### ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2015 TEXAS NONPROFIT HOSPITALS

#### Part I

Please Check "one" your ownership: *

(x) Not-For-Profit

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

() Public

() For-Profit

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

#### 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.

<table>
<thead>
<tr>
<th></th>
<th>Community Benefits Contribution*</th>
<th>Net Patient Revenue (NPR)**</th>
<th>Miles From System Office</th>
<th>Name of Hospital</th>
<th>Physical Address, City, State, Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>17,464</td>
<td>12,595,150</td>
<td>0</td>
<td>Memorial Specialty Hospital</td>
<td>1201 West Frank Ave, Lufkin, TX 75904</td>
</tr>
<tr>
<td>2.</td>
<td>28,253,470</td>
<td>127,962,216</td>
<td>0</td>
<td>Memorial Medical Center of East Texas</td>
<td>1201 West Frank Ave, Lufkin, TX 75904</td>
</tr>
<tr>
<td>3.</td>
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<td>4.</td>
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<td>7.</td>
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<td>8.</td>
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<td>9.</td>
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<td>10.</td>
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<td>11.</td>
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<tr>
<td>12.</td>
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<tr>
<td>13.</td>
<td></td>
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</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:** 28,270,934  140,557,366

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* 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 STDII (Standards Section follows Section II).
## ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT CHARITY CARE PROVIDED - 2015

Total Billed Charges for Charity Care Provided (based on 2015 audited fiscal year): (exclude bad debt)

<table>
<thead>
<tr>
<th>W1A</th>
<th>Financially Indigent</th>
<th>Medically Indigent</th>
<th>Total Charity Care Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>10,773</td>
<td>0</td>
<td>10,773</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10,773</td>
<td>0</td>
<td><strong>(a) 10,773</strong></td>
</tr>
</tbody>
</table>

Cost to Charge Ratio Calculation (based on 2014 audited fiscal year):

<table>
<thead>
<tr>
<th>W1B1</th>
<th>2014 Gross Patient Service Revenue1, 2; .................................................................</th>
<th>(b) 27,692,573</th>
</tr>
</thead>
<tbody>
<tr>
<td>W1B2</td>
<td>2014 Total Patient Care Operating Expenses1,3,... (Bad Debt should be treated as a Deduction)</td>
<td>(c) 4,936,427</td>
</tr>
<tr>
<td>W1B3</td>
<td>Cost to Charge Ratio (Divide (c) by (b)) (please report the ratio as a decimal 0.0000)</td>
<td>(d) 0.1783</td>
</tr>
<tr>
<td>W1C</td>
<td>Estimated Costs of Charity Care Provided ((a) x (d))</td>
<td>(e) 1,920</td>
</tr>
</tbody>
</table>

Payments Received for Charity Care Provided: (based on 2015 audited fiscal year)

<table>
<thead>
<tr>
<th>W1D1</th>
<th>Third-Party Payments ......................................................................................................</th>
<th>3,266</th>
</tr>
</thead>
<tbody>
<tr>
<td>W1D2</td>
<td>Payments from Patients .......................................................................................................</td>
<td>0</td>
</tr>
<tr>
<td>W1D3</td>
<td>Other Payments (4) (Public hospitals report tax appropriations relative to charity care here)</td>
<td>0</td>
</tr>
<tr>
<td>W1D4</td>
<td>Total Payments Received for Charity Care Provided ..................................................................</td>
<td>(f) 3,266</td>
</tr>
</tbody>
</table>

**W1E. Estimated Unreimbursed Costs of Charity Care Provided ((e) - (f))** ........................................... *

1 Use audited data for FY 2014 to complete the Cost to Charge Ratio Calculation section of this worksheet for FY 2015.

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 expense, and 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 - 2015

Calculation of initial Ratio of Cost to Charge

W1AA1. Total Patient Revenues (from 2014 Medicare Cost Report, Worksheet G-3, Line 1)  
(a) 54,879.195

W1AA2. Total Operating Expenses (from 2014 Medicare Cost Report, Worksheet A, Line 118, Col. 7)  
(b) 9,681.276

W1AA3. Initial Ratio of Cost to Charge ((b) divided by (a))  
***THIS IS A PRE-CALCULATED FIELD.  
(c) 0.1764

Application of Initial Ratio of Cost to Charge to 2015 Bad-Debt Expense

W1AB1. Bad-Debt Expense (from 2015 audited financial statement covering your reporting period)  
(d) 142,767

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) 25,184

W1AB3. Add the allowable "Bad-Debt Expense" to "Total Operating Expenses" ((b) + (e))  
***THIS IS A PRE-CALCULATED FIELD.  
(f) 9,706,460

W1AC. Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal)  
(g) 0.1769
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 2014 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.

