

**ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT CHARITY CARE PROVIDED -
2018**

Total Billed Charges for Charity Care Provided (based on 2018 audited fiscal year): (exclude bad debt)

?

W1A.	<u>Financially Indigent</u>	<u>Medically Indigent</u>	<u>Total Charity Care Charges</u>
Inpatient	<u>774,461</u>	<u>0</u>	<u>774,461</u>
Outpatient	<u>0</u>	<u>0</u>	<u>0</u>
Total	<u>774,461</u>	<u>0</u>	(a) <u>774,461</u>
Cost to Charge Ratio Calculation (based on 2017 audited fiscal year):			
W1B1. 2017 Gross Patient Service Revenue ^{1, 2} ;			(b) <u>34,081,215</u>
W1B2. 2017 Total Patient Care Operating Expenses ^{1,3}(Bad Debt should be treated as a Deduction)			(c) <u>8,792,769</u>
W1B3. Cost to Charge Ratio (Divide (c) by (b)) (please report the ratio as a decimal 0.0000)			(d) <u>0.258</u>
***THIS IS A PRE-CALCULATED FIELD.			
W1C. Estimated Costs of Charity Care Provided ((a) x (d))			(e) <u>199,810</u>
Payments Received for Charity Care Provided: (based on 2018 audited fiscal year)			
W1D1. Third-Party Payments.....			<u>153</u>
W1D2. Payments from Patients.....			<u>0</u>
W1D3. Other Payments (4) (Public hospitals report tax appropriations relative to charity care here)			<u>0</u>
W1D4. Total Payments Received for Charity Care Provided			(f) <u>153</u>
***THIS IS A PRE-CALCULATED FIELD.			
W1E. Estimated Unreimbursed Costs of Charity Care Provided ((e) - (f))⁵..... *			(g) <u>199,658</u>

1 Use audited data for FY 2017 to complete the Cost to Charge Ratio Calculation section of this worksheet for FY 2018.

2 Gross Patient Service Revenue excludes Medicaid Disproportionate Share Hospital payments.

3 Total Patient Care Operating Expenses -**(Bad Debt should be treated as a deduction) excludes contractual adjustments.**

4 Do not include charitable contributions and grants received by the hospital.

5 Report zero (0) in (g) if total estimated costs of charity care provided (e) minus total payments (f) is a negative value.

**CALCULATION OF THE RATIO OF COST TO CHARGE -
2018**

Calculation of initial Ratio of Cost to Charge

W1AA1. Total Patient Revenues (from <u>2017</u> Medicare Cost Report1, Worksheet G-3, Line 1)	(a) <u>34,081,214</u>
W1AA2. Total Operating Expenses (from <u>2017</u> Medicare Cost Report1, Worksheet A, Line 118, Col. 7)	(b) <u>7,463,584</u>
W1AA3. Initial Ratio of Cost to Charge ((b) divided by (a)) ***THIS IS A PRE-CALCULATED FIELD.	(c) <u>0.219</u>
 Application of Initial Ratio of Cost to Charge to 2018 Bad-Debt Expense	
W1AB1. Bad-Debt Expense2 (from <u>2018</u> audited financial statement covering your reporting period)	(d) <u>32,759</u>
W1AB2. Multiply "Bad-Debt Expense" by "Initial Cost to Charge Ratio" to determine allowable Bad-Debt Expense ((d) x (c)) ***THIS IS A PRE-CALCULATED FIELD.	(e) <u>7,174</u>
W1AB3. Add the allowable "Bad-Debt Expense" to " Total Operating Expenses" ((b) + (e)) ***THIS IS A PRE-CALCULATED FIELD.	(f) <u>7,470,758</u>
W1AC. Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal)	(g) <u>0.2192</u>

NOTE: This is Worksheet 1-A from the 1994 Annual Statement of Community Benefits Standard form.

1. Use the **PRIOR** year cost report regardless of status of review. For example, use Medicare Cost Report data for FY 2017 to complete the calculation of initial Ratio of Cost to Charge section of this worksheet.
2. Bad debt expense is defined as the provision for actual or expected uncollectibles resulting from the extension of credit.

Additional cost areas that are not reflected in the above calculations may be identified on the back of this form. Do not include these costs in worksheet computations.

