2023	5-Year Line	2023
Gundersen Health System							
Saint Elizabeth's Hospital	Wabasha		$222,000		$295,000		$304,000
HealthPartners – Park Nicollet							
Glencoe Regional Health*	McLeod		$41,000		$111,000		$214,000
Hutchinson Health	McLeod		$24,000		$126,000		$404,000
Lakeview Hospital**	Washington		$16,000		$77,000		$269,000
Methodist Hospital	Hennepin		$20,000		$56,000		$139,000
Olivia Hospital and Clinic**	Renville		$19,000		$38,000		$60,000
Regions Hospital	Ramsey		$62,000		$120,000		$256,000
Lake Region Healthcare							
Elbow Lake Medical Center**	Grant		$5,000		$67,000		$104,000
Fergus Falls Hospital	Otter Tail		$6,000		$99,000		$470,000
M Health Fairview							
Fairview Range	St. Louis		$31,000		$132,000		$368,000
Grand Itasca Clinic and Hospital	Itasca		$36,000		$139,000		$527,000
Lakes Medical Center	Chisago		$41,000		$122,000		$273,000
Northland Medical Center	Sherburne		$55,000		$163,000		$441,000
Ridges Hospital	Dakota		$36,000		$136,000		$314,000
Southdale Hospital	Hennepin		$18,000		$105,000		$365,000
St. John's Hospital	Ramsey		$34,000		$159,000		$433,000
University of Minnesota Medical Center	Hennepin		$44,000		$377,000		$582,000
Woodwinds Hospital	Washington		$44,000		$220,000		$482,000

Reported Community Benefit Spending per Bed, 2019-2023 (continued)

		Limited		Moderate		Expansive	
Hospital	County	5-Year Line	2023	5-Year Line	2023	5-Year Line	2023
Mayo Clinic							
Albert Lea and Austin	Freeborn		$71,000		$319,000		$826,000
Cannon Falls	Goodhue		$50,000		$148,000		$186,000
Fairmont	Martin		$37,000		$195,000		$488,000
Lake City	Goodhue		$25,000		$102,000		$129,000
Mankato	Blue Earth		$49,000		$248,000		$743,000
New Prague	Scott		$49,000		$146,000		$190,000
Red Wing	Goodhue		$50,000		$200,000		$619,000
Rochester	Olmsted		$45,000		$104,000		$188,000
St. James	Watonwan		$42,000		$163,000		$224,000
Waseca	Waseca		$42,000		$202,000		$262,000
North Memorial Health Care							
Maple Grove Hospital**	Hennepin		$8,000		$73,000		$141,000
Robbinsdale Hospital**	Hennepin		$22,000		$119,000		$330,000
Ridgeview Medical Center							
Le Sueur Medical Center**	Le Sueur		$1,000		$34,000		$74,000
Ridgeview Medical Center	Carver		$9,000		$134,000		$589,000
Sibley Medical Center**	Sibley		$1,000		$4,000		$19,000
Sanford Health							
Bagley Medical Center	Clearwater		$13,000		$55,000		$69,000
Bemidji Medical Center	Beltrami		$29,000		$171,000		$478,000
Canby Medical Center	Yellow Medicine		$14,000		$45,000		$54,000
Jackson Medical Center	Jackson		$7,000		$18,000		$32,000
Luverne Medical Center	Rock		$38,000		$81,000		$99,000

Reported Community Benefit Spending per Bed, 2019-2023 (continued)

Hospital	County	Limited		Moderate		Expansive	
		5-Year Line	2023	5-Year Line	2023	5-Year Line	2023
Sanford Health (continued)							
Thief River Falls Medical Center	Pennington		$41,000		$156,000		$241,000
Tracy Medical Center	Lyon		$3,000		$18,000		$24,000
Westbrook Medical Center	Cottonwood		$9,000		$35,000		$53,000
Wheaton Medical Center	Traverse		$16,000		$19,000		$23,000
Worthington Medical Center	Nobles		$20,000		$88,000		$187,000
No Affiliation							
Astera Health*	Wadena		$314,000		$495,000		$504,000
Community Memorial Hospital	Carlton		$55,000		$205,000		$657,000
Cuyuna Regional Medical Center**	Crow Wing		$28,000		$28,000		$112,000
Ely-Bloomenson Community Hospital	St. Louis		$28,000		$119,000		$293,000
Gillette Children's Hospital	Ramsey		$277,000		$1,210,000		$1,330,000
Hendricks Community Hospital Association**	Lincoln		$51,000		$71,000		$89,000
Kittson Healthcare**	Kittson		$0		$20,000		$101,000
Lakewood Health System	Todd		$64,000		$197,000		$427,000
LifeCare Medical Center	Roseau		$262,000		$325,000		$381,000
Madelia Health	Watonwan		$56,000		$91,000		$117,000
Madison Hospital	Lac Qui Parle		$8,000		$47,000		$136,000
Mille Lacs Health System**	Mille Lacs		$85,000		$242,000		$331,000
North Valley Health Center**	Marshall		$12,000		$101,000		$104,000
Olmsted Medical Center**	Olmsted		$25,000		$633,000		$1,518,000

