1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

FY '09	Licensed Beds	Inpatient Admissions	Inpatient Days
Adult	362	21,266	93,803
Newborn	28	2,195	6,751
Transitional Care Unit (Hospital based skilled nursing facility)	30	837	9,651

2. Describe the community your organization serves. The narrative should address the following topic: (The items below are based on IRS Schedule H, Part VI, Question 4).

Peninsula Regional Medical Center is located in Salisbury, Maryland, an approximately 116 mile drive from both Washington D.C. and Baltimore, Maryland. The Medical Center defines its primary service area in general terms as Wicomico County, Worcester County and Somerset County on Maryland's Eastern Shore. Certain primary service area statistics are tabulated not on the basis of county boundaries, but on the basis of the 43 zip codes all or part of which are in those primary service area counties. In fiscal year 2009, approximately 76% of the patients discharged from the Medical Center were residents of the primary service area, which had an estimated population of approximately 176,000 in 2009. The primary service area population has grown by an estimated 13% since 2000.

The secondary service area, accounting for 19% of Peninsula Regional's 2009 discharges, consists of 14 zip codes in the southern portion of Sussex County, Delaware and the northern portion of Accomack County, Virginia. These two counties had a population of approximately 233,000 in 2009 and have experienced growth since 2000 of 19.6%. The primary and secondary service areas combined accounted for 95% of Peninsula Regional's total patient discharges in fiscal year 2009. Additional demographic information indicates the number of elderly (those aged 65+) represent a greater portion of the total population in both the primary and secondary areas as compared to the State of Maryland (26.6% and 25.5% respectively vs. 12.3%). The elderly have additional chronic conditions, consume health care resources at higher rates, and generally require more time and attention than other population segments. Additional demographic characteristics for the Medical Center's population are as follows:

2009 Demographic Information

	Maryland	*5 Co. Service Area*	*3 Co. Primary Service Area*
Median Household Income	67,767	44,112	
Race/Ethnicity			
White	59.0 %	65.3 %	
Black	30.1 %	29.5 %	
Hispanic	6.4 %	4.5 %	
Other	4.5 %	0.7 %	
Unemployment	7.2 %		7.9 %
Uninsured	14.3 %		22.8%
Cancer Death Rates per 100,000	193.3		221.4
Persons Below the Poverty Level (2007)	8.3%		15.2%

Finally, much of the Medical Center's primary service area has been identified as a Health Professional Shortage Area and a Medically Underserved Area by the Health Resources and Services Administration. Peninsula Regional, based upon the findings of a Medical Staff Needs Study requires an additional 100 physicians of varying specialties to meet current and future needs.

3. Identification of Community Needs:

a. ***Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done (based on IRS Schedule H, Part VI, Question 2).***

Peninsula Regional Medical Center in cooperation with the Wicomico, Worcester and Somerset Counties, Health Departments, the Atlantic General Hospital and the Edward W. McCready Memorial Hospital, has been conducting community health surveys of the Tri-County area since 1995. These surveys, administered by Professional Research Consultants (PRC) of Omaha, Nebraska were administered in 1995, 2000 and 2004. A fourth survey is currently being conducted, but results will not be available until January 2010. In addition to these adult surveys, a separate adolescent survey was conducted in 2000 and in 2005 and is being administered again in concert with the adult survey currently in the field. The surveys are conducted via the telephone using a random digit dialing technique of households in Wicomico, Worcester and Somerset counties. To ensure accuracy, selected households were weighted in proportion to the actual

characteristics of the tri-county population distribution at the zip code level. All survey administration, data collection and analysis was conducted by PRC. For statistical purposes, the maximum rate of error for our total sample was +/- 3.5% for the adult survey and +/- 3.9% for the adolescent survey at the 95% level of confidence. Survey findings were compared to earlier studies and to national benchmarks.

Results of these surveys are used by the participants to plan future services. Of particular note was the development of the Tri-County Diabetes Alliance, which is a cooperative venture between all the partners and community agencies to reduce the incidence of diabetes in the tri-county area. Other outcomes resulting from the survey findings include smoking cessation programs, other early detection and screening programs for heart and cancer as well as health promotion and education with a focus on prevention. Survey results are also used to obtain grants for specific testing and treatment programs.

