



STATE OF ILLINOIS  
**HEALTH FACILITIES AND SERVICES REVIEW BOARD**

525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 • (217) 782-3516 FAX: (217) 785-4111

<b>DOCKET ITEM NUMBER:</b> E-02	<b>BOARD MEETING:</b> June 4, 2019	<b>PROJECT NUMBER:</b> NA
<b>BUSINESS ITEM:</b> Declaratory Ruling Request		
<b>REQUESTING ENTITY:</b> Cook County Health and Hospital Systems - <b>Provident and John H. Stroger Hospitals</b>		

**STATE BOARD STAFF REPORT**  
**DECLARATORY RULING REQUEST**

**I. Request for Declaratory Ruling**

Cook County Health and Hospital Systems (operator of Provident and John H. Stroger Hospitals) requests a Declaratory Ruling from the State Board. Specifically, they are petitioning the State Board to adjust its Inventory of Health Care Facilities and Services and Need Determination (“Inventory”) regarding Provident Hospitals’ Inpatients and Outpatients Served by Payor Source (CY 2014 - CY 2017): Inpatient and Outpatient Net Revenue by Payor Source (CY 2014 - CY 2017): and the Outpatient Service Data (CY 2015, CY 2016 and CY 2017). With respect to John H. Stroger Hospital Cook County requests a change to the Inpatients and Outpatients Served by Payor Source (CY 2014- CY 2017) and Inpatient and Outpatient Net Revenue by Payor Source (CY 2014-CY 2017).

**II. Hospitals**

Provident and John H. Stroger Hospitals are in the HSA VI Health Service Area which is the City of Chicago. Provident Hospital is an 85-bed acute care hospital and Stroger Hospital is a 450-bed acute care hospital with a Level I Trauma Center.

**III. Applicable Statute and Rules**

The following Sections of the Act are applicable to this declaratory ruling request:

Section 12(4) states:

*“For the purposes of this Act, the State Board shall exercise the following powers and duties:*

*“Develop criteria and standards for health care facilities planning, conduct statewide inventories of health care facilities, and develop health care facility plans which shall be utilized in the review of applications for permit under this Act.”*

Section 13 states:

*“The State Board shall require all health facilities operating in this State to provide such reasonable reports at such times and containing such information as is needed by it to carry out the purposes and provisions of this Act.”*

The following administrative rules are applicable to this declaratory ruling request:

77 IAC 1100.60 requires all health care facilities operating in Illinois to provide data needed for planning.

77 IAC 1100.70 states that the State Board, in conjunction with the IDPH, will publish data appendices.

77 IAC 1110.1540(d) specifies the State Board’s utilization standard for operating rooms.

77 IAC 1130.810 (Declaratory Rulings) states:

“The State Board shall render determinations on various matters relating to permits and the applicability of the statute and regulations. Request for determination shall be made in writing . . . The following matters shall be subject to declaratory rulings by the State Board:

- b) corrections to the facility inventories utilized by the State Board; . . .

Additionally, pursuant to Section 5-150 of the Illinois Administrative Procedure Act, decisions rendered by the State Board in relation to a declaratory ruling request are final and not subject to appeal.

#### **IV. Request Details**

On May 14, 2019, the State Board Staff received a letter from the Cook County Health and Hospitals System (“CCHHS”) requesting corrections to the 2014-2017 Hospital Profiles for Provident and John H. Stroger Hospitals.

##### **1. Provident Hospital**

CCHHS requests changes to Provident Hospitals’ Inpatients and Outpatients Served by Payor Source for calendar years 2014–2017, Inpatient and Outpatient Net Revenue by Payor Source for calendar years 2014 - CY 2017, and the Outpatient Service Data for calendar years 2015, 2016 and 2017.

a. Outpatient Service Data

Changes of the outpatient service data requires the removal of outpatient visit off campus and recording the total outpatient visits as ALL on campus. Provident Hospital provides outpatient services to its patients through the John Sengstacke Health Center. This Center is housed and operated inside of Provident Hospital. All other CCHHS outpatient services are operated under John H. Stroger Hospital. Therefore, there are no "offsite/off campus" outpatient visits for Provident Hospital. CY 2014 outpatient visits were reported correctly. The changes are reflected in the Table below.

**TABLE ONE**  
**Provident Hospital**  
**Original Submittal**

	2015	2016	2017
Total Outpatient Visits	87,398	62,003	106,221
Hospital Campus	49,115	28,856	50,066
Off Campus	38,283	33,147	56,155
<b>Corrected</b>			
Total Outpatient Visits	87,398	62,003	106,221
Hospital Campus	87,398	62,003	106,221
Off Campus	0	0	0

b. Payor Source

The reason for the errors for the Inpatients and Outpatients served by Payor Source and the Inpatient and Outpatient Net Revenue by Payor Source was the result of:

1. Information for 2014 and 2015 being in error because CCHHS's audited financial statements had not been completed when the data was submitted.
2. Information for 2016 and 2017 being in error based on the omittance of certain operating revenue (such as capitation revenue)
3. The corrected data is based upon audited data for 2014-2017. Charity care expense corresponds to the State Board's definition and CCHHS's own financial assistance policies.

