1. **Chief Financial Officer Report**
    a. Draft January and February, 2018 Financial Statements ,Comments, Balance Sheets, and Statements of Revenue and Expenses (Pages A1-6)
    b. Revenue Cycle Update(Page B1)
    c. Accounts Payable Update (Page C1)
    d. Supplemental Payment Recoveries Update(Page D1)
    e. Cash Report Update (Page E1)
    f. Charity Care Policy (Pages F1-9)
    g. Small Balance Write-Off Policy(Pages G1-3)

Tulare Local Healthcare District dba Tulare Regional Medical Center

Agenda Item: CFO Reports

Board Meeting Date: June 27, 2018

1) Draft January, 2018 and February, 2018 Balance Sheets and Statements of Revenue and Expenses - **Notes and Disclaimer:**

The January and February Statements were prepared based on the following facts:

There has not been a financial audit of the Tulare Local Health Care District dba Tulare Regional Medical Center's accounting books and records for the FYE June 30, 2017. As such, there are numerous items that we believe need to be adjusted to the FYE 6/30/17 financial statements, and these will need to be addressed in-depth at the time the District can afford to hire independent auditors and sufficient internal financial staff needed to prepare and perform an audit.

In the meantime, and in order to close the books and prepare a draft statement for the 7 and 8 months ended January, 2018 and February, 2018 respectively (FYE 2018), we have attempted to identify adjustments that are allocable to the FYE 2017 statements, and simultaneously identify those items that appear to be allocable to the FYE 2018 statements.

The premise that we used to develop these draft statements was to, as best could be determined, adjust the January and February Balance Sheet items to the most appropriate supportable documentation, e.g., bank statement balances, gross accounts receivable and corresponding expected net collections, the latest Supplemental Payment program estimates, and accounts payable invoices or accruals for certain expenses.

As such, we are unable to make any conclusive representations as to the accuracy or completeness of the Tulare Local Health Care District dba Tulare Regional Medical Center DRAFT January, 2018 and February, 2018 Financial Statements. The FYE's 2017 and FYE 2018 books and records must be further analyzed, reconciled, and stated in accordance with uniform and accepted accounting procedures, and audited by an independent financial auditor.

2) Revenue Cycle Update - A listing of current milestones and projected activities is included.

3) Accounts Receivable – Net Collectable Valuation Update

4) Accounts Payable Update as of June 20, 2018 - A summary of the outstanding payables is attached.

5) Cash Report Update as of June 20, 2018 including near-term projections is included.

6) State Audit - An oral update will be provided at the meeting.

7) Charity Care Policy

8) Review and Recommend Approval of renewal of all District Insurance coverages: Hospital Professional & General Liability, Auto Liability, Directors & Officers Liability/Employment Practices Liability, Property, Privacy (Policy is currently cancelled due to Non-Pay), Fiduciary, and Crime (See Attachments)

TULARE REGIONAL MEDICAL CENTER
Balance Sheet for the period ended 1/31/2018 & 2/28/2018
Unaudited - See Attached Notes and Disclaimer

KEY COMPONENTS (ONLY)	December	January	Current Month February	Last year February	Increase/ (Decrease)	Inc/(Dec) percentage
Cash and cash equivalents	$1,364,640	$1,277,344	$471,454	$5,625,446	($5,153,993)	(91.6%)
Gross pt accounts receivable	57,668,340	50,769,190	48,861,288	63,994,643	(15,133,355)	(23.6%)
Net pt accounts receivable	3,838,656	3,934,703	3,884,880	15,600,117	(11,715,237)	(75.1%)
Misc receivables	6,587,777	7,511,419	7,491,468	23,798,080	(16,306,613)	(68.5%)
Net capital assets	168,005,364	168,299,279	168,604,442	163,856,355	4,748,087	2.9%
TOTAL ASSETS	$198,448,046	$200,591,562	$200,622,830	$231,534,483	($30,911,654)	(13.4%)
Accounts payable	33,158,276	34,601,896	35,306,023	15,762,864	19,543,159	124.0%
Est current 3rd party payor settlements	6,821,651	6,366,077	6,366,077	(563,808)	6,929,885	(1229.1%)
Debt borrowings, net of curr maturities	99,136,370	99,695,037	100,253,704	98,732,608	1,521,096	1.5%
TOTAL LIABILITIES	154,226,321	156,191,044	157,901,577	128,431,846	29,469,732	22.9%
Total net assets	44,221,722	44,400,515	42,721,252	103,070,087	(60,348,835)	(58.6%)
TOTAL LIABILITIES & NET ASSETS	$198,448,043	$200,591,559	$200,622,829	$231,534,484	($30,911,654)	(13.4%)