In addition to the Community Health Assessment, Peninsula Regional uses input from its Health Council (community), local and national community health organizations such as the American Cancer Society, the March of Dimes, and American Diabetes Association, local health departments, and state and national data sources such as the CDC Healthy People 2010 and the Maryland State Vital Statistics reports to identify the health needs of our community.

b. In seeking information about community health needs, did you consult with the local health department?

Yes, the three local Lower Shore Health Departments were partners in this community health needs process and were extensively involved in questionnaire design and results reporting and analysis.

4. Please list the major needs identified through the process explained question #3.

Survey responses revealed that many aspects of health status in the Tri-County area are very similar to those recorded nationwide. However, in comparison national benchmarks, health status in the Tri-County area is below average in the following regard:

> ***Chronic Illness***. The local prevalence of chronic illness is particularly high in the Tri-County area for diabetes/high blood sugar, arthritis/rheumatism, and skin cancer.

In terms of modifiable health risks as compared to national benchmark data: Residents of the Tri-County area are much more likely than those nationwide to be overweight; further, a full seven in 10 local adults are at an unhealthy weight (including both over-and underweight).

Blood Pressure and Cholesterol. In comparison to the nation as a whole, residents of the Tri-County area exhibit a much higher prevalence of both hypertension and high cholesterol levels.

Substance Abuse. Local adults are more likely to be binge drinkers when compared with adults across the United States.

In terms of prevention, adults in the Tri-County area exhibit higher levels of consistent seat belt usage (including child seats/seats belts for children under 5), and local residents are consistently higher than the nation in certain aspects of cancer screening (colorectal screening and Pap smears). Other measured aspects of prevention in the Tri-County area are similar to findings across the United States.

Access is a key issue for communities across the county and individuals living at the lowest income levels as well. African-American residents were far more likely to indicate cost or lack of insurance has prevented a physician visit for them in the past two years. African-Americans and those living at or near the poverty level were two to four times more likely than residents overall to indicate they have had trouble getting dental care in the past two years. One-third of individuals living at the lowest income levels and one-fifth of African-Americans are without health insurance coverage, both segments being higher than the community overall. One positive finding is that local residents were more likely to have a regular sources of care when compared to national findings.

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

Based on the information gathered through the most recent Community Health Assessment and the guidelines set forth in Healthy People 2010, the following "health priorities" represent a significant opportunity for health improvement:

- Diabetes
- Heart Disease & Stroke
- Nutrition
- Access to Health Care Services

In addition to these areas, there are multiple other priorities and contributing factors that each partner assessed in conjunction with this survey.

In identifying priorities for community action and designing strategies for implementation, a number of criteria were applied to the consideration process, including:

Impact: The degree to which the issue affects or exacerbates other quality of life and health-related issues.

Magnitude: The number of persons affected, also taking into account variance from benchmark data and year 2010 targets.

Seriousness: The degree to which the problem leads to death, disability or impairs one's quality of life.

Feasibility: The ability of organizations to reasonably impact the issue, given available resources.

Consequences of inaction: The risk of exacerbating the problem by not addressing at the earliest opportunity.

Each partner (Wicomico, Worcester and Somerset Counties, Health Departments, the Atlantic General Hospital and the Edward W. McCready Memorial Hospital) was responsible for engaging in activities specific to the geography within which they operate. Each partner used the results of the survey to plan screenings and/or interventions tailored to the needs of their population. Partners shared plans and collaborated where possible.

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

In addition to the programs already presented, a number other initiatives from the community health survey have been started including:

- Under the priority area of access to care, access to dental services – particularly for children was identified. As a result, grants and gifts were received to expand dental programs at the local Health Department,
- For heart disease, a state grant supplied the money to do work site wellness programs including screenings,

- For cancer, money from the cigarette restitution fund was used to provide colorectal screenings including prevention, education, diagnosis and treatment. Additionally, funds were obtained from a grant to provide mammograms for low income women.
- In terms of obesity, a three year federal grant provided funds targeted at African-American families to participate in a program to make lifestyle changes, quit smoking, control their blood pressure, exercise (through a walking program) and meetings with a nutritionist to modify their eating behavior.
- For substance abuse, a new suboxone (a heroin alternative) clinic was established with great success. This is the only such clinic on the Eastern Shore
- And finally, for mental health care, a new clinic co-located in a primary care site expands care for mental health patients without the stigma of being seen in a Mental Health Clinic.

