ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2020 TEXAS NONPROFIT HOSPITALS

Part I

Please Check "one" your ownership: *

(x) Not-For-Profit

( ) For-Profit (received Medicaid Disproportionate Share Funds)

(X) Public

( ) For-Profit

4396577 2020 ASCBS 6740983
Wise Health Surgical Hospital
Fort Worth TARRANT

TYPE: PUB DISPRO:
REQUIRED TO REPORT ASCBS: YES

Are you reporting as part of a hospital system? ? (x) Yes (X) No

C. Fielding
9/9/21

III HOSPITAL SYSTEMS - List all the hospitals included in this system report. Refer to the instructions on the back of this page in completing this section.

III	Community Benefits Contribution*	Net Patient Revenue (NPR)**	Miles From System Office	Name of Hospital	Physical Address, City, State, Zip
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
TOTAL:					

* The sum of these contributions should equal the entry in II.E (Section II follows Worksheet 5).

** The sum of net patient revenue should equal the entry in STDI1 (Standards Section follows Section II).

ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT CHARITY CARE PROVIDED - 2020

Total Billed Charges for Charity Care Provided (based on 2020 audited fiscal year): (exclude bad debt)

W1A.	Financially Indigent	Medically Indigent	Total Charity Care Charges
Inpatient	0	0	0
Outpatient	59,447	0	59,447
Total	59,447	0	(a) 59,447

Cost to Charge Ratio Calculation (based on 2019 audited fiscal year):

W1B1. **2019** Gross Patient Service Revenue1, 2;..... Colene Fielding 9/8/21 AO — 281,897,555 (b) ~~331,127,032~~

W1B2. **2019** Total Patient Care Operating Expenses1,3.....(**Bad Debt should be treated as a Deduction**) ..... — 95,801,440 (c) ~~104,618,916~~

W1B3. **Cost to Charge Ratio (Divide (c) by (b)) (please report the ratio as a decimal 0.0000)** *****THIS IS A PRE-CALCULATED FIELD.** — 0.3398 (d) ~~0.3159~~

W1C. **Estimated Costs of Charity Care Provided ((a) x (d))** ..... C. Fielding 9/9/21 — 20,203 (e) ~~18,779~~

Payments Received for Charity Care Provided: (based on 2020 audited fiscal year)

W1D1. Third-Party Payments..... — 0

W1D2. Payments from Patients..... — 150

W1D3. Other Payments (4) (Public hospitals report tax appropriations relative to charity care here) — 0

W1D4. **Total Payments Received for Charity Care Provided**..... *****THIS IS A PRE-CALCULATED FIELD.** — (f) 150

W1E. **Estimated Unreimbursed Costs of Charity Care Provided ((e) - (f))5**..... * — 20,053 (g) ~~18,629~~

1 Use audited data for FY 2019 to complete the Cost to Charge Ratio Calculation section of this worksheet for FY 2020.

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.

***Please take a brief second to fill out the four question feedback survey in the link below.**

https://tcnws.co1.qualtrics.com/jfe/form/SV_0lENJ4LgFt35DDv

CALCULATION OF THE RATIO OF COST TO CHARGE - 2019

C alculation of initial Ratio of Cost to Charge

W1AA1. Total Patient Revenues (from **2019** Medicare Cost Report1, Worksheet G-3, Line 1) (a) 301,401,001

W1AA2. Total Operating Expenses (from **2019)** Medicare Cost Report1, Worksheet A, Line 118, Col. 7 (b) 107,079,830

W1AA3. **Initial Ratio of Cost to Charge ((b) divided by (a))**
*****THIS IS A PRE-CALCULATED FIELD.** (c) 0.3553

Application of Initial Ratio of Cost to Charge to 2019 Bad-Debt Expense

Colene Fielding
9/8/21 AO

W1AB1. Bad-Debt Expense2 (from **2020** audited financial statement covering your reporting period) * (d) 0

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) 0

W1AB3. **Add the allowable "Bad-Debt Expense" to " Total Operating Expenses" ((b) + (e))**
*****THIS IS A PRE-CALCULATED FIELD.** (f) 107,079,830

W1AC. **Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal)** (g) 0.36

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 2019 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)

Cost Area	Medicare Cost Report Reference*	**Amount**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY.
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Support to Financially Indigent Patients Provided Through Others 2020

Funding to: W2A

W2A.	Other Nonprofit	Public	Total
Outpatient Clinic	_____	_____	_____
Hospital	_____	_____	_____
Other Health Care Organizations	_____	_____	_____
Total Funding to Others	_____	_____	_____

Financial Support to:

W2B.

W2B	Other Nonprofit	Public	Total
Outpatient Clinic	_____	_____	_____
Hospital	_____	_____	_____
Other Health Care Organizations	_____	_____	_____
Total Other Financial Support	_____	_____	_____

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W2C.	Other Nonprofit	Public	Total
Total Support Provided Through Others:	_____	_____	_____

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 - 2020

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	1,955,088	1,955,088
State Government (CSHCN, Primary Care, Kidney Health, etc.)			
Local Government (County Indigent Health Care, other)			
Other Government			
Total Billed Charges		1955088	1955088

W3B1. **Ratio of Cost to Charge (Worksheet 1, Item d)** (Please report the ratio as a decimal) *****THIS IS A PRE-CALCULATED FIELD.** 0.3398 (b) ~~0.3159~~

W3B2. **Estimated Costs of Government-sponsored Indigent Health Care Provided ((a) x (b)) ***THIS IS A PRE-CALCULATED FIELD.** (c) 664,339

