VIII. Attachments

Attachments Contents

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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	Shannon Health Service Line Summary

Clinical Service Line	SMC	SACMCACMC
Ambulatory Surgery	✓	✓
Allergy & Immunology	✓	✓
Anesthesiology	✓	✓
Behavioral Health	✓	
Cardiology	✓	✓
Cardiovascular Surgery	✓	✓
Dermatology	✓	
Endocrinology & Diabetes Care	✓	
Emergency Services	✓	✓
Ear, Nose & Throat	✓	
Family Practice	✓	✓
Gastroenterology	✓	✓
Home Health	✓	
Hospital Medicine	✓	✓
Imaging & Radiology	✓	✓
Infusion Services	✓	✓
Internal Medicine	✓	✓
Laboratory	✓	✓
Neurology	✓	✓
Neurotherapy	✓	
Occupational Medicine	✓	
Orthopedics	✓	
Pain Management	✓	
Palliative Care	✓	
Pathology	✓	✓
Pediatrics	✓	✓
Pharmacy	✓	✓
Pulmonary Rehabilitation	✓	✓
Rheumatology	✓	
Skilled Nursing	✓	
Sleep Center	✓	
Speech Therapy	✓	✓
Sports Medicine	✓	✓
Stroke Medicine	✓	✓
Surgery	✓	✓
Telemedicine	✓	
Trauma Services	✓	
Urgent Care	✓	✓
Urology	✓	✓
Weight Loss	✓	✓
Women’s Health	✓	✓
Wound Care	✓	✓

Reference	Description
Attachment 3	Shannon Health Form 990

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.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
SHANNON MEDICAL CENTER

Employer identification number
75-2559845

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	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
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 ______ %	3a	Yes	
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		No
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	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	Yes	
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 eligibile for free or discounted care?	5c		No
6a	Did the organization prepare a community benefit report during the tax year?	6a		No
b	If "Yes," did the organization make it available to the public?	6b		

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)			19,999,680		19,999,680	7 200 %
b Medicaid (from Worksheet 3, column a)			24,337,823	20,531,761	3,806,062	1 400 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			1,155,441	148,995	1,006,446	0 400 %
d **Total** Financial Assistance and Means-Tested Government Programs			45,492,944	20,680,756	24,812,188	9 000 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			559,864		559,864	0 200 %
f Health professions education (from Worksheet 5)			837,135		837,135	0 300 %
g Subsidized health services (from Worksheet 6)			19,999,680		19,999,680	7 200 %
h Research (from Worksheet 7)			166,600		166,600	0 100 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			18,592		18,592	
j **Total.** Other Benefits			21,581,871		21,581,871	7 800 %
k **Total.** Add lines 7d and 7j			67,074,815	20,680,756	46,394,059	16 800 %

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 Heathcare Financial Management Association Statement No 15?		1	Yes	
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	25,811,182		
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			
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	92,195,691
6	Enter Medicare allowable costs of care relating to payments on line 5	6	95,879,119
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-3,683,428

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

			Yes	No
9a	Did the organization have a written debt collection policy during the tax year?	9a	Yes	
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	Yes	

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
	See Additional Data Table										

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 SHANNON MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 01

			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		No
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		No
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	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ 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	Yes	
6 a	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		No
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		No
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) SEE PART V, SECTION C			
b	☐ Other website (list url)			
c	☑ 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	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 17			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
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		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on 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 SHANNON 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?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
	a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 0 %			
	b ☐ Income level other than FPG (describe in Section C)			
	c ☐ Asset level			
	d ☐ Medical indigency			
	e ☑ Insurance status			
	f ☑ Underinsurance discount			
	g ☐ Residency			
	h ☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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 ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
	b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
	c ☑ 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	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
	a ☑ The FAP was widely available on a website (list url) SEE PART V, SECTION C			
	b ☑ The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
	c ☑ A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C			
	d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
	e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
	f ☑ 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 ☑ 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 ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
	i ☑ 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

SHANNON MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

			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**	Yes	
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**		No
	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

			Yes	No
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**	Yes	
	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 SHANNON 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?	**23**		No
If "Yes," explain in Section C			
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?	**24**		No
If "Yes," explain in Section C			

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.

Form and Line Reference	Explanation
See Add'l Data	

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? 2

	Name and address	Type of Facility (describe)
1	SHANNON SURGERY CENTER 120 E HARRIS AVENUE SAN ANGELO, TX 76903	AMBULATROY SURGERY CENTER
2	SHANNON HOME HEALTH 2030 PULLIAM STE 6 SAN ANGELO, TX 76905	HOME HEALTH CENTER
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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART III, SECTION A, LINES 2 & 3	COSTING METHODOLOGY LINE 2 AMOUNT REPORTED ON LINE 2 IS BASED ON BAD DEBTS PER THE AUDITED FINANCIAL STATEMENTS LINE 3 THE ORGANIZATION IS UNABLE TO ESTIMATE THE AMOUNT FOR LINE 3 AND HAS ELECTED TO LEAVE IT BLANK
SCHEDULE H, PART III, SECTION A, LINE 4	DESCRIPTION OF BAD DEBT SEE PAGES 9-10 OF THE ATTACHED FINANCIAL STATEMENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART III, SECTION B, LINE 8	SURPLUS OR SHORTFALL SHORTFALL 3,683,428 OBTAINED FROM THE MEDICARE COST REPORT PAYABLE LINE LESS SEQUESTRATION TO COMPUTE NET COST FOR COMPARISON TO NET INTERIM PAYMENTS THE COST REPORT USES COST TO CHARGE RATIOS FOR ANCILLARY DEPARTMENTS, PLUS IN THE ROOM AND BOARD AREAS IT IS A PER DIEM THE STATE OF TEXAS TREATS SHORTFALL AS A COMMUNITY BENEFIT FOR MEETING STATUTORY REQUIREMENTS FOR CHARITY CARE AND COMMUNITY BENEFIT
SCHEDULE H, PART III, SECTION C, LINE 9B	WRITTEN DEBT COLLECTION POLICY CHARITY CARE AND DISCOUNTING FOR UNINSURED PATIENTS WHO ARE NOT ELIGIBLE FOR GOVERNMENT HEALTH CARE PROGRAMS AND WHOSE FINANCIAL CONDITION IS SUCH THAT THEY ARE NOT ABLE TO PAY FOR HOSPITAL SERVICES MAY BE ELIGIBLE FOR ASSISTANCE UNDER THE SHANNON MEDICAL CENTER CHARITY CARE PROGRAM PATIENTS WHO ARE UNINSURED, DO NOT QUALIFY FOR COVERAGE UNDER GOVERNMENT HEALTH CARE PROGRAMS, MAY BE ELIGIBLE FOR A 50% DISCOUNT OFF THE TOTAL BILL FOR HOSPITAL SERVICES, IF THE SERVICES ARE PAID FOR WHEN RECEIVED OR WITHIN 30 DAYS OF DISCHARGE COLLECTION OF ACCOUNTS RECEIVABLE PATIENTS / GUARANTOR WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES RECEIVED AT SHANNON MEDICAL CENTER PATIENTS / GUARANTORS WILL BE RESPONSIBLE FOR FULL CHARGES, OR PATIENT PORTION NOT COVERED BY INSURANCE PAYMENT WILL BE REQUESTED PRIOR TO OR ON THE DATE OF SCHEDULED ELECTIVE SERVICES FULL CHARGES OR PATIENT PORTION NOT COVERED BY INSURANCE FOR URGENT / EMERGENT SERVICES WILL BE COLLECTED UPON DISCHARGE PATIENTS WHO ARE UNABLE TO PAY THE FULL AMOUNT OF THEIR RESPONSIBILITY AT THE TIME OF SERVICE CAN MAKE PAYMENT ARRANGEMENTS UNDER THE FOLLOWING GUIDELINES A BALANCE OF OUTPATIENT SERVICES MUST BE PAID WITHIN SIX (6) MONTHS FROM THE DATE OF SERVICE UNLESS INDIGENT STATUS IS PROVEN B BALANCE OF INPATIENT SERVICES MUST BE PAID WITHIN TWELVE (12) MONTHS FROM THE DATE OF DISCHARGE UNLESS INDIGENT STATUS IS PROVEN MONTHLY STATEMENTS WILL BE SENT THROUGHOUT THE COLLECTION CYCLE COLLECTION LETTERS WILL BE UTILIZED AT THE DISCRETION OF THE PATIENT ACCOUNT REPRESENTATIVE ACCOUNTS WILL BE REVIEWED FOR OUTSIDE COLLECTION AGENCY PLACEMENT ANYTIME FOLLOWING 90 DAYS FROM THE DATE OF SERVICE MEDICARE ACCOUNTS WILL NOT BE CONSIDERED FOR PLACEMENT UNTIL 120 DAYS FROM THE FIRST NOTICE OF PATIENT RESPONSIBILITY IN ACCORDANCE WITH MEDICARE REGULATIONS ANY OVERPAYMENT OF AN ACCOUNT WILL BE REVIEWED FOR REFUND WITHIN 30 DAYS FROM THE DATE THE CREDIT BALANCE IS CREATED BY THE OVERPAYMENT CREDIT BALANCES ON MEDICARE ACCOUNTS WILL BE PROCESSED THROUGH THE NORMAL CREDIT BALANCE PROCESS AND REPORTED ON A QUARTERLY BASIS IN COMPLIANCE WITH MEDICARE REGULATIONS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B	NEEDS ASSESSMENT THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT GATHERED OVERALL HEALTH INFORMATION OF THE COMMUNITY ANALYSIS OF THE COMMUNITY NEEDS ASSESSMENT DATA PROVIDED A MEANS TO EVALUATE AND PRIORITIZE AREAS OF GREATEST NEED TO FACILITATE PRIORITIZATION OF IDENTIFIED HEALTH NEEDS, A RANKING AND PRIORITIZATION PROCESS WAS USED HEALTH NEEDS WERE RANKED BASED ON THE FOLLOWING FIVE FACTORS -HOW MANY PEOPLE ARE AFFECTED BY THE ISSUE OR SIZE OF THE ISSUE? -WHAT ARE THE CONSEQUENCES OF NOT ADDRESSING THIS PROBLEM? -THE IMPACT OF THE PROBLEM ON VULNERABLE POPULATIONS -HOW IMPORTANT THE PROBLEM IS TO THE COMMUNITY? -PREVALENCE OF COMMON THEMES EACH FACTOR RECEIVED A RATING SCORE BETWEEN 0 AND 5 RATINGS WERE BASED ON THE PERCENTAGE OF THE COMMUNITY WHO ARE IMPACTED BY THE IDENTIFIED NEED THE FOLLOWING SCALE WAS UTILIZED >25% OF THE COMMUNITY= 5, >15% AND <25%=4, >10% AND <15%=3, >5% AND <10%=2 AND <5%=1 BELOW ARE THE ISSUES WITH THE TOP FIVE SCORES BY FOCUSING PRIMARILY ON HEALTH NEEDS WITH HIGHER TOTAL SCORES, OVERALL COMMUNITY HEALTH WILL LIKELY IMPROVE AS THESE NEEDS HAVE THE GREATEST IMPACT ON OVERALL HEALTH AND THE HOSPITAL IS MORE LIKELY TO INFLUENCE A POSITIVE IMPACT ON THESE NEEDS HEALTH NEED TOTAL SCORE ____ LACK OF HEALTH KNOWLEDGE/EDUCATION 22 HEALTHY BEHAVIORS/LIFESTYLE CHANGES 21 ADULT OBESITY 20 POVERTY/FINANCIAL RESOURCES/CHILDREN IN POVERTY 19 DIABETES 19 AS A RESULT FROM THE ANALYSIS, PRIORITIES WERE DETERMINED BY TAKING INTO ACCOUNT THE OVERALL RANKING, THE DEGREE TO WHICH SHANNON CAN INFLUENCE LONG-TERM CHANGE AND THE IDENTIFIED HEALTH NEEDS IMPACT ON OVERALL HEALTH THE FOLLOWING PRIORITIES WERE IDENTIFIED -HEALTHY LIVING -PREVENTION AND DISEASE MANAGEMENT -EDUCATION SHANNON MEDICAL CENTER CORRELATED COMMUNITY PRIORITIES HEALTH NEED -- HEALTHY LIVING -ADULT OBESITY -UNINSURED -PHYSICAL INACTIVITY -LIMITED ACCESS TO HEALTH FOODS/NUTRITION PREVENTION AND DISEASE MANAGEMENT -DIABETES -LACK OF PRIMARY CARE PHYSICIANS -HIGH BLOOD PRESSURE EDUCATION -LACK OF HEALTH KNOWLEDGE/EDUCATION -HEALTHY BEHAVIORS/LIFESTYLE CHANGES -LANGUAGE/CULTURAL MINDSET THE HOSPITALS' COMMUNITY HEALTH NEEDS ASSESSMENT & IMPLEMENTATION PLAN CAN BE FOUND AT https //www shannonhealth com/education-resources/health-needs-assessment aspx
SCHEDULE H, PART VI, LINE 3	PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE FINANCIAL ASSISTANCE BROCHURES THAT OUTLINE ACCESS TO INFORMATION ABOUT ASSISTANCE PROGRAMS ARE AVAILABLE IN EACH OF THE REGISTRATION AREAS WE ALSO HAVE CONTRACTED ELIGIBILITY WORKERS WHO SCREEN PATIENTS FOR ALL SOCIAL SERVICE PROGRAMS AND ASSIST WITH THE APPLICATION PROCESS IF NEEDED

