IV. Attachments

Attachments Contents

Reference	Description
Attachment 1	2018 Medicare Cost Report Package

[This Attachment contains proprietary, competitively sensitive information redacted from the public version.]

FILED UNDER SEAL

Reference	Description
Attachment 2	Hendrick Health Service Line Summary

Attachment 2: Hendrick Health Service Line Summary

Clinical Service Line	HMC	ARMC
Anesthesiology	✓	✓
Asthma Care	✓	
Audiology	✓	
Cardiology	✓	✓
Cancer Care	✓	
Diabetes Care	✓	✓
Dialysis	✓	✓
Ear, nose & throat	✓	✓
Emergency Care	✓	✓
Gastroenterology	✓	✓
Health & Fitness Services	✓	✓
Home Health	✓	
Hospice Care	✓	
Hospitalist	✓	✓
Internal Medicine	✓	✓
Laboratory Services	✓	✓
Neurosciences	✓	✓
Occupational Health Services	✓	
Ophthalmology	✓	✓
Orthopedics	✓	✓
Pain Management	✓	
Palliative Care	✓	
Pastoral Care	✓	✓
Pathology	✓	✓
Pediatrics	✓	✓
Pharmacy	✓	✓
Podiatry	✓	✓
Pregnancy & Birth	✓	✓
Radiology & Diagnostic Imaging	✓	✓
Rehabilitation & Therapy	✓	✓
Sleep Disorder Treatment	✓	
Surgery	✓	✓
Transitional Services	✓	
Urology	✓	
Women's Health	✓	✓
Wound Care	✓	✓

✓ - *Service Line Present at Location*

Reference	Description
Attachment 3	Charity Care Policies

Origination:	*12/12/2016*
Last Approved:	*6/16/2020*
Last Revised:	*6/16/2020*
Next Review:	*6/16/2023*
Owner:	*Adalia Provance: Contract Manager*
Policy Area:	*Board of Trustees*
Standards & Regulations:	
References:	

Financial Assistance Policy including Charity Classification, 2.1003

POLICY STATEMENT:

Hendrick Medical Center will provide medically necessary and appropriate treatment to all individuals regardless of their ability to pay. In compliance with IRS Section 501(r), this approved policy fulfills the requirement that Hendrick Medical Center's financial assistance policy and billing and collections policy be adopted by an authorized governing body of the hospital.

RULES:

1. There will be no discrimination under these policies related to eligibility or the provision of assistance because of race, color, creed, religion, sex or national origin.
2. Emergent or Medically Necessary services are defined as inpatient and outpatient services for uninsured or underinsured patients who cannot afford to pay for hospital services according to the guidelines of this policy. Financial assistance does not include contractual allowances from government programs and Insurance, or Uninsured Patient discounts, but may include insurance co-payments or deductibles or both as well as exhausted benefits. Qualified patients will have no obligation, or a discounted obligation to pay for any services received which are deemed to be eligible under the Hospital's Financial Assistance Program.
3. Assistance will only be considered after all efforts to obtain third party coverage have been exhausted.
4. Applicants must provide accurate and complete information regarding their financial circumstances by completing an application or Request for Assistance (RFA). Applications can be obtained at no cost through the Resource Assistance office on the hospital campus of 1900 Pine Street, Abilene Texas, by calling the Resource Assistance office at 325-670-4160, through the Emergency Department, or going online at www.HendrickHealth.org. Applications and required financial documentation must be returned to the Financial Assistance Office for review. The Resource Assistance Office is also available to assist individuals in completing the Financial Assistance Application. Misrepresentation of any facts may be cause for denial of assistance.
5. The Financial Assistance Policy will be made available on the Public Website and is readily available at all registration areas including the Emergency Department. A Spanish translation of the Financial Assistance Policy can be requested by calling the Business Office at 325-670-2434 or the Resource Assistance Office at 325-670-4160.

6. The applicant is responsible for providing all supporting documentation required by the program. Failure to furnish required information within established time frames will be cause for denial. The facility will make every reasonable attempt through two letters to contact the patient for requested information. If the requested information is not received, the facility will begin the statement and collection process outlined in #18.
7. The applicant will be notified in writing of approval or denial. Reason for denial will be stated.
8. If an applicant is denied for assistance he or she has the right to appeal the decision by writing a letter of appeal to the Business Office Director. The letter should be delivered or mailed to 1900 Pine Street, Abilene, TX 79601.
9. The level of assistance is based on household income (which includes cash assets) and family size. Household income will be compared to Federal Poverty Income Levels (FPIL) adjusted for family size. To qualify as a member of the household, one must be an immediate family member of minor age or a full time student. Poverty guidelines are updated annually.
   When household income is below 250% of the FPIL the applicant will be granted full assistance or 100% of billed charges.
   When household income is above 250% of the FPIL the applicant will be granted partial assistance. This means the applicant will pay a portion of the Gross Billed charges. The discounts are applied according to the "sliding scale" below. Hendrick Medical Center will not charge any Financial Assistance eligible person more than the AGB amount.
10. Hendrick Medical Center will use the look back method to ensure approved financial assistance applicants are not being billed more than the amounts generally billed to individuals having insurance coverage. Payments from Commercial payers (including patient share) will be used to determine this percentage. The lookback method will be calculated at the end of each selected 12 month period and the AGB percentage will become effective no later than 120 days from the end of the 12 month period. This amount will be calculated on an annual basis and be reflected in the Financial Assistance Policy. The public may request a written explanation of the methodology for obtaining the AGB by requesting through the Business Services Office at 325-670-2437.

HENDRICK MEDICAL CENTER

INCOME BASED DISCOUNT MATRIX FOR 09/01/2016

Based on HHS poverty guidelines information located at http://aspe.hhs.gov/poverty/poverty.htm $11,880.00 for the first family member and $4,160 for each additional family member.

	FAMILY SIZE & INCOME									
	1	2	3	4	5	6	7	8	9	10
FPIL/MONTH	990	1,335	1,680	2,025	2,370	2,715	3,061	3,408	3,754	4,101
FPIL/YEAR	11,880	16,020	20,160	24,300	28,440	32,580	36,730	40,890	45,050	49,210

DISCOUNT %	PATIENT %	INCOME AS A % OF FPIL	FAMILY SIZE & INCOME (Including Cash Assets)									
			1	2	3	4	5	6	7	8	9	10
100%	0%	250%	29,700	40,050	50,400	60,750	71,100	81,450	91,825	102,225	112,625	123,025
98%	2%	251% - 260%	30,888	41,652	52,416	63,180	73,944	84,708	95,498	106,314	117,130	127,946
95%	5%	261% - 270%	32,076	43,254	54,432	65,610	76,788	87,966	99,171	110,403	121,635	132,867
92%	8%	271% - 280%	33,264	44,856	56,448	68,040	79,632	91,224	102,844	114,492	126,140	137,788
90%	10%	281% - 290%	34,452	46,458	58,464	70,470	82,476	94,482	106,517	118,581	130,645	142,709
88%	12%	291% - 300%	35,640	48,060	60,480	72,900	85,320	97,740	110,190	122,670	135,150	147,630
86%	14%	301% - 325%	38,610	52,065	65,520	78,975	92,430	105,885	119,373	132,893	146,413	159,933
84%	16%	326% - 350%	41,580	56,070	70,560	85,050	99,540	114,030	128,555	143,115	157,675	172,235
82%	18%	351% - 375%	44,550	60,075	75,600	91,125	106,650	122,175	137,738	153,338	168,938	184,538
80%	20%	376% - 400%	47,520	64,080	80,640	97,200	113,760	130,320	146,920	163,560	180,200	196,840
		> 400%	Not Financially Eligible for Income Based Discounts - Consider for Medical Indigency or Uninsured Discount									

11. Once Financial Assistance eligibility is determined, the individual will not be charged more for emergency or other medically necessary care than the amounts generally billed (AGB) to individuals who have insurance covering such care.
12. The Hospital reserves the right to limit charity care on a monthly and annual basis consistent with Texas state law and the right to refuse Financial Assistance for elective services. Income based discounts for qualified applicants are available for all emergency and other medically necessary care provided by the hospital.
13. The following information is required for consideration for Financial Assistance Eligibility:
    - Gross household income
    - Cash Assets
    - Family Size
    - Employment Status
    - Bank Statements (2 month minimum)
    - Other financial resources such as unemployment benefits
    - Other financial obligations
    - The amount and frequency of hospital/medical bills
    - Federal Poverty Income Guidelines
    - Completion of the Hospital's Financial Assistance application form with supporting documentation received within the required time frame.

- Most current tax return or current income verification
- Pay Stubs (2 month minimum)
- Social Security award letter, proof of deposit or copy of SS check
- Veterans Administration letter, proof of deposit or copy of VA check
- Detail or monetary amount of level of support being provided by the indigent care providers such as Red Cross and/or household members or letter of gross income from employer.
- Payer exhausted benefit coverage for covered services to determine presumptive eligibility

14. Cash assets are included in determining income. Cash assets are defined as current cash value of checking account, savings account, cash surrender value of Life Ins, stocks, bonds CD's, mutual funds, and other similar investments.
15. A Medically Indigent patient is a person with a catastrophic illness or injury whose unpaid hospital charges exceed their ability to pay and their gross household income does not exceed 400% of the current Federal Poverty Guidelines. The amount owed by the patient on the hospital bill after payment by third party payers must meet or exceed 20% of their annual gross household income. Patients must complete a financial assistance application provide all required financial documentation (#13) and be determined eligible as a medically indigent patient to have their financial obligation discounted. The Medically Indigent discount will coincide with the income based discount matrix in # 10.
16. Bad debts will be considered for assistance if they are 6 months or less old from the date of application. If a bad debt is older than 6 months old, a letter can be written to the Business Office Supervisor explaining circumstances and why the
applicant would like for the account to be considered for assistance. Each patient is looked at case by case and it is also taken into consideration if the applicant has a payment history on active accounts.
17. Financial indigence status is granted and reviewed on a six-month basis from the date of application.
18. When a patient portion is assigned as a result of the sliding scale, an acceptable payment plan is expected. If nonpayment occurs, the account will be moved through the collection process to a collection agency with possible debt reporting. The account will be aged no less than 300 days prior to going to bad debt.
    - Collection Process
        1. Four patient statements to be mailed to patients address on file. Statements sent in 30 day increments up to 150 days.
        2. Placement with primary collection agency. Average placement 150 days. Agency will send a minimum of one letter and will attempt multiple calls.
        3. Placement with secondary collection agency. Agency will send a minimum of one letter and will attempt multiple calls.
19. Approval for assistance must come from the appropriate level of management. Applications are reviewed and approved at the Business Services Supervisor level. Any single discounts over $10,000 must be approved on a transaction by transaction basis according to the table below.

$10,000 -$50,000	Director of Business Services
Over $50,000	Chief Financial Officer or his designee

20. Presumptive eligibility is granted to currently qualified Medicaid, CIHCP, and Alliance for Women and Children recipients. Presumptive Eligibility is awarded at 100%.

21. Income Based Discounts (IBD)/charity adjustments for qualified Medicaid, CIHCP, and Alliance for Women and Children recipients require only proof of eligibility through NextBar/Passport and/or system notes. Authorization as outlined in rule #19 will apply.
22. Presumptive eligibility is also determined by using a third-party (PARO) to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry recognized predictive model that is based on public record databases. The model's rule-based, electronic technology is calibrated to Hendricks historical approvals for financial assistance under the general application process. Any payments made to presumptive eligibility accounts will be refunded upon completion of the written application for charity assistance.
23. Any services for Crime Victim patients who have services after 30 consecutive days and related to the crime will be considered for charity if required documentation is provided. Presumptive Eligibility is awarded at 100%
24. Presumptive eligibility is granted to deceased patients who have no will to be probated. Presumptive Eligibility is awarded at 100%
25. For deceased patients with an account balance $2,500.00 or less only minimal evidence will be required to demonstrate there is no estate or no other responsible party this qualifying the visit for assistance. Presumptive Eligibility is awarded at 100%
26. For homeless patients they must have no temporary or permanent address and make a declaration that they are homeless. Research must be done by using all resources available to establish that the patient is homeless. Presumptive Eligibility is awarded at 100%
27. Self-pay, uninsured patients are granted a 35% discount upon verification of no insurance and offered additional 15% discount for payment in full within 30 days of bill date.
28. Please see addendum A for a listing of providers providing care at Hendrick Medical Center.
29. HPN and HAN providers **do not** participate in the Charity Assistance Program.

Attachments

No Attachments

Approval Signatures

Approver	Date
Jeremy Walker: CFO/VP, Finance	6/16/2020
Pam Light: Administrative Coordinator	3/9/2020

Subject:	Originally Issued	Date of This Revision	Page	No.
FINANCIAL ASSISTANCE/CHARITY CARE POLICY		*2/18/14*		

POLICY STATEMENT:

In order to serve the health care needs of our community, Abilene Regional Medical Center will provide financial assistance/charity care to patients without financial means to pay *for Inpatient and Emergency Room hospital services.*

Financial Assistance/Charity care will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent according to the hospital's eligibility criteria.

PURPOSE:

To properly identify those patients who are financially indigent, who do not qualify for state and/or government assistance, and to provide assistance with their Inpatient and Emergency Room medical expenses under the guidelines for Financial Assistance/Charity Care.

ELIGIBILITY FOR FINANCIAL ASSISTANCE/CHARITY CARE

1. **FINANCIALLY INDIGENT:**

   A. A financially indigent patient is a person who is uninsured and is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the hospital's eligibility criteria as set forth in this Policy.

   B. To be eligible for charity care as a financially indigent patient, the patient's total household income shall be at or below 100% of the current Federal Poverty Income Guidelines. The hospital may consider other financial assets and liabilities for the person when determining eligibility.

   C. The hospital will use the most current Federal Poverty Income Guideline issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent patient. The Federal Poverty Income Guidelines are published in the Federal Register in January or

February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication.

D. In no event will the hospital establish eligibility criteria for financially indigent patients which sets the income level for charity care lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 100% of the current Federal Poverty Income Guidelines. However, the hospital may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the charity care needs of the community.

E. Patients covered by out of state Medicaid where the hospital is not an authorized provider and where the out of state Medicaid enrollment or reimbursement makes it prohibitive for the hospital to become a provider, will be eligible for charity upon verification of Medicaid coverage for the service dates, since they will be considered uninsured. No other documents will be required in order to approve the charity application. The patient will not be required to make a formal financial assistance/charity application. The hospital may submit the application and verification of Medicaid coverage as proof of qualification.

2. **MEDICALLY INDIGENT:**

A. A medically indigent patient is a person whose medical bills after payment by third party payers exceed a specified percentage of the person's annual gross income and who is unable to pay the remaining bill.

B. Patients covered under state Medical Assistance programs that owe copayments or have a 'spend down' amount are excluded from being considered for financial assistance/charity care. Payment of copayments and spend down amounts are a condition of coverage and should not be written off or discounted.

C. Medically indigent patients are not eligible for charity care due to having third party coverage for their medical bills.

THE PROCESS

1. **Identification of Charity Cases:**

A. The hospital maintains posted signs, in English, *Exhibit "A"* and Spanish, *Exhibit "B"*, one in each admitting offices and one in the emergency lobby that inform customers that charity care is available and what are the charity care criteria. **(SIGNS WILL BE POSTED ONLY IF STATE REQUIRES or if hospital has participated in the Hill Burton Program and will comply with hospital state laws which will be attached to this policy)**

B. All uninsured patients will be provided the income and family size criteria for qualifying for charity and if they meet the income requirements will be asked to

complete the Financial Assistance form "FA", *Exhibit "C",* during the registration or financial counseling process.

C. Where required by state law, (copy attached if applicable) hospital will provide written information about the availability of financial assistance/charity care during the registration process.

D. Where required by state law, (copy attached if applicable) hospital will post information regarding the availability of charity care on the hospital's web site.

E. Where required by state law, (copy attached if applicable) hospital will provide information on all billing notices about the availability of financial assistance/charity care.

F. All uninsured patients will be screened for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process an "FA" will be completed if it is determined that the patient does not appear to qualify for coverage under any program.

G. The "FA" will be sent to the Business Office for final determination by the Financial Counselor or Business Office Manager.

H. If the Financial Counselor determines through the application and documented support that the patient qualifies for financial assistance/charity care she/he will give the completed and approved "FA" to the Business Office Director for approval authorization, prior to write off.

