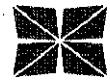

Dimensions Healthcare System

COMMUNITY BENEFITS REPORT FOR THE FISCAL YEAR JULY 1, 2009 – JUNE 30, 2010

Prince George's Hospital Center
3001 Hospital Drive
Cheverly, Maryland 20785
301-618-2000

INTRODUCTION AND BACKGROUND:

Prince George's Hospital Center (PGHC) has been providing quality healthcare services to the southern Maryland region since 1944. Over the past 60 years, Prince George's Hospital Center has grown to become a major tertiary care center for the region and one of its largest employers. However, our greatest service to the community is that Prince George's Hospital Center is a private not-for-profit hospital with a tremendous public mission.

Prince George's Hospital Center was founded in 1944 and is an acute care teaching hospital and regional referral center located in Cheverly, Maryland. Prince George's Hospital Center is a member of the Dimensions Healthcare System.

Leadership: Chairman, Board of Directors – Ric MacPherson
CEO – Kenneth E. Glover
President – John A. O'Brien
Chief Nursing Officer – Ruby Anderson

Location: 3001 Hospital Drive, Cheverly, Maryland 20785

Facility type: Acute care teaching hospital and regional referral center

No. of licensed beds: 244 (plus 40 bassinets)

No. of inpatient admissions: 14,246

No. of Employees: 1,765

Specialty services:

A comprehensive range of inpatient and outpatient medical and surgical services including:

- Emergency and trauma services (designated Level II regional trauma center for southern Maryland)
- Critical care services
- Cardiac care services (comprehensive cardiac care – only program of its kind in the County)
    - Open-heart surgery
    - Two cardiac catheterization labs (diagnostic & therapeutic cardiac caths, cardiac stenting)
    - 10 bed CCU and 66 telemetry beds
    - Cardiac diagnostic evaluation center

    - Cardiac rehabilitation
- Laboratory and pathology testing
- Medical and surgical services (virtually all adult specialties performed)
- Maternal and child health
    - Labor and delivery postpartum units
    - Perinatal diagnostic center
    - Diabetes and pregnancy program
    - Neonatal intensive care unit (designated Level III, regional center for Prince George's County)
    - Inpatient pediatric unit
    - Chronic pediatric inpatient unit and outpatient program

Other specialty services:

- Ambulatory and outpatient services
    - Surgical short-stay center
    - Special procedures
    - Diabetes treatment center
    - Glenridge Medical Center (internal medicine, family practice, ob/gyn)
- Behavioral health services
    - Inpatient psychiatric unit for adults
    - Hospital-based sexual assault center
    - Partial hospitalization program
    - Emergency psychiatric services
- Graduate medical education, internal medicine residency programs

Facilities:

- Intensive services pavilion houses 10 operating suites, a 24-bed intensive care unit, cardiac catheterization labs and endoscopy suites.
- Emergency department includes 15 acute care rooms, 4-bed resuscitation area, 2 isolation rooms, an 8-bed ambulatory emergency area, 2 dedicated trauma rooms, a stat lab and blood bank.

Ownership:

- Member of Dimensions Healthcare System, the largest not-for-profit provider of heath care services in Prince George's County.

Prince George's County Demographics:

According to the U.S. Census Bureau, 2008 American Fact Finder (AFF), Prince George's County has an estimated population of 825,924, making it the second most populous jurisdiction in Maryland. The County, immediately north, east, and south of Washington, D.C. has a population that is 63.8% African-Americans, 23.4% White and reported as 12.2 % of Hispanic origin. Of all Maryland counties, this County has the

largest percent of its population who belong to either a racial or ethnic minority group. In addition, approximately 7.0 % of the population is under 5 years old and 75.1% of the population is age 18 years or over. Persons age 65 years and older represent 8.6% of the population.

Statistics from the AFF 2008 report revealed that the median household income for County residents as of 2008 was $71,242 (in 2008 inflation-adjusted dollars). This is above the national average of $52,175. Also reported in the AFF figures is that for the Prince George's population age 16 years and over, 73.7 % are in the labor force that is higher than the national average of 65.2%. The County poverty level sits at 7.4, which is below the national average of 13.2%. Additionally, for the age 25 and older population in Prince George's County, 86.2% of this age group are high school graduates or higher as opposed to 84.5 % of the general US population.