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TULARE REGIONAL MEDICAL CENTER
Balance Sheet for the period ended 1/31/2018 & 2/28/2018
Unaudited - See Attached Notes and Disclaimer

	December	January	Current Month February	Last year February	Increase/ (Decrease)	Inc/(Dec) percentage
Current assets:						
Cash and cash equivalents	$1,364,640	$1,277,344	$471,454	$5,625,446	($5,153,993)	(91.6%)
Ltd use assets avail for curr debt srvc	6,166,780	6,166,780	6,166,780	4,457,119	1,709,661	38.4%
Patient accounts receivable:						
Gross pt accounts receivable	57,668,340	50,769,190	48,861,288	63,994,643	(15,133,355)	(23.6%)
Contractual allowances	(44,671,445)	(37,677,274)	(35,818,864)	(43,399,688)	7,580,824	(17.5%)
Provision for bad debts & charity	(9,158,239)	(9,157,213)	(9,157,544)	(4,994,838)	(4,162,706)	83.3%
Net pt accounts receivable	3,838,656	3,934,703	3,884,880	15,600,117	(11,715,237)	(75.1%)
Other receiv. & phys. advances						
Tax revenue receivable	5,012,132	5,456,033	6,111,043	6,702,236	(591,193)	(8.8%)
Misc receivables	6,587,777	7,511,419	7,491,468	23,798,080	(16,306,613)	(68.5%)
Physician advances	13,604	13,604	13,604	265,200	(251,596)	(94.9%)
Total other receivables	11,613,513	12,981,056	13,616,115	30,765,516	(17,149,401)	(55.7%)
Inventories	1,211,431	1,211,229	1,199,447	1,510,885	(311,438)	(20.6%)
Prepaid expenses & deposits	748,354	851,744	760,977	842,441	(81,465)	(9.7%)
Total current assets	24,943,374	26,422,856	26,099,653	58,801,524	(32,701,873)	(55.6%)
Assets limited as to use:						
GO bond construction fund	-	-	-	-	-	0.0%
Restricted trust funds, other	5,048,367	5,418,486	5,467,794	8,364,619	(2,896,824)	(34.6%)
Total limited use assets	5,048,367	5,418,486	5,467,794	8,364,619	(2,896,824)	(34.6%)
Capital assets:						
Land & land improvements	3,301,871	3,301,871	3,301,871	3,301,871	-	0.0%
Bldgs & bldg improvements	45,382,391	45,382,391	45,382,391	44,849,285	533,106	1.2%
Leasehold improvements	607,391	607,391	607,391	607,391	-	0.0%
Major movable equipment	38,203,793	38,203,793	38,203,793	36,088,069	2,115,724	5.9%
Construction in progress	145,816,104	146,320,408	146,835,300	144,312,202	2,523,098	1.7%
Gross capital assets	233,311,550	233,815,854	234,330,746	229,158,818	5,171,928	2.3%
Accumulated depreciation	(65,306,186)	(65,516,575)	(65,726,304)	(65,302,463)	(423,841)	0.6%
Net capital assets	168,005,364	168,299,279	168,604,442	163,856,355	4,748,087	2.9%
Bond issuance costs & other assets	450,941	450,941	450,941	479,436	(28,495)	(5.9%)
Intercompany receivable	-	-	-	32,549	(32,549)	(100.0%)
TOTAL ASSETS	$198,448,046	$200,591,562	$200,622,830	$231,534,483	($30,911,654)	(13.4%)
Current liabilities:						
Current maturities of debt borrowings	$1,317,745	$1,268,704	$1,219,548	$3,884,204	($2,664,655)	(68.6%)
Accounts payable	33,158,276	34,601,896	35,306,023	15,762,864	19,543,159	124.0%
Other accrued liabilities	5,028,819	4,986,762	4,953,451	5,436,957	(483,507)	(8.9%)
Accrued payroll & related liabilities	16,927	25,313	54,797	8,056	46,741	580.2%
Est current 3rd party payor settlements	6,821,651	6,366,077	6,366,077	(563,808)	6,929,885	(1229.1%)
Self insurance program accrual	360,000	360,000	360,000	90,519	269,481	297.7%
Total current liabilities	46,703,418	47,608,752	48,259,896	24,618,792	23,641,105	96.0%
Long-term liabilities:						
Deferred revenue	8,386,533	8,887,255	9,387,977	5,080,446	4,307,531	84.8%
Debt borrowings, net of curr maturities	99,136,370	99,695,037	100,253,704	98,732,608	1,521,096	1.5%
TOTAL LIABILITIES	154,226,321	156,191,044	157,901,577	128,431,846	29,469,732	22.9%
Net assets:						
Retained Earnings	59,177,134	60,878,017	60,896,718	95,600,669	(34,703,951)	(36.3%)
Increase in net assets	(14,955,412)	(16,477,502)	(18,175,466)	7,469,418	(25,644,884)	(343.3%)
Total net assets	44,221,722	44,400,515	42,721,252	103,070,087	(60,348,835)	(58.6%)
Intercompany payable	-	-	-	32,551	(32,551)	(100.0%)
TOTAL LIABILITIES & NET ASSETS	$198,448,043	$200,591,559	$200,622,829	$231,534,484	($30,911,654)	(13.4%)

