ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2018 TEXAS NONPROFIT HOSPITALS

Part I

1676223 2018 ASCBS 6740073
Devereux Texas Treatment Network
League City GALVESTON
TYPE: NP DISPRO:
REQUIRED TO REPORT ASCBS: YES **(NP/ND)**

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? ( ) 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 - 2018

Total Billed Charges for Charity Care Provided (based on 2018 audited fiscal year): (exclude bad debt)

.

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 2017 audited fiscal year):

No Charity
A. Nguyen
6/2019 AO

W1B1. **2017** Gross Patient Service Revenue1, 2;..... (b) 9,488,106

W1B2. **2017** Total Patient Care Operating Expenses1,3.....(**Bad Debt should be treated as a Deduction**) ..... (c) 8,457,658

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) 0.8914

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

Payments Received for Charity Care Provided: (based on 2018 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 2017 to complete the Cost to Charge Ratio Calculation section of this worksheet for FY 2018.

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.

CALCULATION OF THE RATIO OF COST TO CHARGE - 2018

C alculation of initial Ratio of Cost to Charge

W1AA1. Total Patient Revenues (from **2017** Medicare Cost Report1, Worksheet G-3, Line 1) (a) 8,456,945

W1AA2. Total Operating Expenses (from **2017)** Medicare Cost Report1, Worksheet A, Line 118, Col. 7 (b) 6,812,156

W1AA3. **Initial Ratio of Cost to Charge ((b) divided by (a))**
*****THIS IS A PRE-CALCULATED FIELD.** (c) 0.8055

Application of Initial Ratio of Cost to Charge to 2018 Bad-Debt Expense

No Bad debt
6/20/19 AO
A. Nguyen

W1AB1. Bad-Debt Expense2 (from **2018** audited financial statement covering your reporting period) (d) 0

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) 0

W1AB3. **Add the allowable "Bad-Debt Expense" to " Total Operating Expenses" ((b) + (e))**
*****THIS IS A PRE-CALCULATED FIELD.** (f) 6,812,156

W1AC. **Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal)** (g) .8055

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 2017 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	_____	_____	_____
Hospital	_____	_____	_____
Other Health Care Organizations	_____	_____	_____
Total Funding to Others	_____	_____	_____

Financial Support to:

W2B.

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

.

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

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.

ESTIMATED UNREIMBURSED COSTS OF GOVERNMENT-SPONSORED INDIGENT HEALTH CARE - 2018

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)	3,841,200	0	3,841,200
State Government (CSHCN, Primary Care, Kidney Health, etc.)	0	0	0
Local Government (County Indigent Health Care, other)	2,822,481	0	2,822,481
Other Government	0	0	0
Total Billed Charges	6,663,681	0	6,663,681

W3B1. **Ratio of Cost to Charge (Worksheet 1, Item d)** (Please report the ratio as a decimal) *****THIS IS A PRE-CALCULATED FIELD.** (b) 0.8914

W3B2. **Estimated Costs of Government-sponsored Indigent Health Care Provided ((a) x (b)) ***THIS IS A PRE-CALCULATED FIELD.** (c) 5,940,005

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) 3,198,283

W3C2. Medicaid Disproportionate Share Hospital payments 0

w3c22. Uncompensated Care Payments

0

w3c22a. Local Provider Participation Fees (LPPF) received for indigent care _____

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

W3C4. Local Government (County Indigent Health Care, other). 2,500,213

W3C5. Other Government. **(Champus Payments and DSRIP "SHOULD NOT" be reported here; report "CHAMPUS Payments only in Worksheet 4b.)** _____

W3C5A. Please specify source of Other Government payments

_____

W3C6. **Total Payments ***THIS IS A PRE-CALCULATED FIELD.** (d) 5,698,496

W3D. **Estimated Unreimbursed Costs of Government-sponsored Indigent Health Care ((c) - (d))1** (e) 241,509

(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 -2018

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) _____

W4AB2. **Unreimbursed Research-Related Costs** (c) _____

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***.** (e) 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).
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 - 2018

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 FIELD***.** (a) 0

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) 0.8914

W4BB2. **Estimated Costs of Government-sponsored Health Care Provided (a x b) ***THIS IS A PRE-CALCULATED FIELD***.** (c) 0

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 FIELD***.** (d) 0

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

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.

