

Health Care Transformation
and Strategic Planning
3910 Keswick Road, Suite N-2200
Baltimore MD 21211
443-997-0731 Fax



Kevin McDonald
Chief, Certificate of Need
4160 Patterson Avenue
Baltimore, Maryland 21215

01/04/2019

**RE: Johns Hopkins Bayview Medical Center Addition of 16 Inpatient
Rehabilitation Beds – Matter # 18-24-2430**

Dear Mr. McDonald:

Enclosed are responses to your request for completeness information, received Thursday, October 4, 2018.

I certify that these documents will be sent to the Baltimore City Health Department, which is the local planning agency.

Thank you for your consideration of this application. I look forward to working with you and your staff during its review. I am available if you have any questions or would like additional information.

Sincerely,

A handwritten signature in blue ink that reads "Spencer Wildonger".

Spencer Wildonger
Director of Health Planning
swildon1@jhmi.edu
443-997-0742

cc: Leana S. Wen, M.D., Health Commissioner, Baltimore City

Project Description

1. Why is Table A showing a change in physical bed capacity for a project that, in essence, is simply a change in bed classification and licensure?

Applicant Response:

Please see Exhibit CQ1.1 for a revised version of Table A. This project will not result in a change in total physical bed capacity at Johns Hopkins Bayview Medical Center. It will only result in a change in bed classification and licensure. Rehabilitation bed physical capacity will increase from 12 beds to 28 beds, and Chronic Care bed physical capacity will decrease from 76 beds to 60 beds.

2. If this proposal is approved, will Bayview be delicensing 16 chronic care beds?

Applicant Response:

Yes. If approved, Bayview commits to delicensing 16 chronic care beds.

Quality of Care

3. Regarding the tables used to respond to this standard:
 - a) What is the unit of measure on the Y-axis of the “FIM Improvement...” table?
 - b) The “FIM Improvement...” and “FIM Efficiency” tables only show a comparison to Maryland peers; does the data reporting not include a national comparison?

Applicant Response:

- a) The Functional Independence Measure (FIM) is an assessment tool that evaluates a patient’s functional ability throughout the rehabilitation process and is typically performed on admission to and departure from a facility. The tool looks at cognitive and motor function and assesses a patient’s functionality in 18 categories. Scores range from a minimum of 18 to a maximum of 126. A score of 126 indicates complete independence.

In the FIM Improvement from Admit to Discharge (Change in FIM score from Admission to Discharge), the Y-axis is the difference in the FIM score from admission to discharge, which is typically when the test is performed. The higher the score, the more significant the improvement in functionality of the patient.

- b) Benchmarked data for “FIM Improvement from Admit to Discharge” and “Length of Stay/FIM Efficiency” are not available for a national comparison, only a state comparison.

4. The table on p. 26 shows infection rates for Bayview but does not compare those rates to any national or state norm. Please provide that perspective.

Applicant Response:

The applicant is unable to provide state or national comparison data for this metric.

5. Exhibits 6 and 8 compare Bayview to some peer group in Press Ganey's NDQI. Please describe that peer group.

Applicant Response:

The peer group is all hospitals that participate in the NDNQI Press Ganey survey, a group of over 2,000 hospitals across the nation that provide information about quality indicators at their facilities.

6. The data provided by the applicant in Exhibit 6 shows patient falls to be well above the mean in four out of eight quarters, with that problem being especially the case during the four most recent quarters. Please summarize: a) the root cause; b) the solutions implemented; c) why, after initial improvement, falls again increased to exceed the norm by a significant margin.

Applicant Response:

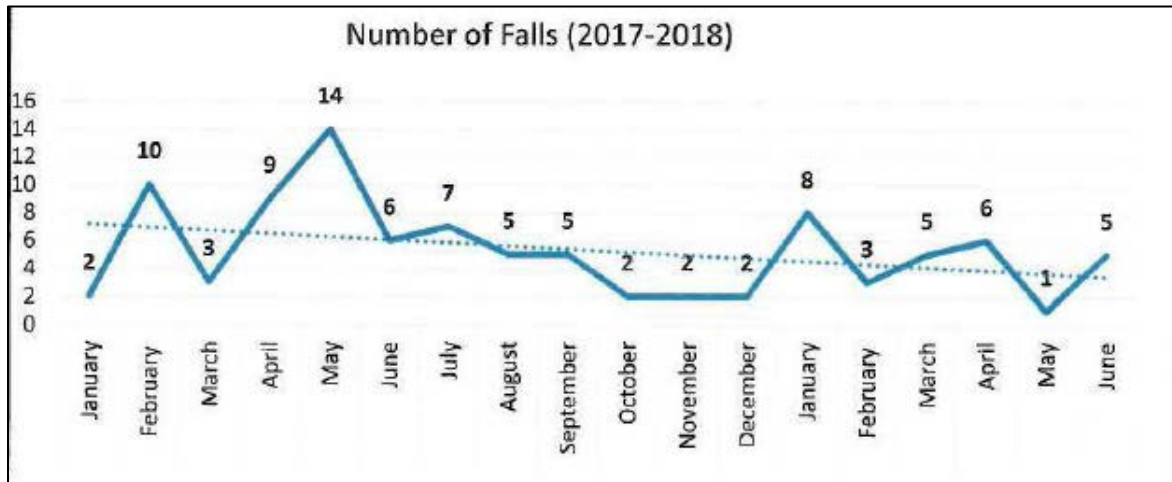
Please see Exhibit CQ1.6 for a detailed description of the unit's falls reduction project, initiated in October 2017.

a) The root cause was identified as the inconsistent application of falls prevention strategies and measures, most often during toileting or transfers, during peak rehab hours (8am-1pm), most commonly in the 60-70 age group, and more commonly women than men.

b) Action Plan:

- Cognitive and impulsivity screening on admission and within 72 hours.
- Falls audit daily.
- Patient and family education (use of yellow identifiers, socks, wrist band, and yellow w/chair tags, and signing of "Call Don't Fall" contract).
- Strengthening safety measures bed/chair alarms, clipped alarms, tele monitoring cameras, peer accountability measures through random safety checks.
- Falls discussed as part of huddle, bedside reporting, patient conferences, and safety rounds.
- Ask sending units specifically about at risk fall behavior and use of sitter.
- Charge Nurse and Primary Nurse will speak to sitters and give specifics of fall concerns with each and every patient.

c) As shown in Exhibit CQ1.6 and copied below, a month-by-month accounting of the number of falls in 2017 and 2018 shows that the overall trend is a decrease in patient falls and that the Action Plan has had its intended effect.