Reported Community Benefit Spending per Bed, 2019-2023 (continued)

Hospital	County	Limited		Moderate		Expansive	
		5-Year Line	2023	5-Year Line	2023	5-Year Line	2023
No Affiliation (continued)							
Rainy Lake Medical Center	Koochiching		$354,000		$467,000		$503,000
RiverView Health**	Polk		$8,000		$142,000		$288,000
Riverwood Healthcare Center**	Aitkin		$610,000		$675,000		$935,000
Stevens Community Medical Center*	Stevens		$15,000		$17,000		$37,000
United Hospital District**	Faribault		$40,000		$189,000		$198,000
Welia Health	Kanabec		$42,000		$279,000		$325,000
Winona Health Services**	Winona		$8,000		$186,000		$644,000

Notes: Four hospitals were government-owned for one or two years over the period 2019-2023: Avera Granite Falls Health Center, Essentia – Moose Lake, Olivia Hospital, and Welia Health. The table includes the community benefit spending for all five years for those hospitals. Prior to 2022, Regina Hospital in Hastings operated under its own license and reported separately to MDH. Beginning that year, Regina Hospital and United Hospital in St. Paul began reporting under the same license. Regina Hospital is excluded from this Appendix.

* Hospital's reported community benefit spending to MDH and the IRS differed by at least 50 percent.

** Hospital's reported community benefit spending to MDH and the IRS differed by at least 100 percent.

Source: Office of the Legislative Auditor, analysis of MDH and IRS data.

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Appendix C: Nonprofit Hospital Requirements in Other States

Below, we list states that require nonprofit hospitals to report or provide community benefits. Many states have specific requirements related to charity care (free or discounted care provided to patients who cannot afford to pay); these are marked in the second and third columns. When states require nonprofit hospitals to report their spending on any other type of community benefit publicly or to a state agency, we place a check mark in the fourth column.

As we discuss in Chapter 4, a few states require nonprofit hospitals to spend a minimum amount on community benefits as a condition of operating or receiving tax benefits. These are marked in the fifth column. When a state has a check mark for "Must Provide Charity Care" but not for "Must Provide a Minimum Amount of Community Benefits," the state broadly requires nonprofit hospitals to provide charity care, but sets no minimum spending requirement.

We do not list state requirements that hospitals create a community benefit plan; the introduction of the federal requirement for nonprofit hospitals to complete Community Health Needs Assessments essentially created a nationwide requirement for such a plan.[1]

This table is derived from listings of state laws related to community benefits compiled by the National Council of State Legislatures (NCSL) and the Hilltop Institute, a research organization at the University of Maryland, Baltimore County.[2] We used their existing work as a starting point and reviewed other states' laws ourselves. However, we did not exhaustively research states' laws to confirm that certain states had *not* passed relevant laws. States not appearing in this appendix either (1) were not listed as having community benefit requirements in the NCSL or Hilltop compilations, or (2) were listed, but we excluded them after reviewing their statutes or rules because the requirements were not applicable.[3]

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[1] 26 *U.S. Code*, sec. 501(r)(3) (2024).

[2] Sarah Jaromin, NCSL, e-mail message with attachment to David Kirchner, "Community Benefit Requirements," September 18, 2024; and Hilltop Institute, Community Benefit State Law Profiles, https://hilltopinstitute.org/our-work/hospital-community-benefit/hospital-community-benefit-state-law-profiles/, accessed September 13, 2024. Several academic and policy advocacy articles that we reviewed in the course of our evaluation work also referred to specific state laws.

