Annual Charity Care Reporting Form

*For Completion by Hospitals Participating in the*

*Charity Care Report (20\_\_)*

*--All Fields Required, pages 1 and 2--*

|  |  |
| --- | --- |
| Hospital: |  |
| Address: |  |
| Phone Number: |  |
| Owner: |  |
| Chief Executive Officer: |  |
| Person Completing Report: |  |
| Phone Number: |  |
| Email Address: |  |
| Reporting Time Period (dates): |  |
| *Report Free Services Only. Please see Charity Care Definitions document for Further Information\** |
| 1. **Cost of Charity Care Provided**
 | $ |
| a) Non-HSF Charity Care Costs: | $ |
| b) HSF Charity Care Costs: | $ |
| 1. **Applications/Requests for Charity Care (non-HSF)**
 |  |
| a) The total number of applications or requests: |  |
| b) The number of applications or requests that were accepted:  |  |
| c) The number of applications or requests that were denied: |  |
| 1. List of facilities to which charity care individuals were referred/transferred. (*Please attach list.)*
 | ***Attach List*** |
| 1. Zip Codes of Charity Care Recipients. (*Please attach* ***Excel*** *spreadsheet.)*
2. Non-HSF only
 | ***Attach Spreadsheet*** |
| 1. Individuals Who Received Charity Care. For all individuals who received charity care:
 |  |
| * 1. The total unduplicated number of patients that received charity care (HSF)
 |  |
| * 1. The total unduplicated number of patients that received charity care (non-HSF)
 |  |
| * 1. The number that received emergency services, incl. ancillary services (HSF)
 |  |
| * 1. The number that received emer. services, incl. ancillary services (non-HSF)
 |  |
| * 1. The number that received inpatient medical care, incl. ancillary services (HSF)
 |  |
| * 1. The number that received inpatient medical care, incl. ancillary services (non-HSF)
 |  |
| * 1. The number that received outpatient medical care, incl. ancillary services (HSF)
 |  |
| * 1. The number that received outpatient medical care, incl. ancillary services (non-HSF)
 |  |
| 1. Medi-Cal Shortfall
 | $ |
| 1. Cost-to-Charge Ratio *(Worksheet provided below.)*
 | ***See Below*** |
| 1. Charity Care Policies and Charity Care Application Forms
 | ***Attach Policies and Forms Separately*** |
| 1. Hospital Description
 | ***Attach Separately*** |
| 1. Non-HSF Charity Care Payor Source (*Please attach* ***Excel*** *spreadsheet.)*
2. The number of non-HSF patients with Medi-Cal
3. The number of non-HSF patients with Medicare
4. The number of non-HSF patients with non-Medi-Cal/non-Medicare payor sources
5. The number of non-HSF patients that are uninsured
 | ***Attach Spreadsheet*** |
| 1. Non-HSF Charity Care Demographics (*Please attach* ***Excel*** *spreadsheet.)*
2. The number of non-HSF patients by race/ethnicity
3. The number of non-HSF patients by age
4. The number of non-HSF patients by sex
5. The number of non-HSF patients by gender
 | ***Attach Spreadsheet*** |

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## COST-TO-CHARGE RATIO WORKSHEET- FY 20\_\_

|  |  |  |
| --- | --- | --- |
| Item | **Location of Source Data:**Refers to Annual OSHPD Report, Page 8, Statement of Income – Unrestricted Funds, Form 7041 d-1 (6-2001) | Data |
| Gross Patient Revenue | Line 30 |  |
| Total Other Operating Revenue | Line 135 |  |
| Total Operating Expenses | Line 200 |  |
| Cost-to-Charge Ratio | (Line 200 – Line 135)/(Line 30) x 100 |  |