TULARE REGIONAL MEDICAL CENTER
Statement of Revenue and Expenses
For the Eight Months Ending January 31, 2018 & February 28, 2018
Unaudited - See Attached Notes & Disclaimer

KEY COMPONENTS (ONLY)	July	August	September	October	November	December	January	February	YTD FY18	YTD FY17
Total operating revenue	6,781,433	5,498,707	4,041,865	(6,084,796)	175,580	2,313,976	(85,206)	24,924	12,666,483	54,688,306
Professional fees	591,421	607,690	493,803	512,355	369,868	648,640	733,032	706,624	4,663,433	4,312,440
Physicians fees	511,275	648,489	554,215	526,485	(45,536)	19,946	6,100	-	2,220,974	3,934,565
Purchased services	954,973	885,348	576,983	594,088	(53,904)	231,850	312,671	269,322	3,771,331	7,521,049
Purchased HCCA Labor	2,929,903	3,901,480	2,685,135	2,357,921	1,907,655	-	0	-	13,782,094	25,144,188
Operating expenses before D&A	6,082,746	7,471,274	5,243,440	4,548,868	2,419,006	1,275,387	1,588,424	1,557,496	30,186,641	50,038,283
EBITDA	698,687	(1,972,567)	(1,201,575)	(10,633,664)	(2,243,426)	1,038,589	(1,673,630)	(1,532,572)	(17,520,158)	4,650,023
Excess of revenues over expenses	592,423	(2,085,674)	(1,319,137)	(11,069,877)	(2,295,367)	1,222,217	(1,522,088)	(1,697,965)	(18,175,468)	7,124,292

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TULARE REGIONAL MEDICAL CENTER
Statement of Revenue and Expenses
For the Eight Months Ending January 31, 2018 & February 28, 2018
Unaudited - See Attached Notes & Disclaimer

	July	August	September	October	November	December	January	February	YTD FY18	YTD FY17
Net patient revenue	$5,265,408	$4,000,227	$2,977,089	($4,142,461)	($76,297)	($8,079)	$74,711	($5,272)	$8,085,326	$39,454,215
Supplemental funds	1,254,200	1,254,200	697,850	(2,290,051)	212,141	2,322,055	(199,956)	-	3,250,439	14,232,795
Other operating revenue	261,825	244,280	366,926	347,716	39,736	-	40,039	30,196	1,330,718	1,001,296
Total operating revenue	6,781,433	5,498,707	4,041,865	(6,084,796)	175,580	2,313,976	(85,206)	24,924	12,666,483	54,688,306
Salaries & wages	-	5,548	-	98	-	110,187	189,222	254,718	559,773	118
Employee benefits	-	-	-	-	-	7,134	46,979	18,935	73,048	1,729
Professional fees	591,421	607,690	493,803	512,355	369,868	648,640	733,032	706,624	4,663,433	4,312,440
Professional fees, physicians	511,275	648,489	554,215	526,485	(45,536)	19,946	6,100	-	2,220,974	3,934,565
Supplies	625,652	687,290	466,864	195,233	97,739	(39,688)	10,990	28,349	2,072,429	5,680,374
Purchased services	954,973	885,348	576,983	594,088	(53,904)	231,850	312,671	269,322	3,771,331	7,521,049
Purchased HCCA Labor	2,929,903	3,901,480	2,685,135	2,357,921	1,907,655	-	0	-	13,782,094	25,144,188
Repairs & maintenance	11,742	35,132	22,258	16,406	36,572	(7,061)	2,852	18,491	136,392	268,930
Utilities & phone	139,238	153,704	185,169	127,088	(45,002)	134,134	98,283	80,896	873,510	1,059,878
Building & equipment rental	73,339	164,350	59,251	36,257	53,545	46,362	42,556	36,669	512,329	304,988
Insurance	119,930	92,325	97,414	83,705	83,705	84,778	83,708	83,708	729,273	646,004
Other operating expenses	125,273	289,918	102,348	99,232	14,364	39,105	62,031	59,784	792,055	1,164,020
Operating expenses before D&A	6,082,746	7,471,274	5,243,440	4,548,868	2,419,006	1,275,387	1,588,424	1,557,496	30,186,641	50,038,283
EBITDA	698,687	(1,972,567)	(1,201,575)	(10,633,664)	(2,243,426)	1,038,589	(1,673,630)	(1,532,572)	(17,520,158)	4,650,023
Depreciation & amortization	(216,566)	(216,566)	(216,566)	(216,378)	(210,562)	(210,389)	(210,389)	(209,728)	(1,707,144)	(2,196,505)
Property tax income	145,090	145,090	151,023	(155,369)	429,009	645,698	154,289	154,289	1,669,119	5,009,755
Investment income	29,152	22,650	9,747	(2,828)	(208,799)	(190,205)	269,162	(48,575)	(119,696)	72,367
Interest expense	(63,940)	(64,281)	(61,766)	(61,638)	(61,589)	(61,476)	(61,520)	(61,379)	(497,589)	(515,183)
Grants & contributions	-	-	-	-	-	-	0	-	0	103,434
Other income	-	-	-	-	-	-	-	-	0	401
Total other revenue/(expenses)	(106,264)	(113,107)	(117,562)	(436,213)	(51,941)	183,628	151,542	(165,393)	(655,310)	2,474,269
Excess of revenues over expenses	592,423	(2,085,674)	(1,319,137)	(11,069,877)	(2,295,367)	1,222,217	(1,522,088)	(1,697,965)	(18,175,468)	7,124,292
Increase in net assets	$592,423	($2,085,674)	($1,319,137)	($11,069,877)	($2,295,367)	$1,222,217	($1,522,088)	($1,697,965)	($18,175,468)	$7,124,292

