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Tax Incentive Evaluation: Rural Hospital Tax Credit

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Executive Summary

The Rural Hospital Tax Credit took effect in tax year 2017 to provide financial support to rural hospitals in Georgia, enabling taxpayers to contribute to eligible hospitals and receive a 100-percent state income tax credit. The purpose of this report is to evaluate this tax credit in accordance with the provisions of O.C.G.A. § 28-5-41.1, in terms of its fiscal and economic impacts as well as its public benefits.

This report was prepared under a contract with the Georgia Department of Audits and Accounts (DOAA). The report begins with background on the Rural Hospital Tax Credit (RHTC) tax credit followed by a discussion of similar policies in other states. Subsequent sections present tax credit utilization, a review of related literature, and IMPLAN analysis of economic and fiscal impacts of the tax credit. Information used in this report was obtained from the Georgia Department of Revenue and IRS Form 990.

Using this information above, we estimate the share of donations received since the credit was enacted that can be attributed to the credit's existence. We estimate a 'but-for' percentage of 28 percent, meaning that 28 percent of all donations would not have occurred if the credit did not exist. We also calculate the economic activity associated with alternative use of the tax expenditure by the State of Georgia. Net economic activity is the remaining activity after accounting for the but-for percentage and the impact of the alternative use. Tables ES1 and ES2 below summarize the state and local fiscal effects of the FTC, adjusted by the 28 percent but-for activity share.

The annual cost to the state for this tax credit is estimated at \$79.5 million in fiscal year (FY) 2025. We use the IMPLAN input-output model to estimate the economic activity associated with the value of the credit in Georgia, as shown in the first row of Tables ES1 and ES2.

As a result of providing the RHTC, the state's general fund expenditures are implicitly reduced by the amount of the tax expenditure. In the absence of this credit, an alternative use of the funds is modeled assuming an increase in state spending by that amount, allocated across various spending categories based on recent state budgets.

Tables ES1 and ES2 show the estimated amount of state and local revenue, respectively, from this alternative use of funds, which are the opportunity costs of the RHTC tax credit. The net fiscal cost to the state, accounting for the tax expenditure and opportunity costs, is estimated at \$98.6 million for FY 2026. Table ES2 shows the net local revenue effects on the same basis.

Table ES1. State Fiscal Effects: RHTC Tax Credit, FY 2026–30

<i>(\$ millions)</i>	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030
Revenue gains from economic impact	\$1.7	\$1.7	\$1.7	\$1.7	\$0.8
Less:					
Tax expenditure cost	-\$92.6	-\$93.6	-\$93.6	-\$93.6	-\$47.0
Alternative use revenue gains	-\$7.6	-\$7.7	-\$7.7	-\$7.7	-\$3.9
Net Fiscal Effects	-\$98.6	-\$99.7	-\$99.7	-\$99.7	-\$50.0

Table ES2. Local Fiscal Effects: RHTC Tax Credit, FY 2026–30

<i>(\$ millions)</i>	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030
Revenue gains from economic impact	\$0.5	\$0.5	\$0.5	\$0.5	\$0.3
Less:					
Alternative use revenue gains	-\$1.9	-\$1.9	-\$1.9	-\$1.9	-\$1.0
Net Fiscal Effects	-\$1.4	-\$1.4	-\$1.4	-\$1.4	-\$0.7

The RHTC tax credit provides several public benefits to state residents. The credit allows taxpayers to redirect a portion of their state income tax liability to local hospital foundations, giving them a sense of control over their tax dollars and often reflecting a belief that hospital foundations can deploy resources more effectively and responsively. RHTC-supported donations also strengthen local hospital capacity and improve public safety. Program rules require that funds are used for qualified expenditures—including equipment, technology, training, and teacher wellness programs. For example, foundations report that RHTC-related donations have financed coding workshops, teacher recruitment efforts as well as literacy projects.

Beyond material improvements, the program has strengthened ties between schools and their communities. Hospital foundations report that RHTC donations have raised awareness of hospital needs, built goodwill, and increased civic engagement by giving residents a direct stake in public safety outcomes. These contributions may also prevent longer-term social costs by improving recruitment, reducing teacher burnout, and ensuring hospital agencies are well-equipped to respond to crime and emergencies.

The policy has been successful in achieving its goals of providing additional support to rural hospitals. As with similar credits, there has been a ramp-up period of several years, but donations now consistently hit the credit cap. Initial evidence suggests that the credit’s success has been a mix of new donations to rural hospitals and some substitution from urban hospitals to rural hospitals. Although available data do not allow us to directly measure the effect on donations to other Georgia hospitals, the substitution mechanism indicates that some non-qualified hospitals likely received a lower amount of donations than they would have in the absence of the credit. While this reallocation can affect local economies, the overall statewide economic impact remains limited to the estimated but-for percentage. As it matures, the policy may induce still greater new giving, as intended, but additional data is needed to evaluate its full impact. Terminating the RHTC program could reduce private support for hospital foundations, particularly outside of metro Atlanta where fundraising capacity is more limited.

Table of Contents

Introduction.....	1
History and Overview of the Tax Credits for Rural Hospitals	1
Purpose.....	2
How the Credit Works	2
Tax Provision-related Activity Data	3
Spatial Distribution of Qualified Rural Hospitals.....	4
Credit Generation.....	4
Credit Utilization	5
Tax Expenditures	6
Tax Credit Claims by Individuals and Pass-through Entities	7
Audit of the Rural Hospital Tax Credit	9
Rural Hospital Donation Tax Credits in Neighboring States	9
Literature Review on Charitable Giving and Qualified Donation Tax Credits	10
Rationale for Tax Preferences in Charitable Giving.....	10
But-for Analysis.....	14
IRS Nonprofit Data.....	14
Characteristics of Top Recipient Hospitals	19
Economic Activity	20
Overview of How Economic Activity Is Measured.....	20
IMPLAN Model.....	20
Alternate Use of Forgone Revenue/Tax Expenditure	22
Fiscal Impact.....	22
Revenue Impacts.....	23
Additional Tax Revenue	23
State and Local Taxes Generated from Alternative Use of Funds.....	25
Administrative Costs.....	25
Methods to Optimize Tax Credit Performance.....	25
Public and Ancillary Benefits	26
References	28
Appendix A: On Federal Deduction	30
Appendix B: Distribution of the Donors and Donations by Income Quintiles.....	31
Distribution of Donors' Adjusted Gross Income	33
Appendix C: Balanced Panel of Hospitals in the 990 Data	36
Appendix D: Characteristics of Ever-Qualified Hospitals.....	37
Appendix E: Value of Alternative Use	39

Introduction

The Rural Hospital Tax Credit (RHTC) was established in 2017 to provide financial support to rural hospitals in Georgia, enabling taxpayers to contribute to eligible hospitals and receive a 100-percent state income tax credit. The purpose of this report is to evaluate this tax credit in accordance with the provisions of O.C.G.A. § 28-5-41.1, in terms of its fiscal and economic impacts as well as its public benefits.

This evaluation was prepared under a contract with the Georgia Department of Audits and Accounts (DOAA). The report begins with background on the tax credit, followed by a discussion of similar policies in other states, and a review of academic literature on charitable giving. Subsequent sections present an IMPLAN analysis of the economic and fiscal impacts of the credit, estimates of the tax expenditure and administrative costs, and an analysis of the public benefits of the program in terms of its presumed goal of increasing total charitable giving to rural hospital systems.

History and Overview of the Tax Credits for Rural Hospitals

Since 2017, Georgia's RHTC (codified at O.C.G.A. § 48-7-29.20) has aimed to address the growing financial distress and closure risk facing rural hospitals across the state. The program was designed to leverage private donations to strengthen rural healthcare infrastructure by offering state income tax credits to individuals and corporations contributing directly to qualified rural hospital organizations—facilities approved and ranked by the Department of Community Health (DCH).

Rural hospital closures result from a variety of factors, including depopulation, a high percentage of Medicaid patients, and lower reimbursement rates. The COVID-19 pandemic and ongoing staffing shortages have exacerbated these financial challenges. As of 2025 130 hospitals in Georgia provide acute, short-term care, including 49 RHTC-eligible hospitals. Hospital closures in certain regions, such as the Southwest, Southeast, and Middle Georgia, can significantly increase the distance some residents must travel for medical care. For example, Southwest Georgia Regional Medical Center in Randolph County closed in October 2020, leaving the surrounding counties without hospital care.

Initially capped at \$50 million statewide, the program's annual ceiling was increased to \$60 million (2018), \$75 million (2019), and \$100 million under the 2022 and 2024 amendments, reflecting bipartisan support for its fiscal role in sustaining access to medical care in rural Georgia. The statute has been amended multiple times (in 2017, 2018, 2019, 2022, and 2024) to refine contribution limits, extend the program's duration, and strengthen reporting, audit, and transparency requirements. The credit is currently authorized through December 31, 2029, when it is scheduled for automatic repeal and reservation.

Purpose

The purpose of the RHTC is to strengthen the financial stability and service capacity of Georgia's rural hospitals by fostering private-sector participation in healthcare funding. The General Assembly established the credit as a targeted fiscal mechanism to offset the disproportionate financial pressures faced by small, rural healthcare facilities—many of which serve low-income or medically underserved populations but operate with limited economies of scale and high uncompensated care costs.

By offering state income tax credits for donations to approved rural hospital organizations, the program seeks to preserve access to essential health services, reduce hospital closures, and stimulate local economic resilience in communities where hospitals often function as anchor institutions and major employers. The law's design—linking preapproved contributions to a DCH ranking of hospitals by financial need—reflects an effort to direct resources strategically, ensuring that the greatest support reaches the facilities at highest risk of financial distress. In this way, the RHTC operates as both a community investment tool and a fiscal relief measure, aligning taxpayer incentives with the state's broader public health and regional development objectives. As we show throughout the report the credit as has been successful in achieving its stated purpose.

How the Credit Works

To qualify, hospitals must:

- Be located in a county with fewer than 50,000 residents or be designated as a Critical Access Hospital.
- Be an acute care licensed hospital that provides inpatient services and participates in Medicare and Medicaid.
- Provide services to indigent patients, with at least 10 percent of annual net revenue coming from indigent care, charity care, or bad debt.
- Be operated by a county/municipal authority or a tax-exempt 501(c)(3) organization.
- Maintain compliance with audits and reports.
- Have a three-year average patient revenue margin, as a percentage of expenses, below one standard deviation above the statewide average for other rural hospitals.

The eligibility criteria have remained relatively stable since the program's inception, although changes in hospital operations, such as conversions from nonprofit to for-profit, have led to some hospitals losing eligibility.¹ Notably, the Rural Emergency Hospital (REH) designation, introduced in 2023, excludes REHs from receiving RHTC contributions for tax year (TY) 2024.

¹According to the DOAA, 60 hospitals have received contributions since the inception of the RHTC, but only 42 have been eligible for the entire duration of the program.

This shift, designed to enhance financial viability by removing inpatient services from some rural hospitals, further restricts the pool of eligible hospitals.

Tax Credit Limits: The annual aggregate RHTC contribution limit was increased from \$60 million to \$75 million in 2023, with a planned increase to \$100 million starting in 2025. However, the individual hospital contribution cap remains at \$4 million annually. Taxpayers may contribute up to \$5,000 (individuals) or \$10,000 (married couples or pass-through entities) before July 1 of each year, with unlimited contributions allowed after that if the aggregate limit has not been met. Contributions to C-corporations are similarly capped at 75 percent of the corporation's tax liability or the actual contribution amount, whichever is less. Unused credits may be carried forward for five years.

Program Changes and Administrative Updates: In recent years, RHTC has undergone several legislative changes, such as expanding eligibility to owners of pass-through entities (PTEs) and implementing a system for undesignated contributions, which are directed to the most financially distressed hospitals based on DCH rankings. An annual audit by DOAA was also mandated to ensure transparency in the distribution of contributions.

Additionally, the third-party administrator, Georgia HEART (Helping Enhance Access to Rural Treatment), plays a critical role in managing contributions. Georgia HEART works with hospitals to facilitate donations, charges a 3-percent administrative fee, and provides an online dashboard for real-time contributions. They also assist with marketing the program to potential contributors, managing pre-approval requests, and providing customer service related to the program.

Contribution Process: Taxpayers can contribute either directly through DOR or via Georgia HEART. Contributions may be designated to a specific hospital or left undesignated, in which case Georgia HEART directs the funds to the highest-ranked hospital on the DCH's financial need list. Once a contribution is submitted, the hospital confirms receipt, and the taxpayer is eligible to claim the tax credit.

Tax Provision-related Activity Data²

To evaluate the extent to which the RHTC has stimulated new economic activity, this report draws on multiple data sources. These include Department of Revenue (DOR) data on tax credit generation (approved amounts) and utilization (amounts claimed), anonymized DOR data on individual and PTE claims, and nonprofit disclosures from IRS Form 990 filings, which provide additional insight into the flow of donations.

