

ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2015 TEXAS NONPROFIT HOSPITALS

Part I

2016330

2015 ASCBS

6740237

Please Check "one" your ownership: *

The Menninger Clinic
Houston

HARRIS

- (x) Not-For-Profit
- () For-Profit (received Medicaid Disproportionate Share Funds)
- () Public
- () For-Profit

TYPE: NP DISPRO:
REQUIRED TO REPORT ASCBS: **YES**

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	<u>Community Benefits Contribution*</u>	<u>Net Patient Revenue (NPR)**</u>	<u>Miles From System Office</u>	<u>Name of Hospital</u>	<u>Physical Address, City, State, Zip</u>
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 STD11 (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.	<u>Financially Indigent</u>	<u>Medically Indigent</u>	<u>Total Charity Care Charges</u>
Inpatient	2,617,593	_____	2,341,975 2,617,593
Outpatient	_____	_____	_____
Total	2,617,593	_____	2,341,975 (a) 2,617,593

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

W1B1. **2014** Gross Patient Service Revenue^{1, 2}..... (b) 57,491,446

W1B2. **2014** Total Patient Care Operating Expenses^{1, 3}.....(Bad Debt should be treated as a Deduction) (c) 52,134,045
~~47,041,429~~

W1B3. Cost to Charge Ratio (Divide (c) by (b)) (please report the ratio as a decimal 0.0000) (d) 0.9068
~~0.8182~~
***THIS IS A PRE-CALCULATED FIELD.

W1C. Estimated Costs of Charity Care Provided ((a) x (d)) (e) 2,123,703
~~2,141,714~~

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

*E. Gonzalez
on 06/28/14*

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..... (f) 0
***THIS IS A PRE-CALCULATED FIELD.

23
2,123,703
(g) ~~2,141,714~~

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

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 Report1, Worksheet G-3, Line 1) (a) 54,351,558

W1AA2. Total Operating Expenses (from 2014) Medicare Cost Report1, Worksheet A, Line 118, Col. 7 (b) 57,226,661
~~47,041,429~~

W1AA3. Initial Ratio of Cost to Charge ((b) divided by (a)) (c) 1.0529
~~0.8655~~
***THIS IS A PRE-CALCULATED FIELD.

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) (d) 525,803

W1AB2. Multiply "Bad-Debt Expense" by "Initial Cost to Charge Ratio" to determine allowable Bad-Debt Expense ((d) x (c)) (e) 553,617
~~455,082~~
***THIS IS A PRE-CALCULATED FIELD.

W1AB3. Add the allowable "Bad-Debt Expense" to " Total Operating Expenses" ((b) + (e)) (f) 57,780,278
~~47,496,511~~

W1AC. Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal) (g) 1.0631

E. Gonzalez
on 06/28/16
JG

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

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

Funding to: W2A

W2A.	<u>Other Nonprofit</u>	<u>Public</u>	<u>Total</u>
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	<u>Other Nonprofit</u>	<u>Public</u>	<u>Total</u>
Outpatient Clinic	0	0	0
Hospital	0	0	0
Other Health Care Organizations	0	0	0
Total Other Financial Support	0	0	0

W2C.

W2C.	<u>Other Nonprofit</u>	<u>Public</u>	<u>Total</u>
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 <i>0,9068</i>
W3B1. Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal) ***THIS IS A PRE-CALCULATED FIELD.			(b) 0.8182 <i>0.8182</i>

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.

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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**UNREIMBURSED COSTS OF PROVIDING COMMUNITY BENEFITS
-2015**

Worksheet 4-A

2

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

W4AD. Total Unreimbursed Costs of Providing Community Benefits ((a) + (b) + (c) + (d)) (e) 0
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).

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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 0

W4BA2. Outpatient 0

W4BA3. Total Billed Charges
***THIS IS A PRE-CALCULATED (a) 0
FIELD***.

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.

0.9068 LG
~~(b) 0.8182~~
E. Gonzalez
on 06/28/16
(c) 0

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

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

W4BC1. Government Payments 0

W4BC2. Payments from Patients 0

W4BC3. Other Payments 0

W4BC4. Total Payments
***THIS IS A PRE-CALCULATED (d) 0
FIELD***.

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.

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 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) 102,986

**Ad Valorem
Taxes**

Amount of Taxes

County Property Tax (Appraised Value of Property (Real and Personal) 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 1,332,376

W5C2. Lease or rental expense 179,430

W5C3. Capital Purchases 915,784

W5C4. Total Estimated Taxable Purchases (1) 2,427,590

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) 200,276

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) 303,262

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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))	2,123,703	2,141,714
IIA2. Support to financially indigent patients provided through others (Worksheet 2, (d))	0	_____
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	2,123,703	2,141,714
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.)	2,123,703	2,141,714
IID. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	0	_____
IIE. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	2,123,703	2,141,714

E. Gonzalez
on 06/28/16 23

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

TaxID. Taxpayer Number:

37-1453409

STD11. 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**

Hospital	System
<u>54,504,512</u>	_____

STD12. The hospital has been designated as **adisproportionate 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 I-3. or I-4. is not required.

I-2
[]

13. 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. []

STD13A1. Tax exempt benefits (Worksheet 5)

Hospital

STD13A2. 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.

STD13B1. Tax-exempt benefits (Worksheet 5)

Hospital	System
_____	_____

STD13B2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year

STD13B3. Total of B.1. and B.2. above

STD13B4. 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.)

dmk
~~C~~

STD13C1. Multiply Net Patient Revenue (I-1.) by 5%	Hospital	System
	2,725,226	_____
STD13C2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	0	_____
STD13C3. Total of C.1. and C.2. above	2,725,226	_____
STD13C4. Enter the amount recorded in item II.E.	2,141,714	_____
	2,123,703	_____
STD13C5. Multiply Net Patient revenue (I-1.) by 4%	2,180,180	_____
STD13C6. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	0	_____
STD13C7. Total of C.5. and C.6. above	2,180,180	_____
STD13C8. Enter the amount recorded in item II.C.	2,141,714	_____
	2,123,703	_____

*E. Gonzalez
on 06/28/16*

*2,123,703
~~2,141,714~~
LJ*

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	Coordinator Title	Phone	Fax	Electronic/internet Mail address
Elizabeth Gonzalez	Senior Accountant	(713) 275-5082	(713) 275-5105	egonzalez@menninger.edu

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 DSHS Charity Care Manual as Required by Texas Health and Safety Code, 311.0461** 2015

Name of Hospital: The Menninger Clinic

County: Harris

Mailing Address: 12301 Main Street

Physical Address if different from above: _____

Effective Date of the current policy: 10/01/2014 
(mm/dd/yyyy)

Date of Scheduled Revision of this policy: 06/30/2016 
(mm/dd/yyyy)

How often do you revise your charity care policy? Annually

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

Name of the office/department: Admissions, The Menninger Clinic

Mailing Address: 12301 Main Street

Contact Person: Charles O'Roark

Title: Manager of Admissions

Phone: (713) 275-5000

Fax: (713) 275-5117

E-Mail: * coroark@menninger.edu