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 4	COMMUNITY INFORMATION SHANNON MEDICAL CENTER IS LOCATED IN SAN ANGELO, TEXAS THE CITY OF SAN ANGELO SERVES AS THE COUNTY SEAT AND POPULATION CENTER OF TOM GREEN COUNTY, WITH AN ESTIMATED POPULATION IN 2018 OF 118,189 TOM GREEN COUNTY'S POPULATION IN 2017 IS REPORTED AT 118,019 THE ESTIMATED POPULATION FOR SHANNON'S SERVICE AREA AS OF 2018, INCLUDING TOM GREEN COUNTY, IS 357,589 (U S CENSUS BUREAU, STATE & COUNTY QUICKFACTS) THE COUNTIES INCLUDED IN THE SHANNON SERVICE AREA ARE BROWN, COKE, CONCHO, COLEMAN, CROCKETT, HOWARD, IRION, KIMBLE, MASON, MCCULLOCH, MENARD, MILLS, MITCHELL, NOLAN, PECOS, REAGAN, RUNNELS, SAN SABA, SCHLEICHER, STERLING, SUTTON, TERRELL, TOM GREEN, UPTON, AND VAL VERDE A BREAKDOWN OF TOM GREEN COUNTY DEMOGRAPHICS IS AS FOLLOWS (SOURCE U S CENSUS BUREAU, STATE & COUNTY QUICKFACTS, THE COUNTY INFORMATION PROJECT, TEXAS ASSOCIATION OF COUNTIES) A Tom Green County Age Distribution 1 Under 18 years old 23 7% (28,011) 2 18-64 years old 61 1% (72,213) 3 65 years and older 15 2% (17,965) B Tom Green County Ethnic Distribution (More than one category may be self-reported) 1 Caucasian 53 2% (62,877) 2 Hispanic 30 0% (47,276) 3 Black 4 4% (5,200) 4 Other 2 4% (2,836) C Tom Green County (Household) 1 Median Household Income $49,662 (Texas $57,051) 2 Persons living in poverty level 13 5 % (Texas 14 7%) D Tom Green County Health Index 1 Tom Green County uninsured 17 9% (Texas 19 4%, United States 10 2%) (Source U S Census Bureau, Quickfacts, 2018)
SCHEDULE H, PART VI, LINE 5	PROMOTION OF COMMUNITY HEALTH IN A COUNTY WITH NO HOSPITAL TAXING AUTHORITY, A HOSPITAL WHOSE MISSION REFLECTS COMMITMENT TO TREATING PATIENTS WITHOUT REGARD TO ABILITY TO PAY IS A HIGHLY DESIRABLE AND PIVOTAL POINT OF COMMUNITY HEALTH CARE FOR MORE THAN 80 YEARS, SHANNON HAS EMBRACED SUCH A MISSION AND FOLLOWS THROUGH ON THE WISHES OF OUR BENEFACTOR, MARGARET SHANNON, IN PROVIDING CARE FOR THE PEOPLE OF WEST TEXAS OUR FY2018 CHARITY CARE FIGURE OF MORE THAN $75,686,016 WOULD BE A BURDEN TO THE TAXPAYERS OF TOM GREEN COUNTY, AND MANY OTHER COUNTIES WHOSE CITIZENS DIRECTLY BENEFIT FROM HER GENEROSITY SHANNON PROVIDES A HOST OF COMMUNITY EDUCATION EVENTS RELATED TO TOPICS SUCH AS CANCER PREVENTION AND SCREENINGS, DIABETES EDUCATION, FITNESS AND NUTRITION, CHILDBIRTH AND CHILD CARE, AND CARDIOVASCULAR HEALTH THROUGH EDUCATIONAL EVENTS LIKE HEALTHBEAT LIVE AND VARIOUS COMMUNITY EVENTS, HEALTH PROFESSIONALS RELAY CURRENT HEALTH INFORMATION TO THE PUBLIC SHANNON PROVIDES HEALTH AND WELLNESS PRESENTATIONS TO NUMEROUS NON-PROFITS, BUSINESSES AND ORGANIZATIONS, INCLUDING REGIONAL SCHOOL DISTRICTS AND ANGELO STATE UNIVERSITY REPRESENTATIVES FROM DIFFERENT DEPARTMENTS PROVIDE SUPPORT AND PARTICIPATE IN LOCAL HEALTH FAIRS AND HEALTH-RELATED COMMUNITY EVENTS WHERE THEY PROVIDE VARIOUS HEALTH SCREENINGS AND EDUCATIONAL MATERIAL IN ADDITION TO PUBLIC OUTREACH EVENTS, SHANNON PUBLISHES THE HEALTHBEAT NEWSLETTER MAGAZINE WHICH IS DELIVERED TO 30,000 HOUSEHOLDS AND PRODUCES HEALTHBEAT TELEVISION SPOTS THAT AIR DURING THE 6 AND 10 P M NEWS HOURS ON TWO LOCAL STATIONS SHANNON CONTRIBUTED $167,700 FOR THESE PROGRAMS SHANNON IS A PROUD SPONSOR AND CONTRIBUTOR TO THE LOCAL GO RED LUNCHEON GO RED IS A NATIONAL INITIATIVE AIMED AT UNITING WOMEN, MEN, AND THEIR FRIENDS AND FAMILY IN THE FIGHT AGAINST HEART DISEASE THE LUNCHEON IS DESIGNED TO HELP EDUCATE AND BRING AWARENESS TO THE COMMUNITY ABOUT HOW HEART DISEASE AFFECTS WOMEN AND MEN DIFFERENTLY, AND HOW TO TAKE STEPS TO ADDRESS THEIR RISK FOR A HEART ATTACK SHANNON UNDERSTANDS THAT CONTINUED EDUCATION AND AWARENESS IS CRUCIAL FOR WOMEN AND MEN TO FIGHT THIS DEADLY DISEASE IN ADDITION, SHANNON OFFERS VARIOUS FREE SCREENING SERVICES, SUCH AS BLOOD PRESSURE CHECKS, AT THIS EVENT APPROXIMATELY 500 COMMUNITY MEMBERS WERE IN ATTENDANCE TO THE GO RED LUNCHEON THIS EVENT IS PROVIDED AT A COST OF $10,344 TO SHANNON SHANNON SUPPORTS HEALTH AND FITNESS ACTIVITIES, AS WELL TO ADDRESS THE GROWING CONCERN OVER CHILDHOOD OBESITY, THE KIDS MARATHON EVENT PROVIDES AN OPPORTUNITY FOR STUDENTS, RANGING FROM KINDERGARTEN THROUGH SIXTH GRADE, TO PARTICIPATE IN A PROGRAM THAT ENCOURAGES HEALTHY HABIT FORMATION EARLY IN LIFE A FULL MARATHON IS CONSIDERED 26 2 MILES STUDENTS ACCUMULATE MILES AND RUN THE LAST 0 2 LAP DURING A CELEBRATORY EVENT AT THE SAN ANGELO STADIUM THE EVENT HOSTS ORGANIZATIONS THAT OFFER LOCAL SUMMER PROGRAMS AND CAMPS THAT ENCOURAGE CHILDREN TO REMAIN ACTIVE THROUGH THE SUMMER MONTHS THIS EVENT IS PROVIDED AT A COST OF $3,720 TO SHANNON SHANNON HAS RECOGNIZED A COMMUNITY NEED TO OFFER SUPPORTIVE SERVICES TO PARENTS AND FAMILIES SUFFERING FROM EARLY PREGNANCY LOSS, STILLBIRTH, OR NEWBORN DEATH THE WHITE ROSE SUPPORT GROUP AT SHANNON HOSTS A 5-PART SESSION CALLED "GRIEVING THE CHILD I NEVER KNEW" TO OFFER INSIGHT, ENCOURAGEMENT, HEALING, HOPE, AND SHARING FOR FAMILIES EXPERIENCING PERINATAL LOSS FURTHERMORE, THE WHITE ROSE SUPPORT GROUP HOSTS A WALK TO REMEMBER AND CANDLELIGHT EVENT FOR THOSE WHO HAVE SUFFERED THESE EVENTS ARE PROVIDED AT A COST OF $19,576 TO SHANNON SHANNON IS THE ONLY PROVIDER THAT OPERATES THE SEXUAL ASSAULT NURSE EXAMINER PROGRAM (SANE) IN THE SHANNON SERVICE AREA SANE TRAINED NURSES WORK WITH THE CHILDRENS ADVOCACY CENTER, THE CONCHO VALLEY RAPE CRISIS CENTER AND OTHER COMMUNITY-BASED ORGANIZATIONS TO PROVIDE TRAINING AND SERVICES RELATED TO SEXUAL ASSAULT CRISES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 6	AFFILIATED HEALTH CARE SYSTEM SHANNON, A NON-PROFIT HEALTH SYSTEM ESTABLISHED IN THE 1930S, PROVIDES THE COMMUNITIES OF WEST CENTRAL TEXAS WITH A VARIETY OF MEDICAL SERVICES DEDICATED TO THE REGIONS HEALTH AND WELL-BEING, OUR FACILITY IS LICENSED FOR OVER 400 BEDS AND PROVIDES A VARIETY OF CLINICAL SERVICES TO MEET EACH PATIENT'S NEEDS WE ARE THE DESIGNATED LEVEL III LEAD TRAUMA FACILITY FOR THE REGION, HAVE A NATIONALLY RECOGNIZED INTENSIVE CARE UNIT, PROVIDE CRITICAL CARE TO NEWBORNS AS YOUNG AS 28 WEEKS GESTATION, PERFORM STATE-OF-THE-ART DIAGNOSTICS IN OUR RADIOLOGY DEPARTMENT, AND PROVIDE COMPLETE TESTING AND SURGICAL CAPABILITIES FOR CARDIOLOGY PATIENTS, AMONG MANY MORE SERVICES SHANNON CONTINUES TO COLLABORATE AND BUILD RELATIONSHIPS WITH A BROAD RANGE OF AGENCIES, ORGANIZATIONS AND INSTITUTIONS TO BUILD COMMUNITY AND ORGANIZATIONAL CAPACITY BY EFFECTIVELY UTILIZING RESOURCES AND WORKING TOGETHER, SHANNON PLANS TO IMPLEMENT STRATEGIES TO IMPROVE THE COMMUNITY IT SERVES
SCHEDULE H, PART VI, LINE 7	STATE FILING OF COMMUNITY BENEFIT REPORT TEXAS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 3C	SHANNON MEDICAL CENTER ALSO USES INSURANCE STATUS AND UNDERINSURANCE STATUS IN DETERMINING ELIGIBILITY FOR FREE OR DISCOUNTED CARE
SCHEDULE H, PART I, LINE 7, COLUMN F	BAD DEBT EXPENSE OF $25,682,365 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

Additional Data

Software ID:
Software Version:
EIN: 75-2559845
Name: SHANNON MEDICAL CENTER

Form 990 Schedule H, Part V Section A. Hospital Facilities

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		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	SHANNON MEDICAL CENTER 120 E HARRIS AVENUE SAN ANGELO, TX 76903 SHANNONHEALTH COM	X	X	X				X			

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5	INPUT FROM COMMUNITY REPRESENTATIVES COMMUNITY INPUT WAS PROVIDED THROUGH KEY STAKEHOLDER INTERVIEWS OF FIVE STAKEHOLDERS AND A COMMUNITY SURVEY WITH 54 RESPONSES RESULTS AND FINDINGS ARE DESCRIBED IN THE KEY STAKEHOLDER INTERVIEW RESULTS SECTION OF THE 2016 CHNA REPORT

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 11	THE BELOW CHNA ACTION PLAN INCLUDES DETAILS ON HOW SHANNON MEDICAL CENTER IS ADDRESSING SI GNIFICANT NEEDS IDENTIFIED IN THE CHNA CONDUCTED IN 2016 THE NEEDS ARE CATEGORIZED IN THR EE PRIORITY AREAS HEALTHY LIVING, PREVENTION AND DISEASE MANAGEMENT, AND EDUCATION PRIOR ITY 1 HEALTHY LIVING -SHANNON PARTNERS WITH SAN ANGELO INDEPENDENT SCHOOL DISTRICT TO HOS T AN EVENT TO PROMOTE PHYSICAL ACTIVITY FOR CHILDREN AND FAMILIES TO ADDRESS THE GROWING C ONCERN OF CHILDHOOD OBESITY THE KIDS' MARATHON EVENT PROVIDES AN OPPORTUNITY FOR STUDENTS , RANGING IN AGES FROM KINDERGARTEN THROUGH SIXTH GRADE, TO PARTICIPATE IN A PROGRAM THAT ENCOURAGES HEALTHY HABIT FORMATION EARLY IN LIFE STUDENTS ACCUMULATE LAPS/MILES DURING A THREE-MONTH PERIOD LEADING UP TO THE EVENT, AND PARTICIPATE IN THE FINAL LAP CELEBRATION -EACH OCTOBER SHANNON ORGANIZES THE PINK RIBBON RUN FOR CANCER AWARENESS AND EDUCATION TH IS EVENT FEATURES A 1 MILE WALK/RUN, AND A 5K, 10K RACE -SHANNON PARTNERS WITH THE LOCAL RESTAURANT ASSOCIATION AND RESTAURANTS TO PROMOTE HEALTHIER CHOICE RESTAURANTS THROUGHOUT THE COMMUNITY -WORKING WITH EMPLOYERS IN THE COMMUNITY TO OFFER WORKSITE WELLNESS PROGRAM S TO THEIR EMPLOYEES SOME ACTIVITIES INCLUDE PROVIDING FLU SHOTS, BIOMETRIC SCREENINGS, EDUCATIONAL LUNCH AND LEARNS, HEALTH FAIRS, HEALTH COACHING, AND RESOURCES -SHANNON OFFER S AN EMPLOYEE WELLNESS PROGRAM FOR SHANNON ASSOCIATES AND SPOUSES SOME ACTIVITIES INCLUDE BIOMETRIC SCREENINGS, HEALTH COACHING, EDUCATIONAL RESOURCES, CHALLENGES, AND HEALTHIER OPTIONS IN THE CAFETERIA PRIORITY 2 PREVENTION AND DISEASE MANAGEMENT -SHANNON IS ONE OF THE COLLABORATING ORGANIZATIONS OF THE TOM GREEN COUNTY PARTNERSHIP FOR BETTER HEALTH TH E PARTNERSHIP BEGAN IN JANUARY 2012 AS A RESULT OF AN INITIATIVE BY THE DEPARTMENT OF STAT E HEALTH SERVICES TO REDUCE POTENTIALLY PREVENTABLE HOSPITALIZATIONS THE COALITION IMPLEM ENTS EVIDENCE-BASED STRATEGIES TO PREVENT HOSPITALIZATIONS FOR THE FOLLOWING THREE CONDITI ONS CONGESTIVE HEART FAILURE (CHF), CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) AND DIAB ETES COMPLICATIONS -THE SHANNON CARE COORDINATION PROGRAM IS DESIGNED TO ASSIST IN THE HE ALTHCARE OF CHRONICALLY ILL PATIENTS WITH MULTIPLE DISEASES PROCESSES THIS PROGRAM PROVID ES AN INTENSIVE COMPREHENSIVE TEAM APPROACH TO MANAGING HIGH RISK PATIENTS BY UTILIZING PA TIENT NAVIGATORS THAT REPORT TO AN INTERDISCIPLINARY TEAM AT SHANNON ONGOING CARE OF THE IDENTIFIED HIGH RISK PATIENTS INCLUDES WEEKLY VISITS FROM THE PATIENT NAVIGATOR AND/OR MEM BER OF THE SHANNON TEAM IN ORDER TO ADDRESS HEALTH CARE ISSUES AS THEY ARISE THE TEAM COO RDINATES THE PATIENTS' HEALTHCARE WITH THE PRIMARY CARE PROVIDER'S GUIDANCE -PROVIDE INDI GENT/CHARITY CARE SERVICES FOR LOW-INCOME CHILDREN, ADULTS AND ELDERLY -PARTNERSHIP WITH SHANNON CLINIC -THE EXPANSION TO THREE URGENT CARE CLINIC LOCATIONS THEY ARE OPEN SEVEN DAYS PER WEEK WITH EXTENDED HOURS -PHYSICIAN RECRUITMENT TO INCREASE ACCESS - INCLUDING T HE ADDITION OF AN ENDOCRINOLOG

