

SPECIAL ARTICLE

Provision of Community Benefits by Tax-Exempt U.S. Hospitals

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ABSTRACT

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) requires tax-exempt hospitals to conduct assessments of community needs and address identified needs. Most tax-exempt hospitals will need to meet this requirement by the end of 2013.

METHODS

We conducted a national study of the level and pattern of community benefits that tax-exempt hospitals provide. The study comprised more than 1800 tax-exempt hospitals, approximately two thirds of all such institutions. We used reports that hospitals filed with the Internal Revenue Service for fiscal year 2009 that provide expenditures for seven types of community benefits. We combined these reports with other data to examine whether institutional, community, and market characteristics are associated with the provision of community benefits by hospitals.

RESULTS

Tax-exempt hospitals spent 7.5% of their operating expenses on community benefits during fiscal year 2009. More than 85% of these expenditures were devoted to charity care and other patient care services. Of the remaining community-benefit expenditures, approximately 5% were devoted to community health improvements that hospitals undertook directly. The rest went to education in health professions, research, and contributions to community groups. The level of benefits provided varied widely among the hospitals (hospitals in the top decile devoted approximately 20% of operating expenses to community benefits; hospitals in the bottom decile devoted approximately 1%). This variation was not accounted for by indicators of community need.

CONCLUSIONS

In 2009, tax-exempt hospitals varied markedly in the level of community benefits provided, with most of their benefit-related expenditures allocated to patient care services. Little was spent on community health improvement.

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A LONG-STANDING POLICY ISSUE IN THE United States concerns tax exemption for nonprofit hospitals. Almost all such hospitals are exempt from income, property, and sales taxes on the basis that they qualify as charitable organizations.¹⁻³ Although federal, state, and local standards for defining a charitable organization differ in many cases, there is a general expectation that tax-exempt hospitals will benefit their communities by providing services and otherwise engaging in activities that they fully or partially subsidize.

However, the question of whether tax-exempt hospitals provide appropriate levels of community benefits has generated considerable controversy. At the local level, a number of hospitals have had their property-tax exemptions challenged or revoked on the grounds that the community benefits they provide are inadequate.^{1,4-6} At the federal level, congressional hearings have been held to address the issue of whether tax-exempt hospitals are sufficiently accountable for providing community benefits at levels that justify the value of their federal income-tax exemption,⁷ which, according to the Government Accountability Office (GAO), is approximately \$13 billion annually.⁸ These hearings provided the impetus for Congress to add a provision to the Patient Protection and Affordable Care Act (ACA), the sweeping health care reform law in the United States, that requires tax-exempt hospitals to conduct an assessment of community needs every 3 years and develop an implementation strategy to address identified needs.⁹ Most tax-exempt hospitals will need to meet this requirement by the end of 2013.

This controversy has also prompted empirical studies of the provision of community benefits by tax-exempt hospitals.^{2,3,8,10} Most such studies have been confined to certain states and to a narrow set of community-benefit measures. Although more comprehensive studies are needed to assess the provision of community benefits among tax-exempt hospitals, such research has been impeded by both a lack of uniform, national data and a lack of standard approaches to defining and measuring community benefits.

A major step toward addressing these limitations occurred in 2007 when the Internal Revenue Service (IRS) revised Schedule H of Form 990 to promote uniform and comprehensive reporting of community benefits.¹ Most tax-exempt organi-

zations are required to complete some version of Form 990, but Schedule H pertains specifically to hospitals. The revised Schedule H requires hospitals to report their expenditures for activities and services that the IRS has classified as community benefits. The revised version of Schedule H includes specific criteria and instructions for reporting these expenditures so that information should be comparable among hospitals. Hospitals were first required to file this revised form in 2009.

We used information from the 2009 revised Schedule H to conduct a national study of the provision of community benefits by tax-exempt hospitals. We combined this information with other data sources to address three questions. First, from a national perspective, what is the level and pattern of community benefits provided by tax-exempt hospitals? Second, how much variation exists among tax-exempt hospitals in the level of benefits provided? Third, is the variation among tax-exempt hospitals associated with institutional-level, community-level, and market-level characteristics?