<table>
<thead>
<tr>
<th>Cost Area</th>
<th>Medicare Cost Report Reference*</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>0</td>
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<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY.
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.
Support to Financially Indigent Patients Provided Through Others 2015

<table>
<thead>
<tr>
<th>Funding to: W2A</th>
<th>Other Nonprofit</th>
<th>Public</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>W2A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Health Care Organizations</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Funding to Others</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Financial Support to:

<table>
<thead>
<tr>
<th>W2B</th>
<th>Other Nonprofit</th>
<th>Public</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Health Care Organizations</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Other Financial Support</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>W2C</th>
<th>Other Nonprofit</th>
<th>Public</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Support Provided Through Others:</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

| W2D. Less: Payments allocated | (c) | 0 |

| W2E. Total Unreimbursed Support Provided Through Others ((a.3. + b.3.) - (c)) | (d) | 0 |

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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### ESTIMATED UNREIMBURSED COSTS OF GOVERNMENT-SPONSORED INDIGENT HEALTH CARE - 2015

**Worksheet 3**

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

<table>
<thead>
<tr>
<th>W3A.</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid (include Medicaid Managed Care charges; exclude Medicaid Disproportionate Share and 1115 Waiver Payments payments)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>State Government (Cshcn, Primary Care, Kidney Health, etc.)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Local Government (County Indigent Health Care, other)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Government</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Billed Charges</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

**W3B1. Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal)**

***THIS IS A PRE-CALCULATED FIELD.***

(b) 0.1783

**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.)*

<table>
<thead>
<tr>
<th>W3C.</th>
<th>Medicaid (include Medicaid Managed Care payments; exclude Medicaid Disproportionate Share Hospital payments)</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>W3C2.</td>
<td>Medicaid Disproportionate Share Hospital payments</td>
<td>0</td>
</tr>
<tr>
<td>w3c22.</td>
<td>Uncompensated Care Payments</td>
<td>0</td>
</tr>
<tr>
<td>W3C3.</td>
<td>State Government (Cshcn, Primary Care, Kidney Health, etc.)</td>
<td>0</td>
</tr>
<tr>
<td>W3C4.</td>
<td>Local Government (County Indigent Health Care, other).</td>
<td>0</td>
</tr>
<tr>
<td>W3C5.</td>
<td>Other Government. <em>(Champus Payments and Dsrip &quot;should not&quot; be reported here; report &quot;Champus Payments only in Worksheet 4b.)</em></td>
<td>0</td>
</tr>
<tr>
<td>W3C6.</td>
<td><strong>Total Payments</strong> <em><strong>THIS IS A PRE-CALCULATED FIELD.</strong></em></td>
<td>(d) 0</td>
</tr>
<tr>
<td>W3D.</td>
<td><strong>Estimated Unreimbursed Costs of Government-sponsored Indigent Health Care ((c) - (d))</strong></td>
<td>(e) 0</td>
</tr>
</tbody>
</table>
(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.

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.
UNREIMBURSED COSTS OF PROVIDING COMMUNITY BENEFITS
-2015
Worksheet 4-A

Unreimbursed Costs of Subsidized Health Services:

W4AA1. Emergency Care

W4AA2. Trauma Care

W4AA3. Neonatal Intensive Care

W4AA4. Freestanding Community Clinics, e.g., rural health clinics

W4AA5. Collaborative effort with local government(s) and/or private agency in preventive medicine, e.g., immunization program

W4AA6. Other Services

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

W4AC2. Scholarships and funding to medical schools, colleges and universities for health professions education

W4AC3. Education of patients concerning diseases and home care in response to community needs

W4AC4. Community health education through informational programs, publications and outreach activities in response to community needs

W4AC5. Other educational services

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***.

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).

To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.
EST. UNREIMBURSED COSTS OF INPAT/OUTPAT. MEDICARE, CHAMPUS AND OTHER GOV'T-SPONSORED
PROGRAMS - 2015
Worksheet 4-B

Total Billed Charges for Medicare (INCLUDE MEDICARE MANAGED CARE), CHAMPUS, and Other Government (DO NOT
REPORT DSRIP)-sponsored 2

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

W4BA1. Inpatient 43,565,780

W4BA2. Outpatient 0

W4BA3. Total Billed Charges 43,565,780
***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) 0.1783
***THIS IS A PRE-CALCULATED FIELD***.

W4BB2. Estimated Costs of Government-sponsored Health Care Provided (a x b) 7,767,779
***THIS IS A PRE-CALCULATED FIELD***.

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

W4BC1. Government Payments 6,264,889

W4BC2. Payments from Patients 759,477

W4BC3. Other Payments 715,940

W4BC4. Total Payments 7,750,315
***THIS IS A PRE-CALCULATED FIELD***.

W4BD. Estimated Unreimbursed Costs of Government-sponsored Health Care Provided ((c) - (d)) 17,464

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.

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).