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 11	IST -OPENING THE ACCESS CLINIC TO PROVIDE FOLLOW-UP APPOINTMENTS POST-DISCHARGE FOR PATIE NTS THAT DO NOT HAVE A PRIMARY CARE PROVIDER -PARTNERSHIP WITH MHMR SERVICES OF THE CONCH O VALLEY TO PROVIDE PRIMARY CARE SERVICES IN THE BEHAVIORAL HEALTH SETTING PRIORITY 3 ED UCATION -SHANNON PROVIDES A HOST OF COMMUNITY EDUCATION EVENTS RELATED TO TOPICS SUCH AS C ANCER PREVENTION AND SCREENINGS, DIABETES EDUCATION, FITNESS AND NUTRITION, AND CARDIOVASC ULAR HEALTH THROUGH EVENTS LIKE GO RED, HEALTH PROFESSIONALS RELAY CURRENT HEALTH INFORMA TION TO THE PUBLIC -SHANNON HOSTS A FREE ONLINE HEALTH LIBRARY AS WELL AS THE WORDS OF WE LLNESS HEALTH BLOG TO ACCESS HEALTH-RELATED INFORMATION -SHANNON HOSTS THREE HEALTHBEAT L IVE TELEVISION SEGMENTS EACH WEEK ON THE NEWS TO RELAY CURRENT HEALTH INFORMATION AND EDUC ATIONAL TIPS -SHANNON PROVIDES A MONTHLY 'HOUSE CALL' ARTICLE IN THE LOCAL NEWSPAPER THI S ARTICLE IS PROVIDED BY SHANNON PHYSICIAN THAT DISCUSSES EDUCATION AND DETECTION OF DISEA SE -SHANNON PROVIDES HEALTH AND WELLNESS PRESENTATIONS TO NUMEROUS NON-PROFITS, BUSINESSE S AND ORGANIZATIONS SOME OF THE ORGANIZATIONS INCLUDE SAN ANGELO INDEPENDENT SCHOOL DIST RICT, EDUCATION SERVICES CENTER REGION 15, REECE ALBERT, DEVON ENERGY, AND ANGELO STATE UN IVERSITY -REPRESENTATIVES FROM DIFFERENT DEPARTMENTS PROVIDE SUPPORT AND PARTICIPATE IN L OCAL HEALTH FAIRS AND HEALTH-RELATED COMMUNITY EVENTS -SHANNON'S TRAUMA SERVICE DEPARTMEN T COORDINATES THE ANNUAL GUS ECKHARDT TRAUMA SYMPOSIUM THIS IS A FULL DAY OF TRAUMA RELAT ED EDUCATION FOR ALL HEALTH CARE PRACTITIONERS IN THE REGION -NURSING, PHYSICAL THERAPY, SPEECH THERAPY, OCCUPATIONAL THERAPY, SOCIAL WORK, AND PSYCHOLOGY STUDENTS PARTICIPATE IN CLINICAL ROTATIONS AT SHANNON AS PART OF THEIR SCHOOL REQUIREMENTS EXPLANATION OF NEEDS N OT ADDRESSED THERE ARE NEEDS THAT SHANNON WILL NOT ADDRESS IN THE CURRENT IMPLEMENTATION S TRATEGY THAT ARE CLEARLY IMPORTANT TO IMPROVING THE HEALTH OF THE COMMUNITY HOWEVER, THEY ARE CONSIDERED TO HAVE LESS IMMEDIATE IMPACT AND WILL BE ADDRESSED IN A FUTURE PLAN, OR I F THE OPPORTUNITY ARISES, COULD BE INCORPORATED WITHIN A CURRENT STRATEGY SHANNON WILL CO NTINUE TO EXPLORE POTENTIAL PARTNERSHIPS AND INTERNAL STRATEGIES TO FIND A WAY TO PROVIDE THESE ESSENTIAL SERVICES TO OUR PATIENTS

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINES 7A & 10A	CHNA AVAILABLE ON HOSPITAL FACILITY'S WEBSITE HTTPS //WWW SHANNONHEALTH COM/EDUCATION-RESOURCES/HEALTH-NEEDS-ASSESSMENT ASPX IMPLEMENTATION STRATEGY AVAILABLE ON HOSPITAL FACILITY'S WEBSITE https //www shannonhealth com/media/1515/signed-implementation-plan-2017 p df

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B LINE 16A	FAP WEBSITE URL https //www shannonhealth com/media/1051/501r-financial-assistance-policy- final-to-marketing-english pdf

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B LINE 16B	FAP APPLICATION FORM URL https //www shannonhealth com/media/1049/shannon-financial-responsibility-report pdf

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B LINE 16C	PLAIN LANGUAGE SUMMARY OF FAP URL https //www shannonhealth com/media/1053/501r-smc-financial-assistance-pol icy-summary-english-final-to-marketing pdf

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/Form990EZ* for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
Shannon Medical Center

Employer identification number
75-2559845

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**	Yes	
b	If "Yes," was it a written policy?	**1b**	Yes	
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 ____ %	**3a**	Yes	
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**		No
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**	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	**5a**	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	**5b**	Yes	
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 eligibile for free or discounted care?	**5c**		No
6a	Did the organization prepare a community benefit report during the tax year?	**6a**		No
b	If "Yes," did the organization make it available to the public?	**6b**		

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)			11,860,020		11,860,020	4 070 %
b Medicaid (from Worksheet 3, column a)			29,375,988	24,750,727	4,625,261	1 590 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			1,189,555	161,199	1,028,356	0 350 %
d Total Financial Assistance and Means-Tested Government Programs			42,425,563	24,911,926	17,513,637	6 010 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			636,949		636,949	0 220 %
f Health professions education (from Worksheet 5)			977,324		977,324	0 340 %
g Subsidized health services (from Worksheet 6)			11,584,205		11,584,205	3 970 %
h Research (from Worksheet 7)			169,303		169,303	0 060 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			203,860		203,860	0 070 %
j Total. Other Benefits			13,571,641		13,571,641	4 660 %
k Total. Add lines 7d and 7j			55,997,204	24,911,926	31,085,278	10 670 %

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 Heathcare Financial Management Association Statement No 15?			1	Yes	
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	44,221,735			
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				
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	99,056,691
6	Enter Medicare allowable costs of care relating to payments on line 5	6	96,432,314
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	2,624,377

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

			Yes	No
9a	Did the organization have a written debt collection policy during the tax year?	9a	Yes	
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	Yes	

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
	See Additional Data Table										

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 SHANNON MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 01

			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		No
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		No
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	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ 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	Yes	
6 a	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		No
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		No
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) See Part V, Section C			
b	☐ Other website (list url)			
c	☑ 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	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 19			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
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		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on 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 SHANNON 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?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
	a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 0 %			
	b ☐ Income level other than FPG (describe in Section C)			
	c ☐ Asset level			
	d ☐ Medical indigency			
	e ☑ Insurance status			
	f ☑ Underinsurance discount			
	g ☐ Residency			
	h ☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	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 ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
	b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
	c ☑ 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	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
	a ☑ The FAP was widely available on a website (list url) SEE PART V, SECTION C			
	b ☑ The FAP application form was widely available on a website (list url) SEE PART V, SECTION C			
	c ☑ A plain language summary of the FAP was widely available on a website (list url) SEE PART V, SECTION C			
	d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
	e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
	f ☑ 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 ☑ 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 ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
	i ☑ 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

SHANNON MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

			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**	Yes	
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**		No
	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

			Yes	No
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**	Yes	
	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 SHANNON 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?	**23**		No
	If "Yes," explain in Section C			
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?	**24**		No
	If "Yes," explain in Section C			

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.

Form and Line Reference	Explanation
See Add'l Data	

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? 2

	Name and address	Type of Facility (describe)
1	SHANNON SURGERY CENTER 120 E HARRIS AVENUE SAN ANGELO, TX 76903	AMBULATORY SURGERY CENTER
2	SHANNON HOME HEALTH 2030 PULLIAM STE 6 SAN ANGELO, TX 76905	HOME HEALTH CENTER
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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 3C	METHOD TO DETERMINE ASSISTANCE ELIGIBILITY SHANNON MEDICAL CENTER ALSO USES INSURANCE STATUS AND UNDERINSURANCE STATUS IN DETERMINING ELIGIBILITY FOR FREE OR DISCOUNTED CARE
SCHEDULE H, PART III, SECTION A, LINE 2 & 3	COSTING METHODOLOGY LINE 2 AMOUNT REPORTED ON LINE 2 IS BASED ON BAD DEBTS PER THE ORGANIZATIONS INTERNAL FINANCIALS LINE 3 THE ORGANIZATION IS UNABLE TO ESTIMATE THE AMOUNT FOR LINE 3 AND HAS ELECTED TO LEAVE IT BLANK

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART III, SECTION A, LINE 4	BAD DEBT FOOTNOTE SEE PAGE 10 OF THE ATTACHED FINANCIAL STATEMENTS
SCHEDULE H, PART III, SECTION B, LINE 8	COSTING METHODOLOGY THE COST REPORT USES COST TO CHARGE RATIOS FOR ANCILLARY DEPARTMENTS, PLUS IN THE ROOM AND BOARD AREAS IT IS A PER DIEM THE STATE OF TEXAS TREATS SHORTFALL AS A COMMUNITY BENEFIT FOR MEETING STATUTORY REQUIREMENTS FOR CHARITY CARE AND COMMUNITY BENEFIT FOR FISCAL YEAR 2019, THERE WAS NO SHORTFALL CALCULATED

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART III, SECTION C, LINE 9B	WRITTEN DEBT COLLECTION POLICY CHARITY CARE AND DISCOUNTING FOR UNINSURED PATIENTS WHO ARE NOT ELIGIBLE FOR GOVERNMENT HEALTH CARE PROGRAMS AND WHOSE FINANCIAL CONDITION IS SUCH THAT THEY ARE NOT ABLE TO PAY FOR HOSPITAL SERVICES MAY BE ELIGIBLE FOR ASSISTANCE UNDER THE SHANNON MEDICAL CENTER CHARITY CARE PROGRAM PATIENTS WHO ARE UNINSURED, DO NOT QUALIFY FOR COVERAGE UNDER GOVERNMENT HEALTH CARE PROGRAMS, MAY BE ELIGIBLE FOR A 50% DISCOUNT OFF THE TOTAL BILL FOR HOSPITAL SERVICES, IF THE SERVICES ARE PAID FOR WHEN RECEIVED OR WITHIN 30 DAYS OF DISCHARGE COLLECTION OF ACCOUNTS RECEIVABLE PATIENTS / GUARANTOR WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES RECEIVED AT SHANNON MEDICAL CENTER PATIENTS / GUARANTORS WILL BE RESPONSIBLE FOR FULL CHARGES, OR PATIENT PORTION NOT COVERED BY INSURANCE PAYMENT WILL BE REQUESTED PRIOR TO OR ON THE DATE OF SCHEDULED ELECTIVE SERVICES FULL CHARGES OR PATIENT PORTION NOT COVERED BY INSURANCE FOR URGENT / EMERGENT SERVICES WILL BE COLLECTED UPON DISCHARGE PATIENTS WHO ARE UNABLE TO PAY THE FULL AMOUNT OF THEIR RESPONSIBILITY AT THE TIME OF SERVICE CAN MAKE PAYMENT ARRANGEMENTS UNDER THE FOLLOWING GUIDELINES A BALANCE OF OUTPATIENT SERVICES MUST BE PAID WITHIN SIX (6) MONTHS FROM THE DATE OF SERVICE UNLESS INDIGENT STATUS IS PROVEN B BALANCE OF INPATIENT SERVICES MUST BE PAID WITHIN TWELVE (12) MONTHS FROM THE DATE OF DISCHARGE UNLESS INDIGENT STATUS IS PROVEN MONTHLY STATEMENTS WILL BE SENT THROUGHOUT THE COLLECTION CYCLE COLLECTION LETTERS WILL BE UTILIZED AT THE DISCRETION OF THE PATIENT ACCOUNT REPRESENTATIVE ACCOUNTS WILL BE REVIEWED FOR OUTSIDE COLLECTION AGENCY PLACEMENT ANYTIME FOLLOWING 90 DAYS FROM THE DATE OF SERVICE MEDICARE ACCOUNTS WILL NOT BE CONSIDERED FOR PLACEMENT UNTIL 120 DAYS FROM THE FIRST NOTICE OF PATIENT RESPONSIBILITY IN ACCORDANCE WITH MEDICARE REGULATIONS ANY OVERPAYMENT OF AN ACCOUNT WILL BE REVIEWED FOR REFUND WITHIN 30 DAYS FROM THE DATE THE CREDIT BALANCE IS CREATED BY THE OVERPAYMENT CREDIT BALANCES ON MEDICARE ACCOUNTS WILL BE PROCESSED THROUGH THE NORMAL CREDIT BALANCE PROCESS AND REPORTED ON A QUARTERLY BASIS IN COMPLIANCE WITH MEDICARE REGULATIONS
SCHEDULE H, PART VI, LINE 3	PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE FINANCIAL ASSISTANCE Financial assistance brochures that outline access to information about assistance programs are available in each of the registration areas We also have contracted eligibility workers who screen patients for all social service programs and assist with the application process if needed

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 4	Community Information Shannon Medical Center is located in San Angelo, Texas The city of San Angelo serves as the county seat and population center of Tom Green County, with an estimated population in 2018 of 118,189 Tom Green Countys population in 2019 of 119,200 The estimated population for Shannons service area as of 2019, including Tom Green County, is 357,190 (U S Census Bureau, State & County Quickfacts) The counties included in the Shannon service area are Brown, Coke, Concho, Coleman, Crockett, Howard, Irion, Kimble, Mason, McCulloch, Menard, Mills, Mitchell, Nolan, Pecos, Reagan, Runnels, San Saba, Schleicher, Sterling, Sutton, Terrell, Tom Green, Upton, and Val Verde A breakdown of Tom Green County demographics is as follows (Source U S Census Bureau, State & County Quickfacts, The County Information Project, Texas Association of Counties) Tom Green County Age Distribution 1 Under 18 years old 23 9% (28,489) 2 18-64 years old 61 6% (72,235) 3 65 years and older 15 5% (18,476) Tom Green County Ethnic Distribution (More than one category may be self-reported) 1 Caucasian 52 7% (62,818) 2 Hispanic 40 5% (48,276) 3 Black 4 4% (5,245) 4 Other 2 4% (2,861) Tom Green County (Household) 1 Median Household Income $51,676 (Texas $59,570) 2 Persons living in poverty level 15 5% (Texas 14 7%) Tom Green County Health Index 1 Tom Green County uninsured 16 8%
SCHEDULE H, PART VI, LINE 5	Promotion of Community Health In a county with no hospital taxing authority, a hospital whose mission reflects commitment to treating patients without regard to ability to pay is a highly desirable and pivotal point of community health care For more than 80 years, Shannon has embraced such a mission and follows through on the wishes of our benefactor, Margaret Shannon, in providing care for the people of West Texas Our FY2019 charity care figure of more than $51,769,930 would be a burden to the taxpayers of Tom Green County, and many other counties whose citizens directly benefit from her generosity Shannon provides a host of community education events related to topics such as cancer prevention and screenings, diabetes education, fitness and nutrition, childbirth and child care, and cardiovascular health Through educational events and various community events, health professionals relay current health information to the public Shannon provides health and wellness presentations to numerous non-profits, businesses and organizations, including regional school districts and Angelo State University Representatives from different departments provide support and participate in local health fairs and health-related community events where they provide various health screenings and educational material In addition to public outreach events, Shannon publishes the Healthbeat newsletter magazine which is delivered to 30,000 households and produces Healthbeat television spots that air during the 6 and 10 p m news hours on two local stations Shannon contributed $172,363 for these programs Shannon is a proud sponsor and contributor to the local Go Red Luncheon Go Red is a national initiative aimed at uniting women, men, and their friends and family in the fight against heart disease The luncheon is designed to help educate and bring awareness to the community about how heart disease affects women and men differently, and how to take steps to address their risk for a heart attack Shannon understands that continued education and awareness is crucial for women and men to fight this deadly disease In addition, Shannon offers various free screening services, such as blood pressure checks, at this event Approximately 500 community members were in attendance to the Go Red Luncheon This event is provided at a cost of $16,937 to Shannon Shannon supports health and fitness activities, as well To address the growing concern over childhood obesity, the Kids Marathon event provides an opportunity for students, ranging from Kindergarten through sixth grade, to participate in a program that encourages healthy habit formation early in life A full marathon is considered 26 2 miles Students accumulate miles and run the last 0 2 lap during a celebratory event at the San Angelo Stadium The event hosts organizations that offer local summer programs and camps that encourage children to remain active through the summer months This event is provided at a cost of $5,057 to Shannon Shannon has recognized a community need to offer supportive services to parents and families suffering from early pregnancy loss, stillbirth, or newborn death The White Rose Support Group at Shannon hosts a 5-part session called Grieving the Child I Never Knew to offer insight, encouragement, healing, hope, and sharing for families experiencing perinatal loss Furthermore, the White Rose Support Group hosts a Walk to Remember and Candlelight event for those who have suffered These events are provided at a cost of $15,908 to Shannon Shannon is the only provider that operates the Sexual Assault Nurse Examiner program (SANE) in the Shannon service area SANE trained nurses work with the Childrens Advocacy Center, the Concho Valley Rape Crisis Center and other community-based organizations to provide training and services related to sexual assault crises