I. The following documents will be required to process the application: current monthly expenses/bills, previous year's income tax return, current employers check stub, proof of any other income, bank statements for prior 3 months, and all other medical bills. The hospital has the option to pull a credit report to verify information and determine if there are credit cards with available credit that the balance, or portion thereof, could be charged to the credit card. Where patient/guarantor indicates no income, no bank account or does not file taxes, a credit report is required and must be reviewed to determine if there is conflicting information that indicates income. However, if the patient is covered by Medicaid or other similar State or Federal programs (such as Family Planning) a credit report would not be required since income verification has already been validated in order for the patient to be covered under such program. Unless the patient can explain why the credit report reflects conflicting information such as open lines of credit that are current, mortgage loans that are current, credit cards that are current(any one or combination), or credit scores above 600, the charity care application will be denied. Acceptable explanations such as recent loss of employment must be supported through documentation such as termination letter or a letter from prior employer stating that the patient/guarantor is no longer employed as of (date). Low credit scores (below 500) will be indication of support for statements such as 'do not file taxes or have no bank account'. Where the patient/guarantor indicates they do not file federal tax returns, the hospital will request that the patient/guarantor complete IRS form 4506-T (Request for Transcript of Tax Return). The patient/guarantor should complete lines 1-5

after the hospital has completed lines 6-9. Hospital will complete line 6 by entering '1040', will check boxes 6(a) and box 7. In box 9, hospital will enter prior year and prior 3 years. (Exhibit F-example and a blank form).

J. The Financial Counselor will contact any vendor who may be working the account, to stop all collection efforts on the account.

K. Once approved for Financial Assistance/Charity, the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to self pay.

L. If the "FA" is incomplete it will be the responsibility of the Financial Counselor to contact the patient via mail or phone to obtain the required information.

M. Applications that remain incomplete after 30 days of 'request of information', and determination has been made that patient does not qualify for Medicaid, may be denied or submitted to the CFO for their consideration/approval. (see # 4 on Page 5)

N. The application may be reopened and reconsidered for financial assistance/charity once the required information is received.

O. The Business Office Director, Assistant BOM or Patient Access Manager is responsible for reviewing every application to make sure required documents are attached, prior to submitting to CFO or CEO for review and approval. All fields on the application must be completed properly. Drawing lines through fields such as income is not appropriate. If the income is zero, zeros must be entered.

P. Medicaid patients who receive covered IP and ER services that meet Medicare medical necessity, but have exhausted state benefit limits (IE limited IP days or limited annual ER visits, for example), limits or have limited Medicaid coverage, such as family planning, will not be required to provide any supporting documents providing verification of Medicaid coverage for the service dates is completed.

Q. Once an account has been written off to bad debt, the patient will not be allowed to apply for Financial Assistance/Charity Assistance.

2. FACTOR TO BE CONSIDERED FOR CHARITY DETERMINATION

A. The following factors are to be considered in determining the eligibility of the patient for charity care:

1. Gross Income
2. Family Size
3. Employment status and future earning capacity
4. Other financial resources

5. Other financial obligations
6. The amount and frequency of hospital and other medical bills

B. The income guidelines necessary to determine the eligibility for charity are attached on *Exhibit "D"*. The current Federal Poverty Guidelines are attached as *Exhibit "E"* and they include the definition of the following:

1. Family
2. Income

3. FAILURE TO PROVIDE APPROPRIATE INFORMATION

A. Failure to provide information necessary to complete a financial assessment within 30 days of the request may result in a negative determination.
B. The account may be reconsidered upon receipt of the required information, providing the account has not been written off to bad debt.

4. EXCEPTION TO DOCUMENTATION REQUIREMENTS

The CFO may waive the documentation requirements and approve a case for Financial Assistance/Charity Care, at his/her sole discretion based on their belief the patient does/should qualify for charity. The amount or percentage of charity care discount will be left to the CFO's discretion. Waiver of the documentation requirements should be noted in the comments section on the patient's account, as well as the percent or dollar amount approved for Charity adjustment, printed out and attached to the Financial Assistance (FA) form.

5. TIME FRAME FOR ELIGIBILITY DETERMINATION

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.

6. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF

Once the eligibility determination has been made, the results will be documented in the comments section on the patient's account and the completed and approved "FA" will be filed attached to the adjustment sheet and maintained for audit purposes. The CEO, CFO, BOM will signify their review and approval of the write-off by signing the bottom of the Charity Care/Financial Assistance Program Application form. The signature requirements will be based on the CHS financial policy for approving adjustments.

7. REPORTING OF CHARITY CARE

Information regarding the amount of charity care provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

8. POLICY REVIEW AND APPROVAL

The below individuals have read and approved this policy:

Hospital CEO	Date 2/26/14
Hospital CFO	Date 2/26/14
Corporate VP, Patient Financial Services	Date 2/27/14
Division VP, Finance	Date 3/4/14

Exhibit A
Example of 'Availability of Charity Care" Sign-English Version

CHARITY CARE POLICY

This hospital will provide care to persons who are unable to pay for their care.

In order to be eligible for charity care, you must:

- **Have no other source of payment such as insurance, governmental assistance or savings; or**
- **Have hospital bills beyond your financial resources; and**
- **Provide proof of income and income resources; and**
- **Complete an application and provide information required by the hospital.**

Forms and information about applying for charity care are available upon request.

Exhibit B
Example of 'Availability of Charity Care" Sign-Spanish Version

REGLAS PARA SERVICIOS DE CARIDAD

El hospital ofrece servicios gratuitos a personas que no pueden pagar por su atencion medica.

Para obtener derecho a servicios caritativos, se necesita tener los siguientes requisitos:

No tener otro medio de pagar, por ejemplo, seguro medico, asistencia del gobierno federal, o sus propios ahorros o bienes

Tener cuentas de hospital que esten mas alla de sus recursos economicos.

Tambien hay que:

Presentar pruebas de sus ingresos y recursos economicos

Completar la solicitud de servicio y dar la informacion que le pide al hospital.

Formularios con informacion y datos tocante a la solicitacion de servicios caritativos se proveeran. A aquellos individuos interesados.

Exhibit C
Financial Assistance Form
Abilene Regional Medical Center
Charity Care/Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

PATIENT INFORMATION	PARENT/GUARANTOR/SPOUSE
Name_____	Name_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
SS#_____	SS#_____
Employer_____	Employer_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
Work Phone_____	Work Phone_____
Length of Employment_____	Length of Employment_____
Supervisor_____	Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Exhibit C (continued)
Charity Care/Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____
VA Benefits: $_____
Workers' Comp: $_____
SSI: $_____
Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____
VA Benefits: $_____
Workers' Comp: $_____
SSI: $_____
Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other (explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 3 months bank statements, last 4 pay check stubs, if applicable, or a letter from employer, or letter from Social Security, etc. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application: _____

==========

The below signatures is indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.

Approval/Authorization of Charity Write-Off **Amount Approved $**_____

BOM_____ **CEO**_____
CFO_____

Exhibit D
(EXAMPLE-remove this line from your final approved policy)
Income Guidelines For Determining % of Charity Care Discount
(For Financially Indigent Patients)

Based on Current Year's Federal Poverty Income Guidelines

% of Poverty Income	Discount from charges
Equal to or Below Poverty	100%

The above is intended to provide an example of what a hospital might want to consider and is not the standard income or charity discounts suggested. Hospitals should discuss with their Division VP of Finance Hospitals should remove this paragraph from their final approved policy..

Exhibit E
Federal Poverty Income Guidelines 2014

Reference: Federal Register: January 22, 2014, Volume 79, Number 14 pp. 3593-3594

2014 Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty Income Guideline
1	$11,670
2	15,730
3	19,790
4	23,850
5	27,910
6	31,970
7	36,030
8	40,090
For families/households with more than 8 persons, add $4,060 for each additional person.	

2014 Poverty Income Guidelines for Hawaii

Persons in family/household	Poverty Income Guideline
1	$13,420
2	18,090
3	22,760
4	27,430
5	32,100
6	36,770
7	41,440
8	46,110
For families/households with more than 8 persons, add $4,670 for each additional person.	

2014 Poverty Income Guidelines for Alaska

Persons in family/household	Poverty Income Guideline
1	$14,580
2	19,660
3	24,740
4	29,820
5	34,900
6	39,980
7	45,060
8	50,140
For families/households with more than 8 persons, add $5,080 for each additional person.	

EXHIBIT F

(Attach IRS Form 4506-T blank form and example of completed form)

Reference	Description
Attachment 4	Patient Choice Policies

HENDRICK HEALTH SYSTEM

Origination: *10/13/2020*
Last Approved: *10/13/2020*
Last Revised: *10/13/2020*
Next Review: *10/13/2023*
Owner: *Elizabeth Henry: Director, Case Management*
Policy Area: *Case Management*
Standards & Regulations:
References:

Job Guide: Case Management

PURPOSE:

POLICY:

TABLE OF CONTENTS

XX. Maintenance of HHA and SNF Provider List.

[redacted]

XXIII. Mental Health Mental Retardation (MHMR)

XXIV. Nursing Home/ Skilled Nursing Facility (SNF) Referral

[redacted]

XXVI. Outpatient IV Antibiotics

[redacted]

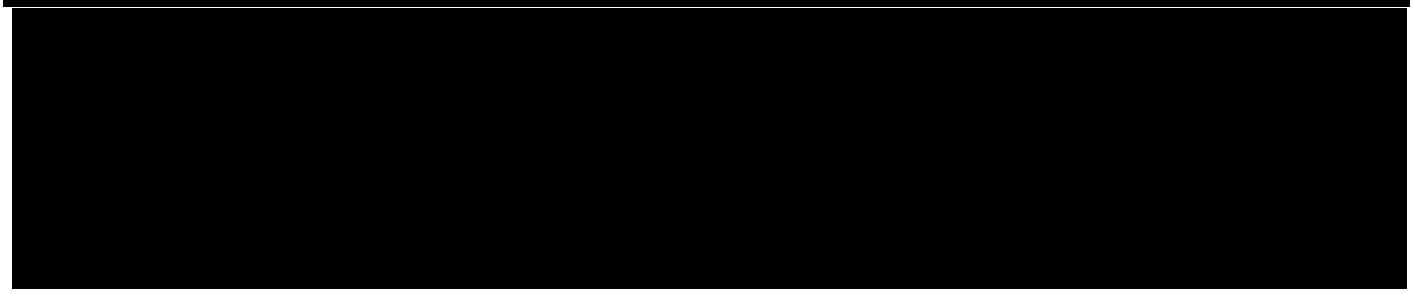
XLIII. Outpatient Dialysis

XLIV. Primary Care Follow-up

XLV. Outpatient Rehab

[redacted]

[redacted]



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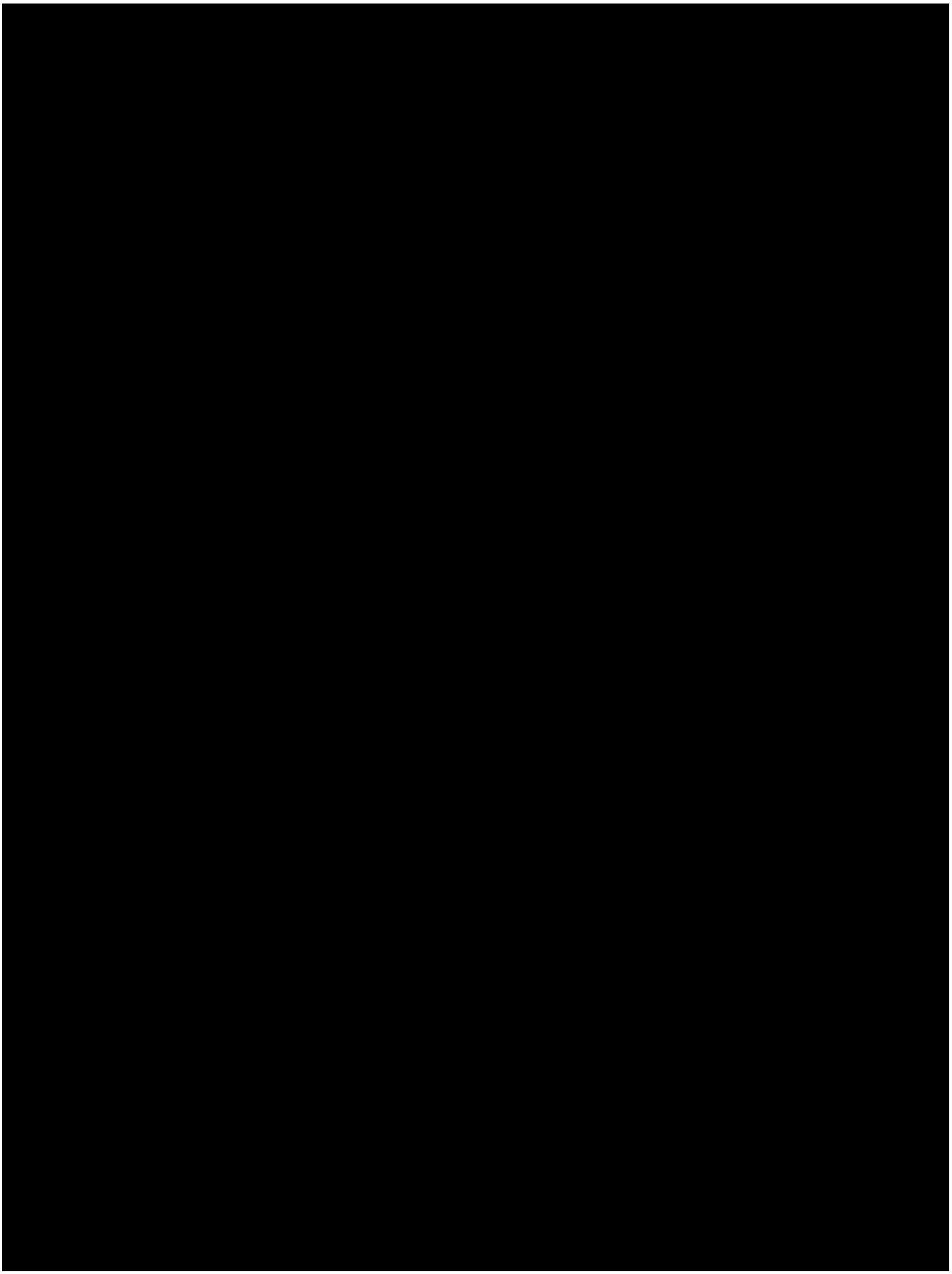


Arranging for Outpatient Wound Care/HBO and Uncomplicated Cellulitis

1. Case Manager/Social Worker to meet with patient and family to provide options for outpatient wound care/HBO.

2. Referral will be made to the Wound Care Center of patient's choice.

3. If HMC Wound Care Center (main) is chosen, a referral is made to Centralized Scheduling (x4270) for next available appointment. For HMC South call referral to 428-2800 and for HMC Brownwood call referral to 649-3640. CM/SW is to coordinate this appointment with the Wound Care Team.

4. For Uncomplicated Cellulitis from the Emergency Department, appointments have been reserved for wound care and infusion.

5. Fax physician order and face sheet to Centralized Scheduling

6. Provide information to nursing and patient.

7. Provide patient with a discharge card with appointment information such as time, location, and date.

[redacted]

Assisted / Independent Living Facilities

1. Case Manager/Social Worker to provide list of facilities to the patient and family to review.
2. The patient and family must follow up with facility choice to make initial contact and facilitate arrangements.
3. Case Manager/Social Worker able to fax referral if requested by facility of choice.
4. Case Manager/Social Worker assists with appropriate transportation as needed.

[redacted]

Durable Medical Equipment Referral (DME)

Procedure for arranging durable medical equipment

1. After order received and chart reviewed, Case Manager and/or Social Worker to discuss qualifiers and insurance criteria for obtaining home DME with patient/patient representative.
2. Inform patient and families of DME providers.
3. Once provider selected, choice sheet will be signed and placed in chart.
4. Referral made to provider of choice including required DME forms and Title 19 if applicable.

5. Complete Discharge Card with provider information/phone number and provide to patient/patient representative.

[redacted]

[redacted]

Home Health Referral

Procedure for arranging home health services

1. After order received and chart reviewed, Case Manager and/or Social Worker to discuss qualifiers

and insurance criteria with patient/patient representatives for obtaining home health services. Must have a Primary Care Provider in order to receive home health services.

