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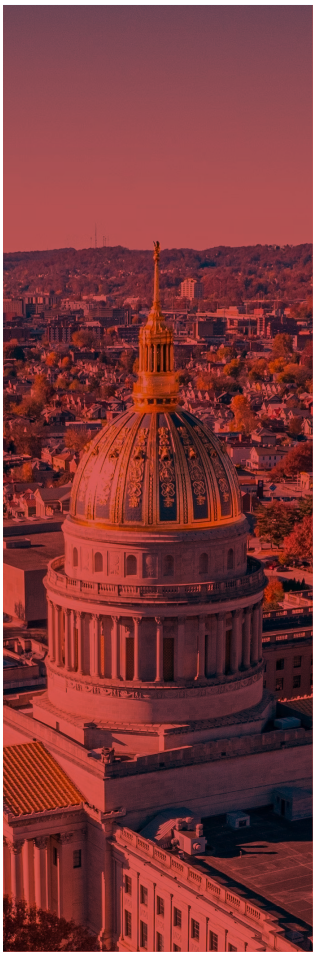

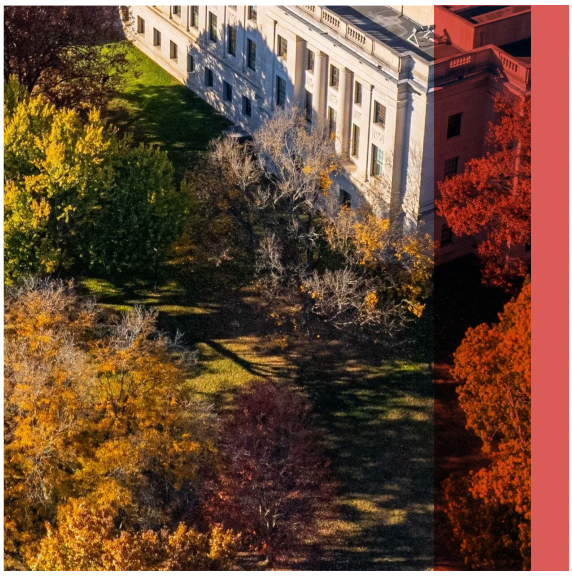

WHO'S CARING FOR WEST VIRGINIA?

A Comprehensive Review on Hospital Charity Care in West Virginia

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Bio: Jessica Dobrinsky is the Chief of Staff at the Cardinal Institute for West Virginia Policy, where she leads internal operations, supports development strategy, and advances the organization's health policy research agenda.

She is a nationally recognized expert on Certificate of Need laws, with broader expertise in healthcare regulation, Medicaid policy, and state-level health reform. Previously, Jessica served as a Policy Analyst and Staff Writer, producing research and commentary on healthcare policy and regulatory barriers to access. Her work has appeared in Forbes, The Washington Examiner, The Spectator, and Real Clear Markets. Earlier in her career, she worked in state government as a Judith A. Herndon Fellow at the West Virginia Department of Health and Human Resources and as a legislative assistant in the West Virginia State Senate.

Jessica holds a Bachelor's degree in Criminology from West Virginia University and a Master of Public Administration and Policy from American University.

Dedication: In the days working on this project, specifically as I finalized the written draft, Charlie Kirk was assassinated in Utah.

In his final moments, he was engaged in conversation.

I met Charlie in 2017 and was blessed to share a friendship with him for some years after. Ultimately the years wore on and we found ourselves in different places in life and fell out of touch.

But even still, it would be dishonest to fail to attribute all I know about how to engage in this chaotic, challenging world of policy without his deep mentorship and respect for civil discourse.

I will not be the first to say it, and also not the last—Charlie Kirk changed my life.

To another entry in my portfolio of civil debate and to my friend, Charlie.

J E S S I C A D O B R I N S K Y

Introduction:

West Virginians are proud people. We have a shared mentality; grit that has carried us through war, poverty, and natural disasters. Generations of Mountaineers have carried this legacy of self-reliance, many choosing to go without rather than depend on others. Independence is not just a core value in the Mountain State, but a way of life.

But when illness strikes, pride cannot pay a hospital bill. West Virginians carry one of the heaviest burdens of medical debt in the nation. Between 2019 and 2021, roughly 180,000 adults, or 13.3% of the state's population, reported having medical debt. This is far above the national average of 8.6%. In rural Appalachia, the problem is even harsher: nearly one in four has a medical debt collection on their credit record.

These struggles develop in a state where the median household income is well below the national average, where deductibles for employer-sponsored insurance run higher than elsewhere, and where more than a third of residents live under 200% of the federal poverty level. In short, West Virginians are asked to carry more weight with fewer resources to do so.

In the face of financial challenges and burdens, hospitals point to hundreds of millions of dollars they provide annually in charity care and community benefits. Yet despite these claims, West Virginia ranks near the bottom nationally in transparency, accountability, and enforcement of non-profit hospital obligations. Charity care policies exist on paper, but in practice, they are diluted and leave many families to navigate the crushing reality of medical debt alone.

Hospitals comprise the largest category of U.S. health spending. In 2022, this spending amounted to $1.4 trillion, nearly 30% of all healthcare costs, or 30 cents of every U.S. health dollar.[1] In 2023, their expenditures grew to $1.5 trillion. This has made hospitals the single largest driver of national health spending. And costs continue to climb. Hospital expenditures grew at the fastest pace since 1990, rising more than 10% in 2023 alone—faster than the rate of inflation. Yet this explosion of spending is not mirrored in charity care: the Kaiser Family Foundation's (KFF), the nation's leading health policy organization, latest hospital facts show the typical hospital devoted less than 1% of operating expenses to charity care in 2023.[2] In other words, the public shoulders the cost of rising hospital budgets while communities see little relief in return.

The following analysis calls into question the social contract West Virginians have made with their healthcare providers—particularly non-profit hospitals.

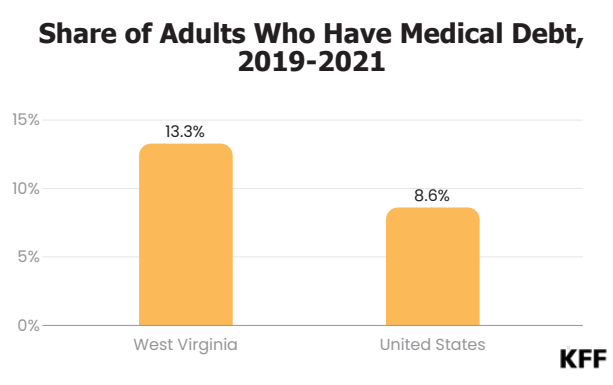
1. Kaiser Family Foundation. Key Facts About Hospitals. Kaiser Family Foundation, 19 Feb. 2025, "National Spending on Hospital Care" section, Key Facts About Hospitals, kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care.

2. Kaiser Family Foundation. Key Facts About Hospitals. Kaiser Family Foundation, 19 Feb. 2025, "National Spending on Hospital Care" section, Key Facts About Hospitals, kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care.

The Burden of Medical Debt in West Virginia and Appalachia

In the Mountain State, medical debt is not just a personal incumbrance, but a structural reality shaping the financial health of entire communities. Roughly 13.3% of West Virginia adults carry medical debt,[3] compared to 8.6% nationally.[4] For rural Appalachia, the picture is even bleaker: nearly one in four residents reports a medical debt in collections, far higher than the national rate of 17%.[5]

Source: Kaiser Family Foundation



But West Virginian vulnerability runs deeper: 36.2% of residents live below twice the federal poverty line, compared to just 28.2% nationally.[6] And despite having a lower uninsured rate than the U.S. average (5.9% vs. 8.0%) [7] , families still face crushing medical debt. This shows the problem is not lack of insurance, but hospital billing and collection practices. [8]

Health Status Table	West Virginia	United States
Percent of Adults Who Are Obese	41.2%	32.8%
Percent of Adults Told They Have Diabetes	20%	13%
Percent of Adults Told They Have Cardiovascular Disease	10.8%	6.4%
Percent Reporting a Mental Health illness in the past year	26.3%	23.1%
Infant Mortality Rate (per 100,000 population)	7.3	5.6
Age-adjusted Death Rate due to Firearms (per 100,000 population)	16.2	14.2
Age-adjusted Opioid Overdose Death Rate (per 100,000 population)	70.5	25

Source: KFF's State Health Facts

According to a 2022 report from the Consumer Financial Protection Bureau, medical debt is the most common third-party collection appearing on consumer credit reports.[9] Its effects cascade across every corner of family finance. For families in rural Appalachia, carrying medical debt more than doubles the likelihood of falling behind on a mortgage, auto loan, or student loan compared to medical debt-free households. In other words, a hospital bill can tip a family from stability into foreclosure, repossession, or bankruptcy.[10]

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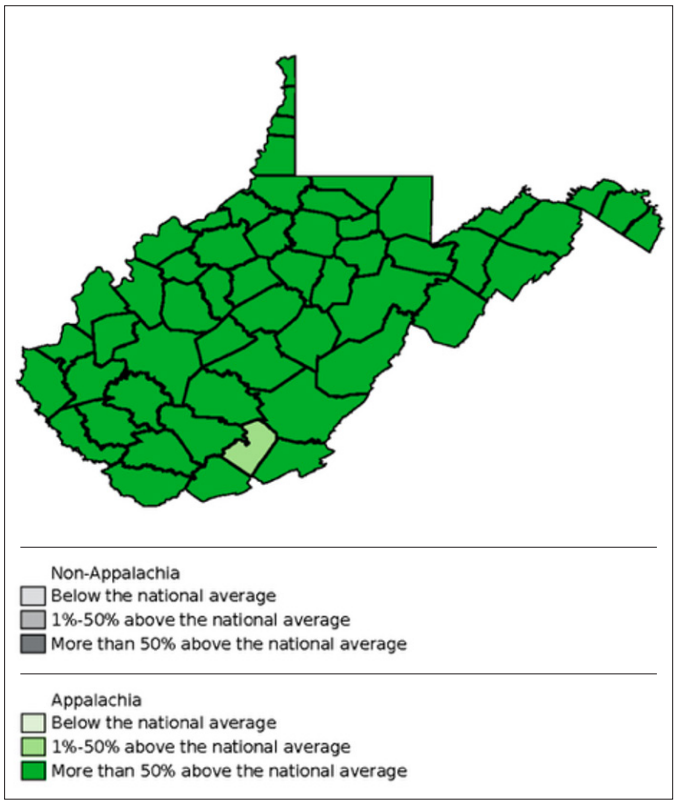
3. Rakshit, Shameek, et al. "The Burden of Medical Debt in the United States." Peterson-KFF Health System Tracker, 12 Feb. 2024, www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/.
4. Rakshit, Shameek, et al. "The Burden of Medical Debt in the United States." Peterson-KFF Health System Tracker, 12 Feb. 2024, www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/. .
5. Sebastian, Shawn, Cooper Luce, Cortnie Shupe, Michael Orevba, and Feng Liu. Consumer Finances in Rural Appalachia. Office of Research, Consumer Financial Protection Bureau, Sept. 1, 2022. CFPB, PDF report.
6. Sebastian, Shawn, Cooper Luce, Cortnie Shupe, Michael Orevba, and Feng Liu. Consumer Finances in Rural Appalachia. Office of Research, Consumer Financial Protection Bureau, Sept. 1, 2022. CFPB, PDF report.
7. Sebastian, Shawn, Cooper Luce, Cortnie Shupe, Michael Orevba, and Feng Liu. Consumer Finances in Rural Appalachia. Office of Research, Consumer Financial Protection Bureau, Sept. 1, 2022. CFPB, PDF report.
8. Kaiser Family Foundation. Key Facts About Hospitals. Kaiser Family Foundation, 19 Feb. 2025, "National Spending on Hospital Care" section, Key Facts About Hospitals, kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care.
9. Sebastian, Shawn, Cooper Luce, Cortnie Shupe, Michael Orevba, and Feng Liu. Consumer Finances in Rural Appalachia. Office of Research, Consumer Financial Protection Bureau, Sept. 1, 2022. CFPB, PDF report.
10. Delinquency rates for rural Appalachians with a medical collection tradeline is 10% for mortgages, compared to 3% for those without medical debt, auto loan delinquency rate is 29%, versus 12% without debt, and credit card holders posses a 37% delinquency rate, compared to 15% for other credit card holders. This suggests that those with medical collections may face multiple, compounding financial challenges.

Medical Debt Collections in Rural Appalachia Compared to Nationwide

	Rural Appalachian PPCs	Appalachian Rural	Non-Appalachian Rural	National Average
Percent w/ medical debt collection	27	24	21	17
Any medical debt collection paid or < $500	22	19	16	12

Note: PPC stands for persistent poverty county. NCRCs are expected to remove paid medical debt as well as that with an initial balance below at least $500 from credit reports in 2023. Source: CCP 2020-2022.

Relative Share of Consumers With Likely Medical Debt Collection Removals From Credit Report



Recent efforts on reform to credit reporting promised some relief, like delaying the reporting of medical collections until they are over a year old and excluding debts under $500.[11] Had these reforms taken effect, West Virginia would have seen more medical collections removed per capita than any other state. Families here stood to benefit more than anyone in the nation. When the rule was struck down in mid-2025, [12] those hopes were dashed, leaving families to continue bearing debts that, in many cases, hospitals could have forgiven through charity care programs.

Regardless of how one may feel about policy change delaying or excluding debt from credit reports, the stark contrast is this: nearly 25% of residents in Appalachia's poorest counties would have seen at least one small debt erased. [13] Instead, some hospital systems pursue collection actions for bills under $500. These are debts they could absorb overnight if they met real charity care obligations. [14] The question is not whether people can pay these bills, but why non-profit hospitals—flush with tax breaks—have documented cases taking patients to court, garnish wages, and place liens on property, [15] rather than extend the community benefits they promise. By failing to honor their side of the social contract, hospitals use legal protections and tax breaks while leaving families trapped in debt.

11. Sebastian, Shawn, Cooper Luce, Cortnie Shupe, Michael Orevba, and Feng Liu. Consumer Finances in Rural Appalachia. Office of Research, Consumer Financial Protection Bureau, Sept. 1, 2022. CFPB, PDF report.

12. Morris, Tamia J. "Federal Court Vacates CFPB's Medical Debt Rule, Finds FCRA Preempts State Laws." Gordon Feinblatt, LLC, 8 Sept. 2025, Insight, bhfs.com/insight/federal-court-vacates-cfpbs-medical-debt-rule-finds-fcra-preempts-state-laws/.

13. Liu, Matthew, et al. Consumer Finances in Rural Appalachia: Data Point. Consumer Financial Protection Bureau, Sept. 2022.

14. Sebastian, Shawn, Cooper Luce, Cortnie Shupe, Michael Orevba, and Feng Liu. Consumer Finances in Rural Appalachia. Office of Research, Consumer Financial Protection Bureau, Sept. 1, 2022. CFPB, PDF report.

15. "Hospitals in West Virginia Are Seizing Bank Accounts, Garnishing Wages over Unpaid Debt during Ongoing Pandemic." Times West Virginian, 20 Apr. 2020, https://www.timeswv.com/news/hospitals-in-west-virginia-are-seizing-bank-accounts-garnishing-wages-over-unpaid-debt-during-ongoing/article_2570a96e-82ac-11ea-b6cb-1f200dcac618.html.

Charity Care and the Broken Social Contract

58% of community hospitals across the country are non-profits. [16] Non-profit hospitals are exempt from federal, and most state and local taxes. In return, these entities are expected to provide benefits to the communities they serve.

Charity care is defined as free or discounted care provided to financially disadvantaged patients (whether low-income, uninsured, or underinsured) without the expectation of payment, intended to directly relieve patients' financial burdens in a time of need. [17] It is the core justification for hospitals' tax-exempt status, the "quid pro quo" that allows them to avoid billions in taxes each year.