Community Challenges & Health Statistics:

Despite the higher than average median household income, educational attainment, and percentage of individuals in the work force represented by Prince Georgians on comparison with national figures, the County does contain several pockets of low socioeconomic status. The 2008 CENSUS American Community Survey data reveal that medically vulnerable Prince Georgian's (uninsured and Medicaid enrolled individuals) number approximately 200,655.

According to the CDC document Summary Health Statistics of the U.S. Population: National Health Interview Survey (2004) being poor and uninsured are two of the strongest determinants of whether a person "did not receive medical care", or whether they "delayed" seeking care.

As a result, issues such as diabetes mortality, heart disease, hypertension, stroke, deaths from breast, colorectal and prostate cancers, HIV and infant mortality all represent significant health challenges for community members. Furthermore, persistent disparities in mortality and health status for several health indices are seen in various racial and ethnic populations. These are certainly planning considerations in this majority minority community. Additionally, the racial and ethnic minorities are approximately 2/3 of Prince George's County Medicaid beneficiaries. County and Maryland State health statistics are in similar to national trends regarding the status of minority health. For example:

- **All cause mortality by race**: The Maryland Vital Statistics Administrations (MD-VSA), 2006 report reveals that residents in Prince George's County have higher rates of mortality for all-cause mortality and five others of the top eight causes of death for the State. In addition to all-cause mortality, the MD-VSA numbers of chronic disease deaths for Prince George's County reported as "significantly above the Maryland average" are associated with diseases of the heart and diabetes.

- **Age adjusted death rate for diabetes by race**: Racial and ethnic minorities have 1.5 to two times the prevalence of diabetes as non-Hispanic Whites for adults age

20 or older. Of Maryland counties, Prince Georges is second to Baltimore City for the number of diabetes related deaths. These figures are from the 2006 MD-VSA. Examining the figures by racial groups, year 2000 age-adjusted African-American mortality rate (67.6 per 100,000) in the County is more than double that seen among County white residents (25.1 per 100,000) and is also significantly higher than the African American rate for Maryland (57.9 per 100,000).

- **Age adjusted death rate for heart disease**: The MD-VSA 2006 figures show that the death rate from heart disease is 1.55 times higher in African-Americans than in whites in Prince George's County.

- **Obesity**: BRFSS, 2007 data reveal that 68.8% of County adults are overweight (39.2 %) or obese (29.6 %). While African-American adults bear the brunt of this epidemic with a reported 75.2 % compared to 58.5 % of whites, it's a significant problem for both groups. Obesity's link with multiple cardiac risk factors (e.g. insulin resistance, diabetes, hypertension, hyperlipidemia, physical inactivity) along with other health problems (e.g. some cancers, degenerative joint disease, asthma, depression) is of concern. According to the County's 2002 Child and Adolescent Health Assessment, 33.7% of African American children age 2 to 19 in Prince George's County were overweight compared to 19.6% of their white counterparts.

- **Age adjusted death rate for strokes**: The MD-VSA 2006 figures show that the death rate from cerebrovascular disease is 1.48 times higher in African-Americans than in whites in Prince George's County. Furthermore, the County leads all others in Maryland for the numbers of "essential hypertension and hypertensive renal disease" deaths.
- **Age adjusted death rate for breast and prostate cancer**: African -American women have lower cancer incidence but higher cancer mortality than whites. Prince George's County has the third highest County figure for deaths from breast cancers. Prostate cancer deaths in the County are 2nd to Baltimore County.
- **Age adjusted death rate for HIV by race**: Figures reported by DHMH / AIDS Administration for Prince George's County show that the burden of cases is found in the mid-County inner beltway zip codes. Within Maryland the HIV mortality ratio disparity is greatest for African Americans who have 5.7 times the HIV death rate in comparison to whites. Also, the County's incidence and prevalence is second only to Baltimore.
- **Infant mortality by race**: Regarding a history of either late or no prenatal care this was the case for 6% of African American women compared to 3.4% of white women. Additionally, according to DHMH, the infant mortality rate for African-American infants is 10.8% as compared to 5.5% for white infants.