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major Community Benefit program initiatives.

Evaluation of Outreach Services Rendered

In an effort to evaluate our Community Outreach, the Medical Center developed an evaluation postcard so that we can receive feedback regarding services provided to the community on an ongoing basis. Cards are distributed to audience members of community programs. It asks two brief questions:

1) Overall, how satisfied were you with the information/service provided to you?

2) How beneficial to your health was the information/service you received?

FY 09 Results

Based on the evaluation postcards we received, the following average score has been tabulated for each question:

Question #1

On a scale of 1 – 10 (1 = Very dissatisfied; 10 = Very Satisfied)

Our overall satisfaction score was 9.4%

Question #2

On a scale of 1 – 10 (1 = Very dissatisfied; 10 = Very Satisfied)

Our overall "benefit of services rendered" score was 9.6%

Conclusion:

Peninsula Regional Medical Center continues to show high satisfaction scores and high benefit scores for the services and programs we offer to the community. We continually strive to meet the needs of the underserved/underinsured by providing free wellness screenings at local festivals and health fairs on the lower Delmarva Peninsula.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

2009 Health & Wellness Expo

The second annual Health & Wellness Expo, sponsored by Peninsula Regional Medical Center and the Wicomico County Convention & Visitors Association March 27 and 28, drew approximately 3,200 people to the two day event, which was the largest of its kind on the Delmarva Peninsula.

Many uninsured and underinsured individuals participated in the Health & Wellness Expo and were able to access over 30 different free health screenings and resources that were beneficial to their health and wellness. Those screenings included blood pressure, stroke assessment, vision, hearing bone density, skin cancer, diabetes risk assessment, cholesterol/blood glucose and foot care. The Medical Center's Wagner Wellness Van was also in attendance serving as the screening location for hearing testing.

Community Flu Shots

The mission of the Medical Center is to *"Improve the health of the communities we serve."* In fiscal year 2009, the Medical Center provided over 1,500 free flu shots to the communities in Wicomico, Worcester, Somerset and Sussex counties.

Altantic United Methodist Church/Diakonia/Phillips Restaurant – 100

Lower Shore Enterprises – 75

Salisbury Substance Abuse Center- 29

Laurel King's Methodist Church – 25

New Macedonia Baptist Church – 75

Homeless Community – 280

Salisbury Urban Ministries/God's Kitchen – 150

Wal-Mart – 51

Westside Fire Department – 13

Trinity United Methodist Church – 200

Oak Ridge Baptist Church – 80

St. James Free Methodist Church – 40

Weeping Mary Full Gospel Church – 20

Joseph House Crisis Center – 180

Village of Hope Clinic – 105

Three Lower Counties (TLC) – 46

Seton Center – 42

Hispanic Health Fair – St. Francis de Sales Church - 77

Wagner Wellness Van

The Wagner Wellness Van has multiple uses. It is on site at local community outdoor festivals with staff providing the following screenings: blood pressure, pulse oximetry, body fat analysis, grip strength, and vision. During FY 09 we screened **365** members of the community with varied "at risk" levels. ***(This only represents our van presence at major community initiatives, and does not represent the multitude of community appearances made by other Medical Center departments at health fairs on the Delmarva Peninsula.)***

In October 2008, in an effort to expand our mobile service to the at-risk and underserved populations, Peninsula Regional Medical Center formed a partnership with the Wicomico Health Department to offer diabetes, stroke and hypertension education and screenings to these populations (sites recommended by the health department). The van went out twice a month between October 2008 – December 2008 screening ***80*** at-risk community members.