As can be seen in Table on the next page these changes will result in significant differences in CY 2014 (a decrease of approximately \$53.2 million) and CY 2016 (a decrease of approximately \$68.5 million) in the amount of revenue reported for Provident Hospital (See Shaded Area).

**TABLE TWO**  
**Provident Hospital**

**Differences in Original Submittal and the Corrected Submittal by Year by number of patients and net revenue**

	Inpatients and Outpatients Served by Payor Source					Inpatient and Outpatient Net Revenue by Payor Source			
	2014	2015	2016	2017		2014	2015	2016	2017
<i>Medicare</i>					<i>Medicare</i>				
<i>Inpatient</i>	-106	10	-17	3	<i>Inpatient</i>	-\$1,754,715	-\$223,851	-\$931,938	-\$133,816
<i>Outpatient</i>	1,626	-7,832	-4,995	-12,226	<i>Outpatient</i>	-\$3,790,745	\$2,219,737	-\$818,030	-\$1,568,694
<i>Medicaid</i>					<i>Medicaid</i>				
<i>Inpatient</i>	-362	29	-21	20	<i>Inpatient</i>	-\$1,707,305	-\$1,088,790	-\$4,737,485	\$195,811
<i>Outpatient</i>	965	-15,915	-8,081	-25,765	<i>Outpatient</i>	-\$6,046,169	\$4,521,677	-\$53,295,393	\$69,140
<i>Other Public</i>					<i>Other Public</i>				
<i>Inpatient</i>	-5	0	13	5	<i>Inpatient</i>	\$0	\$0	\$4,236	-\$4,236
<i>Outpatient</i>	95	101	259	732	<i>Outpatient</i>	\$146,841	-\$247,923	\$22,358	-\$22,358
<i>Private Insurance</i>					<i>Private Insurance</i>				
<i>Inpatient</i>	-16	13	-8	5	<i>Inpatient</i>	\$2,612,734	-\$4,082,809	-\$836,040	-\$132,862
<i>Outpatient</i>	1,303	-1,075	-812	-2,423	<i>Outpatient</i>	\$5,239,658	-\$9,296,375	-\$3,335,681	-\$958,401
<i>Private Pay</i>					<i>Private Pay</i>				
<i>Inpatient</i>	-66	39	18	541	<i>Inpatient</i>	-\$11,998,905	-\$679,356	-\$81,825	-\$72,212
<i>Outpatient</i>	-4,813	5,110	-4,964	31,581	<i>Outpatient</i>	-\$35,963,416	-\$566,423	-\$4,514,921	-\$380,793
<i>Charity Care Expense</i>					<i>Charity Care Expense</i>				
<i>Inpatient</i>	-14	-11	296	171	<i>Inpatient</i>	-\$1,161,949	\$3,326,616	-\$3,819,029	\$408,963
<i>Outpatient</i>	-1,127	-5,784	22,834	5,026	<i>Outpatient</i>	-\$5,725,913	\$4,040,983	\$5,106,603	\$8,743,568
<i>Total</i>					<i>Total</i>				
<i>Inpatient</i>	-569	80	281	745	<i>Inpatient</i>	-\$12,848,191	-\$6,074,806	-\$6,583,052	-\$147,315
<i>Outpatient</i>	-1,951	-25,395	4,241	-3,075	<i>Outpatient</i>	-\$40,413,831	-\$3,369,307	-\$61,941,667	-\$2,861,106

2. John H. Stroger Hospital

CCHHS request changes to John H. Stroger Hospital's Inpatients and Outpatients Served by Payor Source for calendar years 2014 –2017 and Inpatient and Outpatient Net Revenue by Payor Source for calendar years 2014 - CY 2017.

The reason for the errors for the Inpatients and Outpatients served by Payor Source and the Inpatient and Outpatient Net Revenue by Payor Source was the result of:

1. Information for 2014 and 2015 being in error because CCHHS audited financial statements had not been completed when the data was submitted.
2. Information for 2016 and 2017 being in error based on the omittance of certain operating revenue (such as capitation revenue)
3. The corrected data is based upon audited data for 2014-2017. Charity care expense corresponds to the State Board's definition and CCHHS own financial assistance policies.

As can be seen in Table on the next page these changes will result in significant differences in CY 2014 revenue of a \$241 million decrease in inpatient revenue and an increase of \$ 281 million in outpatient revenue. For CY 2016 there is a decrease in revenue of \$945.7 million.