Updating the data published in Exhibit CQ1.6, the number of falls by month for FY19 were:

- July = 2
- August = 2
- September = 3
- October = 5
- November = 2

The Rehabilitation Unit continues to monitor this metric closely and is confident this trend in falls reduction will continue.

7. Exhibit 8, displaying the incidence of pressure sores, showed the applicant to have a strong record (zero incidence) in 7 out of 8 quarters. The one outlier, Q4 of 2016, however, showed a spike with an incidence of almost 3x that of the mean for the compare group. Did Bayview explore the reasons for that occurrence, and what was done about the findings?

Applicant Response:

Bayview monitors each of its quality and safety metrics closely. While there was an increase in pressure sores in 2016 Q4, the incidence rate quickly returned to zero, meaning no action plan was necessary. As shown in Exhibit 8, the incidence rate has remained at zero for 5 consecutive quarters since the spike in 2016 Q4.

Need

8. Your response provides data on “the utilization statistics for the 28 beds used for CIR services at JHBMC.” It is difficult to discern the location of those beds vis a vis the location of the chronic beds. Please provide a “before” and “after” table listing the floors and units containing these beds.

Applicant Response:

All of JHBMC’s Chronic and CIR beds are located in the John R. Burton Pavilion (“Burton Pavilion”) on the JHBMC campus. The Burton Pavilion currently has three inpatient floors:

- Burton 01
- Burton 1
- Burton 2

Before			After		
Floor	Bed Category	Bed Count	Floor	Bed Category	Bed Count
Burton 01	CIR (CARF accredited)	12	Burton 01	CIR (CARF accredited)	12
Burton 01	Chronic (CARF accredited)	8	Burton 01	CIR (CARF accredited)	8
Burton 1 C Wing	Chronic (CARF accredited)	8	Burton 1 C Wing	CIR (CARF accredited)	8
Burton 1 A-B Wing	Chronic	27	Burton 1 A-B Wing	Chronic	27
Burton 2	Chronic	33	Burton 2	Chronic	33
CIR Subtotal		12	CIR Subtotal		28
Chronic Subtotal		76	Chronic Subtotal		60
Total		88	Total		88

Burton 01 contains a total of 20 beds; 12 are currently licensed as CIR beds and 8 are licensed as Chronic beds. The 12 CIR beds and 8 Chronic beds are accredited by the Commission on Accreditation of Rehabilitation Facilities (“CARF”) and are currently used to provide CIR services.

Burton 1 has a total of 35 beds on two wings; the A-B Wing and the C Wing. The A-B Wing contains 27 licensed as Chronic beds, and the Wing C contains 8 licensed Chronic beds. The 8 licenses Chronic beds on the C Wing are accredited by the

Commission on Accreditation of Rehabilitation Facilities (“CARF”) and are currently used to provide CIR services.

Burton 2 contains 33 beds that are licensed as Chronic beds.

JHBMC proposes to convert the 8 Chronic beds on Burton 01 and 8 Chronic beds on the C Wing of Burton 1 to be licensed as CIR, for a total of 16 additional CIR beds.

9. The utilization statistics appearing in the table on p. 30 shows significantly more patient days in FY17 and '18 than FY16, and the application states: "This growth trend reflects an increased demand for rehabilitation services at JHBMC in recent years that has prompted JHBMC to commit additional resources to this service." What caused this growth, and should it be considered a short-term phenomenon or a sustainable shift?

Applicant Response:

Utilization statistics from page 30:

	FY16	FY17	FY18
Inpatient Discharges	441	530	732
Total Patient Days	5,740	8,234	9,365
Beds	20	28*	28
Occupancy (calculated)	78.6%	90.3%	91.6%

*20 beds July 1, 2016 - November 14, 2016, 28 beds November 15, 2016 - June 30, 2017

As discussed on page 6 of the CON application, prior to June 10, 2017, JHUSOM faculty were serving as clinical providers at MedStar Good Samaritan Hospital. The relationship terminated on June 10, 2017, concluding a process that included shifting JHUSOM faculty out of MedStar Good Samaritan and into JHBMC.

As would be predicted, patients once referred to these JHUSOM faculty practicing at MedStar Good Samaritan Hospital were now being referred to the same JHUSOM faculty, now based at JHBMC. To respond to this volume shift, JHBMC increased its number of CARF-accredited beds from 20 to 28 on November 15, 2016. That new capacity was quickly filled, resulting in an occupancy rate that increased from FY17 to FY18.

The shift in volume occurred consistent with the shift of the faculty's site of care. The shift is not a "short-term phenomenon", but the new norm.

10. Since the proposal to add 16 rehabilitation beds exceeds the latest bed need projections, please respond to part (d) of this standard, which states that: *an applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:*

- (i) The project credibly addresses identified barriers to access; and*
- (ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and*
- (iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.*

Applicant Response:

(i) The project does not address barriers to access. JHBMC has addressed what would be barriers to access by serving patients needing rehabilitation services in chronic beds. The applicant seeks to bring its licensed bed compliment into alignment with its current utilization. The applicant currently has 28 CARF-accredited beds, being utilized at a 91.6% occupancy rate. The applicant seeks to convert 16 chronic bed licenses to 16 comprehensive inpatient rehabilitation (CIR) to bring its total number of CIR licenses to 28. Without this conversion, if JHBMC were to stop using chronic beds for rehabilitation services, patients would experience significant disruption in and barriers to access.

(ii) JHBMC's projection of need is based on patients currently being served at JHBMC's CIR program, which necessarily only includes patients with specialty needs that can be met at JHBMC and patients who have already chosen JHBMC for CIR services. Also, JHBMC and MedStar Good Samaritan are CARF accredited for the same inpatient medical rehabilitation programs: Adult Comprehensive and Adult Stroke. Therefore, volume shifts occurring as a result of the termination of this relationship fall into one of these two categories.

