**TRI-CITY HEALTHCARE DISTRICT**
**AGENDA FOR A REGULAR MEETING**
**OF THE FINANCE, OPERATION AND PLANNING COMMITTEE**
**February 13, 2018**
**12:30-3:30**
**Assembly Room 3**
**Tri-City Medical Center**
***4002 Vista Way, Oceanside, CA 92056***

**The Committee may make recommendations on any of the items listed below, unless the item is specifically labeled "Informational Only"**

| | AGENDA ITEM | TIME ALLOTED | PERSON RESPONSIBLE |
|---|---|---|---|
| 1. | Call to Order | 1 min. | Chair |
| 2. | Approval of Agenda | 2 min. | Chair |
| 3. | Public Comments-Announcement<br>Comments may be made at this time by members of the public on any item on the Agenda before the Committee's consideration of the item or on any matter within the jurisdiction of the Committee.<br>NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item. | 2 min. | Chair |
| 4. | Ratification of minutes – January 16, 2018 | 2 min. | Standard |
| 5. | Old Business | | |
| 6. | New Business | | |
| | a) Introduction of New Committee Member:<br>• Dr. Jeffrey Ferber | 2 min. | Chair |
| 7. | Consideration of Consent Calendar-*(All items will be approved with a single motion, unless pulled for discussion)* | 30 min. | Chair |
| | a) Policy Review:<br>• Prior Authorization for Non-Emergency Services for HMO/PPO Patients, #8610-213<br>• Audits for Third Party Insurance, #8610-255<br>• Medi-Cal Treatment Authorization Request (TAR) Requirements, #8610-268<br>*Motion: Request approval of policies, as they have been written.* | | David Benitez<br>Joni Penix<br>David Benitez |
| | b) Managed Resources, Inc. Proposal<br>*Motion: Request approval of the agreement with Managed Resources, Inc. for Clinical Appeals for a term of 24 months, beginning February 25, 2018 and ending February 29, 2020 for an annual expected cost of $154,824, and a total expected cost for the term of $309,648.* | | Joni Penix |
| | c) Locum Tenens Contracts for Crisis Stabilization Unit (CSU)<br>*Motion: Request approval of the agreement with Locum Tenens vendors, with flexibility to add or delete agencies, for supplemental physician staffing of allied health providers for a 4 month term, beginning March 1, 2018 and ending June 30, 2018, for a total expected cost for the term of $660,000.* | | Sharon Schultz |

**NOTE: This meeting is also called and noticed as a meeting of the Board, but shall be conducted as an Administrative and Finance Committee meeting. Members of the Board who are not members of the Committee may attend the entire meeting, but shall not otherwise directly participate or vote on any item. The Committee shall take no final actions, but may make recommendations to be considered at a future meeting of the Board as to any item on the agenda, including information items. All public documents provided to the committee or Board for this meeting including materials related to an item on this agenda and submitted to the Board of Directors within 72 hours prior to this meeting may be reviewed at the District Offices located at 4002 Vista Way, Oceanside, CA 92056 in the office of the Executive Assistant during normal business hours.**

**Note: If you have a disability, please notify us at 760-940-7323 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.**

| | AGENDA ITEM | TIME ALLOTED | PERSON RESPONSIBLE |
|---|---|---|---|
| | d) Physician Recruitment Proposal<br>• Anitha Rajamanickam, M.D.<br>*Motion: Request approval of the expenditure, not to exceed $1,005,000 in order to facilitate this Interventional Cardiology physician practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement (not to exceed a two-year income guarantee with a three-year forgiveness period).* | | Jeremy Raimo |
| 8. | Financials | 10 min. | Ray Rivas |
| 9. | Work Plan | 10 min. | |
| | a) Tri-City Real Estate Holding & Management, LLC *(annual)* | | Ray Rivas |
| | b) Accountable Care Organization (ACO) *(annual)* | | Scott Livingstone |
| | c) Dashboard | | Ray Rivas |
| 10. | Comments by committee members | 2 min. | Chair |
| 11. | Date of next meeting: March 20, 2018 | 2 min. | Chair |
| 12. | Community Member Openings: (0) | 2 min. | Chair |
| 13. | Adjournment | | |
| | Total Budget Time for Meeting | 1 hr. 5 min. | |

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**Tri-City Medical Center**
**Finance, Operations and Planning Committee Minutes**
**January 16, 2018**