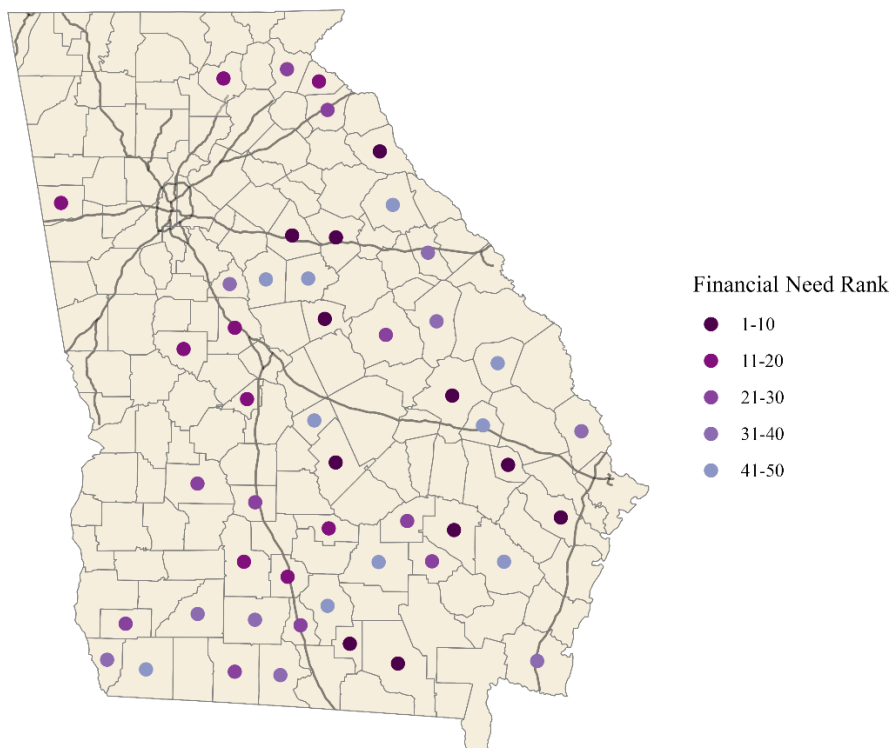
² A federal income tax deduction is available for gifts to qualifying charitable and nonprofit organizations. Under IRS regulations, if a taxpayer receives a state or local tax credit for a charitable contribution, their federal deduction must be reduced by the credit amount. This interaction between the Rural Hospital Tax credit and federal tax policy only affects taxpayers who itemize deductions. In TY 2022, 91 percent of individual taxpayers claimed the standard deduction, so the interaction is largely limited to corporate taxpayers and the small share of individuals who itemize. For a more comprehensive discussion on federal interaction, see the attached appendix (Appendix A).

Spatial Distribution of Qualified Rural Hospitals

To frame the analysis, we present a map of the 49 hospitals eligible for the RHTC in FY 2025 (See Figure 1), ranked by their relative financial need, according to DCH.³ The color gradient highlights the distribution of hospitals from the most financially distressed (dark blue, ranks 1–10) to those with relatively lower—but still significant—need (light blue, ranks 41–50). The map illustrates that financial vulnerability among rural hospitals is not confined to a single part of Georgia but is dispersed across the state, with high-need facilities appearing in nearly every region.

Presenting this landscape at the outset provides essential context: the RHTC was designed to address precisely this broad and uneven pattern of hospital distress. The following analysis evaluates the extent to which tax credit activity has aligned with these needs.

Figure 1. Distribution of RHTC-qualified Hospitals based on Need, FY 2025



Source: Authors' calculations based on DCH reports

Credit Generation

As shown in Table 1, the RHTC has become a significant funding stream for Georgia's rural hospitals, with contributions rising steadily since its launch in 2017.

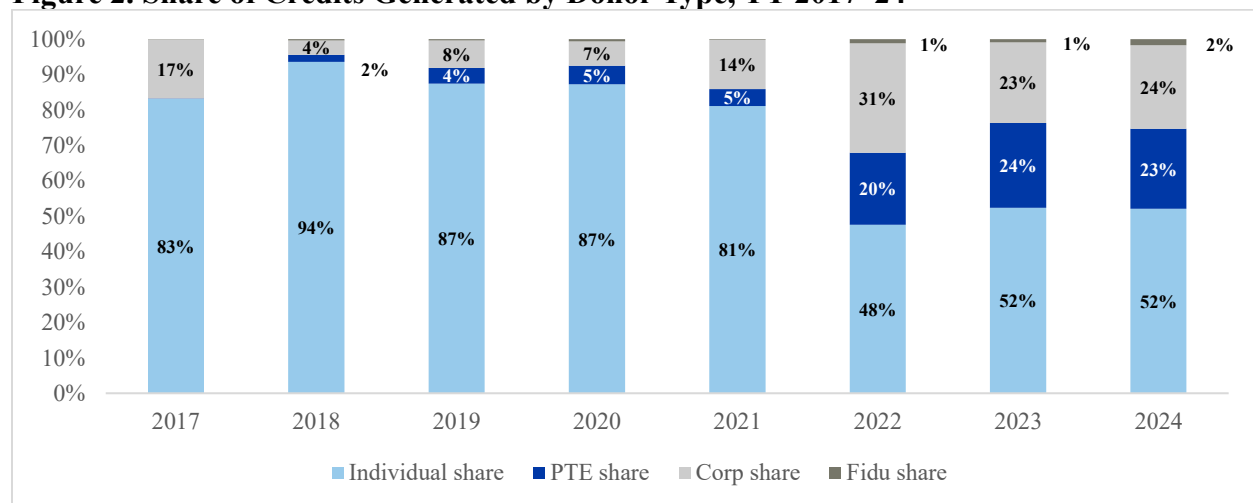
³ The financial-need ranking ranges from 1 to 50 for labeling consistency, even though 49 hospitals were officially reported as qualified in 2025.

Table 1. Credits Generated by Donor Type, TY 2017–24

(\$ millions)	TY 2017	TY 2018	TY 2019	TY 2020	TY 2021	TY 2022	TY 2023	TY 2024
Individual	\$6.85	\$55.31	\$40.61	\$47.39	\$48.27	\$27.94	\$37.96	\$38.68
PTEs	\$0.01	\$1.18	\$2.02	\$2.83	\$2.82	\$11.96	\$17.37	\$16.75
Corporate	\$1.37	\$2.44	\$3.62	\$3.75	\$8.31	\$18.13	\$16.52	\$17.57
Fiduciary	\$0.01	\$0.21	\$0.19	\$0.35	\$0.12	\$0.70	\$0.69	\$1.27
Total	\$8.24	\$59.14	\$46.44	\$54.33	\$59.52	\$58.73	\$72.53	\$74.27

Source: Authors' calculations based on data from GDAC

Initially, individual taxpayers dominated credit generation, accounting for more than 80 percent of contributions between 2017 and 2021 and surpassing \$55 million in 2018 alone. Over time, however, the composition of donors shifted. PTEs (such as partnerships, S-corps, and LLCs) began to play a larger role, while corporate contributions also grew substantially. By 2022, PTEs represented about one-fifth of all contributions and corporations roughly one-quarter, marking a change in the program's donor base. Fiduciary contributions remained negligible throughout.⁴ By 2024, total contributions had nearly reached the statutory cap of \$75 million, reflecting both the program's maturation and the growing importance of business entities in leveraging the credit.

Figure 2. Share of Credits Generated by Donor Type, TY 2017–24

Source: Authors' calculations based on data from GDAC

Credit Utilization

Patterns of credit utilization closely mirror changes in credit generation, while also highlighting differences in the timing of when donors apply contributions against their tax liabilities. From 2017–21, individual taxpayers dominated utilization, accounting for more than 80 percent of all

⁴ Fiduciary donors are estates, trusts, or other taxable entities acting in a fiduciary capacity, as defined in O.C.G.A. § 48-1-2(9).

applied credits (as shown in Figure 3). Beginning in 2021, however, corporate and PTE utilization expanded significantly. Corporations, in particular, showed a sharp increase in 2021 before stabilizing, while PTEs gradually became a meaningful share of utilization by 2023–24. Fiduciary participation remained negligible throughout.

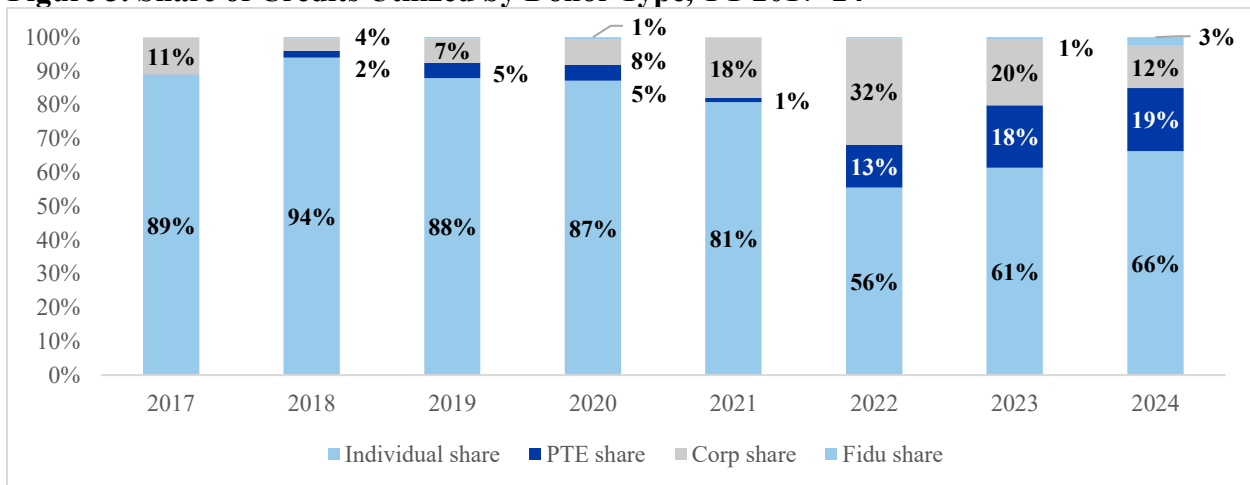
Table 2. Credits Utilized by Donor Type, TY 2017–23⁵

	TY 2017	TY 2018	TY 2019	TY 2020	TY 2021	TY 2022	TY 2023
Individual	\$6.6	\$53.9	\$39.2	\$46.2	\$46.2	\$29.6	\$32.3
PTEs	\$0.0	\$1.2	\$2.0	\$2.5	\$0.7	\$6.7	\$9.7
Corporate	\$0.8	\$2.1	\$3.2	\$4.0	\$10.2	\$16.8	\$10.3
Fiduciary	\$0.0	\$0.2	\$0.1	\$0.3	\$0.1	\$0.2	\$0.3
Total	\$7.4	\$57.3	\$44.6	\$53.1	\$57.3	\$53.4	\$52.6

Source: Authors' calculations based on data from GDAC

Overall, while individuals remain the largest group of utilizers, their dominance has diminished as organizational donors have assumed a growing role, reflecting the gradual diversification of participants in the RHTC program.

Figure 3. Share of Credits Utilized by Donor Type, TY 2017–24



Source: Authors' calculations based on data from GDAC

Tax Expenditures

Table 3 summarizes the tax expenditure created by the credit. According to the upcoming FY 2027 Georgia Tax Expenditure Report, state tax expenditures for the RHTC are projected at \$79 million in FY 2025, \$93 million in FY 2026, and \$94 million in FY 2027. Within these totals, individual income tax expenditures are expected to account for roughly three-quarters of the cost,

⁵ Georgia Data Analytics Center (GDAC) data for recent years are typically incomplete due to carryforwards and the timing of tax filings. For this reason, the Fiscal Research Center does not rely on GDAC data from TY 2024 when calculating or forecasting tax expenditures. Consequently, the credit utilization reported by GDAC for 2024 does not match the tax expenditure estimates shown in Table 3.

while corporate income tax expenditures represent the remaining quarter. Note the credit sunsets at the end of TY 2029, so the estimates for FY 2030 include the carry forwards from the previous years.

Table 3. Tax Expenditure Cost Estimates, FY 2025–30

(\$ millions)	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030
State Tax Expenditure	\$79	\$93	\$94	\$94	\$94	\$47
Individuals	\$59	\$69	\$70	\$70	\$70	\$35
Corporations	\$20	\$24	\$24	\$24	\$24	\$12

Source: Fiscal Research Center

Tax Credit Claims by Individuals and Pass-through Entities

In the program data, ‘individuals’ are taxpayers who contribute in their own name, while pass-through entities (PTEs) are business structures such as partnerships, S corporations, or LLCs, in which income and tax obligations ‘pass through’ to the individual owners. Importantly, these categories are not mutually exclusive: the same donor may appear as an “Individual” in one year and through a PTE in another, depending on how they choose to claim the credit. Thus, what might look like two distinct donor groups is better understood as two alternative channels for giving.