METHODS

STUDY HOSPITALS AND DATA SOURCES

Our study focused on private, tax-exempt hospitals that provide general, acute care services. These organizations represent more than 90% of all tax-exempt hospitals.¹¹

We conducted our investigation using several data sources. Our primary source of data consisted of Form 990 and the related Schedule H for 2009 (see the Supplementary Appendix, available with the full text of this article at NEJM.org). We focused on 2009 because it was the first year in which the IRS required hospitals to file the revised Schedule H and for which the reported information was most complete, since many hospitals receive extensions to file these forms each year. We obtained these data from GuideStar, a company that obtains, digitizes, and sells data that organizations report on Form 990 and related schedules. For each tax filing obtained from GuideStar, we confirmed that the Form 990 and Schedule H belonged to a tax-exempt hospital by matching the name and address of the hospital with information contained in the 2009 American Hospital Association (AHA) Annual Survey of Hospitals.

Following these procedures, we were able to obtain data on more than 1800 hospitals, which, on the basis of the 2009 AHA survey and GuideStar database, represent approximately two thirds of all private, tax-exempt hospitals that provide general, acute care services in the United States. The remaining private, tax-exempt hospitals were not included in the study because they were members of a hospital system that submitted a consolidated report for its member hospitals (e.g., Kaiser Permanente). As such, these hospitals did not file an individual Form 990 and Schedule H. Table 1 compares the structural and operating characteristics of the study hospitals with those of all private, tax-exempt general hospitals in the United States. The study hospitals somewhat underrepresented system-affiliated hospitals but were generally similar to all private, tax-exempt hospitals in the United States that provide general, acute care services. We also compared the study hospitals with all private, tax-exempt U.S. hospitals with respect to hospital location in nine U.S. Census regions and observed no significant differences.

We merged the hospital IRS filings with the 2009 AHA survey data, the Area Resource File from the Department of Health and Human Services, and files from the Centers for Medicare and Medicaid Services. By combining these data, we created a profile for each hospital that included its reported expenditures for community benefits, its institutional characteristics, and pertinent community and market characteristics.

COMMUNITY-BENEFIT MEASURES

We used the seven community-benefit measures that hospitals reported on the 2009 Schedule H. These measures are charity care (i.e., subsidized care for persons who meet the criteria for charity care established by the hospital), unreimbursed costs for means-tested government programs, subsidized health services (i.e., clinical services provided at a financial loss), community health improvement services and community-benefit operations (i.e., activities carried out or supported for the express purpose of improving community health, such as conducting or otherwise supporting childhood immunization efforts), research, health-professions education, and financial and in-kind contributions to community groups (i.e., contributions to carry out any of the activities

Table 1. Characteristics of All Private, Tax-Exempt General Hospitals in the United States and the Subgroup of Hospitals Included in the Study.

Characteristic	All Private, Tax-Exempt General Hospitals (N=2894)	Hospitals Included in the Study (N=1835)
	percent	
No. of beds		
≤100	44.9	45.2
101–299	34.6	36.7
>299	20.5	18.1
Religious affiliation status*		
Secular	84.0	85.7
Church affiliation	16.0	14.3
Hospital-system affiliation status†		
Independent	44.2	52.4
Affiliated	55.8	47.5
Geographic area‡		
Rural	40.9	43.8
Urban	59.1	56.2
Teaching status§		
Nonteaching	92.7	93.7
Teaching	7.3	6.3

* Church affiliation refers to hospitals that were owned and operated by a religious organization. All other hospitals were classified as secular.

† Hospital-system affiliation refers to hospitals that were members of a corporate entity that owned two or more hospitals (i.e., multihospital systems). All other hospitals were classified as independent. $P<0.05$ for the comparison between all hospitals and study hospitals.