A6

TO: Board of Directors, Tulare Local Healthcare District

Finance Committee, Tulare Local Healthcare District

Larry Blitz, Interim CEO, Tulare Regional Medical Center

Dan Heckathorne, Interim CFO, Tulare Regional Medical Center

FROM: Gwynn Smith, Revenue Cycle, Wipfli LLP

Teresa Jacques, Interim Controller, Tulare Regional Medical Center

DATE: June 21, 2018

RE: Revenue Cycle Milestones

Tasks in Process:

- Hospital Collections from March 1, 2018 – June 18, 2018 are $1,057,997.
- Clinic collections for the same period were $94,127.
- Cash posting is continuing the process of working backwards to reconcile the deposits prior to February 1, 2018 in addition to reconciling the zero pay remittances.
- The MS4 self-pay project is not on target due to Cerner not being able to produce the proper code to transfer the balances, until this is complete the project is on hold.
- The ER pro fee billing and coding project has been transferred to Wipfli.
- The Managed Medi-Cal plans received our spreadsheets with the listing of outstanding claims, we have not seen these claims processed yet.
- Managing the accounts receivable vendor.
- Draft Charity Care and Small balance write off policies are on the board agenda for approval. We are also in the process of updating the Charity Care forms including translation to Spanish and Portuguese.
- HRG has identified about $3,000,000 in adjustments that has been assigned to the TRMC staff.

- **Future Action Items:**
- Medicare certification application
- Medi-Cal provider application
- Review charge capture workflows
- Credit balances
- Cerner work flow improvements

TULARE REGIONAL MEDICAL CENTER

Summary of Accounts Payables as of June 21, 2018

TRMC Bankruptcy Status	Date Range: Accrued Payable as of June 21, 2018	0-30	31-60	61-90	91-120	+121	Grand Total
Accrued Payable as of June 21, 2018	400,000.00						400,000.00
Post-Petition		476,792.23	961,480.29	1,082,225.28	1,484,532.29	4,041,504.41	8,046,534.50
Pre-Petition						29,161,990.54	29,161,990.54
Grand Total	**400,000.00**	**476,792.23**	**961,480.29**	**1,082,225.28**	**1,484,532.29**	**33,203,494.95**	**37,608,525.04**

10-C-1

TULARE LOCAL HEALTHCARE DISTRICT dba TULARE REGIONAL DISTRICT HOSPITAL	June 21, 2018
	Wipfli/HFS
PPS RECONCILIATION	288,885.00
MCAL OP SUPPLEMENTAL AB915	
	149,650.00
	197,309.00
	212,877.00
	603,473.00
MCARE COST REPORT FY 2017	(96,698.00)
	1,355,496.00
CASH COLLECTIONS MARCH 1 - JUNE 21	1,108,500.00
TOTAL	2,463,996.00