**TABLE THREE**  
**John H. Stroger Hospital**  
**Differences in Original Submittal and Corrected Submittal by patient number and net revenue**

	Inpatients and Outpatients Served by Payor Source					Inpatients and Outpatients Net Revenue by Payor Source			
	2014	2015	2016	2017		2014	2015	2016	2017
<i>Medicare</i>					<i>Medicare</i>				
<i>Inpatient</i>	0	-110	2	-3	<i>Inpatient</i>	-\$9,005,192	-\$30,311,787	-\$22,505,698	\$4,354,443
<i>Outpatient</i>	0	14,284	10,059	12,597	<i>Outpatient</i>	\$32,045,981	\$35,468,942	\$964,784	\$4,973,447
<i>Medicaid</i>					<i>Medicaid</i>				
<i>Inpatient</i>	0	-330	858	1,125	<i>Inpatient</i>	-\$368,566,728	\$104,816,009	-\$580,598,797	\$14,645,848
<i>Outpatient</i>	0	-35,519	21,377	26,422	<i>Outpatient</i>	\$51,012,600	\$132,811,534	-\$637,499,799	\$17,352,827
<i>Other Public</i>					<i>Other Public</i>				
<i>Inpatient</i>	0	-296	329	206	<i>Inpatient</i>	\$117,026,635	\$108,752,259	\$136,164,098	-\$4,837,090
<i>Outpatient</i>	0	-14,091	29,033	28,615	<i>Outpatient</i>	\$168,381,860	\$191,058,593	\$157,288,925	-\$4,743,123
<i>Private Insurance</i>					<i>Private Insurance</i>				
<i>Inpatient</i>	0	6	40	43	<i>Inpatient</i>	\$14,554,586	\$3,103,012	\$18,086,855	\$20,360,470
<i>Outpatient</i>	0	3,032	-13,296	-13,008	<i>Outpatient</i>	\$29,796,169	-\$2,073,815	\$19,396,862	-\$222,377,710
<i>Private Pay</i>					<i>Private Pay</i>				
<i>Inpatient</i>	0	-484	3,781	3,322	<i>Inpatient</i>	\$1,858,265	-\$203,337	-\$15,750,862	-\$1,365,600
<i>Outpatient</i>	0	-10,996	236,718	245,928	<i>Outpatient</i>	\$283,960	-\$4,417,025	-\$21,201,410	-\$300,153
<i>Charity Care Expense</i>					<i>Charity Care Expense</i>				
<i>Inpatient</i>	0	782	3,622	4,760	<i>Inpatient</i>	\$57,842,132	\$14,654,111	-\$15,379,219	-\$5,899,612
<i>Outpatient</i>	0	34,391	66,354	-54,010	<i>Outpatient</i>	\$108,070,298	\$10,298,232	\$72,057,045	-\$1,718,006
<i>Total</i>					<i>Total</i>				
<i>Inpatient</i>	0	-432	8,632	9,453	<i>Inpatient</i>	-\$244,132,434	-\$23,475,862	-\$464,604,404	\$33,158,071
<i>Outpatient</i>	0	-8,899	350,245	246,544	<i>Outpatient</i>	\$281,520,570	\$87,225,161	-\$481,050,638	-\$205,094,712

## V. State Board Staff Summary:

The State Agency notes the following for the State Board's consideration:

- A. The Act grants the State Board jurisdiction to collect data from health care facilities and to compile an Inventory.
- B. The State Board, through its administrative rules, has delineated policies on the collection of data from health care facilities to compile an Inventory and to assist in comprehensive health care planning.
- C. The State Board is permitted to make Declaratory Rulings regarding "corrections to the facility inventories utilized by the State Board," per 77 IAC 1130.810(b).

As referenced, the State Board's rules provide a mechanism to collect information from health care facilities. This data is an integral component of the State Board's review of proposed projects because it allows for a quantifiable assessment of: 1) a proposal compared to the needs of a specific planning area, 2) the potential impact the proposal will have on existing health care providers and 3) the proposal's ability to meet the mandated requirements of the Health Facilities Planning Act (i.e., increased access, improved quality and unnecessary duplication of services).

Correction of the data for two Hospitals provided above is not used to determine the need for additional beds at a hospital or in a planning area. The outpatient data being revised would not have changed any of the analysis the State Board Staff would have performed because the Board Staff uses total outpatient visits in assessing the need to expand outpatient services. Revenue by payor source and the number of inpatients and outpatients provided care by payor source provides the Board with the amount of Safety Net Services being provided by a health care facility. Those amounts are not used in need analysis performed by the State Board Staff.

The State Board Staff performs an analytical review only of the information submitted by the health care facilities. The responsibility for the data submitted is the health care facility not the State Board or the Illinois Department of Public Health.

## VII. Other Information

Appended to this report are the following:

- CCHHS submittal for correction to the profile data for CY 2014-CY 2017
- 2014-2017 Original Profiles for Provident Hospital and John H. Stroger Hospital
- CCHHS Financial Assistance Policies of the CCHHS
- Comparison of Original Submittal to Corrected Submittal and the Difference.

**RECEIVED**

MAY 14 2019

**HEALTH FACILITIES &  
SERVICES REVIEW BOARD**



**LIN AND PATEL, LLC**  
150 N. Michigan Suite 2800, Chicago, IL 60601  
www.linpatel.com

Amee Patel, Esq.  
Phone: 708.466.7022  
Fax: 312.276.4116  
E-mail: [amee.patel@linpatel.com](mailto:amee.patel@linpatel.com)

May 14, 2019

**VIA EMAIL AND US MAIL**

Jeannie Mitchell, Esq.  
Illinois Health Facilities and Services Review Board  
69 West Washington, 35<sup>th</sup> Floor  
Chicago, Illinois 60605

**Re: Declaratory Ruling Request to change Annual Hospital Profiles-Provident and John H. Stroger Hospitals**

Dear Ms. Mitchell:

We represent Cook County, through Cook County Health and Hospital Systems ("CCHHS"). CCHHS is an agency of Cook County and operates the John. H. Stroger Hospital as well as Provident Hospital ("Hospitals") through CCHHS' Board of Directors.