ESTIMATED VALUE OF TAX EXEMPT BENEFITS
2018

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) _____

Ad Valorem Taxes

.

		Amount of Taxes
County Property Tax (Appraised Value of Property (Real andPersonal) x Tax Rate)		_____
School District Tax (Appraised Value of Property x Tax Rate)		_____
Hospital District Tax (Appraised Value of Property x Tax Rate)		_____
Other Property Taxes (Appraised Value of Property x Tax Rate)		_____
W5B5. **Total Estimated Ad Valorem Taxes**	(b) _____	

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** (d) _____

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) 0

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

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.

II. CHARITY CARE, GOVERNMENT-SPONSORED INDIGENT HEALTH CARE, AND OTHER COMMUNITY BENEFITS INFORMATION - 2018

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))	0	
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	0	
IIB. Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))	241,509	
IIC. Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)	241,509	
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.)	241,509	

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).
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.

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

TaxID. Taxpayer Number: 23-1390618

	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**	5,698,496	

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)	
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%	284,925	
STDI3C2.	Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	0	
STDI3C3.	Total of C.1. and C.2. above	284,925	
STDI3C4.	Enter the amount recorded in item II.E. A. Nguyen 6/20/19 AO 241,509	~~243,434~~	
STDI3C5.	Multiply Net Patient revenue (I-1.) by 4%	227,940	
STDI3C6.	Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	0	
STDI3C7.	Total of C.5. and C.6. above	227,940	
STDI3C8.	Enter the amount recorded in item II.C. 241,509	~~243,434~~	

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

[x] I-4

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

Coordinator Name	Coordinator Title	Phone	Fax	Electronic/internet Mail address
Mary-Laura Hadley	Director of Finance	(281) 335-1000	(281) 554-2571	mhadley@devereux.org

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

****

Completed
6/24/19 AO

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** 2018

Name of Hospital:	Devereux Texas Treatment Network
County:	Galveston
Mailing Address:	1150 Devereux Dr., League City, TX 77573
Physical Address if different from above:	_____
Effective Date of the current policy:	02/01/2018 (mm/dd/yyyy)
Date of Scheduled Revision of this policy:	02/01/2019 (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:	Finance
Mailing Address:	1150 Devereux Drive, League City, TX 77573
Contact Person:	Mary-Laura Hadley
Title:	Director of Finance
Phone:	(281) 335-1000
Fax:	(281) 554-2571
E-Mail: *	mhadley@devereux.org

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 2018 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.

To serve the healthcare needs of the community, Devereux Texas Treatment Network will provide charity care without regard to race, creed, color, or national origin to individuals who are classified as financially indigent or medically indigent according to the hospital's eligibility.

2. Provide the following information regarding your hospital's current charity care policy.

a. Provide the definition of **charity care** for your hospital.	
Services provided to financially or medically indigent patients who are uninsured or under insured and are accepted for care with no obligation to pay for services rendered.	

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 patient is a person whose medical or hospital bills after payment by third-party payers exceeds a specific percent of the person's annual gross income as set forth in the policy and who is unable to pay the bill.

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

( ) Yes (x) No

If yes, please briefly summarize method:

_____

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? *

( ) Yes (x) No *

If yes, please check:

[ ] 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)
(x) 2. The hospital uses patient self-declaration
( ) 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%
[ ] 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?

10 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).

_____

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. *

SEE ATTACHED FOR ANNUAL REPORT OF COMMUNITY BENEFITS PLAN.

Additional Information:

_____