ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2019 TEXAS NONPROFIT HOSPITALS

Part I

Please Check "one" your ownership: *

(x) Not-For-Profit

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

( ) Public

( ) For-Profit

4416205 2019 ASCBS
6740344
ContinueCARE Hospital at Hendrick Medical Center
Abilene
TAYLOR

TYPE: NP DISPRO:
REQUIRED TO REPORT ASCBS: YES
HENDRICK HEALTH SYSTEM

Are you reporting as part of a hospital system? ( ) Yes (x) 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.

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

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

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

ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT CHARITY CARE PROVIDED - 2019

Total Billed Charges for Charity Care Provided (based on 2019 audited fiscal year): (exclude bad debt)

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

Cost to Charge Ratio Calculation (based on 2018 audited fiscal year):

No charity care given; only $60,000 donated to a non-profit hospital

W1B1. **2018** Gross Patient Service Revenue1, 2;..... (b) 34,574,000

W1B2. **2018** Total Patient Care Operating Expenses1,3.....(**Bad Debt should be treated as a Deduction)** 7203000 ..... (c) ~~8,386,000~~

W1B3. **Cost to Charge Ratio (Divide (c) by (b)) (please report the ratio as a decimal 0.0000)** 4.7999
*****THIS IS A PRE-CALCULATED FIELD.** (d) ~~0.2426~~

Per Rozila A. Email 7/10/2020. dc

W1C. **Estimated Costs of Charity Care Provided ((a) x (d))** ..... (e) 0

Payments Received for Charity Care Provided: (based on 2019 audited fiscal year)

W1D1. Third-Party Payments..... 0

W1D2. Payments from Patients..... 0

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

W1D4. **Total Payments Received for Charity Care Provided**.....
*****THIS IS A PRE-CALCULATED FIELD.** (f) 0

W1E. **Estimated Unreimbursed Costs of Charity Care Provided ((e) - (f))5**..... * (g) 0

1 Use audited data for FY 2018 to complete the Cost to Charge Ratio Calculation section of this worksheet for FY 2019.

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

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

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

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

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

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

CALCULATION OF THE RATIO OF COST TO CHARGE - 2018

C alculation of initial Ratio of Cost to Charge

W1AA1.	Total Patient Revenues (from **2018** Medicare Cost Report1, Worksheet G-3, Line 1)	(a) 36,491,362
W1AA2.	Total Operating Expenses (from **2018)** Medicare Cost Report1, Worksheet A, Line 118, Col. 7	(b) 7,620,621
W1AA3.	**Initial Ratio of Cost to Charge ((b) divided by (a)) ***THIS IS A PRE-CALCULATED FIELD.**	(c) 0.2088

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

W1AB1.	Bad-Debt Expense2 (from **2019** audited financial statement covering your reporting period)	(d) 124,000
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) 25,891
W1AB3.	**Add the allowable "Bad-Debt Expense" to " Total Operating Expenses" ((b) + (e)) ***THIS IS A PRE-CALCULATED FIELD.**	(f) 7,646,512
W1AC.	**Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal)**	(g) 0.2095

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 2018 to complete the calculation of initial Ratio of Cost to Charge section of this worksheet.

2. Bad debt expense is defined as the provision for actual or expected uncollectibles resulting from the extension of credit.

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

Worksheet 1-A (continued)

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

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY.
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 2017

Funding to: W2A

W2A.	Other Nonprofit	Public	Total
Outpatient Clinic	0	0	0
Hospital	60,000	0	60,000
Other Health Care Organizations	0	0	0
Total Funding to Others	60,000	0	60,000

Financial Support to:

W2B.