We recently reviewed the CY 2014-CY 2017 Individual Hospital Profiles for Provident Hospital and John H. Stroger Hospital. In accordance with 77 Ill. Admin. Code § 1130.810(b), we are requesting changes to the CY 2014 through CY 2017 Individual Hospital Profiles for the Hospitals. With respect to Provident Hospital, we are requesting a change to Inpatients and Outpatients Served by Payor Source (CY 2014 - CY 2017); Inpatient and Outpatient Net Revenue by Payor Source (CY 2014 - CY 2017); and the Outpatient Service Data (CY 2015, CY 2016 and CY 2017). With respect to John H. Stroger Hospital, we are requesting a change to the Inpatients and Outpatients Served by Payor Source (CY 2014- CY 2017) and Inpatient and Outpatient Net Revenue by Payor Source (CY 2014 - CY 2017).

**A. Provident Hospital**

1. CY 2014 - CY 2017 Inpatients and Outpatients Served by Payor Source and Inpatient and Outpatient Net Revenue by Payor Source should be modified as reflected in Attachments 1 through 4 for the respective years.

The information that was reported for CY 2014 and CY 2015 or Attachments 1 and 2 were reported erroneously because CCHHS' audited financial statements had not been completed when the data was submitted in the respective years. Furthermore, the information that was reported in CY 2016

and CY 2017 or Attachments 3 and 4 were skewed based on the omittance of certain operating revenue such as capitation revenue in the calculations. Attachments 1 through 4 have been calculated based on audited financials for the corresponding fiscal years, the definition of “charity care” as prescribed in the annual hospital questionnaires and CCHHS’ own financial assistance policies.

2. Provident Hospital provides outpatient services to its patients through the John Sengstacke Health Center (“Center”). This Center is housed and operated inside of Provident Hospital. All other CCHHS outpatient services are operated under John H. Stroger Hospital. Therefore, there are no “offsite/off campus outpatient visits” for Provident Hospital.

The CY 2015, CY 2016 and CY 2017 Outpatient Service Data should be reflected as provided below. The CY 2014 Outpatient Service Data is correct and does not need to be modified.

<b>2015 Outpatient Service Data</b>	
Total Outpatient Visits	87,398
Outpatient Visits at the Hospital/Campus:	87,398
Outpatient Visits Offsite/off Campus:	0

<b>2016 Outpatient Service Data</b>	
Total Outpatient Visits	62,003
Outpatient Visits at the Hospital/Campus:	62,003
Outpatient Visits Offsite/off Campus:	0

<b>2017 Outpatient Service Data</b>	
Total Outpatient Visits	106, 221
Outpatient Visits at the Hospital/Campus:	106, 221
Outpatient Visits Offsite/off Campus:	0

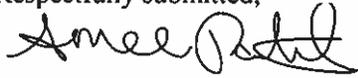
**B. John H. Stroger Hospital**

1. CY 2014 - CY 2017 Inpatients and Outpatients Served by Payor Source and Inpatient and Outpatient Net Revenue by Payor Source should be modified as in Attachments 5 through 8 for the respective years.

The information that was reported for CY 2014 and CY 2015 or Attachments 5 and 6 were reported erroneously because at the time of submission CCHHS did not have their audited financial statements for the respective years. Furthermore, the information that was reported in CY 2016 and CY 2017 or Attachments 7 and 8 were skewed based on the omittance of certain operating revenue such as electronic health record incentive payments in the calculations. Attachments 5 through 8 have been calculated based on audited financials for the corresponding fiscal years, the definition of “charity care” as prescribed in the annual hospital questionnaires and CCHHS’ own financial assistance policies.

At this time, we respectfully request that HFSRB modify the respective reports to reflect the above information. We further request that this Declaratory Ruling be heard at the June 4, 2019 HFSRB Board Meeting. We are happy to supply any other information needed by HFSRB.

Respectfully submitted,

A handwritten signature in black ink that reads "Ameer Patel". The signature is written in a cursive style with a large initial "A" and a long, sweeping tail.