From March 2009 - May 2009 we expanded this outreach effort to include Somerset County. The van was then scheduled to go out each Wednesday of the month, alternating between the two counties. During this time we experienced a decline in participants and, in May, as a collaborative agreement, we put this schedule on hiatus until such time a more definitive goal could be developed and staffing could be identified to support this schedule (i.e. determine what audience we should target: seniors, African Americans, Latino, and what additional screenings we should offer). Based on feedback from the community we have found that the public is better at managing their health care; they are more informed via the internet, and are now seeking more sophisticated services in mobile health outreach. However, during this time we did screen 79 at-risk community members.

APPENDIX 1

It is the intention of Peninsula Regional Medical Center to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost.

Peninsula Regional Medical Center makes every effort to make financial assistance information available to our patients including but not limited to:

- An annual notice regarding financial assistance will be published in a local, widely circulated newspaper.
- Appropriate notices will be posted in patient registration, financial services, the emergency department, labor and delivery and on the PRMC website.
- Individual notice to patients and other persons regarding our financial assistance policy are available at community outreach events, prenatal services, pre-admission, and admission.
- Information insert is included in every patient bill.
- Information pamphlet is provided to patients at registration.

Further detail information can be found in the attached policy found in Appendix 2.

APPENDIX 2

Peninsula Regional Medical Center
Policy/Procedure

Finance Division

Subject:	Financial Assistance
Affected Areas:	Patient Accounting, Financial Services
Policy/Procedure Number:	FD-162

Policy:

It is the intention of Peninsula Regional Medical Center to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost.

Patients requiring elective services may, through consultation with their physician, have their procedure postponed until such time as the patient is able to make full payment or meet the established deposit. Elective procedure patients, who, according to their diagnosis and/or their physician, cannot have their procedure postponed, will be helped with obtaining assistance from agencies. If no other assistance is available, and the patient requests, the account will be reviewed for possible financial assistance.

In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, the patient may be eligible for financial assistance.

Procedure:

When no third party assistance is available to cover the total bill and the patient indicates that they have insufficient funds, the following procedure will occur.

1) The Financial Data Form should be completed by staff to make initial assessment of eligibility.

2) Compare patient's income to current Federal Poverty Guidelines (on file with Collection Coordinator). The Collection Coordinator will get new guidelines as

published in the Federal Register annually. If patient is not eligible, stop here and pursue normal collection efforts.

3) If eligible per Guidelines, send completed Financial Data Form and Request for Financial Assistance Form to patient/guarantor for signature. Patient should attach appropriate documentation and return to representative within 10 days.

   a. If ineligible, forward to Collection Coordinator for determination. Collection Coordinator will inform patient as per 4.a.

4) Upon receipt of the financial assistance request, the Representative will review income and all documentation. The patient must be notified within two business days of their probable eligibility and informed that the final determination will be made once the completed form and all supporting documents are received, reviewed, and the information verified.

   If the patient is over 200% of the Federal Poverty Guideline for household income, the patient is not eligible for financial assistance.

   If the patient is under the income criterion, the patient may qualify for financial assistance.

   If the patient is under the income criterion but has net assets that indicate wealth, the patient does not qualify for financial assistance. If the balance due is sufficient to warrant it and the assets are suitable, a lien will be placed on the assets for the amount of the bill. Collection efforts will consist of placement of the lien which will result in payment to hospital upon sale or transfer of the asset. Refer account to Collection Coordinator for filing lien.

   Accounts over $5,000 with net assets of less than the requested financial assistance will be reviewed on an individual basis to determine if a lien will be placed.

   If eligible, request an itemized bill and forward all information to Collection Coordinator.

   a. If ineligible, the Representative will send the denied request back to the patient and resume normal dunning process and file denial with account. The denials will be kept on file in the collection office.

5. Collection Coordinator will review documentation.

   a. If eligible, and under $2,500, the account will be written off to financial assistance and the "Request for Financial Assistance" form finalized. One copy of the form is to be returned to the Representative who talked with

the patient; and one copy is to be retained by Collection Coordinator. The Representative will call the patient and notify them of the final determination of eligibility.

b. If eligible, and the balance is $2,500 or above, the Collection Coordinator will get appropriate signature and continue as per 5.a.

Peninsula Regional's financial assistance policy is to review only those accounts where the patient or guarantor inquire about financial assistance or in the normal working of the account there is indication that the patient may be eligible. Any patient/customer service representative, financial counselor, or collection representative may begin the request process.