The next set of graphs show how these channels evolved over time.⁶ In 2017, nearly all contributions came directly from individuals. Starting in 2019, however, there was a marked shift: many donors began using PTEs as their preferred vehicle for making contributions. This change reflects how taxpayers adapted their participation in the program, with PTEs offering a more favorable way to claim the credit. Overall donation levels remained relatively stable through 2021 before falling in 2022, but the composition of contributions shifted significantly toward PTEs during this period.⁷

Number of Donors, Total Donations, and Average Donations

Figure 4 shows that donor participation peaked in 2018 with more than 4,000 contributors, almost all filing as individuals.⁸ Beginning in 2019, however, the composition shifted: while the

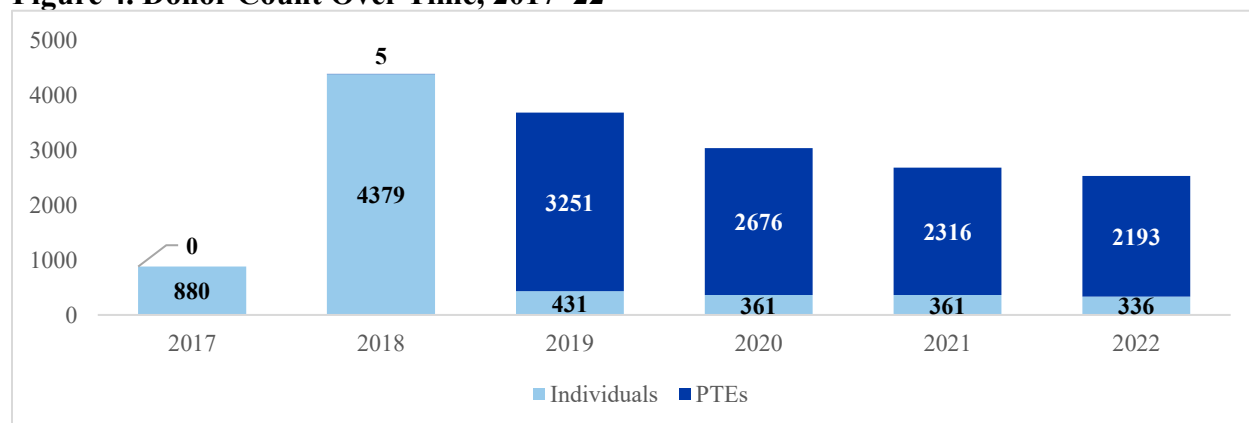
⁶ Individuals reporting donations to the Rural Hospital Tax Credit (RHTC) first appear in the Georgia Department of Revenue administrative data in 2017, the inaugural year of the program.

⁷ The marked appears to have shifted from individual to PTE donations between 2018 and 2019 likely reflecting a combination of binding contribution caps and evolving tax-planning behavior. Georgia’s HEART program limits individual donations to \$5,000 (\$10,000 for joint filers or PTE) before July 1 of each year, while allowing unlimited contributions afterward if statewide caps are not met. Following the 2017 TCJA and the introduction of Georgia’s PTE tax election, some donors may have found it more advantageous to channel contributions through their business entities, though we cannot rule out other administrative or informational factors.

⁸ The discrepancy in donor composition between Figure 2 and Figure 5 likely reflects internal aggregation or classification differences in how data from Georgia DOR were processed and reported. While both figures ultimately rely on DOR data, the Georgia Data Analytics Center (GDAC) aggregates information using slightly different definitions and reporting conventions than those applied in our microdata analysis. As a result, the distribution of donor types differs somewhat across figures, even though the underlying totals are consistent once data preparation differences are considered.

overall number of donors fell to around 2,500 by 2022, a growing share of contributions were routed through PTEs. This pattern indicates that many of the same taxpayers who initially donated directly later switched to the PTE channel.

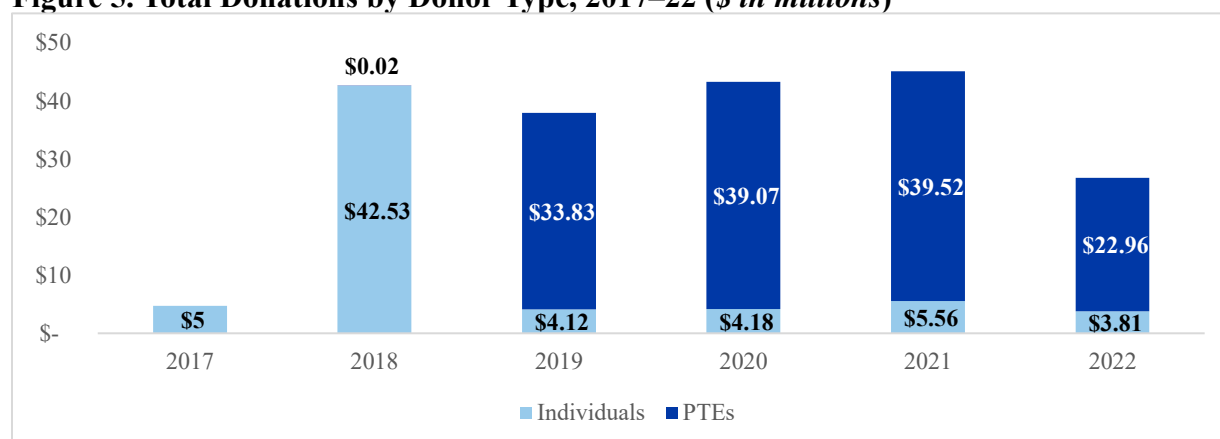
Figure 4. Donor Count Over Time, 2017–22



Source: Authors’ calculations based on anonymized individual files data from the Department of Revenue (DOR).

Total donations confirm this compositional shift (Figure 5).⁹ Aggregate contributions rose between 2017 and 2018, stabilized at roughly \$40–45 million between 2019 and 2021, and then declined to around \$27 million in 2022. While the overall volume of giving remained relatively steady for several years, the share routed through PTEs increased substantially after 2019, reflecting donors’ strategic adaptation to the program’s design.

Figure 5. Total Donations by Donor Type, 2017–22 (\$ in millions)



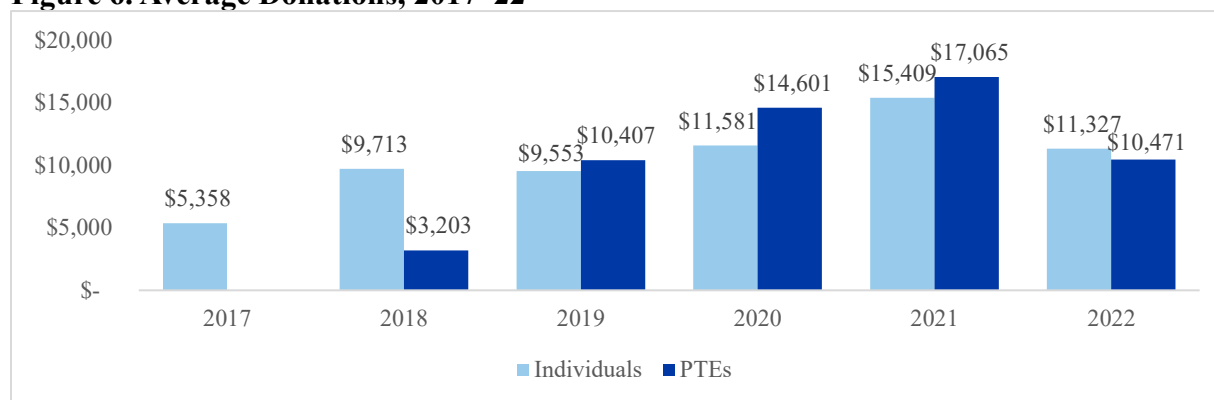
Source: Authors’ calculations based on anonymized individual file data from DOR

In the program’s first two years, individuals made larger contributions on average, reflecting the absence of incentives to use PTEs in 2017 and their relatively small role in 2018. Beginning in

⁹ The slight discrepancy between Figure 5 and Table 1 (credits generated) comes from the difference in the pre-approvals vs. the credits claimed and reported by the individuals when filing their taxes. According to the official reports for which pre-approvals data is available, the amount for 2023 was \$72,533,489 and for 2024 was \$74,265,224, which coincide with the numbers in Table 1.

2019, however, PTEs quickly caught up and surpassed individuals in average donation size, as seen in Figure 6. From 2020 through 2021, PTE averages remained consistently higher, peaking at nearly \$17,000 in 2021 compared with roughly \$15,500 for individuals. In 2022, both groups saw declines in average donation size, but the gap between individuals and PTEs narrowed.¹⁰

Figure 6. Average Donations, 2017–22



Source: Authors' calculations based on anonymized individual file data from DOR

Audit of the Rural Hospital Tax Credit

The Georgia DOAA has performed yearly audits of the RHTC since the inception of the program to analyze all contributions received by rural hospital organizations, credits received by individual and corporate donors, and amounts received by third parties. In its most recent report (2025), DOAA finds that eligible rural hospitals in Georgia received a total of \$74.3 million in RHTC contributions in tax year 2024, with significant variation in the amounts received by individual hospitals. All contributions remained within statutory limits, and the rural hospitals that participated were generally in compliance with state law.

Of the RHTC funds collected since the inception of the program, \$70.5 million was spent by hospitals in 2023, while \$42.0 million from previous years remained unspent. Individual taxpayers claimed most of the tax credits, and undesignated donations were distributed to hospitals in accordance with state law. DOR and Georgia HEART have made strides to improve reporting for contributions that require amendments, though additional improvements in controls and formalization of reporting procedures are recommended. Additionally, DOR is encouraged to ensure that recently finalized controls related to corporate credit limits are implemented within the statute of limitations.

Rural Hospital Donation Tax Credits in Neighboring States

Among Georgia's neighboring states, only Alabama has adopted a nearly identical mechanism. In 2025, the state legislature created the Rural Hospital Investment Program, authorizing a 100-percent tax credit against multiple state taxes (including income, financial institution excise,

¹⁰ For a detailed analysis of the distribution of the donors and donations by income quintiles, see Appendix B.

insurance premium, and utility taxes) for donations to eligible rural hospitals. The program is currently authorized for TY 2026–28, with provisions for per-donor limits and statewide caps similar to those in Georgia.

Other neighboring states have not implemented a comparable donation credit. Florida lacks an income tax and thus does not provide a parallel credit, though it supports rural development through other targeted credits (e.g., Rural Job Tax Credit, Community Contribution Tax Credit). Tennessee supports rural hospitals through grants and transformation initiatives such as the Rural Hospital Transformation Act (2018), but no tax-credit mechanism for private donors exists. North Carolina provides rural hospital support through the Office of Rural Health and federal/state grants, but again no donation-linked tax credit. South Carolina has ongoing rural health funding debates, yet its Department of Revenue’s tax credit programs do not include a rural hospital donation option.

In summary, Georgia pioneered the model, and Alabama has now followed with a very close analog. The remaining neighboring states rely on direct appropriations, grants, or other forms of rural health support rather than donor-linked tax incentives.

Literature Review on Charitable Giving and Qualified Donation Tax Credits

Philanthropy can play an important role in supporting public goods and meeting social needs that governments or markets may undersupply. Many goods and services supported by philanthropy generate positive externalities, meaning their benefits spill over to society at large, rather than accruing only to the donor or recipient (Andrews, 1972).

Broadly, philanthropy distinguishes between pure altruism (where people contribute because they care about the total provision of the public good) and impure altruism or ‘warm glow’ giving (where donors also derive private satisfaction from the act of giving itself) (Andreoni, 1989, 1990). This distinction matters because warm glow implies that incentives like tax subsidies can stimulate giving, even if they do not change the total supply of the public good.

Rationale for Tax Preferences in Charitable Giving

Regarding the question of whether charitable contributions should be taxed, scholars offer three main rationales for tax preference:

Tax base rationale: From this perspective, charitable donations are not ordinary consumption but a voluntary surrender of income for the public good. Therefore, they should not be taxed (Reich, 2013).

Efficiency rationale: Charitable giving can help correct the under-provision of public goods—a classic market failure. Many goods and services supported by philanthropy, such as medical research, education, or environmental protection, generate positive externalities (Andrews, 1972). Tax preferences lower the effective cost of giving and incentivize individuals to increase contributions.

Pluralism rationale: From a political economy perspective, channeling resources through charitable organizations rather than through government bureaucracy allows people to express their preferences directly—'voting with their dollars' and supporting causes beyond the preferences of the median voter (Benshalom, 2008; Reich, 2013). In this sense, philanthropy supplements democracy by diversifying social provision and fostering pluralism.

At the same time, there are also concerns of regressivity, fiscal cost, and democratic imbalance, as high-income taxpayers both benefit disproportionately from deductions and exert more influence over resource allocation (OECD, 2020). Table 3 summarizes the main arguments for and against tax preferences.

Table 3. Arguments For and Against Domestic Philanthropy

Arguments For	Arguments Against
<i>Promotion of Social Welfare and Public Goods:</i> Tax incentives help address market failures related to under-provision of public goods and positive externalities, encouraging societal benefits.	<i>Cost to Government Revenue:</i> Tax concessions reduce public revenues, potentially leading to higher taxes elsewhere or cuts in public services, raising concerns about fiscal sustainability,
<i>Promotes Democratic Values:</i> Encourages the development of civil society, decentralizes decision-making, and supports democratic participation.	<i>Inequity and Regressivity:</i> Tax incentives often benefit higher-income taxpayers more, reinforcing income inequality and conflicting with principles of progressive taxation,
<i>Economic Rationales:</i> Corrects market failure by supporting public goods not supplied privately. Capitalizes on positive externalities for societal benefit.	<i>Democratic and Equity Concerns:</i> Large donors can wield disproportionate influence over societal priorities, undermining democratic processes.
<i>Addressing Funding Gaps:</i> Augments government capacity by mobilizing private resources, expanding financial support for charitable activities.	<i>Market Distortions and Fair Competition:</i> Tax exemptions could give philanthropic entities an unfair advantage over for-profit businesses offering similar goods and services, distorting markets.