Charity care was once the explicit cornerstone of the "non-profit" status. In 1956, the IRS required hospitals to provide free or reduced-cost care to qualify for tax exemption, identified as Revenue Ruling 56-185, 1956-1 C.B. 202. Key specifications of this rule centered around hospitals only qualifying for tax exemptions if they operate for the benefit of those unable to pay. That clear standard was weakened in 1969, under Revenue Ruling 69-545, when the IRS replaced it with the vague "community benefit" test, removing the explicit requirement that non-profit hospitals must provide charity care to qualify for exemption. Since then, hospitals have been allowed to count activities like research projects or staff training as "benefits," even when they do little to relieve financial burdens for patients. [18]

Charity care is also categorically different from "bad debt," which refers to amounts hospitals initially expected to collect but then wrote off in tax filings after unsuccessful collection efforts. Calling bad debt "charity care" is deceptive: it reflects failed collection attempts, not a proactive choice to help low-income patients. The IRS has not taken a definitive position on this accounting but collects data on bad debt separately on Part III, Section A of Schedule H in hospital 990 tax forms.

According to KFF, hospital care makes up nearly one-third of national health spending, but in 2019 hospitals reported just $28 billion in uncompensated care—less than 1% of total health expenditures. Put clearly: for every $100 hospitals received, less than $1 is returned to struggling patients in the form of free or discounted care. That imbalance reveals how little communities receive compared to the immense tax privileges hospitals enjoy. [19]

KFF data show that hospital care accounted for 5.5% of U.S. GDP in 2023, projected to hit 6% by 2032. Private insurers now pay hospitals 267% of Medicare rates (RAND 5.1 [20]) on average, [21] a spread consistent with KFF's national summaries. This is continued evidence that consolidation and market power, not true patient need, is driving hospital revenue. Despite these windfalls, the same KFF data show that uncompensated care across all hospitals totals less than 1% of national health spending.

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16. Mansell, Lawson. Healthcare Abundance: An Agenda to Strengthen Healthcare Supply. Niskanen Center, 28 Oct. 2024, www.niskanencenter.org/healthcare-abundance-an-agenda-to-strengthen-healthcare-supply/.

17. Bai, Ge, et al. "Charity Care Provision by US Non-profit Hospitals." JAMA Internal Medicine, vol. 180, no. 4, Apr. 2020, pp. 606–607.

18. United States Government Accountability Office. Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status. GAO-20-679, Sept. 2020, www.gao.gov/products/GAO-20-679.

19. Kaiser Family Foundation. Key Facts About Hospitals. Kaiser Family Foundation, 19 Feb. 2025, "National Spending on Hospital Care" section, Key Facts About Hospitals, kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care.

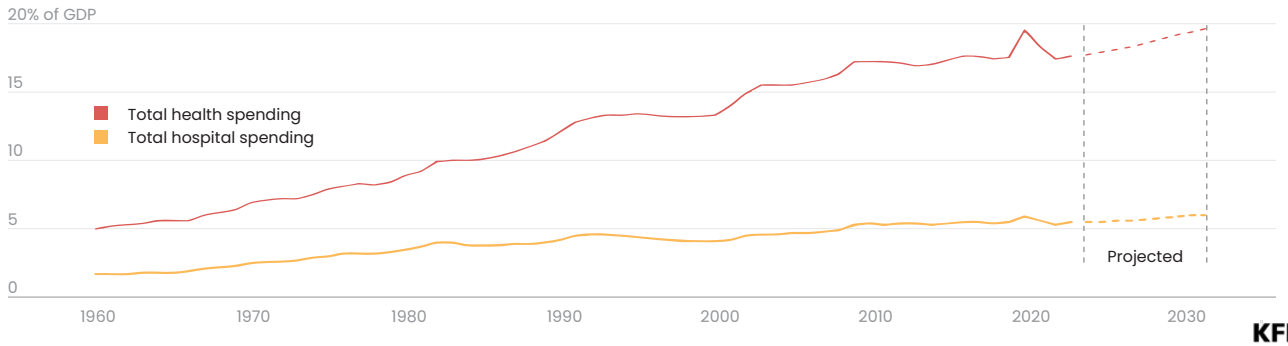
20. RAND 5.1 refers to the fifth round of the RAND Corporation's Hospital Price Transparency Study, which analyzes hospital claims data from 2020–2022 to compare what private insurers pay hospitals relative to Medicare rates. RAND 5.1 found that, on average, private health plans paid about 267% of Medicare prices for the same services, with wide variation across states and hospital systems.

21. RAND 5.1; summarized by Kaiser Family Foundation. Key Facts About Hospitals. Kaiser Family Foundation, 19 Feb. 2025, "National Spending on Hospital Care" section, Key Facts About Hospitals, kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care.

Source: Kaiser Family Foundation

Spending on Hospital Care as a Percent of Gross Domestic Product (GDP) is Projected to Increase From 5.5% in 2023 to 6.0% in 2032

Total and hospital spending as a percentage of GDP, historical and projected, 1960-2032



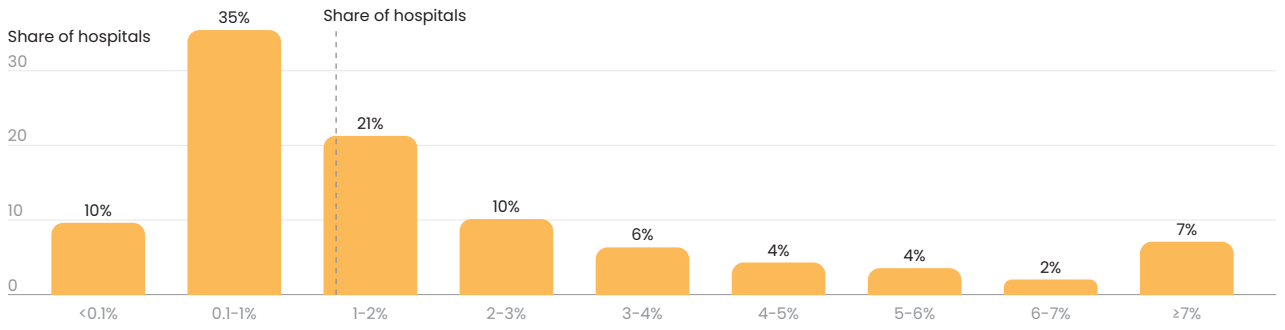
Note: Projections were generated for 2023-2032, but this analysis uses actual data for 2023, which became available after the projections were published. Hospital spending includes expenditures on both inpatient and outpatient services.

Source: KFF analysis Of National Health Expenditure (NHE) data, historical (1960-2023) and projected (2024-2032)

Source: Kaiser Family Foundation

Half of All Hospitals Reported That Charity Care Costs Represented 1.2% or Less of Their Operating Expenses in 2023, Though the Level of Charity Care Varied Substantially Across Facilities

Distribution of hospitals by charity care spending as a percentage of operating expenses, 2023



Note: Analysis of general short-term hospitals, excluding those in U.S. territories. Percentages do not sum to 100% due to rounding.

Source: KFF analysis of RAND Hospital Data, 2023

Examining non-profit hospital activity, the Lown Institute found that 80% spent less on meaningful community investment than the value of their tax breaks, leaving a national "fair share deficit" of $25.7 billion in 2021.[22] Taxpayers are subsidizing hospitals more than hospitals are helping communities. Additionally, a Government Accountability Office (GAO) review confirmed that many hospitals report little to no spending on community benefit at all, and the IRS lacks clear standards to hold them accountable.[23] For instance, the IRS does not have the authority to specify activities that a non-profit hospital must take part in, does not have a reliable documentation process to ensure charity care is being reviewed (they only review hospitals' community benefit activities at least once every 3 years), and does not have codes to track audits. [24]

Looking at the bigger picture, or hospital charity care performance nationally, a 2018 study found non-profit hospitals provided the lowest aggregated charity care per dollar of expense ($2.3 per $100 of expense) compared to government ($4.1) or for-profit hospitals ($3.8).[25] In 46% of hospital service areas containing all three ownership types, government or non-profit hospitals contributed a lower proportion of expenses to charity care than for-profit hospitals. [26]

Furthermore, a 2017 study found non-profit hospitals with the greatest net incomes provide far less charity care than those with much lower net incomes.[27] Notably, the proportion of total charity care to total overall net income in top-quartile hospitals showed extreme contrast from those in the bottom quartile. The bottom quartile facilities incurred losses equal to 15.8% but provided charity care at rates of 17.1% for uninsured patients and 17.7% for insured patients, while top quartile hospitals, representing all of the total overall net income reported by U.S. non-profit hospitals, provided 57.3% for uninsured patients and 54.6% for insured patient. This proportion demonstrates that the amount of charity care provided by profitable "non-profits" is far less than those who lose money, raising questions about whether the charity care level is sufficient to maintain tax-exempt status. [28]

Even among the nation's top non-profit hospitals, charity care remains largely inaccessible. A 2025 analysis of all National Cancer Institute–designated hospitals found that while most offer free care up to 200% of the federal poverty level and discounted care up to 400%, 64% still required proof of assets, one-third limited eligibility to in-state residents, and 27% excluded non-citizens altogether from patients. These criteria create barriers that effectively prevent many low-income patients from qualifying for assistance. [29]

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22. Lown Institute. Hospital Community Benefit Spending: Improving Transparency and Accountability around Standards for Tax-Exempt Hospitals. Policy Brief, Mar. 2024.

23. United States Government Accountability Office. Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status. GAO-20-679, Sept. 2020, www.gao.gov/products/GAO-20-679.

24. Kaiser Family Foundation. Key Facts About Hospitals. Kaiser Family Foundation, 19 Feb. 2025, "National Spending on Hospital Care" section, Key Facts About Hospitals, kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care.

24. Kaiser Family Foundation. Key Facts About Hospitals. Kaiser Family Foundation, 19 Feb. 2025, "National Spending on Hospital Care" section, Key Facts About Hospitals, kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care.

25. Bai, Ge, Hossein Zare, Matthew D. Eisenberg, Daniel Polsky, and Gerard F. Anderson. "Analysis Suggests Government and Non-profit Hospitals' Charity Care Is Not Aligned with Their Favorable Tax Treatment." Health Affairs, vol. 40, no. 4, Apr. 2021, pp. 629–36. doi:10.1377/hlthaff.2020.01627.

26. Bai, Ge, Hossein Zare, Matthew D. Eisenberg, Daniel Polsky, and Gerard F. Anderson. "Analysis Suggests Government and Non-profit Hospitals' Charity Care Is Not Aligned with Their Favorable Tax Treatment." Health Affairs, vol. 40, no. 4, Apr. 2021, pp. 629–36. doi:10.1377/hlthaff.2020.01627.

27. According to analysis by Bai, Yehia, and Anderson (2020), as cited in Antoni and Balat's Hospital Charity Care in Texas (Texas Public Policy Foundation, 2023), the top quartile of U.S. non-profit hospitals generated all of the total net income while providing only about half of total charity care.

28. According to analysis by Bai, Yehia, and Anderson (2020), as cited in Antoni and Balat's Hospital Charity Care in Texas (Texas Public Policy Foundation, 2023), the top quartile of U.S. non-profit hospitals generated all of the total net income while providing only about half of total charity care.

29. Go, Lucas T., Lewis T. Go, and Jithma P. Abeykoon. "Criteria for Charity Care at National Cancer Institute (NCI)-Designated Cancer Centers." Journal of Clinical Oncology, American Society of Clinical Oncology, Oct. 2025, doi.org/10.1200/OP.2025.21.10_suppl.262.

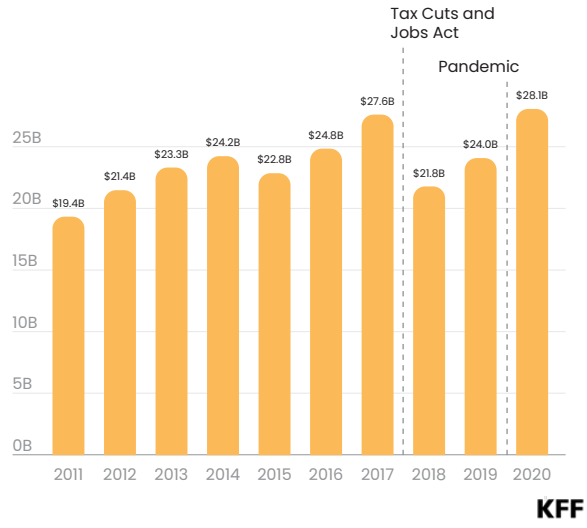
Hospitals increasingly acknowledge that financial hardship affects patient outcomes—but rarely act on that knowledge. A 2025 analysis of more than 57,000 adult cancer patients found that by 2023, only 11% of hospital visits included any documentation of social or financial risk factors, despite new federal incentives for hospitals to identify them. The most common codes reflected housing and economic insecurity, yet there is little evidence that such documentation translated into greater financial aid or debt relief for patients. [30]

The non-profit hospital tax exemption costs taxpayers tens of billions each year. A 2020 GAO review estimated the federal revenue loss from this exemption at more than $24 billion annually. [31] This isn't to say non-profit hospitals shouldn't receive tax exemptions, but raises the question of what could be achieved if those funds were tied to stronger charity care obligations? It could, perhaps, fund rural clinics, expand drug treatment programs, or provide direct patient assistance. Instead, it often subsidizes hospital construction and acquisition that consolidate market power rather than expanding access for those who need care.

Source: Kaiser Family Foundation

The Estimated Value of Tax Exemption Grew From About $19 Billion in 2011 to About $28 Billion in 2020

Estimated value of tax exemption for non-profit hospitals, 2011-2020



Source: KFF, The Estimated Value of Tax Exemption for Non-profit Hospitals Was About $28 Billion in 2020

Adding insult to injury, for-profit hospitals often deliver nearly as much charity care as non-profits—while receiving no tax breaks. A Texas study showed that once outside grants are removed, the charity care gap between for-profit and non-profit hospitals is negligible. Worse, for-profits are 27% more efficient per dollar of charity care delivered, meaning non-profits are less effective, even with subsidies. [32]

Meanwhile, KFF reports that Medicare and Medicaid account for nearly 60 percent of all national spending on hospital care, meaning a majority of hospital revenue ultimately comes from taxpayer-financed programs. [33] Yet instead of prioritizing charity care, hospitals often lobby for more subsidies and sometimes hire aggressive debt collectors to sue patients. [34] In Q1 of 2025 alone, the American Hospital Association increased its lobbying expenses to $7.03 million, an increase of 7% from Q4 in 2024. [35]

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30. Su, Malcolm, et al. "Social Determinants of Health Coding Among Hospital Visits Made by Adults with Cancer." Journal of Clinical Oncology, American Society of Clinical Oncology, Oct. 2025, doi.org/10.1200/OP.2025.21.10_suppl.58.

31. United States Government Accountability Office. Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status. GAO-20-679, Sept. 2020, www.gao.gov/products/GAO-20-679.

32. Antoni, EJ, and David Balat. Hospital Charity Care in Texas. Texas Public Policy Foundation, Jan. 2023.

33. Kaiser Family Foundation. Key Facts About Hospitals. Kaiser Family Foundation, 19 Feb. 2025, "National Spending on Hospital Care" section, Key Facts About Hospitals, kff.org/health-costs/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care.

34. Galewitz, Phil, and Colleen DeGuzman. "In Fight Over Medicare Payments, the Hospital Lobby Shows Its Strength." KFF Health News, 13 Feb. 2024, https://kffhealthnews.org/news/article/medicare-site-neutral-payments-hospital-lobby-fight/; Karliner, Lara, et al. "Lobbying Expenditures in the U.S. Health Care Sector, 2000-2020." JAMA Health Forum, vol. 4, no. 3, 2023, https://doi.org/10.1001/jamahealthforum.2023.0004.; Yucel, Kerem. "Investigation — Many U.S. Hospitals Sue Patients or Threaten Their Credit." KFF Health News, 21 Dec. 2022, https://kffhealthnews.org/news/article/medical-debt-hospitals-sue-patients-threaten-credit-khn-investigation/.; Vaughan, Diana, et al. "Characteristics of U.S. Hospitals Using Extraordinary Collections." JAMA Network Open, vol. 6, no. 7, July 2023, e2318305. https://doi.org/10.1001/jamanetworkopen.2023.18305.