10-D-1

TULARE REGIONAL MEDICAL CENTER

Cash Summary - 2 Months Ending June 15, 2018

	A	B	W	X	Y	Z	AA	AB	AC	AD	AE	AF
1	TULARE REGIONAL MEDICAL CENTER											
2			4/20	4/27	5/4	5/11	5/18	5/25	6/1	6/8	6/15	SUB-TOTAL
3	CASH IN											
4	Receipts		34,021	58,915	183,298	79,819	14,556	75,881	78,508	71,913	45,332	2,333,603
5	DSH Payment		0	0	0	0	0	0	0	0	0	49,818
6	Property Taxes		533,831	0	0	0	172,531	0	0	0	0	1,812,401
7	Property Rentals and Evolutions		0	0	0	0	0	2,034	0	0	0	77,346
8	Short Term Loans		(302,715)	(150,000)	0	0	0	100,000	0	0	0	397,285
9	Supplemental - AB 113 & 915		0	0	0	0	0	0	0	0	346,045	558,922
10	Supplemental - HQAF, Etc.		0	0	0	0	0	0	1,479,997	0	0	2,094,700
11	Other Extraordinary Receipts		0		0	0	275,000	0	0	0	0	309,139
12	*Total Cash In*		265,137	(91,085)	183,298	79,819	462,087	177,914	1,558,505	71,913	391,377	7,633,214
13												
14	EXPENSES											
15	Payroll & Related Expenses		0	125,031	22,396	146,736	257	121,447	22,203	106,011	41,213	1,697,385
16	Insurance		0	63,218	18,349	63,218	0	0	0	0	63,218	893,419
17	Utilities/Phone/Internet		4,660	50,283	33,566	0	4,176	55,093	40,050	50,000	4,299	715,738
18	Legal/ Bankruptcy Counsel		0	0	0	0	175,000	0	0	400,000	0	775,000
19	Consulting & Purchased Services		77,697	15,865	15,000	0	42,102	115,000	15,000	531,011	15,000	1,165,574
20	Physicians		0	0	0	0	0	0	0	0	0	0
21	Software Fees		0	0	0	0	0	0	0	0	0	42,583
22	Supplies		0	0	0	0	0	0	0	0	0	0
23	Leases and Rentals		0	0	13,872	0	7,852	0	17,488	0	0	96,468
24	Revenue Bonds		0	0	0	0	0	0	0	0	0	103,179
25	County of Tulare Revenue Bond		0	0	0	0	0	0	0	0	0	0
26	IGT Advances		0	0	0	0	0	0	0	0	0	443,483
27	Third Party Payments		0	0	0	0	0	0	0	0	48,026	48,026
28	Other		41,363	41,085	64,361	21,268	29,659	39,728	29,558	57,257	40,229	986,419
29	Post-Petition Expense Catch-up		0	0	0	0	0	0	0	0		0
30	Assumed Liabilities, Pre & Post		0	0	0	0	0	0	0	0	0	0
31	Bankruptcy Cure		0	0	0	0	0	0	0	0	0	0
32	Start-up Repairs		0	0	0	0	0	0	0	0	0	0
33	*Total Expense*		123,720	295,481	167,544	231,222	259,046	331,267	124,299	1,144,279	211,985	6,967,274
34												
35	Difference		141,417	(386,566)	15,754	(151,403)	203,041	(153,352)	1,434,206	(1,072,366)	179,393	665,940
36												
37	Cash Balance Forward		597,233	210,668	226,422	75,019	278,060	124,707	1,558,913	486,547	665,940	
38												
39	NOTE: $784,664 of Build America Bonds funds were received by the District in February, 2018 and were paid to Tulare County Tax Assessor. These have been removed from the											
40	report as these are not District funds.											

10-E-1

Tulare Local Healthcare District dba Tulare Regional Medical Center

Agenda Item

Board Meeting Date:

June 27, 2018

Title to Appear on Agenda:

Charity Care Policy

Brief Description:

All California Hospitals are required to maintain a Charity Care Policy.

Background and Details:

The TRMC Charity Care policy has been outdated for some time, and it is imperative to re-establish a new policy that meets current State of California guidelines. The Hospital Interim Controller has prepared a new Policy that complies with appropriate requirements.

Exhibits:

See Attached Policy

Recommended Action:

That the Board approve the Charity Care Policy as presented, and that the Policy be implemented immediately.

TULARE REGIONAL MEDICAL CENTER
(TRMC)
POLICY/GUIDELINE MANUAL

SUBJECT: **Financial Assistance-Charity Care Policy**

DEPARTMENTS: Administration
Finance
Patient Access
Patient Financial Services

I. PURPOSE

The purpose of this policy is to define processes and ensure a fair, non-discriminatory, consistent, and uniform method for the review and completion of charitable Emergency Medical Care and other Medically Necessary care for individuals of our community who may be in need of Financial Assistance.

It is the intent of this policy to comply with all federal, state, and local regulations.