‡ Hospitals classified as urban were those located within a metropolitan statistical area. All other hospitals were classified as rural.

§ Hospitals classified as teaching hospitals were those that were members of the Council of Teaching Hospitals. All other hospitals were classified as nonteaching hospitals.

that are classified as community benefits in Schedule H). For purposes of comparability, we standardized each measure by dividing the reported expenditure of the hospital by its own total operating expenses as reported on Form 990.

Because Schedule H is a new source of hospital data, we took several steps to examine the validity of these data. These steps included comparing the expenditures that hospitals reported on Schedule H with corresponding measures of service activity from independent data sources. For example, we examined the statistical relationship between the expenditures that a hospital reported for health-professions education on

Table 2. Provision of Community Benefits as a Percentage of Hospital Operating Expenses.

Community Benefit	Mean Percentage of Operating Expenses	Standard Deviation	Interquartile Range
All	7.5	6.4	3.9–9.1
Charity care	1.9	1.9	0.6–2.6
Unreimbursed costs for means-tested government programs	3.4	4.3	0.8–4.7
Subsidized health services	1.1	2.8	0–1.0
Community health improvement	0.4	1.0	0–0.4
Cash or in-kind contributions to community groups	0.2	2.4	0–0.1
Research	0.1	0.7	0–0
Health-professions education	0.4	1.1	0–0.3

Schedule H and the number of medical residents and other trainees that the hospital reported to the AHA in 2009. The correlation was 0.91. The other checks we undertook also supported the validity of Schedule H data (see the Supplementary Appendix).

To identify institutional-level characteristics and community-level and market-level characteristics that are associated with the provision of community benefits, we specified analytic models that entailed combining the seven community-benefit measures into two distinct community-benefit variables. For one variable, we added together the reported contributions of a hospital for those measures pertaining to direct patient care — namely, charity care, unreimbursed costs for means-tested programs, and subsidized health services. For the other variable, we added together the reported contributions for the remaining measures pertaining to broader community service.

STATISTICAL ANALYSIS

We used descriptive statistics for each of the community-benefit measures. For the analytic models, we used two multiple-regression models, one for each type of community-benefit measure: patient care and community service. We estimated both regression models using a generalized linear model.

For the regression models, the independent variables comprised institutional-level, community-level, and market-level characteristics. Information for each independent variable is provided in Table S1 in the Supplementary Appendix. In-

stitutional characteristics pertained to the motivation of the hospital to provide community benefits (e.g., sole community provider) and its capability to do so (e.g., profit margin). Community-level and market-level characteristics pertained to the need for community benefits (e.g., percentage of community residents who were uninsured) and the potential supply of community benefits (e.g., the presence of public hospitals). We also accounted for the level of competitive pressures (e.g., market competition) that tax-exempt hospitals face, since such pressures may cause them to curtail their provision of community benefits.

We defined the community and market area of a hospital as the county in which that hospital was located, which is consistent with the definition used in previous studies.² In addition, we accounted for whether a hospital was located in 1 of the 16 states that required hospitals to report expenditures for a broad set of community benefits. Although there is no uniformity among these states in terms of how benefits are defined,^{12–14} such requirements promote transparency and thus may motivate hospitals to provide higher levels of community benefits.

RESULTS

COMMUNITY-BENEFIT MEASURES

Table 2 presents descriptive statistics for the IRS-defined community-benefit measures. Overall, study hospitals expended, on average, 7.5% of their operating expenses for these services and activities. However, there was considerable variation among hospitals in terms of the level of benefits provided. When hospitals were sorted into deciles on the basis of the percentage of operating expenses devoted to community benefits, hospitals in the top decile spent an average of 20.1%, whereas those in the bottom decile spent an average of 1.1% (Fig. S1 in the Supplementary Appendix).