2. Inform patient/patient representative of Home Health providers.

3. Once provider selected, choice sheet will be signed and placed in chart.

4. Referral made to provider of choice.

5. Complete Discharge Card with provider information/phone number and provide to patient and patient representative.

Hospice Referral

Procedure for arranging hospices services

1. After order received and chart reviewed, Case Manager and/or Social Worker to discuss hospice providers with patient/patient representative.

2. Referral made to provider of choice.

3. Hospice agency will evaluate for appropriate level of hospice service. If hospice is deemed appropriate, they will work with patient to make arrangements for home hospice or inpatient hospice.

4, Case Manager and/or Social Worker will assist with completion of Out of Hospital Do Not Resuscitate and ambulance transport as needed.

Maintenance of HHA and SNF Provider List

Case Management will maintain Hendrick Medical Center's (HMC) list of Home Health Agencies (HHA) and Skilled Nursing Facilities (SNF) that are available to patients. The list will be inclusive of those HHAs that are participating in the Medicare program, and that are in the HMC geographic area. Case Management will utilize the CMS compare list for those who reside out the HMC geographic area. This list is updated on a quarterly basis.

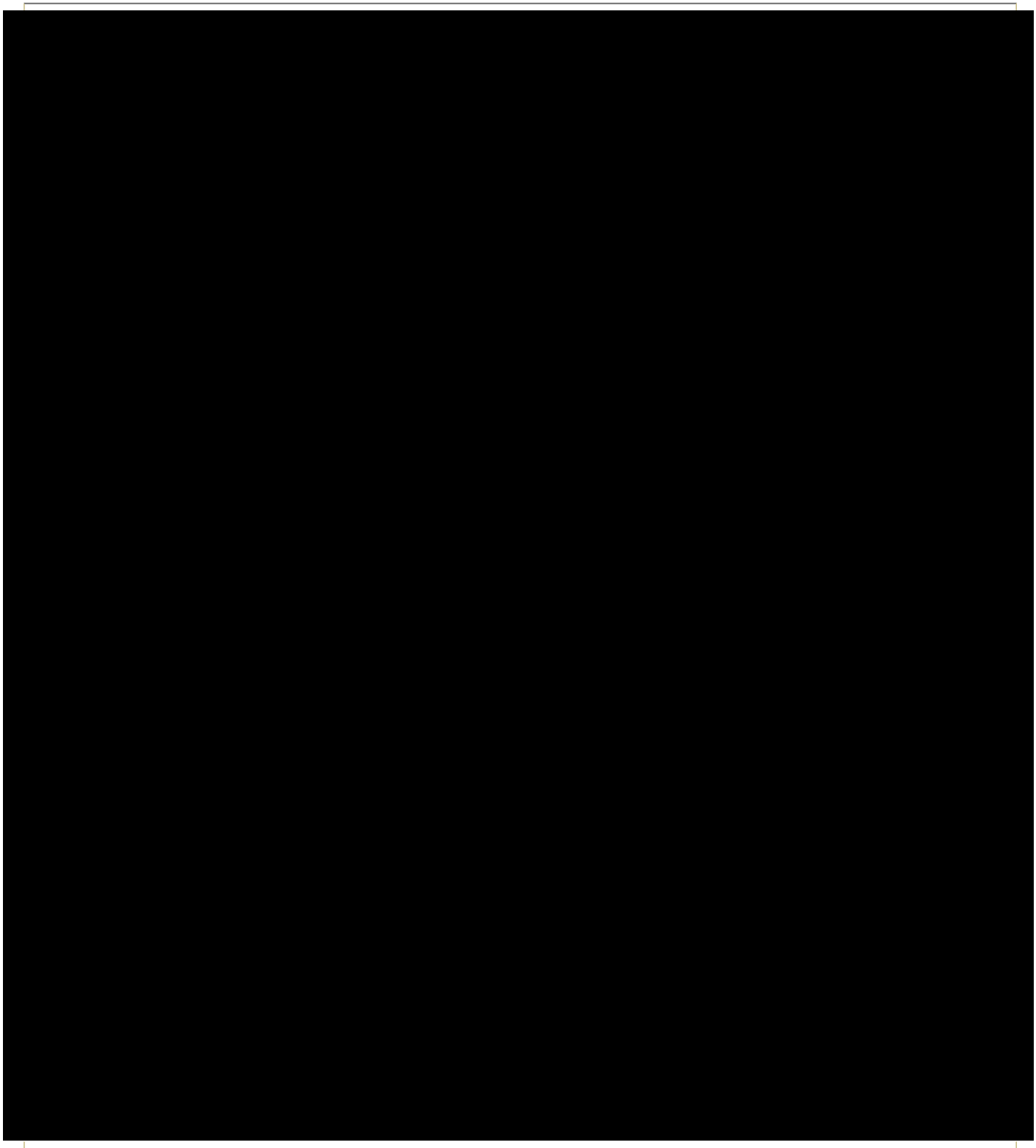
1. The HHA list will be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the a physician order.

2. For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post-hospital extended care services that have a contract with the managed care organizations.

3. The Case Manager and/or Social Worker must document in the patient's medical record that the HHA list was presented to the patient or to the individual acting on the patient's behalf.

4. The Case Manager and/or Social Worker will inform the patient/patient's representative of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed. The Case Manager and/or Social Worker must not specify or otherwise limit the qualified providers that are available to the patient. If HMC is unable to make the preferred arrangement, e.g., if there is no bed available in the preferred SNF, the Case Manager and/or Social Worker will document the reason the patient's preference could not be fulfilled and explain the reason to the patient.

5. The “Choice Letter” will identify any HHA or SNF in which Hendrick Health System has a financial interest in.



Mental Health Mental Retardation (MHMR)

Procedure when contacting MHMR (Betty Hardwick) for evaluations.

1. After order received and chart reviewed, Case Manager/Social Worker to complete assessment of patient to discuss options regarding treatment.

2. If patient has insurance and is agreeable to treatment, Case Manager/Social Worker will send referral to facility of choice.

3. Once facility secured, physician obtained, and bed assigned, Case Manager to complete MOT.

4. Case Manager/Social Worker to arrange transportation to receiving hospital based on recommendations from physician.

5. If the patient is insured and refuses treatment for psychiatric services, a referral can be made directly to Oceans Inpatient Psychiatric Hospital.

6. Once Oceans evaluates, Oceans may decide on an Emergency Detention Order (EDO) for treatment or offer outpatient services with a post assessment referral in place prior to discharge.

7. If the patient is unfunded, then MHMR crisis team will be contacted to complete evaluation of patient.

8. Once MHMR evaluates, MHMR may decide on an EDO for treatment or offer outpatient services with a safety plan in place prior to discharge.

9. If patient is EDO to facility and a facility has been secured, physician obtained, and bed assigned, Case Manager to complete MOT.

10. Case Manager/Social Worker to arrange transportation to receiving hospital based on recommendations from physician.

Nursing Home / Skilled Nursing Facility (SNF) Referral

Procedure for arranging nursing home services

1. After order received and chart reviewed, Case Manager and/or Social Worker to discuss qualifiers and insurance criteria with patient/patient representative for obtaining nursing home/SNF placement.

2. Inform and provide list to patient/patient representatives of nursing home/SNF providers.

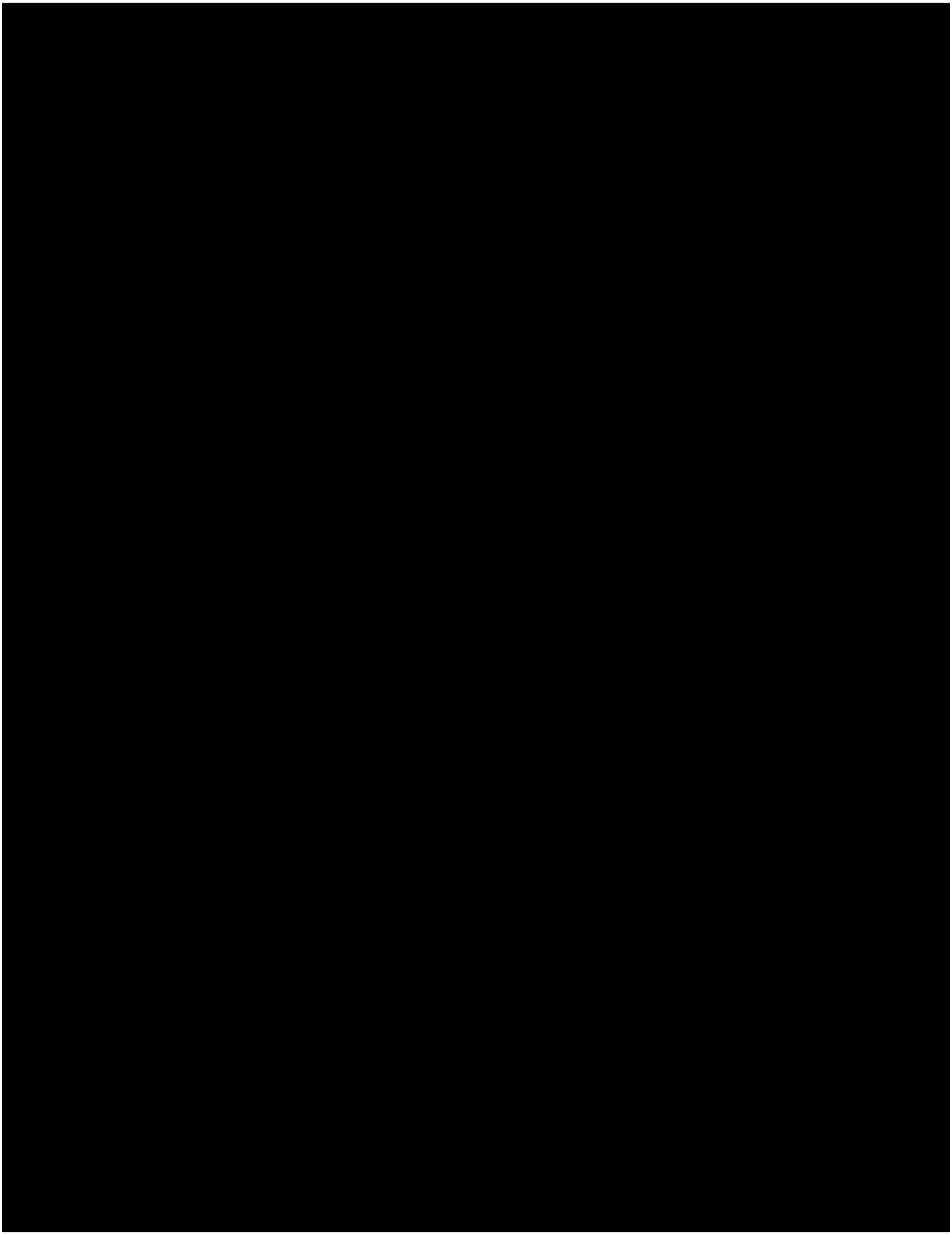
3. Once provider selected, choice sheet will be signed and placed in chart.

4. Referral made to provider of choice.

5. Once approval of placement obtained, Social Worker/Case Manager to inform physician, nursing staff, and patient/family of approval for placement.

6. Case Manager/Social Worker to fax discharge orders, medication reconciliation, and a Preadmission Screening and Resident Review (PASRR) to the nursing home/SNF provider.

7. Case Manager/Social Worker to arrange transportation.



Outpatient IV Antibiotics

Infusion Clinic:

1. Once order received, Case Manager/Social Worker to assure that the order is written on an order form or on a prescription.

2. Case Manager/Social Worker to discuss with patient options regarding outpatient infusions.

3. Make sure to get a paper order or script for facilities outside Hendrick. For the Hendrick Infusion Clinic, the doctor will complete the order set for OP infusion in Apollo.

4. If Hendrick Infusion Clinic is chosen, Case Manager/Social Worker to make referral to Centralized Scheduling for appointment.

5. Case Manager/Social Worker to fax consult order with ICD 10 code and face sheet to Centralized Scheduling.

6. Call Centralized Scheduling to arrange appointment for infusion.

7. If patient is not seen in the infusion clinic by noon on Friday then patient will have to report to the ED for infusion over the weekend. If patient going to ER, send a copy of the orders to the ED and contact charge nurse with information. Make sure to have that the patient has a copy of the infusion orders with them to present to the ED.

8. Discharge card provided to patient with information on appointment and location of infusion clinic. Patient is also provided with a copy of the antibiotic order.

Home Infusion:

1. Once ordered received, Case Manager/Social Worker to assure that the order is written on an order form or on a prescription to include name of drug, dose, durations, as well as flushes and other supplies needed.

2. Case Manager/Social Worker to discuss with patient/patient representative options regarding home infusions as well as criteria and eligibility with insurance.

3. Patient provided with choices on specialty pharmacies and home health agencies.

4. Referrals made to the specialty pharmacy and home health agency.

5. Once pharmacy receives insurance approval, Case Manager / Social Worker to coordinate the delivery of drug and services to the home.

6. Discharge card provided to the patient with information on the specialty pharmacy and home health provider.

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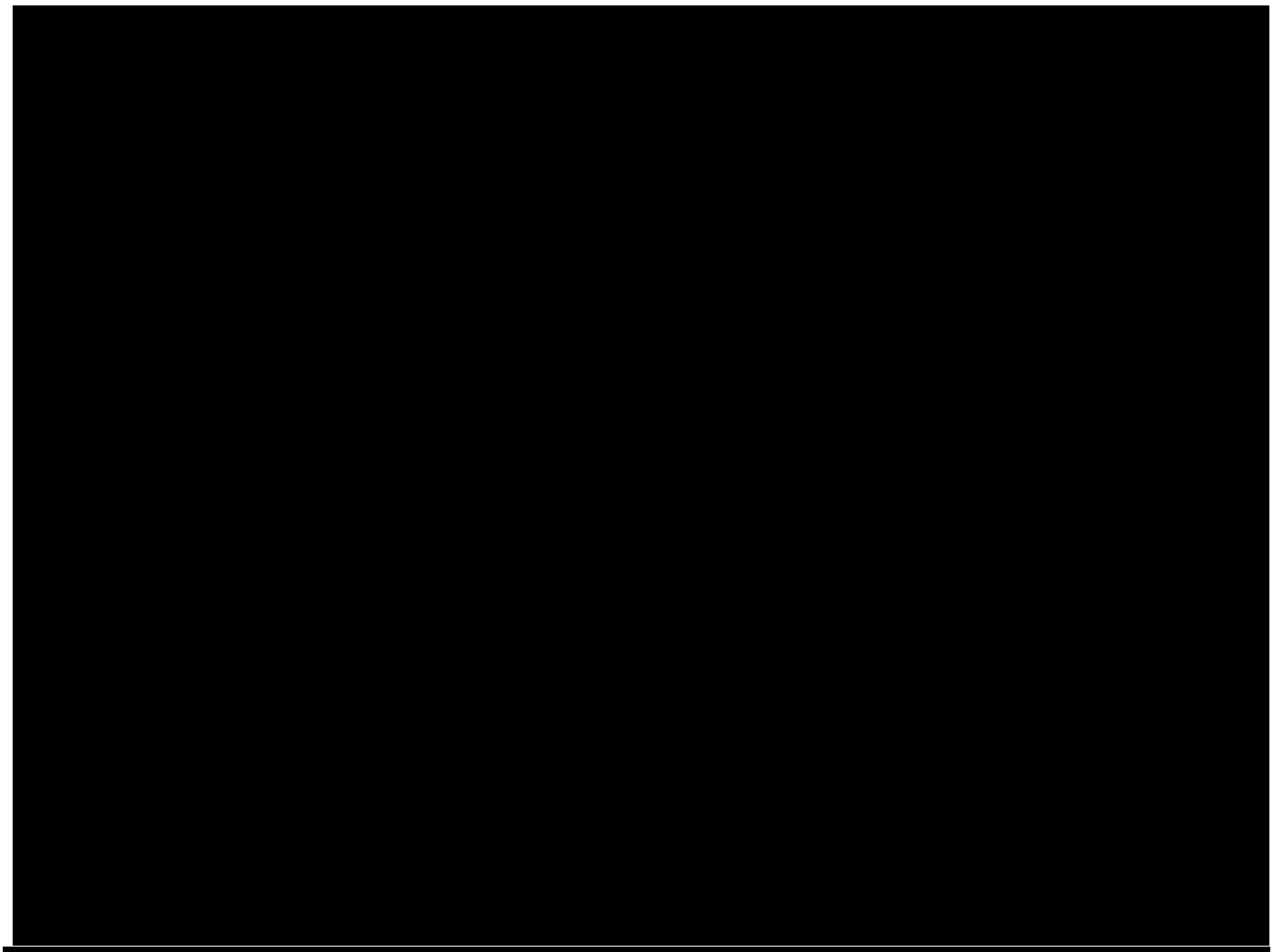

