ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD - 2024
TEXAS NONPROFIT HOSPITALS

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Enclosed is a copy of the blank 2024 Annual Statement of Community Benefits Standard (ASCBS) form for your hospital or hospital system. Under the Health and Safety Code, Sections 311.045 and 311.046, public and for-profit hospitals designated as Medicaid disproportionate share hospitals are required to file (1) the **ASCBS form** and (2) an **annual report of the Community Benefits Plan** with the Texas Department of State Health Services (DSHS). Please remember that the 2024 ASCBS form must also be filed with your local appraisal district. Mailing instructions are included on the back of this page.

Please note that the 78th Texas Legislature introduced amendments to the Health and Safety Code, Chapter 311, Subchapter D. Section 311.045(f) establishes a mechanism for nonprofit hospitals to receive credit for taking care of county indigent patients. The amendment to Section 311.046(d) establishes requirements for each nonprofit hospital in the areas of providing notice about the charity care program, including the charity care and eligibility policies, to each individual seeking care, and publishing public notice in the local newspaper. Section 311.0461 establishes a new responsibility on DSHS to publish an informational manual containing a summary of the charity care and community benefits provided by each nonprofit hospital. **The 2024 ASCBS form is expanded to collect this information on charity care policies and community benefits in a standardized format.**

The ASCBS form (Part I and Part II) is available online! We recommend that you use this web-based tool **(click on www.ahasurvey.org or www.dshs.state.tx.us/chs/hosp/)** as it will enable you to submit data online making it easier and more efficient for you to respond. A copy of the Health and Safety Code, Chapter 311, Subchapters C and D is also available on our DSHS web site under Regulations and Rules. **The filing date for fiscal year 2024 charity care and community benefits reports is July 23, 2025.**

Please note **Public & For-profit** hospitals designated as a **Disproportionate Share Hospital** under the state Medicaid program should only report for the current **2024** year. The hospital, however, is required to provide financial information on the ASCBS form and file an annual report of the Community Benefits Plan. Also note that a hospital located in a county with population below 50,000 where the entire county or the population of the entire county has been designated as a Health Professional Shortage Area is exempt from this reporting. A list of hospitals required to report charity care and community benefit information for 2024 and a list of hospitals exempt from reporting for 2024 are available on our DSHS web site.

Please contact Mr. Dwayne Collins, Center for Health Statistics, at (512) 776-7261 or e-mail dwayne.collins@dshs.texas.gov if you have any questions. Thank you for your cooperation.

James Farris
Director, Center for Health Statistics
Department of State Health Services

MAILING INSTRUCTIONS

NONPROFIT HOSPITAL CHARITY CARE AND COMMUNITY BENEFITS REPORTING REQUIREMENTS

I. Reporting Requirements for the Texas Department of State Health Services

(1) Submit your Annual Statement of Community Benefits Standard (ASCBS) form (Part I) using the online web-based tool located at www.ahasurvey.org or www.dshs.state.tx.us/chs/hosp/. Nonprofit hospitals must also complete Part II of the ASCBS form.

Failure to file the annual report of the Community Benefits Plan and the Annual Statement and accompanying worksheets with the department could result in an assessment of a civil penalty not to exceed $1,000 for each day a report is delinquent. (Health and Safety Code, Section 311.047.)

II. Reporting Requirements for the Local County Appraisal District

Mail one copy of the Annual Statement of Community Benefits Standard (Part I) and accompanying worksheets to your local county appraisal district. If you do not timely file your statement, you could lose your property tax exemption.

Please note: Hospitals are no longer required to file the ASCBS form with the Comptroller's Office**.**

Part I

ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD – 2024
TEXAS NONPROFIT HOSPITALS

NOTE: This form should be used for fiscal reporting periods ending on or after January 1, 2024.

Hospital or Hospital System: _____

Mailing Address: _____
(Street Address/P.O. Box) (City) (State) (Zip Code)

Physical Address (if different than mailing address):

_____
(Street Address/P.O. Box) (City) (State) (Zip Code)

Reporting Period: _____ through _____ **Taxpayer Number:** _____
(MM/DD/YYYY) (MM/DD/YYYY)

I-1. Net Patient Revenue (include Medicaid Disproportionate Share Hospital payment, the incentive payments from Net Patient Revenue; **exclude** Local Provider Participation Funds (LPPF) and **treat Bad Debt as a Deduction from NPR**:

stdi1 **Hospital** $ _____

sysstdi1 **System** $ _____

I-1. AA. Is LPPF included in stdi1 (Net Patient Revenue)? ☐ Yes ☐ No

Please complete worksheets 1 through 4-B, worksheet 5, if the hospital receives tax exempt benefits, and the sections on page 3 before completing sections I-2. through I-4.

I-2. ☐ **Public & For-profit** hospitals designated **Disproportionate Share Hospital** under the state Medicaid program for the current 2024 report only. (**Check I-2 only**)

I-3. 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.

1. Tax exempt benefits (Worksheet 5) ..... stdi3a1 $ _____
2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year ..... stdi3a2 $ _____

☐ **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.)

		Hospital	System
1. Tax-exempt benefits (Worksheet 5)	std3b1	$	
2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year stdi3b2		$	
3. Total of B.1. and B.2. above	stdi3b3	$	
4. Enter the total from item II.C.	stdi3b4	$	

☐ **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.)

1. Multiply Net Patient Revenue (I-1.) by 5%	stdi3c1	$	
2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	stdi3c2	$	
3. Total of C.1. and C.2. above	stdi3c3	$	
4. Enter the amount recorded in item II.E.	stdi3c4	$	
5. Multiply Net Patient revenue (I-1.) by 4%	stdi3c5	$	
6. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	stdi3c6	$	
7. Total of C.5. and C.6. above	stdi3c7	$	
8. Enter the amount recorded in item II.C.	stdi3c8	$	

I-4. ☐ Check this box if your hospital **did not meet** any of the standards in sections I-3. Please attach explanatory information. stdi4

INSTRUCTIONS FOR COMPLETION OF THE ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD

This form should be used by for-profit hospitals for fiscal reporting periods ending on or after January 1, 2024. Please refer to the following instructions in completing the Annual Statement of Community Benefits Standard (ASCBS). Hospitals may elect to report on a consolidated "system" basis. Hospitals electing to report on a system basis shall complete individual surveys for each hospital included in the system and report their consolidated system data on pages 1 and 3 under the columns for System. The consolidated system data may be entered on the survey form for one hospital and need not be entered for other hospitals in the system. Hospitals not reporting on a system basis should leave the System columns and Section III blank.

Hospitals required to report:

The following hospitals are included in the definition of nonprofit hospitals and are required to report:

1. a hospital eligible for tax-exempt bond financing; or exempt from state franchise, sales, ad valorem, or other state or local taxes; and organized as a nonprofit corporation or a charitable trust under the laws of this state or any other state or country; or
2. a Medicaid disproportionate hospital; or
3. a public hospital owned or operated by a political subdivision or municipal corporation of the state, including a hospital district or authority.

Exemptions:

A nonprofit hospital is not required to report if it:

1. a. is exempt from state franchise, sales, ad valorem, or other state or local taxes; and

   b. does not receive payment for providing health care services to any inpatients or outpatients from any source including but not limited to the patient or any person legally obligated to support the patient, third-party payors, Medicare, Medicaid, or any other federal, state, or local indigent care program; payment for providing health care services does not include charitable donations, legacies, bequests, or grants or payments for research; and

   c. does not discriminate on the basis of inability to pay, race, color, creed, religion, or gender in its provision of services; or

2. is located in a county with a population under 50,000 where the entire county or the population of the entire county has been designated as a Health Professionals Shortage Area (HPSA). Note: A nonprofit hospital is required to report if it is located in a county with a population under 50,000 where a subpopulation, partial geographic area, or a facility is designated as a HPSA. In this case, Exemption 2 does not apply.

Reporting Periods: Indicate the 12-month period covered by the report.

Taxpayer Number: Include the 11-digit taxpayer number assigned by the Comptroller of Public Accounts.

Net Patient Revenue: "Net Patient Revenue" used in I-1. is revenue reported at the estimated net realizable amounts from patients, Medicaid disproportionate share payments, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined; exclude Local Provider Participation Funds (LPPF the incentive payments from net patient revenue and treat bad debts as a deduction from net patient revenue**.**

Standards: Select the standard by checking the appropriate box (A, B or C). (Note: Disproportionate share hospitals designated under the state Medicaid program in 2024 should check the box for I-2. If I-2. is selected, completion of sections I-3. and I-4. is not required.) Provide the requested worksheets and additional information, if applicable.

ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD – 2024 (continued)

Hospital or Hospital System: _____ **City:** _____

II. CHARITY CARE, GOVERNMENT–SPONSORED INDIGENT HEALTH CARE, AND OTHER COMMUNITY BENEFITS INFORMATION- *Please refer to the instructions on the back of this page in completing this section.*

			Hospital	System
A.	Unreimbursed costs of charity care			
	1. Unreimbursed costs of providing care to financially and medically indigent (Worksheet 1, (g))	iia1	$	
	2. Support to financially indigent patients provided through others (Worksheet 2, (d))	iia2	$	
	3. Unreimbursed costs of charity care (A.1. + A.2.)	iia3	$	
B.	Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))	iib	$	
C.	Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)	iic	$	
D.	Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	iid	$	
E.	Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	iie	$	

III. HOSPITAL SYSTEMS – *If reporting as a system, list all the hospitals included in this system report. Refer to the instructions on the back of this page in completing this section.*

	Name of Hospital	Physical Address	Miles From System Office	Community Benefits Contribution *	Net Patient Revenue (NPR) **
1.					
2.					
3.					
4.					
			TOTAL		

Note: * The sum of these contributions should equal the entry in II.E.
***** The sum of net patient revenue should equal the entry in I-1 on page 1.***

IV. CERTIFICATION: ☐ ***By checking this box I certify that the information provided on this statement is true, complete and correct to the best of my knowledge.***

Name/ Title (Please Print)	**Phone: Area Code/ Telephone No.**
Signature	**Date:** (MM/DD/YYYY)
Name of Person Completing Form	Ext. **Phone: Area Code/ Telephone No.**
Electronic/Internet Mail Address	**FAX: Area Code/ Fax No.**

INSTRUCTIONS FOR COMPLETION OF THE ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD (continued)

Community Benefits: Include charity care (Worksheet 1), government-sponsored indigent health care (Worksheet 3), and other community benefits (Worksheets 4-A and 4-B).

Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits Information: **Prior to completing Section II.A. through II.E., complete worksheets 1, 1-A, 2, 3, 4-A and 4-B.** Also complete worksheet 5, if the hospital receives tax exempt benefits. Definitions for use in the completion of required worksheets are provided on the back of each worksheet.

Hospital Systems: **If reporting as a system**, list all the hospitals included in this system report. Include their physical address and approximate distance in miles from the physical location of the hospital system's corporate parent office. Specify the community benefits contribution made by each hospital. The sum of these contributions should equal the entry in II.E (System). The sum of net patient revenue reported for each hospital should equal the entry in I-1 (System) on page one.

Certification: Please check the box, sign and date the certification statement. Please include the name, telephone number, FAX number and e-mail address of the person completing the report.

Worksheet 1

ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT CHARITY CARE PROVIDED – 2024

Name of Hospital: _____ **City:** _____

Reporting Period: _____ through _____
(MM/DD/YYYY) (MM/DD/YYYY)

		Financially Indigent		Medically Indigent		Total Charity Care Charges
Total Billed Charges for Charity Care Provided (based on 2024 audited fiscal year): (exclude bad debt)						
Inpatient	w1afi1		w1ami1		w1atot1	
Outpatient	w1afi2		w1ami2		w1atot2	
Total	w1afi3		w1ami3	(a)	w1atot3	

Cost to Charge Ratio Calculation (based on 2023 audited fiscal year):

2023 Gross Patient Service Revenue[1, 2]	w1b1	(b)	
2023 Total Patient Care Operating Expenses[1, 3] **(treat Bad Debt as a Deduction)**	w1b2	(c)	
Cost to Charge Ratio (Divide (c) by (b)) (Please report the ratio as a decimal.)	w1b3	(d)	
Total Estimated Costs of Charity Care Provided ((a) X (d))	w1c	(e)	

Payments Received for Charity Care Provided: (based on 2024 audited fiscal year)

Third-Party Payments		w1d1	
Payments from Patients		w1d2	
Other Payments[4] (Public hospitals report tax appropriations relative to charity care here)		w1d3	
Total Payments Received for Charity Care Provided		w1d4 (f)	
Estimated Unreimbursed Costs of Charity Care Provided ((e) - (f))	w1e	(g)	

[1] Use audited data for FY 2023 to complete the Cost to Charge Ratio Calculation section of this worksheet.

[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.

Worksheet 1

ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT CHARITY CARE PROVIDED BY HOSPITAL

Definitions

Reporting Period: Indicate the beginning and ending dates for your fiscal reporting period.

Financially Indigent: An uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility system.

Medically Indigent: A person whose medical or hospital bills after payment by third-party payors exceed a specified percentage of the patient's annual gross income, determined in accordance with the hospital's eligibility system, and the person is financially unable to pay the remaining bill.

Charity Care: The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as "financially indigent" or "medically indigent."

Billed Charges for Charity Care: The total amount of hospital charges for inpatient and outpatient services attributable to charity care in a cost reporting period. These charges do not include bad debt charges.

Hospital Eligibility System: The financial criteria and procedure used by a hospital to determine if a patient is eligible for charity care. The system shall include income levels and means testing indexed to the federal poverty guidelines; provided, however, that a hospital may not establish an eligibility system which sets the income level eligible for charity care lower than that required by counties under Section 61.023 or higher, in the case of the financially indigent, than 200 percent of the federal poverty guidelines. A hospital may determine that a person is financially or medically indigent pursuant to the hospital's eligibility system after health care services are provided.

Cost to Charge Ratio Calculation: Derived in accordance with generally accepted accounting principles for hospitals.

Cost to Charge Ratio = Prior Year (2023) Total Patient Care Operating Expenses divided by Prior Year (2023) Gross Patient Service Revenue. Note: Use audited data for FY 2023 in calculating the cost to charge ratio.

Worksheet 1-A

CALCULATION OF THE RATIO OF COST TO CHARGE – 2024

Name of Hospital: _____ **City:** _____

Reporting Period: _____ through _____
(MM/DD/YYYY) (MM/DD/YYYY)

Calculation of Initial Ratio of Cost to Charge

Total Patient Revenues
(from **2023** Medicare Cost Report[1], Worksheet G-3, Line 1) .....w1aa1 (a) _____

Total Operating Expenses
(from **2023** Medicare Cost Report[1], Worksheet A, Line 118, Col. 7) .....w1aa2 (b) _____

Initial Ratio of Cost to Charge ((b) divided by (a)) (Please report the ratio as a decimal.) .....w1aa3 (c) _____

Application of Initial Ratio of Cost to Charge to 2024 Bad-Debt Expense

Bad-Debt Expense[2]
(from **2024** audited financial statement covering your reporting period**)**.....w1ab1 (d) _____

Multiply "Bad-Debt Expense" by "Initial Cost to Charge Ratio" to determine allowable
Bad-Debt Expense **((d) x (c))**.....w1ab2 (e) _____

Add the allowable "Bad-Debt Expense" to "Total Operating Expenses" ((b) + (e)).....w1ab3 (f) _____

Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal.)...w1ac (g) _____

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 2023 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)

ADDITIONAL COST AREAS

Cost Area	Medicare Cost Report Reference*	Amount

*** Include worksheet, line number and column, when applicable.**

Worksheet 2

SUPPORT TO FINANCIALLY INDIGENT PATIENTS PROVIDED THROUGH OTHERS – 2024

Name of Hospital: _____ **City:** _____

Reporting Period: _____ through _____
(MM/DD/YYYY) (MM/DD/YYYY)

		Other Nonprofit		Public		Total
Funding to:						
Outpatient Clinic	w2aonp1		w2apub1		w2atot1	
Hospital	w2aonp2		w2apub2		w2atot2	
Other Health Care Organizations	w2aonp3		w2apub3		w2atot3	
Total Funding to Others.	(a.1.) w2aonp4		(a.2.) w2apub4		(a.3.) w2atot4	
Financial Support to:						
Outpatient Clinic	w2bonp1		w2bpub1		w2btot1	
Hospital	w2bonp2		w2bpub2		w2btot2	
Other Health Care Organizations	w2aonp3		w2bpub3		w2btot3	
Total Other Financial Support	(b.1.) w2bonp4		(b.2.) w2bpub4		(b.3.) w2btot4	
Total Support Provided Through Others:	(a.1.+b.1.) w2conp		(a.2.+b.2.) w2cpub		(a.3.+b.3.) w2ctot	

Less: Payments allocated..... w2d (c) _____

Total Unreimbursed Support Provided Through Others ((a.3. + b.3.) - (c) ..... w2e (d) _____

Worksheet 2

SUPPORT TO FINANCIALLY INDIGENT PATIENTS PROVIDED THROUGH OTHERS

Definitions

Reporting Period: Indicate the beginning and ending dates for your fiscal reporting period.

Charity Care: The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services provided to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

LPPF: Local Provider Participation Fund (LPPF) should not be included in the Annual Statement of Community Benefit.

Worksheet 3

ESTIMATED UNREIMBURSED COSTS OF GOVERNMENT-SPONSORED INDIGENT HEALTH CARE – 2024

Name of Hospital: _____ **City:** _____

Reporting Period: _____ through _____
(MM/DD/YYYY) (MM/DD/YYYY)

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

		Inpatient		Outpatient		Total
Medicaid (include Medicaid Managed Care charges; exclude Medicaid Disproportionate Share and UC Pool payments).....	w3aip1	_____	w3aop1	_____	w3atot1	_____
State Government (CIDC, Primary Care, Kidney Health, etc.).....	w3aip2	_____	w3aop2	_____	w3atot2	_____
Local Government (County Indigent Health Care, other).....	w3aip3	_____	w3aop3	_____	w3atot3	_____
Other Government.....	w3aip4	_____	w3aop4	_____	w3atot4	_____
Total Billed Charges.....	w3aip5	_____	w3aop5	_____	(a) w3atot5	_____

Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal.)..... w3b1 (b) _____

Estimated Costs of Government-sponsored Indigent Health Care Provided ((a) x (b))
..... w3b2 (c) _____

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

Medicaid (include Medicaid Managed Care payments; **exclude the following:** Medicaid Disproportionate Share Hospital (DSH) payments, Comprehensive Hospital Increase Reimbursement Program (CHIRP) payments, and Rural Access to Primary and Preventive Services (RAPPS) payments).
Do not include CHIRP and RAPPS payments received on Worksheet 3..... w3c1 _____

Medicaid Disproportionate Share Hospital payments..... w3c2 _____

Uncompensated Care..... w3c22 _____

State Government (CIDC, Primary Care, Kidney Health, etc.)..... w3c3 _____

Local Government (County Indigent Health Care, other)..... w3c4 _____

Other Government **(Champus Payments should not be reported here; report Champus Payments in Worksheet 4B only)** ..... w3c5 _____

Please specify source of Other Government payments..... w3c5a _____

Total Payments..... w3c6 (d) _____

Estimated Unreimbursed Costs of Government-sponsored Indigent Health Care ((c) - (d)).....w3d (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.

Worksheet 3

ESTIMATED UNREIMBURSED COSTS OF GOVERNMENT-SPONSORED INDIGENT HEALTH CARE

Definitions

Reporting Period: Indicate the beginning and ending dates for your fiscal reporting period.

Unreimbursed Costs: The costs a hospital incurs for providing services after subtracting payments received from any source for such services including but not limited to the following: third-party insurance payments; Medicare payments; Medicaid payments; Medicare education reimbursements; state reimbursements for education; payments from drug companies to pursue research; grant funds for research; and disproportionate share payments. For purposes of this definition, the term "costs" shall be calculated by applying the cost to charge ratios derived in accordance with generally accepted accounting principles for hospitals to billed charges. The calculation of the cost to charge ratios shall be based on the most recently completed and audited prior fiscal year of the hospital or hospital system. For purposes of this definition, charitable contributions and grants to a hospital, including transfers from endowment or other funds controlled by the hospital or its nonprofit supporting entities, shall not be subtracted from the costs of providing services for purposes of determining the unreimbursed costs of charity care and government-sponsored indigent health care only.

Government-sponsored Indigent Health Care: The unreimbursed cost to a hospital of providing health care services to recipients of Medicaid and other federal, state, or local indigent health care programs, **eligibility for which is based on financial need.**

Worksheet 4-A

UNREIMBURSED COSTS OF PROVIDING COMMUNITY BENEFITS – 2024

Name of Hospital: _____ **City:** _____

Reporting Period: _____ through _____
(MM/DD/YYYY) (MM/DD/YY)

Unreimbursed Costs of Subsidized Health Services:

Emergency Care	w4aa1	
Trauma Care	w4aa2	
Neonatal Intensive Care	w4aa3	
Freestanding Community Clinics, e.g., rural health clinics	w4aa4	
Collaborative effort with local government(s) and/or private agency in preventive medicine, e.g., immunization program	w4aa5	
Other Services	w4aa6	
Total	w4aa7	(a)

Donations Made by the Hospital	w4ab1	(b)
Unreimbursed Research-Related Costs	w4ab2	(c)

Unreimbursed Education-Related Costs:

Education of physicians, nurses, technicians and other medical professionals and health care providers	w4ac1	
Scholarships and funding to medical schools, colleges and universities for health professions education	w4ac2	
Education of patients concerning diseases and home care in response to community needs	w4ac3	
Community health education through informational programs, publications and outreach activities in response to community needs	w4ac4	
Other educational services	w4ac5	
Total	w4ac6	(d)

Total Unreimbursed Costs of Providing Community Benefits ((a) + (b) + (c) + (d)) w4ad (e) _____

Worksheet 4-A

UNREIMBURSED COSTS OF PROVIDING COMMUNITY BENEFITS

Definitions

Reporting Period: Indicate the beginning and ending dates for your fiscal reporting period.

Subsidized Health Services: Those services provided by a hospital in response to community needs for which the reimbursement is less than the hospital's cost for providing the services and which must be subsidized by other hospital or nonprofit supporting entity revenue sources.

Donations: The unreimbursed costs of providing cash and in-kind services and gifts, including facilities, equipment, personnel, and programs, to other nonprofit or public outpatient clinics, hospitals, or health care organizations.

Research-Related Costs: The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting facilities, equipment, and personnel for medical and clinical research conducted in response to community needs.

Education-Related Costs: The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting educational benefits, services, and programs.

Unreimbursed Costs: The costs a hospital incurs for providing services after subtracting payments received from any source for such services including but not limited to the following: third-party insurance payments; Medicare payments; Medicaid payments; Medicare education reimbursements; state reimbursements for education; payments from drug companies to pursue research; grant funds for research; and disproportionate share payments. For purposes of this definition, the term "costs" shall be calculated by applying the cost to charge ratios derived in accordance with generally accepted accounting principles for hospitals to billed charges. The calculation of the cost to charge ratios shall be based on the most recently completed and audited prior fiscal year of the hospital or hospital system. For purposes of this definition, charitable contributions and grants to a hospital, including transfers from endowment or other funds controlled by the hospital or its nonprofit supporting entities, shall not be subtracted from the costs of providing services for purposes of determining the unreimbursed costs of charity care and government-sponsored indigent health care only.

Worksheet 4-B

ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT MEDICARE, CHAMPUS AND OTHER GOVERNMENT-SPONSORED PROGRAMS – 2024

Name of Hospital: _____ **City:** _____

Reporting Period: _____ through _____
(MM/DD/YYYY) (MM/DD/YYYY)

Total Billed Charges for Medicare *(include Medicare managed care)*, CHAMPUS, and Other Government-sponsored health programs

(Do not include Medicaid charges or government charges previously reported on worksheet 3.)

Inpatient	w4ba1		
Outpatient	w4ba2		
Total Billed Charges	w4ba3	(a)	

Ratio of Cost to Charge (Worksheet 1, Item D) (Please report the ratio as a decimal.)	w4bb1	(b)	
Estimated Costs of Government-sponsored Health Care Provided (a x b)	w4bb2	(c)	

Payments Received for Care Provided:

(Do not include Medicaid payments received.)

Government Payments	w4bc1		
Payments from Patients	w4bc2		
Other Payments[1]	w4bc3		
Total Payments	w4bc4	(d)	

Estimated Unreimbursed Costs of Government-sponsored Health Care Provided ((c) – (d))	w4bd	(e)	

[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.

Worksheet 4-B

ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT MEDICARE, CHAMPUS AND OTHER GOVERNMENT-SPONSORED PROGRAMS

Definitions

Reporting Period: Indicate the beginning and ending dates for your fiscal reporting period.

Unreimbursed Costs: The costs a hospital incurs for providing services after subtracting payments received from any source for such services including but not limited to the following: third-party insurance payments; Medicare payments; Medicaid payments; Medicare education reimbursements; state reimbursements for education; payments from drug companies to pursue research; grant funds for research; and disproportionate share payments. For purposes of this definition, the term "costs" shall be calculated by applying the cost to charge ratios derived in accordance with generally accepted accounting principles for hospitals to billed charges. The calculation of the cost to charge ratios shall be based on the most recently completed and audited prior fiscal year of the hospital or hospital system. For purposes of this definition, charitable contributions and grants to a hospital, including transfers from endowment or other funds controlled by the hospital or its nonprofit supporting entities, shall not be subtracted from the costs of providing services for purposes of determining the unreimbursed costs of charity care and government-sponsored indigent health care only.

Government-sponsored Program Unreimbursed Costs: The unreimbursed cost to the hospital of providing health care services to the beneficiaries of Medicare, the Civilian Health and Medical Program of the Uniformed Services, and other federal, state, or local government health care programs.

Worksheet 5

ESTIMATED VALUE OF TAX-EXEMPT BENEFITS – 2024

Name of Hospital _____ **City:** _____

Reporting Period: _____ through _____
(MM/DD/YYYY) (MM/DD/YYYY)

Franchise Tax

The greater of:

Fund Balance x 0.25 percent (.0025); or

Net Income plus Officers' and Directors' Compensation x 4.5 percent .045).....w5a (a) _____

Ad Valorem Taxes **Amount of Taxes**

County Property Tax (Appraised Value of Property (Real and Personal) x Tax Rate) .....w5b1 _____

School District Tax (Appraised Value of Property x Tax Rate) .....w5b2 _____

Hospital District Tax (Appraised Value of Property x Tax Rate).....w5b3 _____

Other Property Taxes (Appraised Value of Property x Tax Rate).....w5b4 _____

Total Estimated Ad Valorem Taxes .....w5b5 (b) _____

Sales Tax

Supplies expense less pharmacy supplies expense....w5c1 _____

Lease or rental expense .....w5c2 _____

Capital Purchases .....w5c3 _____

Total Estimated Taxable Purchases .....w5c4 (1) _____

Sales Tax Rate .....w5c5 (2) _____

Total Estimated Sales Tax (Multiply (1) by (2)) .....w5c6 (c) _____

Contributions

Non-designated and Charitable Cash Donations Received by the hospital .....w5d1 _____

Fair Market Value of Non-designated and Charitable In-Kind Donations ..... w5d2 _____

Total Contributions .....w5d3 (d) _____

Tax-Exempt Bond Financing

Average Outstanding Bond Principal x Prevailing Interest Rate At Time of Issuance ... .w5e1 (1) _____

Actual Interest Expense for the Reporting Period .....w5e2 (2) _____

Total Estimated Value of Tax-Exempt Bond Financing (Subtract (1) – (2)) .....w5e3 (e) _____

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TOTAL ESTIMATED VALUE OF TAX EXEMPT BENEFITS ((a)+(b)+(c)+(d)+(e)) .....w5f (f) _____