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Big Apple Hospital CEOs are Cooking the Not-for-Profit Hospital Books

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There is something almost too neat—too polished—about the way not-for-profit hospitals tell their financial story. It is a narrative carefully plated for public consumption: billions in "community benefits," selfless care for the underserved, and a moral justification for billions more in tax exemptions. On paper, it looks like altruism at scale. In practice, it often looks like creative accounting.

The latest analysis of New York City's not-for-profit hospitals provides a perfect case study. According to the report, these institutions delivered $9.5 billion in "community benefits" in 2023, rising to $11.3 billion when additional categories are included. Against roughly $2.2 billion in tax exemptions, the conclusion seems obvious: hospitals give far more than they receive.

Case closed—right? Not quite.

Because what counts as a "community benefit" is less a measure of generosity than a masterclass in definitional elasticity. And when you pair that elasticity with how these same institutions compensate their leadership, the question becomes harder to ignore: are we measuring charity—or just cooking the books?

The Art of Redefinition

At the heart of the issue is IRS Form 990 Schedule H—the framework through which hospitals report community benefits. It sounds straightforward: tally up the good works and compare them to tax advantages. But the categories themselves blur the line between charity and cost recovery.

Consider Medicaid. In New York City, Medicaid shortfalls alone account for $3.8 billion of reported community benefit—fully 7% of total hospital expenses. Add other means-tested programs, and the total rises to $4.3 billion.

But Medicaid shortfalls are not charity. They are the predictable result of government reimbursement rates that fall below cost. Hospitals don't choose these losses out of generosity; they absorb them because the system requires it. Yet by reclassifying underpayment as "community benefit," the accounting transforms obligation into altruism. That's not fraud. It's something more refined—and far more effective.

When Losses Become Virtue

The same sleight of hand appears elsewhere. Medicare shortfalls—another $1.8 billion—are frequently folded into broader narratives of community contribution. Bad debt tied to patients eligible for financial assistance is similarly recast as charitable activity.
Again, these are real financial burdens. But they are not discretionary acts of generosity. They are the byproducts of a complex payer mix and pricing structure. When aggregated, they produce a powerful illusion: that hospitals are giving far more away than they are receiving.

Meanwhile, in the C-Suite

If not-for-profit hospitals were truly operating like charities, you might expect their internal economics to reflect that mission. The Lown Institute's research suggests otherwise. Across the country, nonprofit hospital CEOs earn, on average, eight times what lower-wage hospital workers make—and in some cases as much as 60 times more. In New York and neighboring states, the ratios are among the highest in the country, with CEOs earning roughly 10–12 times the wages of typical workers.

And those averages obscure even more dramatic extremes. Some nonprofit hospital executives pull in multi-million-dollar compensation packages, rivaling those of for-profit corporations. The top 10 nonprofit hospital CEOs have earned $7 million or more annually, with some outliers approaching $18 million.

This isn't just a matter of optics—it's a matter of incentives. Lown researchers have found that CEO pay is largely tied to financial performance metrics, particularly revenue and

patient volume. In other words, the system rewards “heads in beds,” not necessarily healthier communities.

Even more troubling: there is little evidence that higher CEO compensation is associated with better patient outcomes, higher-quality care, or greater community benefit spending.

So, while hospitals report billions in “community benefit,” their leadership compensation is driven by metrics that often have little to do with community health.
That’s not a contradiction. It’s the system working exactly as designed.

The Incentive Problem

Put these two realities together—elastic definitions of community benefit and executive compensation tied to revenue—and a pattern emerges.
Hospitals are incentivized to:

- Maximize reported community benefits (by broadening definitions)
- Maximize revenue (to justify executive compensation)
- Maintain tax-exempt status (by ensuring the first number always exceeds the second)

It is a perfectly balanced equation—at least on paper. But it also creates perverse incentives.

As Lown Institute researchers have noted, the current model can encourage hospitals to prioritize profitable services and privately insured patients over less lucrative community needs. And it fosters what they describe as an “ever-spiraling upward cycle” of executive pay, driven by benchmarking against increasingly corporate peers.

In other words, nonprofit hospitals may be nonprofit in tax status—but they are increasingly corporate in behavior.

The Numbers That Matter -- And Those That Don’t

Strip away the accounting layers, and the picture looks different.
Direct financial assistance—what most people think of as charity care—amounts to about $560 million, or just over 1% of total hospital expenses.

One percent.

Everything else—Medicaid gaps, research, training programs, subsidized services—is bundled into a much larger number that serves as the justification for tax exemption.

These activities are valuable. But they are also core components of hospital operations—activities that enhance institutional capacity, prestige, and long-term revenue.
Calling them “community benefit” isn’t wrong.
But it isn’t the whole truth either.

Nonprofit in Name Only

The deeper question is not whether hospitals provide value—they clearly do. It’s whether the current framework accurately reflects that value. When:

- Losses are labeled as charity
- Core operations are labeled as community benefit
- Executives’ pay rivals Wall Street while frontline workers struggle

… the nonprofit label begins to look less like a mission and more like a tax classification. The Lown Institute has gone so far as to highlight cases where hospitals pay executives millions while simultaneously cutting staff or reducing community investment—hardly the behavior one associates with charitable institutions.

What Gets Lost

The real casualty here is clarity. Patients, policymakers, and taxpayers deserve to know:

- How much true charity care is being delivered
- How hospital resources are distributed internally
- What taxpayers are actually getting in return for billions in forgone revenue

Instead, they get a single, polished number—$9.5 billion—that blends fundamentally different activities into a single narrative.
It’s not transparency. It’s storytelling.

The Bottom Line

New York City’s not-for-profit hospitals do enormous good. They save lives, train professionals, and anchor communities. But they also operate within a system that rewards financial engineering as much as social mission.

When accounting definitions stretch, when executive pay soars, and when institutional incentives drift away from community health, the line between nonprofit and corporate begins to blur.

That’s where “cooking the books” becomes less an accusation and more an observation. The ingredients are real. The math adds up. But the final dish—carefully assembled, strategically seasoned, and served with a side of moral justification—tells a story that is

richer than reality. Not only are not-for-profit hospital CEOs cooking the books – there are too many cooks in the kitchen.

And in healthcare, that's not just a problem of accounting. It's a problem of trust.

For more information on issues concerning not-for-profit hospitals in the United States, please visit our website, www.cmpi.org.