(iii) Migration patterns between Maryland health planning regions and bordering states are not applicable to this project. The project seeks to bring JHBMC's licensed bed compliment into alignment with its current utilization, reflecting volumes shifts that have already occurred.

Financial Feasibility

11. Submit a Table F that separates Chronic from Rehabilitation volume projections.

Applicant Response:

Please see Exhibit CQ1.11 for revised version of Table F. Relevant sections are in red.

Charity Care

12. Part (a) (ii)3 of this standard requires: ***Individual notice regarding the hospital's charity care policy {to} be provided at the time of preadmission or admission to each person who seeks services in the hospital.*** Bayview's policy provides that: "A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients **before discharge** and will be available to all **patients upon request.**" Providing information "before discharge" does not align with the standard's requirement to provide it "at the time of preadmission or admission." Please submit a revised policy.

Applicant Response:

Please Exhibit CQ1.12 for revised financial assistance policy.

Viability

13. Table L does not reflect changes to be expected based on this project, but on a much larger renovation/expansion project. Would this addition of 16 rehab beds – which you characterize as a “conversion” -- change current staffing patterns at all? If so, submit a Table L that reflects only this project, not the larger project.

Applicant Response:

The conversion of 16 Chronic beds to 16 CIR beds will not change current staffing patterns.

Please see Exhibit CQ1.13 for an updated version of Table L.

Exhibit CQ1.1

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2018	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing) Red = Project-Related Changes	Based on Physical Capacity				
			Room Count			Bed Count			Room Count			Bed Count	
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity	
ACUTE CARE							ACUTE CARE						
General Medical/ Surgical*							General Medical/ Surgical*						
Medical	FSK 5/Med A	36	8	14	22	36	Medical	FSK 5/Med A	8	14	22	36	
Medical	FSK 5/ Med B	36	8	14	22	36	Medical	FSK 5/ Med B	8	14	22	36	
Medical	BP3/ Hospitalist	38	12	13	25	38	Medical	BP3/ Hospitalist	12	13	25	38	
Medical	FSK 4 West/ PCU	28	6	11	17	28	Medical	FSK 4 West/ PCU	6	11	17	28	
Medicine	A2E/ Chem. Dependency*	22	4	8	12	26	Medicine	A2E/ Chem. Dependency*	4	8	12	26	
Surgical	FSK 6 East Surg	38	10	14	24	38	Surgical	FSK 6 East Surg	10	14	24	38	
Surgical	A4West/ Ortho	10	10	0	10	10	Surgical	A4West/ Ortho	10	0	10	10	
Surgical	FSK 3/ Burn Wound Unit	10	2	4	6	10	Surgical	FSK 3/ Burn Wound Unit	2	4	6	10	
Neurological	FSK 6 West/ Neuro	23	3	10	13	23	Neurological	FSK 6 West/ Neuro	3	10	13	23	
Specialty	GYN- FSK 6 East	2	2	0	2	2	Specialty	GYN- FSK 6 East	2	0	2	2	
SUBTOTAL Gen. Med/Surg		243	65	88	153	247	SUBTOTAL Gen. Med/Surg		65	88	153	247	
ICU/CCU							ICU/CCU						
	FSK 4 East/ MICU	12	12	0	12	12		FSK 4 East/ MICU	12	0	12	12	
	FSK 4 East/ Cardiac ICU	12	12	0	12	12		FSK 4 East/ Cardiac ICU	12	0	12	12	
	FSK 3/ SICU	10	10	0	10	10		FSK 3/ SICU	10	0	10	10	
	FSK 3/ Burn ICU	10	10	0	10	10		FSK 3/ Burn ICU	10	0	10	10	
	FSK 6W/ Neuro ICU	8	8	0	8	8		FSK 6W/ Neuro ICU	8	0	8	8	
TOTAL MSGA		295	117	88	205	299	TOTAL MSGA		117	88	205	299	
Obstetrics	A2 West + Center	22	22	0	22	22	Obstetrics	A2 West + Center	22	0	22	22	
Pediatrics	N. Pavilion 4/Pediatric	5	7	0	7	7	Pediatrics	N. Pavilion 4/Pediatric	7	0	7	7	
Psychiatric	A4 East/Psychiatry	20	2	9	11	20	Psychiatric	A4 East/Psychiatry	2	9	11	20	
TOTAL ACUTE		342	148	97	245	348	TOTAL ACUTE		148	97	245	348	
NON-ACUTE CARE							NON-ACUTE CARE						
Dedicated Observation							Dedicated Observation						
Rehabilitation	BP 01	12	8	2	10	12	Rehabilitation	BP 01, 1	14	7	21	28	
Chronic Care**	BP 01, 1 and 2	76	18	28	46	76	Chronic Care**	BP 1 and 2	12	23	35	60	
ED Clinical Decision Unit	N. Pavilion 3	0	13	0	13	13	ED Clinical Decision Unit	N. Pavilion 3	13	0	13	13	
TOTAL NON-ACUTE							TOTAL NON-ACUTE						
HOSPITAL TOTAL		342	148	97	245	348	HOSPITAL TOTAL		148	97	245	348	

*Chemical Dependency Unit is comprised of (4) private rooms, (5) double rooms and (3) quads for a total physical capacity of (26) beds.

**Current Chronic room count is (18) private rooms, (27) double rooms, (1) quad room and will change to (12) private rooms, (22) double rooms, and (1) quad room.