Of the expenditures reported for community benefits, hospitals devoted, on average, more than 85% to services directly related to patient care (Fig. 1). Almost half these expenditures went to subsidizing the cost of care for patients covered by means-tested government insurance programs, mostly Medicaid. For activities that were not directly related to patient care, most expenditures were devoted to community health-improvement activities and health-professions education. The

proportion of hospital expenditures for community health improvement and education is largely in line with that reported previously by the GAO in its investigation of the provision of community benefits by tax-exempt hospitals in Indiana and Texas.⁸

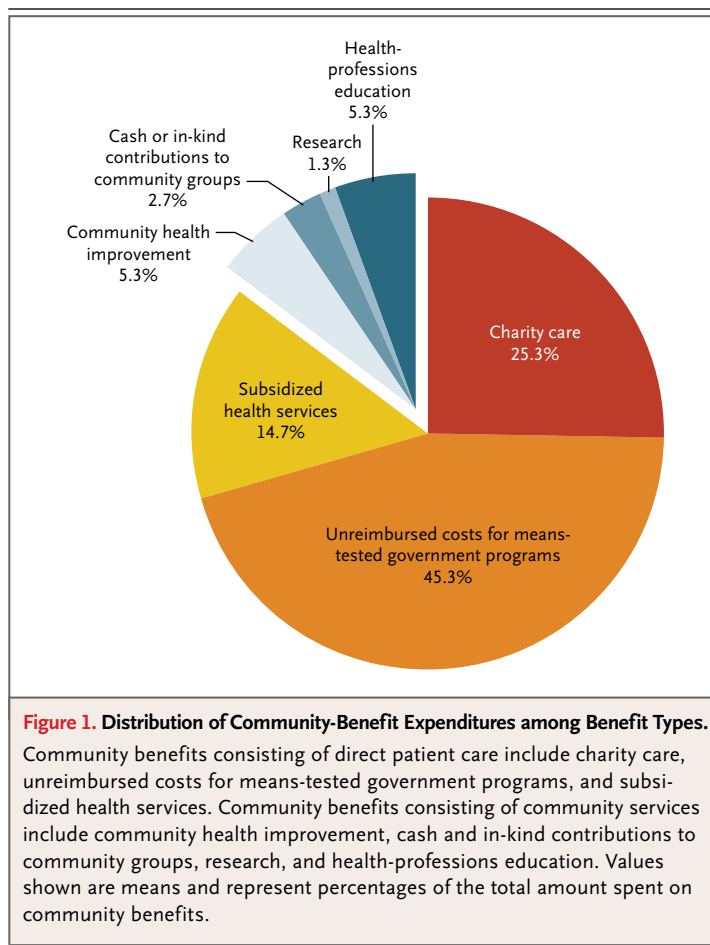
EXPENDITURE PATTERNS

Given the observed variation among hospitals in the level of community benefits provided, we conducted further analyses to assess whether such variation reflects distinct patterns in the level of expenditures by hospitals across the seven community-benefit measures. That is, if a hospital provided a relatively high level of one benefit, was it also likely to provide a relatively high level of another benefit? Our analyses indicate that this is not the case. For example, less than 30% of the study hospitals were in the top quartile for three or more of the seven community-benefit measures. Less than 12% of the study hospitals were in the top quartile for four or more of the measures. In addition, the correlation between the variables for direct patient care and those for community services was only 0.01, indicating that hospitals that provided relatively high levels of benefit for one set of variables did not typically provide relatively high levels of benefits for the other set of variables.

CHARACTERISTICS ASSOCIATED WITH PROVISION OF COMMUNITY BENEFITS

Table 3 presents results from the regression analyses. For the patient care model, hospital expenditures were positively associated with only the state-level requirements for reporting community benefits. For the community-service model, hospital expenditures were positively associated with two institutional-level characteristics — teaching status and sole community provider designation — and also with state-level reporting requirements for community benefits. For both models, there was also some evidence of broad geographic variation, because hospitals in the West (the reference group) appeared, on average, to have relatively higher expenditures than hospitals in other regions of the country.