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 6	Affiliated health care system Shannon, a non-profit health system established in the 1930s, provides the communities of West Central Texas with a variety of medical services Dedicated to the regions health and well-being, our facility is licensed for over 400 beds and provides a variety of clinical services to meet each patient's needs We are the designated Level III Lead Trauma Facility for the region, have a nationally recognized intensive care unit, provide critical care to newborns as young as 28 weeks gestation, perform state-of-the-art diagnostics in our radiology department, and provide complete testing and surgical capabilities for cardiology patients, among many more services Shannon continues to collaborate and build relationships with a broad range of agencies, organizations and institutions to build community and organizational capacity By effectively utilizing resources and working together, Shannon plans to implement strategies to improve the community it serves
SCHEDULE H, PART VI, LINE 7	STATE FILING OF COMMUNITY BENEFIT REPORT Texas

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 2	Needs Assessment Health needs of the community have been identified and prioritized so that Shannon may adopt an implementation strategy to address specific needs of the community The process involved -An evaluation of the implementation strategy from the previous needs assessment which was adopted by Shannon Board of Directors in 2016 -Collection and analysis of a large range of data, including demographic, socioeconomic, and health statistics, and healthcare resources -Obtaining community input through -Interviews with key informants who represent a) broad interests of the community, b) populations of need, or c) persons with specialized knowledge in public health -A health survey which gathered a wide range of information which was distributed to identified stakeholders The purposed of the Community Health Needs Assessment is to understand the unique health of the community served by Shannon and to document compliance with new federal laws Shannon Medical Center engaged BKD, LLP to conduct a formal Community Health Needs Assessment Based on current literature and other guidance from the treasury and the IRS, the following steps were conducted as part of Shannons Community Health Needs Assessment An evaluation of the impact of actions taken to address the significant health needs identified in the fiscal year September 30, 2016 Community Health Needs Assessment was completed and an implementation strategy scorecard was prepared to understand the effectiveness of Shannons current strategies and programs The "community" service by Shannon was defined by utilizing inpatient and outpatient data regarding patient origin This process is further described in Community Served by Shannon Population demographics and socioeconomic characteristics of the community were gathered and reported utilizing various third parties The health status of the community was then reviewed Information on the leading causes of death and morbidity information was analyzed in conjunction with health outcomes and factors reported for the community by countyhealthrankings org Health factors with significant opportunity for improvement were noted Community input was provided through key informant interviews of seven informants and 66 community health needs surveys Results and findings are described in the Key Informant section of the CHNA report Information gathered in the steps above was analyzed and reviewed to identify health issues of uninsured persons, low-income persons and minority groups and the community as a whole Health needs were ranked utilizing a weighted method that weighs 1) the size of the problem (How many people are affected by the issue) 2) the seriousness of the problem (What are the consequences of not addressing the issue) 3) the prevalence of common themes 4) the alignment with Shannons resources
Schedule H, Part I, Line 7, column F	COMMUNITY BENEFIT EXPENSE Bad debt expense of $44,221,735 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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7	COSTING METHODOLOGY THE COST TO CHARGE RATIO CALCULATED ON IRS WORKSHEET 2 WAS USED IN THE CALCULATION OF COST ON IRS WORKSHEETS 1 AND 3 COST COMPUTED ON IRS WORKSHEETS 4, 5 & 7 WERE COMPUTED FROM THE MEDICARE COST REPORT, INCLUDING DIRECT COSTS PLUS OVERHEAD ALLOCATIONS COMPUTED IN THE COST REPORT PROCESS
SCHEDULE H, PART I, LINE 7G	N/A

Additional Data

Software ID:
Software Version:
EIN: 75-2559845
Name: Shannon Medical Center

Form 990 Schedule H, Part V Section A. Hospital Facilities

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		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	SHANNON MEDICAL CENTER 120 E HARRIS AVENUE SAN ANGELO, TX 76903 SHANNONHEALTH COM 000168	X	X	X				X			

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B, LINE 5	INPUT FROM COMMUNITY REPRESENTATIVES COMMUNITY INPUT WAS PROVIDED THROUGH KEY STAKEHOLDER INTERVIEWS OF STAKEHOLDERS FROM THE FOLLOWING ORGANIZATIONS SHANNON MEDICAL CENTER, SOCIAL SERVICE AGENCIES, LOCAL SCHOOL SYSTEMS & UNIVERSITIES, PUBLIC HEALTH AGENCIES, OTHER MEDICAL PROVIDERS, LOCAL ELECTED OFFICIALS & GOVERNMENTAL AGENCIES AND LOCAL BUSINESS ELECTRONIC SURVEYS WERE DISTRIBUTED TO 140 INFORMANTS REPRESENTING THE MEDICAL CENTER'S SERVICE AREA
SCHEDULE H, PART V, SECTION B, LINE 11	NEEDS ADDRESSED & NOT ADDRESSED BASED ON SHANNON'S EVALUATION WITHIN THE CURRENT CHNA, THE MEDICAL CENTER IS CURRENTLY MEETING THEIR GOALS OR HAS ALREADY MET THE GOALS FROM THE 2016 CHNA THE BELOW CHNA ACTION PLAN INCLUDES DETAILS ON HOW SHANNON MEDICAL CENTER IS ADDRESSING SIGNIFICANT NEEDS IDENTIFIED IN THE CHNA CONDUCTED IN 2019 THE NEEDS ARE CATEGORIZED IN THE FOLLOWING PRIORITY AREAS IMPROVE ACCESS TO CARE, ADULT OBESITY, LACK OF HEALTH KNOWLEDGE/EDUCATION, LACK OF MENTAL HEALTH PROVIDERS, SHORTAGE OF PRIMARY CARE PHYSICIANS AND HEALTHY BEHAVIORS/LIFESTYLE PRIORITY 1 IMPROVE ACCESS TO CARE (including shortage of primary care physicians) SHANNON MEDICAL CENTER PLANS TO CONNECT PATIENTS WITH APPROPRIATE HEALTH SERVICES TO IMPROVE THE CONTINUUM OF CARE AND WILL IMPROVE COMMUNITY AWARENESS OF AVAILABLE HEALTH SERVICES, EDUCATION AND SUPPORT PRIORITY 2 HEALTHY BEHAVIORS/LIFESTYLE THE MEDICAL CENTER WILL PROVIDE OPPORTUNITIES TO PROMOTE HEALTHY LIVING IN THE COMMUNITY AND PARTICIPATE AT COMMUNITY OUTREACH EVENTS TO SUPPORT HEALTH LIFESTYLES PRIORITY 3 ADULT OBESITY THE MEDICAL CENTER WILL INCREASE PUBLIC AWARENESS OF THE IMPORTANCE OF HEALTH EATING, NUTRITION AND PHYSICAL ACTIVITY PRIORITY 4 HEALTH EDUCATION/KNOWLEDGE THE MEDICAL CENTER WILL PROVIDE GREATER HEALTH EDUCATION TO CHILDREN, FAMILIES AND VULNERABLE POPULATIONS THE CENTER PLANS TO IMPROVE COMMUNITY OUTREACH EFFORTS THAT WILL PROVIDE MORE HEALTH EDUCATION OPPORTUNITIES WITH LOCAL BUSINESSES THE IMPLEMENTATION STRATEGY WILL ASSURE HEALTHCARE AND SOCIAL SERVICE PROVIDERS IN THE COMMUNITY HAVE THE MOST UP-TO-DATE KNOWLEDGE EXPLANATION OF NEEDS NOT ADDRESSED THERE ARE NEEDS THAT SHANNON WILL NOT ADDRESS IN THE CURRENT IMPLEMENTATION STRATEGY THAT ARE CLEARLY IMPORTANT TO IMPROVING THE HEALTH OF THE COMMUNITY Lack of Mental Health Providers is one need not specifically addressed in the assessment While Shannon is not incorporating strategies to improve access to mental health providers, the community has seen improvement and growth in the accessibility of mental health providers and available mental health services over recent years Furthermore, Shannon will continue to explore potential partnerships and internal strategies to find a way to provide these essential health services to our patients and community

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B LINE 16B	FAP APPLICATION FORM URL https //www shannonhealth com/media/1049/shannon-financial-responsibility-report pdf
SCHEDULE H, PART V, SECTION B LINE 16C	PLAIN LANGUAGE SUMMARY OF FAP URL https //www shannonhealth com/media/224029/501r-SMC-Financial-Assistance-P olicy-Summary-English-2017 pdf

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
SCHEDULE H, PART V, SECTION B LINE 16B	FAP APPLICATION FORM URL https //www shannonhealth com/media/1049/shannon-financial-responsibility-report pdf
SCHEDULE H, PART V, SECTION B LINE 16C	PLAIN LANGUAGE SUMMARY OF FAP URL https //www shannonhealth com/media/224029/501r-SMC-Financial-Assistance-P olicy-Summary-English-2017 pdf

Reference	Description
Attachment 4	Charity Care Policies

Title: **Financial Assistance Policy**
Scope: **Hospital**
Index #: **8310-14**
Effective Date: **10/1/2020**
Last Review/Revision Date: **12/02/20**

PURPOSE:

In furtherance of its charitable mission and values, Shannon Medical Center provides financial assistance to patients who are uninsured or underinsured and unable to pay some or all of the bills related to services deemed to be "medically necessary" (as defined below). In furtherance of this obligation, Shannon will obtain financial information from patients/guarantors who have been identified as uninsured/underinsured and have the potential to qualify for the Shannon Charity Care Program.

DEFINITIONS:

"Geographic Service Area" means the Counties of Tom Green, Crockett, Sutton, Schleicher, Kimble, Menard, Reagan, Irion, Concho, McCulloch, Sterling, Coke, Runnels, Coleman, Brown, Howard, and Mitchell. Proof of residency may be requested.

"**Uncompensated Care"** is defined as "Charity Care" and "Bad Debts" for healthcare provided for those uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on the patients individual financial situation.

"Charity Care" is defined as financial assistance provided to patients who satisfy the statutory definitions of financially indigent or medically indigent. A financially indigent patient is one with income at or below 200 percent of the federal poverty level; a medically indigent patient is one who is unable to pay the remaining balance on hospital bills that, after payment by third-party payers, exceeds a percentage of the patient's annual gross income as specified in the Hospital's Financial Assistance Policy.

"Bad Debt" is defined as uncollectible accounts receivable that remains unpaid after reasonable efforts to collect per Hospital Collection policies. Balances are not deemed bad debt until they have been placed with an outside collection agency for a minimum of 180 days following the date of service or the first notice of patient responsibility and are returned by the outside collection agency as collection efforts are deemed exhausted.

POLICY:

Uninsured or underinsured patients/guarantors who are unable to make mutually agreeable financial arrangements for their medical expenses and patients with coverage from an entity that does not have a contractual relationship with the provider, will be considered a candidate for the Shannon Charity Care Program. Information regarding the program, application/screening documents will be provided to

those wanting to determine their eligibility for the Shannon Charity Care Program. The processing of financial assistance applicants, communication methods of availability, and determining patient allowed billable amount will follow the guidelines to meet the requirements of Section 501(r) of the Affordable Care Act.

PROCEDURES:

1. The Shannon Patient Financial Services Department, which includes Admission Counselors and Customer Service Representatives, will identify patients who may be eligible for Financial Assistance.
2. A patient may also request Financial Assistance if not identified by the Patient Financial Services Department. A patient requesting Financial Assistance will be referred to a Financial Counselor or Customer Services Representative for guidance on the Financial Assistance process.
3. Financial Assistance is only applicable to services deemed "Medically Necessary" by Medicare, Medicaid, or other appropriate industry standards. In instances where medical necessity is unclear, Shannon will follow up with the patient's physician to determine whether services are medically necessary. Determination of medical necessity in collaboration with the patient's physician may take into account the nature of the patient's illness, the likelihood that treatment will lead to a successful outcome, and the disposition of similar cases. 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. Medicaid and Other Indigent Care Non-Covered Services are considered eligible Charity Care write-off amounts under this policy. 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 Policy.
4. Financial Assistance is generally reserved for U.S. citizens and residents of the geographic service area ("GSA") served by Shannon Medical Center who have lived in the GSA for a minimum of 12 months.
5. The Hospital reserves the right to limit charity care on a monthly and annual basis consistent with Texas state law and the Hospital's financial resources. The Hospital reserves the right to refuse Financial Assistance for elective services.
6. Emergent and Medically Necessary charges incurred in any medical treatment setting at Shannon Medical Center will be considered eligible for the Shannon Charity Care Program. Emergent and 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. Elective and Cosmetic procedures are not eligible for the Shannon Charity Care Program. Emergent and Medically Necessary services provided by Shannon Clinic physicians and practitioners will also be eligible for the Shannon Charity Care Program by way of application through Shannon Clinic. A listing of physicians and practitioners who do or do not participate in the Shannon Charity Care Program is attached in Appendix A and is also available on the website at www.Shannonhealth.com. Physician and other professional services are excluded from Charity Care claimed as Uncompensated Care for Medicare cost reporting purposes.
7. Patient and/or guarantor will complete the Legacy Fulfillment Application or similar screening documentation. The application with supporting documentation must be received within 240 days from the date of the first post discharge billing statement. Any personal payments exceeding $4.99 that have been received on an account which subsequently qualifies for financial assistance will be refunded less any amount they are determined to owe. Should a completed application not be

received within 240 days, accounts will process through normal collection activity outlined in the Patient Billing, Payment and Collection of Accounts Receivable policy. Financial Assistance may be presumptively considered for any account occurring within 240 days from the completed application. Patients must re-apply and provide supporting documentation every 240 days. Supporting documentation consists of the following documents or any combination of documents listed below :

a. Employment paycheck records for 3 most recent pay periods;
b. Unemployment Benefit payments;
c. Most recent Income Tax Return or Transcript of Tax Return
d. Bank Statements indicating Direct Deposit of income;
e. Letters of award for Social Security Benefits;
f. Copies of Annuity and/or Retirement Payments received monthly or annually.