Exhibit CQ1.6

A3: Title of Problem/Program/Project

A3 Project Leader: Haimanot Mulat
Rev. Date: July 16, 2018
Scope: Rehabilitation

I. Define:		VI. Analyze (select appropriate method):
Background/Problem: Increased falls rate in the inpatient rehab unit. <ul style="list-style-type: none"> Average falls rate for 2015 and 2016 was 6.12/1000 patient days (NDNQI report, JHBMC n.d). Falls rate for 2nd Quarter and 3rd Quarter in 2017 was 17.84/1000 patient days, and 14.68 /1000 patient days respectively (NDNQI report, JHBMC n.d.). Falls are the most reported adverse events in hospitals. Falls rank at the top of hospital acquired injuries (HAI). Falls are the leading cause of death and injury for Americans older than 65 years. Approximately 30% of hospital patient falls result in physical injury, with 4-6% resulting in serious injury. Average hospital cost for a fall injury is over \$30,000. In 2015, Medicare costs for falls totaled over 31 billion (CDC, 2016). 		The analysis of the HERO reports: <ul style="list-style-type: none"> Toileting was the main reason cited for falls followed by transfers. Most falls occurred during peak hours of rehab (8am – 1pm). Patients in age group 60-70 identified as the largest group of patients with falls. More falls for women than men . Inconsistent application of falls prevention strategies and measures. Bright spots: <ul style="list-style-type: none"> Interdisciplinary staff training on fall interventions was well received. Nursing staff fully engaged in the process. Unit management's ongoing support. Initiatives such as hourly rounds and bedside report implemented. The availability of tele video cameras, and sitters.
II. Objective/Goal:	III. Team Members:	VII. Improve – High-level Timeline with Action Steps:
<ul style="list-style-type: none"> The goal is to reduce falls by 10% from current levels (14.68/1000 patient days) by the end of 2018). Increase staff awareness, accountability, and responsiveness to act on falls prevention measures. Promote patient and family accountability /responsibility. Increased Interdisciplinary collaboration nursing, PT/OT, physical medicine and rehabilitation. . 	PCM, Unit based Interdisciplinary team DON Unit based ACE nurse Unit falls champion(s) Armstrong institute	Action Plan <ul style="list-style-type: none"> Complete cognitive/ Impulsivity screening on admission and 72 hours- Nursing, PT/OT/SLP Falls contract/ patients/families- nurses on admission Implement appropriate interventions- yellow identifiers, fall mats, wheelchair identifiers, video cameras, bed alarms, chair alarms, sitters- nurses, techs, interdisciplinary team- as needed Fall audits- charge nurses once a shift Falls champions & interdisciplinary meetings- monthly Project evaluation after 6 months- Armstrong Institute and team- done Anril
IV. Key Metrics:		
<ul style="list-style-type: none"> NDNQI and Hero Reports 		

A3: Rehab Falls Project

A3 Project Leader: Haimanot Mulat

Rev. Date: 7/16/18

Scope: Rehabilitation Unit

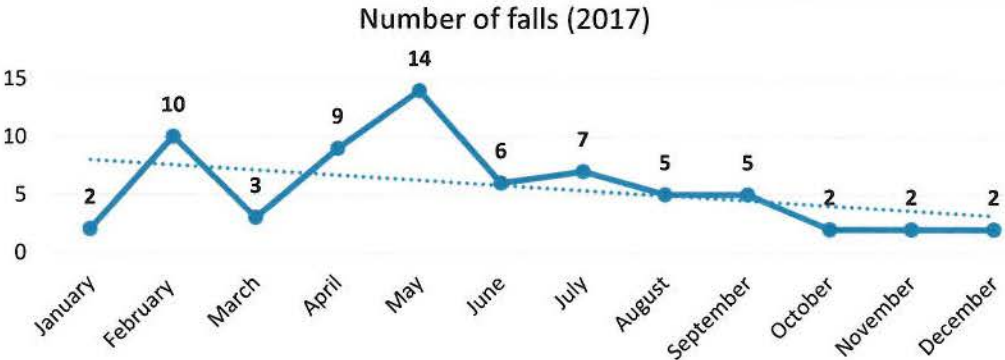
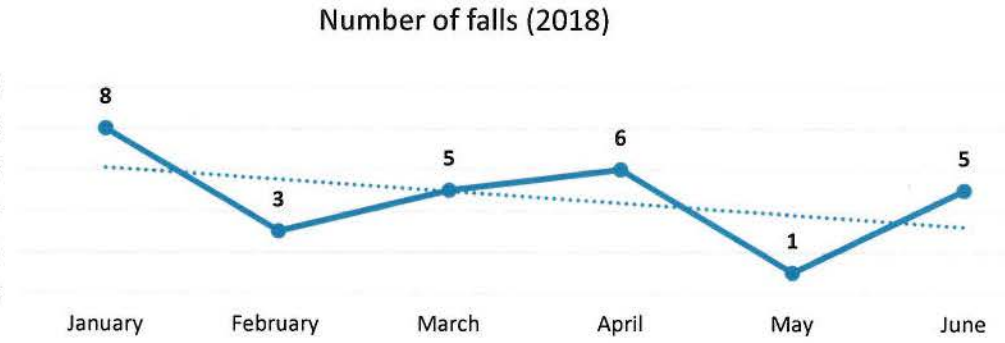
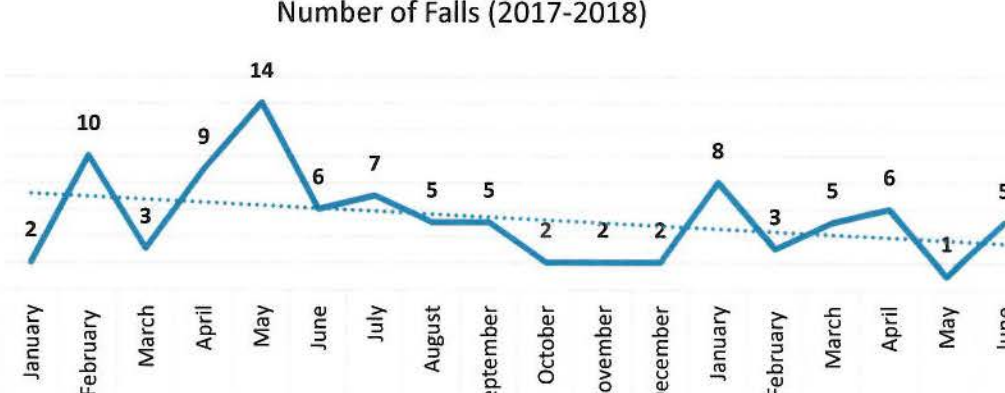
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Exhibit CQ1.11