W2B	Other Nonprofit	Public	Total
Outpatient Clinic	0	0	0
Hospital	0	0	0
Other Health Care Organizations	0	0	0
Total Other Financial Support	0	0	0

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W2C.	Other Nonprofit	Public	Total
Total Support Provided Through Others:	60,000	0	60,000

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

W2E. **Total Unreimbursed Support Provided Through Others ((a.3. + b.3.) - (c))** (d) 60,000

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 - 2019

Worksheet 3

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

W3A.	**Inpatient**	**Outpatient**	**Total**
Medicaid(include Medicaid Managed Care charges; exclude Medicaid Disproportionate Share AND 1115 WAIVER PAYMENTS payments)	0	0	0
State Government (CSHCN, Primary Care, Kidney Health, etc.)	0	0	0
Local Government (County Indigent Health Care, other)	0	0	0
Other Government	0	0	0
Total Billed Charges	0	0	0

W3B1. **Ratio of Cost to Charge (Worksheet 1, Item d)** (Please report the ratio as a decimal) *****THIS IS A PRE-CALCULATED FIELD.** (b) 0.2426

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

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

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

W3C2. Medicaid Disproportionate Share Hospital payments 0

w3c22. Uncompensated Care Payments

0

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

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

W3C5. Other Government. **(Include Local Provider Participation Fees (LPPF); Champus Payments and DSRIP should not be reported here; report Champus Payments in Worksheet 4B only)(Champus Payments and DSRIP "SHOULD NOT" be reported here; report "CHAMPUS Payments only in Worksheet 4b.)** 0

W3C5A. Please specify source of Other Government payments

_____

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

W3D. **Estimated Unreimbursed Costs of Government-sponsored Indigent Health Care ((c) - (d))1** 0

(e)

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

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UNREIMBURSED COSTS OF PROVIDING COMMUNITY BENEFITS -2019

Worksheet 4-A

Unreimbursed Costs of Subsidized Health Services:

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

Unreimbursed Education - Related Costs:

W4AC1. Education of physicians, nurses, technicians and other medical professionals and health care providers	0
W4AC2. Scholarships and funding to medical schools, colleges and universities for health professions education	0
W4AC3. Education of patients concerning diseases and home care in response to community needs	1,204
W4AC4. Community health education through informational programs, publications and outreach activities in response to community needs	0
W4AC5. Other educational services	0

W4AC6. **Total**
*****THIS IS A PRE-CALCULATED FIELD.**

(d) 1,204

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

(e) 1,204

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EST. UNREIMBURSED COSTS OF INPAT./OUTPAT. MEDICARE, CHAMPUS AND OTHER GOV'T-SPONSORED PROGRAMS - 2019

Worksheet 4-B

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

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

W4BA1.	Inpatient		25,393,000
W4BA2.	Outpatient		0
W4BA3.	**Total Billed Charges ***THIS IS A PRE-CALCULATED FIELD***.**	(a)	25,393,000
W4BB1.	**Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal 0.0000) ***THIS IS A PRE-CALCULATED FIELD***.**	(b)	0.2426
W4BB2.	**Estimated Costs of Government-sponsored Health Care Provided (a x b) ***THIS IS A PRE-CALCULATED FIELD***.**	(c)	6,160,342

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

W4BC1.	Government Payments		5,052,810
W4BC2.	Payments from Patients		1,518
W4BC3.	Other Payments		3,231,157
W4BC4.	**Total Payments ***THIS IS A PRE-CALCULATED FIELD***.**	(d)	8,285,485
W4BD.	**Estimated Unreimbursed Costs of Government-sponsored Health Care Provided ((c) - (d))2**	(e)	0

1. Do not include charitable contributions and grants.

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

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ESTIMATED VALUE OF TAX EXEMPT BENEFITS
2019

Worksheet 5

Franchise Tax:

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

Net Income plus Officers' and Directors' Compensation x 4.5 percent (.045) (a) 1,019

Ad Valorem Taxes

.