8. Bad Debts may be considered for assistance if they are 8 months or less old from the date of the application. If a bad debt is older than 8 months old, an appeal can be made to the Business Office Director explaining the circumstances and why the applicant would like for the account to be considered for assistance. Each applicant will be considered on a case by case basis.

9. Patient will pursue county, state or federal assistance programs where eligibility for those programs has been identified prior to being considered for financial assistance. If patient is eligible for a county, state or federal assistance program, but not all dates of service are included in that coverage, they will be eligible for the Shannon Charity Care Program for the non-covered dates of service based on their overall approval for the county, State or Federal assistance program. In some cases, patients eligible for county assistance programs in counties within our Geographic Service Area may automatically qualify for the Shannon Charity Care program. Patients eligible for Tom Green County assistance will automatically qualify for the Shannon Charity Care Program in lieu of Tom Green County assistance. Shannon Medical Center will not bill Tom Green County for charges incurred in any medical treatment setting at Shannon Medical Center or any affiliate of Shannon Medical Center.

10. All patients who qualify for Financial Assistance will be responsible for payment of the Amount Generally Billed (AGB) for emergency or other medically necessary care. The Look Back Method will be used to calculate AGB discount to be applied to gross billed charges to determine the amount of patient responsibility. This calculation will be performed on an annual basis. For FY 2021, the amount the patient will be responsible for paying for Emergent and Medically Necessary services is 28% of gross billed charges. Information on how the discount is calculated may be obtained by contacting our Business Office.

11. There may be circumstances in which the Hospital has billed a patient more than AGB before the patient submitted a completed application or before the Hospital determined the patient was eligible for financial assistance. If an Eligible Patient has paid charges in excess of AGB, the hospital will refund any amount the individual has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as an individual eligible for financial assistance, unless such excess payment is less than $5. Any amount the Eligible Patient is determined to owe may be offset with the refund amount.

12. The Federal Poverty Guidelines of household size and gross family income will be used to determine financial assistance. Gross family income must be at or below 200% of the minimum levels of the Federal Poverty Guidelines published annually in the Federal Register. Patient's whose gross family

income is at or below 200% of the minimum levels of the Federal Poverty Guidelines will qualify for 100% discount of their hospital service.

13. Catastrophic Illness will be defined as uncompensated charges incurred in a 12 month period that exceed 200% of total gross annual family income will be eligible upon review for a Medically Indigent Care discount. Patients who qualify for Medically Indigent discount will be responsible for payment not to exceed 10% of their gross annual income.
14. Applications at no cost will be mailed to you by calling the Business Office at **(325) 657-5307** or **(800) 330-5241**. Applications are also available at any of our Patient Access locations. The applications are available in English and Spanish. Should you need assistance completing the application, please call our Business Office at the numbers listed above. A printable version of the application, a summary of the Financial Assistance Policy, the detailed Financial Assistance Policy and the detailed Hospital Collection Policy are available on our website at www.Shannonhealth.com.
15. Information provided in the application/screening document will be reviewed promptly. Present income will be a measurement in assessing qualification for financial assistance, but will not be the sole determining factor. Use of other industry measures may assist in determination of patients/ guarantors ability to pay.
16. The Hospital may use presumptive eligibility by way of the review of credit reports and other publicly available information to determine financial assistance eligibility when a patient does not provide an Assistance Application or supporting documentation.
17. Patients/guarantors for whom legal notice of bankruptcy is received, will have any outstanding balances applicable to the bankruptcy notice adjusted to charity.
18. Financial Assistance in excess of $25,000 requires the approval of the Chief Financial Officer or Chief Executive Officer.
19. The applicant will be notified in writing of the outcome of the application.

Appendix A

Shannon Clinic Physicians	Participates in the Shannon Clinic Charity Care Program
Aligned Telehealth	Does not participate in Shannon Charity Care Program
Angelo Oral & Maxilofacial Surgery, PA	Does not participate in Shannon Charity Care Program
Angelo Podiatry	Does not participate in Shannon Charity Care Program
Cook Children's Heart Center	Does not participate in Shannon Charity Care Program
Cook Children's Hematology/Oncology Group	Does not participate in Shannon Charity Care Program
Cook Children's Nephrology	Does not participate in Shannon Charity Care Program
Cook Children's Neurology	Does not participate in Shannon Charity Care Program

Direct Radiology	Does not participate in Shannon Charity Care Program
NeuroCall	Does not participate in Shannon Charity Care Program
Office of Don M. Lewis, MD	Does not participate in Shannon Charity Care Program
Office of Mark Ramirez, MD	Does not participate in Shannon Charity Care Program
Office of Richard McGraw, MD	Does not participate in Shannon Charity Care Program
Office of Thomas S. Jeter, MD, DDS	Does not participate in Shannon Charity Care Program
Office of Vayden Stanley, MD	Does not participate in Shannon Charity Care Program
Office of W. Paul Bowman, MD	Does not participate in Shannon Charity Care Program
Office of William Buche, DDS	Does not participate in Shannon Charity Care Program
Pediatric Cardiology Associates of San Antonio	Does not participate in Shannon Charity Care Program
Pediatric Dentistry of San Angelo	Does not participate in Shannon Charity Care Program
Pulmonary and Critical Care Consultants of Austin	Does not participate in Shannon Charity Care Program
Regional Cancer Treatment Center	Participates in Shannon Charity Care Program
Rivercrest Hospital	Does not participate in Shannon Charity Care Program
Seton Heart Institute	Does not participate in Shannon Charity Care
Program Texas Cardiac Arrhythmia Institute	Does not participate in Shannon Charity Care
Program	
Weatherby Locums	Does not participate in Shannon Charity Care Program
West Texas Medical Associates	Does not participate in Shannon Charity Care Program
Raghavendri Moturi, MD	Does not participate in Shannon Charity Care Program

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Standard Policy and Procedure</td><td>P&P 0512
Page 1 of 27</td></tr>
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<tr><td>EFFECTIVE DATE:</td><td colspan="5">5/96</td></tr>
<tr><td>REVIEWED:</td><td colspan="5">12/01; 5/02; 6/05; 4/08; 5/11; 3/17; 11/19; 2/20;</td></tr>
<tr><td>REVISED:</td><td colspan="5">2/99; 4/14</td></tr>
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Department Generating Policy	Administration	Prepared by	Admin. Asst.
Department / Committee Approval	N/A	Date	N/A
Medical Staff Approval	N/A	Date	N/A
Board Approval	N/A	Date	N/A

I. **Purpose:** To establish the Company policy for identifying patients eligible for Charity Care.

II. **Scope:** This policy applies to certain affiliates of CHSPSC, LLC (hereinafter "The Company").

III. **Corporate Policy and Procedures**

A. **Eligible Services:** Services eligible for Charity Care should be determined in accordance with "Eligibility for Charity Care Guidelines" policies and procedures established by the respective Company entity (e.g. hospital, clinic, etc.). Some services such as those that are elective, non-medically necessary and / or cosmetic services may not be eligible for charity care.

B. **Applying for Charity Care**

i. A patient may apply for Charity Care at the time of service or after care has been provided.

C. **Eligibility for Charity Care**

i. **Presumptive Eligibility**. Presumptive eligibility for charity care will be determined through the criteria listed below and will include only accounts which have no identifiable payment or funding source.[1]

1. All self-pay patients should be evaluated for presumptive eligibility for the Charity Care at the time of service.

[1] For state specific requirements, please consult Appendix A.

2. A patient may be deemed presumptively eligible for Charity Care if the patient meets all the below criteria,

    a. Is Uninsured;
    b. Received or is scheduled to receive emergency or medically necessary services;
    c. Is not eligible for Medicare, Medicaid or is not pending Medicare or Medicaid approval;
    d. Is not presumed to qualify for other financial programs;
    e. Financial status is validated through the use of a health care industry-recognized predictive model based on public record databases and financial criteria that meets the Poverty Guidelines established by the Department of Health and Human Services and the Eligibility for Charity Care Guidelines established by the respective company entity.

3. If a patient is determined to be presumptively eligible for Charity Care the patient's account should be flagged.

4. Information from the predictive model may be used to satisfy the documentation requirements for Charity Care.

5. Where state regulations require the submission of a Charity Care application, the application will be provided to the patient or responsible party and returned completed prior to any write-off transaction being applied to the account.

6. Accounts flagged as presumptive charity care may be subject to a waiting period while the patient is screened for eligibility for alternative financial assistance programs.

7. Once a flagged account has been screened for alternative financial assistance programs and it has been determined that the patient is not eligible for any other program, the account should be given Charity Care Status. The entity should make an attempt to notify the patient of the determination. Notification will include the option to decline Charity Care.

ii. **Non-Presumptive Eligibility**. Non-presumptive eligibility for charity care will be determined through the criteria listed below and may include accounts for which other payment or funding sources exist.[2]

1. A patient that wishes to apply for Charity Care that is not eligible for presumptive Charity Care must provide adequate documentation, as

[2] For state specific requirements, please consult Appendix A.

outlined below, supporting their financial income and expenses to be considered for charity care.

2. A patient that is not been determined to be presumptively eligible for Charity Care may still be considered for Charity Care either at the time of service or after service is provided.

3. All patients that wish to apply to the Charity Care program or are identified as a possible candidate for Charity Care should be sent a charity application. The application will contain a request for the following financial information:

    a. A copy of their last two pay checks stubs;
    b. Prior year Federal 1040 tax return;
    c. Unemployment benefits (check stubs);
    d. Social Security benefits (copy of check or letter from Social Security); and
    e. Department of Social Services grants and/or amount of food stamps
    f. List of personal expenses including, but not limited to, rent, house payment, utilities, car payment, insurance, food, etc.
    g. Other documents needed to determine Charity Care eligibility

4. The patient will be given 30 days to return the completed forms and all necessary documentation to the hospital or the Shared Services Center (SSC).

5. A patient is deemed eligible for Charity Care if the patient,

    a. Received or is scheduled to receive emergency or medically necessary services;
    b. Financial criteria meet the Poverty Guidelines established by the Department of Health and Human Services and the Eligibility for Charity Care Guidelines established by the respective Company entity.
    c. Financial status is validated using documentation provided by the patient.

6. Every patient that applies for Charity Care should be notified in writing whether they have qualified for Charity Care.

7. Where federal and/or state regulations require the submission of a Charity Care application, the application will be provided to the patient or responsible party, completed and returned prior to any write-off transaction being applied to the account.

8. A patient that is deemed not eligible for Charity Care may be considered for other financial assistance programs.

9. Services such as those that are elective, non-medically necessary and / or cosmetic services may be eligible for charity care, as approved the Hospital CEO or Shared Services Center may approve on a case by case basis.

iii. Information Not Available

1. A patient who is unable to provide the above mentioned documentation to support a Charity Care application may contact the hospital or the SSC to discuss other available evidence that may demonstrate eligibility. Notarized letters from family members, neighbors, etc. stating or certifying the patient has no income or other financial resources are not considered adequate documentation.

2. Accounts for which complete documentation is not received will be returned to the normal self-pay collections workflow.

3. The patient's account predictive scoring may be an option for additional consideration at the discretion of the hospital CFO.

iv. Incomplete Information

1. Complete personal, financial and other information is required to verify a patient's financial status to determine eligibility for Charity Care, and Charity Care may be denied due to incomplete information.

2. If the patient has private health insurance, but does not supply adequate information to obtain reimbursement, assistance should not be considered.

3. A patient should be notified in-person, by mail, or by telephone if required information received is incomplete. The patient may submit the missing information within 30 days from the date the notice was mailed, the in-person conversation took place, or the telephone conversation occurred.

v. Out-of-State Medicaid Recipient

1. Alabama, Alaska, Arizona, Arkansas, Georgia, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, Pennsylvania West Virginia, and Virginia Hospitals

a. 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 not cost effective for the hospital to become a provider will be eligible for charity care 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. Indiana, New Mexico and Texas Hospitals
    a. 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 not cost effective for the hospital to become a provider will be eligible for charity care upon verification of Medicaid coverage for the service dates, if the out-of-state Medicaid Program's eligibility standards are not more generous than what would otherwise qualify an in-state patient for charity care under this policy. 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.

    b. If it is determine that a patients' out-of-state Medicaid coverage has more generous eligibility limits then the state where service is provided, then additional verification of the patient's income should be performed before making a charity care eligibility determination.

3. Florida and Tennessee Hospitals

    a. 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 not cost effective for the hospital to become a provider will be eligible for charity care upon verification of Medicaid coverage for the service dates and receipt of any state required documentation.

vi. Denial

1. A patient who applied for Charity Care but was denied should be informed that their request for Charity Care was denied in writing.

2. A patient who believes that his or her application was not properly considered may appeal the decision. Instructions for completing the appeal process should be included in the Charity Care denial letter.

vii. Length of Eligibility

1. The patient's account status will never be permanently designated as Charity Care; rather the patient's status will be reviewed every three (3) months, meaning that accounts occurring within three months after a previous approval may be added to the previous approval. The Practice/Clinic/Hospital reserves the right to require a new application or presumptive qualifications evaluation within the three (3) month period if a patient's financial situation appears to or is suspected to have changed.

2. A patient's Charity Care award may be revoked, rescinded or amended if,

   a. A patient received the award due to circumstances which undermines the Charity Care program
   b. Other payment sources are identified after receiving the Charity Care award.
   c. A change in healthcare coverage is identified after receiving the Charity Care award.

D. Collection Efforts

i. All collection efforts should be suspended if,

1. The patient has an active Charity Care award.

2. The patient has initiated a Charity Care application. Collection efforts should be suspended until a final eligibility determination is made.

3. The patient account is in a protected financial class such as J (charity) or equivalent based on patient accounting system.

ii. In a patient is awarded charity care, any deposits or payments received from the patient for that care must be refunded.

E. Communication of Charity Care.

i. At the time of service, all patients should be notified of the Charity Care program.

ii. An opportunity to complete a Financial Screening Form should be given to all patients that wish to apply to the Charity Care program or have been recommended by practice staff, a physician or a financial counselor for the Charity Care program.

iii. A patient may request a charity care application in-person, by phone, by mail, or by accessing the electronic version via the Hospital, Practice or Clinic's website if available (electronic version is required for 501r facilities). Copies of the policy, application forms, and instructions should be made available free of charge.

iv. Patients should be provided a written notice with their bill that contains information regarding the charity care policy including information about applying for charity care and contact information for the Business Office where the patient may obtain further information about these policies.