Source: OECD (2020)

Types of Tax Relief: Deductions vs. Credits

The most common form of tax relief globally is the *charitable deduction*, which reduces taxable income. Its generosity rises with the donor's marginal tax rate, disproportionately benefiting higher-income taxpayers. By contrast, *charitable tax credits* reduce liability dollar-for-dollar and provide equal proportional benefits to all donors, improving vertical equity (OECD, 2020).

Other mechanisms include *matching schemes*, where the government tops up donations so that the recipient can claim the tax relief. Finally, an *allocation scheme* is a device through which

taxpayers are able to allocate a share of their income tax to a beneficiary directly through their tax return.

Empirical Evidence: Price Elasticity and Donor Response

Tax incentives for charitable giving work by lowering the effective cost of donating (i.e., the after-tax cost of a \$1 donation). At the federal level, a deduction for charitable contributions has been in place since 1917. Earlier research formed a rough consensus that established a price-of-giving elasticity of approximately -1 (Peloza and Steel, 2005; Auten et al., 2002; Barret et al., 1997; Randolph, 1995). This implies that additional giving induced by the policy is approximately equal to foregone tax revenue at the margin. Newer research, which considers the impact of the 2017 Tax Cuts and Jobs Act, estimates giving to be less responsive for the average donor in recent years (Han et al., 2024; Gravelle and Sherlock, 2020).

At the state level, however, most charitable tax incentives are credits rather than deductions, which are a common incentive meant to increase giving in certain areas and allow taxpayers some discretion in the use of their state tax liability (De Vita and Twombly, 2004). The drawback is that credits may be less visible, or less salient to taxpayers, which can reduce their effectiveness at promoting certain behavior (Duflo et al., 2006; Chetty et al., 2009; Chetty and Saez, 2013).

State-level evidence on qualified donation credits is more mixed. The structure of these policies varies along multiple dimensions, including the size of the credit as a percentage of the donation, individual and aggregate caps, and the eligible donor pool. Empirical studies evaluating the impact of credits with differing structures find these structural elements—particularly the size of the individual cap—play a major role in shaping donor responses to the credits (Gupta and Spreen, 2024; Hungerman and Ottoni-Wilhelm, 2016; Teles, 2016). For instance, Gupta and Spreen (2024) find no measurable effect following the elimination of three small individual limit credits (\$100 for single filers, \$200 for joint filers) in Michigan, whereas North Dakota's introduction of a \$10,000 credit cap produced persistent 25- to 30-percent increases in contributions.

Teles (2016) uses the synthetic control method to estimate causal effects of two differing state-level charitable giving tax credits. The Endow Iowa Tax Credit provides a targeted 25-percent credit with a cap of \$300,000 per person, and the Arizona Working Poor Tax Credit provided a broadly targeted 100-percent credit with a cap of \$200 per person. The results indicate there was no evidence of a measurable effect for the smaller-cap Arizona credit, while the larger cap of the Endow Iowa credit increased contributions by as much as 125 percent.

Duquette et al. (2018) explore state-level charitable tax credits across a panel data of 23 states from 2000 to 2016. They find that these credits have much weaker effects than the federal charitable deduction. Furthermore, the estimated impacts are not statistically significant. In other words, there is little evidence that state credits lead households to give more or donate more often, even though many of these credits are technically more generous than the well-known

federal deduction. Why might this be the case? The findings from the literature can be summarized with some key points.

Saliency and Complexity Issues

- Many taxpayers may not realize such credits exist because they operate at the state rather than federal level.
- Credits are often targeted to specific causes and capped at relatively low amounts, which makes it hard for donors to know whether their gift qualifies.
- Even when aware, donors may not fully understand the credit mechanism. By contrast, people tend to be more familiar with the ‘pre-tax’ mechanism behind deductions, making those policies easier to grasp and respond to.

Effect of Individual Cap Limits

- Low individual caps may fail to provide sufficient economic incentive to shift or increase total giving.
- Evidence from Arizona’s charitable credits show contributions rise as caps increase (Brunner, 2023).
- High-income individuals tend to claim a large portion of these tax credits (Duquette et al., 2018). It follows then that small cap credits elicit weaker responses.

Eligible Donor Pool

- Allowing businesses to claim the credit expands the donor pool to entities with potentially large capacity and incentive to donate, thus making the policy more likely to have an impact on total giving.

Crowding-Out Concerns

One concern with targeted tax credits is whether they actually raise *net* charitable giving or simply *redirect* donations toward qualifying charities. Chatterjee et al. (2020) provides empirical evidence of crowding out in the context of Arizona’s state income tax credit for charitable contributions. Their findings show that while donations to qualifying charities increased significantly, there was a corresponding decrease in donations to non-qualifying organizations.

Additionally, Andreoni and Payne (2003) explored how government grants to private charities can lead to reductions in private donations. They show that charities receiving government support might reduce their own fundraising efforts. This strategic response can diminish the effectiveness in increasing total charitable contributions. Andreoni and Payne (2011) extends these findings to Canada. Their study shows that for every dollar of government funding, approximately 75 cents of private donations were displaced. These results provide support to the crowding-out hypothesis, where government incentives shift private giving rather than increase net contributions (Payne, 2009).

In summary, states provide tax credits for certain charitable activities to increase donations in these areas, provide taxpayers with discretion in how their tax liability is used, and increase the efficiency of dollars going to these causes. Research on state level charitable giving tax credits is less common than research on the federal deduction, but the existing literature suggests donor responses to these credits depend on the structure of the policy. Credits with smaller caps and donor pools may not induce additional giving, while larger credits can have a significant impact on donations. It is less clear if observed effects are additional new donations or a crowding out effect with some research indicating redirection of funds toward qualifying organizations, while others argue credits increase overall net giving.

Evaluations of the RHTC

Besides DOAA reports, the RHTC program has drawn increasing attention in the academic literature as a state-level fiscal intervention. Apenteng et al. (2021) evaluate the program using panel data from 2015–19 and a difference-in-differences design. They find that participation is associated with a substantial improvement in self-reported financial health among rural hospitals, primarily through increased total margins. The study includes extensive robustness checks and highlights the potential of tax credit incentives to stabilize providers facing financial distress.

Opoku et al. (2021) complement these quantitative findings with qualitative insights drawn from interviews with 21 hospital executives in Georgia. Participants generally viewed the tax credit as a vital financial lifeline but identified barriers to full program participation, including administrative complexity, limited public awareness, and rigid donor contribution rules. Suggestions for improvement included extending donation periods, raising the annual cap, and revising hospital eligibility criteria to better target the most vulnerable institutions.

But-for Analysis

An important part of this analysis is to determine whether qualified, credit-receiving donations represent additional net giving induced by the incentive. In practice, some portion of these contributions may have occurred absent the credit or may reflect substitution from non-qualifying to qualifying organizations, rather than an overall increase in total giving.

IRS Nonprofit Data

This portion of the analysis relies on IRS Form 990, which all tax-exempt organizations are required to file annually. The Statement of Revenue (Part VIII of the form), breaks out different types of contributions and grants on line 1, including (1a) contributions from federated campaigns such as United Way; (1b) membership dues; (1c) fundraising events; (1d) transfers from related organizations; (1e) government grants reported as contributions; and (1f) all other contributions, gifts, grants, and similar amounts not otherwise classified. Noncash contributions included in these categories are reported separately on line 1g. Because donations made under Georgia’s RHTC are voluntary cash contributions from individual taxpayers—not pooled

campaigns, dues, fundraising events, affiliate transfers, or direct government grants—they are most appropriately classified under line 1f: all other contributions.

We construct a balanced panel of hospitals observed in the IRS Form 990 data from 2012 to 2022 and classify them into *qualified* and *non-qualified* categories for analytical purposes.¹¹ The final sample includes 19 qualified and 22 non-qualified hospitals. These counts are smaller than the official lists published annually by the Georgia Department of Community Health (DCH) under the HEART program, which typically include around 50 hospitals. This discrepancy arises for several reasons. First, not all qualifying hospitals are organized as nonprofit entities; some are operated by local governments and therefore do not appear in the Form 990 filings.¹² Second, differences in reporting conventions contribute to underrepresentation. Many hospitals file under their corporate or authority names, which often differ from their public-facing names, while others report jointly under consolidated health-system returns rather than as individual facilities. To address these issues, we match the Form 990 supplemental files to the consolidated health-system listings that include the names and numbers of affiliated facilities, identifying whether each was eligible for the HEART program. For consistency over time, hospitals that qualified in any year are treated as qualified throughout the entire analysis period.

As shown in Table 4 and Figures 8 and 9, donations to qualified hospitals rose sharply—from about \$2 million before 2017 to nearly \$24 million by 2022—with the steepest increase occurring between 2017 and 2018, the first full year of the RHTC. In contrast, non-qualified hospitals maintained relatively stable donation levels through 2018 and experienced only a temporary spike in 2020, consistent with pandemic-era giving that later subsided. Over 2012–22, total donations grew at a compound annual rate (CAGR) of about 10 percent, with qualified hospitals donations growing rapidly at roughly 30 percent per year compared with 9 percent among non-qualified hospitals.

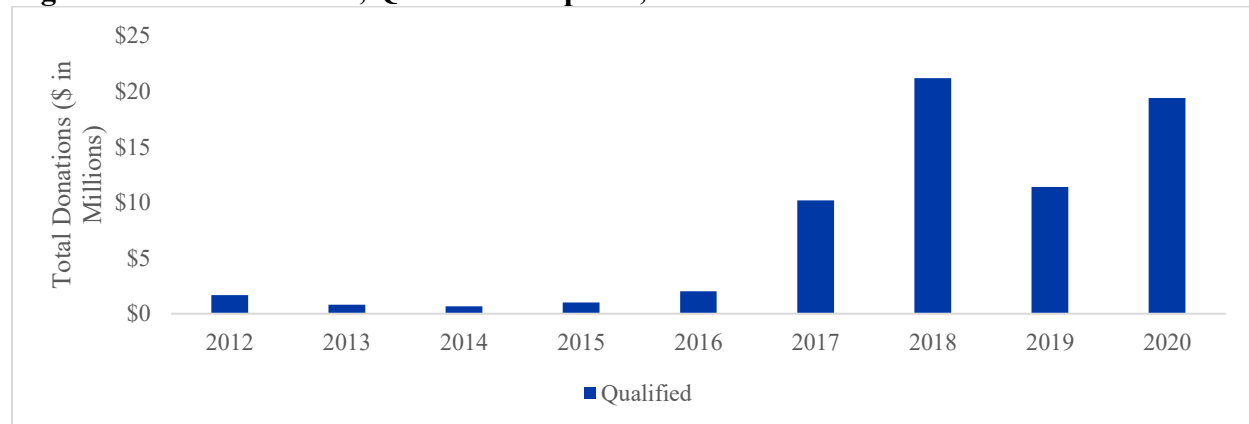
¹¹ A balanced panel means the same set of units (here, hospitals) is observed in every year of the study window; any unit missing a year is excluded. This holds composition constant over time. See Appendix C for more details.

¹² Of the 56 hospitals that were qualified at least once under the program and listed in the HEART reports, 9 are owned by local governments, 33 operate under hospital authorities, and 14 are organized as private nonprofits. Although hospital authorities are public entities and therefore not generally required to file IRS Form 990, some appear in the data because they operate through or are affiliated with nonprofit corporations—typically when the authority leases its facilities to, or manages them under, a 501(c)(3) organization responsible for filing the return. See Appendix D for more details.