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
1. DISCHARGES										
a. General Medical/Surgical*	14,729	15,976	16,085	15,908	15,593	15,301	15,042	15,010	15,005	14,897
b. ICU/CCU	1,423	1,177	1,211	1,198	1,174	1,152	1,133	1,131	1,131	1,123
Total MSGA	16,152	17,153	17,296	17,106	16,767	16,453	16,175	16,141	16,136	16,020
c. Pediatric	314	262	280	279	277	275	272	269	266	266
d. Obstetric	1,403	1,451	1,442	1,500	1,500	1,500	1,500	1,600	1,700	1,800
e. Acute Psychiatric	750	701	712	725	731	737	739	739	739	739
e2. Other - NICU	282	357	355	368	368	368	368	390	411	433
Total Acute	18,901	19,924	20,085	19,978	19,643	19,333	19,054	19,139	19,252	19,258
f. Rehabilitation	441	530	732	732	732	732	732	732	732	732
g. Comprehensive Care	0	0	0	0	0	0	0	0	0	0
h. Chronic Care	436	350	280	280	280	280	280	280	280	280
Total Non-Acute	877	880	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012
TOTAL DISCHARGES	19,778	20,804	21,097	20,990	20,655	20,345	20,066	20,151	20,264	20,270
i. Other - Outpatient Observation in Inpt Beds	3,734	4,350	4,380	4,603	4,934	5,250	5,492	0	0	0
j. Other - Outpatient Observation in Obsv Unit Beds	0	0	0	0	0	0	0	5,668	5,753	5,857
Total Acute Inpatient + Outpt Observation Discharges	22,635	24,274	24,465	24,581	24,577	24,583	24,546	19,139	19,252	19,258

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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Indicate CY or FY	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
2. PATIENT DAYS										
a. General Medical/Surgical*	60,874	62,981	69,680	68,913	67,549	66,284	65,162	65,023	65,001	64,534
b. ICU/CCU	15,607	15,285	16,363	16,187	15,863	15,566	15,309	15,282	15,282	15,174
Total MSGA	76,481	78,266	86,043	85,100	83,412	81,850	80,471	80,305	80,283	79,708
c. Pediatric	832	815	921	918	911	904	893	882	871	871
d. Obstetric	4,023	3,935	3,738	3,888	3,888	3,888	3,888	4,148	4,407	4,666
e. Acute Psychiatric	6,400	6,362	6,650	6,770	6,830	6,890	6,910	6,910	6,910	6,910
e2. Other - NICU	5,905	5,712	5,680	5,888	5,888	5,888	5,888	6,240	6,576	6,928
Total Acute	93,641	95,090	103,032	102,564	100,929	99,420	98,050	98,485	99,047	99,083
f. Rehabilitation	5,740	8,234	9,365	9,365	9,365	9,365	9,365	9,365	9,365	9,365
g. Comprehensive Care	0	0	0	0	0	0	0	0	0	0
h. Chronic Care	14,311	11,681	9,028	9,028	9,028	9,028	9,028	9,028	9,028	9,028
Total Non-Acute	20,051	19,915	18,393	18,393	18,393	18,393	18,393	18,393	18,393	18,393
TOTAL PATIENT DAYS	113,692	115,005	121,425	120,957	119,322	117,813	116,443	116,878	117,440	117,476
i. Other - Outpatient Observation in Inpt Beds	5,750	6,368	5,253	5,521	5,918	6,297	6,587	0	0	0
j. Other - Outpatient Observation in Obsv Unit Beds	0	0	0	0	0	0	0	6,798	6,900	7,025
Total Acute Inpatient + Outpt Observation	99,391	101,458	108,285	108,085	106,847	105,717	104,637	105,283	105,947	106,108

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	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	4.1	3.9	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3
b. ICU/CCU	11.0	13.0	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5
Total MSGA	4.7	4.6	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0
c. Pediatric	2.6	3.1	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3
d. Obstetric	2.9	2.7	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6
e. Acute Psychiatric	8.5	9.1	9.3	9.3	9.3	9.3	9.3	9.3	9.3	9.3
e2. Other - NICU	20.9	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0	16.0
Total Acute	5.0	4.8	5.1	5.1	5.1	5.1	5.1	5.1	5.1	5.1
f. Rehabilitation	13.0	15.5	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8
g. Comprehensive Care	-	-	-	-	-	-	-	-	-	-
h. Chronic Care	32.8	33.4	32.2	32.2	32.2	32.2	32.2	32.2	32.2	32.2
Total Non-Acute	22.9	22.6	18.2	18.2	18.2	18.2	18.2	18.2	18.2	18.2
TOTAL AVERAGE LENGTH OF STAY	5.7	5.5	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8
i. Other - Outpatient Observation	1.5	1.5	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Total Acute Inpatient + Outpt Observation	4.4	4.2	4.4	4.4	4.3	4.3	4.3	5.5	5.5	5.5

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Indicate CY or FY	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	242	231	243	243	243	243	216	216	216	216
b. ICU/CCU	52	52	52	52	52	52	56	56	56	56
Total MSGA	294	283	295	295	295	295	272	272	272	272
c. Pediatric	5	5	5	5	5	5	5	5	5	5
d. Obstetric	22	22	22	22	22	22	18	18	18	18
e. Acute Psychiatric	20	20	20	20	20	20	20	20	20	20
e2. Other - NICU	25	25	25	25	25	25	22	22	22	22
Total Acute	366	355	367	367	367	367	337	337	337	337
f. Rehabilitation	9	12	12	28	28	28	28	28	28	28
g. Comprehensive Care	0	0	0	0	0	0	0	0	0	0
h. Chronic Care	76	76	76	60	60	60	60	60	60	60
Total Non-Acute	85	88	88	88	88	88	88	88	88	88
TOTAL LICENSED BEDS	451	443	455	455	455	455	425	425	425	425
i. Outpatient Observation										
Total Inpatient Beds	451	443	455	455	455	455	425	425	425	425