| | |
|---|---|
| **Members Present** | Director Julie Nygaard, Director Cyril Kellett, Director Leigh Anne Grass, Dr. Marcus Contardo, Steve Harrington, Wayne Lingenfelter |
| **Non-Voting Members Present:** | Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Carlos Cruz, CCO, Susan Bond, Director-Legal Services |
| **Others:** | Director Laura Mitchell, Colleen Thompson, David Bennett, Brent Wiest, Glen Newhart, Thomas Moore, Mark Albright, Charlene Carty, Sherry Miller, Esther Beverly, Cristina Barrera, Steve Young, Jane Dunmeyer, Candice Parras, Chris Miechowski, Tara Eagle, Debra Fellar, Sharon Schultz, Dr. Scott Worman, Barbara Hainsworth |
| **Members Absent**: | Dr. Gene Ma, Dr. Mark Yamanaka, Dr. Jeffrey Ferber |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 1. Call to order | Director Nygaard called the meeting to order at 12:36 p.m. | | |
| 2. Approval of Agenda | | <u>**MOTION**</u><br>**It was moved by Director Kellett, Director Grass seconded, and it was unanimously approved to accept the agenda of January 16, 2018.** | |
| 3. Comments by members of the public on any item of interest to the public before committee's consideration of the item. | Director Nygaard read the paragraph regarding comments from members of the public. | | Director Nygaard |
| 4. Ratification of minutes of December 7, 2017 | Minutes were ratified. | Minutes were ratified.<br><u>**MOTION**</u><br>**It was moved by Director Kellett, Dr. Contardo seconded, that the minutes of December 7, 2017 are to be approved, with Director Grass abstaining from the vote.** | |
| 5. Old Business | | | |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| 6. New Business | | | |
| a. Introduction of New Committee Member:<br>• Director Leigh Anne Grass | Director Nygaard welcomed Director Grass to the Finance, Operations and Planning Committee. | | Chair |
| 7. Consideration of Consent Calendar: | Mr. Harrington requested that the following items be pulled:<br>**7.b.** Coding Support Services- Contract Increase Proposal for Oxford Global Resources, LLC<br><br>**7.f.** Harris Healthcare (QuadraMed) Software Support Renewal Proposal. | **MOTION**<br>**Director Grass moved to approve the Consent Calendar minus the items pulled. Dr. Contardo seconded the motion.**<br>**Members:**<br>**AYES: Nygaard, Kellett, Grass, Contardo, Harrington, Lingenfelter**<br>**NOES: None**<br>**ABSTAIN: None**<br>**ABSENT: Ma, Yamanaka, Ferber** | |
| a. Policy Review:<br>• Plan to Manage and Estimate Project Cost, #8610-277 | | **Approved via Consent Calendar** | Chris Miechowski |
| b. Coding Support Services – Contract Increase Proposal<br>• Oxford Global Resources, LLC | Colleen Thompson conveyed that this write-up is to request additional funds, as the original expenditure, approved in May 2017, had already been exceeded. She stated that continued outside service support for time sensitive coding/billing is needed, while recruitment continues of qualified coder candidates. She emphasized that the goal is to hire skilled coders, as well as implement a training plan which would assist in staff retention. It was also mentioned that HR is expanding the coder recruitment pool. | **It was moved by Mr. Harrington, seconded by Dr. Contardo to approve the agreement for Coding Support Services – Contract Increase Proposal with Oxford Global Resources, LLC for Coding Support for a term of 12 months, beginning May 1, 2017 and ending April 30, 2018 for an increased cost of $330,000, for a total cost for the term of $630,000.**<br>**Members:**<br>**AYES: Nygaard, Kellett, Grass, Contardo, Harrington, Lingenfelter**<br>**NOES: None**<br>**ABSTAIN: None**<br>**ABSENT: Ma, Yamanaka, Ferber** | Colleen Thompson |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| c. Nova Biomedical Glucometer Contract for Renewal for Point of Care Glucose Testing Proposal | | **Approved via Consent Calendar** | Tara Eagle |
| d. Physician Agreement for MDQA-Peer Review and QAPI Committees<br>• Dr. James L. Johnson (Manta Med) | | **Approved via Consent Calendar** | Sherry Miller |
| e. Copier and Print Management Services Proposal<br>• Vereco, Inc. | | **Approved via Consent Calendar** | Thomas Moore |
| f. Harris Healthcare (QuadraMed) Software Support Renewal Proposal | Mark Albright conveyed that this write-up was for renewal of QuadraMed software support. This agreement provides software support 7-days a week, 24-hours a day and covers break/fix issues, software enhancements and software upgrades. He emphasized this support is critical to ensure system reliability, uptime and prevent potential disruption to cash flow. Discussion ensued. | **It was moved by Dr. Contardo, seconded by Director Kellett to approve the agreement with Harris Healthcare for Affinity Software Support for a term of 24 months, beginning January 1, 2018 and ending December 31, 2019 for an annual cost of $451,697.62 and a total cost for the term of $903,395.24.**<br>**<u>Members:</u>**<br>**AYES: Nygaard, Kellett, Grass, Contardo, Harrington, Lingenfelter**<br>**NOES: None**<br>**ABSTAIN: None**<br>**ABSENT: Ma, Yamanaka, Ferber** | Mark Albright |
| 8. Financials: | Ray Rivas presented the financials ending December 31, 2017 (dollars in thousands)<br>**<u>TCHD – Financial Summary</u>**<br>**<u>Fiscal Year to Date</u>**<br>Operating Revenue $ 178,874<br>Operating Expense $ 185,591<br>EBITDA $ 3,619 | | Ray Rivas |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | EROE $ (4,173)<br>**TCMC – Key Indicators**<br>**Fiscal Year to Date**<br>Avg. Daily Census 170<br>Adjusted Patient Days 55,959<br>Surgery Cases 3,220<br>Deliveries 1,182<br>ED Visits 31,459<br>**TCHD – Financial Summary**<br>**Current Month**<br>Operating Revenue $ 30,355<br>Operating Expense $ 31,177<br>EBITDA $ 908<br>EROE $ (383)<br>**TCMC – Key Indicators**<br>**Current Month**<br>Avg. Daily Census 173<br>Adjusted Patient Days 9,205<br>Surgery Cases 512<br>Deliveries 166<br>ED Visits 5,345<br>**TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year**<br>Net Patient A/R Avg. (in millions) $ 45.7<br>Days in Net A/R Avg. 49.0<br>**Graphs:**<br>• TCMC-Net Days in Patient Accounts Receivable<br>• TCMC-Average Daily Census, Total Hospital-Excluding Newborns<br>• TCMC-Adjusted Patient Days | | |
| 9. Work Plan: | | | |
| a. Wellness Center *(quarterly)* | David Bennett and Wellness Center Manager Brent Wiest went over the | | David Bennett |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | membership statistics for quarters 3 and 4.<br>Brent explained that operational changes have been made, resulting in improved customer satisfaction and enhanced employee morale.<br>He emphasized that communication and interaction with both members and staff has had a very positive effect, and that the energy level at the Wellness Center has improved significantly. He highlighted that the employees are being encouraged to provide concierge level service. In addition, some equipment issues have been resolved, and some modifications have been made to class variety and time schedules.<br>A question was raised about the potential for generating revenue by renting out the Wellness Center conference rooms. Brent conveyed that he had recently established a rental fee schedule, and that one rental had already been scheduled.<br>Director Nygaard conveyed that the timeframe for updates on the Wellness Center will be changed from quarterly to bi-monthly and it was also requested that the revenue and expenses for the Wellness Center be included in these bi-monthly updates. | | |
| b. Construction Report *(quarterly)* | Chris Miechowski briefly went over the Construction Report. Several questions were asked regarding Campus Redevelopment. He | | Chris Miechowski |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
| --- | --- | --- | --- |
| | conveyed that they are very close to beginning work on paving the parking area behind the Security building, which is expected to provide an additional 290 parking stalls. Upon completion of this project there are plans for two other parking areas, one of which will be a multi-level parking structure. Chris emphasized that despite the planned construction, there are no plans to have less than the current number of available parking spaces. | | |
| c. E.D. Throughput *(bi-monthly)* | Candice Parras gave a brief PowerPoint presentation detailing the ongoing efforts of to improve the overall patient flow in the Emergency Department. She conveyed that the arrival to discharge time for the E.D. had been reduced by 51 minutes in 2017. Candice also detailed that there had been numerous changes implemented, which have led to greater patient satisfaction, and a significant reduction in left without being seen (LWBS) patients. She also updated the “No Wall Time” project for paramedic patients. The goal is to get patients brought in by paramedic into a bed in 20 minutes, which enables the ambulance and crew to return to service.<br>Director Nygaard praised Candice Parras and her team for the overall improvements that have been | | Candice Parras |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
| --- | --- | --- | --- |
| | accomplished in the Emergency Department. She also conveyed that due to this progress all future Work Plan updates for this item would be changed from bi-monthly to quarterly. | | |
| d. I.T. Physician Liaison *(semi-annual)* | Mark Albright gave a brief PowerPoint presentation provided by Dr. Worman, reviewing the projects that are currently in process, as well as the strategic priorities of future projects for the full utilization of Information Technology potential. Some discussion ensued. | | Mark Albright |
| e. Crisis Stabilization Unit (CSU) *(bi-monthly)* | Sharon Schultz gave a brief PowerPoint presentation detailing the statistics for the CSU, including the payer mix, the overall admissions volumes and average length of stay, as well as the Medi-Cal admission volumes and average length of stay. Additionally, a slide was included with five bullet points that reflected process improvements for the CSU. She further conveyed that Dr. Ahmed was slated to begin on February 1st, but that he had already begun working.<br>Sharon with confirmation from Candice Parras, described the CSU as extremely busy. Discussion ensued. | | Sharon Schultz |
| f. Institute for Clinical Effectiveness (ICE) *(semi-annual)* | Scott Livingstone on behalf of Jeremy Raimo stated that although there had initially been some interest | | Jeremy Raimo |

