

**ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2019 TEXAS NONPROFIT HOSPITALS**

**Part I**

Please Check "one" your ownership: \*

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

3032377	<b>2019 ASCBS</b>	6742377
<b>Grace Medical Center</b>		
Lubbock		LUBBOCK
TYPE: NP	DISPRO:	EXCLUDED
REQUIRED TO REPORT ASCBS: <b>Yes</b>		

Are you reporting as part of a hospital system?   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	<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.					
<b>TOTAL:</b>					

\* 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 - 2019**

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



W1A.	<u>Financially Indigent</u>	<u>Medically Indigent</u>	<u>Total Charity Care Charges</u>
Inpatient	<u>390,683</u>	<u>5,246</u>	<u>395,929</u>
Outpatient	<u>6,979,145</u>	<u>44,627</u>	<u>7,023,772</u>
<b>Total</b>	<u>7,369,828</u>	<u>49,873</u>	(a) <u>7,419,701</u>

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

W1B1. **2018** Gross Patient Service Revenue<sup>1, 2</sup>..... (b) 302,704,568

W1B2. **2018** Total Patient Care Operating Expenses<sup>1,3</sup>.....(Bad Debt should be treated as a Deduction) ..... (c) 69,689,486

W1B3. **Cost to Charge Ratio (Divide (c) by (b)) (please report the ratio as a decimal 0.0000)** ..... (d) 0.2302  
**\*\*\*THIS IS A PRE-CALCULATED FIELD.**

W1C. **Estimated Costs of Charity Care Provided ((a) x (d))** ..... (e) 1,708,015

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

W1E. **Estimated Unreimbursed Costs of Charity Care Provided ((e) - (f))<sup>5</sup>..... \*** (g) 1,708,015

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

<sup>2</sup> 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\\_0IENJ4LgFt35DDv](https://tcnws.co1.qualtrics.com/jfe/form/SV_0IENJ4LgFt35DDv)

**CALCULATION OF THE RATIO OF COST TO CHARGE -  
2018**

Calculation of initial Ratio of Cost to Charge

W1AA1. Total Patient Revenues (from <b>2018</b> Medicare Cost Report1, Worksheet G-3, Line 1)	(a) <span style="border: 1px solid red; padding: 2px;">302,704,568</span>
W1AA2. Total Operating Expenses (from <b>2018</b> ) Medicare Cost Report1, Worksheet A, Line 118, Col. 7	(b) <span style="border: 1px solid red; padding: 2px;">70,705,620</span>
W1AA3. <b>Initial Ratio of Cost to Charge ((b) divided by (a))</b> <b>***THIS IS A PRE-CALCULATED FIELD.</b>	(c) <span style="border: 1px solid red; padding: 2px;">0.2336</span>
 <b>Application of Initial Ratio of Cost to Charge to 2019 Bad-Debt Expense</b>	
W1AB1. Bad-Debt Expense2 (from <b>2019</b> audited financial statement covering your reporting period)	(d) <span style="border: 1px solid red; padding: 2px;">2,825,606</span>
W1AB2. Multiply "Bad-Debt Expense" by "Initial Cost to Charge Ratio" to determine allowable Bad-Debt Expense ((d) x (c)) <b>***THIS IS A PRE-CALCULATED FIELD.</b>	(e) <span style="border: 1px solid red; padding: 2px;">660,062</span>
W1AB3. <b>Add the allowable "Bad-Debt Expense" to " Total Operating Expenses" ((b) + (e))</b> <b>***THIS IS A PRE-CALCULATED FIELD.</b>	(f) <span style="border: 1px solid red; padding: 2px;">71,365,682</span>
W1AC. <b>Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal)</b>	(g) <span style="border: 1px solid red; padding: 2px;">0.2358</span>

**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.

<b>Worksheet 1-A (continued)</b>		
<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 2017

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
<b>Total Funding to Others</b>	<b>0</b>	<b>0</b>	<b>0</b>

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
<b>Total Other Financial Support</b>	<b>0</b>	<b>0</b>	<b>0</b>

W2C.