Since the regression analyses that included all hospitals in the study population revealed few determinants of hospital expenditures for community benefits, we also examined whether institutional and community characteristics dis-



tinguished hospitals that had relatively high levels of community-benefit expenditures from those that had relatively low levels of such expenditures. We used logistic regression where the dependent variable was specified to indicate whether hospitals had relatively high or low expenditures for community benefits (i.e., analyses were conducted for hospitals at the top and bottom 5% of the distribution, and also for the top and bottom 10%). These analyses did not reveal any pattern of differences between hospitals that provided a relatively high level of community benefits and those that provided a relatively low level (Table S2 in the Supplementary Appendix).

To further investigate the relationships between the provision of community benefits by hospitals and key community characteristics, we sorted hospitals into three groups on the basis of the percentage of uninsured residents in the communities they served and compared the level as well as the pattern of expenditures among the

three groups (Fig. 2). Using analysis of variance, we found no significant differences among these groups regarding either the level or the pattern of expenditures. We obtained similar results for other community characteristics.

DISCUSSION

The analysis presented in this article offers a national assessment of the level and pattern of benefits that tax-exempt hospitals provided before the implementation of the ACA requirements. On a national basis, we found that hospitals devoted, on average, 7.5% of their operating expenditures to community benefits. However, the level of benefits provided varied widely among the hospitals. Moreover, hospitals that provided relatively high levels of one type of benefit were not likely to have provided high levels of other types of benefits.

Among the many variables we examined that potentially underlie the variation among hospitals

with respect to community benefits, few emerged as significant. In particular, the provision of community benefits was not associated with either of two community-level socioeconomic characteristics: the percentage of uninsured residents and per capita income. A previous study of hospitals in Florida and California showed no effect of these socioeconomic characteristics on the provision of community benefits.² This finding suggests a lack of correspondence between community need and the provision of benefits by hospitals. Moreover, it raises questions regarding how hospitals, given their limited resources for such endeavors, decide which community benefits to provide.

One variable that did show a relationship with community-benefit expenditures was state-level requirements for broad community-benefit reporting, which were significantly and positively associated with hospital expenditures for both patient care and community services. As noted

Table 3. Provision of Community Benefits According to Institutional, Community, and Market Characteristics.*

Characteristic	Community Benefit			
	Direct Patient Care	P Value	Community Service	P Value
Institutional characteristics				
No. of beds	0.07±0.11	0.56	0.11±0.06	0.09
System affiliation†	-0.38±0.33	0.25	0.19±0.17	0.27
Network affiliation‡	-0.13±0.31	0.68	-0.14±0.17	0.41
Case-mix index§	-1.57±0.95	0.11	0.70±0.50	0.16
Wage index¶	-0.00±0.04	0.92	-0.02±0.02	0.50
Teaching hospital	0.59±0.68	0.38	2.78±0.36	<0.001
Contract managed**	0.39±0.49	0.42	-0.05±0.26	0.83
Church affiliation††	-0.40±0.44	0.36	-0.18±0.23	0.44
Sole community provider‡‡	0.23±0.52	0.52	0.65±0.28	0.02
Profit margin§§				
High	-0.17±0.36	0.62	-0.15±0.19	0.43
Negative	0.33±0.41	0.43	0.15±0.22	0.49
Community and market characteristics				
State-level community-benefit reporting requirements¶¶	0.62±0.26	0.02	0.41±0.17	0.02
Per capita income in the local community	0.00±0.00	0.12	0.00±0.00	0.14
Market competition	0.10±0.61	0.87	-0.20±0.32	0.53
Percentage of uninsured persons in the local community	0.05±0.03	0.11	-0.03±0.02	0.23
Percentage of hospital beds controlled by for-profit hospitals in the local community	-0.27±1.28	0.83	-0.51±0.68	0.45