| Topic | Discussions, Conclusions Recommendations | Action Recommendations/ Conclusions | Person(s) Responsible |
|---|---|---|---|
| | in this program, the 60 day investing period had elapsed with no packets being returned. Physician feedback reflected that concerns were expressed regarding too low of a distribution, and whether the institute could be designed around a single large metric. Further inquiry into this request would require additional funds to move forward with the initiative, but without sufficient buy-in from prospective investors this institute is currently on hold. | | |
| g. Dashboard | No discussion | | Ray Rivas |
| 10. Comments by committee members | | | |
| 11. Date of next meeting | Tuesday, February 13, 2018 | | Chair |
| 12. Community Openings (0) | | | |
| 13. Adjournment | Meeting adjourned 1:41 p.m. | | |

# Finance, Operations and Planning Committee

## Date of Meeting: February 13, 2018

## Introduction:

## Jeffrey M. Ferber, M.D.

Physician Member

**Tri-City Health Care District**
**Oceanside, California**

**Administrative Policy**
**District Operations**

**7.a.**

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**ISSUE DATE:** 07/92

**SUBJECT:** PRIOR AUTHORIZATIONS FOR NON-EMERGENCY SERVICES FOR HMO/PPO PATIENTS

**REVISION DATE(S):** 07/94, 06/01, 10/05, 11/08, 09/10, 01/11

**POLICY NUMBER:** 8610-213

| | |
|---|---|
| **Department Review:** | **01/18** |
| **Administrative Policies & Procedures Committee Approval:** | **~~06/14~~01/18** |
| **Finance & Operations Committee Approval:** | **02/15** |
| **Board of Directors Approval:** | **02/15** |

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A. **PURPOSE:**
1. To set forth guidelines to ensure Tri-City Healthcare District's (TCHD) control and compliance with the utilization policies of Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) pay~~o~~ers and to reduce the number of denied services due to the lack of required authorization.
2. It is the intention of this policy to ensure prior-authorization is received from all pay~~o~~ers for all services performed at ~~Tri-City Medical Center~~TCHD.

B. **PROCEDURE:**
1. The Director or designee of each department that schedules non-emergency services which require prior authorization from either the HMO/PPO or physician groups will ensure that said services shall not be scheduled prior to receipt of an authorization number either by telephone, fax, or mail.
   a. In the event that a physician, physician's office, patient, patient's family, HMO/PPO staff or any other party or agent requests to be scheduled for a service that requires prior authorization but can~~-~~not provide the authorization number, he/she shall be referred to the referral specialist's office or to the patient's primary care physician.
      i. If a patient who presents for a scheduled service and ~~Tri-City Healthcare District~~TCHD does not have a record of the required authorization number, then the patient's service will be postponed until said authorization is obtained.
      ii. The Access Management Manager, Supervisor or designee will phone physician's office to inform them of the information.
      ~~ii.~~iii. The Patient Access Director/Manager or designee can approve the scheduling of a procedure with a pending authorization based on patient's condition and service.

C. **CLARIFICATION:**
1. For clarification of this policy, contact the ~~Tri-City Healthcare District~~TCHD's Main Registration, extension 3151. ~~Department of Managed Care, ext. 3376.~~

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations



ISSUE DATE: 10/96

SUBJECT: AUDITS FOR THIRD PARTY INSURANCE

REVISION DATE: 10/99, 08/02, 12/02, 12/03, 11/08, 09/10

POLICY NUMBER: 8610-255

| | |
|---|---|
| Department Review: | 01/18 |
| Administrative Policies & Procedures Committee Approval: | ~~02/15~~01/18 |
| Finance & Operations Committee Approval: | 03/15 |
| Board of Directors Approval: | 03/15 |

A. **PURPOSE:**

1. Cooperate with reasonable third-party payor audits performed in accordance with the provisions set forth herein.

B. **POLICY:**

1. To ensure all medical billing audits are performed efficiently and effectively, thereby, promoting the accuracy and integrity of hospital charges. ~~A comprehensive medical billing audit program will serve to:~~