35. American Hospital Association Spends $7M in Q1 2025 Lobbying on Healthcare Workforce, Medicare Financing." Legis1 Newsroom, 22 Aug. 2025, https://legis1.com/news/american-hospital-association-spends-7m-in-q1-2025-lobbying-on-healthcare-workforce-medicare-financing/#:~:text=Why%20it%20matters%3A%20The%20American,and%20rural%20healthcare%20sustainability%20issues.

Rather than providing essential care, hospital systems have become real estate empires and investment vehicles. Billions flow into gleaming new offices, outpatient centers, and lucrative acquisitions, while the promise of non-profit status—direct charity care for vulnerable families—remains unmet. Much of what hospitals label as "community benefit" help the hospital's reputation but do little to reduce the medical debt burden crushing patients.

Recent state investigations confirm this pattern nationwide:

- In Washington, Providence Health was forced to forgive $157.8 million in wrongful debt collections against patients eligible for charity care. [36]
- North Carolina's Treasurer found that non-profit hospitals received more than $1.8 billion in tax breaks in 2020, but the vast majority failed to provide charity care equal to the value of those subsidies. Fewer than 20 of the state's 105 hospitals met or exceeded their tax exemption with charity care spending. [37]
- In Montana, audits revealed hospital "community benefit" reporting had no measurable effect on patient health. [38]
- Allina Health in Minnesota and Wisconsin denied care to patients with over $4,500 in unpaid bills. [39]
- And in Pennsylvania, a court revoked a hospital's property tax exemption after finding it did not operate free from profit motive. [40]

These findings make clear that West Virginia's experience is not an outlier, but a piece of a national puzzle where hospitals are using weak laws at the expense of the patients they are supposed to serve.

At its core, this is a broken contract. Taxpayers provide hospitals with massive exemptions. Communities provide land, workers, and public support. In return, hospitals are supposed to provide charity care to those who cannot pay. But across West Virginia, that contract is being violated, families are left with lawsuits and garnishments [41] while hospitals reinvest tax breaks into marble and marketing campaigns.

West Virginia illustrates the worst-case scenario. A Cicero Institute review ranked our state dead last for charity care oversight, scoring just 2 out of 10 possible points on transparency, accountability, and enforcement. Hospitals here face no mandatory spending floors, no state audits, and no penalties for failing to provide charity care. Families are left defenseless while non-profit hospitals enjoy exemptions worth millions.

The contrast could not be clearer: West Virginia families are at risk of losing homes and wages over hospital bills, [42] while non-profit hospital systems spend millions and hand out CEO salaries that top seven figures. Taxpayers subsidize these institutions as charities, but what they get in return are lawsuits, debt, and bad health.

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36. Ferguson, Bob. Providence Must Provide $157.8 Million in Refunds and Debt Relief for Unlawful Medical Charges to Low-Income Washingtonians. Washington State Attorney General's Office, Feb. 1, 2024.
37. "Some North Carolina Non-profit Hospitals are Billing Poor Patients Instead of Providing Charity Care, Despite Receiving More than $1.8 Billion in Tax Breaks." State of North Carolina, 26 Jan. 2022.
38. Montana Legislative Audit Division. Community Benefit & Charity Care Obligations at Montana Non-profit Hospitals: Performance Audit 18P-07. Sept. 2020.
39. "Allina Health Suspends Policy That Denied Care to Patients With Unpaid Medical Bills." Kain & Henehan, 26 June 2023.
40. "Commonwealth Court Rejects Four Non-profit Hospitals' Claims to Tax Exemption: Hospital Could Not Satisfy Its Burden of Showing It Operated Entirely Free from a Private Profit Motive Under the HUP Test." Commonwealth Court of Pennsylvania, 10 Feb. 2023.
41. "Hospitals in West Virginia Are Seizing Bank Accounts, Garnishing Wages over Unpaid Debt during Ongoing Pandemic." Times West Virginian, 20 Apr. 2020, https://www.timeswv.com/news/hospitals-in-west-virginia-are-seizing-bank-accounts-garnishing-wages-over-unpaid-debt-during-ongoing/article_2570a96e-82ac-11ea-b6cb-1f200dcac618.html.
42. Settle, Katharine. "WVU Medicine's COVID-19 Guidelines on Debt Collection Raises Concern for Patients." Times West Virginian, 26 Apr. 2020, www.timeswv.com/covid-19/wvu-medicines-covid-19-guidelines-on-debt-collection-raises-concern-for-patients/article_5b9458f4-874a-11ea-8e17-e788c6e25955.html.

How Certificate of Need (CON) Protects Bad Actors

West Virginia's Certificate of Need (CON) laws do more than regulate healthcare expansion—they shield these giants from further means of accountability. About 180,000 West Virginians carry medical debt. Rural Appalachians fare worse—one in four. Yet the dominant hospital systems that should be absorbing these costs through charity care are instead suing patients, garnishing wages, and placing liens on property. [43] By restricting competition, CON laws are locking in dominance for systems that fail their charity care obligation. Hospitals exploit their market positions, knowing patients have nowhere else to turn.

Potential entrants, such as smaller hospitals, specialty clinics, or faith-based providers, may be willing to offer more charity care and upfront pricing transparency. In a state where 36.2% of residents live below 200% of the federal poverty line and incomes lagging $21,000 below the national median, families desperately need more options at a lower cost, especially charitable ones. Yet under the CON regime, these providers cannot open their doors without state approval, which surely favors the incumbents. Patients are left with fewer choices and fewer protections.

At its core, this is a free-market issue. True competition forces hospitals to win patients through cost, quality, access, transparency, and goodwill. Without CON, hospitals must compete not only on price and quality but also on their willingness to extend charity care to vulnerable families. In a state where West Virginians are saddled with some of the nation's highest medical debt burdens, charity care should not be an afterthought. It should be a competitive necessity.

Policy Solutions for West Virginia

West Virginia cannot afford to continue subsidizing hospital monopolies that underdeliver on charity care. The path forward is clear.

Repeal the state's Certificate of Need (CON) laws. By eliminating these artificial barriers to entry, the state can open the door for new, community-focused providers that are more likely to provide charity care and transparent pricing. Competition is what forces hospitals to deliver value.

Transparency must be non-negotiable. Hospitals should be required to publish itemized, facility-level reports on charity care spending. These reports must disclose charity care at cost, not padded numbers that include bad debt or marketing expenses. Currently, West Virginia ranks last in the nation on charity care oversight. Patients and policymakers deserve to know exactly how much relief their communities are receiving.

Maryland, for instance, models a good approach to this issue in Md. Code Ann., Health–Gen. §19-303(c):

"Each non-profit hospital shall annually submit a community benefit report including: (1) the hospital's mission statement; (2) a list of the community benefit initiatives undertaken by the hospital; (3) the cost of each initiative and the objectives for the community; and (4) a description of efforts to evaluate the initiative's effectiveness. The report shall also describe gaps in the availability of medical specialists for uninsured persons and the hospital's efforts to track and reduce health disparities in the community."

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43. Hospitals in West Virginia Are Seizing Bank Accounts, Garnishing Wages over Unpaid Debt during Ongoing Pandemic." Times West Virginian, 20 Apr. 2020, https://www.timeswv.com/news/hospitals-in-west-virginia-are-seizing-bank-accounts-garnishing-wages-over-unpaid-debt-during-ongoing/article_2570a96e-82ac-11ea-b6cb-1f200dcac618.html.; Moran, John R. "WVU Medicine's COVID-19 Guidelines on Debt Collection Raises Concern for Patients." Times West Virginian, 25 Apr. 2020, https://www.timeswv.com/covid-19/wvu-medicines-covid-19-guidelines-on-debt-collection-raises-concern-for-patients/article_5b9458f4-874a-11ea-8e17-e788c6e25955.html.

Accountability must be built into the system.[44] West Virginia should adopt minimum charity care floors tied directly to the value of hospitals' tax benefits. States like Texas and Illinois already link tax exemption to clear thresholds, such as devoting at least 5% of net patient revenue to community benefit and 4% to direct charity care. [45] If hospitals cannot meet these basic obligations, they should not enjoy the privileges of non-profit status.

Texas provides among the clearest examples in:

> **Texas Tax Code Sec. 11.1801(a)(3):** *"A non-profit hospital shall provide charity care and community benefits in an amount that is at least equal to 5% of the hospital's net patient revenue, provided that charity care and government-sponsored indigent health care are at least 4% of net patient revenue."*

> **Texas Tax Code Section 11.1801(a)(1):** *"The level of charity care must be reasonable in relation to community needs, as determined through the community needs assessment, the hospital's available resources, and the tax-exempt benefits received by the hospital."*

Illinois goes even further, offering a gold standard for charity care accountability. Under the **Illinois Hospital Property Tax Exemption Law (35 ILCS 200/15-86)**, non-profit hospitals must provide charity care or other community benefits equal in value to their property tax exemptions. [46] If a hospital's charity spending falls short of its tax savings, it risks losing its exemption entirely. This simple "no community benefit, no tax break" rule forces hospitals to demonstrate real, measurable value to the public.

According to the Cicero Institute,[47] Illinois ranks #1 nationally (10/10) for transparency, accountability, and enforcement: [48]

- Hospitals file itemized community benefit reports with the Illinois Attorney General
- The state may revoke tax exemptions for underperformance or non-compliance
- The law has already prompted large hospital systems to increase their charity care spending to maintain compliance

Illinois demonstrates that when lawmakers tie non-profit privileges to measurable community return, hospitals adapt quickly—and patients, not bureaucracies, benefit.

Enforcement is key. Hospitals that fail to meet charity care floors or engage in deceptive accounting should face real consequences. This may include fines, loss of state tax exemptions, or revocation of non-profit designation. Even when hospitals report giving nothing back, the IRS rarely acts, the GAO concluded.[49] West Virginia should not, and can not, repeat that failure at the state level. **Without teeth, reforms will remain empty promises.**

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44. United States Government Accountability Office. Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status. GAO-20-679, Sept. 2020.
45. Lown Institute. Hospital Community Benefit Spending: Improving Transparency and Accountability around Standards for Tax-Exempt Hospitals. Policy Brief, Mar. 2024.
46. Illinois General Assembly. Illinois Property Tax Code, 35 ILCS 200/15-86. "Hospital Property Tax Exemption Law." Illinois General Assembly, enacted 2012, effective 14 June 2012. https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=003502000K15-86.
47. Cicero Institute. Non-profit Hospitals and Community Benefits: State Accountability Rankings. Cicero Institute, Mar. 2025, pp. 3–5.
48. Office of the Illinois Attorney General. Community Benefits Act Annual Reporting Requirements for Non-profit Hospitals. Community Benefits Bureau, Illinois Attorney General, 2024. https://illinoisattorneygeneral.gov/charities/hospital_reports.html.
49. United States Government Accountability Office. Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status. GAO-20-679, Sept. 2020, www.gao.gov/products/GAO-20-679.

Once more, Texas sets the bar:

Texas Tax Code §11.1801(a): *"To qualify as a charitable organization under Section 11.18(d)(1), a non-profit hospital or hospital system must provide charity care and community benefits as follows: (1) charity care and government-sponsored indigent health care must be provided at a level that is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system; (2) charity care and government-sponsored indigent health care must be provided in an amount equal to at least four percent of the hospital's or hospital system's net patient revenue; (3) charity care and government-sponsored indigent health care must be provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax; or (4) charity care and community benefits must be provided in a combined amount equal to at least five percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue."*

Texas Tax Code §11.1801(j): *"In any fiscal year that a hospital or hospital system, through unintended miscalculation, fails to meet any of the standards in Subsection (a) or fails to be considered to be in compliance with the standards in Subsection (a) under Subsection (b), (c), or (d), the hospital or hospital system shall not lose its tax-exempt status without the opportunity to cure the miscalculation in the fiscal year following the fiscal year the failure is discovered by both meeting one of the standards and providing an additional amount of charity care and government-sponsored indigent health care that is equal to the shortfall from the previous fiscal year. A hospital or hospital system may apply this provision only once every five years."*

California also provides useful guidance:

Cal. Code Regs. Tit. 22, §95309: *"A hospital that fails to file a report by a due date established pursuant to Section 95306 is liable for a fine of one hundred dollars ($100) for each day that the required report is not filed up to the annual statutory maximum of $5,000."*

Patients need stronger protections. Aggressive collection actions (lawsuits, wage garnishments, property liens) should be banned. Families should never lose their homes or paychecks over bills that hospitals, by law and mission, are supposed to forgive.

Comparative Case Studies

Other states show that West Virginia's failures are not inevitable.

Pennsylvania provides a useful contrast. Scoring a 7 out of 10 on charity care accountability, Pennsylvania combines moderate regulatory oversight with a strong tradition of Catholic hospitals, many of which voluntarily limit lawsuits and expand financial aid. For example, the University of Pittsburgh Medical Center does not report debts to credit agencies or pursue extraordinary collections.[50] **As a result, Pennsylvania's rural Appalachian counties report far lower levels of medical debt collection, at 15%, than neighboring West Virginia's 24%.[51] This demonstrates that a different cultural and regulatory approach can produce more humane outcomes.**

50. Sebastian, Shawn, Cooper Luce, Cortnie Shupe, Michael Orevba, and Feng Liu. Consumer Finances in Rural Appalachia. Office of Research, Consumer Financial Protection Bureau, Sept. 1, 2022. CFPB, PDF report.

51. Sebastian, Shawn, Cooper Luce, Cortnie Shupe, Michael Orevba, and Feng Liu. Consumer Finances in Rural Appalachia. Office of Research, Consumer Financial Protection Bureau, Sept. 1, 2022. CFPB, PDF report.

Meanwhile, Texas is the leading example of charity care reform. Texas not only repealed its CON law but also created robust charity care requirements. Under Texas Tax Code §11.1801, non-profit hospitals must provide community benefits equal to at least 5% of net patient revenue, with at least 4% going to direct charity care for financially indigent patients. Hospitals may also meet the standard by providing charity care and community benefit spending equal to or greater than the value of their tax exemption. This model ensures that hospitals give back in proportion to what they take from taxpayers while allowing new entrants to compete and innovate. Notably, Texas for-profit hospitals—despite receiving no tax breaks—deliver charity care almost equal to non-profit hospitals and 27% more efficiently per dollar.[52]

West Virginia, by contrast, is an outlier. With no transparency requirements, no charity care floors, and CON laws that protect monopolies, the state represents the worst of both worlds: patients burdened with crushing medical debt and hospitals shielded from accountability.

More Comparative Policy Models: Pre-Screening and Debt Protections

Texas (H.B. 3708, 2025 – Proposed Model)

Texas law already holds non-profit hospitals to measurable charity care and community-benefit standards tied to their tax exemptions (Texas Health and Safety Code § 311.043–311.0455; Texas Tax Code § 11.1801). While H.B. 3708 (2025) did not pass, it reflected a broader push to strengthen enforcement through administrative penalties.

Under existing Texas statutes, non-profit hospitals must:

- Provide measurable charity care and community benefits tied to their tax-exempt status.
- Meet one of several thresholds, such as:
  - Charity care and government-sponsored indigent care at least equal to the value of their tax-exempt benefits or
  - Charity care and community benefits totaling at least 5 percent of net patient revenue, with 4 percent specifically devoted to charity care.
- Adopt and make publicly available written financial-assistance and charity care policies accessible to patients at admission, billing, and online.
- File annual reports to the Texas Health and Human Services Commission detailing charity care spending, community benefits, and the value of tax exemptions.
- Maintain documentation demonstrating how charity care eligibility is determined and how community-benefit activities are calculated.
- Face potential loss of tax-exempt status if the hospital fails to meet statutory charity care thresholds or reporting requirements.