To navigate the worksheet pages of the Annual Statement of Community Benefits standards for Texas nonprofit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.
**ESTIMATED VALUE OF TAX EXEMPT BENEFITS**

2015

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 (0.045)  

(a) □

**Ad Valorem Taxes**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount of Taxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Property Tax (Appraised Value of Property (Real and Personal) x Tax Rate)</td>
<td>0</td>
</tr>
<tr>
<td>School District Tax (Appraised Value of Property x Tax Rate)</td>
<td>0</td>
</tr>
<tr>
<td>Hospital District Tax (Appraised Value of Property x Tax Rate)</td>
<td>0</td>
</tr>
<tr>
<td>Other Property Taxes (Appraised Value of Property x Tax Rate)</td>
<td>0</td>
</tr>
<tr>
<td><strong>W5B5. Total Estimated Ad Valorem Taxes</strong></td>
<td>(b) □</td>
</tr>
</tbody>
</table>

**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

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)

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 - 2015

IIA. Unreimbursed costs of charity care

<table>
<thead>
<tr>
<th>Description</th>
<th>Hospital</th>
<th>System</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIA1. Unreimbursed costs of providing care to financially and medically indigent (Worksheet 1, (g))</td>
<td>0</td>
<td>61,305</td>
<td>61,305</td>
</tr>
<tr>
<td>IIA2. Support to financially indigent patients provided though others (Worksheet 2, (d))</td>
<td>0</td>
<td>8,693,657</td>
<td>8,693,657</td>
</tr>
<tr>
<td>IIA3. Unreimbursed costs of charity care (A.1. + A.2.)</td>
<td>0</td>
<td>8,693,657</td>
<td></td>
</tr>
<tr>
<td>IIB. Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IIC. Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)</td>
<td>0</td>
<td>8,693,657</td>
<td></td>
</tr>
<tr>
<td>IID. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))</td>
<td>17,464</td>
<td>19,577,277</td>
<td></td>
</tr>
<tr>
<td>IIE. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)</td>
<td>17,464</td>
<td>28,279,934</td>
<td></td>
</tr>
</tbody>
</table>

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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STD1. Net Patient Revenue (include Medicaid Disproportionate Share Hospital payments): (exclude DSRIP incentive payments from "Net Patient Revenue"
TREAT BAD DEBT AS A DEDUCTION FROM NET REVENUE

The hospital has been designated as a disproportionate share hospital under the state Medicaid program in the period covered by this report (2013) or in either of its two previous fiscal years. Completion of section 1-3. or 1-4. is not required.

A. []

STD1A1. Tax exempt benefits (Worksheet 5)

STD1A2. 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.

STD1B1. Tax-exempt benefits (Worksheet 5)

STD1B2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year

STD1B3. Total of B.1. and B.2. above

STD1B4. 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. [x]
STD13C1. Multiply Net Patient Revenue (I-1.) by 5%  
STD13C2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year  
STD13C3. Total of C.1. and C.2. above  
STD13C4. Enter the amount recorded in item II.E.  
STD13C5. Multiply Net Patient revenue (I-1.) by 4%  
STD13C6. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year  
STD13C7. Total of C.5. and C.6. above  
STD13C8. Enter the amount recorded in item II.C.  

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

15. Certification Contact Information - Annual Statement of Community Benefits  
Coordinator Name: Lynn Montes  
Coordinator Title: Internal Auditor  
Phone: (936) 639-7136  
Fax: (936) 639-7992  
Electronic/internet Mail address: lmontes@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 DHSH Charity Care Manual as Required by Texas Health and Safety Code, 311.0461** 2015

Name of Hospital: Memorial Specialty Hospital

County: Angelina

Mailing Address: 1201 West Frank Ave, Lufkin, TX 75904

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? reviewed annually and revised as needed

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

Name of the office/department: Business Office

Mailing Address: 1201 West Frank Ave, Lufkin, TX 75904

Contact Person: Kathy Bates

Title: Director, Revenue Cycle

Phone: (936) 639-7110

Fax: (936) 639-7004

E-Mail: * kbates@memorialhealth.org
Person completing this form if different from above:

Name: Shelli Brooks

Phone: (936) 639-7166

*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 2015 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 %
      (x) Less than 200 %
      ( ) Other, specify ____________

   c. Is eligibility based upon net or gross income?

      ( ) Net
      (x) Gross

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

      (x) Yes ( ) No

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

      A medically indigent person is a person whose medical or hospital bills after payment by third party payors exceed a specified percentage of the person's annual gross income and is unable to pay the remaining bill.

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

      (x) Yes ( ) No

      If yes, please briefly summarize method:

      A review is completed to determine patient eligibility based on the patient's total resources, including but not limited to, family income level, personal assets, and other pertinent information.

   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
      [x] 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?

   (x) 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 (x) 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? *

      (x) Yes ( ) No *

      If yes, please check:

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

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

   [x] a. At time of admission
   [x] b. During hospital stay
   [x] c. At discharge
   [x] 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.

   [x] a. 100%
   [x] 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 (x) 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?

   (x) 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.

   [x] a. In person
   [x] b. By telephone
   [x] c. By correspondence
   [ ] d. Other, specify _______________

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

   () Yes (x) No

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

   Not medically necessary elective services

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

   () Yes (x) 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 Fair
   Health Screenings
   Awareness of various diseases: heart, stroke, cancer prevention, wellness

Additional Information:

______________________________