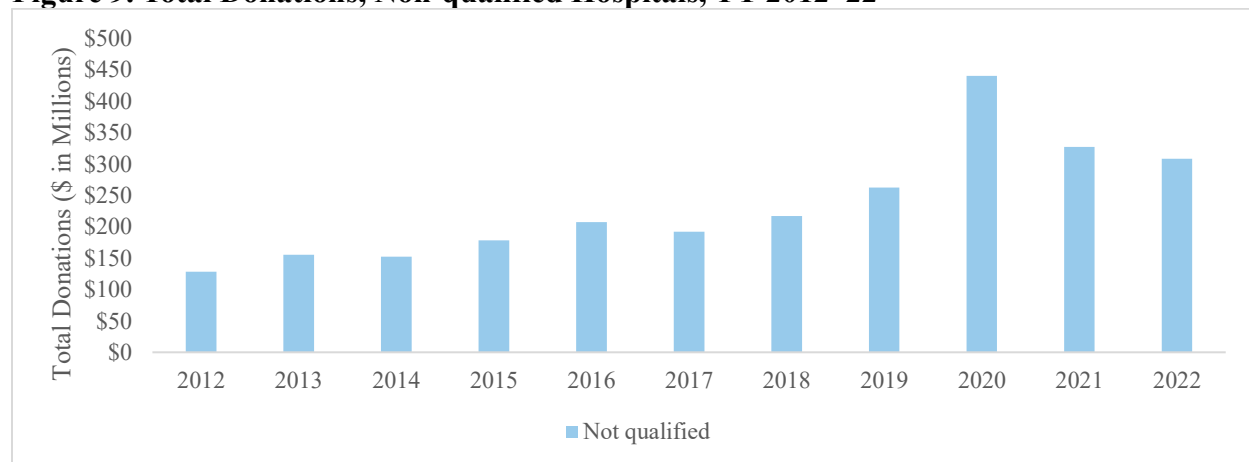
Table 4. Total Donations, Qualified vs. Not Qualified, TY 2012–22¹³

(\$ in millions)	TY 2012	TY 2013	TY 2014	TY 2015	TY 2016	TY 2017	TY 2018	TY 2019	TY 2020	TY 2021	TY 2022
Not qualified	\$128	\$155	\$152	\$178	\$207	\$192	\$217	\$262	\$440	\$327	\$308
Qualified	\$2	\$1	\$1	\$1	\$2	\$10	\$21	\$11	\$19	\$28	\$24
Total	\$130	\$156	\$153	\$179	\$209	\$202	\$238	\$273	\$459	\$355	\$332

Source: Authors' calculations based on data from IRS Form 990

Figure 8. Total Donations, Qualified Hospitals, TY 2012–22

Source: Authors' calculations based on data from IRS Form 990

Figure 9. Total Donations, Non-qualified Hospitals, TY 2012–22

Source: Authors' calculations based on data from IRS Form 990

IRS 990 data indicate that qualified rural hospitals experienced a steady and sustained rise in aggregate donations—from low single-digit millions before 2017 to the mid-\$20 million range by 2022—whereas non-qualified hospitals, although consistently receiving much larger totals

¹³ Year 2016 excludes the \$11.78 million donation reported by Phoebe Sumter Medical Center, which is treated as a one-time event that does not reflect the underlying trajectory of donations among qualified hospitals prior to 2017. Excluding this outlier does not materially affect the compound annual growth rate calculations.

because of their size and urban or system affiliations, show modest growth prior to 2020. Consistent with the per-filer analysis, qualified hospitals display meaningful long-term growth in giving, suggesting that the RHTC generated a dedicated stream of philanthropy for eligible rural facilities, even as overall donor counts declined and giving shifted toward pass-through entity (PTE) channels.

The RHTC therefore appears to have induced donations to rural hospitals that previously received limited philanthropic support. Yet an important question remains: are these contributions genuinely new, or do they reflect a substitution effect—that is, urban donors redirecting existing charitable giving toward rural hospitals to obtain the credit? To shed light on this distinction, we examine the *geographic composition* of donors—specifically, where donations originate. This analysis is conducted at the Core-Based Statistical Area (CBSA) level, a geographic classification defined by the U.S. Office of Management and Budget (OMB) that groups counties around an urban core with established commuting ties. There are two types of CBSAs: (1) Metropolitan Statistical Areas (MSAs), which have urban cores of 50,000 or more residents, and (2) Micropolitan Statistical Areas, which have cores of 10,000 to 49,999 residents.

CBSA 12060 corresponds to the Atlanta–Sandy Springs–Alpharetta metropolitan area, Georgia’s largest urban region. All other CBSA codes represent smaller metro or micropolitan areas, while CBSA 99999 denotes ZIP codes outside any CBSA—nonmetropolitan or rural locations.¹⁴ As reported in Table 5, approximately 44 percent of donations originate from the Atlanta MSA, 42 percent from other urban areas, and 14 percent from rural (non-CBSA) areas. Figure 10 illustrates this spatial pattern: dark-blue areas indicate the dominant share of donations from the Atlanta MSA, light-blue areas represent other urban CBSAs, and white areas correspond to rural donors.

Table 5. Geographical composition of the Origin of Donations in 2022

Group	Share of taxpayers	Share of claimed amount
Atlanta MSA	37%	44%
Other urban	43%	42%
Rural	20%	14%

Source: Authors’ calculations based on data from DOR

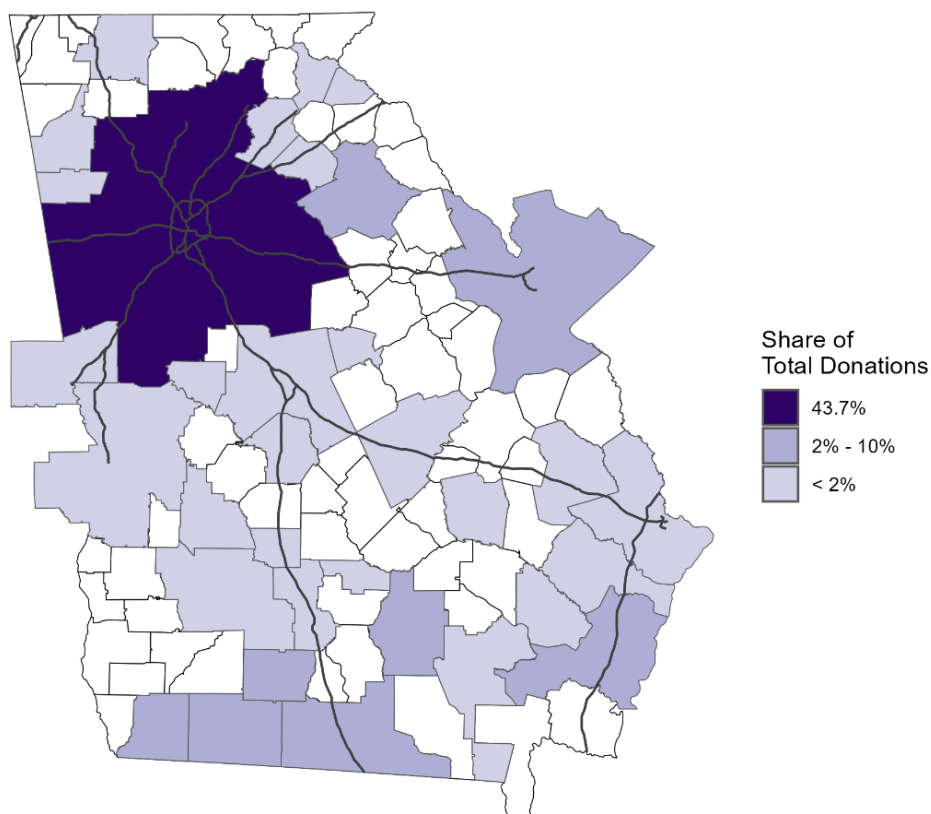
Based on the patterns observed in the 990 data, we interpret the rural share as new giving induced by the RHTC, reflecting contributions from donors who were previously less engaged in hospital philanthropy. As Figure 10 shows the lighter blue shaded CBSAs generally border a rural area (the white areas of the map). Thus, it is likely that these residents are familiar with a nearby rural hospital or know someone treated at one. This salience is relevant when it comes to tax planning and the decision to utilize the credit for the higher income individuals in these

¹⁴ Some examples of other urban areas: 15260 → Columbus, GA-AL; 16860 → Dalton, GA; 23580 → Gainesville, GA; 31420 → Savannah, GA.

CBSAs. It is estimated that a comparable share (14 percent) of donations from the other urban CBSAs likewise represents new giving, as many hospitals in those areas that receive donations were not eligible for the credit. The total estimated portion contributions attributable to the program comes from these two areas and is 28 percent. This estimate should be viewed as an illustrative upper bound, since the actual share of newly induced giving is not observable. But based on the limited data it is likely this share is between 14 and 28 percent depending on the extent of substitution among urban donors.

While a 44 percent of donations to rural hospitals originate in the Metro Atlanta area, we consider these to be merely a shift in giving from urban hospitals to rural hospitals to take advantage of the now more favorable tax treatment. As was shown in Table 4, giving to non-qualified urban hospitals in our balanced panel is orders of magnitude larger than donations to qualified rural hospitals even after the credit is established in 2017. The limited data suggest a slightly lower rate of growth in the non-qualified hospitals after 2017, again supporting a substitution effect from urban to qualifying rural hospitals.

Figure 10. Share of Total Rural Hospital Donations by CBSA TY 2022



Source: Authors' calculations based on data from DOR. ATL CBSA = 43.7%, 9999 (white counties) = 14.1%, Other metro/micro areas combined = 42.2%.

The magnitude of our estimated effect is economically meaningful considering prior research. As discussed in the previous section, state-level evidence generally finds little or no response to

low-cap or less salient credits, whereas large-cap and highly visible programs can generate sizable increases in donations. The RHTC's structure places it within a middle range: its individual cap is substantially higher than the \$200 limits typical of smaller programs but well below the \$300,000 ceiling of Iowa's Endow Credit. Our estimates therefore align with the literature emphasizing that credit generosity, donor eligibility, and policy salience jointly determine the effectiveness of charitable tax incentives. We note that these caps tend to be binding for most donors. However, as we show in a later section, average donations by the highest income donors utilize the unlimited exemption period, donating on average considerably more than the \$10,000 cap.

Characteristics of Top Recipient Hospitals

An analysis of the five hospitals receiving the largest amounts of donations within each group (qualified and non-qualified) reveals striking contrasts. The most evident difference is geographic: all of the leading non-qualified recipients are large urban hospitals, most of them located in metro-Atlanta, while the qualified group consists of rural facilities.

Top 5 non-qualified Georgia Department of Community Health (DCH) recipients: Grady Memorial Hospital, Children's Healthcare of Atlanta, Northside Hospital, Shepherd Center, and Phoebe Putney Memorial Hospital

Top 5 qualified DCH recipients: John D. Archbold Memorial Hospital, Southeast Georgia Health System, Effingham Health System, Phoebe Sumter Medical Center, and Crisp Regional Hospital

It is important to note that the urban–rural classification is not without ambiguity.

A recent *Health Affairs* article documents that following 2016 changes in Medicare policy, many hospitals located in urban areas have been *administratively* reclassified as rural—rising from 3 in 2017 to 425 in 2023.¹⁵ In Georgia, for example, Georgia Health System and Effingham Health System are located in counties that DCH classifies as urban, yet they have qualified for rural hospital credits.

In terms of scale, the gap is substantial. In 2023, the average expenses of the top five rural qualified hospitals amounted to less than 6 percent of the average expenses of the top five non-qualified hospitals. Capacity differs just as dramatically: non-qualified hospitals each operate more than 200 beds, compared with only 50–100 in the top rural hospitals. These comparisons underscore how the program separates large, resource-rich urban institutions from smaller, resource-constrained rural hospitals, with the latter relying more heavily on the RHTC to sustain their operations.

¹⁵ Yang Wang et al., *Sharp Rise in Urban Hospitals With Rural Status in Medicare, 2017–23*, *Health Affairs*, Aug 2025, www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00019

Economic Activity

Overview of How Economic Activity Is Measured

We measure economic activity using data on estimated hospital spending, with FY 2025 as the representative year. As the credit is new, we use this estimate because it represents the estimated reasonable magnitude, given future year estimates. We calculate the net effect of the state-level exemption by assuming that 72 percent of the economic activity would occur without the exemption, as discussed in the but-for section. We then subtract the estimated economic activity associated with an alternative use of the funds to arrive at net economic impact. Table 6 summarizes the estimated economic activity. The remainder of this section provides details.

Table 6. Net Economic Activity – Hospital Services Provided

<i>(\$ millions)</i>	Employment	Labor Income	Value Added	Output
Gross Activity for Period	830	\$64.3	\$92.1	\$159.6
Less: But-for Reduction	598	\$46.3	\$66.3	\$115.0
Activity Net of But-for	232	\$18.0	\$25.8	\$44.7
Less: Alternative Use Impacts	1,739	\$83.6	\$104.7	\$156.8
Net Economic Impact	-1,507	-\$65.6	-\$78.9	-\$112.1

Source: IMPLAN and authors' calculations

IMPLAN Model

To estimate the economic impact of RHTC in Georgia, the IMPLAN model is used. IMPLAN is a regional input-output model that estimates how an initial change in spending or revenue for any industry category works its way through a regional economy. It also has data on the size of each industry in the economy in terms of revenue and employment at the state and county level. The model includes detailed data on industry size by revenue and employment at the state and county levels and applies sector-specific multipliers to estimate the effects of initial spending by firms on suppliers and labor. For this analysis, we use 2023 IMPLAN data, adjusted to reflect average annual revenues and wages in 2024 dollars. Below is an overview of key IMPLAN terms used in the report.

- *Output* is the value of production. This includes the value of all final goods and services, as well as all intermediate goods and services used to produce them. IMPLAN measures output as annual firm-level revenues or sales, assuming firms hold no inventory.
 - Estimates of output changes resulting from all hospital-related economic activity, including medical and related services provided, are then used to estimate state and local sales tax revenue.
- *Labor income* includes total compensation—wages, benefits, and payroll taxes—for both employees and self-employed individuals. Wage-gain estimates are used to estimate incremental state income tax revenue.

- *Employment* includes full-time, part-time, and temporary jobs, including the self-employed. Job numbers do not represent full-time equivalents, so one individual may hold multiple jobs.
- Three changes (effects) comprise the *total impact* and can be calculated for relevant activity reviewed (output, employment, and labor income):
 - *Direct effects* are the changes that initiate the ripple effects through the economy. For this analysis, direct effects are increased firm output (revenue) directly attributable to the credit.
 - *Indirect effects* are the economic activity supported by business-to-business purchases in the supply chain for hospitals. For example, hospitals may purchase medical equipment and other hospital supplies to support medical staff. Each of the supplying businesses subsequently spends a portion of the money they receive on their own production inputs, such as office space, computers, and supplies, which in turn prompts spending by the suppliers of these inputs. This spending continues but progressively diminishes in its in-state impacts due to ‘leakages,’ which occur when firms spend money on imports (including imports from other states), taxes, and profits.
 - *Induced effects* are economic activity that occurs from households spending labor income earned from direct and indirect activities. This activity results from household purchases of items such as food, healthcare, and entertainment. The labor income spent to generate these effects does not include taxes, savings, or compensation of nonresidents (commuters), as these leave the local economy (leakage).