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52. Antoni, E. J., and David Balat. Hospital Charity Care in Texas. Texas Public Policy Foundation, Jan. 2023.

Oregon (H.B. 3076, 2019)

Oregon paired statewide minimum charity care discounts with a strict pre-collection screening rule:

- Hospitals must screen patients (upon request or as required) for eligibility for financial assistance before referring a medical debt to a collection agency.
- They must provide the patient with the hospital's financial-assistance policy and application before transferring the debt.
- Hospitals may use electronic tools or third-party services for screening but cannot pursue collections without offering assistance first.
- If a patient qualifies for assistance, the hospital or debt collector may not charge interest on the medical debt.
- If the hospital or collection agency violates these requirements, it becomes an unlawful debt-collection practice under Oregon law (ORS 646.639)

Evidence from Oregon

Oregon offers a successful model through its House Bill 3320 (2023), passed following public scrutiny of non-profit hospital billing practices. The law required hospitals to implement presumptive screening of patients for financial-assistance eligibility before billing or collections.

The results have been dramatic. At Oregon Health & Science University (OHSU), the state's largest teaching hospital, implementation of such presumptive screening using a third-party tool increased the percentage of patients identified as eligible for charity care from about 12% under the prior application-based process to 64%.

"The presumptive screening process (using a third-party estimating tool) is currently identifying 64% of patients eligible, compared to 12% under the prior 'application' process."

OHSU Board of Directors Meeting, Jan. 2025 (Slide 27, OHSU Board Materials; Board Meeting Video)

OHSU's experience demonstrates that presumptive pre-screening is both feasible and effective, even for a major academic medical center. If Oregon's flagship teaching hospital can adopt a universal screening process and substantially expand Charity Care eligibility, without jeopardizing financial stability, then hospitals in other states, such as West Virginia, can do the same.

Recommended Actions for West Virginia

To translate the mentioned frameworks into actionable reform, West Virginia should adopt the following measures to ensure hospitals earn their non-profit privileges, patients receive the charity care they are promised, and market competition drives better access and accountability:

1. Establish a Hard Charity Care Floor (Texas-Style Model)

- Set a **minimum 5% of Net Patient Revenue (NPR)** charity care requirement at cost (not "charges foregone").
- Condition all **state and local tax exemptions** on meeting this threshold.
- Require **corrective action plans and public notice** after two consecutive sub-floor years.
- Mirror **Texas Health & Safety Code § 311.045 and Tax Code § 11.1801,** which link non-profit status to measurable community-benefit and charity care performance.
- Include enforcement through Texas **H.B. 3708 (2025)**-style administrative penalties for repeat non-compliance.

2. Make Financial Assistance Programs Accessible (Oregon-Style Screening)

- Require **universal pre-billing screening** for charity care eligibility before any collections activity.
- Mandate **presumptive eligibility screening** for patients flagged through participation in public programs such as SNAP or WIC.
- Standardize plain-language, one-page financial assistance policies in multiple languages.

- Prohibit **Extraordinary Collection Actions (ECA)** until all screening and "reasonable effort" documentation is completed.
- Model these standards on Oregon **H.B. 3076 (2019) (ORS 442.614 & 646A.677) and Oregon H.B. 3320 (2023)**, which mandate presumptive screening prior to billing and make violations an unlawful debt-collection practice.

3. Stop Converting Eligible Patients into Bad Debt

- Require hospitals to **report bad debt and estimated FAP**-eligible proportions side-by-side with charity care at cost.
- If over 50% of bad debt is FAP-eligible while charity care is under 3%, trigger financial penalties or partial loss of tax benefits.
- Implement this reporting as part of hospitals' **annual state community benefit filings** to the Department of Health and State Tax Department.

4. Repeal Certificate of Need (CON) and Open the Market

- Fully repeal **West Virginia's CON law**.
- Pair repeal with charity care floors and debt-collection protections to maintain patient access while enabling competition.
- Encourage entry of community-based and faith-based hospitals that provide transparent pricing and voluntary charity care, restoring a genuine free-market dynamic.

5. Strengthen Debt Collection Guardrails

- Prohibit lawsuits for medical debts under $500 and ban wage garnishments and property liens for FAP-eligible patients.
- Impose a 120-day waiting period before any collection activity, with charity care screening and eligibility verification.
- Ban debt sales unless the buyer agrees to charity care and collection-standard requirements.
- Align these rules with Oregon H.B. 3076 (2019) and Texas H.B. 3708 (2025) models for fair billing and administrative enforcement.

Implementation and Oversight:

- Assign enforcement to the **West Virginia Department of Health (DHS)** in coordination with the State Tax Department.
- Require public posting of annual hospital compliance reports and corrective action plans.
- Establish civil penalties and loss of state tax exemption for repeat or willful violations.

Supporting Models:

- Texas Health & Safety Code § 311.043–311.0455; Texas Tax Code § 11.1801; Texas H.B. 3708 (2025)
- Oregon H.B. 3076 (2019), codified at ORS 442.614 and 646A.677; Oregon H.B. 3320 (2023)

Conclusion

The evidence is overwhelming: West Virginians are trapped in cycles of medical debt not because they are reckless, but because anticompetitive hospitals use weak laws to sue, garnish, and seize while providing little in return. Families in West Virginia face some of the highest rates of medical debt in the nation, yet their hospitals give back less than the value of the tax breaks they enjoy. More than one in eight West Virginians carry medical debt, one in four rural Appalachians face collections, and families in persistent-poverty counties are hit hardest.

The solution is straightforward: repeal CON laws to break hospital monopolies, set enforceable charity care standards tied to tax benefits, and empower patient choice through transparency and accountability. This approach mirrors successful models in Texas, Illinois, and Oregon, where non-profit status is conditioned on measurable community benefit. Competition forces hospitals to win patients, not in courtrooms, but by offering real financial assistance and fair prices.

This effort restores the original social contract between hospitals and the people they serve: if taxpayers subsidize hospitals as charities, then hospitals must act like charities. Anything less is unacceptable. It is time for West Virginia to put a stop to it.

Part Two

WEST VIRGINIA CHARITY CARE

By The Numbers

In part one of *Who's Caring for West Virginia? A Comprehensive Review on Hospital Charity Care* we examined how West Virginians face some of the highest medical debt burdens in the nation. Now, our research aims to turn attention to the hospitals in our own backyard.

West Virginia non-profit hospitals receive millions in tax breaks every year. This is an understood public investment, premised on a simple deal: you give back to the community, and the community supports your tax-free status. Are West Virginia's hospitals holding up their end of the bargain?

The answer, backed by data and tax filings, is simple: *no.*

Executive Summary

Charity care obligations are the foundation of the non-profit hospital social contract. In West Virginia, hospitals receive extensive tax privileges and federal safety-net subsidies, yet the public benefit they deliver through free or discounted care remains minimal.

Part two of *Who's Caring for West Virginia? A Comprehensive Review on Hospital Charity Care in West Virginia* analyzes three verified public datasets to measure hospital charity care and related accountability between 2019 and 2024: 1) the National Academy for State Health Policy (NASHP) Cost Tool (2023), 2) IRS Form 990 Schedule H, and 3) Centers for Medicare and Medicaid Services Inpatient Prospective Payment System (CMS IPPS) Final Rule Impact File (FY 2024). We sought to compare activity in charity care from a facility level, system level, and safety-net subsidies, respectively. The analysis covers all major non-profit hospital entities active in West Virginia, including WVU Medicine (a consolidated system), the Vandalia Health network (CAMC and Mon Health, which file separately), Marshall Health Network (Cabell Huntington), and the independent Davis Health System.

Together these sources show that West Virginia's non-profit hospitals allocate less than 1% of net patient revenueto direct charity care despite strong profitability and above-market commercial pricing. IRS filings confirm that financial-assistance policies are unevenly applied and that hospitals frequently classify eligible patients as bad-debt accounts. CMS data for FY 2024 show that only three West Virginia hospitals—WVU Medicine's J.W. Ruby Memorial, Charleston Area Medical Center, and Cabell Huntington Hospital—qualified for IPPS DSH or IME payments that year. These are the state's major urban systems; most rural and Critical Access hospitals are reimbursed outside IPPS and therefore did not receive these specific payments.

The findings demonstrate a structural imbalance: financial advantages and subsidies are concentrated among the same institutions reporting minimal free care. To realign public benefit with public cost, West Virginia policymakers should (1) establish an enforceable minimum-charity benchmark tied to expenses, (2) require public disclosure of community benefit metrics, and (3) integrate charity care compliance into state certificate of need and tax-exemption reviews.

Introduction

Non-profit hospitals occupy a privileged position in American health care. In exchange for exemption from income, property, and sales taxes, they are expected to provide measurable community benefits—chief among them, charity care for patients unable to pay. Yet the size of these benefits, and whether they justify the tax advantages granted, remains contested.

In part one of Who's Caring for West Virginia? we examined how West Virginians face some of the highest medical debt burdens in the nation, setting the foundation for the errs in charity care policy and its detrimental impact on patient fiscal health.

In part two, we examine West Virginia as a concentrated case study: a small number of hospital systems dominate statewide inpatient care, enjoy non-profit status, and receive federal safety-net payments through Medicare, while local governments forgo tens of millions of dollars in revenue. West Virginia's hospital landscape is also geographically uneven. WVU Medicine, and CAMC anchor the state's urban corridors; Mon Health, Cabell Huntington, and Davis Memorial serve mixed or rural regions.

Tax exemption and federal subsidies presume that non-profit hospitals offset their fiscal advantages with charity and other community benefits. However, neither the federal government nor West Virginia State Code enforces a minimum charity care standard. The result is a patchwork of self-reported figures with no consistent accountability mechanism. Accordingly, many non-profits function indistinguishably from for-profits, accumulating reserves while providing limited direct relief. Moreover, with the security of the state's protection of the certificate of need program to prohibit potential rivals, there is little incentive for facilities to perform competitively not only as it relates to cost, quality, and access—but also for charity care.

This report forms the quantitative backbone of a broader policy analysis of charity care. It extends prior descriptive work by integrating three independent federal data streams to create a consistent, multi-year view of hospital performance in West Virginia. The aim is not to single out individual facilities but to evaluate whether current structures including tax policy, regulatory oversight, and subsidy allocation produce adequate public benefit.

This report therefore addresses two primary policy questions:

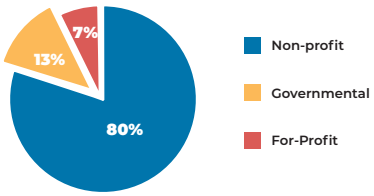
1. How much charity care do West Virginia hospitals actually provide relative to their size and profitability?

2. Do ownership, operating margin, or commercial-price levels predict charity care performance?

Figure 1

Profit Status of Hospitals in West Virginia

Displays ownership distribution across all facilities. Non-profit hospitals dominate the state's market share.



Ownership categories per NASHP (non-profit, for-profit, government).

Chart: Cardinal Institute analysis of NASHP HCT 2023. • Source: NASHP Hospital Cost Tool 2023 (FY 2021-2022) • Created with Datawrapper

Analytic Framework

The analysis proceeds in three tiers:

- Facility-Level (NASHP):

  Quantifies differences in charity, revenue, and pricing by ownership type.

- System-Level (IRS Form 990):

  Evaluates financial-assistance and bad-debt behavior across five major systems from 2019 to 2023.

- Federal Subsidy Level (CMS IPPS):

  Maps DSH and IME payments—based on FY 2022 cost-report data—onto IRS charity ratios to test alignment.

Each tier is presented visually through Figures 1 to 15 with interpretive commentary. Findings are synthesized into policy options for state oversight reform.

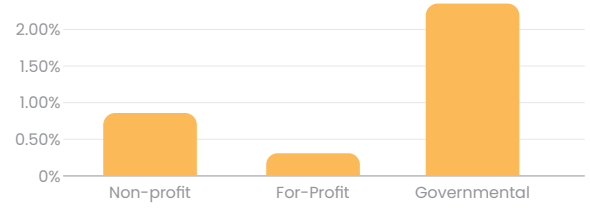
By combining these public datasets, this report converts fragmented financial disclosures into an integrated accountability map. The results challenge prevailing assumptions that non-profit status ensures community benefit and highlight the fiscal inefficiencies of untargeted federal and state subsidies.

We hope the analysis also provides a replicable template for other states examining comparable disparities.

Figure 2

Average Charity Care % of Net Patient Revenue by Ownership Type

Compares charity spending as a share of NPR. Non-profits deliver marginally more than for-profits, far below government hospitals.



Interpreted as: Non-profit = 0.9 %, For-profit = 0.3 %, Government 2.3 %. Facility-level data from NASHP's Hospital Cost Tool, FY 2021-2022.

Chart: Cardinal Institute analysis of NASHP HCT 2023. Source: NASHP Hospital Cost Tool 2023 (FY 2021-2022) Created with Datawrapper

Data Sources

This analysis draws on three verified federal datasets covering fiscal years 2018 through 2024. Each file is publicly available.

National Academy for State Health Policy (NASHP) Hospital Cost Tool 2023

Facility-level data derived from Medicare Cost Reports and AHRQ Compendium. Variables:

- Net Patient Revenue (NPR) – gross charges minus contractuals, charity, and bad-debt allowances.
- Operating Margin % – operating profit ÷ NPR.
- Other Income and Expense – includes both operating and non-operating sources (investment, donations, cafeteria, etc.).
- Net Charity Care Cost – hospital-reported cost of charity care less grants or patient payments.
- RAND Price Index – ratio of commercial to Medicare reimbursement (RAND 4.0).

Internal Revenue Service Form 990 Schedule H (2019–2023)

System-level data (Schedule H Parts I & III):

- Line 7a = Charity Care (at cost)
- Line 18 = Total Expenses
- Part III Line 3 = Financial Assistance Policy (FAP)-Eligible Bad Debt
- Part III Line 2 = Total Bad Debt*
- Part III Line 7 = Medicaid Shortfall

Reporting unit = hospital system, not facility.

Additional IRS fields were reviewed for community-benefit context, including grant revenue, lobbying disclosures, and Schedule H narrative statements. Grant data was identified using the Form 990 financial sections, lobbying activity through Schedule C and Part VI.

*Bad debt reflects IRS Form 990, Schedule H, Part III, Section A, line 2. Hospitals differ in whether they report bad debt in accordance with HFMA Statement 15/ASC 606 (line 1), so cross-system values may reflect different accounting methodologies.