Identification of Community Needs:

- A Prince George's County Health Profile Snapshot Report was completed by PGHC in June 2006. The Report was generated as a result of a collaborative effort of PGHC and the Prince George's County Health Department. The data referenced in the Report was acquired from U. S. Census data and from the Public Health Quick Stats for Prince George's County, Maryland and the most recent Maryland Vital Statistics Report.

- PGHC management has carefully reviewed the Prince George's County healthcare assessment report, Assessing Health and Health Care in Prince George's County, completed by the RAND Corporation in February 2009 for the Prince George's County Health Department, to assess the status of community health needs.

- In March 2008, the PGHC Board of Directors established a Community Health Task Force (CHTF) committee. The CHTF includes collaborations with such organizations as the Prince George's County Health Action Forum and the Prince George's County Health Department. The purpose of the CHTF is to assist management in the development of relationships and a plan to work with identified community-based health services and to make an optimal range of services more widely available to improve community health status. To date, the CHTF has focused attention on community health needs, provided improved health information, and is currently working the National Institute of Health – National Library of Medicine (NIH – NLM) to identify sustainable community health delivery initiatives.

- The main findings of both the 2006 PG County Health Profile Snapshot Report and the 2009 Rand Report is that there are significant health disparities in Prince George's County and that the County lacks a robust health safety net. The mission of PGHC is to continue to provide high quality and efficient healthcare services to preserve, restore and improve health status in partnership with the community, and to continually seek to expand the health safety net available to the uninsured and vulnerable residents of the County. The largest community benefit expenditure made by PGHC is the mission-driven, non-reimbursed subsidies paid to its physicians to guarantee the continuation of the PGHC safety net mission.

Decision Making:

- Given that PGHC's overall mission is to provide community benefit in the form of safety net health services, the Board of Directors of PGHC is involved in the high-level decision making process regarding community benefit. However, given the financial challenges the hospital has faced in recent years, PGHC has not devoted significant human or capital resources to the development of a detailed community benefit program. All PGHC department managers are aware of PGHC's community benefit mission and, therefore develop, oversee and report on department level programs.

Community Benefit Program Evaluation:

- As stated above, the largest community benefit expenditure made by PGHC is the mission-driven, non-reimbursed subsidies paid to its physicians to guarantee continuation of the PGHC safety net mission. As mentioned, the PGHC Board of Directors is continually involved in reviewing and evaluating the status of the Hospital's mission. All other community benefit services are evaluated at the department level.

Description of the Gaps in the Availability of Specialist Providers to Serve the Uninsured:

- Although PGHC has one of the largest populations of uninsured patients in the State, we believe that all patients should receive the highest level of care regardless of economic standing. This goal can only be achieved with experienced specialist physicians caring for all of our patients even when so many of our patients cannot afford to pay. To overcome this obvious dilemma, we pay physicians to cover their bad debts so the "gap" exists in the hospital's profits but not in patient care. We get no funds from the regulated system to offset these physician payments but, in light of PGHC's safety net mission, we will always put the patients first.

APPENDIX 1

Description of the PGHC Financial Assistance Program:

- Dimensions Healthcare System provides compassionate care for all, regardless of an individual's ability to pay. We serve as the safety net for the uninsured and underinsured. It is our mission to help save lives and improve the quality of living.

- Dimensions Healthcare System through its health care services, provides financial assistance to those who need medical and health care services but do not have the resources to pay for that care, and it does so by preserving the dignity of the individual who needs assistance.

- In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs may be eligible for free or discounted healthcare services based on established criteria.

- Eligibility for the Dimensions Healthcare System Financial Assistance Program is based on income and family size. Should a patient be found eligible for financial assistance, the patient will receive a Financial Approval Letter indicating his/her eligibility amount. Any balance due after the financial assistance allowance has been applied, will become the responsibility of the patient. Physicians bill separately and their charges are not included in the financial assistance program.

APPENDIX 2

- See attached Financial Assistance Program Policy #200-41.

APPENDIX 3

Description of the PGHC Mission, Vision and Value Statements:

- The mission of PGHC is to provide high quality and efficient healthcare services to preserve, restore and improve health status, in partnership with its community.
- The vision of PGHC is to be the best community health system in the United States, with excellent customer satisfaction experience.
- The values of PGHC include compassion, accountability, respect, excellence, and service.
- PGHC also has service priorities that include safety, courtesy, care and efficiency.