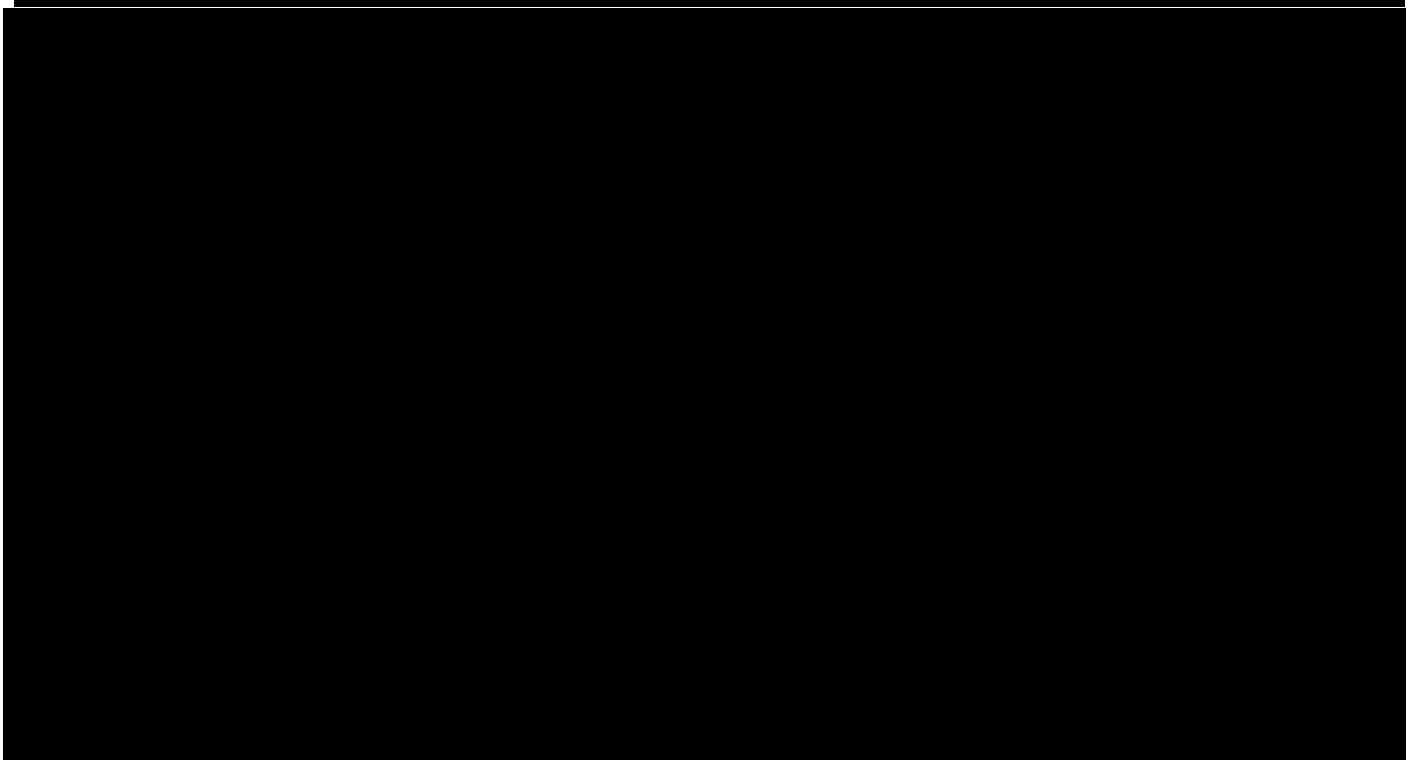

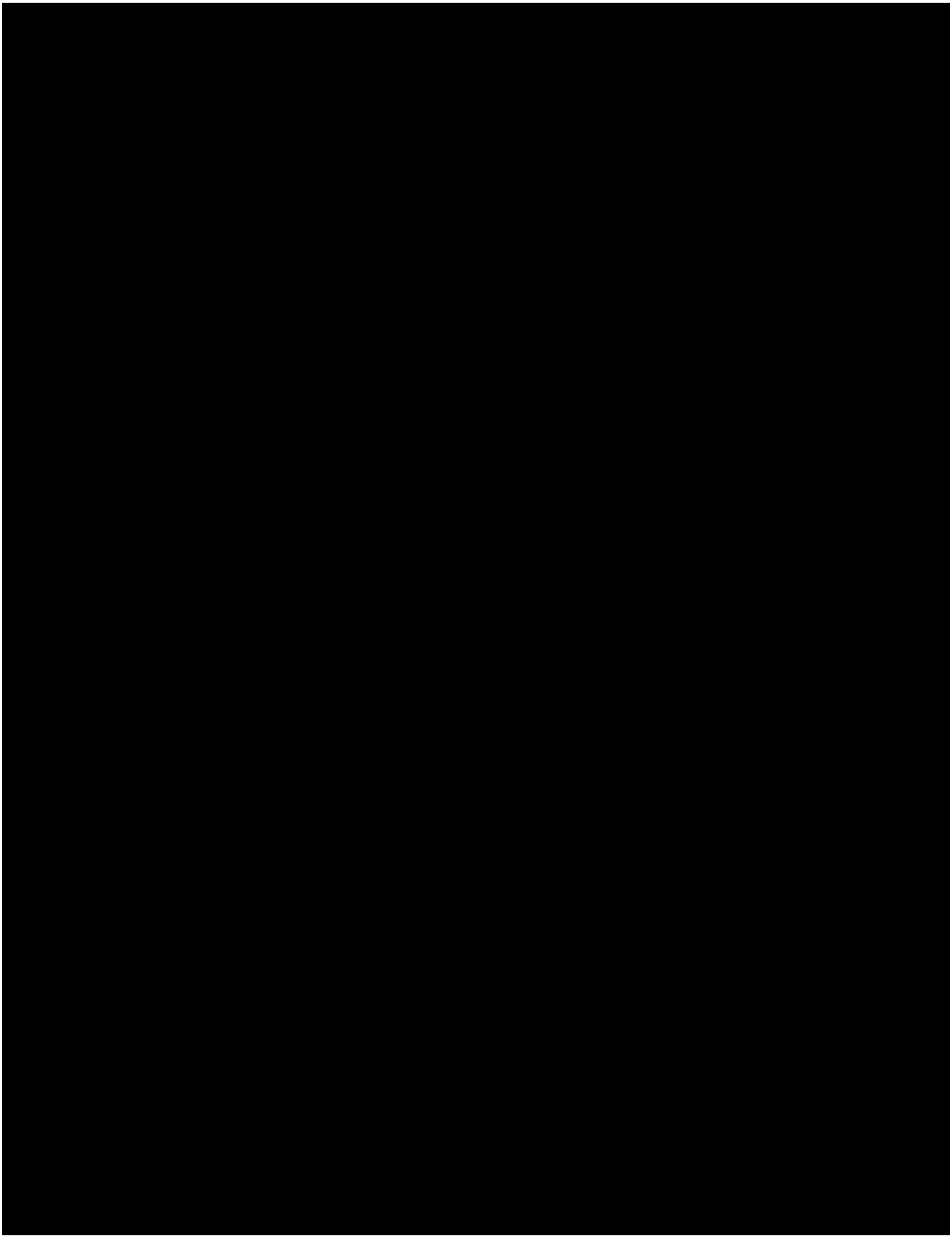

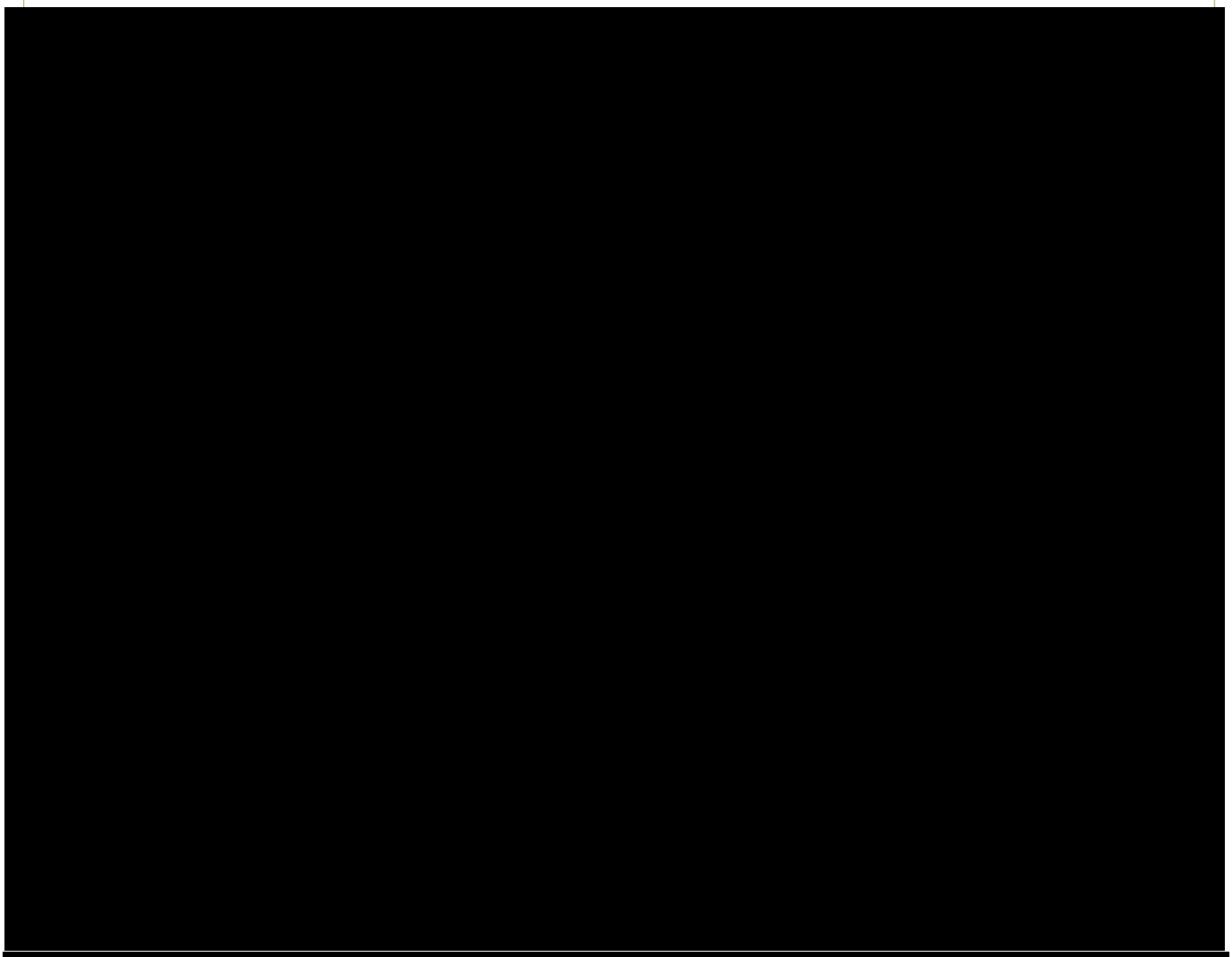

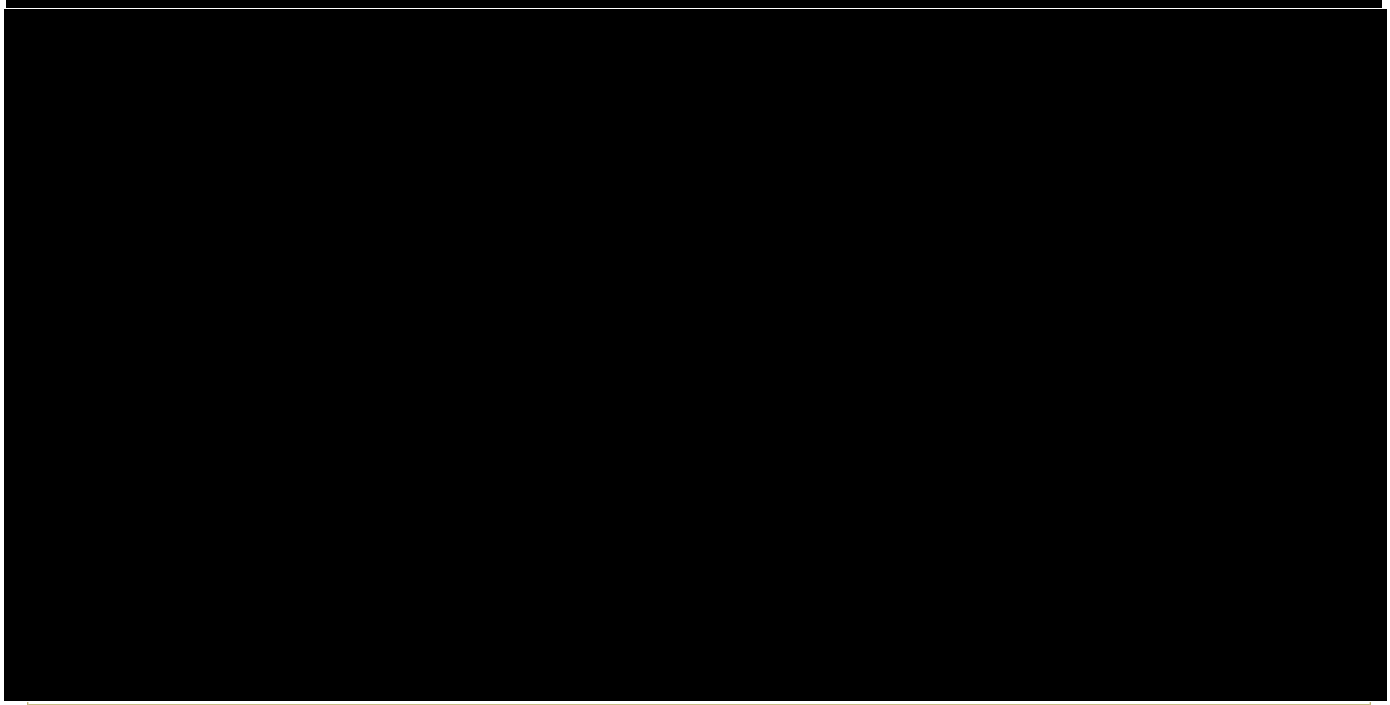

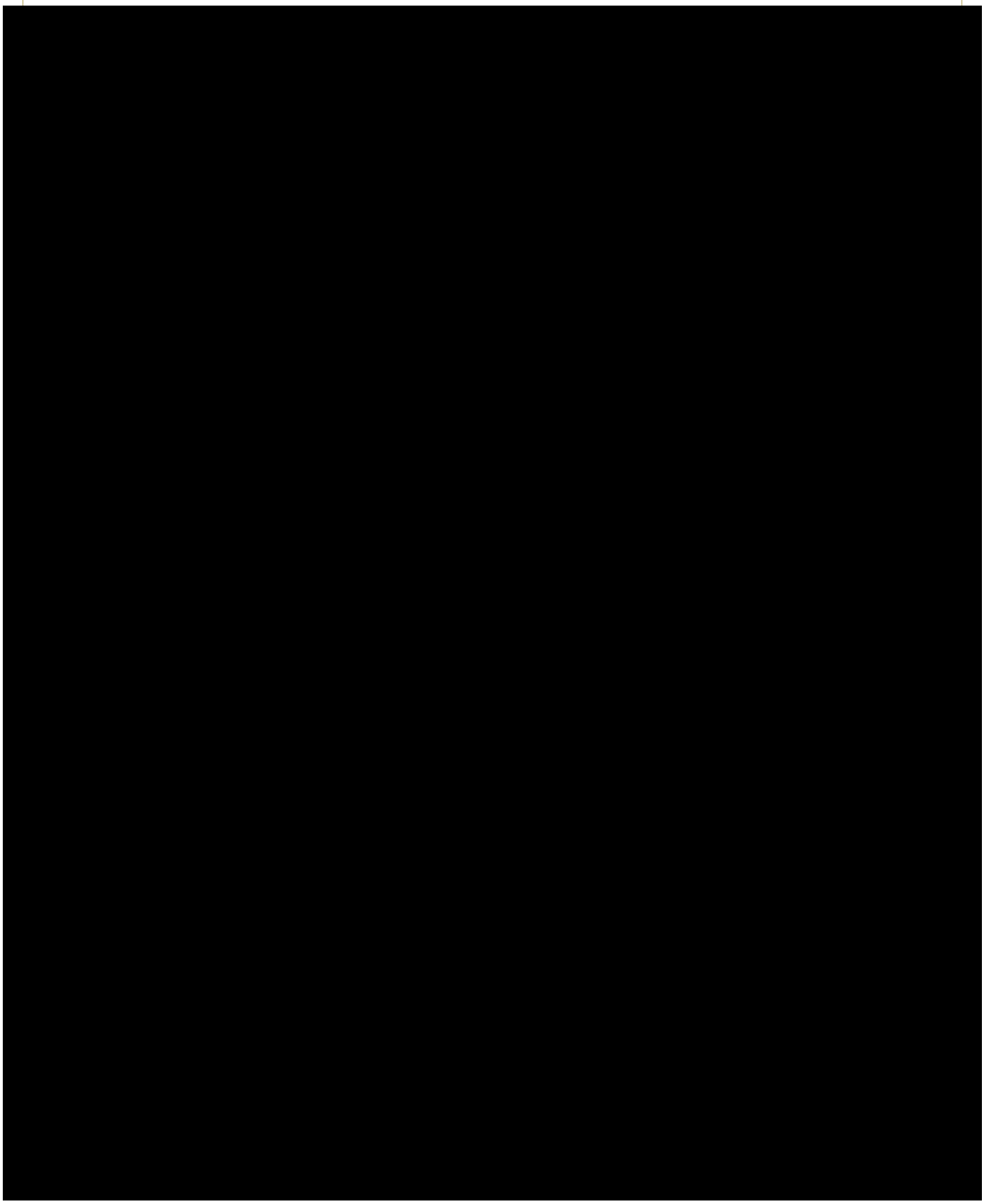

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Referral for Outpatient Dialysis

Procedure for arranging Outpatient Dialysis

1. After order received and chart reviewed, Case Manager and/or Social Worker to discuss with patient Outpatient Dialysis and choice patient for facility. Must discuss facility, chair time, and date preference with patient. However, mention to patient that referrals are subject to chair availability.