Ameer Patel, Esq.

cc: Ms. Courtney Avery, Administrator, Illinois Health Facilities and Services Review Board via email;  
Mr. Mike Constantino, Supervisor, Project Review Section



**ATTACHMENT 2**

<b>FY '15 Provident Hospital</b>		<b>Inpatients and Outpatients by Payor Source</b>						<b>Totals</b>
	<b>Medicare</b>	<b>Medicaid</b>	<b>Others</b>	<b>Private Insurance</b>	<b>Private Pay</b>	<b>Charity Care</b>	<b>Totals</b>	
<b>%</b>	19.19%	55.97%	0.00%	7.38%	13.29%	4.16%	100.00%	
<b>Inpatients</b>	143	417	0	55	99	31	745	
<b>%</b>	9.18%	53.97%	0.45%	5.60%	29.34%	1.46%		
<b>Outpatients</b>	5,689	33,462	281	3,470	18,193	908	62,003	
<b>Financial Year Reported: 12/1/2014-11/30/2015</b>								
		<b>Inpatients and Outpatients Net Revenue by Payor Source</b>						<b>Total Charity Care Expense</b>
	<b>Medicare</b>	<b>Medicaid</b>	<b>Others</b>	<b>Private Insurance</b>	<b>Private Pay</b>	<b>Charity Expense</b>	<b>\$</b>	
<b>%</b>	32.61%	47.20%	0.00%	19.50%	0.69%		100.00%	
<b>Inpatient Revenue</b>	\$ 1,724,351	\$ 2,495,433	\$ -	\$ 1,031,014	\$ 36,577	\$ 5,211,180.91	\$ 16,810,261	
<b>Outpatient Revenue</b>								
<b>%</b>	31.01%	51.65%	0.00%	17.17%	0.18%		100.00%	
<b>Outpatient Revenue</b>	\$ 3,045,214	\$ 5,071,403	\$ -	\$ 1,685,505	\$ 17,288	\$ 11,599,080	\$ 11,599,080	
		<b>Total Charity Care as a % of Net Revenue</b>						<b>111%</b>

**ATTACHMENT 3**

<b>FY '16 Provident Hospital</b>									
<b>Inpatients and Outpatients Served by Payor Source</b>									
	<b>Medicare</b>	<b>Medicaid</b>	<b>Others</b>	<b>Private Insurance</b>	<b>Private Pay</b>	<b>Charity Care</b>	<b>Totals</b>		
<b>%</b>	12.28%	38.60%	1.27%	4.58%	11.40%	31.87%	100.00%		
<b>Inpatients</b>	126	396	13	47	117	327	1,026		
<b>%</b>	9.64%	34.99%	0.74%	3.66%	18.24%	32.73%	100.00%		
<b>Outpatients</b>	6,994	25,381	540	2,658	13,229	23,742	72,544		
<b>Inpatient and Outpatient Net Revenue by Payor Source</b>									
<b>Financial Year Reported: 12/1/2015-11/30/2016</b>									
	<b>Medicare</b>	<b>Medicaid</b>	<b>Others</b>	<b>Private Insurance</b>	<b>Private Pay</b>	<b>Charity Expense</b>	<b>Totals</b>		
<b>%</b>	22.68%	38.96%	0.51%	29.18%	8.68%		100.00%		
<b>Inpatient Revenue</b>	\$ 189,991	\$ 326,378	\$ 4,236	\$ 244,456	\$ 72,674	\$ 2,013,271	\$ 837,735	\$ 2,013,271	<b>Total Charity Care Expense \$ 20,132,947</b>
<b>%</b>	28.46%	38.83%	0.51%	23.53%	8.68%		100.00%		<b>Total Charity Care as a % of 383%</b>
<b>Outpatient Revenue</b>	\$ 1,258,380	\$ 1,717,026	\$ 22,358	\$ 1,040,244	\$ 383,573	\$ 18,119,676	\$ 4,421,581	\$ 18,119,676	

**ATTACHMENT 4**

**FY '17 Provident Hospital**

Inpatients and Outpatients Served by Payor Source							
	Medicare	Medicaid	Others	Private Insurance	Private Pay	Charity Care	Totals
%	14.90%	43.59%	0.61%	3.54%	11.36%	26.01%	100.00%
Inpatients	122	357	5	29	93	213	819
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%	15.72%	48.97%	1.54%	5.72%	28.05%	100.00%	
Outpatients	7,731	24,089	758	2,813	13,799	18,565	67,755
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Inpatient and Outpatient Net Revenue by Payor Source							
Financial Year Reported: 12/1/2016-11/30/2017							
	Medicare	Medicaid	Others	Private Insurance	Private Pay	Charity Expense	Totals
%	37.10%	46.67%	0.00%	16.16%	0.07%		100.00%
Inpatient Revenue	\$ 256,175	\$ 322,189	\$ -	\$ 111,594	\$ 462	\$ 1,974,308	\$ 2,764,268
<hr/>							
%	31.38%	47.18%	0.00%	21.27%	0.18%		100.00%
Outpatient Revenue	\$ 489,686	\$ 736,166	\$ -	\$ 331,843	\$ 2,780	\$ 22,821,863	\$ 24,648,575
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						Total Charity Care Expense	\$ 24,796,171
						Total Charity Care as a % of Net Revenue	1102%