APPENDIX 4

- See attached Mission, Vision, Values, and Service Priorities Policy #200-24.

DIMENSIONS HEALTHCARE SYSTEM **January 23, 2008**
Policy No. 200-41

FINANCIAL ASSISTANCE PROGRAM

PURPOSE: To identify circumstances when Dimensions Healthcare System (DHS) may provide care without charge or at a discount commensurate with the ability to pay, for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies only to facility charges and not physician or other independent company billings. The provision of free and discounted care through our Financial Assistance Program is consistent, appropriate and essential to the execution of our mission, vision and values, and is consistent with our tax-exempt, charitable status.

Resources are limited and it is necessary to set limits and guidelines. These are not designed to turn away or discourage those in need from seeking treatment. They are intended to assure that the resources the Hospital can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Financial assessments and the review of patients' assets and financial information is intended for the purpose of assessing need as well as gaining a holistic view of the patients' circumstances. Dimensions Healthcare System is committed to:

- Communicating this purpose to the patient so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process;
- Avoiding seeking or demanding payment from or seizing exempt income or assets; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

CANCELLATION: This is a new corporate policy. It supersedes all policies on this subject at the facility level.

POLICY: Dimensions Healthcare System has a long tradition of serving the poor, the needy, and all who require health care services. However, our hospitals alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. Our hospitals will continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon the Federal Poverty guidelines and will be updated annually in conjunction with the published updates by the United States Department of Health and Human Services. All open self-pay balances may be considered for financial assistance. If a determination is made that the patient has the ability to pay all or a portion of the bill, such a determination does not prevent a

reassessment of the person's ability to pay at a later date. The need for financial assistance is to be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When an account that is closed is to be reopened, or
- When the last financial evaluation was completed more than six months before.

To be considered for financial assistance, the patient must cooperate with the facility to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as Medicaid. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.

Appropriate signage will be visible in the facility in order to create awareness of the financial assistance program and the assistance available. At a minimum, signage will be posted in all patient intake areas, including, but not limited to, the Emergency Department, the Billing Office, and the Admission/Patient Registration areas. Information such as brochures will be included in patient services/information folders and/or at patient intake areas. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area in accordance with the state's Language Assistance Services Act.

The necessity for medical treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

SPECIAL INSTRUCTIONS/FORMS TO BE USED:

DEFINITIONS:

A. 1. *Assets:* Assets include immediately available cash and investments such as savings and checking as well as other investments, including retirement or IRA funds, life insurance values, trust accounts, etc. The following are to be considered exempt and shall not be considered in determining whether the uninsured patient qualifies for an uninsured discount:

a. Homestead property
b. $2,000 for the uninsured patient, or $3,000 for the uninsured patient and one dependent residing together.
c. $50 for each additional dependent residing in the same household.
d. Personal effects and household goods that have a total value of less than $2,000.
e. A wedding and engagement ring and items required due to medical or physical condition.
f. One automobile with fair market value of $4,500 or less.
g. Patient must have less than $10,000 in net assets.

2. *Bad Debt Expense:* Uncollectible accounts receivable that were expected to result in cash inflows (i.e. the patient did not meet the facility's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectibles resulting from the extension of credit.

3. *Financial Assistance:* Health care services that were never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.

4. *Financial Assistance Committee:* A committee consisting of the Chief Financial Officer, the Corporate Director of Patient Financial Services, the Risk Manager, the Director of Case/Care Management, and the Director of Patient Relations, or a similar mix of individuals.

5. *Contractual Adjustments:* Differences between revenue at established rates and amounts realized from third party payers under contractual agreements.

6. *Disposable Income:* Annual family income divided by 12 months, less monthly expenses as requested on the application in Attachment I.

7. *Family:* The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

8. *Family Income:* Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, veterans benefits, training stipends, military allotments, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.