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) 138,283

W3C2. Medicaid Disproportionate Share Hospital payments 0

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w3c22. Uncompensated Care Payments

0

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

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

W3C5. Other Government. **Champus Payments, VA and DSRIP should not be reported here; report Champus Payments in Worksheet 4B only)(Champus Payments and DSRIP "SHOULD NOT" be reported here; report "CHAMPUS Payments only in Worksheet 4b.)**

W3C5A. Please specify source of Other Government payments

W3C6. **Total Payments ***THIS IS A PRE-CALCULATED FIELD.** (d) 138,283

W3D. **Estimated Unreimbursed Costs of Government-sponsored Indigent Health Care ((c) - (d))1** 526,056

(e)

(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 -2020

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

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

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EST. UNREIMBURSED COSTS OF INPAT./OUTPAT. MEDICARE, CHAMPUS AND OTHER GOV'T-SPONSORED PROGRAMS - 2020

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 48,255,154

W4BA2. Outpatient 90,489,283

W4BA3. **Total Billed Charges ***THIS IS A PRE-CALCULATED FIELD***.** (a) 138,744,437

0.3398

W4BB1. **Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal 0.0000) ***THIS IS A PRE-CALCULATED FIELD***.** (b) 0.3159

47,145,360

W4BB2. **Estimated Costs of Government-sponsored Health Care Provided (a x b) ***THIS IS A PRE-CALCULATED FIELD***.** (c) ~~43,829,368~~

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

W4BC1. Government Payments 33,000,586

W4BC2. Payments from Patients 258,535

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W4BC3. Other Payments 0

W4BC4. **Total Payments ***THIS IS A PRE-CALCULATED FIELD***.** (d) 33,259,121

13,886,239

W4BD. **Estimated Unreimbursed Costs of Government-sponsored Health Care Provided ((c) - (d))2** (e) ~~0~~

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
2020

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) _____

Ad Valorem Taxes

.

Amount of Taxes

County Property Tax (Appraised Value of Property (Real andPersonal) x Tax Rate) _____

School District Tax (Appraised Value of Property x Tax Rate) _____

Hospital District Tax (Appraised Value of Property x Tax Rate) _____

Other Property Taxes (Appraised Value of Property x Tax Rate) _____

W5B5. **Total Estimated Ad Valorem Taxes** (b) _____

Sales Tax

W5C1. Supplies expense less pharmacy supplies expense _____

W5C2. Lease or rental expense _____

W5C3. Capital Purchases _____

W5C4. Total Estimated Taxable Purchases (1) _____

W5C5. Sales Tax Rate.....(**Please report RATE (.0000), not a percent**) (2) _____

W5C6. **Total Estimated Sales Tax (Multiply (1) by (2)) ***THIS IS A PRE-CALCULATED FIELD.** (c) _____

Contributions

W5D1. Nondesignated and Charitable Cash Donations received by the hospital _____

W5D2. Fair Market Value of Nondesignated and Charitable In-Kind _____

Donations

W5D3. **Total Contributions** (d) _____

Tax-Exempt Bond Financing

W5E1. Average Outstanding Bond Principal x Prevailing Interest Rate at Time of Issuance (1) _____

W5E2. Actual Interest Expense for the Reporting Period (2) _____

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) _____

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II. CHARITY CARE, GOVERNMENT-SPONSORED INDIGENT HEALTH CARE, AND OTHER COMMUNITY BENEFITS INFORMATION - 2020

IIA. Unreimbursed costs of charity care

		Hospital	System Total
IIA1. Unreimbursed costs of providing care to financially and medically indigent (Worksheet 1, (g))	20,053	~~18,629~~	
IIA2. Support to financially indigent patients provided through others (Worksheet 2, (d))		~~0~~	
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	20,053	~~18,629~~	
IIB. Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))	526,056		
IIC. Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)	546,109	~~18,629~~	
IID. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	13,886,239	~~0~~	
IIE. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	14,432,348	~~18,629~~	

C. Fielding
9/9/21

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

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY.DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).
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STD **STANDARDS - Please check the appropriate box (A, B or C) below and provide the requested information.**

TaxID. Taxpayer Number: 751250450

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
129,514,726	~~373,065,308~~

STDI2. The hospital has been designated as a**disproportionate share hospital** under the state Medicaid program in the period covered by this report (2020) 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 appopriate 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
0

STDI3A2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year 0

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
0	~~7,465,373~~

STDI3B2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	0	0
STDI3B3. Total of B.1. and B.2. above	0	~~7,465,373~~
STDI3B4. Enter the total from item II.C	~~18,629~~	0

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.[ ]

STDI3C1. Multiply Net Patient Revenue (I-1.) by 5%

Hospital	System
6,475,736	~~18653266~~

STDI3C2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year 0 0

STDI3C3. Total of C.1. and C.2. above	C. Fielding 9/9/21	6,475,736	~~18,653,266~~
STDI3C4. Enter the amount recorded in item II.E.	14,432,348	~~18,629~~	0
STDI3C5. Multiply Net Patient revenue (I-1.) by 4%		5,180,589	~~14922612~~
STDI3C6. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year		0	0
STDI3C7. Total of C.5. and C.6. above		5,180,589	~~14922612~~
STDI3C8. Enter the amount recorded in item II.C.	546,109	~~18,629~~	0

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

[X] I-4

I5. Certification Contact Information - Annual Statement of Community Benefits
*

Coordinator Name	Coordinator Title	Phone	Fax	Electronic/internet Mail address
Todd Scroggins	CFO/ SR VP	(940) 626-1228	(940) 626-0101	tscroggins@wisehealthsystem.co

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

****

Completed
10/15/21
AO