**ATTACHMENT 5**

**FY '14 Stroger Hospital**

Inpatients and Outpatients by Payor Source									
	Medicare	Medicaid	Others	Private Insurance	Private Pay	Charity Care	Totals		
%	13.44%	54.92%	1.50%	3.30%	12.35%	14.49%	100.00%		
Inpatients	2,761	11,286	309	679	2,537	2,978	20,550		
%	13.30%	43.81%	0.15%	3.09%	17.28%	22.36%	100.00%		
Outpatients	121,921	401,522	1,377	28,324	158,421	204,962	916,527		
Inpatients and Outpatients Net Revenue by Payor Source									
	Medicare	Medicaid	Others	Private Insurance	Private Pay	Charity Expense	Totals		
%	16.04%	21.73%	48.30%	12.67%	1.26%		100.00%		
Inpatient Revenue	\$ 38,851,479.00	\$ 52,653,233.00	\$ 117,026,635.00	\$ 30,706,053.00	\$ 3,051,289.00	\$ 57,842,132	\$ 242,288,689		Total Charity Care Expense \$ 165,912,430
%	13.34%	21.81%	53.21%	10.15%	1.50%		100.00%		Total Charity Care as a % of Net Revenue 30%
Outpatient Revenue	\$ 42,198,369	\$ 69,009,730	\$ 168,381,860	\$ 32,114,975	\$ 4,736,503	\$ 108,070,298	\$ 316,441,437		

**ATTACHMENT 6**

**FY '15 Stroger Hospital**

Inpatients and Outpatients by Payor Source									
	Medicare	Medicaid	Others	Private Insurance	Private Pay	Charity Care	Totals		
%	15.26%	47.30%	0.02%	4.62%	13.64%	19.17%	100.00%		
Inpatients	3,218	9,973	4	974	2,875	4,041	21,085		
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%	15.65%	39.47%	0.06%	5.77%	13.66%	25.39%	100.00%		
Outpatients	148,385	374,115	597	54,684	129,454	240,629	947,864		
<hr/>									
Inpatients and Outpatients Net Revenue by Payor Source									
	Medicare	Medicaid	Others	Private Insurance	Private Pay	Charity Expense	Totals		
%	15.65%	26.24%	46.85%	9.93%	1.33%		100.00%		
Inpatient Revenue	\$ 36,321,147	\$ 60,923,957	\$ 108,752,259	\$ 23,044,751	\$ 3,096,282	\$ 99,171,905	\$ 232,138,396	\$	\$ 248,929,193
<hr/>									
%	14.09%	26.06%	50.55%	7.95%	1.35%		100.00%		
Outpatient Revenue	\$ 53,249,467	\$ 98,502,092	\$ 191,058,593	\$ 30,049,723	\$ 5,109,636	\$ 149,757,288	\$ 377,969,511	\$	\$ 41%

ATTACHMENT 7

FY '16 John H. Stroger Hospital									
Inpatients and Outpatients Served by Payor Source									
	Medicare	Medicaid	Others	Private Insurance	Private Pay	Charity Care	Totals		
%	10.84%	36.45%	1.12%	3.41%	22.40%	25.79%	100.00%		
Inpatients	3,220	10,831	333	1,014	6,656	7,663	29,717		
<hr/>									
%	12.21%	30.47%	2.28%	3.19%	28.21%	23.65%	100.00%		
Outpatients	158,444	395,492	29,630	41,388	366,172	306,983	1,298,109		
<hr/>									
Inpatient and Outpatient Net Revenue by Payor Source									
Financial Year Reported: 12/1/2015-11/30/2016									
	Medicare	Medicaid	Others	Private Insurance	Private Pay	Charity Expense	Totals		
%	13.15%	19.50%	56.93%	8.43%	2.00%		100.00%		
Inpatient Revenue	\$ 31,786,806	\$ 47,148,744	\$ 137,624,920	\$ 20,373,850	\$ 4,827,838	\$ 105,027,934	\$ 241,762,158		
<hr/>									
%	13.15%	20.06%	56.93%	7.87%	2.00%		100.00%		
Outpatient Revenue	\$ 37,361,744	\$ 57,008,400	\$ 161,762,309	\$ 22,356,664	\$ 5,674,570	\$ 198,543,972	\$ 284,163,687		
<hr/>									
								Total Charity Care as a % of Net Revenue	58%

**ATTACHMENT 8**

<b>FY'17 John H. Stroger Hospital</b>									
<b>Inpatients and Outpatients Served by Payor Source</b>									
	<b>Medicare</b>	<b>Medicaid</b>	<b>Others</b>	<b>Private Insurance</b>	<b>Private Pay</b>	<b>Charity Care</b>	<b>Totals</b>		
<b>%</b>	10.51%	35.33%	0.73%	3.13%	21.21%	29.09%	100.00%		
<b>Inpatients</b>	2,973	9,994	207	884	5,998	8,229	28,285		
<b>%</b>	13.57%	31.10%	2.46%	3.29%	33.08%	16.50%	100.00%		
<b>Outpatients</b>	160,263	367,290	29,097	38,866	390,637	194,845	1,180,998		
<b>Inpatient and Outpatient Net Revenue by Payor Source</b>									
<b>Financial Year Reported: 12/1/2016-11/30/2017</b>									
	<b>Medicare</b>	<b>Medicaid</b>	<b>Others</b>	<b>Private Insurance</b>	<b>Private Pay</b>	<b>Charity Expense</b>	<b>Totals</b>		
<b>%</b>	13.15%	21.73%	48.30%	15.56%	1.26%		100.00%		
<b>Inpatient Revenue</b>	\$ 36,141,249	\$ 59,744,592	\$ 132,787,830	\$ 42,784,320	\$ 3,462,238	\$ 87,711,971	\$ 274,920,228		<b>Total Charity Care Expense \$ 273,397,515</b>
<b>%</b>	13.39%	22.26%	49.68%	12.97%	1.70%				<b>Total Charity Care as a % of Net Revenue 46%</b>
<b>Outpatient Revenue</b>	\$ 42,335,191	\$ 70,361,227	\$ 157,019,186	\$ 40,978,954	\$ 5,374,417	\$ 185,685,544	\$ 316,068,975		