C. **PROCEDURE:**

1. General Information:
    a. The scope of a medical billing audit is limited to verifying that charges on the detailed hospital bill are accurate, represent services rendered to the patient, and are ordered by a physician. However, services or items may be provided based upon standard hospital practices and/or Nursing protocols and procedures.
    b. The audit does not assess the "reasonableness" of the charges, or medical necessity related to patient bills. A review of medical necessity for the services provided may be performed, but the billing audit process does not encompass these tasks.
    c. Documentation: In concert with the position taken by the American Hospital Association's (AHA) publication, Billing Audit Guidelines (1992), the hospital does not attempt to make the patient's Medical Record a duplicate bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by nursing protocol and/or standard hospital practices, which are not reflected in the Medical Records. Furthermore, Ancillary departments may have information or documentation not contained in the Medical Record that may be used to substantiate charges. In a business relationship, the hospital will act in good faith during the course of all transactions involving a patient's account, and the same is expected of all outside parties acting on behalf of the patient.
2. Hospital Auditor Responsibilities:
    a. The hospital will designate an individual to be responsible for coordinating all medical billing audit activities (i.e., Patient Account Auditor; hereafter referred to as Chart Auditor). Medical billing audit activities are prompted via both internal and external processes, and include concurrent, focus, miscellaneous, patient request, and insurance defense audit types. In addition to coordinating all internal audit activities, (i.e., concurrent, focus, and miscellaneous audits)~~,~~ the Chart Auditor will serve as the primary liaison between the hospital and all outside parties requesting patient account audits. All medical billing audit activities are to be documented and logs maintained within the

hospital. All audit-related account adjustments are to be processed only after appropriate facility-level sign off approval has been obtained. All audit related account adjustments are to be signed and dated by the requestor. Principles related to segregation of duties dictate that audit-related account adjustments shall not be processed by the requestor. All audit-related account adjustment documents are to be maintained in accordance with applicable hospital record retention policies.

3. Third-Party Pay~~o~~er (Insurance Defense) Audits:
   a. Tri-City ~~Medical Center~~Healthcare District (TCHD) will have a Chart Auditor on staff or a person assigned the responsibility to properly conduct third-party pay~~o~~er (insurance defense) audits. This person will serve as the primary liaison between the hospital and any outside audit party. Direct contact by the pay~~o~~er/outside audit parties with department heads is strictly prohibited. All questions regarding clarification of charging practices and protocols are to be directed to the Chart Auditor to prevent disruption of the normal flow of operation within the hospital.
   b. The hospital Chart Auditor must have a current Charge Description Master (CDM) in order to provide accurate billing to the Third-Party Auditor. He/she will submit all audit adjustments to the Chart Auditor at the conclusion of the audit.
   c. Third-party pay~~o~~er (Insurance Defense) audits of patient accounts will be conducted in accordance with all policies and procedures set forth herein. The costs incurred, and utilization of resources imposed on the hospital in connection with such audits, must not be unduly borne by other patients. Therefore, these policies and procedures, along with associated fees and requirements, will be strictly enforced so that all reasonable audits can be performed efficiently. Involved parties must be aware that specific managed care contract language which references audit procedures is legally binding for the duration of the contract.
   d. Third-party pay~~o~~er audits are not a forum for addressing questions concerning the level or scope of care, medical necessity, or the pricing structure of items or services delivered by the hospital. Qualified personnel and mechanisms exist to deal with these issues outside the scope of the medical billing audit process~~,~~ and, therefore, will not be considered during the course of the audit.

4. Written Notice of Intent To Audit:
   a. Any intent to audit an account requires written notice from the outside audit party to the hospital Chart Auditor within four months of patient discharge. Under no circumstances will telephone contact alone be sufficient means to initiate the audit process.
      i. The written notice must state the reason the claim was selected for audit and must contain the following information:
         1. Name of patient
         2. Patient account number
         3. Dates of service
         4. Name of insurance carrier requesting an audit
         5. Name of firm and name of person, if known, who will perform the audit
         6. Total charges to be audited
      ii. Written notice of intent to audit will not be considered if received more than four months after patient discharge. The onsite audit must be scheduled and completed within sixty (60) days of receipt of intent to audit. These guidelines are to be used for all external entities, unless there is a signed contract in place that has language specific to the audit process, and then the contract will supersede the audit policy.
      iii. Audits requested by Third-Party Audit Company representatives on behalf of an insurance carrier will not be scheduled or conducted until the hospital Chart Auditor is in receipt of a signed and dated copy of the Business Associate Contract between the insurance carrier and the Third-Party Audit Company. Auditors who contractually represent Third-Party Audit Companies must provide

written proof of their contractual relationship before an audit will be scheduled or conducted.

iv. All audits must be conducted on site. The hospital's Chart Auditor must ensure that only the portion of the Medical Record that applies to the account being audited is provided for onsite review. Under no circumstances is any portion of a patient's Medical Record to be provided to, reviewed, or considered by Third-Party Audit personnel unless a contrary audit procedure (a) is expressly set forth in the managed care contract that applies to the account, or (b) is required by applicable federal, state, or local law. The Third-Party Audit personnel shall be required to furnish to the Chart Auditor written evidence proving that the exceptions referred to in the previous clauses (a) and (b) ~~of the previous sentence~~ apply to the account under audit, or such exceptions shall not apply to the audit. A complete Medical Record may not be copied for the purpose of offsite reviews.

v. A single account may not be audited by a third party more than once. Any additional third-party requests for an audit will be denied. The findings of the first audit will be used as the results for any additionally requested audits.

vi. It is hospital policy to allow no offsite audits. All audits are conducted on site under the direction and coordination of the hospital Chart Auditor.

b. Account Status Requirements:
   i. Payment of 100% of policy benefits must be received prior to scheduling the audit.
   ii. The Medical Record must be complete prior to conducting the audit.
   iii. Audits will not be performed on interim bill claims.

c. Audit Fees:
   i. An auditing fee is required by the hospital if an internal audit of the account has previously been performed. The minimum audit fee of $1,000.00 must be received prior to, or upon commencement of the onsite audit, irrespective of any pre-audit payment of policy benefits.