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

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Indicate CY or FY	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.										
a. General Medical/Surgical*	68.7%	74.7%	78.6%	77.7%	76.0%	74.7%	82.7%	82.5%	82.2%	81.9%
b. ICU/CCU	82.0%	80.5%	86.2%	85.3%	83.3%	82.0%	74.9%	74.8%	74.6%	74.2%
Total MSGA	71.1%	75.8%	79.9%	79.0%	77.3%	76.0%	81.1%	80.9%	80.6%	80.3%
c. Pediatric	45.5%	44.7%	50.5%	50.3%	49.8%	49.5%	48.9%	48.3%	47.6%	47.7%
d. Obstetric	50.0%	49.0%	46.6%	48.4%	48.3%	48.4%	59.2%	63.1%	66.9%	71.0%
e. Acute Psychiatric	87.4%	87.2%	91.1%	92.7%	93.3%	94.4%	94.7%	94.7%	94.4%	94.7%
e2. Other - NICU	64.5%	62.6%	62.2%	64.5%	64.3%	64.5%	73.3%	77.7%	81.7%	86.3%
Total Acute	69.9%	73.4%	76.9%	76.6%	75.1%	74.2%	79.7%	80.1%	80.3%	80.6%
f. Rehabilitation	174.3%	188.0%	213.8%	91.6%	91.4%	91.6%	91.6%	91.6%	91.4%	91.6%
g. Comprehensive Care	-	-	-	-	-	-	-	-	-	-
h. Chronic Care	51.4%	42.1%	32.5%	41.2%	41.1%	41.2%	41.2%	41.2%	41.1%	41.2%
Total Non-Acute	64.5%	62.0%	57.3%	57.3%	57.1%	57.3%	57.3%	57.3%	57.1%	57.3%
TOTAL OCCUPANCY %	68.9%	62.7%	65.2%	65.1%	64.2%	63.7%	67.5%	67.9%	68.1%	68.4%
i. Outpatient Observation										
Total Acute Inpatient + Outpt Observation in Inpt Beds	72.4%	75.1%	76.3%	76.2%	75.2%	74.7%	79.3%	75.3%	75.5%	75.7%

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY


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	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
6. OUTPATIENT VISITS										
a. Emergency Department	56,219	58,787	59,921	61,686	63,503	65,376	67,304	69,290	71,336	73,443
b. Same-day Surgery	7,995	8,385	8,649	8,884	9,182	9,381	9,513	9,613	9,709	9,806
c. Laboratory	15,059	23,047	22,704	22,704	22,704	22,704	22,704	22,704	22,704	22,704
d. Imaging	72,371	83,419	82,179	82,179	82,179	82,179	82,179	82,179	82,179	82,179
e. Clinic Services	212,953	216,661	213,441	205,716	205,716	205,716	205,716	205,716	205,716	205,716
f. Radiation Therapy Treatments	5,663	6,270	6,584	6,913	7,051	7,192	7,336	7,483	7,557	7,633
Total Acute Hospital	370,260	396,569	393,478	388,082	390,335	392,548	394,752	396,985	399,201	401,481
g. Other - Psychiatry Special Programs	187,557	189,366	194,806	194,806	194,806	194,806	194,806	194,806	194,806	194,806
Total Non-Acute Services	187,557	189,366	194,806	194,806	194,806	194,806	194,806	194,806	194,806	194,806
TOTAL OUTPATIENT VISITS	557,817	585,935	588,284	582,888	585,141	587,354	589,558	591,791	594,007	596,287
7. OBSERVATIONS**										
a. Number of Patients (Includes inpatient admissions)	6,988	7,320	7,370	7,289	7,145	7,011	6,892	6,877	6,875	6,826
b. Hours	139,192	127,500	128,371	126,960	124,452	122,118	120,045	119,784	119,749	118,895

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

Exhibit CQ1.12

	Johns Hopkins Medicine Finance Financial Assistance Policies Manual General	<i>Policy Number</i>	PFS035
		<i>Effective Date</i>	10/02/2018
		<i>Approval Date</i>	10/02/2018
	<i>Subject</i> Financial Assistance for JHH, JHBMC and JHBCC	<i>Page</i>	1 of 7
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This document applies to the following Participating Organizations:

Johns Hopkins Bayview Medical Center The Johns Hopkins Hospital

Keywords: assistance, debt, financial, medical

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Appendix G: Medical Financial Hardship Application - Exhibit C	Click Here
Appendix H: Spanish Medical Financial Hardship Application - Exhibit C	Click Here

I. POLICY


This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc., Acute Care Hospital and Special Programs (JHBMC) and the Chronic Specialty Hospital of the Johns Hopkins Bayview Care Center (JHBCC).

II. PURPOSE

The Johns Hopkins Health System Corporation (JHHS) is committed to providing financial assistance to patients who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or excessive Medical Debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, and will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

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Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. Review for Medical Financial Hardship Assistance shall include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt) and any projected medical expenses. Financial Assistance Applications and Medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted, so long as other requirements are met.

FINANCIAL ASSISTANCE FOR PHYSICIANS PROVIDING CASE NOTICE:

Attached as Exhibit D is a list of physicians that provide emergency and medically necessary care as defined in this policy at JHH, JHBMC and JHBCC. The list indicates if the doctor is covered under this policy. If the doctor is not covered under this policy, patients should contact the physician's office to determine if the physician offers financial assistance and if so what the physician's financial assistance policy provides.

III. DEFINITIONS


Medical Debt	Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the Hopkins hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles. Medical Debt does not include those hospital bills for which the patient chose to be registered as Voluntary Self Pay (opting out of insurance coverage, or insurance billing)
Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of \$150,000 in equity in patient's primary residence shall not be considered an asset convertible to cash. Equity in any other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non qualified deferred compensation plans.
Elective Admission	A hospital admission that is for the treatment of a medical condition that is not considered an Emergency Medical Condition.
Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.
Emergency Medical Condition	<p>A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, or other acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in any of the following:</p> <ol style="list-style-type: none"> 1. Serious jeopardy to the health of a patient; 2. Serious impairment of any bodily functions; 3. Serious dysfunction of any bodily organ or part. 4. With respect to a pregnant woman: <ol style="list-style-type: none"> a. That there is inadequate time to effect safe transfer to another hospital prior to delivery. b. That a transfer may pose a threat to the health and safety of the patient or fetus. c. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

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Emergency Services and Care	Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician which is necessary to relieve or eliminate the emergency medical condition, within the service capability of the hospital.
Medically Necessary Care	Medical treatment that is necessary to treat an Emergency Medical Condition. Medically necessary care for the purposes of this policy does not include Elective or cosmetic procedures.
Medically Necessary Admission	A hospital admission that is for the treatment of an Emergency Medical Condition.
Family Income	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.
Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

IV. PROCEDURES


- A. An evaluation for Financial Assistance can begin in a number of ways:
 1. For example:
 - a. A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
 - b. A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
 - c. A patient with a hospital account referred to a collection agency notifies the collection agency that he/she cannot afford to pay the bill and requests assistance.
 - d. A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.
- B. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.
- C. Designated staff will meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
 1. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, (as defined by Medicaid regulations). To help applicants complete the process, we will provide a statement of conditional approval that will let them know what paperwork is required for a final determination of eligibility.