When patients indicate the inability to pay the total bill but will be able to pay a portion, an allowance may be made for the partial amount, if eligible, by following the above guidelines.

Pre-planned service may only be considered for financial assistance when the service is medically necessary. For example, no cosmetic surgery will be eligible. Inpatient, outpatient, emergency, and physician charges are all eligible.

Special exception – Financial assistance could be considered if patient is over income criterion, but has excessive medical debts. A letter of request must be presented by patient and reviewed by Patient Accounts Manager with Director of Patient Financial Services and appropriate documentation placed in the file. This may only be considered in cases of very large debt and no assets.

The patient/guarantor will be required to pay an amount equal to the amount his/her annual household income is over 200% of the Federal Poverty Guideline.

PENINSULA REGIONAL MEDICAL CENTER

APPENDIX 2

Example: Patient's household consists of patient and spouse (2 people). Household annual income is $26,750.

The sum of the household's self-pay accounts with Peninsula Regional is $20,000.

200% of the Federal Poverty limit for a 2 person household is $24,980.

Formula to determine amount eligible for financial assistance write off:

Household Income	$26,750
Less Federal Poverty Limit	- $24,980
Amount patient/guarantor must pay	$ 1,770
Account balance	$20,000
Less amount patient/guarantor must pay	$ 1,770
Amount to written off to Financial Assistance	$18,230

Special exception – A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for PRMC's Financial Assistance program. In cases where PRMC is unable to obtain a provider number for a particular line of business (e.g., Physical Medicine), those accounts may be written off to Financial Assistance with verification of Medicaid eligibility.

Once a request has been approved, service three months before the approval and three months after the approval may be included in the adjustment if a written request is made by the patient/guarantor. If this should occur, a copy of the letter and original request should be attached to the original account and a copy should be retained by the Collection Coordinator. Service dates outside this six-month window may be included if approved by a Supervisor, Manager, or Director.

Financial assistance requests should be finalized through write-off in the month of service whenever possible.

PENINSULA REGIONAL MEDICAL CENTER

APPENDIX 2

The following have authority as noted to make financial assistance adjustments to accounts; no other individuals may make adjustments:

(1) Chief Financial Officer – Unlimited
(2) Controller – Adjustments up to $80,000.
(3) Director of Patient Financial Services – Adjustments up to $50,000.
(4) Manager of Patient Accounts – Adjustments up to $20,000.

Note:	This policy was formerly part of FD-30 established in 11/85. Name was changed from Charity Care 8/05.
Date:	6/03 Split into policies FD-30 & FD-162.
Reviewed:	7/86, 7/89, 7/91
Revised:	9/88, 4/92, 6/93, 2/95, 8/97, 7/98, 9/99, 6/02, 6/03, 9/04, 4/05, 8/05, 5/09

APPENDIX 2

Peninsula Regional Medical Center
Policy/Procedure

Finance Division

Subject: Self-Pay Follow-Up

Affected Areas: Financial Services, Patient Accounts

Policy/Procedure Number: FD-141

Policy:

A. Peninsula Regional Medical Center (the hospital) operates on an entirely non-discriminatory basis.

B. No patient needing emergency or urgently medically necessary care will be denied service.

C. Payment is due when services are rendered.

D. In lieu of payment, the hospital will accept assignment of third party benefits when proof of coverage is presented at the time of registration.

E. Any amounts not paid by third parties are the responsibility of the patient/guarantor.

F. The hospital will make every reasonable effort to collect monies due through use of HIS tools, generally accepted collection/follow-up practices in accordance with all federal and state regulations; cognizant of the hospital's mission, corporate values, and in the spirit of exceptional customer service.

G. After the hospital has exhausted reasonable efforts (mailing of statements, letters, and phone calls), accounts not paid will be referred to outside agencies and/or attorneys for further collection action.

H. Outside agencies/firms may utilize accepted collection tools and processes up to and including reporting of debt to credit bureaus, pursuit of litigation and placement of liens and/or wage attachments, within the scope of all federal and state regulations; and cognizant of the hospital's mission and corporate values.