Figure 3

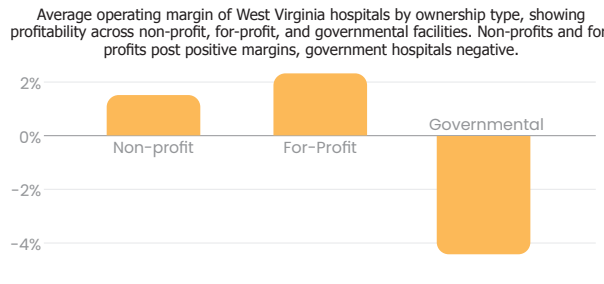


Figure 4

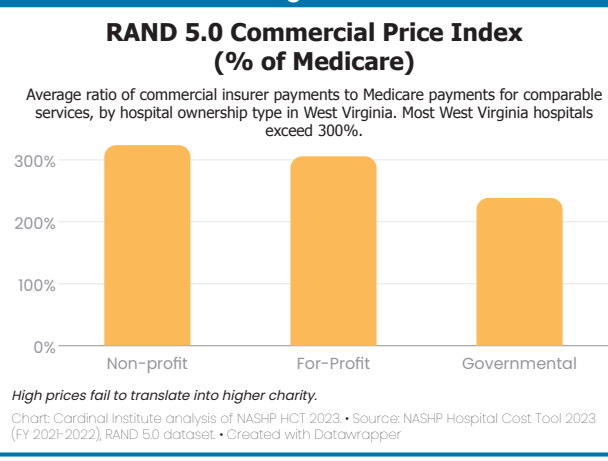


Figure 5A

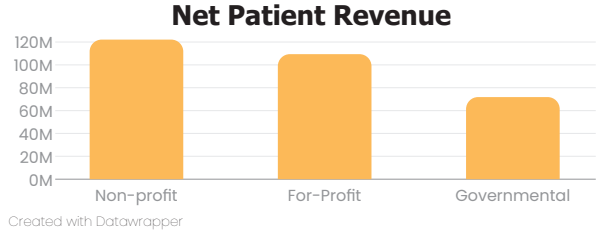
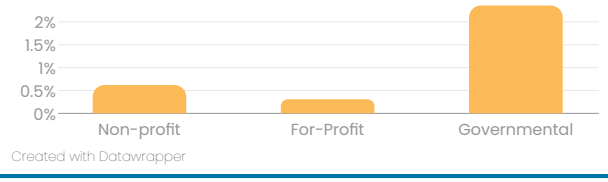


Figure 5B



Centers for Medicare & Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) Final Rule Impact File FY 2024

Facility-level data for FY 2024 (payment year based on FY 2022 cost reports), consistent with IRS/NASHP datasets:

- Identified only three IPPS-eligible hospitals from this set:
  - WVU Medicine (J.W. Ruby Memorial)
  - Charleston Area Medical Center
  - Cabell Huntington Hospital
- Reflects payment factors applied to FY 2022 cost reports.
- Variables:
  - Disproportionate Share Hospital (DSH) Patient %
  - DSH Operating and Capital Payments ($)
  - Indirect Medical Education (IME) Payment ($)
- Only subsection (d) short-term acute hospitals appear
- Critical Access Hospitals (CAHs) and specialty facilities are excluded

Results, or *The State of Hospital Charity Care In West Virginia*

According to the Kaiser Family Foundation's 2023 American Hospital Association Annual Survey, non-profit hospitals control more than 75% of all hospital beds in West Virginia. This is among the highest concentrations of non-profit ownership in the nation. This market structure gives a small number of non-profit systems decisive economic leverage. Ownership concentration sets the context for later comparisons of financial performance and charity activity.

NASHP 2023 Facility-Level Data (FY 2021–2022)

Figure 1 shows that non-profit hospitals dominate West Virginia's inpatient capacity, operating roughly three-quarters of all facilities. This concentration gives a few systems substantial market leverage.

Figure 2 compares charity care as a percent of net patient revenue.

Average charity care equals 0.9% of revenue for non-profits, 0.3% for for-profits, and 2.3% for government hospitals. Differences are small and statistically trivial. These data demonstrate that tax status alone does not predict generosity: non-profits provide only slightly more charity than for-profits despite extensive fiscal privileges.

Figure 3 presents average operating margins.

Both non-profit and for-profit hospitals reported positive operating margins in FY 2021–2022 (1.5 % and 2.3 %, respectively), while government facilities averaged – 4.4 %. The correlation between margin and charity care is r = – 0.07, confirming that profitability does not translate into increased free or discounted care.

Figure 4 displays the RAND 5.0 price index. Most hospitals charge roughly 300% of Medicare reimbursement. Yet, even at these elevated price levels, hospitals do not increase charity spending. In fact, charity levels remain flat (r = –0.09). Market power improves institutional revenue but not public benefit.

Together, these figures show that profitability and pricing power have little connection to charitable performance.

Figure 5A and 5B are a side-by-side comparison of the average net patient revenue and the average charity care percentage by hospital ownership type. Higher revenue does not yield higher charity percentages.

Non-profits average more than $120 million in annual NPR but provide under 1% in charity, whereas government hospitals, with smaller budgets, devote proportionally more to uncompensated care.

For-profit hospitals are not exempt from tax liability but provide somewhat comparable charity care as their non-profit counterparts who are exempt.

Figure 6 translates percentages into dollars to clarify scale: government hospitals contribute roughly $23,500 in charity per $1 million revenue, non-profits $6,500, and for-profits $3,100.

The pattern holds whether revenue is defined as NPR alone or NPR plus other income. Facility size or accounting base does not explain the shortfall.

Summary of Figures 1–6:

Ownership, profitability, and pricing explain little of the variation in charity provision. Non-profits and for-profits behave similarly despite different tax treatment, and price mark-ups well above Medicare benchmarks yield no additional community benefit.

The "Fair Share" Gap

If charity care is the price of tax exemption, most West Virginia hospitals are short-changing taxpayers. Hospitals often claim they can't afford to provide more care. But financial data tells a different story.

Taken together, these charts reveal a "fair share deficit," or the gap between what hospitals give and what they take in tax subsidies.

These figures paint a clear picture. Non-profits hospitals are not strapped for cash. They're just not spending it on care.

IRS Form 990 System-Level Data (FY 2019–2023)

Figure 7 plots charity care as a percent of total expenses.

Average charity care spending across all systems equals 1.18% of expenses. Davis Memorial leads (2.39 %), followed by CAMC (1.26 %), Mon Health (1.29 %), WVU (0.82 %), and Cabell (0.13 %). These ratios confirm that even the most generous systems devote less than 3% of total expenses to free care

Figure 6

Charity per $1 M Revenue = (Net Charity Care Cost + [Net Patient Revenue + Other Operating Income]) x 1,000,000. Uses facility-level data from NASHP Hospital Cost Tool, FY 2021-2022.
Chart: Compiled by the Cardinal Institute from NASHP 2023 facility-level data. • Source: NASHP Hospital Cost Tool (2023) using Medicare Cost Reports. • Created with Datawrapper

Figure 7

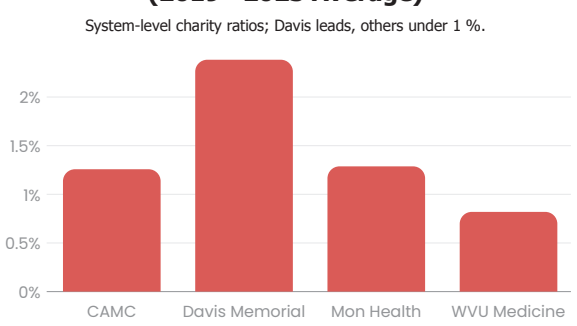


Figure 8 shows financial-assistance and bad-debt ratios.

Cabell's bad-debt-to-charity ratio of 13:1 means it sent 13 times more to collections than it forgave. CAMC and Mon range 3–5:1, and WVU about 1:1.

Figure 9 illustrates FAP-eligible bad debt. IRS records show that several systems classified patients as eligible for assistance yet pursued collections anyway. This contradicts federal guidance requiring good-faith effort to apply financial assistance policies before billing

Figure 10 adds Medicaid shortfalls—public-payer under-reimbursement—as another community-benefit dimension. Medicaid shortfalls average 11–16% of expenses for Cabell and WVU but do not correlate with higher charity. Systems serving public payers recoup losses through DSH and UCP payments rather than direct write-offs.

Figure 11 from the Kaiser Family Foundation, State Health Facts Federal Medicaid DSH Allotments (2008–2023) show that total federal Medicaid DSH allotments to West Virginia hospitals have increased from roughly $63 million in FY 2008 to $94 million in FY 2023. This is a 49% rise over 15 years. These state-level appropriations, reported by KFF from CMS State Health Facts, represent the maximum federal funds available for DSH payments to eligible hospitals. Despite this growth, hospital charity care spending has remained stagnant, indicating that higher federal safety-net funding has not translated into greater direct financial assistance to patients.

Figure 12 compares two different measures that are often assumed to track together but, in practice, do not. The first is the DSH patient percentage, a federal metric used by CMS to determine whether a hospital qualifies for Disproportionate Share Hospital subsidies. All three major urban non-profit systems in West Virginia—WVU (Ruby), CAMC, and Cabell—report DSH patient loads of about 3–3.5%. On paper, this suggests that each institution treats a similar share of low-income patients and therefore warrants safety-net support.

The second measure is the share of hospital expenses actually devoted to charity care, as reported to the IRS on Form 990 Schedule H. When these IRS data are averaged over 2019–2023, the picture changes substantially. WVU's charity care averages 0.82% of expenses, CAMC reports 1.26%, and Cabell reports only 0.13%.

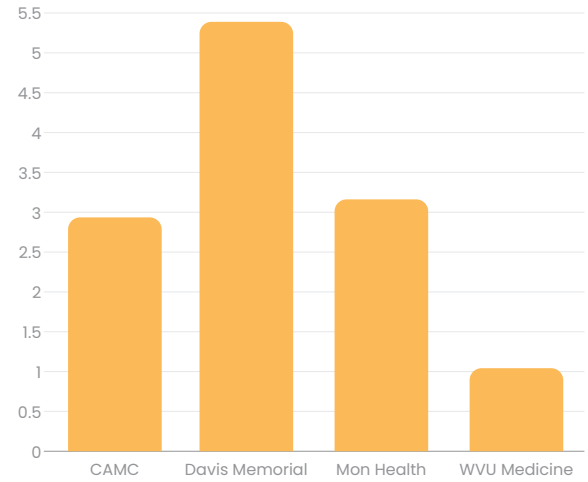
By placing these two measures side by side, the figure highlights a key policy problem: the federal metric that triggers safety-net subsidies does not reliably reflect the amount of free or discounted care hospitals ultimately provide. Hospitals can qualify for substantial DSH support based on their low-income patient mix yet still devote a very small share of their budgets to charity care. For Cabell, the gap is especially large, with one of the highest DSH percentages in the state and the lowest charity care output.

The figure illustrates that federal designation as a safety-net provider does not guarantee meaningful charity care performance, underscoring the need to reassess how safety-net status is defined, measured, and enforced.

Figure 8

Financial Assistance & Bad-Debt Ratios

Compares bad-debt-to-charity ratios. High values = collection bias.



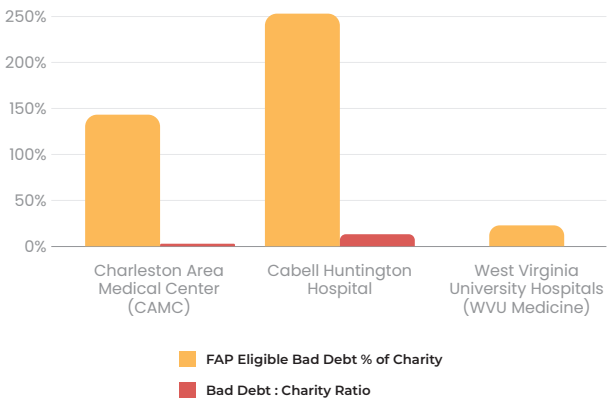
Bad debt reflects IRS Form 990, Schedule H, Part III, Section A, line 2. Hospitals differ in whether they report bad debt in accordance with HFMA Statement 15/ASC 606 (line 1), so cross-system values may reflect different accounting methodologies.

Chart: Cardinal Institute analysis of IRS Form 990 Schedule H • Source: IRS Schedule H Lines 2-3 vs 7a. • Created with Datawrapper

Figure 9

FAP Eligible Bad Debt Compared to Bad Debt to Charity Ratio

Comparison of FAP-eligible bad-debt percentages and bad-debt-to-charity ratios for West Virginia hospital systems. Two systems did not report FAP-eligible data (Davis Memorial and Mon Health), underscoring inconsistent financial-assistance reporting.



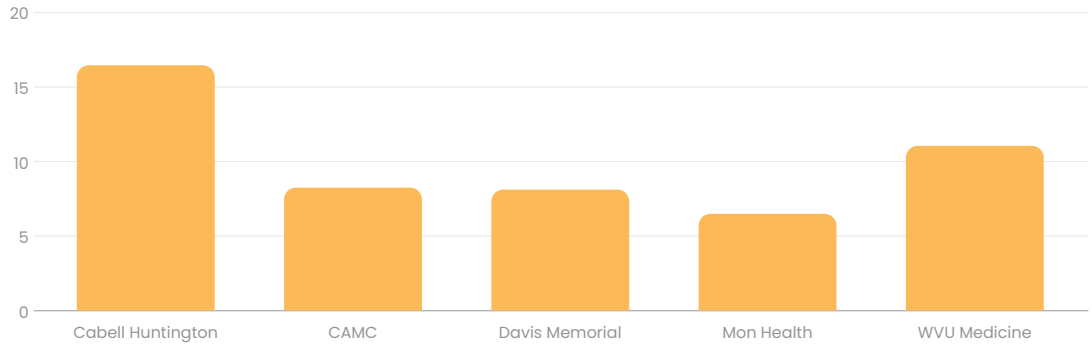
Bad debt reflects IRS Form 990, Schedule H, Part III, Section A, line 2. Hospitals differ in whether they report bad debt in accordance with HFMA Statement 15/ASC 606 (line 1), so cross-system values may reflect different accounting methodologies.

Chart: Cardinal Institute analysis of IRS Form 990 Schedule H • Source: IRS Form 990 Schedule H. • Created with Datawrapper

Figure 10

Medicaid Shortfall % of Expenses by System

Shows public-payer burden to contextualize community benefit beyond charity.



Medicaid Shortfall = Schedule H Part I Line 7b (column e) + Total Expenses.

Chart: Cardinal Institute analysis of IRS Form 990 Schedule H • Source: IRS Schedule H Part III Line 7 (2019—2023) • Created with Datawrapper

Summary of Figures 7–10b:

System-level data reinforce facility-level findings: West Virginia's largest hospitals maintain low charity spending relative to size, convert eligible accounts into bad debt, and rely on public-payer subsidies to balance budgets rather than delivering uncompensated care.

Federal Safety-Net Payments (CMS IPPS FY 2024)

In the FY 2024 IPPS data, only the principal facilities of WVU Medicine (Ruby Memorial), CAMC (General Hospital, CCN 510006), and Cabell Huntington (CCN 510008, part of Marshall Health Network) qualified for DSH or IME payments. Their DSH patient percentages range 3–4%, yet IRS charity ratios remain below 1%. Rural and CAH facilities receive no DSH or IME support. This demonstrates that federal subsidies are concentrated in urban systems already providing minimal charity care.

Fair-Share and Patient Impact

While hospitals often point to a wide range of "community benefit" activities, IRS data show that only charity care directly relieves patients' financial burden—the central purpose of their tax exemption.

IRS data also show inconsistent reporting of FAP-eligible bad debt across systems, and two hospitals do not report this data at all. Because the definitions vary and charity care denominators are extremely small, ratio-based comparisons are not meaningful and are excluded from visual analysis.

Health Status Table

System	Avg Charity % of Expenses	Avg FAP % of Charity	Avg Bad-Debt : Charity
CAMC	1.26 %	143 %	2.94×
Cabell Huntington (2018–2022)	0.13 %	253 %	13.35×
Davis Memorial	2.39 %	Not Reported	5.40×
Mon Health	1.29 %	Not Reported	3.17×
WVU Medicine	0.82 %	23 %	1.05×

Narrative and supplemental Form 990 fields revealed minimal disclosure on endowments or restricted funds used for community benefit. No hospital reported measurable lobbying costs or grant funding explicitly tagged for community-benefit purposes. These omissions reinforce the quantitative finding that reported charity care represents the primary, and often the only, measurable community contribution.

- "FAP-Eligible*" Bad Debt:

  Hospitals frequently argue that patients "failed to apply" for aid. Yet the hospitals' own IRS filings show they knew many of those patients met eligibility criteria and pursued collections anyway. Accordingly, FAP-Eligible Bad Debt represents the share of unpaid bills that hospitals themselves identify as *likely eligible for financial assistance*. Once more, these patients are assumed to have likely qualified for charity care, but the hospital still recorded their bills as bad debt.

  * It's important to note that "FAP-eligible" refers to a hospital's own Financial Assistance Policy (FAP), not an external rule or government standard. Each hospital defines for itself which patients qualify for discounted or free care based on income, insurance status, or other factors.

    In hospital accounting, bad debt refers to bills the hospital tried to collect from patients but never received payment for. These amounts are eventually written off as uncollectible, but only after the hospital has pursued billing or even perhaps sent the accounts to collections. This is very different from charity care, where the hospital recognizes up front that a patient cannot afford to pay and forgives the bill according to its financial assistance policy.