2. If patient is unfunded, contact Resource Cooperation of America (RCA) and inform them of patient's unfunded status.

3. Make referral to facility of choice.

Arrange for Primary Care Follow Up with Medical Care Mission and Abilene Community Care Clinic

Procedure for arranging Primary Care Physician (PCP) follow up:

1. If patient has no PCP then discuss PCP options such as Medical Care Mission, Abilene Community Health Clinic, Hendrick Provider Network (HPN), or In-Network Provider with the patient's insurance as appropriate.

2. If patient wants Medical Care Mission (MCM), provide patient with a new patient application to the MCM and patient is encouraged to follow up with the MCM on the day of discharge. MCM does not want SW/CM staff to refer as they prefer patient schedule or visit them regarding appointment.

3. If patient wants Abilene Community Clinic, CM/SW to fax requested documentation to clinic and indicate request for use of an HMC appointment. CM/SW staff to call to schedule appointment if patient is in need of urgent follow up such as Coumadin or home health follow up.

4. If patient wants HPN or another provider, CM/SW to contact office directly to schedule next available appointment.

5. Once appointment arranged, CM/SW to indicate appointment time, date, location, and contact information on a discharge card which will be provided to patient upon discharge.

Arrangements for Outpatient Rehab

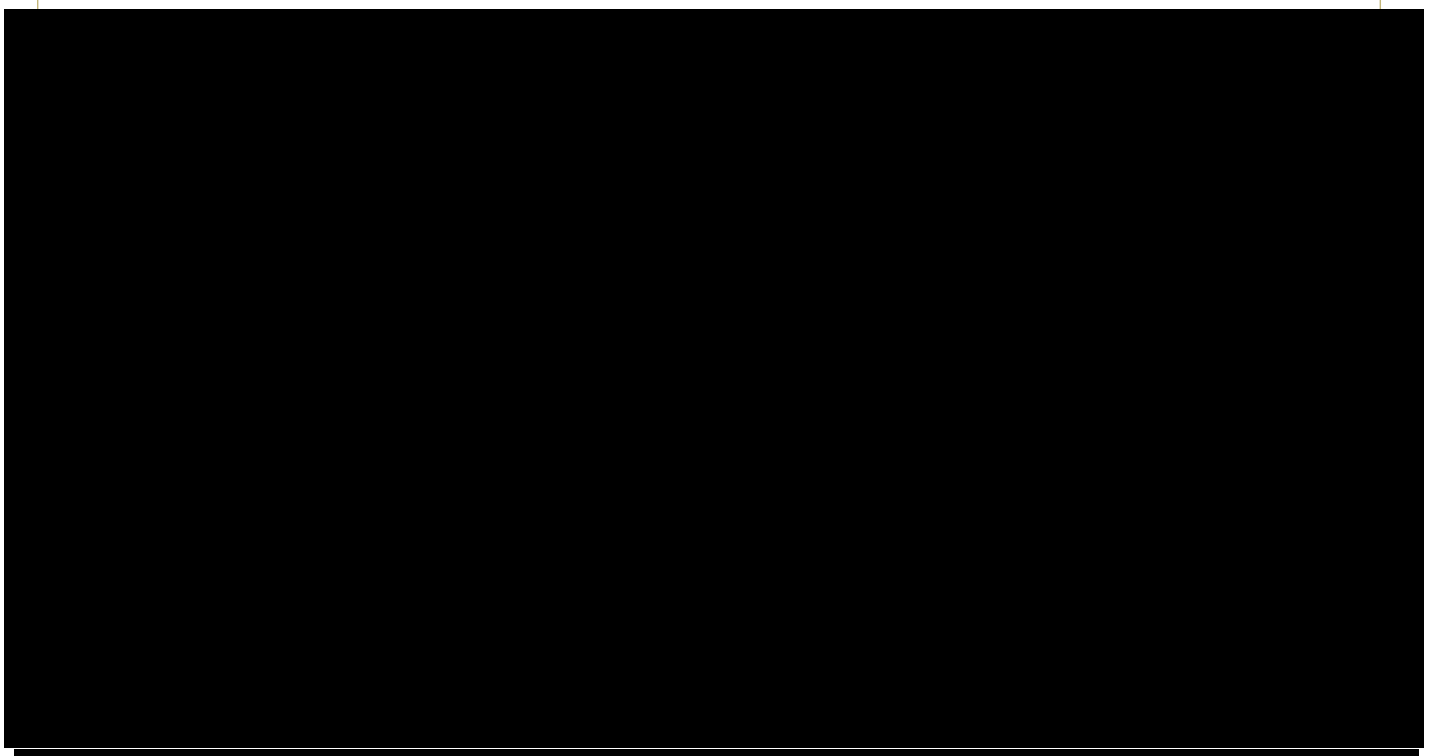
Procedure for arranging Outpatient Rehab

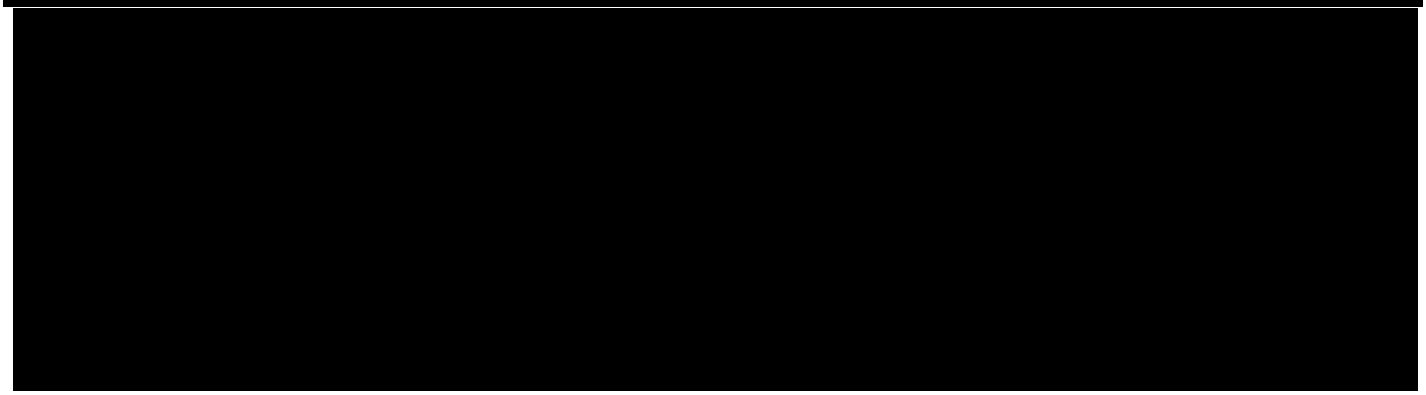
1. After order received and chart reviewed, Case Manager and/or Social Worker to discuss options for Outpatient Rehab such as Hendrick Center Rehab, Early Childhood Intervention, etc.

2. Once provider selected, choice sheet will be signed and placed in chart.

3. Referral made to provider of choice via Allscripts Care Manager and CM/SW to follow up with a phone call for appointment date/time.

4. Complete Discharge Card with provider information such as location, contact information, and appointment date/time. CM/SW to provide to patient and family upon discharge.





Arrangements for Pulmonary Rehab

Procedure for referral to Pulmonary Rehab

1. When a patient is newly diagnosed or has difficulty managing COPD, the CM/SW will either request order or receive order to contact Pulmonary Rehab.

2. CM/SW will discuss with patient/patient representative the order and opportunity to benefit from the service. Once consent is obtained CM/SW will call Pulmonary Rehab and will provide patient's name and room number.

3. Pulmonary Rehab to follow up with patient while they are still in-house.

Attachments

No Attachments

Approval Signatures

Approver	Date
Elizabeth Henry: Director, Case Management	10/13/2020

Abilene Regional Medical Center

Policy/Procedure Title	Policy for Discharge Planning and Referral of Patients to Post-Ancillary Providers (Patient Choice)	**Manual Location**	Administrative		
Policy/Procedure #	104	**Effective**	6/2010	**Page**	1 of 4
Department Generating Policy	Case Management				
Affected Departments	Clinical Departments Health Information Department Registration / Patient Access Health Information Management				
Prepared By	Rosemary Lara, RN Linda Speegle, RN Tonya Anderson, RN Susan Fisher, Interim HIM Director	**Dept/Title**	Case Management Case Management Quality HIM		
Dept / Committee Approval (If Applicable)		**Date/Title**			
Dept / Committee Approval (If Applicable)		**Date/Title**			
Dept / Committee Approval (If Applicable)		**Date/Title**			
Medical Staff Approval (If Applicable)		**Date/Title**			
Board Approval (If Applicable)		**Date/Title**			

PURPOSE: To ensure .that hospital personnel perform the hospital function of discharge planning and that patients are informed of their options as to Ancillary Service Providers (i.e., skilled nursing, home health, DME,, hospice, outpatient and inpatient rehab, including free standing rehab facilities, etc) and have the ultimate choice in selecting a provider.

INTRODUCTION AND OVERVIEW:
SECTION 4321 (A) of the Balanced Budget Act (BBA) of 1997 and Section 1861 (ee) of the Social Security Act (SSA) requires that Medicare participating hospitals referring patients to Ancillary Service Providers must meet the following requirements:

Provide beneficiaries with a list of Medicare – certified Ancillary Service Providers (i.e., skilled nursing, home health, DME, etc. serving the beneficiary's geographic area. Note: the ancillary service provider list for the home health agencies must include those providers submitting a request in writing to be listed and should be reviewed/updated annually.

Not specify or limit the patient's choice of an ancillary service provider. However, patients must be advised if they do not make a selection, they will automatically be referred to an affiliated ancillary service provider, unless that referral would not be appropriate for the patient.

Inform the beneficiary of any provider or supplier in which the hospital has a disc losable financial interest, if that provider or supplier is selected by the patient for post-hospital services.

The intent of section 4321 (a) is to protect "patient choice". The patient choice will be documented in writing signed by the patient and/or significant other using the Patient Information and Choice Form (CM-2201) attached to this policy. A copy of the completed for will be filed in the permanent medical record. This policy applies to all treatment settings and to patients in all payor classifications. Ancillary service Provider lists should be prepared or notification provided if a payor's network is exclusive or limited.

CHS OWNED OPERATED ENTITIES:

As Community Health Systems affiliates (collectively, the Company) include ancillary service providers, it is necessary to address the potential antitrust, anti-kickback, and false statement claims implications of certain practices, which may occur in the absence of proper understanding of the law.
The potential legal implications of various arrangements are briefly summarized s follows:

Antitrust Concerns – the typical claims arising in this area are either that the hospital and the Ancillary Service Providers are conspiring to monopolize the post-discharge referral market (a potentially viable claim if the agency and the hospital are not under common ownership and the hospital has a large market share) or that the hospital, by treating one Ancillary Service Provider (even an affiliate) more favorably than its competitors, is engaging in unfair competition. The law is not decided in this area and not all courts treat the issue the same. Accordingly, to avoid expensive and highly publicized litigation, the Company has taken a conservative approach in the arrangements and structures that will be permitted.

Anti-kickback Concerns – if the hospital and the Ancillary Service Providers are not under common ownership and the Ancillary Service Provider provides free services to the hospital, such as a home care coordinator or free DME equipment for the in facility use,, a concern is raised that these free services or goods are offered in exchange for the stream of referrals. In accordance with Company policy, such arrangements are not permitted.

False Claims/False Statement Concerns – discharge planning is a hospital only function and payment for these activities from the Medicare system is included in the DRG payment for each discharge. Presently, home health services are paid on a prospective payment system of reimbursement. A potential problem arises with the hospital and the home health agency cost reports if an employee identified as a home health coordinator is providing discharge planning services to the hospital and the employee's time is not properly allocated between the two functions. Although time studies can be performed, in an integrated delivery system the allocation can still be somewhat subjective and subject to change.

ORGANIZATIONAL AND HUMAN RESOURCE MATTERS:

Each affiliated hospital and Ancillary Service Provider should:
Require that all discharge planning personnel be employed by the hospital, not the affiliated Ancillary Service Providers. This will negate the appearance of an inappropriate attempt to influence the patient's choice of an Ancillary Service Provider and will permit the discharge planning personnel to market other company services.
Not allow Ancillary Service Providers personnel (independent as well as affiliated) to wear hospital jackets or tags with the hospital name. Ancillary Service Providers personnel must always wear nametags with the name of the Ancillary Service Provider company visible.

CONTACT WITH PATIENTS
Do not allow employees of the Ancillary Service Providers to perform any functions in a hospital that would normally be performed by any hospital employee. Note: employees of an owned/operated CHS entity (i.e., home health rehab) are considered "CHS" employees.

Ancillary Service Providers should not be allowed any contact with or access to the patient or their medical records until after referral has been made. The reason for this requirement is to avoid even the appearance that the services are being provided to the hospital in return for a referral of the patient to the Ancillary Service Providers.

PHYSICIAN ORDERS
A physician order is required for any patient discharge to an Ancillary Service Provider. There are no exceptions. If the patient has an Ancillary Service Provider, prior to admission a physician order for continuation of service is still a requirement. In this instance, the patient should be requested to sign the Patient information and Choice Letter to acknowledge their continued selection of the existing provider.

DISCHARGE PLANNING SELECTION PROCESS

Under the hospital conditions of participation, hospitals are to properly counsel patients and family members regarding post – hospital care, and to refer patients to appropriate agencies for follow-up care.

Under the Medicare Conditions of Participation (COP) for Hospitals: discharge planning, (42 CFR Section 482.43 (b) (3) and (6), hospitals must have a discharge planning process in place that applies to all patients. The discharge planning process must include an evaluation of the patient's capacity for self-care and determine the need for post-hospital services.

ADDITIONAL HOSPITAL RESPONSIBILITIES

Each hospital must:

Disclose the relationship between the hospital and any affiliated Ancillary Service Providers. Highlight the positive qualities of the affiliated Ancillary Service Providers, which includes the fact that there is a business relationship between the hospital and the affiliated Ancillary Service Provider.

Be prepared to provide each patient with a list of Ancillary Service Providers that are Medicare certified, serving the geographic area in which the patient resides, and not just those owned or affiliated with the Company. Ancillary Service Providers must request in writing to be listed as a provider. The form and conte4nt of the list may vary by hospital depending upon its particular circumstances. For managed care patients, it is appropriate to prepare a separate list or otherwise inform them which Ancillary Service Provider(s) are included in their in –network benefit.
Give the patient a meaningful opportunity to select an Ancillary Service Provider by providing a list. For example, in a small or rural community, the list may be relatively short and should include all Ancillary Service Providers that serve the hospital's community. Conversely in a large, urban community, there may be hundreds of Ancillary Service Providers and the list may reasonably be limited to those within a particular zip code or other geographic area.