Original Provident Hospital					Provident Hospital Inpatient and Outpatient by Payor Source Corrected Provident Hospital					Difference				
	2014	2015	2016	2017		2014	2015	2016	2017	2014	2015	2016	2017	
Medicare					Medicare					Medicare				
Inpatient	239	133	143	119	Inpatient	133	143	126	122	Inpatient	-106	10	-17	3
Outpatient	11,895	13,521	5,689	19,957	Outpatient	13,521	5,689	694	7,731	Outpatient	1,626	-7,832	-4,995	-12,226
Medicaid					Medicaid					Medicaid				
Inpatient	750	388	417	337	Inpatient	388	417	396	357	Inpatient	-362	29	-21	20
Outpatient	48,362	49,377	33,462	49,854	Outpatient	49,327	33,462	25,381	24,089	Outpatient	965	-15,915	-8,081	-25,765
Other Public					Other Public					Other Public				
Inpatient	5	0	0	0	Inpatient	0	0	13	5	Inpatient	-5	0	13	5
Outpatient	85	180	281	26	Outpatient	180	281	540	758	Outpatient	95	101	259	732
Private Insurance					Private Insurance					Private Insurance				
Inpatient	58	42	55	24	Inpatient	42	55	47	29	Inpatient	-16	13	-8	5
Outpatient	3,242	4,545	3,470	5,236	Outpatient	4,545	3,470	2,658	2,813	Outpatient	1,303	-1,075	-812	-2,423
Private Pay					Private Pay					Private Pay				
Inpatient	126	60	99	65	Inpatient	60	99	117	606	Inpatient	-66	39	18	541
Outpatient	17,896	13,083	18,193	17,609	Outpatient	13,083	18,193	13,229	49,190	Outpatient	-4,813	5,110	-4,964	31,581
Charity Care Expense					Charity Care Expense					Charity Care Expense				
Inpatient	56	42	31	42	Inpatient	42	31	327	213	Inpatient	-14	-11	296	171
Outpatient	7,819	6,692	908	13,539	Outpatient	6,692	908	23,742	18,565	Outpatient	-1,127	-5,784	22,834	5,026
Total					Total					Total				
Inpatient	1,234	665	745	587	Inpatient	665	745	1,026	1,332	Inpatient	-569	80	281	745
Outpatient	89,299	87,398	62,003	106,221	Outpatient	87,348	62,003	66,244	103,146	Outpatient	-1,951	-25,395	4,241	-3,075