	Amount of Taxes
County Property Tax (Appraised Value of Property (Real andPersonal) x Tax Rate)	1,457
School District Tax (Appraised Value of Property x Tax Rate)	2,875
Hospital District Tax (Appraised Value of Property x Tax Rate)	0
Other Property Taxes (Appraised Value of Property x Tax Rate)	1,847

W5B5. **Total Estimated Ad Valorem Taxes** (b) 6,179

Sales Tax

W5C1. Supplies expense less pharmacy supplies expense 409,554

W5C2. Lease or rental expense 218,927

W5C3. Capital Purchases 11,797

W5C4. Total Estimated Taxable Purchases (1) 640,278

W5C5. Sales Tax Rate.....(**Please report RATE (.0000), not a percent**) (2) 0.0825

W5C6. **Total Estimated Sales Tax (Multiply (1) by (2)) ***THIS IS A PRE-CALCULATED FIELD.** (c) 52,822

Contributions

W5D1. Nondesignated and Charitable Cash Donations received by the hospital 0

W5D2. Fair Market Value of Nondesignated and Charitable In-Kind Donations 0

W5D3. **Total Contributions** (d) 0

Tax-Exempt Bond Financing

W5E1. Average Outstanding Bond Principal x Prevailing Interest Rate at Time of Issuance (1) 0

W5E2. Actual Interest Expense for the Reporting Period (2) 0

W5E3. Value of Tax-Exempt Bond Financing ((1) - (2)) (e) 0

W5F. **TOTAL ESTIMATED VALUE OF TAX EXEMPT BENEFITS ((a)+(b)+(c)+(d)+(e))** (f) 60,020

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II. CHARITY CARE, GOVERNMENT-SPONSORED INDIGENT HEALTH CARE, AND OTHER COMMUNITY BENEFITS INFORMATION - 2019

IIA. Unreimbursed costs of charity care

	Hospital	System Total
IIA1. Unreimbursed costs of providing care to financially and medically indigent (Worksheet 1, (g))	0	
IIA2. Support to financially indigent patients provided through others (Worksheet 2, (d))	60,000	
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	60,000	
IIB. Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))	0	
IIC. Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)	60,000	
IID. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	1,204	
IIE. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	61,204	

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

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

TaxID. Taxpayer Number: 463607347

		Hospital	System
STDI1.	Net Patient Revenue (include Medicaid Disproportionate Share Hospital payments):**(exclude DSRIP= the incentive payments from "Net Patient Revenue) TREAT BAD DEBT AS A DEDUCTION FROM NET REVENUE**	8,040,000	

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

I-2
[ ]

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

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

A.[ ]

		Hospital
STDI3A1.	Tax exempt benefits (Worksheet 5)	60,020
STDI3A2.	Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	0

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

[x] B.

Per Rozila A. Email 7/10/2020. dc

		Hospital	System
STDI3B1.	Tax-exempt benefits (Worksheet 5)	60020	
STDI3B2.	Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year		
STDI3B3.	Total of B.1. and B.2. above	60020	
STDI3B4.	Enter the total from item II.C	60000	

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.[ ]

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

STDI3C2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	_____	_____
STDI3C3. Total of C.1. and C.2. above	_____	_____
STDI3C4. Enter the amount recorded in item II.E.	_____	_____
STDI3C5. Multiply Net Patient revenue (I-1.) by 4%	_____	_____
STDI3C6. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	_____	_____
STDI3C7. Total of C.5. and C.6. above	_____	_____
STDI3C8. Enter the amount recorded in item II.C.	_____	_____

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

[ ] I-4

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

Coordinator Name	Coordinator Title	Phone	Fax	Electronic/internet Mail address
Rozila Aziz	Sr Accountant	(972) 943-6489	(972) 943-6401	raziz@communityhospitalcorp.co

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

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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** 2019

Name of Hospital: _____

County: _____

Mailing Address: _____

Physical Address if different from above: _____

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

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

How often do you revise your charity care policy? _____

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

Name of the office/department: _____

Mailing Address: _____

Contact Person: _____

Title: _____

Phone: ( )_____-_____

Fax: ( )_____-_____

E-Mail: * hpowell@communityhospitalcorp.com

Person completing this form if different from above:

Name: _____

Phone: ( )_____-_____

*This summary form is to be completed by each nonprofit hospital. Hospitals in a system must report on an individual hospital basis. Public hospitals, for-profit hospitals participating in the Medicaid disproportionate share hospital program and exempt hospitals are not required to complete this form. This form is also available in PDF format at DSHS web site: www.dshs.state.tx.us/chs/hosp under 2019 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.