Worksheet 1-A (continued)		
<u>Cost Area</u>	<u>Medicare Cost Report Reference*</u>	<u>Amount</u>
_____	_____	0
_____	_____	0
_____	_____	0
_____	_____	0
_____	_____	0
_____	_____	0
_____	_____	0
_____	_____	0
_____	_____	0
_____	_____	0

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Support to Financially Indigent Patients Provided Through Others 2017

Funding to: W2A

W2A.	<u>Other Nonprofit</u>	<u>Public</u>	<u>Total</u>
Outpatient Clinic	_____	_____	0
Hospital	_____	_____	0
Other Health Care Organizations	_____	_____	0
Total Funding to Others	_____	_____	0

Financial Support to:

W2B.

W2B	<u>Other Nonprofit</u>	<u>Public</u>	<u>Total</u>
Outpatient Clinic	_____	_____	0
Hospital	_____	_____	0
Other Health Care Organizations	_____	_____	0
Total Other Financial Support	_____	_____	0

W2C.

W2C.	<u>Other Nonprofit</u>	<u>Public</u>	<u>Total</u>
Total Support Provided Through Others:	_____	_____	0

W2D. Less: Payments allocated

(c) 0

W2E. Total Unreimbursed Support Provided Through Others ((a.3. + b.3.) - (c))

(d) 0

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**ESTIMATED UNREIMBURSED COSTS OF GOVERNMENT-SPONSORED INDIGENT HEALTH CARE -
2018**

Worksheet 3

Billed Charges for Government-sponsored Indigent Health Care Provided:(Do not include Medicare or Non-government charges.)

W3A.	Inpatient	Outpatient	Total
Medicaid(include Medicaid Managed Care charges; exclude Medicaid Disproportionate Share AND 1115 WAIVER PAYMENTS payments)	_____	_____	0
State Government (CSHCN, Primary Care, Kidney Health, etc.)	_____	_____	0
Local Government (County Indigent Health Care, other)	_____	_____	0
Other Government	0	0	0
Total Billed Charges	_____	_____	0
W3B1. Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal) ***THIS IS A PRE-CALCULATED FIELD.			(b) <u>0.258</u>

W3B2. **Estimated Costs of Government-sponsored Indigent Health Care Provided ((a) x (b))**
***THIS IS A PRE-CALCULATED FIELD. (c) 0

Payment Received for Government-sponsored Indigent Health Care Provided:(Do not include Medicare or non-government payments received.)

W3C1. Medicaid (include Medicaid Managed Care payments; exclude Medicaid Disproportionate Share Hospital payments) 0

W3C2. Medicaid Disproportionate Share Hospital payments 0

w3c22. Uncompensated Care Payments
0

w3c22a. Local Provider Participation Fees (LPPF) received for indigent care _____

W3C3. State Government (CSHCN, Primary Care, Kidney Health, etc.) 0

W3C4. Local Government (County Indigent Health Care, other). 0

W3C5. Other Government. (Champus Payments and DSRIP "SHOULD NOT" be reported here; report "CHAMPUS Payments only in Worksheet 4b.) 0

W3C5A. Please specify source of Other Government payments

W3C6. **Total Payments**
***THIS IS A PRE-CALCULATED FIELD. (d) 0

W3D. Estimated Unreimbursed Costs of Government-sponsored Indigent Health Care ((c) - (d))1

(e) 0

(1) Report zero (0) in (e) if estimated costs of government-sponsored indigent health care provided (c) minus total payments (d) is a negative value.

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**UNREIMBURSED COSTS OF PROVIDING COMMUNITY BENEFITS
-2018**

Worksheet 4-A



Unreimbursed Costs of Subsidized Health Services:

W4AA1. Emergency Care	0
W4AA2. Trauma Care	0
W4AA3. Neonatal Intensive Care	0
W4AA4. Freestanding Community Clinics, e.g., rural health clinics	0
W4AA5. Collaborative effort with local government(s) and/or private agency in preventive medicine, e.g., immunization program	0
W4AA6. Other Services	0
W4AA7. Total ***THIS IS A PRE-CALCULATED FIELD.	(a) 0
W4AB1. Donations Made by the Hospital	(b) 0
W4AB2. Unreimbursed Research-Related Costs	(c) 0

Unreimbursed Education - Related Costs:

W4AC1. Education of physicians, nurses, technicians and other medical professionals and health care providers	0
W4AC2. Scholarships and funding to medical schools, colleges and universities for health professions education	0
W4AC3. Education of patients concerning diseases and home care in response to community needs	0
W4AC4. Community health education through informational programs, publications and outreach activities in response to community needs	0
W4AC5. Other educational services	0

W4AC6. **Total** (d) 0
*****THIS IS A PRE-CALCULATED FIELD.**

W4AD. **Total Unreimbursed Costs of Providing Community** (e) 0
Benefits ((a) + (b) + (c) + (d))
*****THIS IS A PRE-CALCULATED FIELD***.**

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EST. UNREIMBURSED COSTS OF INPAT./OUTPAT. MEDICARE, CHAMPUS AND OTHER GOV'T-SPONSORED PROGRAMS - 2018

Worksheet 4-B

Total Billed Charges for Medicare (INCLUDE MEDICARE MANAGED CARE), CHAMPUS, and Other Government (DO NOT REPORT DSRIP)-sponsored .