PENINSULA REGIONAL MEDICAL CENTER

APPENDIX 2

I. The hospital retains all rights and controls over accounts placed with agencies/firms.

Procedure:

A. Accounts determined to be self-pay at the time of registration will be placed in financial class "P," statement code "U."

B. Statement messages and collection letters will be sent as set up in the letter/statement parameters of the system.

C. Accounts determined to be self-pay after insurance has paid a portion of the claim will retain the financial class initially assigned, but will be changed to statement code "R." Accounts determined to be self-pay after insurance has denied or rejected a claim will retain the financial class initially assigned but will be changed to statement code "Q."

D. Upon receipt of payment and/or notice of denial/rejection, the statement code will be changed to "R" via account overview or automatically via the cash posting module.

E. A demand letter will be generated explaining the reason the account is now considered self-pay.

F. Additional statement messages and collection letters will be sent as set up in the letter/statement parameters of the system.

G. In addition to automated statements and letters, accounts with large balances will be reviewed and calls made to the patient/guarantor to resolve the unpaid balance.

H. All phone calls and interaction with the patient/guarantor will be documented in the Patient Accounts System.

I. After a minimum of three (3) statements and/or letters and a period of sixty (60) days from the point of self-pay determination/notice, the account will be considered for referral of bad debt and placement with an outside agency/firm.
   1. Any placements prior to 60 days/3statements are reviewed by a senior collector prior to acceptance as a bad debt.
   2. Any placements prior to 60 days/3 statements must be reviewed by the Patient Accounts Manager or his/her designee prior to transfer. After review, normal sign-off authority is to be used.

APPENDIX 2

Note: Policy changed from PA-9528 to FD-141during 9/99 revision

Date: 4/79
Reviewed: 8/97, 7/98
Revised: 6/93, 2/95, 9/99, 5/09

APPENDIX 2

Peninsula Regional Medical Center
Policy/Procedure

Finance Division

Subject: Collection Agencies – Use of

Affected Areas: Patient Accounting, Patient Registration

Policy/Procedure Number: FD-166

Purpose:

To ensure only qualified, approved collection agencies are used by the Finance Division, and to ensure that our community image is not adversely affected by our collection practices to the extent possible.

Policy:

Collection agencies must be approved for use by the Chief Financial Officer prior to providing any services for the Finance Division.

Procedure:

The Controller will seek approval from the Chief Financial Officer for use of an agency for collection related functions. When adding or changing agencies, the Director of Patient Financial Services and the Controller will jointly review the need(s) and the agency's qualifications. The agency must agree to abide by the Medical Center's patient billing and legal practices. The significant portions will be described in a written document to be signed by the agency prior to their beginning service for the Medical Center.

Collection agencies may suggest legal action in concert with PRMC policy; however, no legal action can advance without the prior case-by-case sign-off by an authorized PRMC employee (including Collection Coordinator, A/R Supervisor, Director of Patient Financial Services, Controller).

Date: 11/04
Reviewed:
Revised:

APPENDIX 2

Peninsula Regional Medical Center
Policy/Procedure

Finance Division

Subject: Adjustments to Bills, Bad Debt, and Other (Uncompensated Care)

Affected Areas: Patient Accounting, Financial Services

Policy/Procedure Number: FD-30

Policy:

Peninsula Regional Medical Center will make available to all patients the highest quality of medical care possible within the resources available. Finance is responsible for collection of accounts and through interaction with patients and based on procedure will make decisions regarding disposition of accounts.

Procedure:

Uncompensated care and other adjustments are any services given for which the medical center does not receive reimbursement. The following are examples of this:

1. Charity - Based on income and lack of substantial assets, the patient is not able to pay full charges. See policy on Financial Assistance, FD-162.

2. Bad Debt - The patient/guarantor does not qualify for financial assistance and/or patient has not cooperated in completing required forms or documentation for financial assistance or another type of uncompensated care; and/or the patient guarantor does not respond to phone calls or written correspondence.

    a. Hospital, physician, unregulated.

3. Customer Service Reductions - Based on unmet needs or unfavorable conditions, some portion of charges are reduced.

    a. Hospital, physician, unregulated.