Must accommodate a competitor's (Medicare-certified provider) Written request to be added to your list of ancillary suppliers. You are not required, however, to conduct any marketing for your competitors. The least desirable method of communicating options to patients is to refer them to the telephone directory; how\ever, this may be a practical addition to other resources if a patient is looking for the name of a particular agency with which they are familiar.

Policy/Procedure Title	Policy for Discharge Planning and Referral of Patients to Post-Ancillary Providers (Patient Choice)	Manual Location	Administrative
Policy/Procedure #	104	Page	4 of 4

POST – SELECTION PROCESS:

Each hospital must:

Require that each patient and/or significant other make a specific choice of an Ancillary Service Provider, in writing, so that a permanent record exists. The Patient Choice letter must have signature of the patient, family member, caregiver or Durable Power of Attorney (DPOA) for healthcare in order to be valid and the original or a copy must be filed in the patient's medical record. Verbal choice is not acceptable unless the patient has no family member, caregiver or DPOA and is unable to sign. If the patient has no family member, caregiver or DPOA and is unable to sign the Patient Information and Choice letter, the Case Manager is responsible for completing the "unable to sign" statement. Inform the patient that if he or she declines to make a specific choice, then the hospital owned or affiliated organization will be utilized. Documentation must ensure that patient choicer has been observed, without regard o whether a Company affiliates provides the service.

If a patient chooses a competing Ancillary Service Provider, the facility should cooperate fully with the representatives of the Independent Ancillary Service Provider and allow them as much access to the patient's record as you would to representatives of an affiliated Ancillary Service Provider. Do not attempt to make patients change or reconsider their decision to use the services or supplies of an independent Ancillary Service Provider

Do not disparage or offer negative opinions regarding the services of an independent Ancillary Service Provider. If you do offer factual information about the Ancillary Service Provider, make sure it is accurate and current. Remember that it is ultimately the patient's decision which service to use.

Do not attempt to coerce a physician or other who has recommended the services or supplies of an independent Ancillary Service Provider. It is important that independent Ancillary Service Provider remain free to market their services, do not tell employees in the discharge planning department, or other who may be in a position to influence patient choice, that is inappropriate to use the services of independent Ancillary Service Providers.

Be sensitive to patient complaints about the quality of service they receive. Report any complaints about quality of service to the appropriate persons at the Ancillary Service Provider.

The use of Patient Information and Choice Form (CM-2201), Attachment A to this policy is mandatory. Discharge planners re to use this form for the documentation of patient choice for any to Ancillary Service Providers (i.e., skilled nursing, home health, DME,, hospice, outpatient and inpatient rehab, including free standing rehab facilities, etc). Note: this form may be ordered directly through Emprint (through GHX)

COMPLIANCE PROGRAM POLICY STATEMENT:

The adoption of and adherence to this policy by this facility is pursuant to and in furtherance of the Fraud and Abuse element of Code of Conduct of CHS and its affiliates. Failure to comply with this policy shall constitute a serious violation of policy and shall subject an employee to disciplinary action up to and including suspension or termination of employment.

Policy revised January 2011.approval -> approved by Andi Bosshart, Vice President Corporate Compliance and Privacy Officer.

1st 2nd 3rd 4th 5th

Reviews/Revisions:

Date:	9/2011	7/16/2012
By:	Rosemary Lara, RN; Linda Speegle, RN	Rosemary Lara, RN

Reference	Description
Attachment 5	Listing of Open Positions

Job Title	Job Code	Department	Date Posted
Nurse Aide I	9434	P5 - Neuro/Tele	1/14/2020
Nurse Aide I	9434	HCR A6 Skilled Nursing Facilit	1/27/2020
Registered Technician	3805	PHM Pharmacy - Main	1/30/2020
Nurse Aide I	9434	CCS C3 Progressive Care	1/31/2020
Admitting Representative III	5552	Hendrick Surgery Center-Brownw	2/6/2020
Groundskeeper	8005	GRD Grounds	2/10/2020
Groundskeeper	8005	GRD Grounds	2/10/2020
Nursing Clerk	--	CCS C7 / Med-Tele	2/10/2020
Environmental Services Tech I	9151	ENV Services-Main	2/13/2020
Registered Nurse	2438	CS P3/CICU/IMCU	2/18/2020
Registered Nurse	2438	TWC Neonatal ICU	2/19/2020
RN-NOV	2440	H/C Housecalls Med Skilled Nsg	2/24/2020
Registered Nurse	2438	CCS Renal Dialysis	2/28/2020
Sleep Lab Technician	3285	RT EEG	3/3/2020
Reimbursement Representative	5101	BSN Business Services Mngmnt	3/19/2020
Environmental Services Tech I	9151	ENV Services-Main	3/24/2020
Housecalls Pool LVN	3466	H/C Housecalls Med Skilled Nsg	4/16/2020
Nurse Aide I	9434	HCR A6 Skilled Nursing Facilit	5/20/2020
Licensed Vocational Nurse, HPN	3404	HPN Southside Clinic	5/20/2020
Nurse Aide I	9434	MSN P7 Med Surg Tele	5/27/2020
Nurse Aide I	9434	MSN P7 Med Surg Tele	5/27/2020
Nurse Aide I	9434	MSN P7 Med Surg Tele	5/27/2020
CV Sonographer-Pool	3682	CS - Non Invasive Cardiology	6/1/2020
Registered Nurse	2438	HCR A6 Skilled Nursing Facilit	6/10/2020
Biller/Collector	5112	BSN Business Services Mngmnt	6/15/2020
Physical Therapist, Pool	2263	H/C Housecalls Med Physical Th	6/17/2020
Practice Manager I, HPN	5190	HPN Administration	6/17/2020
Nurse Aide I	9434	CCS C7 / Med-Tele	6/18/2020
Nurse Aide I	9434	CCS A 5 Observation Unit	6/24/2020
Certified Histotechnician	--	HRL Pathology Anatomic	6/25/2020
Registered Nurse	2438	TWC Labor & Delivery Recov Rm	6/30/2020
Licensed Vocational Nurse, CHS	3438	CHS Corr Hlth Svs-Robertson	6/30/2020
Licensed Vocational Nurse, CHS	3438	CHS Corr Hlth Svs-Robertson	6/30/2020
Licensed Vocational Nurse, CHS	3438	CHS Corr Hlth Svs-Middleton	6/30/2020
Registered Nurse	2438	MSN J8 Ortho	6/30/2020
Licensed Vocational Nurse, HPN	3404	HPN Internal Medicine	7/3/2020
Care Coordinator-LVN	2445	HPN Referral & Scheduling	7/3/2020
Admitting Representative I	5550	ADS Admissions	7/7/2020
Registered Nurse	2438	CCS C6 Tele	7/8/2020
Registered Nurse	2438	CCS C6 Tele	7/8/2020
Construction Technician III	6810	FM Construction Management	7/8/2020
Registered Nurse	2438	CCS Renal Dialysis	7/10/2020
Central Staffing Specialist	5569	TWC Centralized Support Svcs	7/10/2020
Registered Nurse	2438	TWC Centralized Support Svcs	7/10/2020
Registered Nurse	2438	TWC Trauma Center	7/21/2020
Hospice On-Call RN	2447	HHC Hospice Program	7/22/2020
Nurse Aide I	9434	CCS C5-PCU	7/22/2020
Registered Nurse	2438	CCS C5-PCU	7/22/2020
Nurse Aide I	9434	MSN A3/A4 Oncology/Med Surg	7/23/2020

Job Title	Job Code	Department	Date Posted
Nurse Aide I	9434	MSN A3/A4 Oncology/Med Surg	7/23/2020
Network/Telephone Technician	5768	ISS Telecommunications	7/24/2020
Blood Bank Coordinator	2335	HRL Blood Bank Donor Center	7/27/2020
PACS Analyst	3604	RAD Radiology Diagnostic	7/28/2020
Clinical Informatics Educator	2424	ISS Clinical Informatics	7/28/2020
Physical Therapist Asst, Pool	3261	H/C Housecalls Med Physical Th	7/30/2020
Nurse Aide I	9434	MSN P6 Surgical Unit	7/30/2020
Nurse Aide	9432	CCS Centralized Support Services Nurse Aide	8/4/2020
Nurse Aide	9432	CCS Centralized Support Services Nurse Aide	8/4/2020
Nurse Aide	9432	CCS Centralized Support Services Nurse Aide	8/4/2020
Paramedic	3497	TWC Trauma Center	8/5/2020
Access Center Representative I	5066	HPN Referral & Scheduling	8/7/2020
Specialty Technician	3425	TWC Trauma Center	8/10/2020
Technical Support Spec I	5755	ISS Information Systems	8/10/2020
Registered Nurse	2438	SRS OR - Operating Room	8/11/2020
Pharmacist II	2810	PHM Pharmacy - Main	8/11/2020
Registered Technician	3805	PHM Pharmacy - Main	8/11/2020
Licensed Vocational Nurse, HPN	3404	HPN Rheumatology	8/12/2020
Licensed Vocational Nurse, HPN	3404	HPN Internal Medicine, Brownwo	8/12/2020
Specialty Technician	3425	CS Cardiac Cath Lab	8/14/2020
Cert Reg Nurse Anesthetist	2598		8/17/2020
Environmental Services Tech I	9151	ENV Services-Main	8/17/2020
CL Tech IV	3652	CS Cardiac Cath Lab	8/19/2020
Licensed Vocational Nurse, HPN	3404	HPN Urology	8/19/2020
Licensed Vocational Nurse, HPN	3404	HPN Cardiology	8/19/2020
Certified Medical Assistant	9807	HPN Internal Medicine, Brownwo	8/19/2020
Registered Nurse	2438	MSN P7 Med Surg Tele	8/20/2020
Scheduling Representative I	5055	HPN Southside Clinic	8/24/2020
Registered Nurse	2438	CCS A 5 Observation Unit	8/26/2020
Nursing Clerk	5405	TWC Neonatal ICU	8/26/2020
Patient Placement Nurse II	2446	TWC Centralized Support Svcs	8/27/2020
Certified Medical Assistant	9807	HPN Cardiology	9/1/2020
Registered Nurse	2438	HCR A6 Skilled Nursing Facilit	9/3/2020
Technical Support Spec II	5765	ISS Information Systems	9/3/2020
Evening Spvr II, Env Svs	9175	ENV Services-Main	9/3/2020
Licensed Vocational Nurse I	3442	MSN P6 Surgical Unit	9/4/2020
Nurse Aide I	9434	MSN P6 Surgical Unit	9/4/2020
Registered Nurse	2438	HCR A6 Skilled Nursing Facilit	9/7/2020
Registered Nurse	2438	HCR Nursing Unit Rehab	9/7/2020
CV Sonographer I	3677	CS - Non Invasive Cardiology	9/8/2020
Nurse Aide I	9434	CCS C3 Progressive Care	9/8/2020
Nurse Aide I, Hospice	9431	HHC Hospice Program	9/8/2020
RN, PROF	2466	TWC Prof OnBoarding-W & C	9/11/2020
Certified Medical Assistant	9807	HPN Cedar Mall	9/11/2020
Admitting Representative I	5550	ADS Admissions	9/15/2020
Irrigation Technician	9160	GRD Grounds	9/15/2020
Groundskeeper	8005	GRD Grounds	9/16/2020
Groundskeeper	8005	GRD Grounds	9/16/2020
Environmental Services Tech I	9151	ENV Services-Main	9/16/2020

Job Title	Job Code	Department	Date Posted
Clinical Therapist I	3275	RT Respiratory Therapy	9/17/2020
Medical Staff Coordinator I	5845	MS Medical Staff Office	9/17/2020
Specialty Team Supervisor	2584	SRS OR - Recovery Room PACU	9/18/2020
Specialty Technician	3425	SRS OR - Recovery Room PACU	9/18/2020
Rehab Specialist I	9442	HCR Nursing Unit Rehab	9/18/2020
Security Officer I	9300	SEC Security	9/18/2020
Manager, Nursing Services	2580	CS Cardiac Cath Lab	9/21/2020
Technician, HCR	9250	HCR O/P Physical Therapy	9/21/2020
Technical Support Spec II	5765	ISS Information Systems	9/22/2020
Network/Telephone Technician	5768	ISS Telecommunications	9/22/2020
Network/Telephone Technician	5768	ISS Telecommunications	9/22/2020
Manager, Operations	2970	HPN Administration	9/22/2020
Cashier/Payment Poster	5109	BSN Business Services Mngmnt	9/23/2020
Certified Medical Assistant	9807	HPN Urology	9/23/2020
Scheduling Representative I	5055	HPN Urology	9/23/2020
Cashier/Payment Poster	5109	BSN Business Services Mngmnt	9/24/2020
Medical Technologist	2305	HRL Pathology Clinical	9/25/2020
Registered Nurse, Pool	2443	Hospice-Inpatient	9/28/2020
Nurse Aide I, Hospice	9431	Hospice-Inpatient	9/28/2020
Registered Nurse	4438	CS Valve Clinic	9/28/2020
Housecalls Pool RN	2448	H/C Housecalls Med Skilled Nsg	9/30/2020
Licensed Vocational Nurse, HPN	3404	HPN Family Medicine	10/2/2020
Registered Nurse	2438	CCS A 5 Observation Unit	10/2/2020
Manager, Risk Management	1310	ADS Patient Relations	10/6/2020
Peritoneal (PD) RN	2415	Hendrick Dialysis Center	10/6/2020
Medical Records Specialist	5530	CHS Corr Hlth Svs-Middleton	10/8/2020
Technical Support Spec I	5755	ISS Information Systems	10/8/2020
Client/Server Analyst	3925	ISS Information Systems	10/8/2020
Accounting Clerk III, HMS	5617	HMS Business Office	10/8/2020
Registered Nurse	2438	CCS Prof OnBoarding	10/9/2020
Registered Nurse	2438	CCS Prof OnBoarding	10/9/2020
Attendant I	9401	SRS OR - Operating Room	10/9/2020
Cert Surgical Technologist II	3461	SRS OR - Operating Room	10/9/2020
Blood Bank Technician I	3310	HRL Blood Bank Donor Center	10/9/2020
Certified Coder I	5536	HIS Health Information Svs	10/9/2020
Certified Coder I	5536	HIS Health Information Svs	10/9/2020
Collector	5114	HPN Billing	10/12/2020
Pharmacist I	2800	PHM Pharmacy - Main	10/14/2020
Transitional Care Pharmacist	2808	PHM Pharmacy - Main	10/14/2020
Pharmacist I	2800	PHM Pharmacy - Main	10/14/2020
Pharmacist I	2800	PHM Pharmacy - Main	10/14/2020
Social Worker	2281	C/M Case Management	10/14/2020
Registered Nurse	2438	TWC Neonatal ICU	10/14/2020
Nursing Clerk	5405	CHS Corr Hlth Svs-Robertson	10/15/2020
Executive Assistant	5285	ADM Administration Services	10/15/2020
Infection Preventionist	2155	PIM Infection Prevention	10/15/2020
Licensed Vocational Nurse II	3452	H/C Housecalls Med Skilled Nsg	10/16/2020
Nurse Clerk	5405	MSN P6 Surgical Unit	10/16/2020
Medical Technologist	2305	HRL Pathology Clinical	10/20/2020

Job Title	Job Code	Department	Date Posted
Specialty Technician	3425	RAD Radiology CT Scanner	10/20/2020
Environmental Services Tech I	9151	ENV Services-Main	10/20/2020
Nurse Aide I	9434	P5 - Neuro/Tele	10/20/2020
Certified Medical Assistant	9807	HPN - COVID-19	10/20/2020
Transporter I	9456	ENV-Centralized Transpor	10/26/2020
Linen Svcs Tech	9101	ENV Linen Distribution	10/26/2020
Software Engineer III	3915	ISS Information Systems	10/26/2020
Mechanical Systems Tech II	6316	SS Facility Mgmt-Support	10/26/2020
Central Staffing Specialist	5569	TWC Centralized Support Svcs	10/27/2020
Registered Nurse	2438	HCR Nursing Unit Rehab	10/27/2020
CT Scan Technologist I	3625	SS Radiology-CT Scanner	10/27/2020
CT Scan Technologist I	3625	Radiology-CT Scanner	10/27/2020
MRI Technologist I	3630	BW Radiology-MRI	10/27/2020
Insurance Verification Spec I	5110	BW Admissions	10/28/2020
Telecommunications Operator	5084	BW Communications	10/29/2020
Cert Surgical Technologist II	3461	BW Operating Room	10/30/2020

Reference	Description
Attachment 6	Directory of Privileged Providers

[This Attachment contains proprietary, competitively sensitive information redacted from the public version.]

