

Bond Case Briefs

Municipal Finance Law Since 1971

House Committee Advances New Reporting Requirements for Tax-Exempt Hospitals: Davis Wright Tremaine

H.R. 9504 would require tax-exempt hospitals to report more detailed community benefit, financial, operational, and 340B information

On July 1, 2026, the U.S. House of Representatives Ways and Means Committee approved H.R. 9504, the [Tax-Exempt Hospital Transparency Act](#), which would expand reporting obligations for tax-exempt hospitals. The measure passed the committee by a 25-15 partisan vote. Opponents argue that the bill will create an administrative burden on hospitals without any clear benefit.

While the bill still faces substantial legislative hurdles before becoming law, if enacted, it would significantly expand operational, financial, and community benefit reporting obligations for tax-exempt hospitals reported on Schedule H of the IRS Form 990.

Below are some of the key proposed changes and their implications:

New Reporting Requirements for All Tax-Exempt Hospitals

All tax-exempt hospitals must disclose:

- How they are addressing needs identified in their most recent Community Health Needs Assessment (CHNA), including any identified needs they are not addressing and the reasons why;
- Audited financial statements;
- Centers for Medicare & Medicaid Services (CMS) certification numbers;
- The value of financial assistance provided for charity care; and
- Number of financial assistance applications received, granted, and denied.

New Reporting Requirements for Large Tax-Exempt Hospital Organizations

Hospitals with more than 100 staffed inpatient beds and that are not critical access or rural emergency hospitals have additional requirements, including disclosing:

- The three highest-priority health needs identified in the most recent CHNA, including related spending, actions taken, and resulting community impacts;
- Spending on quality improvement, including activities related to Medicare quality improvement programs; and
- Spending on nonclinical programming, including medical billing and coding, regulatory compliance, discharge planning, appointment scheduling, financial counseling, IT, administration, and related support functions.

Large hospitals (with greater than 100 inpatient beds, excluding critical access and rural hospitals)

and high-revenue (defined below) hospitals must report required information both for the organization as a whole and separately for each hospital facility. Facility-level reporting may require hospitals to revisit internal allocation methodologies and confirm that they can support reported figures at the individual facility level.

New Reporting Requirements for High-Revenue Tax-Exempt Hospital Organizations

Finally, hospitals that generate more than \$100 million annually in net patient revenue and that are not critical access or rural emergency hospitals must report:

- Allowable and unallowable advertising costs;
- Descriptions of each health service line, defined as discrete clinical programs, departments, or care categories, and reported using a standardized service-line taxonomy that the secretary of health and human services must publish and maintain within two years of the bill's enactment.
- Amounts of gross receipts and costs for each health service line;
- Number of individuals receiving drugs purchased under the federal 340B Drug Pricing Program (42 U.S.C. § 256b), categorized by insurance type; and
- Aggregate net 340B payment amount and aggregate costs of participating in and complying with the 340B program.

These 340B disclosures could be among the bill's most burdensome and controversial requirements. By requiring public reporting on 340B utilization, payer mix, payment amounts, program costs, and compliance infrastructure, the bill could make public information that hospitals may view as commercially and politically sensitive, particularly given current scrutiny of, and litigation regarding, the 340B program.

Additional Medicare and Operational Considerations

The bill would create new public reporting implications for information that hospitals already maintain or report in Medicare-related contexts. For example, H.R. 9504: (1) appears to rely on Medicare cost reporting concepts to determine staffed inpatient beds, (2) would require certain advertising costs to be reported by reference to costs reported to CMS for cost-reimbursement purposes, and (3) requires certain high-revenue tax-exempt hospitals to report revenue and cost by service line, creating a new reporting framework that is informed by, but not identical to, existing Medicare cost reporting requirements. As a result, hospitals may need to reconcile IRS Form 990 reporting with Medicare cost reports, audited financial statements, internal cost-accounting systems, service line reporting, and provider-enrollment records.

In addition, the bill would not amend Medicare provider-based rules or directly change when a hospital department may bill as a provider-based department of the hospital. However, expanded service line and cost-center reporting could make provider-based structures more visible and may increase scrutiny of how hospitals organize, report, and support outpatient department revenue and related cost allocations.

Timing and Next Steps

Although the bill has advanced out of committee, stakeholders will likely continue advocating for changes as the legislation moves through Congress. If enacted, key provisions of the bill would generally not take effect for two to three years. However, tax-exempt hospitals may wish to begin evaluating whether their existing data collection and reporting systems can support the bill's

proposed disclosures and any related facility-level allocation requirements. As part of that review, hospitals may wish to identify gaps across tax, finance, compliance, reimbursement, 340B, and operational data systems, including whether Medicare-related reporting inputs can be coordinated with IRS Form 990 disclosures in a consistent and supportable way. Hospitals may also wish to confirm who holds the relevant data internally and whether current processes allow that information to be gathered, reconciled, and supported across facilities.

+++

By Adam R. Romney, Thomas C. Schroeder, and Sarah Kwon*

07.13.26

Davis Wright Tremaine LLP

+++

Adam Romney is a partner and head of DWT's Healthcare industry group. Thomas Schroeder is a partner in the firm's Foundations and Nonprofits practice group and serves as head of the Education industry group. Our Healthcare and Foundations and Nonprofits groups will continue to monitor the proposed legislation and can help tax-exempt hospitals assess and navigate any new requirements that may result. For any questions, please reach out to Adam, Tom, or another member of our Healthcare and Foundations and Nonprofits teams. To stay informed, sign up for our alerts.

*Sarah Kwon is a 2026 summer associate at DWT.