Table 7 shows the economic impact associated with the representative fiscal year of hospital spending. The benefit of the tax credit is modeled as additional income to the hospital sector. Direct spending by this sector, due to the additional income, supported 376 direct jobs with a total labor income of \$37.5 million. Hospital sector spending supported an additional 454 indirect and induced jobs, but it should be noted that these do not necessarily reflect full-time employment. In total, hospital spending associated with the RHTC also supported \$64.3 million in total labor income, \$92.1 million in value added, and \$159.6 million in total output.

Table 7. Economic Impact of Hospital Spending, FY 2025

(\$ millions)	Employment	Labor Income	Value Added	Output
Direct Effect	376	\$37.5	\$44.6	\$79.5
Indirect Effect	219	\$13.4	\$21.0	\$37.4
Induced Effect	235	\$13.4	\$26.5	\$42.7
Total Effect	830	\$64.3	\$92.1	\$159.6

Source: IMPLAN and authors' calculations

Alternate Use of Forgone Revenue/Tax Expenditure

The induced economic impacts estimated above do not account for forgone state revenues, i.e., the economic impacts of alternative uses of the funds currently expended through this tax credit. SB 366 requires evaluations of tax incentives to include estimates of *net* economic and fiscal impacts, thus requiring consideration of the economic and revenue effects of alternative uses of the revenues that would be available for other purposes in the absence of the exemption.

Alternatives could include other economic incentives, spending in other policy areas across state government, or a reduction in taxes—all of which could also result in direct, indirect, and induced economic effects. However, absent information as to how the General Assembly would otherwise choose to spend foregone revenue if not on the credit, we estimate the impact of using the revenue to fund an equivalent increase in state government spending in proportion to existing expenditures. That is, we allocate the foregone revenue to industry sectors as direct effects based on the sector shares of spending in the state budget. The two largest categories of spending—education (47 percent) and healthcare (21 percent)—account for about 68 percent of the state budget for FY 2025 (See Appendix E for details).

As detailed in Table 8, if the state received the forgone revenue associated with the excluded hospital spending, it could be expected to generate approximately \$156.8 million in gross output. This estimate includes \$79.5 million in annual direct government outlays (the fiscal year hospital estimated tax expenditure for the credit) plus the amounts shown for indirect and induced effects resulting from the initial, direct outlays.

Table 8. Summary of Alternative Use Economic Impacts

(\$ millions)	Employment	Labor Income	Value Added	Output
Direct Effect	1,323	\$59.5	\$58.6	\$79.5
Indirect Effect	110	\$6.7	\$11.7	\$21.8
Induced Effect	306	\$17.4	\$34.4	\$55.5
Total Effect	1,739	\$83.6	\$104.7	\$156.8

Source: IMPLAN and authors' calculations

Fiscal Impact

A summary of the fiscal impacts of the RHTC credit is presented in Table 9 below. We then detail the estimates of the revenue effects of the credit's economic impacts and the opportunity cost of the tax expenditure—the revenues that could be expected from the alternate use of funds. The detailed estimates are projected forward to obtain the amounts below.

Table 9. Fiscal Impact Summary*

(\$ millions)	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030
Tax Expenditure Cost						
State	-\$79.5	-\$92.6	-\$93.6	-\$93.6	-\$93.6	-\$47.0
Revenue Gains from Economic Impact						
State	\$1.4	\$1.7	\$1.7	\$1.7	\$1.7	\$0.0
Local	\$0.4	\$0.5	\$0.5	\$0.5	\$0.5	\$1.0
Alternative Use Reduction						
State	-\$6.6	-\$7.6	-\$7.7	-\$7.7	-\$7.7	-\$3.9
Local	-\$1.6	-\$1.9	-\$1.9	-\$1.9	-\$1.9	-\$1.0
Net Fiscal Effects						
State	-\$84.6	-\$98.6	-\$99.7	-\$99.7	-\$99.7	-\$50.0
Local	-\$1.2	-\$1.4	-\$1.4	-\$1.4	-\$1.4	-\$0.7
Total Net Fiscal Effects	-\$85.8	-\$100.0	-\$101.1	-\$101.1	-\$101.1	-\$50.7
State ROI	-0.06	-0.06	-0.06	-0.06	-0.06	-0.06

*Reflects adjustment for but-for estimate of 28 percent; Note: The ROI value indicates for every dollar invested, 6 additional cents are lost.

Revenue Impacts

Forgone Revenue

We estimate foregone revenue associated with project expenditures of the representative year, outlined below in Table 10, estimating lost revenue from RHTC based on expected growth in donations, as discussed earlier.

Table 10. Tax Expenditure Cost Estimates

(\$ millions)	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030
State Tax Expenditure	-\$92.6	-\$93.6	-\$93.6	-\$93.6	-\$47.00

Source: DOR, BTS, EIA data and authors' calculations

We next estimate the additional tax revenue associated with this economic activity.

Additional Tax Revenue

Below, Table 10 shows the estimates for state and local tax revenues attributable to economic activity associated with rural hospitals, with the representative year of FY 2025. State income taxes are estimated using employee compensation generated by IMPLAN. Labor income estimated in this sector is comprised mostly of hospital personnel, with an average income of approximately \$77,000 per job. Based on Georgia DOR tax data—specifically, the net tax liability relative to adjusted gross income (AGI) for taxpayers with similar AGI in TY 2022—we estimate an average effective tax rate under current law of 5.15 percent on labor income for in-state residents.

IMPLAN incorporates estimates of sales and property taxes. However, the model relies on levels of economic activity rather than sales or property tax rates and tax bases; thus, they are not our

preferred estimates. Instead, to estimate sales tax revenues, we use the model’s estimated incremental output for various retail sectors and adjust for the taxable portion of sector sales to arrive at estimates of taxable sales. For retail sectors, IMPLAN reports as output only the retail gross margin, not the total sales at retail, so these estimates are grossed up using average gross margin rates from IMPLAN for each retail sector to arrive at estimated sales to which the tax would be applied. The state sales tax is calculated using the state sales tax rate of 4 percent, and the local sales tax is calculated using an average local sales tax rate of 3.38 percent—the population-weighted average as of January 2024, according to the Tax Foundation. The state and local sales tax estimates for the base year are also shown in Table 10.

To estimate the additional property tax due to the economic activity associated with the tax credit, we calculate the ratio of the IMPLAN estimate of sales tax to our preferred estimate of sales tax above and apply this to the IMPLAN estimate of property tax revenue. This estimate assumes that economic activity generating IMPLAN’s sales tax estimates is like that which generates the property tax—thus, this estimate should be treated cautiously.

Finally, about 76 percent of Georgia state tax collections come from personal income and state sales taxes. Georgia collects a host of other taxes that make up the remaining 24 percent, on average. Two taxes make up about one-half of the 24 percent: corporate income tax and title ad valorem tax (TAVT) on motor vehicles.

Table 11 shows the base-year estimated revenue from these other taxes, assuming a proportional 24 percent effect. Recall that the but-for analysis concludes that, in the short term, 72 percent of hospital donations would be made if the tax credit was removed. Thus, the estimates in Table 11 show the fiscal impact on the state of the 28 percent deemed to have an economic impact.

Table 11. State and Local Tax Revenue from Rural Hospitals (FY 2025 base, \$ millions)

Tax Type	State Revenue	Local Revenue
Personal Income Tax	\$0.93	
Sales Tax	\$0.16	\$0.15
Property Tax	\$0.00	\$0.28
All Other State Taxes	\$0.34	
Total	\$1.43	\$0.43

Source: IMPLAN and authors’ calculations

State and Local Taxes Generated from Alternative Use of Funds

New annual tax revenues resulting from the alternative use case are estimated in a similar manner as that generated by projected expenditures.

Table 12. State and Local Tax Revenues: Alternative Use of Funds (\$ millions)

Tax Type	State Revenue	Local Revenue
Personal Income Tax	\$4.31	
Sales Tax	\$0.67	\$0.66
Property Tax	\$0.00	\$0.96
All Other State Taxes	\$1.57	
Total	\$6.55	\$1.62

Source: IMPLAN and authors' calculations

Administrative Costs

The Rural Hospital Credit are in a group of several other credits that require pre-approval and have a cap on the total donations. These credits include:

- Qualified Foster Care Credit
- Qualified Education Expense Credit
- Qualified Law Enforcement Credit
- PEACH Education Credit

These credits are generally administered by a team of 7 individuals in the Taxpayer Services Division of the Department of Revenue as well as a team of business testers to make sure the credits work in a testing environment. It is estimated that the total personnel cost is \$505,000 annually when including fringe benefits. The Department also estimates that it costs approximately \$325,000 per year from an IT perspective to program and update all of its tax credits. Finally, the Department estimates it costs about \$5,000/year from a tax policy perspective. Thus, on an annual basis, it costs approximately \$835,000 for the administration of this type of tax credits.

Methods to Optimize Tax Credit Performance

As noted earlier, the annual aggregate RHTC contribution limit was increased from \$60 million to \$75 million in 2023, with a planned increase to \$100 million starting in 2025. However, the individual hospital contribution cap remains at \$4 million annually. For the last several years for which data is available the \$75 million cap was reached. Our but-for estimates, while based on limited data, suggest that the credit has had some success in generating new donations, not merely shifting donations from non-qualifying hospitals to qualifying ones.

The RHTC is one of the leaders in credit optimization in terms of reaching the cap. It follows all the best practices suggested by the Department of Revenue. First, it utilizes one intermediary,

Georgia HEART. Georgia HEART markets the credit, reaches out to potential donors and guides them from pre-approval through utilization.

Another important feature of successful credit management by intermediaries is an “addback” program. Such a program monitors tax payers’ federal filings and deducts any amount taken or intended to be taken against federal income. This amount then is returned to the state credit and allowed to be utilized. Georgia HEART also manages this program. Note that the rules on addbacks are changing, and in fiscal year 2026 all credit addbacks will be administered by the Department of Revenue.

In recent years, RHTC has expanded eligibility to owners of PTEs. Finally, RHTC allows for additional donations with higher cap limits after a certain date if the cap limit has not been reached. As is noted in previous sections, these make-up donations on average greatly exceed the standard cap, but are also a critical component to the credit hitting the cap.

Public and Ancillary Benefits

The Rural Hospital Tax Credit in Georgia produces a range of public and ancillary benefits that extend beyond simple fiscal relief. Through the Georgia HEART program, eligible rural hospitals receive donated funds coordinated via the tax credit mechanism, enabling tangible improvements in infrastructure, staffing, and service capacity. Georgia HEART has become a de facto intermediary that matches donors to hospitals, administers preapproval and compliance processes, and ensures that contributions are distributed in alignment with statutory guidelines. For example, in 2024 the program reached record levels, with \$74.2 million in donor contributions—just shy of the statutory cap—and since its inception has generated more than \$432 million in support to rural hospitals statewide.

Audits of the RHTC have found that hospitals commonly direct these funds toward capital projects, equipment acquisition, workforce recruitment, and other operational enhancements, with Georgia HEART charging hospital-paid administrative fees capped at 3 percent in compliance with statute. Because the program requires hospitals to report how funds are used and subjects them to external audit, these investments are more transparent and accountable than many ad hoc grant programs.

These public benefits resonate widely when viewed through the lens of the rural hospital crisis documented in the literature. As Carroll, Berquist, and Chernew (2024) point out, rural hospitals nationwide face sustained financial strain, declining inpatient volume, high shares of publicly insured patients, and frequent closures—even in the presence of federal support, such as Medicare add-ons and drug pricing discounts. The RHTC model helps fill gaps in the national landscape by enabling state-level, flexible injections of capital targeted to hospitals with the greatest need. Likewise, Mason (2017) argues for reconfiguring rural hospitals into community health hubs, capable of integrating telehealth, emergency services, and social supports—an approach that RHTC funds can facilitate by reducing capital constraints. Empirical research such

as Kaufman et al. (2016) and Chatterjee, Lin, and Venkataramani (2022) establish that closures disproportionately afflict smaller, financially fragile hospitals and exacerbate rural economic decline. In Georgia, RHTC contributions allow vulnerable hospitals to remain viable by preserving essential services and reducing the likelihood of closure. In effect, the tax credit acts as both a health-system stabilizer and a regional economic safeguard—preserving jobs, sustaining healthcare access, and anchoring institutional presence in rural communities. In summary the policy has been successful in achieving its goals of providing additional support to rural hospitals.

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Appendix A: On Federal Deduction

The 2017 Tax Cuts and Jobs Act (TCJA) materially weakened the federal tax incentive by nearly doubling the standard deduction and cutting individual rates. Consequently, there was a large reduction in the number of taxpayers who itemize, which reduced the effective federal subsidy for charitable donations for millions of filers. Additionally, TCJA capped the federal deduction for state and local taxes (the SALT deduction) at \$5,000 for individual filers and \$10,000 for married filing jointly.