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2. Applications received will be sent to the JHHS Revenue Cycle Management Department's dedicated Financial Assistance application line for review; a written determination of probable eligibility will be issued to the patient.
- D. To determine final eligibility, the following criteria must be met:
1. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
 2. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.
 3. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year).
 4. All insurance benefits must have been exhausted.
- E. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:
1. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).
 2. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
 3. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
 4. A Medical Assistance Notice of Determination (if applicable).
 5. Proof of U.S. citizenship or lawful permanent residence status (green card) if applicable.
 6. Proof of disability income (if applicable).
 7. Reasonable proof of other declared expenses.
 8. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...
- F. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements for medical costs billed by a Hopkins hospital. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Revenue Cycle Management Department for final determination of eligibility based upon JHMI guidelines.
1. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee for final evaluation and decision.
 2. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee. This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Committee will have a final determination made no later than 30 days from the date the application was considered complete. The Financial Assistance Evaluation Committee will base its determination of financial need on JHHS guidelines.
- G. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
- H. Services provided to patients registered as Voluntary Self Pay patients do not qualify for Financial Assistance.

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- I. A department operating programs under a grant or other outside governing authority (i.e., Psychiatry) may continue to use a government-sponsored application process and associated income scale.
- J. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient make a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.
- K. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is either a partial or a 100% write-off of the account balance, dependent income and FPL amounts. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patient's representative request an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.
- L. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.
- M. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
- N. Patients who receive coverage on a Qualified Health Plan and ask for help with out of pocket expenses (co-payments and deductibles) for medical costs resulting from medically necessary care shall be required to submit a Financial Assistance Application if the patient is at or below 200% of Federal Poverty Guidelines.
- O. If a patient account has been assigned to a collection agency, and patient or guarantor request financial assistance or appears to qualify for financial assistance, the collection agency shall notify RCM and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to RCM for review and determination and shall place the account on hold for 45 days pending further instruction from RCM.
- P. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding \$25. If the hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.

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- Q. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.
- R. JHHS Hospitals may extend Financial Assistance to residents with demonstrated financial need, regardless of citizenship, in the neighborhoods surrounding their respective hospitals, as determined by the hospital's Community Health Needs Assessment. The zip codes for The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) are: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231 and 21052. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. Financial Counselors will refer these patients to The Access Partnership program at Hopkins (see PFS127 for specific procedures).
- S. Actions JHHS hospitals may take in the event of non-payment are described in a separate billing and collections policy (PFS046). To obtain a free copy of this policy please contact Customer Service at 1-855-662-3017 (toll free) or send an email to pfscs@jhmi.edu or visit a Financial Counselor in the Admission Office of any JHHS Hospital.

V. REFERENCE

JHHS Finance Policies and Procedures Manual

- Policy No. PFS120 - Signature Authority: Patient Financial Services
- Policy No. PFS034 - Installment Payments


Charity Care and Bad Debts, AICPA Health Care Audit Guide

Code of Maryland Regulations COMAR 10.37.10.26, et seq
 Maryland Code Health General 19-214, et seq
 Federal Poverty Guidelines (Updated annually) in Federal Register

NOTE: Standardized applications for Financial Assistance, Patient Profile Questionnaire and Medical Financial Hardship have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A, B and C.

VI. RESPONSIBILITIES – JHH, JHBMC

- A. Financial Counselor (Pre-Admission/Admission/In-House/ Outpatient) Customer Service Collector Admissions Coordinator
- Any Finance representative designated to accept applications for Financial Assistance
1. Understand current criteria for Assistance qualifications.
 2. Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form.
 3. On the day preliminary application is received, fax to Patient Financial Services Department's dedicated fax line for determination of probable eligibility.
 4. Review preliminary application, Patient Profile Questionnaire and Medical Financial Hardship Application (if submitted) to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments.
 5. If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review.
 6. Review and ensure completion of final application.
 7. Deliver completed final application to appropriate management.

 FINANCE JOHNS HOPKINS MEDICINE	Johns Hopkins Medicine Finance Financial Assistance Policies Manual General	<i>Policy Number</i>	PFS035
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8. Document all transactions in all applicable patient accounts comments.
 9. Identify retroactive candidates; initiate final application process.
- B. Management Personnel (Supervisor/Manager/Director)
1. Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies.
 2. Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.]
 3. Notices will not be sent to Presumptive Eligibility recipients.
- C. Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent)
CP Director and Management Staff
1. Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No.PFS120 - Signature Authority: Patient Financial Services.

VII. SPONSOR

- VP Revenue Cycle Management (JHHS)
- Director, PFS Operations (JHHS)

VIII. REVIEW CYCLE

Two (2) years

IX. APPROVAL

Electronic Signature(s)	Date
Mike Larson SVP Finance/Chief Financial Officer, JHHS; VP Finance/ Chief Financial Officer, JHHC; Exec. JHHS FIN	10/02/2018