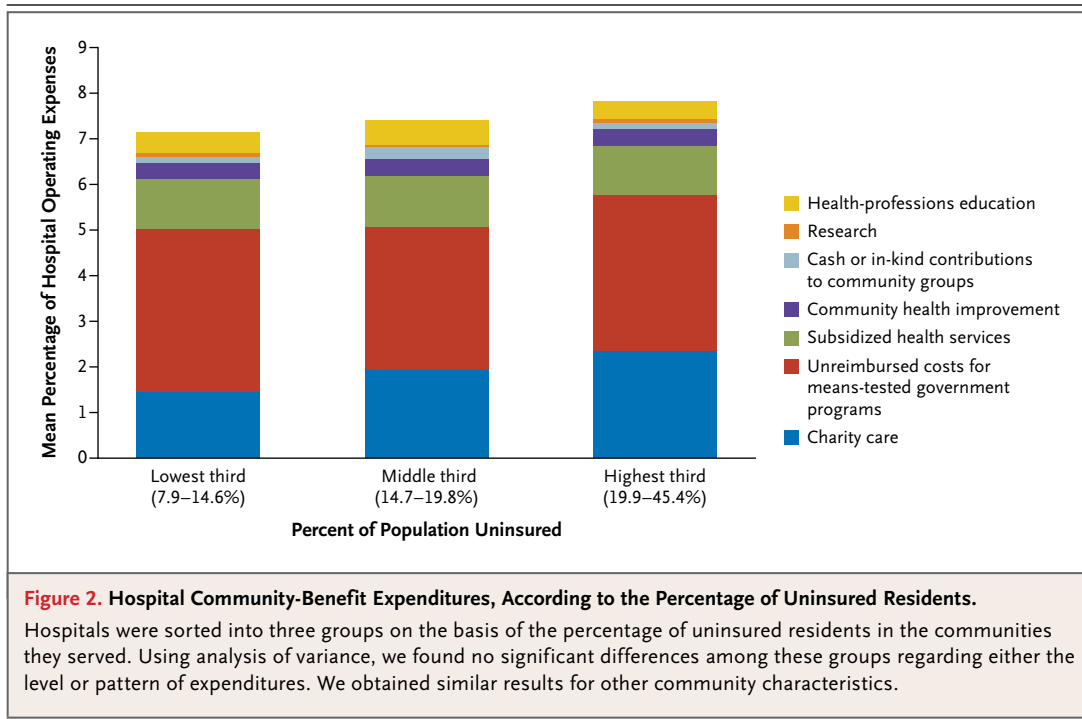
Table 3. (Continued.)

Characteristic	Community Benefit			
	Direct Patient Care	P Value	Community Service	P Value
Percentage of hospital beds controlled by state or local government in the local community	-0.27±0.96	0.78	-0.62±0.51	0.22
Urban setting***	0.36±0.48	0.37	-0.16±0.22	0.46
Geographic region†††				
Northeast	-2.04±0.59	<0.001	-0.71±0.31	0.02
Midwest	-0.98±0.54	0.06	-0.65±0.29	0.03
South	-1.61±0.56	0.004	-0.54±0.30	0.07