In response, many states sought workarounds to preserve deductibility for their residents. One of the earliest strategies adopted by some states was to create charitable funds to which taxpayers could ‘donate’ in exchange for state income or property-tax credits. For example, New York established the Charitable Gifts Trust Fund, allowing donations to health and education sub-funds in return for an 85 percent state income tax credit, while New Jersey allowed local governments to grant up to a 90-percent property tax credit for contributions to municipal charitable funds.

However, the Treasury Department and IRS quickly issued regulations that curtailed these efforts. These regulations required taxpayers to reduce their federal charitable deduction by the value of any state or local tax credit received in exchange, effectively neutralizing most of these SALT workaround schemes.

At the same time, these developments spurred renewed interests on targeted, state-level ‘qualified’ donation tax credits, programs that pre-dated the TCJA but gained salience as alternative vehicles for channeling private contributions toward public purposes. Unlike the broad charitable SALT workarounds, qualified donation credits are narrowly defined, typically supporting education scholarships, foster care, or conservation easements, and are subject to strict caps and certification requirements.

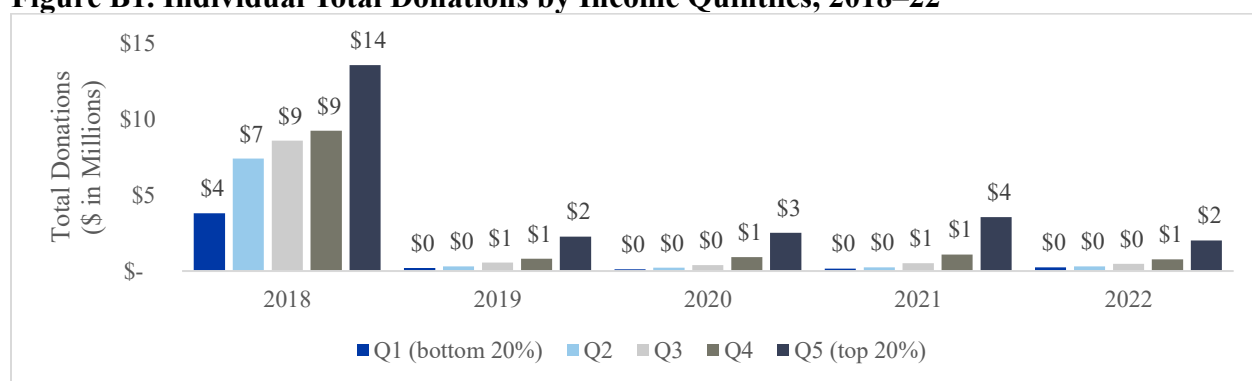
The One Big Beautiful Bill (OBBB) Act, enacted in July 2025, introduced additional tax changes that significantly altered federal charitable incentives. It created a universal above-the-line charitable deduction for non-itemizers. This measure allows individuals who take the standard deduction to also deduct up to \$1,000 in cash donations (\$2,000 for married filing jointly). OBBB narrows the tax value of itemized charitable deductions by imposing a cap on the tax benefit available to itemizers (a 35-percent cap for top-bracket filers, reduced from 37 percent) and introducing an AGI floor (0.5 percent of AGI for individuals) that donors must exceed before itemized charitable deductions apply. Taxpayers cannot claim the federal deduction on amounts for which they claim federal SGO credit.

Appendix B: Distribution of the Donors and Donations by Income Quintiles

Returning to the individual tax files, breaking down donations by income distribution provides further insight into who participates in the program and how. The following figures distinguish between the lowest 20 percent of income earners (Q1) through the top 20 percent (Q5), for both individuals and PTEs. Note that donors generally have substantial incomes.¹⁶

Figure B1 shows that among individuals, total donations were concentrated in 2018, with the top two quintiles (Q4 and especially Q5) accounting for the largest shares.¹⁷ After 2018, total donations from individuals fell and remained modest, though higher-income donors (Q5) consistently represented the bulk of contributions.

Figure B1. Individual Total Donations by Income Quintiles, 2018–22



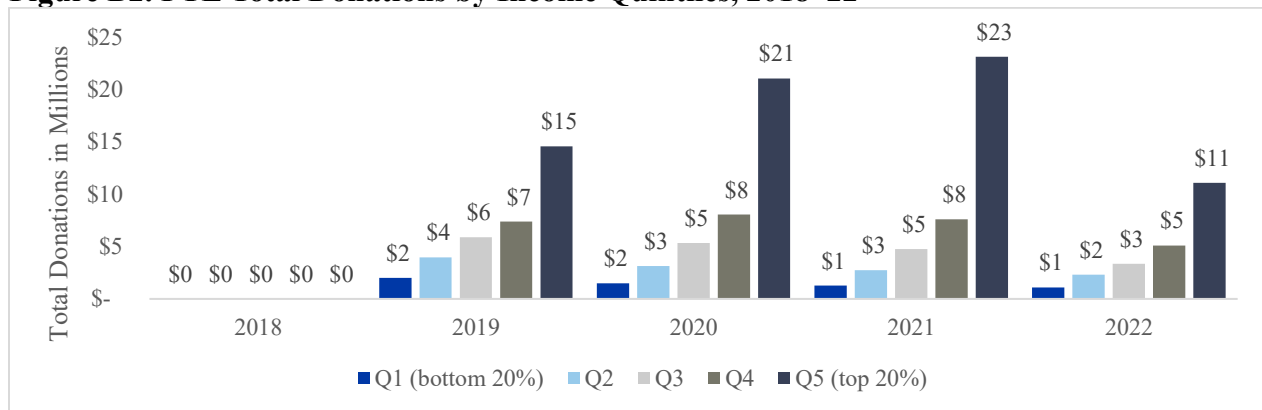
Source: Authors' calculations based on data from DOR

By contrast, Figure B2 shows PTE donations became the dominant channel after 2019, with Q5 consistently leading total donations among quintiles. Even in years when overall giving declined (e.g., 2022), high-income donors through PTEs provided the most donations.

¹⁶ For reference, in 2021 the quintile thresholds for federal adjusted gross income *among donors* were approximately \$160,000 (20th percentile), \$310,000 (40th), \$470,000 (60th), and \$840,000 (80th). We report these figures only as rough benchmarks, since income distributions vary by year and may be influenced by sample composition or outliers.

¹⁷ As noted in footnote 8, the discrepancy in donor composition between Table 1 and the figures presented in this appendix likely reflects internal aggregation or classification differences in how GDAC processed and reported data from the Georgia DOR.

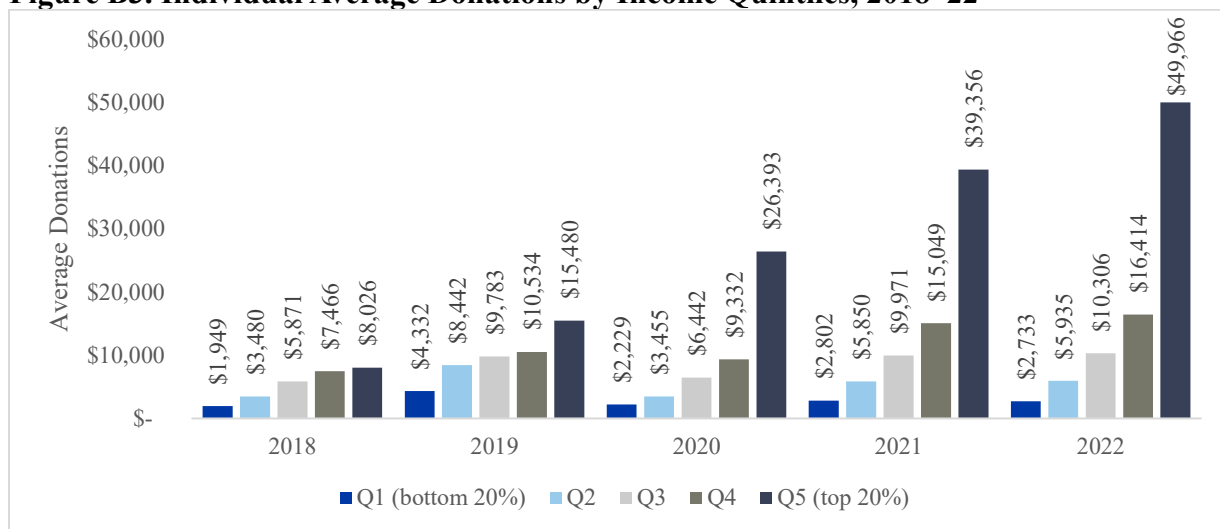
Figure B2. PTE Total Donations by Income Quintiles, 2018–22



Source: Authors' calculations based on data from DOR

The average contribution size also rises with income, and this gradient is visible for both channels. As illustrated in Figure B3, among individuals, Q5 donors gave on average nearly \$50,000 by 2022—compared to less than \$10,000 for Q1–Q3.

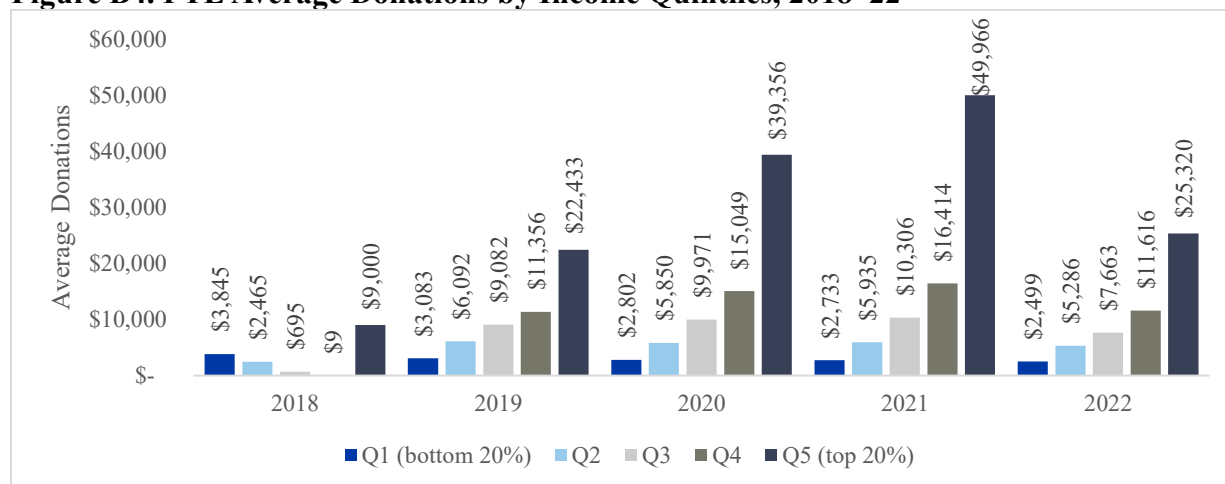
Figure B3. Individual Average Donations by Income Quintiles, 2018–22



Source: Authors' calculations based on data from DOR

The same pattern holds for PTEs in Figure B4, where the top quintile consistently reported the largest average donations, nearly \$50,000 in 2021 before falling somewhat in 2022. Lower- and middle-income quintiles participated at much smaller average amounts.

Figure B4. PTE Average Donations by Income Quintiles, 2018–22



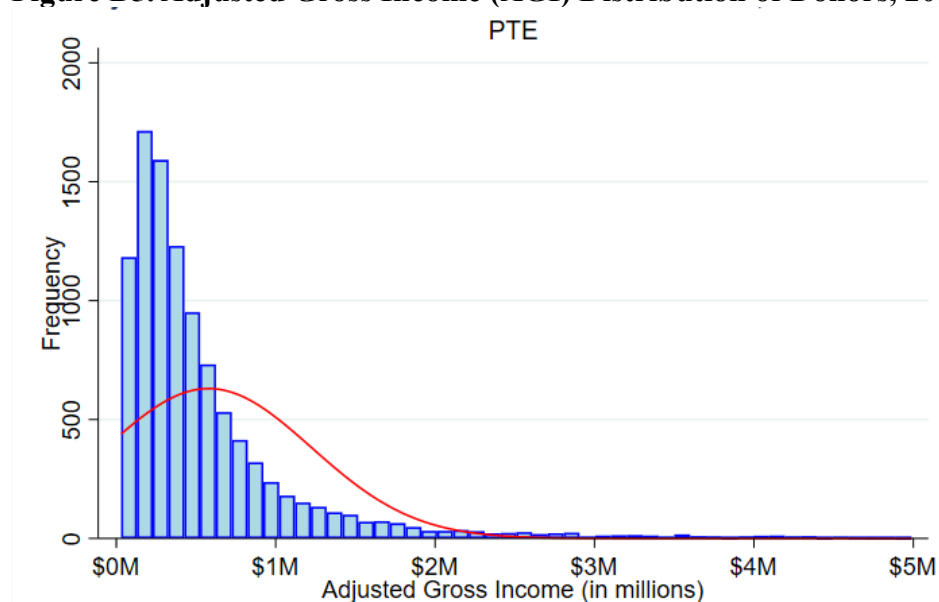
Source: Authors' calculations based on data from DOR

Distribution of Donors' Adjusted Gross Income

Because most donations have been made through PTEs since 2019, the analysis in this section focuses on PTE donors. Results for individuals mirror the overall patterns.