d. Disclosure Authorization:
   i. Specific state regulations determine procedures for release of records containing sensitive information. Consult Medical Records' policy for handling of these records.

e. Pre-Audit Procedure:
   i. The hospital should respond to the written notice of intent to audit by supplying the Third-Party Auditor with a written copy of the ~~Tri-City Medical Center~~TCHD Third-Party Audit Policy Statement ~~(refer to Exhibit A)~~.
   ii. A log must be maintained by the hospital documenting dates and recipients of all audit policies sent to outside parties.
   iii. Onsite audits are not to be scheduled until the hospital receives written acknowledgement that the Third-Party Auditor agrees to abide by the ~~Tri-City Medical Center~~TCHD Third-Party Audit Policy Statement.
   iv. All requests by Third-Party Auditors to reschedule or cancel a previously scheduled audit must be received prior to the date of the audit. All such requests must be made in writing exclusively through the hospital Chart Auditor and are subject to a minimum re-schedule fee of $150.00. This fee may be charged to the carrier or its agent if notice is not received within ten days of the originally scheduled audit date. An audit may be rescheduled only once.
   v. Should the auditor fail to appear as scheduled, the audit may not be re-scheduled.

f. Audit Process:
   i. All accounts, without exception, are to be pre-audited in their entirety by the hospital Chart Auditor prior to the date of the scheduled audit.

ii. To document the audit, an itemization of under and overcharges must be individually completed by both auditors and signed at the conclusion of the audit. All parties will agree to recognize, record, and present any identified unsupported or unbilled charges.

iii. An onsite exit conference will be conducted at the conclusion of each audit. Once both parties agree, in writing, to the audit findings, audit results are final.

iv. A final written report of the audit findings is to be submitted to the hospital by the Third-Party Auditor within ten (10) business days of the exit conference.

v. Both unbilled (undercharges) and unsupported (overcharges) charges must be provided in the final report. These results must be detailed by description and price, and summarized by department.

vi. Upon receipt of the written report, the hospital will advise the payor whether the results are accepted or will be contested.

vii. If necessary, the hospital will submit an additional bill that itemizes previously unbilled charges identified in the audit.

viii. Charges submitted to the Chart Auditor are required to be itemized by line item. The Business Office is to be notified of the date the audit was completed and the total adjustment to the bill.

ix. If indicated, a net refund or adjustment of charges will be completed by the Business Office within the regular course of business.

g. Personal/Non-Covered/Unbillable Items:

i. Some charges may be considered personal, non-covered, or unbillable pursuant to the terms and conditions of a particular contract between the payor and the hospital. If identified as such via specific current contract language, these items are to be listed separately from the audit and not included in stated overcharges. Under no circumstances is it acceptable to apply government regulations/methodologies to non-government accounts, unless so stipulated by contract.

## D. RELATED DOCUMENT(S):

ii. 1. Third-Party Audit Policy Statement

## E. REFERENCE(S):

iii. 1. American Hospital Association's (AHA) publication, Billing Audit Guidelines (1992)

Third-Party Audit Policy StatementExhibit A: - **Sample**

**TRI-CITY MEDICAL CENTERTHIRD-PARTY AUDIT POLICY STATEMENT**

The hospital wishes to cooperate with any commercial audits of patient accounts that are reasonable and that are performed in accordance with the provisions set forth herein. These policies and procedures, along with the associated fees and charges, are necessary so all audits can be performed efficiently, and the costs imposed on the hospital, in connection with such audits, will not be unduly borne by other patients.

In concert with the position taken by the AHA, the hospital does not attempt to make the patient's Medical Record a duplicate patient bill. Rather, the purpose of the Medical Record is to reflect clinical data on diagnosis, treatment, and outcome. Charges on patient bills may be substantiated by Nursing protocol and/or standard hospital practices, which are not reflected in the Medical Records. Furthermore, Ancillary departments may have information or documentation not contained in the Medical Record that can be used to substantiate charges. Moreover, questions regarding scope of care or medical necessity and/or issues relating to the cost of particular items or services are, as defined by the joint guidelines for billing audits, inappropriate in the forum of a charge audit.

**POLICY DESCRIPTION**

Policy 1

1. The hospital requires written notice of intent to audit be received within four months from the date of the discharge bill. Audit requests received after four months from the discharge bill will not be considered. Onsite audits are to be scheduled and completed within 60 days of receipt of intent to audit.

Policy 2

2. Written notice must state the reason for audit, and identify name of patient, account number, dates of service, carrier requesting audit, name of firm and name of person, if known, who will perform the audit, and total charges to be audited.

Policy 3

3. Audits requested by Third-Party Audit Company representatives on behalf of an insurance carrier will not be scheduled or conducted until the hospital Chart Auditor is in receipt of a signed and dated copy of the Business Associate Contract between the insurance carrier and the Third-Party Audit Company. Auditors who contractually represent Third-Party Audit Companies must provide written proof of their contractual relationship before an audit will be scheduled or conducted.

Policy 4

4. Upon receipt of written notice, the hospital will respond by sending the TRI-CITY MEDICAL CENTER Third-Party Audit Policy Statement. Audits will not be scheduled until the hospital receives written acknowledgement that the Third-Party Auditor agrees to abide by the policy.

Policy 5

5. All audits will be conducted on site. Offsite reviews of photocopied records are unacceptable. Under no circumstances is any portion of a patient's Medical Record that does not pertain to the dates of service for the account being audited to be provided to, reviewed, or considered by the Third-Party Audit personnel unless a contrary audit procedure (a) is expressly set forth in the managed care contract that applies to the account, or (b) is required by applicable federal, state, or local law. The Third-Party Audit personnel shall be required to furnish to the Chart Auditor written evidence proving that the exceptions referred to in clauses (a) and (b) of the previous sentence apply to the account under audit, or such exceptions shall not apply to the audit.

Policy 6

6. A single account may not be audited by a third party more than once. Any additional third-party requests for audit will be denied. The findings of the first audit will be used as the results for any additionally requested audits.

Policy 7

7. Tri-City Medical Center personnel will provide copies of the discharge bill. All requests for itemized statements and UB-04's will be approved.