[3] For example, the Hilltop Institute listing indicated that Iowa required county-operated hospitals to provide charity care. Our review of Iowa law indicated this requirement did not extend to nonprofit hospitals, so we excluded Iowa from the appendix.

State	Must Report Charity Care	Must Provide Charity Care	Must Report Other Benefits (Beyond Charity Care)	Must Provide a Minimum Amount of Community Benefits	Notes	Citation
California	✓		✓		Does not apply to certain hospitals excluded in law, including independent small rural hospitals.	*California Health and Safety Code*, secs. 127340-127360 (West 2024).
Colorado	✓		✓		Does not apply to long-term care hospitals or small rural hospitals.	*Colorado Revised Statutes Annotated*, sec. 25.5-1-703 (West 2024).
Delaware		✓			Requirement is a condition of obtaining a Certificate of Public Review, required to construct, expand, or transfer ownership of a hospital.	*Delaware Code Annotated*, title 16, secs. 9304 and 9311 (West 2024).
Florida		✓				*Florida Statutes Annotated*, sec. 617.2002 (West 2024).
Georgia	✓				Requirement is a condition of obtaining a Certificate of Need, required to expand a hospital.	*Georgia Code Annotated*, secs. 31-6-70 and 31-7-280 (West 2024).
Idaho	✓		✓		Applies only to hospitals with at least 150 beds.	*Idaho Code*, sec. 63-602D (West 2024).
Illinois	✓	✓	✓	✓	Hospitals must provide a minimum level of community benefits in order to obtain property tax exemption. Reporting requirements apply only to metropolitan-area hospitals with more than 100 beds.	210 *Illinois Compiled Statutes Annotated*, secs. 76/1-99 and 89/1-30; and 35 *Illinois Compiled Statutes Annotated*, secs. 105/3-8, 120/2-9, and 200/15-86 (West 2024). Laws passed in response to *Provena Covenant Medical Center v. Department of Revenue*, 925 N.E.2d 1131 (Ill. 2010).
Indiana	✓		✓			*Indiana Code*, sec. 16-21-9-7 (West 2024).
Maine	✓	✓				*Maine Revised Statutes Annotated*, title 22, secs. 1715-1716 (West 2024); and *Code of Maine Rules*, 10-144, chapter 150 (West 2024).
Maryland	✓	✓	✓		Requirement to provide charity care does not apply to certain specialized hospitals.	*Maryland Code Annotated, Health-General*, secs. 19-303 and 19-214.1, as amended by 2024 *Maryland Laws*, chapter 959 (West 2024).
Massachusetts		✓			Does not apply to certain specialized hospitals.	*Massachusetts General Laws Annotated*, chapter 111, sec. 51G (West 2024).

State	Must Report Charity Care	Must Provide Charity Care	Must Report Other Benefits (Beyond Charity Care)	Must Provide a Minimum Amount of Community Benefits	Notes	Citation
Minnesota	✓		✓			*Minnesota Statutes* 2024, 144.587 and 144.698.
Mississippi		✓			Requirement is a condition of obtaining a property tax exemption.	*Mississippi Code Annotated*, sec. 27-31-1(f) (West 2024).
Missouri	✓					*Missouri Annotated Statutes*, sec. 192.667(1) (West 2024).
Montana	✓	✓	✓			*Montana Code Annotated*, sec. 50-5-121 (West 2024); and *Montana Administrative Rules* 37.106.138 (West 2024).
Nevada	✓	✓	✓	✓	Hospitals with more than 100 beds in counties with more than one hospital must spend a minimum amount on charity care. Counties reimburse hospitals for some charity care costs. Community benefit reporting requirement applies to hospitals with at least 100 beds.	*Nevada Revised Statutes Annotated*, secs. 439B.300-439B.340 and 449.490 (West 2024).
New Hampshire	✓		✓		Applies to hospitals with more than $100,000 in fund balance. Hospitals may seek an exemption.	*New Hampshire Revised Statutes*, secs. 7:32-c to 7:32-l (West 2024).
New Jersey	✓	✓	✓	✓	Tax-exempt hospitals must make a "community service contribution" to local governments based on the number of beds. Hospitals are excluded if they do not charge for their services and provide a minimum level of community benefits. All nonspecialized hospitals must provide charity care and must report on costs in order to receive state reimbursement.	*New Jersey Statutes Annotated*, sec. 40:48J-1 (West 2024). Law passed in response to *AHS Hospital Corporation v. Town of Morristown*, 28 N.J. Tax 456 (N.J. Tax 2015).
New Mexico	✓	✓				*New Mexico Statutes Annotated*, sec. 24A-1-7 (West 2024); and *New Mexico Administrative Code* 7.1.24.12 (West 2024).
New York	✓	✓	✓			*New York Public Health Law*, sec. 2803-l (McKinney 2024).