Health Care Provided: (Do not include Medicaid charges or other government charges previously reported on worksheet 3.)

W4BA1. Inpatient 24,068,893

W4BA2. Outpatient 0

W4BA3. **Total Billed Charges** (a) 24,068,893
*****THIS IS A PRE-CALCULATED FIELD***.**

W4BB1. **Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal 0.0000)** (b) 0.258
*****THIS IS A PRE-CALCULATED FIELD***.**

W4BB2. **Estimated Costs of Government-sponsored Health Care Provided (a x b)** (c) 6,209,774
*****THIS IS A PRE-CALCULATED FIELD***.**

Payments Received for Care Provided: (Do not include Medicaid payments received.)

W4BC1. Government Payments 3,291,336

W4BC2. Payments from Patients 104,528

W4BC3. Other Payments 768,701

W4BC4. **Total Payments** (d) 4,164,565
*****THIS IS A PRE-CALCULATED FIELD***.**

W4BD. **Estimated Unreimbursed Costs of Government-sponsored Health Care Provided ((c) - (d))2** (e) 2,045,209

1. Do not include charitable contributions and grants.

2. Report zero (0) in (e) if estimated cost of government-sponsored health care provided (c) minus total payments (d) is a negative value.

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**ESTIMATED VALUE OF TAX EXEMPT BENEFITS
2018**

Worksheet 5

Franchise Tax:

W5A. The greater of Fund Balance x 0.25 percent (.0025); -OR-

Net Income plus Officers' and Directors' Compensation x 4.5 percent (.045) (a) 0

**Ad Valorem
Taxes**

Amount of Taxes

County Property Tax (Appraised Value of Property (Real and Personal) x Tax Rate)	0
School District Tax (Appraised Value of Property x Tax Rate)	0
Hospital District Tax (Appraised Value of Property x Tax Rate)	0
Other Property Taxes (Appraised Value of Property x Tax Rate)	0
W5B5. Total Estimated Ad Valorem Taxes	(b) 0

Sales Tax

W5C1. Supplies expense less pharmacy supplies expense	0
W5C2. Lease or rental expense	0
W5C3. Capital Purchases	0
W5C4. Total Estimated Taxable Purchases	(1) 0
W5C5. Sales Tax Rate.....(Please report RATE (.0000), not a percent)	(2) 0
W5C6. Total Estimated Sales Tax (Multiply (1) by (2)) ***THIS IS A PRE-CALCULATED FIELD.	(c) 0

Contributions

W5D1. Nondesignated and Charitable Cash Donations received by the hospital	0
W5D2. Fair Market Value of Nondesignated and Charitable In-Kind Donations	0

W5D3. **Total Contributions**

(d) 0

Tax-Exempt Bond Financing

W5E1. Average Outstanding Bond Principal x Prevailing Interest Rate at Time of Issuance

(1) 0

W5E2. Actual Interest Expense for the Reporting Period

(2) 0

W5E3. Value of Tax-Exempt Bond Financing ((1) - (2))

(e) 0

W5F. **TOTAL ESTIMATED VALUE OF TAX EXEMPT BENEFITS ((a)+(b)+(c)+(d)+(e))**

(f) 0

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II. CHARITY CARE, GOVERNMENT-SPONSORED INDIGENT HEALTH CARE, AND OTHER COMMUNITY BENEFITS INFORMATION - 2018

IIA. Unreimbursed costs of charity care

	Hospital	System	Total
IIA1. Unreimbursed costs of providing care to financially and medically indigent (Worksheet 1, (g))	<u>199,658</u>	<u>11,965,395</u>	
IIA2. Support to financially indigent patients provided through others (Worksheet 2, (d))	<u>0</u>	<u>63,623</u>	
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	<u>199,658</u>	<u>12,029,018</u>	
II B. Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))	<u>0</u>	<u>0</u>	
II C. Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)	<u>199,658</u>	<u>12,029,018</u>	
II D. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	<u>2,045,209</u>	<u>25,842,255</u>	
II E. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	<u>2,244,867</u>	<u>37,871,273</u>	