Policy 8

8. The Medical Record must be complete prior to conducting the audit. Payment of 100 % of policy benefits must be received prior to scheduling the audit. Audits will not be performed on interim bill claims.

~~Policy 9~~

9. Audit fees will be imposed in the absence of pre-audit payment of policy benefits. A minimum fee of $1,000.00 is required on any account previously audited internally. This fee is irrespective of any pre-audit payment of policy benefits.

~~Policy 10~~

10. All requests by Third-Party Auditors to reschedule or cancel a previously scheduled audit must be received prior to the date of the audit. All such requests must be made in writing exclusively through the hospital Chart Auditor and are subject to a minimum re-schedule fee of $150.00. This fee may be charged to the carrier or its agent if notice is not received within days of the originally scheduled audit date. An audit may be rescheduled only once. No-shows will not be rescheduled.

~~Policy 11~~

11. Third-Party Auditors will report to the hospital Chart Auditor upon arrival at the facility. To prevent disruption of hospital operations, Third-Party Auditors are prohibited from making direct contact with hospital department personnel. All questions regarding clarification of charging practices and/or protocols are to be directed exclusively to the hospital Chart Auditor.

~~Policy 12~~

12. An itemization of under and overcharges must be individually completed by both auditors and signed at the conclusion of the audit. All parties will agree to recognize, record, and present any identified unsupported or unbilled charges.

~~Policy 13~~

13. An onsite exit conference will be conducted at the conclusion of each audit. Once both parties agree, in writing, to the audit findings, audit results are final. A final written report of the audit findings is to be submitted to the hospital by the Third-Party Auditor within ten business days of the exit conference. Both unbilled (undercharges) and unsupported (overcharges) charges must be provided in the final report.

~~Policy 14~~

14. Upon receipt of the written report, the hospital will advise the payor whether the results are accepted or will be contested.

~~Policy 15~~

15. If necessary, the hospital will submit an additional bill that itemizes previously unbilled charges identified in the audit. If indicated, a net refund or adjustment of charges will be completed by the hospital Business Office within the regular course of business.

~~Policy 16~~

16. Some charges may be considered personal, non-covered, or unbillable pursuant to the terms and conditions of a particular contract between the payor and the hospital. If identified as such via specific current contract language, these items are to be listed separately from the audit and not included in stated overcharges. Under no circumstances is it acceptable to apply government regulations/methodologies to non-government accounts, unless so stipulated by contract.

**Tri-City Health Care District**
**Oceanside, California**

**Administrative Policy**
**District Operations**

**7.a.**

**ISSUE DATE:** 04/99

**SUBJECT:** MEDI-CAL TREATMENT AUTHORIZATION REQUEST (TAR) REQUIREMENTS

**REVISION DATE(S):** 05/03, 01/06, 09/10, 01/11

**POLICY NUMBER:** 8610-268

| | |
|---|---|
| **Department Review:** | 01/18 |
| **Administrative Policies & Procedures Committee Approval:** | ~~02/15~~01/18 |
| **Finance & Operations Committee Approval:** | 03/15 |
| **Board of Directors Approval:** | 03/15 |

A. **PURPOSE:**
1. To ensure the appropriate approved Treatment Authorization Request (TAR) has been received for all Medi-Cal admissions.

B. **DEFINITION(S):**
1. Medi-Cal Pending Patients: Patients who have applied to California Department of Public Health (CDPH) for assistance and have not been approved. These patients are considered cash paying and the hospital's deposit/payment policies apply.
2. Medi-Cal Eligible Patients: Patients who have provided valid proof of eligibility by way of a CDPH 1410 form and/or verification on the Medi-Cal Point of Service (POS) Online website (eTAR).
3. Approved TAR: A treatment authorization request, which has been submitted by the physician's office and has been approved by the field office. An approved TAR is required in advance of all elective and urgent procedures.

C. **POLICY:**
1. All Medi-Cal approved elective admissions or procedures requiring a TAR will have one obtained by the treating physician's office prior to the scheduled date of service.
2. Registration will follow the usual procedures for admission ensuring that the approved TAR has been received. Case Management and Registration will coordinate any questionable admissions to insure TARs are appropriate and timely.
3. It will be the responsibility of the Registration Department to notify Surgical Services of any change. Surgery Scheduling informs the physician's office a TAR is required prior to the services being rendered and if TAR is not received within 48 hours of the scheduled time the case will be rescheduled.
4. If Medi-Cal TAR is approved with a share of cost:
    a. Registration is responsible for verifying a patient's share of cost has been met. If the share of cost has not been met, Registration shall request payment in full or contact the in-house Preadmitter to make appropriate payment arrangements with the patient. In accordance with hospital policy, payment arrangements will not extend beyond a six month period.
    b. Medi-Cal pending admits will be handled as cash. The hospital policy regarding deposits and payment apply. Med Assist will, as needed, screen patients and continue to follow up to secure applications and/or ensure eligibility.

D. **PROCESS:**
1. Case Management will perform initial clinical review utilizing InterQual Criteria at Hospital points

of entry (ED, Procedural Areas etc) and Case Management will contact the admitting / treating physician to discuss the case to determine appropriate level of care: Inpatient or Observation level of care.

2. Case Management - performs concurrent daily clinical review for Managed Medi-Cal – (Molina, CHG for example and APRDRG clinical review for standard Medi-Cal beneficiaries)
   a. Case Manager's clinical reviews are documented in Allscripts under "TAR (Medi-Cal) REVIEW"
   b. Registration Staff presents the "TAR (Medi-Cal) REVIEW" Case Management with the E-TAR
3. Case Management will facilitate communication with treating physician to clarify any issues surrounding appropriate level of care (Inpatient versus Observation versus 10-Bed-Call) and obtain appropriate physician orders.
4. Case Management will facilitate communication with UM Medical Director for issues regarding medical necessity and to coordinate MD to MD communication
5. Registration is responsible for notifying Surgical Services of any changes.