9. *Qualified Patient:*

   a. *Financially Needy*: A person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the medical facility's eligibility criteria set forth in this policy.

   b. *Medically Needy:* A patient who does not qualify as financially needy, but whose medical or hospital bills, even after payment by third-party payers, exceed 50% of their gross income. The patient who incurs catastrophic medical expenses is classified as medically needy when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.

10. *Medically Necessary Service:* Any inpatient or outpatient hospital service that is covered by and considered to be medically necessary under Title XVIII of the federal Social Security Act. Medically necessary services do not include any of the following:

    a. Non-medical services such as social, educational, and vocational services.
    b. Cosmetic surgery.

B. **Financial Assistance Guidelines and Eligibility Criteria (see PFS Department for current form)**

a. To be eligible for a 100 percent (100%) reduction from the patient portion of billed charges (i.e. full write-off) the patient's household income must be at or below 150 percent of the current Federal Poverty Guidelines. 150 percent (150%) of the Federal Poverty Guidelines represents an individual earning minimum wage.

b. Patients with household income that exceeds 150 percent (150%) but is less than 300 percent (300%) of the Federal Poverty Guidelines will be eligible for a sliding scale discount of the patient portion of billed charges.

c. Medically needy patient accounts will be considered on a case-by-case basis by the Financial Assistance Committee. The discounts to be applied will be based on a determination of what the family could reasonably be expected to pay, based on a review of current disposable income and expenses.

d. Individuals who are deemed eligible by the State of Maryland to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Financial Assistance Committee.

e. Financial assistance applications will be considered as long as an account is open or when a change in patient financial status is determined.

f. After the financial assistance adjustment has been computed, the remaining balances will be treated in accordance with Patient Financial Services policies regarding self-pay balances. Payment terms will be established on the basis of a reasonable proportion of disposable income negotiated with the patient. No interest charges will accrue to the account balance while payments are being made. This also applies to payments made through a collection agency.

PROCEDURE:

A. **Identification of Potentially Eligible Patients:**

Admitting

1. Where possible, prior to the admission of the patient, the Hospital will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the Hospital's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial interview, the following information should be gathered:

   a) Routine and comprehensive demographic data.
   b) Complete information regarding all existing third party coverage.

2. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process.

3. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.

Dir., PFS

4. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Corporate Director of Patient Financial Services to make sure that no application for financial assistance was ever received. Prior to a summons being filed, the CFO's approval is required. Dimensions Healthcare System Facilities will not request body attachments from the court system for payment of an outstanding account; however it is recognized that the court system may take this action independently.

B. **Determination of Eligibility:**

PFS

1. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, or in the case of outpatients or emergency patients, a Patient Financial Services representative will mail a financial assistance application to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed.

2. Requests for financial assistance may be received from:

   a. the patient or guarantor;
   b. Church-sponsored programs;
   c. physicians or other caregivers;
   d. various intake department of the institutions;
   e. administration;

f. other approved programs that provide for primary care of indigent patients.

3. The patient should receive and complete a written application (Attachment I) and provide all supporting data required to verify eligibility.

4. In the evaluation of an application for financial assistance, a patient's total resources will be taken into account which will include, but not be limited to, analysis of assets (identified as those convertible to cash and unnecessary for the patient's daily living expense), family income and medical expenses. A credit report may be generated for the patient as well as for the purpose of identifying additional expense, obligations, assets and income to assist in developing a full understanding of the patients' financial circumstances.

5. If a patient qualifies as medically needy, then the application should be referred to the Financial Assistance Committee for review and determination.

Dir., PFS 6. Approval for financial assistance for amounts up to $50,000 should be approved by the Director of Patient Financial Services. Those greater than $50,000 should be approved by the CFO.

PFS 7. Upon completion of the application and submission of appropriate documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet (see PFS Department for current form). The information shall be forwarded to the Director of Patient Financial Services or their designee for determination. Financial assistance approval will be made in accordance with the guidelines and documented on the worksheet (see PFS Department for current form).

8. Accounts where patients are identified as medically needy or accounts where the collector or Director has identified special circumstances that affect the patient's eligibility for financial assistance will be referred to the Financial Assistance Committee for consideration and final determination. The Committee's review of accounts that do not clearly meet the criteria and the decisions and rationale for those decisions will be documented and maintained in the account file (see PFS Department for current form).