4. HSCRC permitted discounts.

a. Hospital charges only.

5. Employee discount of 25%.

a. Hospital, physician, unregulated.

6. Denied days and charges due to non-acute status or not necessary.

a. Hospital charges only.

7. Out-of-state Medical Assistance amounts over their allowable, and total charges where Peninsula Regional cannot bill due to contractual discounts.

a. Hospital, physician, unregulated.

b. The hospital will have no contract for regulated services which includes hospital acceptance of less than full charge for any regulated charges. This does not preclude the hospital from billing out-of-state Medical Assistance MCO's and recouping partial reimbursement.

8. Amounts over allowable fees (does not pertain to hospital).

a. Physician and unregulated charges.

9. Contracted capitation limits.

a. Physicians and/or unregulated charges.

10. Risk management reductions.

a. Hospital, physician, unregulated.

11. Late charge allowance under $50.

a. Hospital only.

12. Small balance write-off under $10 and over 90 days old.

a. Hospital, unregulated.

b. $5 for physicians.

13. Peninsula Regional Worker's Comp. and employee health, and physicals.

a. Hospital, physician, unregulated.

14. Medical Assistance unbillable due to billing time elapse.

a. Hospital, physician, unregulated.

15. Bad Debt adjustment, reduction of a bad debt balance.

a. Hospital, physician, unregulated.

16. Error Write-Offs – Write Offs resulting from not obtaining proper authorization, not following up timely, or any other reasons related to processing.

a. Hospital, physician, unregulated

Each category above will have associated transaction adjustment code(s) and will be recorded in the general ledger and financial statement.

The following have authority as noted to make adjustments to accounts, no other individuals may make adjustments:

1) CFO - Unlimited
2) Controller - Adjustments of any type up to $80,000.
3) Director of Patient Financial Services - Adjustments of any type up to $50,000.
4) Patient Accounts Manager - Adjustments of any type up to $20,000.
5) Billing Supervisor/System Specialist - Insurance adjustments, late charges, with balances up to $10,000.
6) Collection Coordinator - Adjustments of any type up to $2,500; bad debt up to $10,000.
7) Patient Accounting Coordinators or Exception Clerk - Adjustments other than bad debt and charity, up to $2,500.
8) Physician Billing Reps. - Adjustments other than bad debt and charity, up to $2,500.
9) Cashiers and Voucher Processor - Adjustments other than bad debt and charity, up to $2,500.

BAD DEBT

Any account where the patient continues to refuse to pay, does not qualify for financial assistance, has not cooperated in completing required forms or supplying documentation for financial assistance or another type of uncompensated care; and/or the

patient/guarantor does not respond to phone calls or written correspondence will be considered Bad Debt.

Normal collection process requires that a patient be given a minimum of 60 days from the first statement (which shows that the amount is now due from the patient) before referral to an outside collection agency. Exception to the 60-day rule may be made for repeated bad debt patients and for those who clearly state they will never pay.

A lien or wage attachment may be placed against the patient when other collection efforts fail.

A lien will be filed against the estate of every deceased adult patient with accounts totaling $5,000 or more.

Body attachments (bench warrants) will not be used without the written permission of the Director of Patient Financial Services.

Accounts may not be written-off with the bad debt transaction code for any reason other than referral to an agency, filing of a lien, wage attachment, or bankruptcy.

OTHER

All Patient Accounting personnel are responsible for requesting necessary adjustments to bills. These should be recorded on the appropriate adjustment form and given daily to the Collection Coordinator (at end of month all adjustments must be turned in on next to last business day of month).

Discounts: The HSCRC has strict guidelines regarding discounts. Regulations are on file in the Budget & Reimbursement area.

Discounts in lieu of commercial insurance audits are not permitted.

Note:	Section on Financial Assistance became policy FD-162 at 6/03 revision.
Date:	11/85
Reviewed:	7/86, 7/89, 7/91
Revised:	9/88, 4/92, 6/93, 2/95, 8/97, 7/98, 9/99, 6/02, 6/03, 9/04, 3/09

APPENDIX 2

Peninsula Regional Medical Center
Policy/Procedure

Finance Division

Subject: Patient Payment Arrangements

Affected Areas: Emergency Admitting, Patient Registration
Patient Accounting, Financial Services

Policy/Procedure Number: FD-53

Policy:

A. Payment is due when services are rendered; charges related to medical necessity and delivery of emergency care are not required to be paid at time of service. We do not withhold emergency treatment based on payment.