## E. REFERENCE(S):

~~5.~~ 1. California Code of Regulations (CCR), Title 22, the Department of Health Care Services (DHCS), Medi-Cal Form 50-1 Treatment Authorization Request (TAR) http://www.dhcs.ca.gov/provgovpart/Pages/TAR.aspx

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: February 13, 2018**
**Managed Resources, Inc. Proposal**

| **Type of Agreement** | | Medical Directors | | Panel | | Other: |
|---|---|---|---|---|---|---|
| **Status of Agreement** | | New Agreement | X | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** Managed Resources Inc. (MRI)

**Area of Service:** Clinical and Coding Appeal Services for Revenue Cycle

**Term of Agreement:** 24 months, Beginning, February 25, 2018 – Ending, February 29, 2020

**Maximum Totals:**

| Expected Monthly Cost | Expected Annual Cost | Expected Total Term Cost |
|---|---|---|
| $12,902 | $154,824 | $309,648 |

**Description of Services/Supplies:**

- MRI will review, at the direction of TCMC, encounters that have received a letter of denial from any carrier. Denials may be for any reason, including coding, admission or continued stay criteria.
- MRI will provide a team approach when reviewing combination denials. A Certified Coder will review and respond to coding denials. A Registered Nurse will review and respond to the clinical denials.
- MRI will send out an appeal letter on behalf of TCMC to address and appeal the denial.
- If additional levels of appeal are required, MRI will discuss available options with TCMC.
- MRI provides comprehensive reports to assist prospective prevention.
- MRI presents appeal results at a quarterly leadership meeting while also providing onsite education and recommendations to reduce denials.

| | | | | |
|---|---|---|---|---|
| Document Submitted to Legal for Review: | X | Yes | | No |
| Approved by Chief Compliance Officer: | X | Yes | | No |
| Is Agreement a Regulatory Requirement: | | Yes | X | No |
| Budgeted Item: | X | Yes | | No |

**Person responsible for oversight of agreement:** Joni Penix, Director, Patient Financial Services / Ray Rivas, Chief Financial Officer

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Managed Resources, Inc. for Clinical Appeals for a term of 24 months, beginning February 25, 2018 and ending February 29, 2020 for an annual expected cost of $154,824, and a total expected cost for the term of $309,648.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: February 13, 2018**
**Locum Tenens Contracts for Crisis Stabilization Unit (CSU)**

| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Amendment |
|---|---|---|---|---|---|---|
| **Status of Agreement** | | New Agreement | X | Renewal – New Rates | | Renewal – Same Rates |

**Vendor's Name:** Locum Tenens Vendors (Nurse Practitioners/Physician Assistants)

**Area of Service:** Crisis Stabilization Unit (CSU)

**Term of Agreement:** 4 months, Beginning, March 1, 2018 – Ending, June 30, 2018

**Maximum Totals:**

| Average Monthly Cost | Expected Term Cost |
|---|---|
| $165,000 | $660,000 |

**Description of Services/Supplies:**

- Estimate is based on current and anticipated usage of locum tenens.
- Two per diem nurse practitioners have been hired but can only work weekends; difficult to retain as employees.
- Rates range from $235-315/hr., depending on the shift and any overtime.
- Working with UCSD on a contract they will have for Telemedicine to cover nights and weekends.
- Intent is to keep current TCMC per diem nurse practitioners on contract for emergencies.

| Document Submitted to Legal: | X | Yes | | No |
|---|---|---|---|---|
| Approved by Chief Compliance Officer: | N/A | Yes | | No |
| Is Agreement a Regulatory Requirement: *(Per San Diego County Contract)* | X | Yes | | No |
| Budgeted Item: | | Yes | X | No |

**Person responsible for oversight of agreement:** Candice Parras, Director, Crisis Stabilization Unit & Emergency Department / Sharon Schultz, Chief Nurse Executive

**Motion:**

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Locum Tenens vendors, with flexibility to add or delete agencies, for supplemental physician staffing of allied health providers for a 4 month term, beginning March 1, 2018 and ending June 30, 2018, for a total expected cost for the term of $660,000.

**FINANCE, OPERATIONS & PLANNING COMMITTEE**
**DATE OF MEETING: February 13, 2018**
**Physician Recruitment Proposal**

| **Type of Agreement** | | Medical Directors | | Panel | X | Other: Recruitment Agreement |
|---|---|---|---|---|---|---|
| **Status of Agreement** | X | New Agreement | | Renewal-New Rates | | Renewal – Same Rates |

**Physician Name:** Anitha Rajamanickam, M.D.
**Areas of Service:** Interventional Cardiology

**Key Terms of Agreement:**

- Effective Date: July 1, 2018 or the date Dr. Rajamanickam becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff
- Community Need: TCHD Physician Needs Assessment shows significant community need for Interventional Cardiology
- Service Area: Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients
- Income Guarantee: $495,000 annually ($990,000 for two-years with a three-year forgiveness period)
- Sign-on Bonus: $15,000
- Relocation: $5,000 (Not part of the Loan)
- Total Not to Exceed: $1,005,000 (Loan Amount)

**Requirements:**

**Business Pro Forma**: Must submit a two-year business pro forma for TCHD approval relating to the addition of this physician to the medical practice, including proposed incremental expenses and income. TCHD may suspend or terminate income guarantee payments if operations deviate more than 20% from the approved pro forma and are not addressed as per agreement.

**Expenses:** The agreement specifies categories of allowable professional expenses (expenses associated with the operation of physician's practice and approved at the sole discretion of TCHD) such as billing, rent, medical and office supplies, etc. If the incremental monthly expenses exceed the maximum, the excess amount will not be included.

| Document Submitted to Legal: | X | Yes | | No |
|---|---|---|---|---|
| Approved by Chief Compliance Officer: | X | Yes | | No |
| Is Agreement a Regulatory Requirement: | | Yes | X | No |
| Budgeted Item: | X | Yes | | No |

**Person responsible for oversight of agreement:** Jeremy Raimo, Sr. Director Business Development / Steve Dietlin, Chief Executive Officer

**Motion:**

I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure, not to exceed $1,005,000 in order to facilitate this Interventional Cardiology physician practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement (not to exceed a two-year income guarantee with a three-year forgiveness period).