II. SCOPE / COVERAGE

Hospital-Wide

III. DEFINITIONS

For the purpose of this policy, the terms below are defined as follows:

Allowable Medical Expenses: Total Family Members' medical expenses that would be deductible for federal income tax purposes without regard to whether the expenses exceed the medical expense deduction allowed by the IRS. Paid and unpaid bills may be included.

Amount Generally Collected (AGC): The charge amount generally collected for services paid by Medicare. The AGC is calculated annually based on a historical look-back of actual Medicare reimbursement for outpatient claims, including coinsurance and deductibles collected. Example: 2018 AGC is of 21% of Gross charges.

Application Period: The later of: 360 days from the patient's discharge from the hospital or the date of the patient's Eligible Service, or 240 days from the date of the initial post-discharge bill for the Eligible Service.

Billed Charges: Charges for services by facility as published in the charge description master (CDM).

Charity Care: Full charity or free care is provided when the patient is not expected to pay or pay only a nominal amount of the Billed Charges.

Discounted Care: Facility determines that the patient does not qualify for Charity Care, but is eligible for a discount and is expected to pay only a portion of Billed Charges.

Emergency Medical Care: Emergency Medical Care means care provided by a hospital facility for: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy

Essential Living Expenses (ELE): Any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses - including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Family Members: Family Members of **persons 18 years and older** include spouse, domestic partner as defined by the State where the facility is licensed, and dependent children under 21 years, whether living at home or not. Family Members of **persons under 18 years** include parents, caretaker relatives and other children less than 21 years of age of the parent or caretaker relative, whether living at home or not

Federal Income Tax Return: The form which is submitted to the IRS for purpose of reporting taxable income. The form must be a copy of the signed and dated form submitted to the IRS.

Federal Poverty Level (FPL): The FPL is defined by the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at http://aspe.hhs.gov/poverty-guidelines

Financial Assistance: The reduction of Self-Pay liability owed by Uninsured Patient or Underinsured Patient for Emergency Medical Care and other Medically Necessary services provided by TRMC.

High Medical Costs: Defined as any of the following: a) annual Out-of-Pocket Costs incurred by the individual at the facility that exceed ten percent (10%) of the patient's family income in the prior 12 months; OR b) annual Out-of-Pocket expenses that exceed ten percent (10%) of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

Household Income: Income of all Family Members who reside in the same household as the patient, or at the address the patient uses on tax returns or other government documents as the home address.

Medically Necessary: A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant

disability, or to alleviate severe pain. See California Welfare & Institutions Code §14059.5.

Out-of-Pocket Costs: Costs which the patient pays from personal funds.

Patient Financial Services (PFS): The department responsible for billing, collection, and payment processing.

Qualifying Assets: Monetary assets that are counted toward the patient's income in determining if the patient will meet the income eligibility for the program. For purposes of this policy, "Qualifying Assets": 1) include 50% of the patient's monetary assets in excess of $10,000, including cash, stocks, bonds, savings accounts, or other bank accounts; 2) exclude IRS qualified retirement plans, such as IRAs, 401(k) or 403(b) retirement accounts, or deferred-compensation plans; 3) exclude certain real property or tangible assets (primary residences, automobiles, etc.; however, additional residences in excess of a single primary residence and recreational vehicles may be included).

Qualifying Patient: Patient who meets the financial qualifications for the Financial Assistance program as defined in this policy.

Self-Pay Liability: Any balance due when the financially responsible party is the patient or the patient's guarantor (not a third-party payer).

Third-party Insurance: An entity (corporation, company health plan or trust, automobile medical pay benefit, workers' compensation, etc.) other than the patient that will pay all or a portion of the patient's medical bills.

Uninsured Patient: A patient who does not have third-party insurance from a health insurer, health care service plan, Medicare or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the facility.

Underinsured Patient A patient who has some level of Third-party insurance or assistance but still has Out- of-Pocket Costs that exceed the patient's financial abilities

IV. POLICY

It shall be the policy of Tulare Regional Medical Center (TRMC) to provide, without discrimination, Emergency Medical Care and other Medically Necessary care as defined in this policy, to individuals regardless of their ability to pay, their eligibility under this policy, or eligibility for government assistance. TRMC will discount its charges for those patients who request consideration, demonstrate limited income, or have high medical costs. The following information is an outline for those patients and the requirements to be considered for this program.

A. Qualified Care

This Policy applies to all Emergency Medical Care and Other **Medically Necessary services**. Emergency Medical Care Services Prior to 11/01/17 include the charges for emergency room physician. For Emergency Medical Care Services after 11/01/17 The emergency room physicians, are not covered by this policy. However these physician are required, by law, to have their own Financial Assistance policies to limit expected payment from eligible patients that are uninsured or have High Medical Costs who are at or below 350% of the Federal Poverty Level. Patients who are uninsured or have High Medical Costs and income at or below 350% of the Federal Poverty Level and receive a bill from an emergency room physician should contact that physician's office and inquire about their Financial Assistance policy.