FILED UNDER SEAL

Reference	Description
Attachment 7	IRS Form 990s

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization
HENDRICK MEDICAL CENTER

Employer identification number
75-0827446

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other 250.0000 %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other _____ %	3b	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			16,519,420.	1,121,175.	16,519,420.	4.28
b Medicaid (from Worksheet 3, column a)			35,117,943.	31,606,214.	3,511,728.	.98
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			51,637,363.	32,727,389.	20,031,148.	5.26
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			44,189.		44,189.	.01
f Health professions education (from Worksheet 5)			700,174.	398,329.	301,845.	.08
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			44,408.	35,000.	9,408.	
j **Total.** Other Benefits			788,771.	433,329.	355,442.	.09
k **Total.** Add lines 7d and 7j			52,426,134.	33,160,718.	20,386,590.	5.35

Part II **Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total						

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2 62,323,883.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3 3,739,433.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5 106,353,655.		
6	Enter Medicare allowable costs of care relating to payments on line 5	6 141,603,337.		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7 -35,249,682.		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other			

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a	X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X	

Part IV **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest - see instructions)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 HENDRICK MEDICAL CENTER 1900 PINE STREET ABILENE TX 79601 WWW.EHENDRICK.ORG 000500	X	X					X		REHABILITATION CTR	
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group HENDRICK MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 16			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): SEE PART V, SECTION C			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 2015			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): SEE PART V, SECTION C			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group HENDRICK MEDICAL CENTER

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	X	
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250.0000 % and FPG family income limit for eligibility for discounted care of 400.0000 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[ ] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[ ] Underinsurance status			
g	[X] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): SEE PART V, SECTION C			
b	[X] The FAP application form was widely available on a website (list url): SEE PART V, SECTION C			
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE PART V, SECTION C			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	[X] Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[X] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	[ ] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group HENDRICK MEDICAL CENTER

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☒ None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):

- **a** ☒ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs
- **b** ☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process
- **c** ☒ Processed incomplete and complete FAP applications
- **d** ☒ Made presumptive eligibility determinations
- **e** ☐ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	21	X	
	If "No," indicate why:			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

Name of hospital facility or letter of facility reporting group HENDRICK MEDICAL CENTER

			Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period			
b	☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
c	☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
d	☐ The hospital facility used a prospective Medicare or Medicaid method			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	**23**		X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	**24**		X

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SCHEDULE H, PART V, SECTION B, LINE 11

ALL NEEDS IDENTIFIED THROUGH THE CHNA ARE BEING ADDRESSED BY THE IMPLEMENTATION STRATEGY. THE COMMUNITY WAS PRESENTED WITH THE CHNA RESULTS AND COMMITTEES HAVE BEEN FORMED WITH COMMUNITY MEMBERS TO ADDRESS NEEDS IDENTIFIED BY THE CHNA.

SCHEDULE H, PART V, SECTION B, LINES 7A & 10A

THE HOSPITAL'S CHNA AND IMPLEMENTATION STRATEGY ARE POSTED AT THE FOLLOWING WEBSITE: HTTP://WWW.HENDRICKHEALTH.ORG/MAIN/CHNA.ASPX

SCHEDULE H, PART V, SECTION B, LINES 16A, 16B,& 16C

THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE AT THE FOLLOWING WEBSITE: HTTP://WWW.HENDRICKHEALTH.ORG/PATIENTS/FINANCIAL-ASSISTANCE.ASPX

SCHEDULE H, PART V, SECTION B, LINE 5

COMMUNITY INPUT WAS PROVIDED THROUGH KEY INFORMANT INTERVIEWS OF 38 STAKEHOLDERS. THE INFORMATION GATHERED WAS ANALYZED AND REVIEWED TO IDENTIFY HEALTH ISSUES OF UN-INSURED PERSONS, LOW-INCOME AND UNDERSERVED POPULATIONS, AND THE COMMUNITY AS A WHOLE.

Part V **Facility Information** *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART III, SECTION A, LINE 2

AMOUNTS REPORTED ON LINE 2 IS BASED ON BAD DEBTS PER THE AUDITED

FINANCIAL STATEMENTS.

SCHEDULE H, PART III, SECTION A, LINE 3

THE ORGANIZATION'S ESTIMATE OF THE AMOUNT OF BAD DEBT ATTRIBUTABLE TO

CHARTY CARE PATIENTS IS ESTIMATED AT 6%.

SCHEDULE H, PART III, SECTION A, LINE 4

THE FINANCIAL STATEMENT FOOTNOTE DESCRIBING BAD DEBT IS LOCATED ON PAGES

27-28 OF THE AUDITED FINANCIAL STATEMENT REPORT.

SCHEDULE H, PART III, SECTION B, LINE 8

THE ORGANIZATION HAD A MEDICARE SHORTFALL IN THE AMOUNT OF 35,249,682.

THE STATE OF TEXAS TREATS MEDICARE SHORTFALL AS A COMMUNITY BENEFIT FOR

MEETING STATUTORY REQUIREMENTS FOR CHARITY CARE AND COMMUNITY BENEFIT.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART III, SECTION C, LINE 9B

NEITHER THE ORGANIZATION, NOR THIRD PARTIES AUTHORIZED BY THE ORGANIZATION, TAKE ANY ACTIONS UPON NON-PAYMENT FROM A PATIENT BEFORE MAKING A REASONABLE EFFORT TO DETERMINE IF THE PATIENT IS ELIGIBLE FOR THE FACILITY'S FINANCIAL ASSISTANCE POLICY.

SCHEDULE H, PART VI, LINE 2

HENDRICK MEDICAL CENTER ("HENDRICK") CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") IN JANUARY THROUGH JUNE OF 2016, WITH THE ASSISTANCE OF BKD, LLP, A CPA AND ADVISORY FIRM. THE ASSESSMENT DETERMINED THE MOST PRESSING HEALTH NEEDS OF TAYLOR, JONES AND CALLAHAN COUNTIES. BASED ON CURRENT LITERATURE AND OTHER GUIDANCE FROM THE TREASURY AND THE IRS, THE FOLLOWING STEPS WERE TAKEN AS PART OF HENDRICK'S CHNA:

- THE "COMMUNITY SERVED" WAS DEFINED UTILIZING INPATIENT DATA REGARDING PATIENT ORIGIN.

- POPULATION DEMOGRAPHICS AND SOCIOECONOMIC CHARACTERISTICS OF THE COMMUNITY WERE GATHERED AND REPORTED UTILIZING VARIOUS THIRD PARTIES.

-HEALTH STATUS OF THE COMMUNITY WAS REVIEWED.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

- AN INVENTORY OF HEALTH CARE FACILITIES AND RESOURCES WAS PREPARED.

- COMMUNITY INPUT WAS PROVIDED THROUGH KEY INFORMANT INTERVIEWS OF 33

STAKEHOLDERS. THE INFORMATION GATHERED WAS ANALYZED AND REVIEWED TO

IDENTIFY HEALTH ISSUES OF UN-INSURED PERSONS, LOW-INCOME AND UNDERSERVED

POPULATIONS, AND THE COMMUNITY AS A WHOLE.

WE ARE CURRENTLY BEGINNING THE PROCESS FOR THE 2019 CHNA AND

IMPLEMENTATION PROCESS.

SCHEDULE H, PART VI, LINE 3

HENDRICK PROVIDES MANY OPPORTUNITIES FOR PATIENT EDUCATION ON

FINANCIAL ASSISTANCE. THE PROGRAMS ARE OUTLINED ON HENDRICK'S WEBSITE,

SIGNS AND BROCHURES ARE AT EVERY REGISTRATION POINT, PRE-ADMIT LETTERS

ARE SENT TO SURGERY PATIENTS THAT CONTAIN FINANCIAL ASSISTANCE

INFORMATION, AND APPLICATIONS ARE GIVEN TO EVERY UNINSURED TRAUMA CENTER

PATIENT.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART VI, LINE 4

HENDRICK IS ACTIVELY DELIVERING CARE FOR A 24 COUNTY SERVICE AREA WITH A BROAD RANGE OF DEMOGRAPHICS.

SCHEDULE H, PART VI, LINE 5

THE COMMUNITY BUILDING ACTIVITIES ARE USED TO POSITIVELY IMPACT THE COMMUNITY AND EDUCATE THE COMMUNITY ON HEALTH TOPICS. THESE ARE DESIGNED TO MEET THE SPECIFIC NEEDS OF THE COMMUNITY.

SCHEDULE H, PART VI, LINE 6

HENDRICK MEDICAL CENTER IS PART OF AN ORGANIZATION OF AFFILIATED COMPANIES THAT PROVIDE MEDICAL AND OTHER HEALTH CARE RELATED SERVICES TO TAYLOR COUNTY AND SURROUNDING COUNTY SERVICE AREAS. THE PRIMARY BUSINESS AREAS ARE INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES, SUB-ACUTE CARE, INPATIENT AND OUTPATIENT REHABILITATION, LONG-TERM CARE, NURSING HOME CARE, HOME HEALTH CARE, HOSPICE CARE, MEDICAL OFFICE BUILDING LEASING, DURABLE MEDICAL EQUIPMENT SALES AND LEASING, PHYSICIAN PRACTICES AND A REGIONAL HEALTH MAINTENANCE ORGANIZATION. AFFILIATES INCLUDE

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

HENDRICK MEDICAL DEVELOPMENT CORPORATION, HENDRICK MEDICAL CENTER

FOUNDATION, HENDRICK PROVIDER NETWORK, HENDRICK MEDICAL OFFICE BUILDINGS,

LLC, HENDRICK ANESTHESIA NETWORK, HENDRICK HOSPICE CARE, HENDRICK

SOUTHWESTERN HEALTH DEVELOPMENT CORPORATION, HENDRICK HEALTH NETWORK AND

HENDRICK SURGERY CENTER.

SCHEDULE H, PART VI, LINE 7

TX

SCHEDULE H, PART I, LINE 7, COLUMN F

BAD DEBT EXPENSE OF $ 62,323,883 WAS INCLUDED ON FORM 990, PART IX, LINE

25, COLUMN (A), BUT WAS SUBTRACTED FROM TOTAL EXPENSE FOR THE CALCULATION

OF "PERCENT OF TOTAL EXPENSE" IN THIS COLUMN.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
HENDRICK MEDICAL CENTER

Employer identification number
75-0827446

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [ ] 200% [X] Other 250.0000 %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [ ] 300% [ ] 350% [X] 400% [ ] Other _____ %	3b	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			20,257,647.	9,442,600.	10,815,047.	2.81
b Medicaid (from Worksheet 3, column a)			37,012,537.	42,316,507.	-5,303,970.	
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total.** Financial Assistance and Means-Tested Government Programs			57,270,184.	51,759,107.	5,511,077.	2.81
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			11,307.		11,307.	
f Health professions education (from Worksheet 5)			693,547.	510,170.	183,377.	.05
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			447,026.	35,000.	412,026.	.11
j **Total.** Other Benefits			1,151,880.	545,170.	606,710.	.16
k **Total.** Add lines 7d and 7j			58,422,064.	52,304,277.	6,117,787.	2.97

Part II **Community Building Activities** Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total						

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	134,530,569.	
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	8,071,834.	
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	110,067,133.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	115,956,079.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-5,888,946.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a	X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X	

Part IV **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest - see instructions)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 HENDRICK MEDICAL CENTER 1900 PINE STREET ABILENE TX 79601 WWW.EHENDRICK.ORG 000500	X	X					X		REHABILITATION CTR	
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group HENDRICK MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

			Yes	No
	Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): SEE PART V, SECTION C			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 18			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): SEE PART V, SECTION C			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group HENDRICK MEDICAL CENTER

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	X	
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250.0000 % and FPG family income limit for eligibility for discounted care of 400.0000 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[ ] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[ ] Underinsurance status			
g	[X] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): SEE PART V, SECTION C			
b	[X] The FAP application form was widely available on a website (list url): SEE PART V, SECTION C			
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE PART V, SECTION C			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	[X] Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[X] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations			
j	[ ] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group HENDRICK MEDICAL CENTER

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☒ None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):

- **a** ☒ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)
- **b** ☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- **c** ☒ Processed incomplete and complete FAP applications (if not, describe in Section C)
- **d** ☒ Made presumptive eligibility determinations (if not, describe in Section C)
- **e** ☐ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	21	X	
	If "No," indicate why:			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

Name of hospital facility or letter of facility reporting group HENDRICK MEDICAL CENTER

			Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period			
b	☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
c	☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
d	☐ The hospital facility used a prospective Medicare or Medicaid method			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	**23**		X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	**24**		X

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SCHEDULE H, PART V, SECTION B, LINE 11

ALL NEEDS IDENTIFIED THROUGH THE CHNA ARE BEING ADDRESSED BY THE IMPLEMENTATION STRATEGY. THE COMMUNITY WAS PRESENTED WITH THE CHNA RESULTS AND COMMITTEES HAVE BEEN FORMED WITH COMMUNITY MEMBERS TO ADDRESS NEEDS IDENTIFIED BY THE CHNA.

SCHEDULE H, PART V, SECTION B, LINES 7A & 10A

THE HOSPITAL'S CHNA AND IMPLEMENTATION STRATEGY ARE POSTED AT THE FOLLOWING WEBSITE: HTTP://WWW.HENDRICKHEALTH.ORG/MAIN/CHNA.ASPX

SCHEDULE H, PART V, SECTION B, LINES 16A, 16B,& 16C

THE FINANCIAL ASSISTANCE POLICY, APPLICATION FORM, AND PLAIN LANGUAGE SUMMARY ARE WIDELY AVAILABLE AT THE FOLLOWING WEBSITE: HTTP://WWW.HENDRICKHEALTH.ORG/PATIENTS/FINANCIAL-ASSISTANCE.ASPX

SCHEDULE H, PART V, SECTION B, LINE 5

COMMUNITY INPUT WAS PROVIDED THROUGH KEY INFORMANT INTERVIEWS OF COMMUNITY STAKEHOLDERS. THE INFORMATION GATHERED WAS ANALYZED AND REVIEWED TO IDENTIFY HEALTH ISSUES OF UN-INSURED PERSONS, LOW-INCOME AND UNDERSERVED POPULATIONS, AND THE COMMUNITY AS A WHOLE. COMMUNITY SURVEYS WERE ALSO CONDUCTED ALONG WITH MARKETING AND TREND ANALYSIS.

Part V **Facility Information** *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART III, SECTION A, LINE 2

THE HOSPITAL HAS ADOPTED THE NEW REVENUE RECOGNITION STANDARD ASU 2014-09. UNDER ASU 2014-09, THE ESTIMATED AMOUNTS DUE FROM PATIENTS FOR WHICH THE HEALTH SYSTEM DOES NOT EXPECT TO BE ENTITLED OR COLLECT FROM THE PATIENTS ARE CONSIDERED IMPLICIT PRICE CONCESSIONS AND EXCLUDED FROM THE HEALTH SYSTEM'S ESTIMATION OF THE TRANSACTION PRICE OR REVENUE RECORDED. BAD DEBT EXPENSE WAS NOT SIGNIFICANT TO THE AUDITED FINANCIAL STATEMENTS FOR THE YEAR ENDED AUGUST 31, 2019. HOWEVER, THE HOSPITAL INTERNALLY TRACKS BAD DEBT EXPENSE CONSISTENT WITH HISTORICAL PRACTICES AND THAT AMOUNT HAS BEEN REPORTED ON SCHEDULE H, PART III, SECTION A, LINE 2.

SCHEDULE H, PART III, SECTION A, LINE 3

THE ORGANIZATION'S ESTIMATE OF THE AMOUNT OF BAD DEBT ATTRIBUTABLE TO CHARTY CARE PATIENTS IS ESTIMATED AT 6%.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART III, SECTION A, LINE 4

THE FINANCIAL STATEMENT FOOTNOTE DESCRIBING BAD DEBT IS LOCATED ON PAGES

27-28 OF THE AUDITED FINANCIAL STATEMENT REPORT.