- * Plus-minus values are coefficients (\pm SE). For continuously measured variables (e.g., number of beds), coefficients refer to the change in community-benefit expenditures (as a percentage of total operating expenditures) that corresponds to a one-unit change in the variable. The P values are for the comparison of the likelihood of the observed change in community-benefit expenditures with no change in these expenditures. For categorical variables, coefficients refer to the average difference between hospitals in the relevant category and those in the omitted reference category. The P values are for this comparison.
- † System affiliation refers to hospitals that were members of a corporate entity that owned two or more hospitals (i.e., a multihospital system). The reference group comprised independent hospitals.
- ‡ Network affiliation refers to hospitals that participated in a strategic alliance or joint venture with one or more hospitals. Unlike system affiliation, these arrangements do not entail common ownership of the participating hospitals. The omitted reference group comprised hospitals that did not participate in networks.
- § The case-mix index is defined as the average diagnosis-related group weight for all the Medicare patients in a particular hospital. Medicare uses diagnostically related groups to compute case-mix index values. Hospitals with case-mix values of more than 1 have patients with diagnoses that are relatively more resource intensive than the national average. Hospitals with index values of less than 1 have patients whose diagnoses are relatively less resource intensive than the national average.
- ¶ The Medicare wage index reflects geographic differences in hospital wage levels. The index value for a particular hospital reflects the wage level for its geographic area, as compared with the national average hospital wage level.
- || The reference group comprised nonteaching hospitals.
- *** "Contract managed" refers to hospitals that had in place a contractual relationship with an outside company to manage their operations. The reference group comprised hospitals that did not have such a contract.
- †† The reference group comprised secular hospitals.
- ‡‡ Sole community provider is a designation under the Medicare program for hospitals that meet at least one of several criteria (e.g., located at least 35 miles from other, similar hospitals). The reference group comprised hospitals without this designation.
- §§ Profit margin was computed by subtracting the operating costs of a hospital from its operating revenue and dividing the result by the operating revenue. Hospitals with a high margin were defined as those that had a margin of more than 3%, and hospitals with a negative margin as those that had a margin at or below 0. The reference group comprised hospitals that had margins of more than 0 and not more than 3%.
- ¶¶ Data on state-level reporting requirements are for hospitals located in 1 of 16 states that required hospitals to report expenditures for a broad range of community benefits in addition to charity care.
- ||| Market competition was measured in accordance with the Herfindahl-Hirschman index, which for purposes of the study was computed by summing the squared values, for each hospital, of the proportion of total patients admitted to general, acute care hospitals within its market (defined as county). The theoretical range for the Herfindahl-Hirschman index is 0 to 1, where 1 indicates a monopoly (i.e., one firm in the market). For example, if there are two hospitals in a market, one with a 0.25 share of total admissions and the other with a 0.75 share of the admissions, the Herfindahl-Hirschman index for the market is 0.625 (i.e., $0.25^2+0.75^2$).
- *** The reference group comprised rural hospitals.
- ††† The reference group comprised hospitals that were located in the western region of the United States.

above, these requirements promote transparency among hospitals regarding the provision of community benefits. However, because our study consisted of a cross-sectional analysis, the causal connection between the reporting requirements and provision of benefits cannot be ascertained and thus requires further investigation.

The provisions of the ACA have important implications for the general pattern of hospital expenditures on community benefits. As the ACA mandate for individual health insurance is fully implemented, the need for hospital-based charity care should decline substantially. However, the required expansion of Medicaid cover-



age may add financial pressure on hospitals to cover the costs of patient care that exceed Medicaid payments.¹⁴

Moreover, as the results of our study reveal, community-benefit expenditures have been largely directed to patient care services. Although these expenditures provide an important safety net for the uninsured and the poor, they do not contribute to preventive care and population health, which are key priorities of the ACA. Accordingly, a possible response by tax-exempt hospitals to the ACA, including the previously noted provisions requiring community-needs planning, is a shift in expenditures toward community health-improvement activities.

It should also be noted that the selection of community-benefit measures by the IRS has itself generated controversy. For example, some hospital industry officials have expressed strong objections to the decision by the IRS to exclude bad debt and Medicare shortfall from its set of community-benefit measures.⁸ Currently, the IRS requires hospitals to report these expenditures on Schedule H, even though the agency does not classify them as community benefits. The inclu-

sion of these measures would substantially increase the average level of benefit expenditures by hospitals. According to the results of our analysis, the inclusion of bad debt alone would increase the average level of total hospital expenditures on community benefits from 7.5% to more than 11%.

Finally, with the enactment of the ACA, tax-exempt hospitals are facing substantially new requirements for accountability and transparency regarding the community benefits they provide. Since 1969, when the IRS eliminated a requirement that tax-exempt hospitals provide charity care to the extent of their financial capability,¹⁵ there has been much debate about whether the level of community benefits that these hospitals provide is high enough to justify their tax exemptions. Although this debate may well continue for the foreseeable future, the availability of new sources of data and research for assessing the provision of community benefits by tax-exempt hospitals will at least make the debate a more informed one.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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