# Finance, Operations and Planning Work Plan
## Program Tracking Schedule
## FY2018
**February 13, 2018**

| | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb 2017 | Mar | Apr | May | June | Responsible Party |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Wellness Center *(Bi-Monthly)*, (Since 2009) (Changed from quarterly to bi-monthly, January 2018) | ● | | ● | | ● | | ● | | ● | | ● | | David Bennett |
| Physician Recruitment Tracking *(Annual)*, (Since 2009) | | | | | | | | | | | | ● | Jeremy Raimo |
| Tri-City Real Estate Holding and Management LLC *(Annual)*, (Since 2011) | | | | | | | | ● | | | | | Ray Rivas |
| Finance, Operations and Planning Charter, *(Annual)* | | | | | | | | | | 2020 ● | | | Chair |
| Construction Report, *(Quarterly)* | ● | | | ● | | | ● | | | ● | | | Scott Livingstone |
| Accountable Care Organization (ACO) *(Annual)*, (Since 2013) | | | | | | | | ● | | | | | Scott Livingstone |
| Infusion Center, *(Annual)* (Report quarterly until Oct. 2015 then annual) | | | | ● | | | | | | | | | Sharon Schultz |
| ED Throughput, *(Quarterly)* (Changed from bi-monthly to quarterly, January 2018) | ● | | | ● | | | ● | | | ● | | | Candice Parras |

| | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb 2017 | Mar | April | May | June | Responsible Party |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dashboard | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | Ray Rivas |
| Meaningful Use, *(Semi-Annual)* (Begin reporting September 2015 for one year then semi-annually) | | | ● | | | | | | ● | | | | Mark Albright |
| Medical Director – Surgery *(Quarterly)* (Began reporting in July 2015) | | | | ● | | | | | | ● | | | Debra Feller / Mary Diamond |
| IT Physician Liaison *(Semi-Annual)* (Began reporting in July 2016) | ● | | | | | | ● | | | | | | Mark Albright |
| Institutes Update *(Annual)*: • Cardiovascular • Neuroscience • Orthopaedic (Added August 2016, began reporting August 2017) | | ● | | | | | | | | | | | Jeremy Raimo |
| PRIME Update *(Annual)*: (Timeline pending for update) | | | | | | | | | | | | | Scott Livingstone |
| Crisis Stabilization Unit (CSU) Update *(Bi-Monthly)*: (Changed from semi-annual to bi-monthly, December 2017) (Added January 2017, begin reporting July 2017) | ● | | ● | | ● | | ● | | ● | | ● | | Sharon Schultz |
| Institute for Clinical Effectiveness *(Semi-Annual)*: (Added July 2017, ~~begin reporting January 2018~~) Timeline pending | | | | | | | | | | | | | Jeremy Raimo |

**Tri-City Real Estate Holding & Management, LLC:**

February 13, 2018

- Ray Rivas to provide verbal update

# Accountable Care Organization, (ACO):

February 13, 2018

- Scott Livingstone to provide verbal update

# Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

## Financial Information

TCMC Days in Accounts Receivable (A/R)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD Avg | Goal Range |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY18 | 47.7 | 47.8 | 48.9 | 50.8 | 49.6 | 49.5 | 49.8 | | | | | | 49.1 | 48-52 |
| FY17 | 51.2 | 50.2 | 48.7 | 50.5 | 49.6 | 50.5 | 48.9 | 49.0 | 48.8 | 49.4 | 48.1 | 46.5 | 49.9 | |

TCMC Days in Accounts Payable (A/P)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD Avg | Goal Range |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY18 | 82.1 | 79.1 | 78.8 | 83.4 | 87.7 | 81.3 | 82.9 | | | | | | 82.2 | 75-100 |
| FY17 | 78.9 | 81.6 | 86.5 | 88.1 | 91.6 | 87.9 | 84.6 | 79.9 | 74.6 | 79.9 | 81.5 | 81.9 | 85.6 | |

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY18 | ($394) | ($429) | ($224) | ($171) | ($2,571) | ($383) | ($1,242) | | | | | | ($5,415) | ($1,246) |
| FY17 | $288 | $211 | $746 | $1,118 | $414 | $317 | ($226) | $181 | ($2,912) | ($63) | $296 | $1,510 | $2,869 | |

TCHD EROE % of Total Operating Revenue

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY18 | -1.33% | -1.39% | -0.76% | -0.55% | -9.47% | -1.26% | -3.94% | | | | | | -2.57% | -0.59% |
| FY17 | 1.04% | 0.75% | 2.69% | 3.99% | 1.51% | 1.15% | -0.79% | 0.67% | -9.92% | -0.22% | 0.99% | 5.04% | 1.47% | |

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

# Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY18 | $898 | $864 | $1,091 | $1,146 | ($1,288) | $908 | $81 | | | | | | $3,700 | $8,039 |
| FY17 | $1,583 | $1,496 | $2,015 | $2,365 | $1,711 | $1,556 | $1,010 | $1,428 | ($1,630) | $1,213 | $1,558 | $2,741 | $11,735 | |

TCHD EBITDA % of Total Operating Revenue

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY18 | 3.03% | 2.80% | 3.69% | 3.66% | -4.74% | 2.99% | 0.26% | | | | | | 1.76% | 3.79% |
| FY17 | 5.70% | 5.32% | 7.27% | 8.43% | 6.27% | 5.64% | 3.52% | 5.28% | -5.55% | 4.23% | 5.21% | 9.16% | 6.01% | |

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | C/M YTD | C/M YTD Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY18 | 6.51 | 5.92 | 6.90 | 6.26 | 6.50 | 6.43 | 5.95 | | | | | | 6.33 | 6.28 |
| FY17 | 6.04 | 5.84 | 5.74 | 5.85 | 6.43 | 6.16 | 6.26 | 6.14 | 6.25 | 6.30 | 6.18 | 6.56 | 6.04 | |

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY18 | $58.5 | $49.8 | $42.3 | $48.2 | $58.6 | $54.5 | $54.7 | | | | | | |
| FY17 | $29.1 | $29.4 | $26.8 | $18.9 | $23.0 | $25.9 | $35.7 | $34.6 | $73.6 | $74.3 | $77.9 | $64.0 | |