If you're reporting as a system, please provide system aggregate data for sections I, II, and III

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STD **STANDARDS - Please check the appropriate box (A, B or C) below and provide the requested information.**

TaxID. Taxpayer Number: 752492741

STDI1. Net Patient Revenue (include Medicaid Disproportionate Share Hospital payments):**(exclude DSRIP= the incentive payments from "Net Patient Revenue) TREAT BAD DEBT AS A DEDUCTION FROM NET REVENUE** Hospital System
5,246,945 199,677,258

STDI2. The hospital has been designated as **disproportionate share hospital** under the state Medicaid program in the period covered by this report (2014) or in either of its two previous fiscal years. Completion of section I-3. or I-4. is not required.

I-2

I3. STANDARDS - Please check the appropriate box (A, B, or C) below and provide the requested information.

A. Charity care and government-sponsored indigent health care are provided at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital, and the tax-exempt benefits received by the hospital.

A.

STDI3A1. Tax exempt benefits (Worksheet 5) Hospital

STDI3A2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year _____

B. Charity care and government-sponsored indigent health care are provided in an amount equal to at least 100 percent of the hospital's tax-exempt benefits, excluding federal income tax. (Standard B is met if B.4. is greater than or equal to B.3.)

B.

STDI3B1. Tax-exempt benefits (Worksheet 5) Hospital System
_____ _____

STDI3B2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year _____ _____

STDI3B3. Total of B.1. and B.2. above _____ _____

STDI3B4. Enter the total from item II.C _____ _____

C. Charity care and community benefits are provided in a combined amount equal to at least five (5) percent of the hospital s net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four (4) percent of net patient revenue. (Standard C is met if C.4. is greater than or equal to C.3. and C.8. is greater than or equal to C.7.)

C.~~input checked~~

	Hospital	System
STDI3C1. Multiply Net Patient Revenue (I-1.) by 5%	<u>262,347</u>	<u>9,983,863</u>
STDI3C2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	<u>0</u>	<u>0</u>
STDI3C3. Total of C.1. and C.2. above	<u>262,347</u>	<u>9,983,863</u>
STDI3C4. Enter the amount recorded in item II.E.	<u>2,244,867</u>	<u>37,871,273</u>
STDI3C5. Multiply Net Patient revenue (I-1.) by 4%	<u>209,878</u>	<u>7,987,090</u>
STDI3C6. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	<u>0</u>	<u>0</u>
STDI3C7. Total of C.5. and C.6. above	<u>209,878</u>	<u>7,987,090</u>
STDI3C8. Enter the amount recorded in item II.C.	<u>199,658</u>	<u>12,029,018</u>

I4. Check this box if your hospital **did not meet** any of the standards in sections I-3. Please attach explanatory information.

I-4

I5. Certification Contact Information - Annual Statement of Community Benefits

*

Coordinator Name	Coordinator Title	Phone	Fax	Electronic/internet Mail address
Gary Porter	Financial Analyst	(936) 639-7392	(936) 639-7004	gporter@memorialhealth.org

If you're reporting as a system, please provide system aggregate data

Texas Nonprofit Hospitals*
Part II


Summary of Current Charity Care Policy and Community Benefits for Inclusion in DSHS Charity Care Manual as Required by Texas Health and Safety Code, 311.0461** 2018

Name of Hospital: _____

County: _____

Mailing Address: _____

Physical Address if different from above: _____

Effective Date of the current policy: ____/____/____ 
(mm/dd/yyyy)

Date of Scheduled Revision of this policy: ____/____/____ 
(mm/dd/yyyy)

How often do you revise your charity care policy? _____

Provide the following information on the office and contact person(s) processing requests for charity care.

Name of the office/department: _____

Mailing Address: _____

Contact Person: _____

Title: _____

Phone: () _____ - _____

Fax: () _____ - _____

E-Mail: * read@memorialhealth.org

Person completing this form if different from above:

Name: _____

Phone: () _____ - _____

*This summary form is to be completed by each nonprofit hospital. Hospitals in a system must report on an individual hospital basis. Public hospitals, for-profit hospitals participating in the Medicaid disproportionate share hospital program and exempt hospitals are not required to complete this form. This form is also available in PDF format at DSHS web site: www.dshs.state.tx.us/chs/hosp under 2018 Annual Statement of Community Benefits Standard.

This information will be made available for public use. Please report most current information on the charity care policy and community benefits provided by the hospital.