State	Must Report Charity Care	Must Provide Charity Care	Must Report Other Benefits (Beyond Charity Care)	Must Provide a Minimum Amount of Community Benefits	Notes	Citation
North Carolina	✓	✓	✓		Charity care provision requirement is a condition of obtaining a Certificate of Need, required to establish, change the size of, or transfer ownership of a hospital. Reporting requirements apply only to hospitals that obtain tax-exempt bonding through a state commission.	*North Carolina General Statutes Annotated*, secs. 131A-7 and 131E-183 (West 2024); and "North Carolina Medical Care Commission Community Benefits Report (Hospitals)," https://info.ncdhhs.gov/dhsr/ncmcc/pdf /mcccbform.pdf, accessed September 18, 2024.
Oregon	✓	✓	✓	✓	The minimum community benefit level for each individual hospital is set by state agency on a case-by-case basis.	*Oregon Revised Statutes Annotated*, secs. 442.601 to 442.624 (West 2024); and Oregon Administrative Rules, 409-023-0100 to 409-023-0115 (2024).
Pennsylvania	✓		✓	✓	All tax-exempt nonprofits that provide direct services (not just hospitals) must demonstrate that they benefit the community using one of several standards related to the percentage of recipients granted free goods or services or the percentage of net income used to provide free goods or services. There are no hospital-specific requirements.	10 *Pennsylvania Statutes*, 375 and 379 (West 2024).
Rhode Island	✓	✓	✓		Hospitals must provide charity care to patients meeting state-specified income requirements. However, there is no requirement that hospitals spend a minimum amount overall.	*Rhode Island General Laws*, sec. 23-17-43 (West 2024); and 216 *Rhode Island Code of* Rules, sec. 40-10-23.14 (2024).
Tennessee	✓					*Tennessee Code Annotated*, sec. 68-1-109 (West 2024).
Texas	✓	✓	✓	✓	Minimum community benefit requirement does not apply to hospitals serving disproportionately large Medicaid populations or hospitals in low-population counties designated a "health professionals shortage area."	*Texas Health and Safety Code Annotated*, secs. 311.041 to 311.048 (West 2024); and *Texas Tax Code Annotated*, sec. 11.1801 (West 2024).

State	Must Report Charity Care	Must Provide Charity Care	Must Report Other Benefits (Beyond Charity Care)	Must Provide a Minimum Amount of Community Benefits	Notes	Citation
Utah		✓		✓	Under a state supreme court decision (not legislative action), hospitals must show that their "gifts to the community" exceed their property tax liability in order to receive a property tax exemption.	*Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985); and Utah State Tax Commission, Property Tax Division, *Property Tax Exemptions: Standards of Practice* (Salt Lake City: August 2024), https://propertytax.utah.gov/standards/standard02.pdf, accessed September 19, 2024.
Virginia	✓	✓			Requirement is a condition of obtaining a Certificate of Need, required to establish or expand a hospital.	*Virginia Code Annotated*, sec. 32.1-102.4 (West 2024).
Washington	✓	✓			Hospitals are required to report the number of charity care applications and approvals.	*Revised Code of Washington Annotated*, secs. 43.70.052(7) and 70.170.060 (West 2024).
West Virginia					Hospitals are required to provide charity care or community benefits as a condition of property tax exemption, but there is no minimum amount required.	*West Virginia Code of State Rules*, sec. 110-3-24 (2024).
Wisconsin	✓					*Wisconsin Administrative Code*, Department of Human Services 120.12 (2024).

Notes: Requirements were accurate as of September 2024. Some requirements apply to all hospitals, not just nonprofit hospitals. In some states, the listed requirements apply to tax-exempt hospitals; we have assumed that tax-exempt hospitals include all nonprofit hospitals. Some states may define "hospital" slightly differently than others; we did not examine each state's legal definition.

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