SCHEDULE H, PART III, SECTION B, LINE 8

THE ORGANIZATION HAD A MEDICARE SHORTFALL IN THE AMOUNT OF 5,888,946.

THE STATE OF TEXAS TREATS MEDICARE SHORTFALL AS A COMMUNITY BENEFIT FOR

MEETING STATUTORY REQUIREMENTS FOR CHARITY CARE AND COMMUNITY BENEFIT.

SCHEDULE H, PART III, SECTION C, LINE 9B

NEITHER THE ORGANIZATION, NOR THIRD PARTIES AUTHORIZED BY THE

ORGANIZATION, TAKE ANY ACTIONS UPON NON-PAYMENT FROM A PATIENT BEFORE

MAKING A REASONABLE EFFORT TO DETERMINE IF THE PATIENT IS ELIGIBLE FOR

THE FACILITY'S FINANCIAL ASSISTANCE POLICY.

SCHEDULE H, PART VI, LINE 2

HENDRICK MEDICAL CENTER (HENDRICK) CONDUCTED A COMMUNITY HEALTH NEEDS

ASSESSMENT (CHNA) IN JANUARY THROUGH JUNE OF 2019, WITH THE ASSISTANCE

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

OF CRESCENDO CONSULTING GROUP. THE ASSESSMENT DETERMINED THE MOST

PRESSING HEALTH NEEDS OF TAYLOR, JONES AND CALLAHAN COUNTIES. BASED ON

CURRENT LITERATURE AND OTHER GUIDANCE FROM THE TREASURY AND THE IRS, THE

FOLLOWING STEPS WERE TAKEN AS PART OF HENDRICK'S CHNA:

- THE COMMUNITY SERVED WAS DEFINED UTILIZING INPATIENT DATA REGARDING

PATIENT ORIGIN.

- POPULATION DEMOGRAPHICS AND SOCIOECONOMIC CHARACTERISTICS OF THE

COMMUNITY WERE GATHERED AND REPORTED UTILIZING VARIOUS THIRD PARTIES.

-HEALTH STATUS OF THE COMMUNITY WAS REVIEWED.

- AN INVENTORY OF HEALTH CARE FACILITIES AND RESOURCES WAS PREPARED.

- COMMUNITY INPUT WAS PROVIDED THROUGH KEY INFORMANT INTERVIEWS OF

COMMUNITY STAKEHOLDERS. THE INFORMATION GATHERED WAS ANALYZED AND

REVIEWED TO IDENTIFY HEALTH ISSUES OF UN-INSURED PERSONS, LOW-INCOME AND

UNDERSERVED POPULATIONS, AND THE COMMUNITY AS A WHOLE.

WE ARE CURRENTLY UNDERGOING THE IMPLEMENTATION PROCESS OF THE 2019 CHNA.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART VI, LINE 3

HENDRICK PROVIDES MANY OPPORTUNITIES FOR PATIENT EDUCATION ON FINANCIAL ASSISTANCE. THE PROGRAMS ARE OUTLINED ON HENDRICK'S WEBSITE, SIGNS AND BROCHURES ARE AT EVERY REGISTRATION POINT, PRE-ADMIT LETTERS ARE SENT TO SURGERY PATIENTS THAT CONTAIN FINANCIAL ASSISTANCE INFORMATION, AND APPLICATIONS ARE GIVEN TO EVERY UNINSURED TRAUMA CENTER PATIENT.

SCHEDULE H, PART VI, LINE 4

HENDRICK IS ACTIVELY DELIVERING CARE FOR A 24 COUNTY SERVICE AREA WITH A BROAD RANGE OF DEMOGRAPHICS.

SCHEDULE H, PART VI, LINE 5

THE COMMUNITY BUILDING ACTIVITIES ARE USED TO POSITIVELY IMPACT THE COMMUNITY AND EDUCATE THE COMMUNITY ON HEALTH TOPICS. THESE ARE DESIGNED TO MEET THE SPECIFIC NEEDS OF THE COMMUNITY.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART VI, LINE 6

HENDRICK MEDICAL CENTER IS PART OF AN ORGANIZATION OF AFFILIATED COMPANIES THAT PROVIDE MEDICAL AND OTHER HEALTH CARE RELATED SERVICES TO TAYLOR COUNTY AND SURROUNDING COUNTY SERVICE AREAS. THE PRIMARY BUSINESS AREAS ARE INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES, SUB-ACUTE CARE, INPATIENT AND OUTPATIENT REHABILITATION, LONG-TERM CARE, NURSING HOME CARE, HOME HEALTH CARE, HOSPICE CARE, MEDICAL OFFICE BUILDING LEASING, DURABLE MEDICAL EQUIPMENT SALES AND LEASING, PHYSICIAN PRACTICES AND A REGIONAL HEALTH MAINTENANCE ORGANIZATION. AFFILIATES INCLUDE HENDRICK MEDICAL CENTER FOUNDATION, HENDRICK PROVIDER NETWORK, HENDRICK MEDICAL OFFICE BUILDINGS, LLC, HENDRICK ANESTHESIA NETWORK, HENDRICK HOSPICE CARE, HENDRICK SOUTHWESTERN HEALTH DEVELOPMENT CORPORATION, HENDRICK HEALTH NETWORK, HENDRICK SURGERY CENTER AND HENDRICK DIALYSIS CENTER LLC.

SCHEDULE H, PART VI, LINE 7

TX

Reference	Description
Attachment 8	Meeting Minutes

MINUTES
CALLED MEETING
BOARD OF TRUSTEES
HENDRICK MEDICAL CENTER
JANUARY 30, 2020

The names of those present are underlined.

Cathy Ashby	Joe Melson
Richard Darden	David Morris
Ron Fogle	Shannon Nix
Scott Hibbs	Janet O'Dell
Diane Leggett	Larry Smith, Chair
Randy Lloyd	Lanny Vinson
J. V. Martin	Paul Waldrop
	Mike Woodard

Also present: Brad Holland, Norm Archibald, Brian Bessent, Susie Cassle, Brett Emmett, America Farrell, Susan Greenwood, Joe Pearson, Tim Riley, David Stephenson, Susan Wade, Jeremy Walker and Pam Light.

[redacted]

CALL TO ORDER

Mr. Smith called the meeting to order at 12:04 p.m. in the Wilkins Board Room in the Shelton Building at Hendrick Medical Center and acknowledged a quorum was present. Mr. Smith gave the invocation.

[redacted]

[redacted] The COPA application has been revised [redacted]

[redacted]

[redacted]

ADJOURN

There being no further business the meeting was adjourned.

Respectfully submitted,

_____

Janet O'Dell, Secretary

MINUTES
CALLED MEETING
BOARD OF TRUSTEES
HENDRICK HEALTH SYSTEM
APRIL 22, 2020

The names of those in attendance via teleconference are underlined.

Cathy Ashby	Joe Melson
Richard Darden	David Morris
Ron Fogle	Shannon Nix
Scott Hibbs	Janet O'Dell
Diane Leggett	Larry Smith, Chair
Randy Lloyd	Lanny Vinson
J. V. Martin	Paul Waldrop
	Mike Woodard

Also present: Brad Holland, Norm Archibald, Brian Bessent, Susie Cassle, Brett Emmett, America Farrell, Susan Greenwood, Joe Pearson, David Stephenson, Tim Riley, Susan Wade, Jeremy Walker, and Pam Light.

[redacted]

CALL TO ORDER

Mr. Smith called the meeting to order at 12:03 p.m. and acknowledged a quorum was present. He gave the invocation.

[redacted]

[redacted]

[redacted]

The State of Texas Health and Human Services Commission (HHSC) is currently working on posting the rules for the Certificate of Public Advantage (COPA) application. The process has been delayed due to COVID-19. The rules could be posted as early as next week. [redacted]

[redacted]

[redacted]

ADJOURN
There being no further business the meeting was adjourned.

Respectfully submitted,

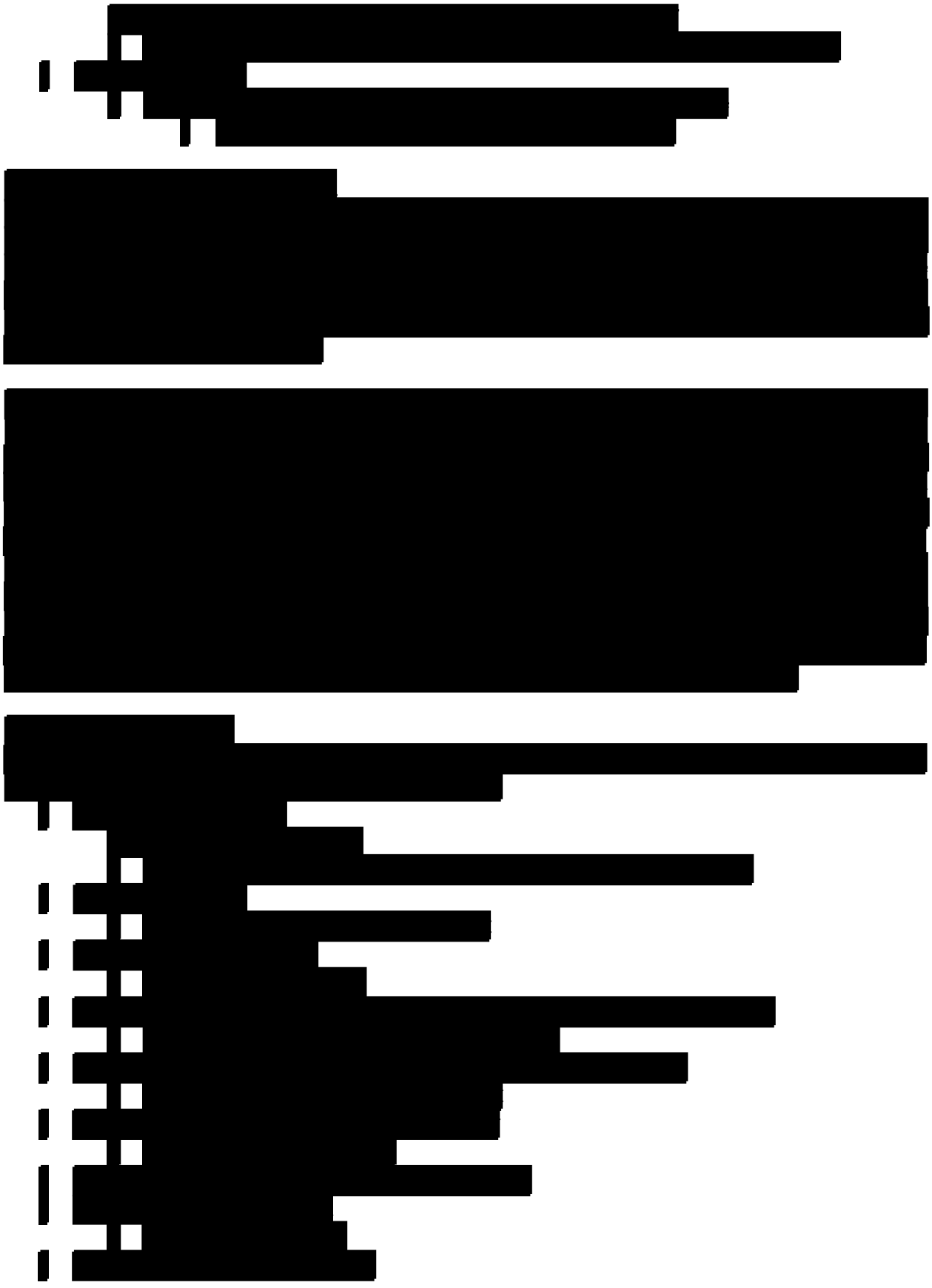
_____
Janet O'Dell, Secretary

HENDRICK MEDICAL CENTER
MANAGEMENT COUNCIL MEETING MINUTES
JULY 30, 2020 8:30 A.M.
VIRTUAL

WELCOME

Joe Pearson, Senior Vice President, welcomed everyone and called the meeting to order at 8:32 a.m.

[redacted]



[redacted]

Hendrick's COPA application was submitted on June 12, 2020

[redacted]

ADJOURNMENT

Respectively Submitted,

Susan Wade
Vice President
SW/tm

HENDRICK MEDICAL CENTER
MANAGEMENT COUNCIL MEETING MINUTES
SEPTEMBER 24, 2020 8:30 A.M.
VIRTUAL

WELCOME
Brad Holland, President and CEO, welcomed everyone and called the meeting to order at 8:33 a.m.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted] Hendrick now has 18 days until the COPA approval process expires and 32 days until the projected close date. [redacted]

[redacted]

[redacted]

[redacted] The COPA is focused on access, quality, and cost, and Hendrick needs to show that those three factors are met and exceeded compared to the loss of competition in the area. [redacted]

[redacted]

ADJOURNMENT

Respectively Submitted,

Susan Wade
Vice President
SW/tm

HENDRICK MEDICAL CENTER
CALLED MANAGEMENT COUNCIL MEETING MINUTES
OCTOBER 5, 2020 8:30 A.M.
AUXILIARY CONFERENCE CENTER

WELCOME

Brad Holland, President and CEO, welcomed everyone and called the meeting to order at 10:01 a.m.

COPA APPLICATION UPDATE

Mr. Holland confirmed that on Friday evening, October 2, 2020, the state of Texas approved the COPA application for Hendrick at the same time it approved the COPA application for Shannon Medical Center in San Angelo. External communications of the approval will come from Abilene Regional Medical Center (ARMC) and Brownwood Regional Medical Center (BRMC) by their current owner and operator, Community Health Services (CHS), however internal communication will start today in preparation.

Only 7 out of 254 counties in the state of Texas are eligible for COPAs based off of county population and medical coverage. Hendrick has proven the advantage to the community in lieu of the loss of competition, however there will be ongoing review from the state that requires robust reporting requirements. Hendrick will be required to hold an annual public hearing that has to be logged and turned into the state. Additionally, a semiannual report is required to be submitted to the department of Health and Human Services. [redacted]

[redacted]

DAY 1 PREPARATION

America Farrell, Vice President of Integration, gave an update on next steps of the preparation process now that COPA has been approved. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

ADJOURNMENT

Mr. Holland concluded the meeting at 11:13 am.

[redacted]

Respectively Submitted,

Susan Wade
Vice President
SW/tm

MINUTES
CALLED MEETIN□
□OARD OF TRUSTEES
□ENDRIC□ □EALT□ SYSTEM
OCTO□ER 20, 2020

The names of those in attendance are underlined.

Cathy Ashby	Joe Melson
Richard Darden	David Morris
Ron Fogle	Shannon Nix
Scott Hibbs (phone)	Janet O'Dell
Diane Leggett	Larry Smith, Chair
Randy Lloyd (phone)	Lanny Vinson
J. V. Martin	Paul Waldrop
	Mike Woodard

Also present: Brad Holland, Norm Archibald, Krista Baty, Brian Bessent, Gary Binkley, D.O., Susie Cassle, Brett Emmett, David Evans, America Farrell, Susan Greenwood, Stephen Lowry, M.D., Joe Pearson, Tim Riley (phone), David Stephenson, Susan Wade, Jeremy Walker, Rob Wiley, M.D., and Pam Light.

[redacted]

CALL TO ORDER
Mr. Smith called the meeting to order at 12:05 p.m. in the Auxiliary Conference Center in the Shelton Building at Hendrick Medical Center and acknowledged a quorum was present. He gave the invocation.

[redacted]

SUMMARY OF COPA FEED□AC□ FROM □□SC
Mr. Martin reminded the Board that Hendrick received approval for the COPA application from the Health and Human Services Commission (HHSC). Hendrick also received the Determination of Findings and Terms and Conditions documents. The Determination of Findings details the office of the Attorney General and the HHSC reviews of the COPA and includes public feedback.

Ms. Farrell reviewed the reporting requirements outlined in the Terms and Conditions. The conditions mandated in this document are necessary to ensure that the merger benefits the public and includes rate reviews, annual and quarterly reporting and an annual public hearing. The quarterly reports must include data measuring quality,

efficiency and accessibility. Hendrick must meet these reporting requirements for the duration of the COPA.

[redacted]

MEDICAL STAFF REPORT

[redacted]

MINUTES
CALLED MEETIN□
□OARD OF TRUSTEES
□ENDRIC□ □EALT□ SYSTEM
OCTO□ER 20, 2020
PA□E T□REE

[redacted]

AD□OURN
There being no further business the meeting was adjourned.

Respectfully submitted,

□□□□□□□□□□□□□□□□□□□□□□□□
Janet O'Dell, Secretary

[redacted]