The Charity Care policy should be posted in conspicuous places including, but not limited to posting notices in the emergency rooms, urgent care centers, admitting and registration departments, business offices, and patient financial services offices that are located at the Facility.[3]

[3] For state specific requirements, please consult Appendix A.

Appendix A

State	Does the State Have Requirements for Qualifying a Patient for Charity Care?	Does the State Require Patient Notification of Charity Care Eligibility Determinations?	Does the State Have Charity Care Application Requirements?
Alabama	**No**. Although hospitals are required to make available written information about any financial assistance policies they have, Alabama law does not prescribe the content of those policies or mandate the steps to qualify a patient for charity care.[4] Each hospital bill or other summary of charges to a patient must include a statement that a patient who meets certain income criteria may qualify for the hospital's financial assistance policy. ALA. CODE § 22-21-300(b)(1). Further, hospitals must conspicuously post a sign in the admission and registration areas of the hospital with the following notice: "You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For additional information, contact the hospital financial assistance	**No**, Alabama law appears to be silent on issues surrounding notification of eligibility.	**Arguably, no**. If financial assistance is available at the hospital, the hospital must post in a prominent place on its website: (i) a description of the application process; and (ii) a copy of the application. ALA. CODE § 22-21-300(b)(4). The statute appears to be concerned with ensuring patients have access to an application and does not technically require the hospital to obtain a completed application in order to assess a patient's eligibility for charity care.

[4] Alabama State Health Planning and Development Agency (SHPDA) regulations specifically define "charity care" as "health services for which a provider's policies determine a patient is unable to pay. Charity care could result from a provider's policies to provide health care services free of charge to individuals who meet certain pre-established criteria. Charity care is measured as revenue forgone, at full-established rates or charges. Charity care would not include contractual write-offs, but could include partial write-offs for persons unable to pay the full amount of a particular patient's bill." ALA. ADMIN. CODE r. 410-2-2-.06(1)(e). Although SHPDA regulations encourage providers to "pursue collections based upon economic means based policies in order to recover part of the cost of uncompensated care, and according to generally accepted standards," this is an aspirational policy statement rather than an obligation. *Id.* r. 410-2-2-.06(1)(c).

	representative." ALA. CODE § 22-21-300(b)(2). The sign must be in English and in any other language that is the primary language of at least 5% of the patients annually served by the hospital. ALA. CODE § 22-21-300(b)(3).[5]		
Alaska	**No**. The regulations governing prospective payment rates for health facilities under the Alabama Medicaid program generally define "charity care" as "health care services that (A) a facility does not expect to result in cash payments; and (B) result from a facility's policy to provide health care services free of charge to an individual who meets certain financial criteria." 7 ALASKA ADMIN. CODE § 150.990(9). However, Alaska law does not prescribe the content of such policies or mandate the steps to qualify a patient for charity care.	**No**, Alaska law appears to be silent on issues surrounding notification of eligibility.	**No**, Alaska law does not appear to impose any particular application requirements.
Arizona	**No**. For purposes of the hospital Uniform Accounting Reports that must be submitted annually to the Arizona Department of Health Services, the term	**No**, Arizona law appears to be silent on issues surrounding notification of eligibility.	**No**, Arizona law does not appear to impose any particular application requirements.

[5] The term "hospital" includes "general and specialized hospitals, including ancillary services; independent clinical laboratories; rehabilitation centers; ambulatory surgical treatment facilities for patients not requiring hospitalization; end stage renal disease treatment and transplant centers, including free-standing hemodialysis units; abortion or reproductive health centers; hospices; health maintenance organizations; and other related health care institutions when such institution is primarily engaged in offering to the public generally, facilities and services for the diagnosis and/or treatment of injury, deformity, disease, surgical or obstetrical care." Long-term care facilities such as, but not limited to, skilled nursing facilities, intermediate care facilities, assisted living facilities, and specialty care assisted living facilities rising to the level of intermediate care also fall within the definition of a "hospital" for purposes of the financial assistance policy disclosure requirements. Private offices of physicians or dentists, as well as county or district health departments, are specifically excluded. ALA. CODE § 22-21-20.

	"charity care" is generally defined to mean "services provided without charge to an individual who meets certain financial criteria established by a health care institution." ARIZ. ADMIN. CODE R9-11-101(14). However, there are no restrictions or requirements surrounding qualification of a patient for charity care.		
Arkansas	**No**. The Arkansas Medicaid provider manual for hospitals defines "charity care" as "care provided to individuals who have no source of payment" and are not eligible for Medicaid, including charges for services not covered by an individual's insurance which he or she is unable to pay. ARK. ADMIN. CODE 016.06.20-250.301(C). However, there are no specific requirements around how a hospital qualifies a patient for charity care.	**No**, Arkansas law appears to be silent on issues surrounding notification of eligibility.	**No**, Arkansas law does not appear to impose any particular application requirements.
Florida	**Yes**, Florida law establishes general eligibility guidelines for what constitutes "charity care" in the context of hospital data reporting and requires providers to furnish certain information about their financial assistance policies to patients. For purposes of the Florida Hospital Uniform Reporting System and receipt of disproportionate share payments under Medicaid, "charity care" or "uncompensated charity care" is defined by statute to mean "that portion of hospital charges reported to the Agency for Health Care	**No**, Florida law appears to be silent on issues surrounding notification of eligibility.	**Arguably, yes**. The Florida Hospital Uniform Reporting System Manual requires hospitals to determine which patients are charity care patients by a "verifiable process" subject to certain documentation requirements. Documentation must include one of the following forms: ● W-2 withholding forms; ● Paycheck stubs; ● Income tax returns; ● Forms approving or denying unemployment compensation or worker's compensation; ● Written verification of wages from the patient's employer; ● Written verification

	Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity." FLA. STAT. § 409.911(1)(c). Hospitals and other licensed facilities must provide information to prospective patients on their website regarding the facility's financial assistance policy, including the application process, payment plans, and discounts, as well as the facility's charity care policy and collection procedures. FLA. STAT. § 395.301(1)(a)(1); *see also* FLA. ADMIN. CODE § 59A-3.256(1)(d). Further, upon request and before providing any nonemergency medical services, hospitals and other licensed facilities must provide in writing or electronically a good faith estimate of reasonably anticipated charges for treatment of the patient's condition, along with information on the facility's financial assistance policy,		from public welfare agencies or any governmental agency which can attest to the patient's income status over the course of the past 12 months; ● A witnessed statement signed by the patient or responsible party, as provided for in the Hill-Burton Act, except that such statement need not be obtained within 48 hours of the patient's admission to the hospital. The statement must include an acknowledgement that providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree; or ● A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted. To the extent this information could only be obtained directly from the patient, a written application would be required.

	including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures. FLA. STAT. § 395.301(1)(b); *see also* FLA. ADMIN. CODE § 59A-3.256(2)(a)(3). Note that licensed health care practitioners have a similar obligation to provide information to uninsured patients and insured patients for whom the practitioner is not a network provider or preferred provider which discloses the practitioner's financial assistance policy, including the application process, payment plans, discounts, or other available assistance, and the practitioner's charity care policy and collection procedures. FLA. STAT. § 456.0575(2). This seems to apply only where the health care practitioner furnishes nonemergency medical services in a licensed health care facility and the patient requests an estimate of charges.		
Georgia	**No**, Georgia law does not appear to contain any requirements relative to qualifying patients for charity care.	**No**, Georgia law appears to be silent on issues surrounding notification of eligibility.	**No**, Georgia law does not appear to impose any particular application requirements.
Indiana	**Yes**. Indiana law includes general guidelines for establishing a patient's charity care eligibility and, for nonprofit hospitals only, mandates notice to patients about the facility's charity care program. For purposes of annual	**No**, Indiana law appears to be silent on issues surrounding notification of eligibility.	**No**, Indiana law does not appear to impose any particular application requirements.

	reporting under the Hospital Financial Disclosure Law, "charity care" is defined to mean "the unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services . . . to a person classified by the hospital as financially indigent or medically indigent on an inpatient or outpatient basis." IND. CODE ANN. § 16-18-2-52.5(a)(1). An uninsured or underinsured person may be deemed financially indigent based on the hospital's financial criteria and procedure, which "must include income levels and means testing indexed to the federal poverty guidelines." *Id*. § 16-18-2-52.5(b). "Medically indigent" means that the person has medical or hospital bills after payment by third-party payors that "exceed a specified percentage of the patient's annual gross income as determined in accordance with the hospital's eligibility system, and . . . is financially unable to pay the remaining bill." *Id.* § 16-18-2-52.5(c). Note that only nonprofit hospitals are statutorily required to "develop a written notice about any charity care program operated by the hospital and how to apply for charity care." This notice must be in appropriate languages "if possible," and posted in the following areas: (i) the general waiting area; (ii) the waiting area for emergency services; (iii) the business office; and (iv) any other area that the hospital considers an appropriate area in which to provide notice of		

	a charity care program. *Id.* § 16-21-9-7(d).		
Louisiana	**No**. Louisiana law contains specific requirements for state-supported charity hospitals, and mandates reporting of certain patient-specific uncompensated care data to the Department of Health in order for hospitals and other health care facilities to receive supplemental payments. *See* LA. REV. STAT. §§ 46:6, 46:2761. However, there do not appear to be specific requirements for qualifying a patient for charity care.	**No**, Louisiana law appears to be silent on issues surrounding notification of eligibility.	**No**, Louisiana law does not appear to impose particular application requirements.
Mississippi	**No**, Mississippi does not appear to prescribe any requirements for qualifying a patient for charity care.	**No**, Mississippi law appears to be silent on issues surrounding notification of eligibility.	**No**, Mississippi law does not appear to impose particular application requirements.
Missouri	**No**. Missouri requires hospitals to provide financial data related to charity care to the Department of Health and Senior Services, but does not appear to have any requirements for qualifying a patient for charity care. *See* MO. REV. STAT. §§ 192.665(4), 192.667(1); 19 CSR 10-33.030(1). Further, while applicable MO HealthNet (*i.e.*, Missouri Medicaid) regulations generally define "charity care" as resulting "from a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient," the regulations do not prescribe any particular requirements for such a policy. 13 CSR	**No**, Missouri law appears to be silent on issues surrounding notification of eligibility.	**No**, Missouri law does not appear to impose particular application requirements.

	70-15.010(2)(E).		
New Mexico	**Yes**. New Mexico has general charity care guidelines for purposes of hospital data reporting and mandates the provision of certain information to patients about a facility's financial assistance policies. For purposes of New Mexico Health Policy Commission (NMHPC) data reporting requirements, "charity care" means "the provision of medically necessary health care without any expectation of cash inflow and without classification as revenue or receivables in a financial statement, as determined by the criteria established in a formal policy by the facility providing the care." N.M. ADMIN. CODE § 7.1.24.7.C. A hospital's formal charity care policy must establish "criteria for classifying the provision of medically necessary health care as charity care and include[ ] as a criterion the level of qualifying income as a percentage of the applicable federal poverty level." *Id.* § 7.1.24.7.F. All non-federal health care facilities required to report charity care data must also submit their policies to the NMHPC. *Id.* § 7.1.24.8.C. Additionally, hospitals must provide to patients, upon request, information on financial assistance available through the hospital. *Id.* § 7.7.2.19(A)(1)(m).	**No**, New Mexico law appears to be silent on issues surrounding notification of eligibility.	**No**, New Mexico law does not appear to impose particular application requirements.
North Carolina	**No**. North Carolina does not	**No**, North Carolina law appears to be silent with	**No**, North Carolina law does not appear to impose particular

	appear to have requirements for qualifying a patient for charity care, although hospitals and ambulatory surgical facilities "that contract[ ] with a collections agency, entity, or other assignee shall require the collections agency, entity, or other assignee to inform the patient of the hospital's or ambulatory surgical facility's charity care and financial assistance policies when engaging in collections activity." N.C. GEN. STAT. ANN. § 131E-91(d)(3). For purposes of health care cost reporting requirements, North Carolina hospital licensing rules define the term "financial assistance" to mean "a policy, including charity care, describing how the organization will provide assistance at its hospital(s) and any other facilities. Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services." 10a N.C. ADMIN. CODE 13B.2101(4). The rules do not contain any requirements surrounding how a hospital offers financial assistance. Note that, while hospitals and ambulatory surgical facilities must provide the public access to their financial assistance policies and annual financial assistance costs, including display of that information in a "conspicuous place in the organization's place of business," these general disclosure standards	respect to notification of eligibility.	application requirements.

	technically only apply to nonprofit organizations that are required to file IRS Forms 990. N.C. GEN. STAT. ANN. § 131E-214.14(a); 10a N.C. ADMIN. CODE 13B.3502(b)(6) (requiring that the hospital's governing authority establish written policies and procedures for the provision of charity care and financial assistance policies to the patient or patient's representative).		
Oklahoma	**No**, although Oklahoma requires hospitals to offer discounts to patients meeting certain statutorily established criteria. All hospitals must establish discount programs for hospital charges for qualified self-pay patients who have household incomes of up to 300% of the federal poverty guidelines, and who are not eligible for or enrolled in private or public insurance plans providing hospital coverage. OKLA. STAT. tit. 63, § 1-723.2.A. Patients are responsible for establishing their eligibility for the discount, and no discount need be provided on procedures that are not medically necessary per the patient's treating physician. *Id.* § 1-723.2.B–C. The statute generally seeks to limit the hospital's charges to qualified self-pay patients and does not prescribe any particular process a hospital must use to qualify patients for charity care.	**No**, Oklahoma law appears to be silent with respect to notification of eligibility.	**No**, Oklahoma law does not appear to impose particular application requirements.
Pennsylvania		**Yes**. According to the	**Arguably, yes**. DHS has

	Yes. In order for a hospital to receive supplemental payments from the Hospital Uncompensated Care Program (HUCP), the hospital must meet a number of requirements relating to qualification of a patient for charity care. First, the hospital must post adequate notice of the availability of medical services and its obligation to provide free services. 35 PA. STAT. § 5701.1104(b)(5). The Pennsylvania Department of Human Services (DHS) issued a Medical Assistance Bulletin[6] in late 2017 clarifying requirements for hospitals participating in the HUCP. DHS will consider a hospital in compliance with the statutory notice requirement if notice is provided: • n multiple locations throughout the hospital, such as inpatient, outpatient, and emergency room patient registration areas, and billing offices where patients meet with financial counselors; • n paperwork sent to patients, such as hospital discharge paperwork and invoices; and • n the hospital's website, unless the hospital does not have a website.	Bulletin, if patients are not eligible for publicly funded programs, the hospital should give the patient information about the hospital's charity care program; assist them in completing the charity care application; and notify the patient of the ultimate charity care eligibility determination. Notification to the patient of the hospital's charity care eligibility determination is a prerequisite to the hospital's eligibility for receipt of payment under the HUCP.	developed a Model Charity Care Application,[7] though hospitals may choose the format in which they wish to collect the applicant information (*e.g.*, through an electronic or paper application) and the format, organization, and layout of their forms. While it is permissible for the hospital to collect less information than set forth in the model application – as long as it is adequate to make a determination about patient eligibility – this form sets forth the maximum scope of information hospitals may collect and use in the charity care eligibility determination. The Bulletin does not specifically state that a written application must be used in all cases, but this is likely the prudent course of action.