I. Charity Care Policy:

1. Include your hospital's Charity Care Mission statement in the space below.

2. Provide the following information regarding your hospital's current charity care policy.

a. Provide the definition of charity care for your hospital.	

b. What percentage of the federal poverty guidelines is financial eligibility based upon?

- Less than 100 %
- Less than 133 %
- Less than 150 %
- Less than 200 %
- Other, specify _____

c. Is eligibility based upon net or gross income?

- Net
- Gross

d. Does your hospital have a charity care policy for the Medically indigent?

- Yes No

If yes, provide the definition of the term **Medically Indigent**.

e. Does your hospital use an Assets test to determine eligibility for charity care?

- Yes No

If yes, please briefly summarize method:

f. Whose income and resources are considered for income and/or assets eligibility determination?

- 1. Single parent and children
- 2. Mother, Father and Children
- 3. All family members
- 4. All household members
- 5. Other, please explain _____

g. What is included in your definition of income from the list below? Check all that apply.

- 1. Wages and salaries before deductions
- 2. Self-employment income

- 3. Social security benefits
- 4. Pensions and retirement benefits
- 5. Unemployment compensation
- 6. Strike benefits from union funds
- 7. Worker's compensation
- 8. Veteran's payments
- 9. Public assistance payments
- 10. Training stipends
- 11. Alimony
- 12. Child support
- 13. Military family allotments
- 14. Income from dividends, interest, rents, royalties
- 15. Regular insurance or annuity payments
- 16. Income from estates and trusts
- 17. Support from an absent family member or someone not living in the household
- 18. Lottery winnings
- 19. Other, specify: _____

3. Does application for charity care require completion of a form?

Yes No

If Yes:

a. **Please send a copy of the charity care application form.**

b. How does a patient request an application form? Check all that apply.

- 1. By telephone
- 2. In person
- 3. Other, please specify: _____

c. Are charity care application forms available in places other than the hospital? *

Yes No *

If Yes, please provide the name and address of the place:

Name: _____

Address: _____

d. Is the application form available in language(s) other than English? *

Yes No *

If yes, please check:

- Spanish
- Other, please specify: _____

4. When evaluating a charity care application:

a. How is the information verified by the hospital?

- 1. The hospital independently verifies information with third party evidence (W2, pay stubs)
- 2. The hospital uses patient self-declaration
- 3. The hospital uses both independent verification and patient self-declaration

b. What documents does your hospital use/require to verify income, expenses, and assets? Check all that apply.

- 1. W2-form
- 2. Wage and earning statement
- 3. Pay check remittance
- 4. Worker's compensation
- 5. Unemployment compensation determination letters
- 6. Income tax returns
- 7. Statement from employer
- 8. Social security statement of earnings
- 9. Bank statements
- 10. Copy of checks
- 11. Living expenses
- 12. Long term notes
- 13. Copy of bills
- 14. Mortgage statements
- 15. Document of assets
- 16. Documents of sources of income
- 17. Telephone verification of gross income with the employer
- 18. Proof of participation in govt assistance programs such as Medicaid
- 19. Signed affidavit or attestation by patient
- 20. Veterans benefit statement
- 21. Other, please specify: _____

5. When is a patient determined to be a charity care patient? Check all that apply.

- a. At time of admission
- b. During hospital stay
- c. At discharge
- d. After discharge
- e. Other, please specify _____

6. How much of the bill will your hospital cover under the charity care policy? Check all that apply.

- a. 100%
- b. A specified amount/percentage based on the patient's financial situation
- c. A minimum or maximum dollar or percentage amount established by the hospital
- d. Other, please specify _____

7. Is there a charge for processing an application/request for charity care assistance?

- Yes No

8. How many days does it take for your hospital to complete the eligibility determination process?

9. How long does the eligibility last before the patient will need to reapply?

- a. Per admission
- b. Less than six months
- c. One year
- d. Other, specify _____

10. How does the hospital notify the patient about their eligibility for charity care? Check all that apply.

- a. In person
- b. By telephone
- c. By correspondence
- d. Other, specify _____

11. Are all services provided by your hospital available to charity care patients?

- Yes No

If NO, please list services not covered for charity care patients (e.g. transplant services, ER services, other outpatient services, physician's fees).

12. Does your hospital pay for charity care services provided at hospitals owned by others?

- Yes No

II. Community Benefits Projects/Activities:

Provide information on name, brief description (3 lines), target population or purpose (3 lines) for each of the community benefits projects/activities CURRENTLY being undertaken by your hospital (example: diabetes awareness). If more space is needed, please send additional information in a Word or PDF file. *

Health Fairs Health Screenings Diabetes Awareness

Additional Information:
