

ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD - 2024 TEXAS NONPROFIT HOSPITALS



Texas Department of State
Health Services

**Texas Department of State Health
Services
Center for Health Statistics
Hospital Survey Unit
1100 West 49th Street
PO Box 149347
Austin, Texas 78714-9347
Phone: (512) 776-7261
Fax: (512) 776-7344**

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 [DSHS Hospital Survey Unit](#)**) 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 [DSHS Hospital Survey Unit](#). 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 payments; **exclude** Uncompensated Care (UC), Comprehensive Hospital Increase Reimbursement Program (CHIRP), Rural Access to Primary and Preventive Services (RAPPS), Quality Incentive Payment Program (QIPP), Texas Incentives for Physicians and Professional Services (TIPPS), Hospital Augmented Reimbursement Program (HARP), Medicaid Graduate Medical Education (GME), Network Access Improvement Program (NAIP); and **treat Bad Debt as a Deduction from NPR:** stdi1 **Hospital** \$ _____
sysstdi1 **System** \$ _____

I-1. AA. Is either UC, CHIRP, RAPPS, QIPP, TIPPS, HARP, GME, or NAIP 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.

**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 Uncompensated Care (UC), Comprehensive Hospital Increase Reimbursement Program (CHIRP), Rural Access to Primary and Preventive Services (RAPPS), Quality Incentive Payment Program (QIPP), Texas Incentives for Physicians and Professional Services (TIPPS), Hospital Augmented Reimbursement Program (HARP), Medicaid Graduate Medical Education (GME), Network Access Improvement Program (NAIP) 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.*

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

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. TOTAL

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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 Payments⁴ (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. $\text{Cost to Charge Ratio} = \frac{\text{Prior Year (2023) Total Patient Care Operating Expenses}}{\text{Prior Year (2023) Gross Patient Service Revenue}}$ 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 Report¹, Worksheet G-3, Line 1)w1aa1 (a) _____

Total Operating Expenses
(from **2023** Medicare Cost Report¹, 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 Expense²
(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

<u>Cost Area</u>	<u>Medicare Cost Report Reference*</u>	<u>Amount</u>

* 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	_____
	(a.1.)	(a.2.)		(a.3.)	
Total Funding to Others..... w2aonp4	_____	w2apub4	_____	w2atot4	_____

Financial Support to:					
Outpatient Clinic..... w2bonp1	_____	w2bpub1	_____	w2btot1	_____
Hospital.....w2bonp2	_____	w2bpub2	_____	w2btot2	_____
Other Health Care Organizations.....w2aonp3	_____	w2bpub3	_____	w2btot3	_____
	(b.1.)	(b.2.)		(b.3.)	
Total Other Financial Support..... w2bonp4	_____	w2bpub4	_____	w2btot4	_____

	(a.1.+b.1.)		(a.2.+b.2.)		(a.3.+b.3.)
Total Support Provided Through Others:..... w2conp	_____	w2cpub	_____	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.)

	<u>Inpatient</u>	<u>Outpatient</u>	<u>Total</u>
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), Uncompensated Care (UC), Comprehensive Hospital Increase Reimbursement Program (CHIRP), Texas Incentives for Physicians and Professional Services (TIPPS), Rural Access to Primary and Preventive Services (RAPPS) payments, Quality Incentive Payment Program (QIPP), Hospital Augmented Reimbursement Program (HARP), Medicaid Graduate Medical Education (GME), and Network Access Improvement Program (NAIP). Do not include, CHIRP, RAPPS, TIPPS, QIPP, HARP, GME, and NAIP 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 <u>only</u> .
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 <u>only</u> .

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 _____

Outpatientw4ba2 _____

Total Billed Chargesw4ba3 (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 Paymentsw4bc1 _____

Payments from Patientsw4bc2 _____

Other Payments¹w4bc3 _____

Total Paymentsw4bc4 (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 <u>only</u> .
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 Taxesw5b5 (b) _____

Sales Tax

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

Lease or rental expensew5c2 _____

Capital Purchasesw5c3 _____

Total Estimated Taxable Purchasesw5c4 (1) _____

Sales Tax Ratew5c5 (2) _____

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

Contributions

Non-designated and Charitable Cash Donations

Received by the hospitalw5d1 _____

Fair Market Value of Non-designated and

Charitable In-Kind Donations w5d2 _____

Total Contributionsw5d3 (d) _____

Tax-Exempt Bond Financing

Average Outstanding Bond Principal x Prevailing Interest Rate

At Time of Issuancew5e1 (1) _____

Actual Interest Expense for the Reporting Periodw5e2 (2) _____

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

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