B. Eligibility

Eligibility is based only on the family's income (as verified by receipt of the latest tax returns and/or pay records) and family size. Any decisions made under this policy, including the decision to grant or deny Financial Assistance, shall be based on an individualized determination of financial need, and shall not take into account race, color, national origin, citizenship, religion, creed, gender, sexual preference, age, or disability. Financial Assistance will be considered for those individuals who are uninsured and underinsured with High Medical Costs and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy.

Medicaid Share of Cost (SOC) amounts are not eligible for Financial Assistance, as the SOC is determined by the State to be an amount the patient must pay before the patient is eligible for Medicaid

A patient may qualify for Financial Assistance under this policy if they meet one of the following guidelines based on income or expenses.

1. Income. A patient is eligible to receive Charity or Discounted Care for emergent and/or medically necessary services based on income under this policy if Household Income (as defined in policy) is at or below 400% of the FPL.

2. Expenses. Patients not eligible based on income may be eligible for Financial Assistance through an exception-based review if their Allowable Medical Expenses have depleted the family's income and resources so that they are unable to pay for eligible services. The following two qualifications must both apply:
   - Expenses: The patient's Allowable Medical Expenses must be greater than 50% of the Household Income.
   - Resources: The patient's excess medical expenses (the amount by which Allowable Medical Expenses exceed 50% of the Household Income) must be greater than available Qualifying Assets

Charity Care: In determining eligibility for full Charity Care where patient owes nothing, household income and qualifying assets do not exceed an amount equal to 200% of the Federal Poverty Level.

Uninsured / Underinsured Patients	
Family Income	Amounts Owed
200% or less of the Federal Poverty Level	Zero

Discounted Care: In determining eligibility for Discounted Care, documentation of income shall include recent pay stubs or income tax returns and will be adjusted based on the levels below when applicable.

Uninsured/Underinsured	
Family income	**Amounts Owed**
>200% to 300% of the Federal Poverty Level	50% of the Amount Generally Collected
>300% to 400% of the Federal Poverty Level	75% of the Amount Generally Collected
>400% of the Federal Poverty Level	Not covered under the Financial Assistance Policy. **Refer to the Self Pay Discount Policy**

Patients with Insurance Coverage	
Following the same discount rules as above, a patient's responsibility will be determined on the Amount Generally Collected, LESS the amount paid by the insurance plan. The patient will owe the difference. If the insurance plan paid an amount equal to or greater than the Amount Generally Collected, the patient's liability is zero.	
Example 1	
Total Gross Charge	2,000.00
Amount Generally Collected (AGC). Based on 21% of gross charge	420.00
Amount Owed (Based on a family who is at 330% of Federal Poverty Level) 75% of AGC	315.00
Primary Insurance Paid	110.00
Patient will owe the difference	**205.00**
Example 2	
Total Gross Charge	2,000.00
Amount Generally Collected (AGC). Based on 21% of gross charge	420.00
Amount Owed (Based on a family who is at 300% of Federal Poverty Level) 50% of AGC	210.00
Primary Insurance Applied total amount to deductible	0.00
Patient will owe	**210.00**

C. Applying for Financial Assistance

1. In order to qualify for Financial Assistance under this Policy, a patient or guarantor must;

- Cooperate in identifying and determining alternative sources of payment or coverage from public and private payment programs:
  - An uncooperative patient is any patient or guarantor who is unwilling to disclose the necessary financial information as requested for Medicaid and/or Financial Assistance determination during the application process. Uncooperative patients or guarantors will be notified in writing that unless they comply and provide information, no further consideration will be given for Financial Assistance processing and standard A/R follow-up will commence.

- Submit a true, accurate and complete confidential Financial Assistance application within 240 days of the first post-discharge self-pay billing statement;
- Provide a copy of patient's or guarantor's most recent pay stub (or certify that he or she is currently unemployed);
- Provide a copy of patient's or guarantor's most recent Federal Income Tax Return (including all schedules);
- Provide such documents and information regarding patient's or guarantors' monetary assets

2. If the patient has Third-party insurance that would have covered the qualifying services, the patient or guarantor is responsible for complying with the conditions of coverage for their health insurance. Failure to do so, when the patient could have reasonably complied, may result in a denial of eligibility under the Financial Assistance program.

D. Eligibility for Other Government Programs

The facility shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered to a patient, If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a facility Financial Assistance program, neither application shall preclude eligibility for the other program.