9. A record, paper or electronic, should be maintained reflecting authorization of financial assistance (see PFS Department for current form). These documents shall be kept for a period of seven (7) years.

C. **Notification of Eligibility Determination:**

PFS 1. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason(s) for denial will be provided, generally within thirty (30) days of

receipt of a complete application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.

FAC 2. If a patient disagrees with the decision, the patient may request an appeal process in writing within seven (7) days of the denial. The Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within two (2) weeks, and reflect the organization's final and executive review.

3. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, Medicaid, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance process is complete. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.

4. If the patient complies with a payment plan that has been agreed to by the Hospital, the Hospital shall not otherwise pursue collection action against the patient.

Patient 5. If the patient has a change in their financial status, the patient should promptly notify Patient Financial Services. The patient may request and apply for financial assistance, or a change in their payment plan terms.

D. **Availability of Policy:**

PFS 1. Every hospital, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policy.

E. **Application Forms:**

PFS 1. Every hospital must make available, upon request by a member of the public, a copy of the application used by the Hospital to determine a patient's eligibility for financial assistance.

F. **Monitoring and Reporting:**

PFS 1. A financial assistance log from which periodic reports can be developed shall be maintained aside from any other required financial statements. Financial assistance logs will be maintained for a period of seven (7) years. At a minimum, the financial assistance logs are to include:

a. account number,
b. date of service,
c. application mailed (y/n),
d. application returned and complete (y/n),
e. total charges,
f. self-pay balances,
g. amount of financial assistance approved,
h. date financial assistance was approved.

2. The cost of financial assistance will be reported annually in the community Benefit Report. Financial will be reported as the cost of care provided (not charges) using the most recently audited Medicare cost report and the associated cost to charge ratio.

ORIGINATOR: Administration

APPROVAL:

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G. T. Dunlop Ecker
President & Chief Executive Officer

Financial Assistance Program 200-41 (1/23/2008)

ATTACHMENT:

Application for Financial Assistance

DIMENSIONS HEALTHCARE SYSTEM **NOVEMBER 1, 2010**
POLICY No. 200-24

MISSION, VISION, VALUES AND SERVICE PRIORITIES

MISSION

Our mission is to provide high quality and efficient healthcare services to preserve, restore and improve health status, in partnership with our community.

VISION

To be the best community health system in the United States, with excellent customer satisfaction experience.

VALUES

Our values consistently show that Dimensions ***CARES***. These values include:

- **Compassion** - We demonstrate care, concern and consideration for our patients, their families and each other. We take seriously our role as patient advocates. We strive to bring the "human touch" to all our interactions and help each other.

- ***Accountability*** – We take responsibility for our actions. We strive to achieve excellent results and accept responsibility for overcoming problems. We avoid blaming others. We never say "It's not my job". We are committed to honesty in words and actions.

- ***Respect*** – We treat all patients, visitors, and staff equally and with dignity. We show our respect by the courtesy we extend to everyone. We greet everyone politely and appropriately. We are forgiving of one another. We recognize the value, diversity and importance of each other, those we serve and the organization.

- ***Excellence*** – We show excellence in the way we strive to exceed expectations in everything we do. We demand competence and encourage professional and personal growth for every member of our healthcare team. We pursue excellence through teamwork, continuous improvement and prudent resource management.

- ***Service*** – We strive to do the "right thing" and ensure our actions are in line with our mission, vision and values. We are committed to understanding and meeting the needs and expectations of patients and customers.

SERVICE PRIORITIES

- **Safety** - We work to ensure that all employees, patients and visitors are protected from danger, risk or injury while on the premises of any Dimensions Healthcare System facility.

- **Courtesy** - We strive to make each person we encounter feel important and respected. We pleasantly greet fellow employees, physicians, patients and visitors. We identify ourselves whether the encounter is in person or over the telephone.

- **Caring** - We empathize, show compassion and concern to those we encounter each day.

- **Efficiency** - We work collaborative and effectively, taking advantage of economies of scale when possible. We continually evaluate the effectiveness of procedures and processes.

APPROVAL:

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Kenneth E. Glover
President & Chief Executive Officer

Mission, Vision, Values and Service Priorities (6/6/2006, 4/16/2009, 11/1/2010)