    That means when hospitals label a portion of their bad debt as "FAP-eligible," they are acknowledging that by their own policy, those patients should have received financial assistance. Yet, instead of applying those policies, they pursued collections. In other words, hospitals are not only overlooking patients in need, but they are also failing to follow the very guidelines they wrote to protect them.

Across the years, the data shows a troubling trend: Hospitals acknowledge that many patients likely qualify for financial aid. But, instead of helping them, they frequently classify those bills as bad debt (an accounting write-off for uncollected payments) and send them to collections.

In short, there is a gap between what hospitals know (that patients are eligible for help) and what they do (prioritize collections over assistance).

Figure 11-14 show this same trend year by year for West Virginia's three largest systems. Over time, the gap between what hospitals could forgive and what they actually forgive has grown, even in years when hospitals had healthy profits.

Figure 15 shows West Virginia hospital's, represented by a single dot, relationship between operating profitability and charity care spending as a share of net patient revenue. Higher operating margins do not indicate a greater likelihood to provide greater charity care. Accordingly, there is no meaningful connection between financial success and community benefit.

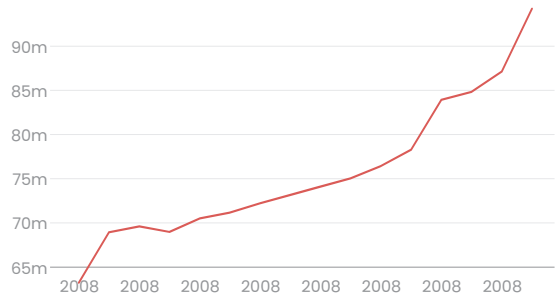
Overall Summary of Results

Across facility, system, and federal subsidy datasets, West Virginia's non-profit hospitals devote less than 1% of resources to charity care. They earn positive margins, charge commercial prices triple Medicare levels, and benefit from federal subsidies without delivering commensurate community benefit. Rural providers with smaller budgets offer more charity proportionally but receive no subsidy.

Figure 10 A

Federal Medicaid DSH Allotments to West Virginia Hospitals (FY 2008-2023)

Annual federal Medicaid Disproportionate Share Hospital (DSH) allotments to West Virginia, showing a steady increase in federal safety-net funding over the past 1 5 years



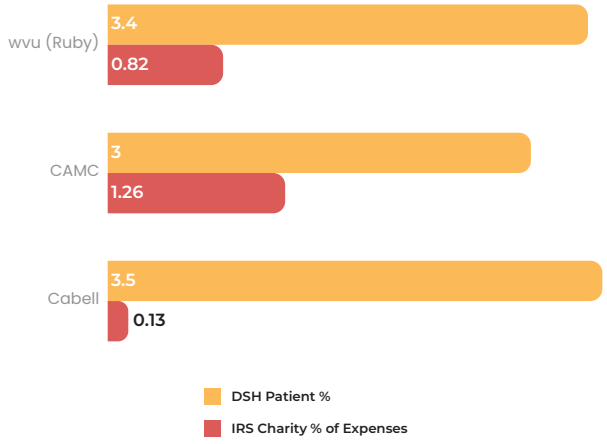
KFF defines the federal DSH allotment as the total federal funding each state may claim to make DSH payments to eligible hospitals serving high volumes of Medicaid and uninsured patients. This chart reflects allotments, not actual disbursements.

Chart: Compiled by the Cardinal Institute using CMS data. • Source: Kaiser Family Foundation (KFF), State Health Facts — Federal Medicaid DSH Allotments (2008–2023). • Created with Datawrapper

Figure 10 B

CMS DSH Patient % vs IRS Charity % (2019—2023 vs FY 2024)

Compares federal safety-net exposure to charity performance.



DSH 0/0= FY 2024 IPPS (based on FY 2022 reports); Charity 0/0= IRS avg 2019-2023. Shows subsidies concentrated in urban non-profits.

Chart: Cardinal Institute analysis of CMS IPPS and IRS Form 990 Schedule H. • Source: CMS IPPS FY 2024 Final Rule Impact File + IRS Schedule H. • Created with Datawrapper

Discussion

This three-tiered analysis confirms a consistent pattern across West Virginia hospitals: charitable performance is largely unrelated to profitability, ownership status, or market leverage. The financial and structural advantages enjoyed by non-profit hospitals like tax exemption, higher commercial prices, and eligibility for federal subsidies, do not yield measurable community benefit.

Across facility, system, and federal-payment datasets, charity care in West Virginia remains below 1% of revenue for most hospitals despite positive margins and extensive subsidies

DSH and IME results reflect a single fiscal year of data. However, eligibility and payment formulas change gradually, so these results reasonably represent the current distribution of federal safety-net subsidies across West Virginia hospitals.

Ownership and Profitability Do Not Predict Charity Care

Figure 1-4 demonstrate that hospital profit status and operating margins have negligible influence on charity care provision. Both non-profit and for-profit hospitals post positive margins yet contribute less than 1% of revenue to charity care. This finding challenges the assumption that non-profit designation ensures public benefit. Government-owned hospitals, despite budget constraints, remain the most generous, supporting the interpretation that mission, not margin, drives charity behavior.

Revenue Scale and Charity Deficits

Figure 5-6 reveal the gap between institutional scale and community return. As revenue rises, charity ratios remain flat. Non-profits generate multiple times the revenue of government facilities but contribute less charity per dollar. When measured in real terms, the difference is striking: for every $1 million in revenue, government hospitals provide nearly four times more charity. The implication is that West Virginia's largest systems could increase free-care spending substantially without jeopardizing fiscal stability.

System-Level Accountability Gaps

Through IRS Form 990 data, **Figure 7-14** extend this pattern to entire systems. Even the most generous system spends less than 3% of expenses on charity. Meanwhile, bad-debt-to-charity ratios reveal aggressive collection practices inconsistent with federal policy intent. Cabell's 13:1 ratio shows that the hospital collects or pursues payment thirteen times more often than it forgives care. Evidence that hospitals continue to bill patients they have identified as FAP-eligible suggests a compliance, not capacity, failure.

Federal Subsidies Concentrated in Low-Charity Systems

CMS IPPS data for FY 2024 show that only three large urban hospitals (WVU Medicine's Ruby Memorial, Charleston Area Medical Center, and Cabell Huntington) received any DSH or IME adjustments, while all other West Virginia hospitals reported zeros in these categories. This demonstrates the geographic skew in federal safety-net payments. Rural and Critical Access hospitals, which often treat poorer populations, received none. Thus, federal subsidies flow to financially strong institutions already providing minimal charity. Aligning subsidy policy with actual uncompensated-care delivery could redistribute federal support more equitably.

Fair-Share and Patient Impact

Figure 11-15 illustrate the patient-level consequences. FAP-eligible bad debt consistently exceeds charity cost, indicating hospitals are not applying assistance consistently. As shown in Figure 15's scatterplot linking charity to operating margin and price index, we confirm there is no relationship; hospitals can be highly profitable yet indifferent to charity care. These patterns collectively demonstrate that West Virginia's current charity-care framework neither incentivizes nor rewards community benefit.

Conclusion

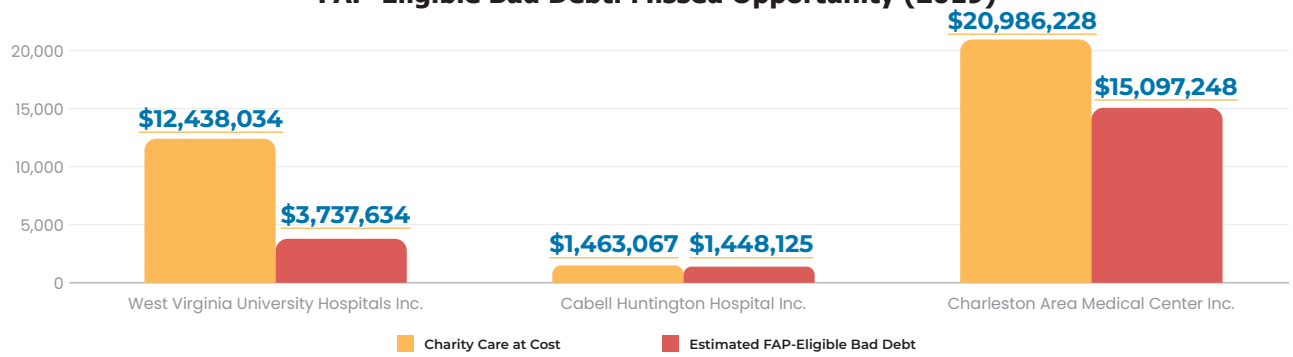
West Virginia's non-profit hospitals function as dominant market actors with profitability and pricing power indistinguishable from for-profits. Across three independent datasets, charity-care spending remains below 1% of revenue or expenses. Federal DSH and IME subsidies, designed to offset uncompensated care, are concentrated in urban systems already reporting minimal charity.

The findings call for a recalibration of the non-profit hospital compact. Transparent benchmarks, public reporting, and enforceable standards are essential to ensure that tax privileges and federal transfers translate into real community benefit. Without reform, charity care will remain an accounting entry rather than a lived reality for West Virginia patients.

> *All underlying data are publicly available via NASHP HCT, IRS Form 990, and CMS IPPS files, ensuring full transparency and reproducibility.*

Figure 11

FAP-Eligible Bad Debt: Missed Opportunity (2019)

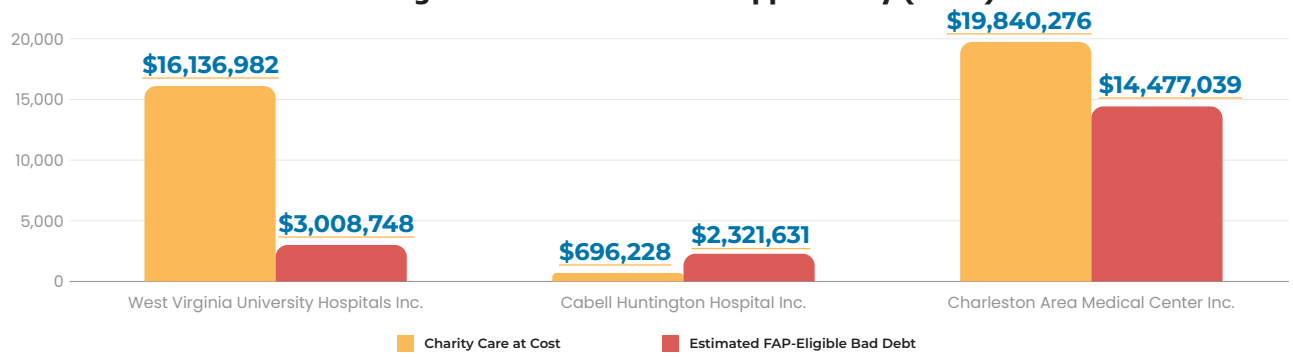


Bad debt reflects IRS Form 990, Schedule H, Part III, Section A, line 2. Hospitals differ in whether they report bad debt in accordance with HFMA Statement 15/ASC 606 (line 1), so cross-system values may reflect different accounting methodologies.

Created with Datawrapper

Figure 12

FAP-Eligible Bad Debt: Missed Opportunity (2020)



Bad debt reflects IRS Form 990, Schedule H, Part III, Section A, line 2. Hospitals differ in whether they report bad debt in accordance with HFMA Statement 15/ASC 606 (line 1), so cross-system values may reflect different accounting methodologies.

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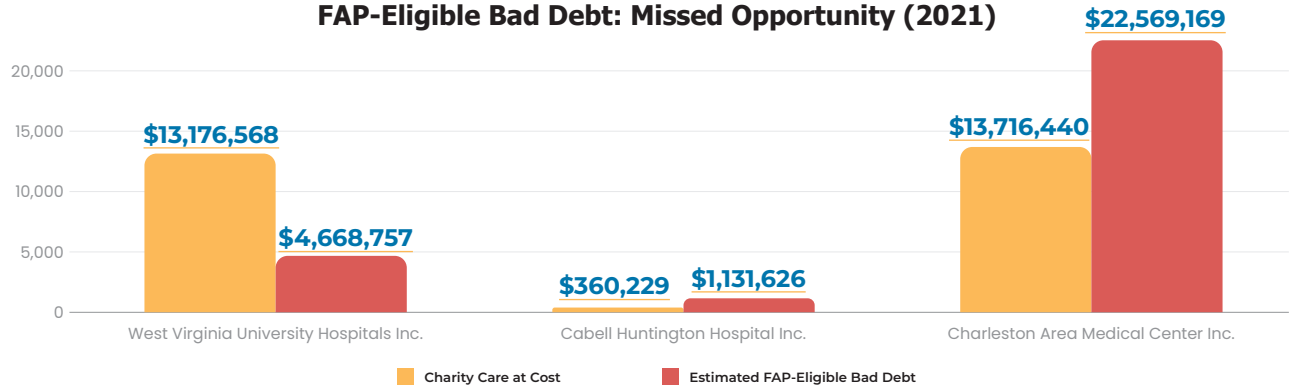
Figure 13

FAP-Eligible Bad Debt: Missed Opportunity (2021)



Bad debt reflects IRS Form 990, Schedule H, Part III, Section A, line 2. Hospitals differ in whether they report bad debt in accordance with HFMA Statement 15/ASC 606 (line 1), so cross-system values may reflect different accounting methodologies.

Created with Datawrapper

Policy Solutions for West Virginia

The evidence points to three clear policy deficiencies: absence of a quantitative standard, lack of transparency, and misalignment between subsidy allocation and community need. States such as Texas, Illinois, and Oregon have addressed these gaps through enforceable charity benchmarks and disclosure laws. West Virginia can adopt similar reforms.

Repeal the state's Certificate of Need (CON) laws. By eliminating these artificial barriers to entry, the state can open the door for new, community-focused providers that are more likely to provide charity care and transparent pricing. Competition is what forces hospitals to deliver value.

Transparency must be non-negotiable. Hospitals should be required to publish itemized, facility-level reports on charity care spending. These reports must disclose charity care at cost, not padded numbers that include bad debt or marketing expenses. Currently, West Virginia ranks last in the nation on charity care oversight. Patients and policymakers deserve to know exactly how much relief their communities are receiving.

Maryland, for instance, models a good approach to this issue in Md. Code Ann., Health–Gen. §19-303(c):

> *"Each nonprofit hospital shall annually submit a community benefit report including: (1) the hospital's mission statement; (2) a list of the community benefit initiatives undertaken by the hospital; (3) the cost of each initiative and the objectives for the community; and (4) a description of efforts to evaluate the initiative's effectiveness. The report shall also describe gaps in the availability of medical specialists for uninsured persons and the hospital's efforts to track and reduce health disparities in the community."*

Accountability must be built into the system.[53] West Virginia should adopt minimum charity care floors tied directly to the value of hospitals' tax benefits. States like Texas and Illinois already link tax exemption to clear thresholds, such as devoting at least 5% of net patient revenue to community benefit and 4% to direct charity care.[54] If hospitals cannot meet these basic obligations, they should not enjoy the privileges of non-profit status.

Texas provides among the clearest examples in:

> **Texas Tax Code Sec. 11.1801(a)(3):** *"A nonprofit hospital shall provide charity care and community benefits in an amount that is at least equal to 5% of the hospital's net patient revenue, provided that charity care and government-sponsored indigent health care are at least 4% of net patient revenue."*

> **Texas Tax Code Section 11.1801(a)(1):** *"The level of charity care must be reasonable in relation to community needs, as determined through the community needs assessment, the hospital's available resources, and the tax-exempt benefits received by the hospital."*

Illinois goes even further, offering a gold standard for charity care accountability. Under the Illinois Hospital Property Tax Exemption Law (35 ILCS 200/15-86), non-profit hospitals must provide charity care or other community benefits equal in value to their property tax exemptions.[55] If a hospital's charity spending falls short of its tax savings, it risks losing its exemption entirely. This simple "no community benefit, no tax break" rule forces hospitals to demonstrate real, measurable value to the public.

