ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2018 TEXAS NONPROFIT HOSPITALS

Part I

Please Check "one" your ownership: *

( ) Not-For-Profit

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

(x) Public

( ) For-Profit

3830327 **2018 ASCBS** 6740327
Reagan Memorial Hospital
Big Lake REAGAN
TYPE: PUB 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	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	23,729	0	23,729
Outpatient	84,371	0	84,371
Total	108,100	0	(a) 108,100

Cost to Charge Ratio Calculation (based on 2017 audited fiscal year):

W1B1. **2017** Gross Patient Service Revenue1, 2;..... (b) 9,161,362

W1B2. **2017** Total Patient Care Operating Expenses1,3.....(**Bad Debt should be treated as a Deduction)** ..... (c) 12,339,723

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) 1.3469

W1C. **Estimated Costs of Charity Care Provided ((a) x (d))** ..... (e) 145,599

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) 145,599

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) 8,135,439

W1AA2. Total Operating Expenses (from **2017)** Medicare Cost Report1, Worksheet A, Line 118, Col. 7 (b) 14,040,497 ~~12,339,723~~

Per S. Cannaday on 7/1/2019 L.J.

W1AA3. **Initial Ratio of Cost to Charge ((b) divided by (a))**
*****THIS IS A PRE-CALCULATED FIELD.** (c) 1.7258 ~~1.5168~~

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

W1AB1. Bad-Debt Expense2 (from **2018** audited financial statement covering your reporting period) (d) 2,357,482

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) 4,068,542 ~~3,575,829~~

W1AB3. **Add the allowable "Bad-Debt Expense" to " Total Operating Expenses" ((b) + (e))**
*****THIS IS A PRE-CALCULATED FIELD.** (f) 18,109,039 ~~15,915,551~~

W1AC. **Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal)** (g) 2.2259 ~~1.9563~~

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	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

.

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)	0	276,933	276,933
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	276,933	276,933

W3B1. **Ratio of Cost to Charge (Worksheet 1, Item d)** (Please report the ratio as a decimal) *****THIS IS A PRE-CALCULATED FIELD.** (b) 1.3469

W3B2. **Estimated Costs of Government-sponsored Indigent Health Care Provided ((a) x (b)) ***THIS IS A PRE-CALCULATED FIELD.** (c) 373,001

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) 70,573

W3C2. Medicaid Disproportionate Share Hospital payments 0

w3c22. Uncompensated Care Payments

314,404

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

W3C5A. Please specify source of Other Government payments

N/A

W3C6. **Total Payments ***THIS IS A PRE-CALCULATED FIELD.** (d) 384,977

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).

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		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

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	202,875	
W4BA2.	Outpatient	721,345	
W4BA3.	**Total Billed Charges ***THIS IS A PRE-CALCULATED FIELD***.**	(a) 924,220	
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) 1.3469
W4BB2.	**Estimated Costs of Government-sponsored Health Care Provided (a x b) ***THIS IS A PRE-CALCULATED FIELD***.**		(c) 1,244,832

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

W4BC1.	Government Payments	880,615	
W4BC2.	Payments from Patients	0	
W4BC3.	Other Payments	0	
W4BC4.	**Total Payments ***THIS IS A PRE-CALCULATED FIELD***.**	(d) 880,615	
W4BD.	**Estimated Unreimbursed Costs of Government-sponsored Health Care Provided ((c) - (d))2**		(e) 364,217

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) 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) 0	
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) 0

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

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))	145,599	
IIA2. Support to financially indigent patients provided through others (Worksheet 2, (d))	0	
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	145,599	
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.)	145,599	
IID. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	364,217	
IIE. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	509,816	

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: 75-6003050

		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**	7,043,054	

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 [x] Per S. Cannaday on 7/1/2019 L.J.

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.[ ]

		Hospital	System
STDI3C1.	Multiply Net Patient Revenue (I-1.) by 5%	352,153	
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	352,153	
STDI3C4.	Enter the amount recorded in item II.E.	509,816	
STDI3C5.	Multiply Net Patient revenue (I-1.) by 4%	281,722	
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	281,722	
STDI3C8.	Enter the amount recorded in item II.C.	145,599	

Per L.J. on 7/1/2019

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
Renae Thomas	Interim CFO	(903) 243-0725	(325) 884-2891	renae.thomas@reaganhealth.com

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

****