ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2015 TEXAS NONPROFIT HOSPITALS

Part I 56222 **2015 ASCBS** 6740208
CHI St Luke's Health Memorial Specialty Hospital
Lufkin ANGELINA

TYPE: NP DISPRO: Yes
REQUIRED TO REPORT ASCBS: **YES**
MEMORIAL HEALTH SYSTEM OF EAST TEXAS

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.

III	Community Benefits Contribution*	Net Patient Revenue (NPR)**	Miles From System Office	Name of Hospital	Physical Address, City, State, Zip
1.	17,464	12,595,150	0	Memorial Specialty Hospital	1201 West Frank Ave, Lufkin, TX 75904
2.	28,253,470	127,962,216	0	Memorial Medical Center of East Texas	1201 West Frank Ave, Lufkin, TX 75904
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
TOTAL:	28,270,934	140,557,366			

DSH

* 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 - 2015

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

W1A.	Financially Indigent	Medically Indigent	Total Charity Care Charges
Inpatient	10,773	0	10,773
Outpatient	0	0	0
Total	10,773	0	(a) 10,773

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

W1B1. 2014 Gross Patient Service Revenue1, 2;..... * confirm (b) 27,692,573

W1B2. 2014 Total Patient Care Operating Expenses1,3.....**(Bad Debt should be treated as a Deduction)** ..... (c) 4,936,472

W1B3. **Cost to Charge Ratio (Divide (c) by (b)) (please report the ratio as a decimal 0.0000)**
*****THIS IS A PRE-CALCULATED FIELD.** (d) 0.1783

W1C. **Estimated Costs of Charity Care Provided ((a) x (d))** ..... (e) 1,920

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

W1D1. Third-Party Payments..... 3,266

W1D2. Payments from Patients..... NAV 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) 3,266

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

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

C alculation of initial Ratio of Cost to Charge

W1AA1. Total Patient Revenues (from **2014** Medicare Cost Report1, Worksheet G-3, Line 1) (a) 54,879,195

W1AA2. Total Operating Expenses (from **2014**) Medicare Cost Report1, 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 Expense2 (from **2015** audited financial statement covering your reporting period) confirm * (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.

Worksheet 1-A (continued)

Cost Area	Medicare Cost Report Reference*	Amount
		0
		0
		0
		0
		0
		0
		0
		0
		0

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY.
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Support to Financially Indigent Patients Provided Through Others 2015

Funding to: W2A

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

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:	0	0	0

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

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

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

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) 0.1783

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.)

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. **(Champus Payments and DSRIP "SHOULD NOT" be reported here; report "CHAMPUS Payments only in Worksheet 4b.)** 0

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

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

(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 -2015

Worksheet 4-A

Unreimbursed Costs of Subsidized Health Services:

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

Unreimbursed Education - Related Costs:

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

W4AC6. **Total**
*****THIS IS A PRE-CALCULATED FIELD.** (d) 0

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

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EST. UNREIMBURSED COSTS OF INPAT./OUTPAT. MEDICARE, CHAMPUS AND OTHER GOV'T-SPONSORED PROGRAMS - 2015

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 43,565,780

W4BA2. Outpatient 0

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

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) 0.1783

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

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

W4BC1. Government Payments 6,264,889

W4BC2. Payments from Patients 769,477

W4BC3. Other Payments 715,949

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

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

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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 (.045) (a) 0

Ad Valorem Taxes

	Amount of Taxes
County Property Tax (Appraised Value of Property (Real andPersonal) x Tax Rate)	0
School District Tax (Appraised Value of Property x Tax Rate)	0
Hospital District Tax (Appraised Value of Property x Tax Rate)	0
Other Property Taxes (Appraised Value of Property x Tax Rate)	0

W5B5. **Total Estimated Ad Valorem Taxes** (b) 0

Sales Tax

W5C1. Supplies expense less pharmacy supplies expense 0

W5C2. Lease or rental expense 0

W5C3. Capital Purchases 0

W5C4. Total Estimated Taxable Purchases (1) _____

W5C5. Sales Tax Rate.....**(Please report RATE (.0000), not a percent**) (2) 0

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 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) 0

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II. CHARITY CARE, GOVERNMENT-SPONSORED INDIGENT HEALTH CARE, AND OTHER COMMUNITY BENEFITS INFORMATION - 2015

IIA. Unreimbursed costs of charity care

	Hospital	System Total
IIA1. Unreimbursed costs of providing care to financially and medically indigent (Worksheet 1, (g))	0	8,632,352
IIA2. Support to financially indigent patients provided through others (Worksheet 2, (d))	0	61,305
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	0	8,693,657
IIB. Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))	0	0
IIC. Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)	0	8,693,657
IID. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	17,464	19,577,277
IIE. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	17,464	28,270,934

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: 75-2492741

	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**	12,595,150	140,557,366

STDI2. The hospital has been designated as a **disproportionate share hospital** under the state Medicaid program in the period covered by is report (2013) or in either of its two previous fiscal years. Completion of section I-3. or I-4. is not required.

I

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

re and government-sponsored indigent health care are provided at a level which is reasonable in relation to the community 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)	
STDI3A2. 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.

	Hospital	System
STDI3B1. Tax-exempt benefits (Worksheet 5)		
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		
STDI3B4. 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]

	Hospital	System
STDI3C1. Multiply Net Patient Revenue (I-1.) by 5%	629,758	7027869
STDI3C2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	0	0
STDI3C3. Total of C.1. and C.2. above	629,758	7,027,869
STDI3C4. Enter the amount recorded in item II.E.	17,464	28,270,934
STDI3C5. Multiply Net Patient revenue (I-1.) by 4%	503,806	5622295
STDI3C6. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	0	0
STDI3C7. Total of C.5. and C.6. above	503,806	5622295
STDI3C8. Enter the amount recorded in item II.C.	0	8693657

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
Lynn Montes	Internal Auditor	(936) 639-7136	(936) 639-7992	lmontes@memorialhealth.org

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** 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 then 100 %
( ) Less then 133 %
( ) Less then 150 %
(x) Less then 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.

[x] 1. Wages and salaries before deductions
[x] 2. Self-employment income
[x] 3. Social security benefits
[x] 4. Pensions and retirement benefits
[x] 5. Unemployment compensation
[x] 6. Strike benefits from union funds
[x] 7. Worker's compensation
[x] 8. Veteran's payments
[x] 9. Public assistance payments
[x] 10. Training stipends
[x] 11. Alimony
[x] 12. Child support
[x] 13. Military family allotments
[x] 14. Income from dividends, interest, rents, royalties
[x] 15. Regular insurance or annuity payments
[x] 16. Income from estates and trusts
[x] 17. Support from an absent family member or someone not living in the household
[x] 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.

[x] 1. By telephone
[x] 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?

7 business days

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:

_____