53. United States Government Accountability Office. Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status. GAO-20-679, Sept. 2020.

54. Lown Institute. Hospital Community Benefit Spending: Improving Transparency and Accountability around Standards for Tax-Exempt Hospitals. Policy Brief, Mar. 2024.

55. Illinois General Assembly. Illinois Property Tax Code, 35 ILCS 200/15-86. "Hospital Property Tax Exemption Law." Illinois General Assembly, enacted 2012, effective 14 June 2012. https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=003502000K15-86.

According to the Cicero Institute,[56] Illinois ranks #1 nationally (10/10) for transparency, accountability, and enforcement:[57]

- Hospitals file itemized community benefit reports with the Illinois Attorney General
- The state may revoke tax exemptions for underperformance or non-compliance
- The law has already prompted large hospital systems to increase their charity care spending to maintain compliance

Illinois demonstrates that when lawmakers tie non-profit privileges to measurable community return, hospitals adapt quickly—and patients, not bureaucracies, benefit.

Enforcement is key. Hospitals that fail to meet charity care floors or engage in deceptive accounting should face real consequences. This may include fines, loss of state tax exemptions, or revocation of non-profit designation. Even when hospitals report giving nothing back, the IRS rarely acts, the GAO concluded.[58] West Virginia should not, and can not, repeat that failure at the state level. **Without teeth, reforms will remain empty promises.**

Once more, Texas sets the bar:

Texas Tax Code §11.1801(a): *"To qualify as a charitable organization under Section 11.18(d)(1), a nonprofit hospital or hospital system must provide charity care and community benefits as follows: (1) charity care and government-sponsored indigent health care must be provided at a level that is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system; (2) charity care and government-sponsored indigent health care must be provided in an amount equal to at least four percent of the hospital's or hospital system's net patient revenue; (3) charity care and government-sponsored indigent health care must be provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax; or (4) charity care and community benefits must be provided in a combined amount equal to at least five percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue."*

Texas Tax Code §11.1801(j): *"In any fiscal year that a hospital or hospital system, through unintended miscalculation, fails to meet any of the standards in Subsection (a) or fails to be considered to be in compliance with the standards in Subsection (a) under Subsection (b), (c), or (d), the hospital or hospital system shall not lose its tax-exempt status without the opportunity to cure the miscalculation in the fiscal year following the fiscal year the failure is discovered by both meeting one of the standards and providing an additional amount of charity care and government-sponsored indigent health care that is equal to the shortfall from the previous fiscal year. A hospital or hospital system may apply this provision only once every five years."*

California also provides useful guidance:

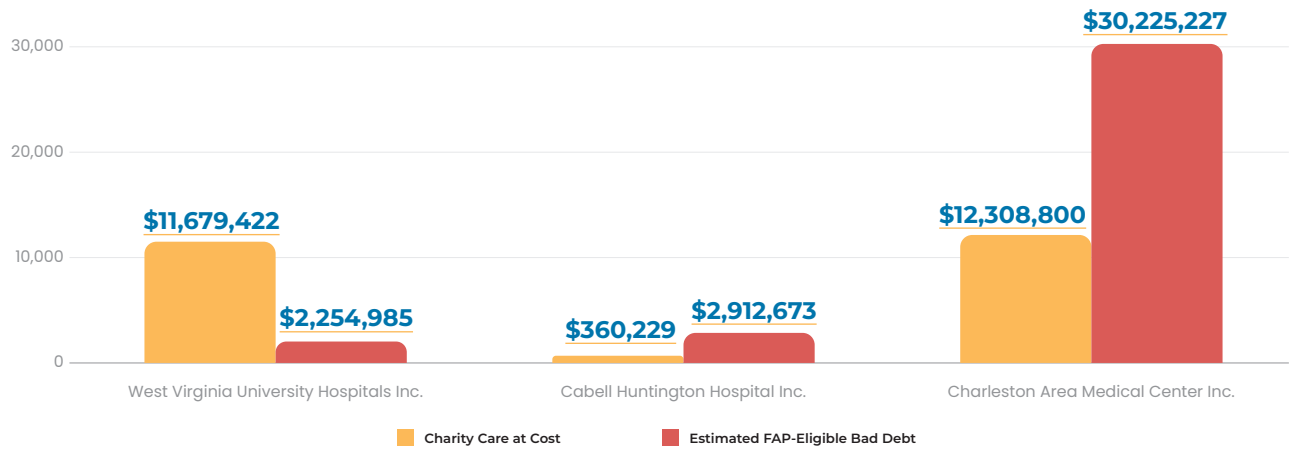
Cal. Code Regs. Tit. 22, §95309: *"A hospital that fails to file a report by a due date established pursuant to Section 95306 is liable for a fine of one hundred dollars ($100) for each day that the required report is not filed up to the annual statutory maximum of $5,000."*

Patients need stronger protections. Aggressive collection actions (lawsuits, wage garnishments, property liens) should be banned. Families should never lose their homes or paychecks over bills that hospitals, by law and mission, are supposed to forgive.

56. Cicero Institute. Nonprofit Hospitals and Community Benefits: State Accountability Rankings. Cicero Institute, Mar. 2025, pp. 3–5.
57. Office of the Illinois Attorney General. Community Benefits Act Annual Reporting Requirements for Nonprofit Hospitals. Community Benefits Bureau, Illinois Attorney General, 2024. https://illinoisattorneygeneral.gov/charities/hospital_reports.html.
58. United States Government Accountability Office. Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status. GAO-20-679, Sept. 2020, www.gao.gov/products/GAO-20-679.

Figure 14

FAP-Eligible Bad Debt vs. FAP-Eligible Bad Debt: Missed Opportunity (2022)



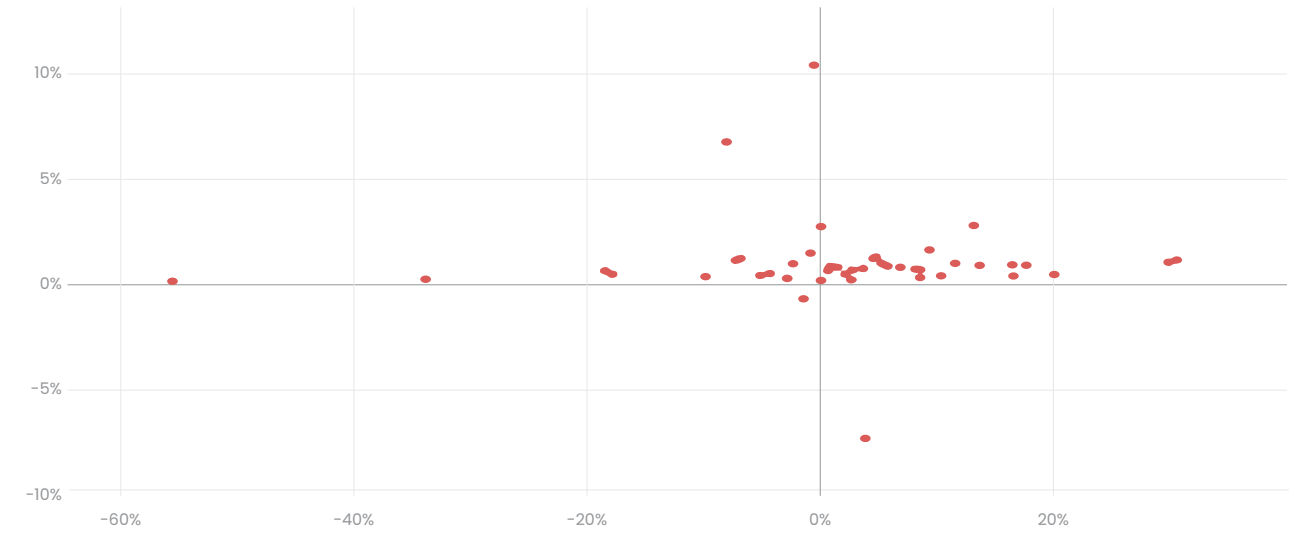
Bad debt reflects IRS Form 990, Schedule H, Part III, Section A, line 2. Hospitals differ in whether they report bad debt in accordance with HFMA Statement 15/ASC 606 (line 1), so cross-system values may reflect different accounting methodologies.

Created with Datawrapper

Figure 15

Charity Care vs Operating Margin, West Virginia Hospitals

Each dot represents a West Virginia hospital. The scatterplot shows the relationship between operating profitability and charity care spending as a share of net patient revenue. Hospitals with higher operating margins are not more likely to provide greater charity care, indicating no meaningful relationship between financial performance and community benefit.



Data represent FY 2021—2022 hospital-level values from NASHP's Hospital Cost Tool. Facilities with missing data for either variable were excluded.

Chart: Cardinal Institute analysis of NASHP Hospital Cost Tool • Source: NASHP Hospital Cost Tool (FY 2021-2022) • Created with Datawrapper

Recommended Actions for West Virginia

To translate the mentioned frameworks into actionable reform, West Virginia should adopt the following measures to ensure hospitals earn their non-profit privileges, patients receive the charity care they are promised, and market competition drives better access and accountability:

1. **Establish a Hard Charity Care Floor (Texas-Style Proposed Model)**

- Set a minimum 5% of Net Patient Revenue (NPR) charity care requirement at cost (not "charges foregone").
- Condition all state and local tax exemptions on meeting this threshold.
- Require corrective action plans and public notice after two consecutive sub-floor years.
- Mirror Texas Health & Safety Code § 311.045 and Tax Code § 11.1801, which link non-profit status to measurable community-benefit and charity care performance.
- Include enforcement through Texas H.B. 3708 (2025)-style administrative penalties for repeat non-compliance.

2. **Make Financial Assistance Programs Accessible (Oregon-Style Screening)**

- Require universal pre-billing screening for charity care eligibility before any collections activity.
- Mandate presumptive eligibility screening for patients flagged through participation in public programs such as SNAP or WIC.
- Standardize plain-language, one-page financial assistance policies in multiple languages.
- Prohibit Extraordinary Collection Actions (ECA) until all screening and "reasonable effort" documentation is completed.
- Model these standards on Oregon H.B. 3076 (2019) (ORS 442.614 & 646A.677) and Oregon H.B. 3320 (2023), which mandate presumptive screening prior to billing and make violations an unlawful debt-collection practice.

3. **Stop Converting Eligible Patients into Bad Debt**

- Require hospitals to report bad debt and estimated FAP-eligible proportions side-by-side with charity care at cost.
- If over 50% of bad debt is FAP-eligible while charity care is under 3%, trigger financial penalties or partial loss of tax benefits.
- Implement this reporting as part of hospitals' annual state community benefit filings to the Department of Health and State Tax Department.

4. **Repeal Certificate of Need (CON) and Open the Market**

- Fully repeal West Virginia's CON law.
- Pair repeal with charity care floors and debt-collection protections to maintain patient access while enabling competition.
- Encourage entry of community-based and faith-based hospitals that provide transparent pricing and voluntary charity care, restoring a genuine free-market dynamic.

5. **Strengthen Debt Collection Guardrails**

- Prohibit lawsuits for medical debts under $500 and ban wage garnishments and property liens for FAP-eligible patients.
- Impose a 120-day waiting period before any collection activity, with charity care screening and eligibility verification.
- Ban debt sales unless the buyer agrees to charity care and collection-standard requirements.
- Align these rules with Oregon H.B. 3076 (2019) and Texas H.B. 3708 (2025) models for fair billing and administrative enforcement.

Implementation and Oversight:

- Assign enforcement to the West Virginia Department of Health (DHS) in coordination with the State Tax Department.
- Require public posting of annual hospital compliance reports and corrective action plans.
- Establish civil penalties and loss of state tax exemption for repeat or willful violations.

Supporting Models:

- Texas Health & Safety Code § 311.043–311.0455; Texas Tax Code § 11.1801; Texas H.B. 3708 (2025).
- Oregon H.B. 3076 (2019), codified at ORS 442.614 and 646A.677; Oregon H.B. 3320 (2023).

Methods

This analysis integrates three complementary datasets that capture hospital financial performance and charity care from distinct reporting frameworks.

Facility-Level Data (NASHP 2023)

Facility-level measures were drawn from the National Academy for State Health Policy's Hospital Cost Tool (HCT) 2023 dataset, which compiles Medicare Cost Report data for fiscal years 2021–2022. Variables include Net Patient Revenue (NPR), Operating Margin (%), Other Income and Expense, Net Charity Care Cost, and the RAND 5.0 Price Index, representing the ratio of commercial payments to Medicare-allowed amounts for equivalent services.

facility n = 46

System-Level Data (IRS Form 990)

System-level measures were obtained from IRS Form 990 filings (primarily Schedule H, Parts I and III) for West Virginia's five major non-profit hospital entities active in West Virginia, including WVU Medicine (a consolidated system), the Vandalia Health network (CAMC and Mon Health, which file separately), Marshall Health Network (Cabell Huntington), and the independent Davis Health System. IRS Schedule H data were compiled for fiscal years 2019–2023 for all systems except Cabell Huntington Hospital, whose most recent filing available at the time of analysis was FY 2022. For Cabell, data from 2018–2022 were used to maintain a five-year window. Key fields include Part I Line 7a (Charity Care Cost), Part I Line 18 (Total Expenses), Part III Line 3 (FAP-Eligible Bad Debt), and Part III Line 2 (Total Bad Debt).

These filings aimed to capture aggregated system finances rather than facility-level operations.

system n = 5

CMS IPPS Analysis

To quantify federal safety-net subsidies, we merged the Centers for Medicare & Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) FY 2024 Final Rule Impact File with the 2023 Hospital Cost Report using the Medicare Provider CCN.

CMS IPPS DSH and IME payment data were obtained from the FY 2024 Final Rule Impact File, which applies FY 2022 cost-report values. Only this most recent fiscal year was used because CMS does not publish a consistent multi-year Impact File series.

It provides Disproportionate Share Hospital (DSH) patient percentages and Indirect Medical Education (IME) payment adjustments for subsection (d) hospitals paid under IPPS. Facilities reimbursed outside IPPS (such as Critical Access, rehabilitation, psychiatric, and children's hospitals) were excluded because they do not receive DSH or IME payments. The analytic subset comprised the three large urban hospitals (WVU Medicine – J.W. Ruby Memorial, Charleston Area Medical Center, and Cabell Huntington Hospital) that qualified for IPPS payments in FY 2024. DSH percentages and payment amounts were compared with each system's IRS Form 990 Schedule H charity care percentages for 2019–2023 to assess alignment between federal subsidies and reported uncompensated-care activity.

Variable Construction

Metric	Formula	Source
Charity Care % of Net Patient Revenue (NPR)	Net Charity Care Cost ÷ NPR × 100	NASHP
Operating Margin %	Operating Income ÷ NPR × 100	NASHP
RAND Price Index	Commercial Price ÷ Medicare Price × 100	NASHP
Charity Care % of Total Expenses	Schedule H Line 7a ÷ Line 18 × 100	IRS
FAP-Eligible Bad Debt % of Charity	Schedule H Line 3 ÷ Line 7a × 100	IRS
Bad-Debt-to-Charity Ratio	Schedule H Line 2 ÷ Line 7a	IRS
Charity per $1M Revenue (Sensitivity)	(Charity Care Cost ÷ (NPR + Other Operating Income)) × 1,000,000	NASHP
DSH Patient %	Medicaid + SSI Discharges ÷ Total Discharges	CMS IPPS
Total DSH $	DSHOPP + DSHCPP	CMS IPPS
IME $	IME_TACMIV41	CMS IPPS

Data Management

Facility-level data (NASHP) were merged with ownership identifiers. System-level Form 990 entries were averaged over 2019–2023 to smooth year-to-year variation. CMS IPPS data were matched by six-digit Medicare Provider CCN to the 2022 HCRIS roster.

Figures were generated via Datawrapper.