[6] *See* Medical Assistance Bulletin No. 01-17-03: Hospital Responsibilities Related to the Uncompensated Care Program and Charity Care Plans, Penn. Dep't of Human Services (Dec. 27, 2017), http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_268692.pdf (hereinafter, "Bulletin").

[7] *See* Bulletin, Attachment A.

	Following is an example of notice language that would satisfy DHS's requirements: "This hospital provides free care to persons who qualify. If you cannot afford the cost of care, you are encouraged to apply for free care. You may obtain information and an application at (specify a location on the premises) or by calling (insert telephone number) or you may download an application at (provide the web address)." The hospital's charity care policy should be available upon request, and to patients who cannot or will not pay for services rendered by the hospital. Second, although hospitals remain free to establish their own charity care criteria, DHS *recommends*: (i) an income limit for charity care of 200% of the federal poverty level guideline, based on family size; and (ii) a countable resource standard of $10,000. DHS has stated that it recommends an income limit of at least 200% FPL because that encompasses the core population of patients that depend on assistance to obtain medical care, is consistent with the income limits used by the majority of hospitals in Pennsylvania, and is minimally burdensome for the hospital community. Third, the hospital must also attempt to obtain health care coverage for patients, including helping patients apply for Medicaid, the Children's Health Insurance Program, or the Adult Basic Coverage Insurance Program. 35 PA. STAT.		

	§ 5701.1104(b)(3). The Bulletin informs hospitals they should: • eet with patients or obtain adequate individual patient information to assist them in completing a paper Medicaid application (PA 600), paper CHIP application (CHIP 2), online COMPASS application for either health care coverage, or Presumptive Eligibility application (MA332); • rovide pregnant women appropriate verification of pregnancy; • rovide patients with a list of additional documentation needed for the application and contact information for the County Assistance Office (CAO); • rovide copies of the patient's invoices to the CAO; and/or • eet with patients to explain the hospital's charity care program, assist in the completion of a charity care application, and advise patients they may be eligible for the program if they are not found eligible for publicly funded programs.		
Tennessee	**Yes**. Tennessee has adopted specific standards for what constitutes charity care for purposes of hospital reporting to the Department of Health,	**No**, Tennessee law appears to be silent with respect to notification of eligibility.	**Arguably, yes**. While Tennessee does not require a particular charity care application to be used, the guidelines for assessing the

	and hospitals must provide certain information about their charity care policies to patients. TENN. CODE ANN. § 68-1-109(2) defines "charity care" as "reductions in charges made by the provider of services because of indigence or medical indigence of the patient." By statute, providers must follow the below guidelines when making this determination: ● The patient's indigence must be determined by the provider, not the patient (*i.e.*, a patient's signed declaration of inability to pay the patient's medical bills cannot be considered proof of indigence). ● The provider should take into account a patient's total resources, which include, but are not limited to, an analysis of assets, only those convertible to cash and unnecessary for the patient's daily living, liabilities, and income and expenses. Indigence income means an amount not to exceed 100% of the federal poverty guidelines. Medical indigence is a status reached when a person uses or commits all available current and expected resources to pay for medical bills and is not limited to a defined percent of the federal poverty guidelines. In making this analysis, the provider should take		patient's indigence require an analysis of certain information that may only be collectible from the patient. To the extent this information cannot be obtained through other means, an application should be used.

	into account any extenuating circumstances that would affect the determination of the patient's indigence. ● The provider must determine that no source other than the patient is legally responsible for the patient's medical bill (*e.g.*, Medicaid, local welfare agency, or guardian). ● The patient's file should contain documentation of the method by which indigence was determined, in addition to all backup information to substantiate the determination. Hospitals must as a condition of licensure develop a concise statement of their charity care policies, which shall be posted in a place accessible to the public. *See* TENN. CODE ANN. § 68-11-268; TENN. COMP. R. & REGS. § 1200-08-01-.04(13).		
Texas	**Yes**, Texas has adopted standards for what constitutes charity care, and licensed health care facilities – including hospitals and ambulatory surgical centers – must provide certain information to patients about their charity care policies. For purposes of hospital data reporting requirements and receipt of disproportionate share hospital payments, "charity care" means	**Arguably, yes**. The regulations governing receipt of supplemental payments to defray the costs of uncompensated charity care under the Texas Medicaid program appear to incorporate by reference the principles set forth in the HFMA Principles and Practices Board Statement 15. That document states that, for a service to be considered charity care, "the provider must make reasonable attempts to notify the patient of the	**No**, Texas law does not appear to impose any particular application requirements. In fact, the HFMA Principles and Practices Board Statement 15 – which is incorporated by reference into the Texas Medicaid rules – contemplates that there may be other mechanisms to support a charity care eligibility determination where the patient does not cooperate. *See* Section 3.7 (stating that, "The charity care policy

	"providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as 'financially indigent' or 'medically indigent.'" TEX. HEALTH & SAFETY CODE § 311.031(2)(A). The term "financially indigent" means an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay, based on the hospital's eligibility system. *Id.* § 311.031(7). "Medically indigent" means a person whose medical or hospital bills (after payment by third-party payors) exceed a specified percentage of the patient's annual gross income, determined in accordance with the hospital's eligibility system, and who cannot pay the remaining bill. *Id.* § 311.031(13). While hospitals are free to develop their own eligibility criteria, the system must include income levels and means testing indexed to the federal poverty guidelines. The income level eligible for charity care may not be lower than that required under the County Indigent Health Care Program (21% of the federal poverty guidelines) or higher, in the case of financially indigent patients, than 200% of the federal poverty guidelines. *Id.* § 311.031(11); *see also* 1 TEX. ADMIN. CODE § 355.8065(b)(6). Note that a separate definition of "charity care" exists for hospitals that participate in the Texas Healthcare	determination and make no further attempt to collect anything (except in cases where sliding-scale payments are part of a charity care policy)." *See* Section 4.4.	should address eligibility for charity care when there is insufficient information provided by the patient to fully evaluate all the criteria and the ability to pay cannot be reliably determined. Policies may refer to external sources such as credit reports or Medicaid enrollment to help support such determinations.").

	Transformation and Quality Improvement Program § 1115 Medicaid demonstration waiver. In particular, 1 TEX. ADMIN. CODE § 355.8212 suggests that, to receive supplemental payments under this program, a hospital's charity care policy "should" adhere to the principles of the Healthcare Financial Management Association Principles and Practices Board Statement 15 (December 2012). Facilities, including hospitals and ambulatory surgical centers, must develop, implement, and enforce written policies for the billing of health care services and supplies, which must address, among other things, any discounting of facility charges: (i) extended to uninsured patients; and (ii) provided to a financially or medically indigent patient who qualifies based on a sliding fee scale or a written charity care policy established by the facility and the documented income and other resources of the patient. TEX. HEALTH & SAFETY CODE § 324.101(a)(1)–(2). Each facility must post in the general waiting area and in the waiting areas of any off-site or on-site registration, admission, or business office a clear and conspicuous notice of the policies' availability. *Id.* § 324.101(c).		
Virginia	**No**. While Virginia law does not impose requirements to qualify a patient for charity care, hospitals must make	**No**, Virginia law appears to be silent with respect to notification of eligibility.	**No**, Virginia law does not appear to impose any particular application requirements.

	their policies in this area publicly accessible.[8] By statute, all hospitals must provide written information about the hospital's charity care policies, including policies related to free and discounted care. Such information shall be posted conspicuously in public areas of the hospital, including admissions or registration areas, emergency departments, and associated waiting rooms. Information regarding specific eligibility criteria and procedures for applying for charity care must be: (i) provided to a patient at the time of admission or discharge, or at the time services are provided; (ii) included with any billing statements sent to uninsured patients; and (iii) included on any website maintained by the hospital. VA. CODE ANN. § 32.1-137.01.		
West Virginia	**Yes**. For purposes of hospital cost-based rate-setting, West Virginia does provide guidelines for hospitals to use in defining the elements of uncompensated care. Apart from that, West Virginia's charity care laws generally apply to governmental and nonprofit hospitals only.	**No**, West Virginia law appears to be silent with respect to notification of eligibility.	**No**, West Virginia law does not appear to impose particular application requirements.

8 In addition, as a condition of their certificates of public need, certain medical care facilities are required to report charity care data to the State Health Commissioner. VA. CODE ANN. § 32.1-276.5.C. For that purpose, the term "charity care" is statutorily defined to mean "health care services delivered to a patient who has a family income at or below 200 percent of the federal poverty level and for which it was determined that no payment was expected (i) at the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person or (ii) at some time following the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person." *Id.* § 32.1-102.1.

	Hospital rate-setting laws provide the following guidelines for who should qualify for charity care: ● Persons deemed to be bankrupt either by the filing of a bankruptcy notice or proof of bankruptcy claim; ● Persons who meet West Virginia Department of Health and Human Services Income and Resource Guidelines, but who are not eligible for Medicaid coverage; ● Persons who fall within the U.S. Department of Health and Human Services (HHS) Annual Update of the Poverty Income Guidelines published annually in the Federal Register and who are further impoverished as a result of an extended uninsured illness; ● Persons who fall within 101% and 200% of the HHS Poverty Income Guidelines may also be considered eligible for charity care, but should be considered on a graduated scale ranging from 99% to 0%; and ● Medicaid recipients who have exhausted the covered days allowed by the Medicaid program. W. VA. CODE ST. R. § 65-5-5.9.9.a. Note that W. VA. CODE ST. R. § 110-3-24.9.4.5 requires that governmental and nonprofit hospitals plainly post in their emergency and admitting areas a notice containing a statement of their obligation to provide free and below		

	cost care and of the criteria and mechanism for receiving such care. Such hospitals must provide written notification of the existence, criteria, and mechanism for receiving charity care, at a minimum, to each person admitted or treated who does not demonstrate payment coverage under governmental programs or private insurance. Such hospitals must create and maintain records demonstrating that the required criteria and mechanisms are established; that the required policies have been posted and distributed; and which record any and all requests for free or below cost care, the disposition of such request, the rationale for such disposition, and the amount of charity care provided.		

Reference	Description
Attachment 5	Patient Choice Policies

Title: **Discharge Planning**
Scope: **Hospital**
Index #: **8410-2**

PURPOSE:
To assure that the organization has an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care.

To assure that the discharge planning process and the discharge plan are consistent with the patient's goals for care and his or her treatment preferences, and to ensure an effective transition of the patient from the hospital to post-discharge care, as well as reduce factors leading to preventable hospital readmissions.

SCOPE & APPLICABILITY:
This policy applies to all care settings where discharge planning services are available.

IDENTIFYING THE NEED FOR DISCHARGE PLANNING SERVICES
Screening for Discharge Planning Services - Inpatient

All patients admitted for inpatient care shall receive a screen by nursing staff at an early stage of hospitalization to identify the potential need for discharge planning services. Any patient who meets one of the following criteria shall be referred for a formal discharge planning evaluation.

- Acute change in functional or cognitive status that may impact post-hospitalization care needs
- Currently require post-hospitalization care services
- Inability to perform ADL's with limited or no support system in place
- Likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning
- Suspicion for abuse or neglect
- Lives alone or with little or no discernable support system
- Readmission to acute care within the last 30 days
- Upon request of the patient, patient's representative, or patient's physician

Changes in the patient's condition during hospitalization may warrant the need for discharge planning services previously determined to be unnecessary. In these situations, a referral shall be made for a discharge planning evaluation.

DISCHARGE PLANNING EVALUATION
The discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

The patient or patient representative shall be actively involved in the discharge planning evaluation. Information should be actively solicited not only from the patient or the patient's representative, but also – as needed – from family/friends/support persons.

The discharge planning evaluation shall be performed by qualified personnel. The following are considered qualified personnel:

- Registered Nurses
- Social Workers
- Individuals with previous experience in discharge planning, knowledge of clinical and social factors that affect the patient's functional status at discharge, knowledge of community resources to meet post-discharge clinical and social needs, and appropriate assessment skills.

All personnel performing or supervising discharge planning evaluations, including Registered Nurses and Social Workers, must have knowledge of clinical, social, insurance/financial and physical factors that must be considered when evaluating how a patient's expected post-discharge care needs can be met.

The discharge planning evaluation shall include, but not necessarily be limited to, the following:

- An evaluation of what the current and anticipated patient's post-discharge care needs.
- An evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.
- An evaluation of the likelihood of a patient needing post-hospital services and of the availability of those services. Services include and are not limited to hospice care services, post-hospital extended care services, home health services, and non-healthcare services and community based providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.

The results of the discharge planning evaluation must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the results of the evaluation.

DEVELOPMENT OF A DISCHARGE PLAN

If the results of the discharge planning evaluation indicate the need for a discharge plan, then a plan shall be developed to meet the needs identified by the evaluation. The plan shall take into consideration the patient's goals and treatment preferences.

The patient and/or the patient's representative have the right to participate in the development of the discharge plan. Even if the discharge planning evaluation indicates no need for a discharge plan, the patient's physician may request a discharge plan. In such a case, a discharge plan shall be developed for the patient.

The discharge plan shall be developed by qualified personnel. The following are considered qualified personnel:

- Registered Nurses
- Social Workers
- Individuals with previous experience in discharge planning, knowledge of clinical and social factors that affect the patient's functional status at discharge, knowledge of community resources to meet post-discharge clinical and social needs, and appropriate assessment skills.

All personnel developing discharge plans, including Registered Nurses and Social Workers, must have knowledge of clinical, social, insurance/financial and physical factors that must be considered when evaluating how a patient's expected post-discharge care needs can be met.

The discharge plan should be initiated as soon as possible. As changes in the patient's condition and needs occur, the discharge plan must be reassessed and—if necessary-- updated to address those changes. When indicated, the organization shall arrange for the initial implementation of the discharge plan prior to the patient's discharge.

The results of the discharge plan must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the discharge plan.

POST-ACUTE CARE PROVIDERS

For the purpose of this policy, post-acute care providers are defined as home health agencies (HHA), skilled nursing facilities (SNF), long-term acute care hospitals (LTCH), and inpatient rehabilitation facilities (IRF) .

If the discharge plan for a patient involves the need for post-acute care providers, the organization shall provide a list of post-acute care providers that are available to the patient that are participating in the Medicare program and that serve the geographic area (as defined by the HHA, IRF or LTCH) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHA's must request to be listed by the organization as available. This list must only be presented to patients for whom post-acute care services are indicated and appropriate as determined by the discharge planning evaluation.

- For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has this information, it shall share it with the patient or the patient's representative.

- The organization shall document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

The organization shall assist patients, their families or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF or LTCH CMS data on quality measures and data on resource use measures. The organization shall ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

The organization shall inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care discharge services and must, when possible, respect patient and family preferences when they are expressed.