Exhibit CQ1.13

TABLE L. WORKFORCE INFORMATION

INSTRUCTION : List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G. See additional instruction in the column to the right of the table.											
	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	FTEs	Average Salary per FTE	Total Cost (should be consistent with projections in Table G, if submitted).	FTEs	Average Salary per FTE	Total Cost	FTEs	Total Cost (should be consistent with projections in Table G)
1. Regular Employees											
Administration (List general categories, add rows if needed)											
Management	126.1	\$ 114,788	\$ 14,477,855	-	\$ -	\$ -	(2.0)	\$ 114,788	\$ (228,428)	124.1	\$ 14,249,427
Office/Clerical	283.6	\$ 42,516	\$ 12,056,467	-	\$ -	\$ -	0.3	\$ 42,516	\$ 10,629	283.8	\$ 12,067,096
Total Administration	409.7	\$ 64,765	\$ 26,534,322	-	\$ -	\$ -	(1.7)	\$ 125,172	\$ (217,799)	408.0	\$ 26,316,523
Direct Care Staff (List general categories, add rows if needed)											
Ancillary	240.9	\$ 75,077	\$ 18,089,221	-	\$ -	\$ -	(3.8)	\$ 75,077	\$ (285,294)	237.1	\$ 17,803,927
Nursing	1,004.3	\$ 84,762	\$ 85,122,682	-	\$ -	\$ -	9.9	\$ 84,762	\$ 835,750	1,014.1	\$ 85,958,432
Patient Care Asst.	366.5	\$ 39,220	\$ 14,374,875	-	\$ -	\$ -	(5.8)	\$ 39,220	\$ (226,694)	360.7	\$ 14,148,181
Pharmacy	72.4	\$ 79,991	\$ 5,787,881	-	\$ -	\$ -	1.6	\$ 79,991	\$ 129,585	74.0	\$ 5,917,466
Respiratory Therapy	60.3	\$ 64,490	\$ 3,889,380	-	\$ -	\$ -	0.8	\$ 64,490	\$ 52,882	61.1	\$ 3,942,262
Total Direct Care	1,744.4	\$ 72,956	\$ 127,264,040	-	\$ -	\$ -	2.7	\$ 186,113	\$ 506,229	1,747.1	\$ 127,770,269
Support Staff (List general categories, add rows if needed)											
Environmental Service	109.5	\$ 33,334	\$ 3,650,123	-	\$ -	\$ -	24.0	\$ 28,142	\$ 675,418	133.5	\$ 4,325,541
Environmental Service II	-	\$ -	\$ -	-	\$ -	\$ -	(2.1)	\$ 33,334	\$ (68,335)	(2.1)	\$ (68,335)
Facilities	69.1	\$ 64,512	\$ 4,455,541	-	\$ -	\$ -	8.8	\$ 64,512	\$ 564,478	77.8	\$ 5,020,019
Food Service	119.9	\$ 39,093	\$ 4,687,816	-	\$ -	\$ -	3.0	\$ 29,106	\$ 87,318	122.9	\$ 4,775,134
Food Service II	-	\$ -	\$ -	-	\$ -	\$ -	(1.9)	\$ 39,093	\$ (75,450)	(1.9)	\$ (75,450)
Materials	51.2	\$ 40,109	\$ 2,051,711	-	\$ -	\$ -	2.2	\$ 40,109	\$ 86,235	53.3	\$ 2,137,946
Other	492.2	\$ 59,799	\$ 29,431,862	-	\$ -	\$ -	4.0	\$ 28,142	\$ 112,570	496.2	\$ 29,544,431
Other II	-	\$ -	\$ -	-	\$ -	\$ -	(7.8)	\$ 59,799	\$ (465,836)	(7.8)	\$ (465,836)
Patient Registrar	103.6	\$ 39,127	\$ 4,055,458	-	\$ -	\$ -	(1.6)	\$ 39,127	\$ (63,777)	102.0	\$ 3,991,682
Total Support	945.5	\$ 51,121	\$ 48,332,511	-	\$ -	\$ -	28.5	\$ 29,917	\$ 852,621	974.0	\$ 49,185,132
REGULAR EMPLOYEES TOTAL	3,099.5	\$ 65,213	\$ 202,130,873	-	\$ -	\$ -	29.5	\$ 38,706	\$ 1,141,050	3,129.0	\$ 203,271,923
2. Contractual Employees											
Administration (List general categories, add rows if needed)											
Office/Clerical	11.4	\$ 108,851	\$ 1,241,993	-	\$ -	\$ -	-	\$ -	\$ -	11.4	\$ 1,241,993
Other	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -
Total Administration	11.4	\$ 108,851	\$ 1,241,993	-	\$ -	\$ -	-	\$ -	\$ -	11.4	\$ 1,241,993
Direct Care Staff (List general categories, add rows if needed)											
Pharmacy	2.3	\$ 48,752	\$ 111,154	-	\$ -	\$ -	-	\$ -	\$ -	2.3	\$ 111,154
Nursing	59.8	\$ 125,969	\$ 7,536,716	-	\$ -	\$ -	-	\$ -	\$ -	59.8	\$ 7,536,716
Ancillary	8.0	\$ 146,983	\$ 1,175,864	-	\$ -	\$ -	-	\$ -	\$ -	8.0	\$ 1,175,864
Total Direct Care Staff	70.1	\$ 125,856	\$ 8,823,734	-	\$ -	\$ -	-	\$ -	\$ -	70.1	\$ 8,823,734
Support Staff (List general categories, add rows if needed)											
Environmental Service	11.7	\$ 32,741	\$ 383,726	-	\$ -	\$ -	-	\$ -	\$ -	11.7	\$ 383,726
Food Service	16.0	\$ 37,551	\$ 598,935	-	\$ -	\$ -	-	\$ -	\$ -	16.0	\$ 598,935
Other-Security Contract	43.4	\$ 96,941	\$ 4,209,166	-	\$ -	\$ -	5.2	\$ 23,400	\$ 121,680	48.6	\$ 4,330,846
Total Support Staff	71.1	\$ 73,032	\$ 5,191,827	-	\$ -	\$ -	5.2	\$ 23,400	\$ 121,680	76.3	\$ 5,313,507
CONTRACTUAL EMPLOYEES TOTAL	152.6	\$ 99,977	\$ 15,257,554	-	\$ -	\$ -	5.2	\$ 23,400	\$ 121,680	152.6	\$ 15,379,234
Benefits (State method of calculating benefits below) :			\$ 62,894,508			\$ -			\$ 355,046	\$ 63,249,554	
= Total Ben\$ / Total Sal\$ x Table L Sal\$											
TOTALS	3,252.2		\$ 280,282,935	-		\$ -	34.7		\$ 1,617,776	3,281.6	\$ 281,900,711