Figure B5 shows the adjusted gross income (AGI) distribution of PTE donors between 2017 and 2022. Most contributors fall in the lower end of the income distribution, with a large concentration below \$500,000 in AGI. However, the distribution has a long right tail, indicating the presence of very high-income donors who, while fewer in number, play a significant role in shaping overall donation patterns.

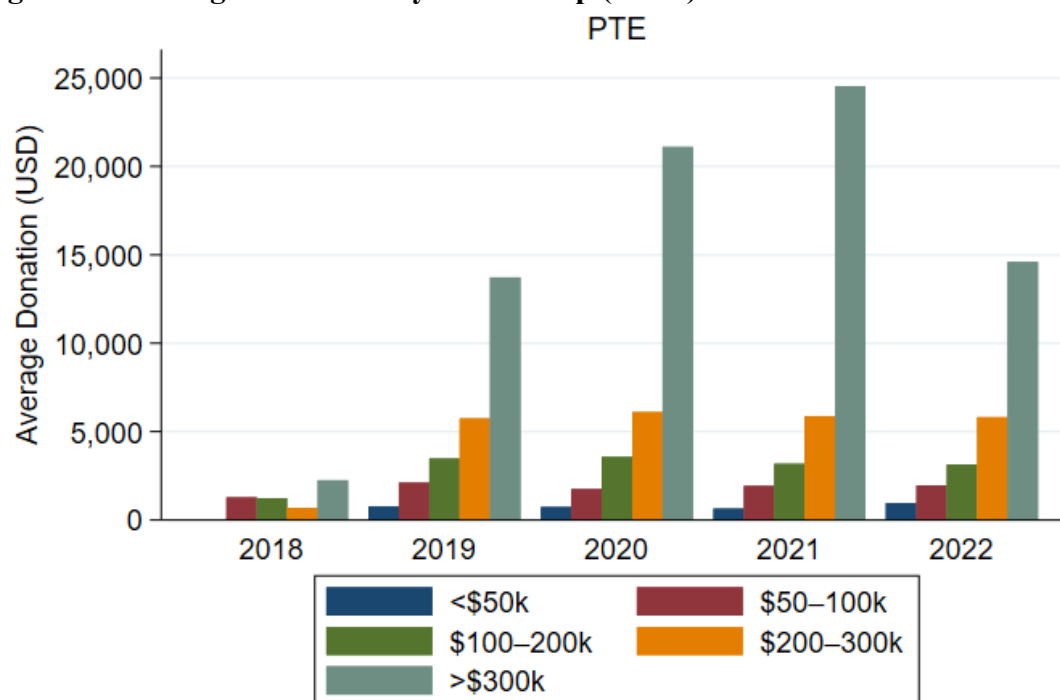
Figure B5. Adjusted Gross Income (AGI) Distribution of Donors, 2017–22



Source: Authors' calculations based on data from DOR. Bars reflect AGI levels using \$100,000 bin widths; kernel density overlaid.

We also illustrate how average donation size rises steeply with income. Donors with AGI above \$300,000 consistently give the largest amounts, averaging over \$20,000 per year between 2020 and 2021 (Figure B6). By contrast, donors with AGI under \$100,000 contribute at much lower levels, typically below \$5,000. This income gradient is stable across years, underscoring the strong relationship between donor income and donation size.

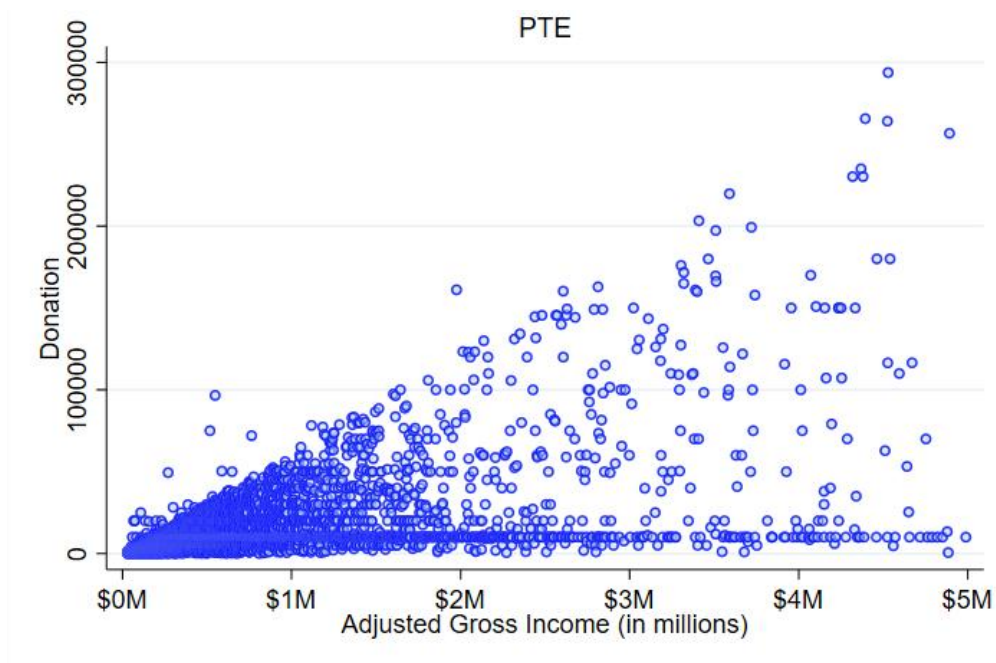
Figure B6. Average Donations by AGI Group (PTEs)



Source: Authors' calculations based on data from DOR

Figure B7 further highlights this relationship at the individual level. The scatter plot shows a clear positive association between AGI and donation amounts: as income rises, both the probability of giving larger amounts and the variance of donations increase. While most donors cluster below \$50,000 in contributions, a small number of very high-income PTE donors make donations exceeding \$100,000, driving much of the aggregate totals.

Figure B7. PTE Donations vs. AGI, 2017–22



Source: Authors' calculations based on data from DOR.

Appendix C: Balanced Panel of Hospitals in the 990 Data

Number	Name of the Facility	Ever Qualified
1	Phoebe Sumter Medical Center Inc	Yes
2	Piedmont Mountainside Hospital Inc	Yes
3	Phoebe Worth Medical Center Inc	Yes
4	John D Archbold Memorial Hospital Inc	Yes
5	Candler Hospital Inc	Yes
6	Taylor Regional Hospital	Yes
7	Donalsonville Hospital Inc	Yes
8	Adventist Health System Georgia Inc	Yes
9	The Medical Center Inc	Yes
10	Upson County Hospital Inc	Yes
11	Kings Bay Comm Hospital Inc	Yes
12	Crisp Regional Hospital Inc	Yes
13	Bacon County Health Services Inc	Yes
14	Evans Memorial Hospital Inc	Yes
15	Chatuge Regional Hospital Inc	Yes
16	Stephens County Hospital Authority	Yes
17	Union County Hospital Authority	Yes
18	Coffee Regional Medical Center Inc	Yes
19	Tanner Medical Center Group Return	Yes
20	Piedmont Newnan Hospital Inc	No
21	Grady Memorial Hospital Corporation	No
22	Hughston Hospital Inc	No
23	Shepherd Center Inc	No
24	Piedmont Hospital Inc	No
25	St Mary's Health Care System Inc	No
26	Saint Joseph's Hospital Inc	No
27	Hillside Inc	No
28	Cobb Hospital Inc	No
29	Hamilton Medical Center Inc	No
30	University Health Services Inc	No
31	Northeast Georgia Medical Center Inc	No
32	Phoebe Putney Memorial Hospital Inc	No
33	Northside Hospital Inc	No
34	Douglas Hospital Inc	No
35	Kennestone Hospital Inc	No
36	Paulding Medical Center Inc	No
37	Piedmont Henry Hospital Inc	No
38	Fayette Community Hospital Inc	No
39	Houston Hospitals Inc	No
40	Children's Healthcare of Atlanta Group Return	No
41	Emory Group Return	No

Source: HEART reports and IRS 990 form

Appendix D: Characteristics of Ever-Qualified Hospitals

Hospital	County	Urban	Beds	Owner Type
AdventHealth Murray	Murray	No	42	Hosp Authority
Appling Hospital	Appling	No	64	Hosp Authority
Atrium Health Polk Medical Center	Polk	No	53	Hosp Authority
Bacon County Hospital	Bacon	No	47	Hosp Authority
Bleckley Memorial Hospital	Bleckley	No	64	Hosp Authority
Brooks County Hospital*	Brooks	No	45	Hosp Authority
Burke Medical Center	Burke	No	34	Local Govt
Candler County Hospital	Candler	No	60	Local Govt
Chatuge Regional Hospital	Towns	No	42	Hosp Authority
Clinch Memorial Hospital	Clinch	No	25	Hosp Authority
Coffee Regional Medical Center	Coffee	No	98	Hosp Authority
Colquitt Regional Medical Center	Colquitt	No	155	Hosp Authority
Crisp Regional Hospital	Crisp	No	73	Hosp Authority
Dodge County Hospital	Dodge	No	94	Hosp Authority
Donalsonville Hospital, Inc.	Seminole	No	65	Not for Profit
Dorminy Medical Center	Ben Hill	No	75	Hosp Authority
Effingham Health System	Effingham	Yes	45	Hosp Authority
Elbert Memorial Hospital	Elbert	No	52	Hosp Authority
Emanuel Medical Center****	Emanuel	No	72	Not for Profit
Evans Memorial Hospital	Evans	No	49	Hosp Authority
Grady General Hospital*	Grady	No	60	Hosp Authority
Higgins General Hospital***	Haralson	No	57	Hosp Authority
Jasper Memorial Hospital	Jasper	No	17	Hosp Authority
Jeff Davis Hospital	Jeff Davis	No	50	Local Govt
Jefferson Hospital	Jefferson	No	65	Local Govt
John D. Archbold Memorial Hospital	Thomas	No	264	Not for Profit
Liberty Regional Medical Center	Liberty	Yes	32	Hosp Authority
Medical Center of Peach County, Navicent Health	Peach	No	36	Local Govt
Memorial Hospital of Bainbridge	Decatur	No	80	Hosp Authority
Miller County Hospital	Miller	No	38	Hosp Authority
Mitchell County Hospital*	Mitchell	No	33	Hosp Authority
Monroe County Hospital	Monroe	No	40	Local Govt
Morgan Medical Center	Morgan	No	25	Local Govt
Navicent Health - Baldwin	Baldwin	No	140	Not for Profit

Northeast Georgia Medical Center Habersham**	Habersham	No	53	Not for Profit
Northeast Georgia Medical Center Lumpkin**	Lumpkin	No	52	Not for Profit
Phoebe Sumter Medical Center	Sumter	No	143	Hosp Authority
Phoebe Worth Medical Center	Worth	No	50	Not for Profit
Piedmont McDuffie Hospital	McDuffie	No	47	Local Govt
Piedmont Mountainside Medical Center	Pickens	No	76	Not for Profit
Putnam General Hospital	Putnam	No	50	Hosp Authority
South Georgia Medical Center - Berrien Campus	Berrien	No	63	Hosp Authority
South Georgia Medical Center Lanier Campus	Lanier	No	40	Hosp Authority
Southeast Georgia Health System - Camden Campus	Camden	Yes	40	Not for Profit
Southwell Medical Center a Campus of Tift Regional Medical Center	Cook	No	0	Not for Profit
St. Mary's Good Samaritan Hospital	Greene	No	49	Not for Profit
St. Mary's Sacred Heart Hospital	Franklin	No	56	Not for Profit
Stephens County Hospital	Stephens	No	90	Hosp Authority
Taylor Regional Hospital	Pulaski	No	55	Not for Profit
Tift Regional Medical Center	Tift	No	241	Hosp Authority
Union General Hospital	Union	No	45	Hosp Authority
Upton Regional Medical Center	Upton	No	115	Hosp Authority
Washington County Regional Medical Center	Washington	No	56	Hosp Authority
Wayne Memorial Hospital	Wayne	No	84	Local Govt
Wellstar Sylvan Grove Hospital	Butts	No	28	Not for Profit
Wills Memorial Hospital	Wilkes	No	25	Hosp Authority

Source: DCH and IRS 990 form. * Part of the John D Archbold Memorial Hospital Inc. consolidated health system. ** Part of Northeast Georgia Health System Inc consolidated health system. *** Part of the Tanner Medical Center Group Return consolidated health system. **** GA Heart Hosp Program

Appendix E: Value of Alternative Use

Table E1 shows the approximate breakdown of state expenditures into functional areas that either directly correspond or are similar to the specified IMPLAN sectors in terms of the nature of labor and other inputs.

Table E1. State Expenditures by Functional Area

Category	Share of State Spending	IMPLAN Codes	IMPLAN Sector Descriptions
Education, PK-12	40.0%	462	Elementary and secondary schools
Ed., Post-Sec	15.1%	463	Post-secondary education, colleges
Health Care	22.7%	475	Individual and family services
Public Safety, excl Corrections	3.4%	453	Facilities support services
Public Safety, Corrections	4.3%	457	Investigation and security services
Mobile Georgia	7.2%	439	Architectural, engineering, related svcs.
Growing Georgia	1.9%	451	Management of companies and enterprises
General Government	5.4%	469	Management of companies and enterprises

Source: Spending shares based on AFY 2019, AFY 2025 Governor's Budget Report
opb.georgia.gov/budget-information/budget-documents/governors-budget-reports