The organization shall not specify or otherwise limit the qualified providers that are available to the patient.

The discharge plan must identify any HHA or SNF to which the patient is referred in which the organization has a financial interest, and any HHA or SNF that has a financial interest in the organization under Medicare.

INITIAL IMPLEMENTATION OF THE DISCHARGE PLAN

The organization shall arrange for the initial implementation of the discharge plan. This includes providing in-hospital education/training to the patient for self-care or to the patient's family or other support person(s) who will be providing care in the patient's home. It also includes arranging:

- Transfers to rehabilitation hospitals, long-term care hospitals or long-term care facilities;
- Referrals to home health or hospice agencies;
- Referral for follow-up with physicians/practitioners, occupational or physical therapists, etc.;
- Referral to medical equipment suppliers; and
- Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation or other post-discharge needs.

Staff shall document in the patient's medical record the arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient's informal caregiver or representative, as

applicable.

TRANSFER OR REFERRAL
The organization shall assure that necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, are provided to the appropriate post-acute care providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.

ASSESSING THE EFFECTIVENESS OF THE DISCHARGE PLANNING PROCESS
The organization shall assess its discharge planning process on a regular basis. The assessment shall include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.The Quality department will be responsible for tracking readmission rates.

For identified potentially preventable readmissions, the organization shall conduct an in-depth review of the discharge planning process for a sample of such readmissions (at least 10% of potentially preventable readmissions, or 15 cases/quarter, whichever is larger) in order to determine whether there was an appropriate discharge planning evaluation, discharge plan and implementation of the discharge plan.

Issues or trends identified shall be followed up to determine if changes to discharge planning services are warranted.

RELEVANT REFERENCES:

REFERENCES:
CMS Conditions of Participation for Acute Care Hospitals, §482.43(c)
CMS Conditions of Participation for Critical Access Hospitals §483.21(b) & §483.21(c)
Center for Improvement in Healthcare Quality, Standard DC-1, DC-2, DC-3, DC-4 & DC-5

Policy Title: Discharge of Acute Care Patients to Post-Acute Providers, including Patient Choice Policy

Audience: CEO, CFO, CNO, SNF, IRF, HIM, PFS, Acute Care Services, Free Standing Post-Acute Care Providers, Case Management/Discharge Planner, Transitional Care Units, Swing Bed Services, Home Care/ Hospice, Administration

References and Citations: Section 4321(a) of the Balanced Budget Act of 1997
Section 1861(ee) of the Social Security Act,
CFR 42 Section 482.43 Conditions of Participation: Discharge Planning
42 U.S.C. §1395 x (M), 42 U.S.C. §1395 x (ee) (2) (D)
Patient Information and Choice Form (CM-2201)

SCOPE:

This policy applies to (1) CHSPSC, LLC and its wholly owned subsidiaries and affiliates; (2) any other entity or organization in which CHSPSC or an Affiliate owns a direct or indirect equity interest or greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate owns a significant ownership interest **and** either manages or controls the day-to-day operation of the facility.

POLICY:

Hospital Affiliates shall conduct discharge planning as provided in the Medicare Conditions of Participation for Hospitals. Hospital Affiliates whose case management departments have questions about Post-Acute Services patient suitability or eligibility criteria shall consult with other Hospital personnel (e.g., swing-bed/skilled unit, rehab department, and other distinct-part unit clinical managers) and local free-standing Affiliates operating Post-Acute Services (e.g., home health care, hospice, psychiatric hospital, rehabilitation facility). If assistance is needed regarding patient suitability and the particular Post-Acute Service is not provided by the Hospital or a local Affiliate provider, Hospital case management departments should consult with CHSPSC Regional Case Management Directors or the applicable CHSPSC Post-Acute Service Department or Division.

For those patients who require post-acute care services after discharge, the hospital, as part of the discharge planning process, will inform the patient and/or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services, will respect the patient's or the patient/s representative's goals of care and treatment preferences they express, and accommodate their goals and preferences whenever possible.

For patients enrolled in managed care organizations, the hospital will make the patient aware of the need to verify with the payer which providers are in the managed care organization's network. In these cases, should the patient and/or patient's representative select a provider out of network, the hospital will alert the patient and/or patient's representative of their potential financial liability.

These post-acute care services may include but not be limited to: Behavioral Health, Skilled Nursing Facility, Home Health Agencies, Durable Medical Equipment suppliers, Hospices, Outpatient and Inpatient Rehabilitation facilities (IRF), and long term acute care.

PURPOSE:

The primary goals of the Policy are as follows: (1) to ensure appropriate hospital personnel perform the required hospital function of discharge planning; and (2) to ensure patients are informed of their options, have a free choice in selecting their post-acute service provider, and have been informed of any financial interest the hospital has with those providers.

DEFINITIONS:

Post-Acute Service Provider - Refers to a post-acute care provider and may include Behavioral Health, Skilled Nursing Facility, Home Health Agencies, Durable Medical Equipment suppliers, Hospices, Outpatient and Inpatient Rehabilitation facilities (IRF), and long term acute care; such services are referred to as Post-Acute Service(s)

Affiliate or Affiliated Post-Acute Service Provider – Means a business, legal entity, or person who is owned by (including indirect ownership such as through a joint venture), controlled by, or under common control with Community Health Systems, Inc. or CHSPSC, LLC. Examples of Affiliated Post-Acute Service Providers include, without limitation, freestanding Skilled Nursing Facilities, Inpatient Rehabilitation Facilities or joint venture Home Care Agencies.

COMPLIANCE CONSIDERATIONS:

The key compliance considerations are:

- Adhering to the Discharge Planning element of the Medicare Conditions of Participation for Hospitals
- Ensuring that patients are provided with the opportunity to freely choose their Post-Acute Service Providers
- Avoiding inappropriate relationships between the Hospital and third-party Post-Acute Service Providers which could implicate Federal Fraud and Abuse laws and Federal Antitrust laws. (Note: These compliance considerations are not implicated when involving Hospital personnel, local Affiliate Post-Acute Service Provider personnel, or CHSPSC personnel in the discharge planning process.)

PROCEDURE FOR DISCHARGE PLANNING FOR SMOOTH TRANSITIONS OF CARE:

1. The discharge planning process requires that the healthcare team begins to identify, early in the hospital stay, the anticipated post-discharge needs of the patient in order to develop an appropriate discharge plan tailored to the patient's unique goals, preferences and needs. This is an ongoing process throughout the hospital stay as the patient's condition and post-discharge needs may change. Patient's will be informed of the Post-Acute Service Providers available to them and have the ultimate choice in selecting the service provider. The multidisciplinary team involved in the discharge planning process includes physicians and individuals employed by the hospital, such as nursing, case managers, social workers, therapists and clinical managers from the Hospital's and its Affiliates' employees.
    - Note: Participation of Hospital personnel and personnel from Affiliates' Post-Acute Service Providers in the discharge planning process does not guarantee that the patient will be referred to these providers. All referrals first and foremost require obtaining the patient's choice of provider.
2. Once the need for post-acute services is determined, the case manager and/or social worker will inform the patient and/or patient representative of the right to choose the post-acute service provider.

3. The case manager and/or social worker will then provide a list of post-acute providers that are within the patient's preferred geographic area and can provide the services needed post-discharge. The provider list must include:

- available Medicare-participating Post-Acute Service Providers. Note, however, that only Home Health agencies that request in writing to be included must be listed on the Hospital's resource list.

- available quality and performance data for the providers listed; this may be the simple inclusion of the STAR rating on the CMS Home Health Compare and Nursing Home Compare websites.

- For Post-Acute Service Providers owned by or affiliated with the hospital (e.g., a home care agency operated by a sister entity), the provider list must include a notation of the affiliation.

4. For patients enrolled in a managed care organization, the case manager and/or social worker will alert the patient and/or patient's representative of the need to verify which providers are in the managed care network. The patient and/or patient's representative will still be provided an opportunity to choose the post-acute provider. The case manager and/or social worker will inform the patient and/or patient's representative of any potential financial liability should the patient choose an out-of-network provider.

5. In the event a Hospital patient may require multiple levels of providers after discharge from the hospital, and the physician refers the patient for post-discharge services, the patient may make choices for both the first and second level of services needed after discharge. For example: The patient is admitted to acute care for a stroke. The discharge planning staff determines the patient may require multiple progressive providers upon discharge and the patient's physician refers the patient for inpatient rehabilitation and home care following discharge from inpatient rehabilitation. The patient should be offered a choice of providers for both inpatient rehabilitation and home health. Hospital Case Management will notify both the selected inpatient rehabilitation center and the home care agency at the time of discharge from the hospital to allow for improved coordination in transition from one level of care to the next.

6. Once the patient selects a post-acute provider and the case manager or social worker has notified the provider of their selection, a representative from that provider may meet with the patient in the hospital and participate in the balance of the patient's discharge planning process to support a smooth transition of care. When provider's representatives are in the hospital, they are expected to wear name tags with the name of their company visible. These representatives must also be enrolled in the vendor screening system – VendorMate.

    - Note: Hospital personnel and personnel of Hospital Affiliates are not required to enroll in VendorMate.

    - Note: To avoid any appearance of impropriety, the personnel from Affiliated Post-Acute Service Providers who participate in the initial phase of the discharge planning process (i.e., determining suitability, eligibility, etc., (but not including any bed-side patient visit)) should not be the same personnel who participate in either (a) presenting the patient with their "patient choice" options, nor (b) the face-to-face meeting with the patient after the selection has been made.

7. If the patient was receiving services from a non-affiliated Post-Acute Service Provider immediately prior to admission and chooses to resume services with the same provider after

discharge, representatives from that provider may also participate in the patient's discharge planning process to support a smooth transition of care. When in the hospital, they are expected to wear name tags with the name of their company visible. In the event that a patient and/or patient's representative elects to change their choice of post-acute provider, the case manager and/or social worker will notify the provider that the patient will not be continuing services.

8. The patient and/or patient representative will be informed by the case manager and/or social worker if the physician has a recommendation for a specific provider. If the patient's and/or patient representative's choice conflicts with the physician's recommendation, the patient's and/or patient representative's choice will supersede the physician's recommendation.

9. If the patient and/or patient's representative does not have a preference of post-acute provider, the case manager and/or social worker will offer to make a referral to a CHS-affiliated provider if the patient does not object. The financial relationship shall be disclosed to the patient at the time of the patient choice discussion.

10. The patient and/or patient's representative will be asked to sign the Patient Information and Choice Form (CM-2201) to demonstrate that choice was offered and made. This signed document will become part of the legal medical record. If the patient is unable to sign and he or she has no Surrogate Decision Maker who can sign on the patient's behalf, then the case manager and/or social worker is responsible for completing the section of the Patient Information and Choice Form (CM-2201) labeled "Patient unable to sign due to…"

11. The case manager and/or social worker will provide the selected post-acute providers with the necessary information to assist in facilitating a safe and timely transition from the hospital to the care of the post-acute provider.

12. The case manager and/or social worker will obtain a physician's order for the selected service(s) prior to discharge.

13. Patients may amend their choice of providers at any time.

Reference	Description
Attachment 6	Listing of Open Positions

Job Title	Job Code	Department	Date Posted
Billing Manger	CLINI07387	Billing	8/10/2020
Cath Lab Tech FT	CATHL81188	Cath Lab	1/10/2020
Central Scheduler FT	CENTR07812	Admissions	8/10/2020
Certified Medical Assistant FT	MEDIC09919	Cardio Clinic	8/21/2020
Certified Medical Assistant FT	FTCER55963	Express Care	7/29/2019
Certified Medical Assistant FT	MEDIC04689	Express Care	7/24/2020
Certified Medical Assistant FT	MEDIC86809	Float	2/17/2020
Certified Medical Assistant FT	CERTI98813	Gen Surg	6/22/2020
Certified Surgical Tech PT	SURGI69074	L&D	10/14/2019
Clinical Coord- FT	CLINI84856	PCU	1/31/2020
ER Tech PRN	ERTEC89343	ER	3/13/2020
HC Evening/Weekend Supervisor FT	HEALT02976	Health Club	7/27/2020
LVN FT	LVNAT09528	CMA Gastro	8/31/2020
LVN FT	Terrill	Pedi	8/10/2020
Medical Lab Scientist FT	MEDIC87210	Lab	2/17/2020
Monitor Tech PT Nights	MONIT86330	Telemetry	2/19/2020
Nurse Asst (CNA) PRN Days	NURSE77774	Med Tele	12/16/2019
Nurse Asst (CNA) PRN Days	NURSE77771	Med Tele	12/16/2019
Phlebotomist- FT	PHLEB04954	Main Lab	8/4/2020
Physical Therapist Inpatient PRN	PHYSI65147	Therapy Services	9/12/2019
Registered Nurse-FT Days	REGIS95835	ASC	6/24/2020
Registered Nurse- FT Days	CMACA04728	Cardio Clinic	7/24/2020
Registered Nurse FT Nights	REGIS03677	ER	8/17/2020
Registered Nurse FT Afternoon	REGIS03676	ER	8/13/2020
Registered Nurse PT Afternoon Shift/ Rotation if needed	REGIS80028	ER	1/10/2020
Registered Nurse Float	REGIS71448	Float	1/27/2020
Registered Nurse FT Days	REGIS02496	ICU	7/16/2020
Registered Nurse FT Days	REGIS02359	ICU	7/16/2020
Registered Nurse PT Nights	REGIS60146	ICU	9/27/2019
Registered Nurse FT Nights (CON)	REGIS01552	Joint Center	7/2/2020
Registered Nurse FT Days (CON)	REGIS93799	Joint Center	7/2/2020
Registered Nurse FT Days	RNMOT93291	OB/GYN	5/29/2020
Registered Nurse PRN Nights	REGIS70252	PCU	10/15/2019
Registered Nurse FT Days	REGIS02494	PCU	8/17/2020
Registered Nurse FT Days	REGIS02493	PCU	8/6/2020
Registered Nurse FT Days	REGIS98840	PCU	8/6/2020
Registered Nurse FT Days	REGIS02491	PCU	7/16/2020
Registered Nurse FT Night Charge	REGIS67312	Pedi	10/14/2019
Registered Nurse PRN Days	REGIS91753	Tele	5/26/2020
Registered Nurse FT Nights	REGIS88655	Tele	3/13/2020
Registered Nurse FT Nights	REGIS03732	Tele	8/6/2020
Registered Nurse PRN Nights	REGIS88926	Tele	3/30/2020
Registrar PRN	REGIS87751	Admissions	2/25/2020
Respiratory Therapist- Ft Nights	RESPT07562		8/13/2020
Screener PRN	SCREE06133	CMA	8/4/2020

Job Title	Job Code	Department	Date Posted
Social Worker	SOCIA00638	Case Mgmt	7/2/2020
Supervisor Surgical Services	SUPSU05506	OR	7/27/2020
Teacher/Child Care Worker PRN	TEACH97910	Health Club	8/17/2020

Reference	Description
Attachment 7	Directory of Privileged Providers

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

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