E. Presumptive Financial Assistance Eligibility

On an individual patient basis, the staff or management member of Patient Financial Services will complete an internal Financial Assistance application to include a full explanation of:

- The reason the patient or patient's guarantor cannot apply on his/her own behalf, and the patient's documented extenuating medical or socio-economic circumstances that preclude the patient or patient's guarantor from completing the application.

- TRMC may also assign accounts to presumptive Charity Care eligibility, without a

Financial Assistance application submitted by the patient, based on predetermined criteria collected from approved sources. These criteria include:

- The patient having documented in his/her medical record as being homeless
- Verification received that the patient is expired with no known estate or currently incarcerated;
- The patient qualifies for a public benefit program including:
  - Social Security
  - Unemployment Insurance Benefits
  - Medicaid (Excluding Share of Cost)
  - County Indigent Health
  - AFDC
  - Food Stamps
  - WIC
  - Other similar indigent-related programs with eligibility requirements that reasonably meet the qualifications for the Financial Assistance program;

These accounts will be reclassified under the Financial Assistance policy and all collection activity shall cease

F. Eligibility Period

If a patient qualifies for Charity Care or Discounted Care for a specific eligible service or facility stay, a retroactive Financial Assistance discount will be applied to patient balances for eligible services within in the same year. Also, any eligible services for an additional 180 days after the approval date of an application will qualify for a Financial Assistance discount. For any services that occur 180 days after the application approval date, the patient must submit a new application to be considered for Financial Assistance for that episode of care.

G. Refund of Amounts Previously Paid

In the event a patient pays all or part of his or her bill for services rendered, and is subsequently determined to qualify for Charity Care or Discounted Care under this policy, qualifying amounts shall be promptly refunded.

H. Dispute Regarding Determination of Eligibility for Financial Assistance

If a patient or patient's legal representative does not agree with the hospital's decision, the patient or the patient's legal representative may submit a written request for reconsideration to the Chief Financial Officer (CFO) of TRMC who shall make the final decision.

I. Billing and Collection

Upon submission of a Financial Assistance application for a patient or guarantor, all collection activity will cease until a determination has been made and the patient is notified of that determination.

2018 FEDERAL POVERTY LEVEL

Persons in Household	Period	200% of FPL	300% of FPL	400% of FPL
1	Yearly	$24,280	$36,420	$48,560
	Monthly	$2,023	$3,035	$4,047
2	Yearly	$32,920	$49,380	$65,840
	Monthly	$2,743	$4,115	$5,487
3	Yearly	$41,560	$62,340	$83,120
	Monthly	$3,463	$5,195	$6,927
4	Yearly	$50,200	$75,300	$100,400
	Monthly	$4,183	$6,275	$8,367
5	Yearly	$58,840	$88,260	$117,680
	Monthly	$4,903	$7,355	$9,807
6	Yearly	$67,480	$101,220	$134,960
	Monthly	$5,623	$8,435	$11,247
7	Yearly	$76,120	$114,180	$152,240
	Monthly	$6,343	$9,515	$12,687
8	Yearly	$84,760	$127,140	$169,520
	Monthly	$7,063	$10,595	$14,127
Add $4,320 for each				

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Small Balance Write-Off

OBJECTIVE:

To ensure all accounts meeting the criteria for small balance are processed appropriately and timely.

POLICY:

To ensure patient and insurance account balances are written off appropriately. The following guidelines should be used in determining the write off.

> Hospital account balances between -$0.99 - $9.99 that are in an active status
> Hospital/Clinic account balances between -$0.99 - $24.99 in a bad debt status
> Clinic account balances between -$0.99 - $4.99 that are in an active status

The balance shall be charged to a small balance adjustment code.

PROCEDURE:

1. The Patient Financial Services (PFS) Department/ outsource vendor will pull all identified account balances that are within the above listed criteria on the end of the month.
2. The PFS Department/ outsource vendor will review the listing of accounts written off to assure that the account balances are within the guidelines.
3. The PFS Department/ outsource vendor will process the accounts and ensure they are written off automatically or manually depending on the financial class.
4. If a payment is received on an account that has a zero balance resulting from a small balance write off, the small balance write off will be reversed and the payment will be applied.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

Effective Date: 01/29/15 (11) Fiscal & Business
Patient Accounting:
Finance Charges
#11-3034

APPROVED:

Board Of Directors: 01/28/15

10-G-1

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Small Balance Write-Off
Descriptive Type:	Revised Policy
Document Number:	11-3034
Attachments:	None
Author:	Teresa Jacques (Interim Controller/ Daniel Heckathorne (Interim CFO)
Typist:	Kathleen Campbell
Creation Date:	01/19/15
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Prev. Dist. Date:	None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	01/28/15	

Effective Date:	01/29/15
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	