B. Every effort will be made to obtain payment in full, always keeping Peninsula Regional's Corporate Values and Customer Service Goals in mind.

C. Patient/guarantors should be encouraged to use bank loans, credit cards and other financing options prior to establishing payment arrangements.

D. In situations where patient/guarantor cannot pay balance due, payment arrangements will be made to clear the account.

E. When proposed payments exceed twelve (12) months, the Financial Data Sheet must be completed in order to determine payments that are acceptable to both the patient/guarantor and the Hospital (if account is less than $500 and will clear within one year data sheet does not need to be completed).

F. Any account that will exceed three months to clear will be sent to an outside agency for contract monitoring.

G. Liens may be filed against any real property where balances exceed $5,000 and/or payment exceeds two years. If payment plan is followed, no lien will be placed.

H. Payments large enough to clear the account as quickly as possible will be made.

I. The minimum acceptable payment is $25, if less a supervisor must approve (if the account will clear as in K, supervisor does not need to approve).

PENINSULA REGIONAL MEDICAL CENTER

APPENDIX 2

J. Patients who fail to make payments as agreed will be transferred to bad debt and referred to agency.

K. Authority to make payment arrangements is as follows:

Billers, Collectors, Financial Service Reps, Registrars	Up to 12 months
Coordinators	1 -- 2 years
Supervisors	2 -- 5 years
Director of Patient Financial Services	5 -- 10 years
Controller	Over 10 years

Procedure:

A. Requests for payment arrangements exceeding a staff member's authority (and all generated outside of Patient Accounts) will be written up on the Contract Pay Approval Form. Requests generated outside of Patient Accounts should be sent to the Collections Office which will follow through with the necessary remaining steps. All contracts should be filed in the Collections Office.

B. Upon approval of payments, the account will be changed to Statement Code "I".

C. Payment arrangement information will be entered under the Contract portion of the Account Overview Screen. The contract form letter will be sent to the patient/guarantor if account will be paid within three months. The I5 letter will be sent to patient/guarantor if account will exceed three months to clear.

D. The outside agency sets up account for monitoring. If no payment has been made in sixty days, the account is then referred back to PRMC for investigation. Then if no payment, transferred to regular collections at the collection agency. The agency code should be changed to reflect the change in status. A record of this should be kept in the Finance area.

E. Clear notes and comments related to the patient/guarantor's financial situation and payment negotiations will be entered in the system.

F. Patients whose payments are delinquent 15 - 30 days will be sent Collection Letter I2 and the action documented in patient notes.

1. If payment is received, further action will not be necessary.

2. If payment is not received within twenty days of the I2 letter, the account will be referred.

APPENDIX 2

NOTE: 3/97 revision changed from Patient Accounting Policy to Finance Division Policy.

Date: 5/93
Reviewed: 7/98
Revised: 2/95, 3/97, 8/97, 9/99, 3/03, 11/04

PENINSULA REGIONAL MEDICAL CENTER

APPENDIX 3

Peninsula Regional Medical Center is committed to the people of Delmarva. We strongly believe it is not just our job to care for you when you are ill but it is our mission to "improve the health of the communities we serve."

PENINSULA REGIONAL
MEDICAL CENTER
Part of Peninsula Regional Health System

MISSION

Improve the health of the communities we serve.

VALUES

- Respect for every individual
- Delivery of exceptional service
- Continuous improvement
- Safety, effectiveness
- Trust and compassion
- Transparency

VISION

As the Delmarva Peninsula's referral medical center, we will be the leader in providing a system of regional access to comprehensive care that is interconnected, coordinated, safe and the most clinically advanced. We will deliver an exceptional patient and family experience, while fostering a rewarding environment for physicians and employees. Together, Peninsula Regional Medical Center and its physicians will be a trusted partner in improving the health of the region.

7/09