Analytic Approach

Facility-Level (NASHP)

Facility-level data were used to assess market behavior across ownership types (non-profit, for-profit, government). Descriptive statistics were computed for Charity % of NPR, Operating Margin %, and RAND Price Index. Two Pearson correlation tests measured the relationship between charity care and (a) profitability and (b) pricing power. Scatterplots were generated to visualize (1) accountability—Operating Margin vs Charity % of NPR—and (2) market power—RAND Index vs Charity % of NPR.

System-Level (IRS)

IRS data were analyzed to evaluate accountability among West Virginia's five major non-profit hospital entities active in West Virginia, including WVU Medicine (a consolidated system), the Vandalia Health network (CAMC and Mon Health, which file separately), Marshall Health Network (Cabell Huntington), and the independent Davis Health System. Each metric was averaged across 2019–2023 tax years. These include the mean Charity % of Expenses, mean FAP-Eligible Bad Debt % of Charity, and mean Bad-Debt-to-Charity Ratio.

Data Cleaning

Non-numeric or text entries (e.g., "Not Reported") were left blank. Facilities with missing NPR or Charity Care Cost were excluded from denominators. Percentage fields stored as text were converted to numeric using Excel's NUMBERVALUE function.

Handling of Missing Data

- RAND Index values were unavailable for approximately one-quarter of facilities and were excluded from ownership-level averages.
- Two systems (Davis Memorial and Mon Health) did not report FAP-Eligible Bad Debt on Schedule H Line 3; these were treated as missing rather than zero.

Analytic Sequence

The study proceeded in four phases:

1. Ownership and Charity Correlation

Facility-level charity % was correlated with ownership type and operating margin.

r = –0.07 for margin vs charity and r = –0.09 for price index vs charity confirm no relationship.

2. System-Level Aggregation

Five primary entities—WVU Medicine, Charleston Area Medical Center (CAMC), Cabell Huntington, Mon Health, and Davis Memorial—were analyzed.

Mean charity %, bad-debt ratio, and FAP-eligible share were calculated.

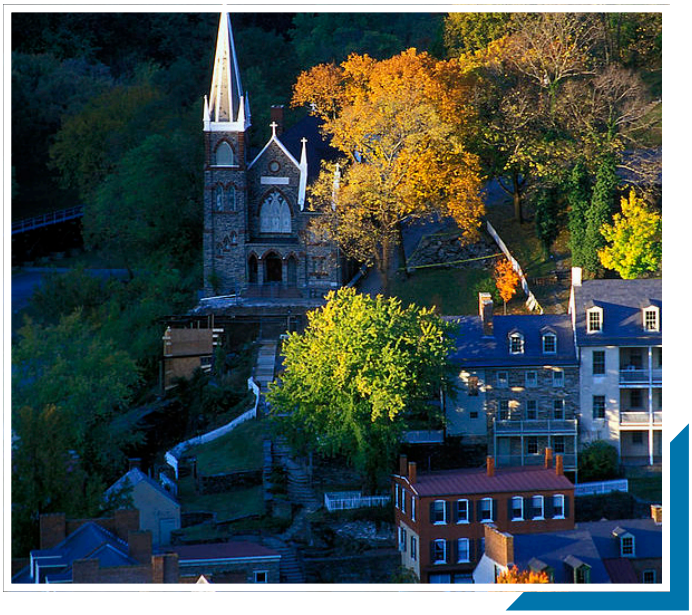
3. Federal Subsidy Overlay

IPPS data (DSH %, DSH $, IME $) were merged to system records.

For each system: Total Subsidy = DSH $ + IME $.

4. Visualization and Interpretation

Figures summarize results. Each visual includes title, description, notes, and sources.



Limitations

Unit of Analysis Mismatch

NASHP data are facility-level; IRS Form 990 filings are more so system-level. The two datasets measure different organizational scopes and cannot be directly merged. Analyses were therefore conducted in parallel rather than as pooled samples.

Revenue Definition Ambiguity

NASHP's Other Income and Expense includes both operating and non-operating sources (investment income, donations). Using NPR + Other Income as "Total Revenue" potentially understates Charity-per-Revenue ratios if non-operating income is large. Sensitivity analysis mitigates this bias.

Reporting Heterogeneity

Hospitals vary in how they interpret Schedule H lines and cost-report rules. Apparent differences across systems may reflect accounting methods rather than actual charity behavior.

Missing Data

RAND indices and FAP metrics are incomplete, reducing sample size for correlations and limiting statistical inference. "Not Reported" entries indicate absence of disclosure, not absence of activity.

Temporal Alignment

NASHP 2023 represents fiscal years 2021–2022, whereas IRS data extend through 2023. This offset prevents perfect year-to-year alignment but still captures overlapping trends.

No Case-Mix or Demographic Adjustment

The analysis does not control for patient acuity, payer mix, or regional socioeconomic variation that could influence charity care levels.

Descriptive, Not Causal.

Correlations identify relationships, not causation. Results show associations between financial performance and charity behavior, not definitive effects.

Definitions/Glossary

Affordable Care Act (ACA): Federal law that added requirements for non-profit hospitals to keep their tax-exempt status, including conducting a community health needs assessment, having a financial assistance policy, and limiting aggressive collections.

Bad Debt: Hospital bills that were expected to be paid but never collected. Bad debt is not charity care.

Certificate of Need (CON): A state law that requires hospitals or clinics to get government approval before expanding or opening new services.

Charity Care: Free or discounted medical care provided to financially disadvantaged patients without expectation of payment. Charity care is the main justification for non-profit hospitals' tax exemptions and is meant to directly relieve financial hardship for patients.

Community Benefit: A broad IRS category that includes all activities hospitals claim as a public good, from charity care to research or staff training.

Community Health Needs Assessment (CHNA): A report hospitals must complete every three years to identify local health needs. It is supposed to guide how hospitals provide charity care and other benefits, but there is little enforcement or accountability.

Extraordinary Collection Actions (ECA): Aggressive debt collection practices such as lawsuits, wage garnishments, or property liens. Federal law prohibits ECAs until hospitals have made a good faith effort to determine if a patient qualifies for charity care.

Fair Share Deficit: The gap between the value of the tax breaks hospitals receive and what they spend on direct community benefit. A fair share deficit means taxpayers are giving hospitals more than hospitals give back.

Financial Assistance Policy (FAP): The written policy that sets out who qualifies for charity care and how to apply. Hospitals are required to make it easy to find and understand.

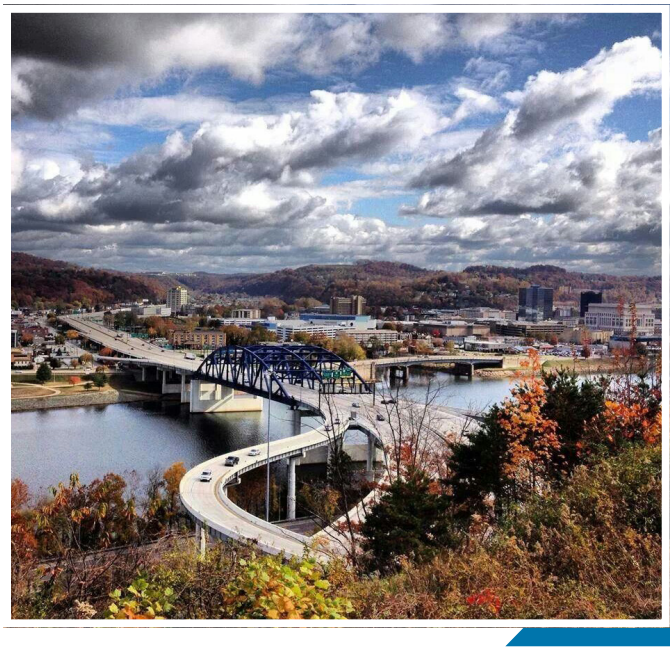
Form 990 and Schedule H: Annual IRS filings that non-profit hospitals must submit. Schedule H lists how much a non-profit hospital spends on charity care, bad debt, and other community benefits. These forms are the main public record for tracking charity care performance.

Net Patient Revenue (NPR): The total money hospitals collect from patients and insurers after discounts and allowances. Many charity care standards, such as in Texas, measure performance as a percentage of NPR.

Non-profit Hospital: A hospital that is exempt from paying most taxes because it is supposed to serve the community through charity care and other benefits. Non-profits receive millions in tax breaks each year and are expected to provide measurable returns to the public.

Revenue Ruling 56-185 and Revenue Ruling 69-545: IRS rulings that define what qualifies a hospital for tax exemption. The 1956 ruling required hospitals to provide free or reduced-cost care to those unable to pay. The 1969 ruling replaced that clear standard with the "community benefit" test, allowing hospitals to count many non-patient activities toward their exemption.

Tax Exemption: The financial privilege that allows non-profit hospitals to avoid paying property, sales, and income taxes. In return, they are expected to provide charity care and community benefits equal to or greater than the value of those tax breaks.



METHODOLOGY:

This analysis evaluates hospital charity care performance in West Virginia, with a focus on ownership type (non-profit, governmental, and for-profit) and system-level accountability. All figures derive from the 2023 NASHP dataset, supplemented with IRS Form 990 (Schedule H) filings and RAND 5.1 hospital pricing data, unless otherwise noted.

The methodology aligns with standard health policy reporting practices while emphasizing transparency and comparability across facilities.

Exclusion Criteria

To ensure meaningful comparisons, we excluded facilities that met any of the following criteria:

- Fewer than 5 licensed beds
- Occupancy rates below 10%
- Reported zero or negative charity care

These filters eliminate outliers and ensure the data reflects general acute care hospitals with substantial patient volume.

System-Level Scope and Limitations

This report focuses on five major hospital systems in West Virginia: WVU Medicine, Charleston Area Medical Center (CAMC, part of Vandalia Health), Cabell Huntington Hospital (part of the Marshall Health Network), Mon Health (part of Vandalia Health), and Davis Memorial..

Because Vandalia Health and Marshall Health Network do not publish consolidated IRS Form 990 filings or Schedule H charity care data at the system level, each hospital's own Form 990 and Schedule H were used to calculate charity care percentages and other performance measures. Results are then interpreted narratively at the "regional system" level to reflect each network's broader footprint.

In contrast, WVU Medicine files as a consolidated system, meaning its Form 990 and Schedule H data already reflect system-wide totals across multiple facilities. WVU's results are therefore analyzed directly from its consolidated filing, while CAMC and Cabell represent facility-level proxies for their respective systems.

Other Data Limitations

- Financial values are self-reported by hospitals:
  - Charity care data is based on IRS Form 990 Schedule H, Line 7a.
  - Bad debt and FAP-eligible estimates follow Schedule H reporting standards but may vary by hospital in methodology or precision.
- Benchmarks such as the national non-profit average (≈1.8% of expenses) were used for comparative context where applicable.
- NASHP data reflect FY 2021–2022; IRS covers FY 2019–2023 (2018–2022 for Cabell Huntington); RAND 5.1 reports 2022 pricing.
- CMS IPPS DSH and IME data (FY 2024, based on FY 2022 cost reports) were used to contextualize federal safety-net funding.

Figure 2:

Average Charity Care Percentage of Net Patient Revenue by Ownership Type

- **Data Source:** 2023 NASHP
- **Purpose:** Compares the average net charity care cost as a percentage of net patient revenue.
- **Metric:** Charity Care % = Net Charity Care / Net Patient Revenue × 100.
- **Approach:** Hospitals were grouped by ownership and the average ratio was computed after exclusions.

Figure 3:

Average Operating Margin by Ownership Type

- **Data Source:** 2023 NASHP
- **Purpose:** Compares average operating across hospital ownership categories.
- **Metric:** Operating Margin % = Operating Income ÷ Net Patient Revenue × 100.
- **Approach:** Calculated for each facility from reported operating income and NPR, then averaged by ownership type. Missing or negative margins were included to reflect true variation in performance.

Figure 14:

Hospital Prices vs. Medicare (RAND 5.1)

- **Data Source:** 2023 NASHP
- **Purpose:** Compare commercial hospital prices to standardized Medicare rates.
- **Metric:** Hospital Price Index = (Avg Commercial Payment / Medicare Rate) × 100%.
- **Example:** A 300% index indicates the hospital charges 3× the Medicare rate for equivalent services.

Figure 5:

Average Revenue and Charity Care Percent by Ownership Type

- **Data Source:** 2023 NASHP
- **Purpose:** Compare average net patient revenue (absolute dollars) and charity care (% of revenue) within each ownership group.
- **Metric:** Net Charity Care % = Charity Care Cost / Net Patient Revenue × 100.
- **Approach:** Calculated at the hospital level, then average by ownership type.

Figure 6:

Charity Care per $1 Million Revenue

- **Data Source:** 2023 NASHP
- **Purpose:** Normalize charity care contributions by total revenue.
- **Metric:** Charity Care per $1M Revenue = (Charity Care Cost / Total Revenue) × 1,000,000.
- **Approach:** Calculated at the hospital level, then average by ownership type.

Figure 7:

Charity Care as a Percent of Expenses by Health System

- **Data Source:** IRS Form 990 Schedule H, Lines 7a, Part III Lines 2–3.
- **Metric:** Charity Care % of Expenses = (Charity Care at Cost ÷ Total Expenses)

Figure 8:

Financial Assistance and Bad-Debt Ratios

- **Data Source:** IRS Form 990 Schedule H (2019–2023).
- **Purpose:** Evaluate how much reported bad debt is considered eligible under financial-assistance policies and how total bad-debt expense compares with charity care among West Virginia hospital systems.
- **Metrics:**
  - FAP-Eligible Bad Debt % of Charity = (Line 3 ÷ Line 7a) × 100.
  - Bad-Debt : Charity Ratio = (Line 2 ÷ Line 7a).
- **Approach:** Derived from Schedule H Part III (Lines 2–3) and Part I (Line 7a). Values averaged across 2019–2023 for each system. Missing ("Not Reported") FAP data left blank; Bad-Debt:Charity ratios computed for all available years.

Figure 9:

FAP-Eligible Bad Debt vs Bad-Debt-to-Charity Ratio

- **Data Source:** IRS Form 990 Schedule H (2019–2023).
- **Purpose:** Visualize the relationship between the percentage of bad debt deemed FAP-eligible and the overall bad-debt-to-charity ratio for each hospital system.
- **Metrics:**
  - FAP-Eligible Bad Debt % of Charity = (Line 3 ÷ Line 7a) × 100.
  - Bad-Debt : Charity Ratio = (Line 2 ÷ Line 7a).
- **Approach:** Averages for 2019–2023 calculated by system. Displayed as a grouped-column chart with two bars per system. Systems lacking FAP data (Davis Memorial and Mon Health) show only Bad-Debt : Charity values; no imputation performed.

Figure 10:

Medicaid Percent of Expenses by Health System

- **Data Source:** IRS Form 990 Schedule H (2018–2023).
- **Purpose:** Measure the proportion of total hospital-system expenses attributable to unreimbursed Medicaid costs over time.
- **Metric:** Medicaid Shortfall % of Expenses = (Line 7b column (e) ÷ Line 18) × 100.
- **Approach:** Extracted from Schedule H Part I Line 7b for each tax year and divided by total expenses (Line 18). Five-year averages (2018–2023) computed for each system; blank years excluded from means.

Figure 11:

FAP-Eligible Bad Debt vs. Charity Care

- **Data Source:** IRS Schedule H, Part I, Line 7a, Part I, Line 18, and Part III Lines 2–3.
- **Purpose:** Quantify unrecovered charity care obligations due to failure to screen or enroll eligible patients.
- **Calculated Ratios:**
  - Bad Debt ÷ Charity Care = (Bad Debt Expense ÷ Charity Care at Cost)
  - Charity Care % of Expenses = (Charity Care at Cost ÷ Total Expenses)
  - % of Bad Debt FAP-Eligible = (Estimated FAP-Eligible Bad Debt ÷ Bad Debt Expense)

Figures 12-14 reflect the same as 11, broken out by year of filing.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