W2C.	<u>Other Nonprofit</u>	<u>Public</u>	<u>Total</u>
<b>Total Support Provided Through Others:</b>	<b>0</b>	<b>0</b>	<b>0</b>

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 -  
2019**

**Worksheet 3**

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

W3A.	<b>Inpatient</b>	<b>Outpatient</b>	<b>Total</b>
Medicaid(include Medicaid Managed Care charges; exclude Medicaid Disproportionate Share AND 1115 WAIVER PAYMENTS payments)	<u>1,461,528</u>	<u>7,828,495</u>	<u>9,290,023</u>
State Government (CSHCN, Primary Care, Kidney Health, etc.)	<u>7,313</u>	<u>39,171</u>	<u>46,484</u>
Local Government (County Indigent Health Care, other)	<u>0</u>	<u>0</u>	<u>0</u>
Other Government	<u>0</u>	<u>0</u>	<u>0</u>
<b>Total Billed Charges</b>	<u>1,468,841</u>	<u>7,867,666</u>	<u>9,336,507</u>

W3B1. **Ratio of Cost to Charge (Worksheet 1, Item d)** (Please report the ratio as a decimal)  
\*\*\*THIS IS A PRE-CALCULATED FIELD. (b) 0.2302

W3B2. **Estimated Costs of Government-sponsored Indigent Health Care Provided ((a) x (b))**  
\*\*\*THIS IS A PRE-CALCULATED FIELD. (c) 2,149,263

**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) 790,168

W3C2. Medicaid Disproportionate Share Hospital payments 0

w3c22. Uncompensated Care Payments  
1,645,098

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) 2,435,266

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	_____
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. <b>Total</b> ***THIS IS A PRE-CALCULATED FIELD.	(a) <u>0</u>
W4AB1. <b>Donations Made by the Hospital</b>	(b) _____
W4AB2. <b>Unreimbursed Research-Related Costs</b>	(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** (d) 0  
**\*\*\*THIS IS A PRE-CALCULATED FIELD.**

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

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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 18,422,321

W4BA2. Outpatient 98,676,894

W4BA3. **Total Billed Charges** (a) 117,099,215  
**\*\*\*THIS IS A PRE-CALCULATED FIELD\*\*\*.**

W4BB1. **Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal 0.0000)** (b) 0.2302  
**\*\*\*THIS IS A PRE-CALCULATED FIELD\*\*\*.**

W4BB2. **Estimated Costs of Government-sponsored Health Care Provided (a x b)** (c) 26,956,239  
**\*\*\*THIS IS A PRE-CALCULATED FIELD\*\*\*.**

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

W4BC1. Government Payments 18,485,089

W4BC2. Payments from Patients 834,200

W4BC3. Other Payments 0

W4BC4. **Total Payments** (d) 19,319,289  
**\*\*\*THIS IS A PRE-CALCULATED FIELD\*\*\*.**

W4BD. **Estimated Unreimbursed Costs of Government-sponsored Health Care Provided ((c) - (d))2** (e) 7,636,950

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) \_\_\_\_\_

**Ad Valorem  
Taxes**

**Amount of Taxes**

County Property Tax (Appraised Value of Property (Real and Personal) 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)	_____
<b>W5B5. Total Estimated Ad Valorem Taxes</b>	<b>(b) _____</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) \_\_\_\_\_

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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))	<u>1,708,015</u>	_____
IIA2. Support to financially indigent patients provided through others (Worksheet 2, (d))	0	_____
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	<u>1,708,015</u>	_____
II B. Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))	0	_____
II C. Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)	<u>1,708,015</u>	_____
II D. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	<u>7,636,950</u>	_____
II E. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	<u>9,344,965</u>	_____

**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: \_\_\_\_\_

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**      Hospital      System  
 \_\_\_\_\_  
 \_\_\_\_\_

**61,519,522**

STDI2. The hospital has been designated as **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 appropriate 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.

STDI3A1. Tax exempt benefits (Worksheet 5)      Hospital  
 \_\_\_\_\_

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.

STDI3B1. Tax-exempt benefits (Worksheet 5)      Hospital      System  
 \_\_\_\_\_  
 \_\_\_\_\_

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%	3,075,976	_____
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	3,075,976	_____
STDI3C4. Enter the amount recorded in item II.E.	9,344,965	_____
STDI3C5. Multiply Net Patient revenue (I-1.) by 4%	2,460,781	_____
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	2,460,781	_____
STDI3C8. Enter the amount recorded in item II.C.	1,708,015	_____

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
<u>Tina Frazier</u>	<u>Coordinator</u>	<u>(806) 788-4000</u>	<u>(806) 788-4218</u>	<u>tina.frazier@gracehealthsystem</u>

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

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