	Original Provident Hospital				Inpatient and Outpatient by Net Revenue Corrected Provident Hospital				Difference					
	2014	2015	2016	2017	2014	2015	2016	2017	2014	2015	2016	2017		
Medicare					Medicare					Medicare				
Inpatient	\$2,906,700	\$1,948,202	\$1,121,929	\$389,991	Inpatient	\$1,151,985	\$1,724,351	\$189,991	\$256,175	Inpatient	-\$1,754,715	-\$223,851	-\$931,938	-\$133,816
Outpatient	\$4,279,664	\$825,477	\$2,076,410	\$2,058,380	Outpatient	\$488,919	\$3,045,214	\$1,258,380	\$489,686	Outpatient	-\$3,790,745	\$2,219,737	-\$818,030	-\$1,568,694
Medicaid					Medicaid					Medicaid				
Inpatient	\$3,826,572	\$3,584,223	\$5,063,863	\$126,378	Inpatient	\$2,119,267	\$2,495,433	\$326,378	\$322,189	Inpatient	-\$1,707,305	-\$1,088,790	-\$4,737,485	\$195,811
Outpatient	\$6,765,540	\$549,726	\$55,012,419	\$667,026	Outpatient	\$719,371	\$5,071,403	\$1,717,026	\$736,166	Outpatient	-\$6,046,169	\$4,521,677	#####	\$69,140
Other Public					Other Public					Other Public				
Inpatient	\$0	\$0	\$0	\$4,236	Inpatient	\$0	\$0	\$4,236	\$0	Inpatient	\$0	\$0	\$4,236	-\$4,236
Outpatient	\$0	\$247,923	\$0	\$22,358	Outpatient	\$146,841	\$0	\$22,358	\$0	Outpatient	\$146,841	-\$247,923	\$22,358	-\$22,358
Private Insurance					Private Insurance					Private Insurance				
Inpatient	\$410,949	\$5,113,823	\$1,080,496	\$244,456	Inpatient	\$3,023,683	\$1,031,014	\$244,456	\$111,594	Inpatient	\$2,612,734	-\$4,082,809	-\$836,040	-\$132,862
Outpatient	\$1,264,758	\$10,981,880	\$4,375,925	\$1,290,244	Outpatient	\$6,504,416	\$1,685,505	\$1,040,244	\$331,843	Outpatient	\$5,239,658	-\$9,296,375	-\$3,335,681	-\$958,401
Private Pay					Private Pay					Private Pay				
Inpatient	\$12,422,219	\$715,933	\$154,499	\$72,674	Inpatient	\$423,314	\$36,577	\$72,674	\$462	Inpatient	-\$11,998,905	-\$679,356	-\$81,825	-\$72,212
Outpatient	\$36,315,363	\$583,711	\$4,898,494	\$383,573	Outpatient	\$351,947	\$17,288	\$383,573	\$2,780	Outpatient	-\$35,963,416	-\$566,423	-\$4,514,921	-\$380,793
Charity Care Expense					Charity Care Expense					Charity Care Expense				
Inpatient	\$2,767,898	\$1,884,565	\$5,832,300	\$1,565,345	Inpatient	\$1,605,949	\$5,211,181	\$2,013,271	\$1,974,308	Inpatient	-\$1,161,949	\$3,326,616	-\$3,819,029	\$408,963
Outpatient	\$12,149,711	\$7,558,097	\$13,013,073	\$14,088,295	Outpatient	\$6,423,798	\$11,599,080	\$18,119,676	\$22,831,863	Outpatient	-\$5,725,913	\$4,040,983	\$5,106,603	\$8,743,568
Total					Total					Total				
Inpatient	\$19,566,440	\$11,362,181	\$7,420,787	\$837,735	Inpatient	\$6,718,249	\$5,287,375	\$837,735	\$690,420	Inpatient	-\$12,848,191	-\$6,074,806	-\$6,583,052	-\$147,315
Outpatient	\$48,625,325	\$13,188,717	\$66,363,248	\$4,421,581	Outpatient	\$8,211,494	\$9,819,410	\$4,421,581	\$1,560,475	Outpatient	-\$40,413,831	-\$3,369,307	#####	-\$2,861,106

Original Stroger Hospital					Stroger Hospital Inpatient and Outpatient by Payor Source Corrected Stroger Hospital					Difference				
	2014	2015	2016	2017		2014	2015	2016	2017		2014	2015	2016	2017
Medicare					Medicare					Medicare				
Inpatient	2,761	3,328	3,218	2,976	Inpatient	2,761	3,218	3,220	2,973	Inpatient	0	-110	2	-3
Outpatient	121,921	134,101	148,385	147,666	Outpatient	121,921	148,385	158,444	160,263	Outpatient	0	14,284	10,059	12,597
Medicaid					Medicaid					Medicaid				
Inpatient	11,286	10,303	9,973	8,869	Inpatient	11,286	9,973	10,831	9,994	Inpatient	0	-330	858	1,125
Outpatient	401,522	409,634	374,115	340,868	Outpatient	401,522	374,115	395,492	367,290	Outpatient	0	-35,519	21,377	26,422
Other Public					Other Public					Other Public				
Inpatient	309	300	4	1	Inpatient	309	4	333	207	Inpatient	0	-296	329	206
Outpatient	1,377	14,688	597	482	Outpatient	1,377	597	29,630	29,097	Outpatient	0	-14,091	29,033	28,615
Private Insurance					Private Insurance					Private Insurance				
Inpatient	679	968	974	841	Inpatient	679	974	1,014	884	Inpatient	0	6	40	43
Outpatient	28,324	51,652	54,684	51,874	Outpatient	28,324	54,684	41,388	38,866	Outpatient	0	3,032	-13,296	-13,008
Private Pay					Private Pay					Private Pay				
Inpatient	2,537	3,359	2,875	2,676	Inpatient	2,537	2,875	6,656	5,998	Inpatient	0	-484	3,781	3,322
Outpatient	158,421	140,450	129,454	144,709	Outpatient	158,421	129,454	366,172	390,637	Outpatient	0	-10,996	236,718	245,928
Charity Care Expense					Charity Care Expense					Charity Care Expense				
Inpatient	2,978	3259	4041	3,469	Inpatient	2,978	4041	7663	8,229	Inpatient	0	782	3,622	4,760
Outpatient	204,962	206238	240629	248,855	Outpatient	204,962	240629	306983	194,845	Outpatient	0	34,391	66,354	-54,010
Total					Total					Total				
Inpatient	20,550	21,517	21,085	18,832	Inpatient	20,550	21,085	29,717	28,285	Inpatient	0	-432	8,632	9,453
Outpatient	916,527	956,763	947,864	934,454	Outpatient	916,527	947,864	1,298,109	1,180,998	Outpatient	0	-8,899	350,245	246,544

					<b>Stroger Hospital</b>									
					Inpatient and Outpatient by Net Revenue									
<b>Original Stroger Hospital</b>					<b>Corrected Stroger Hospital</b>				<b>Difference</b>					
	2014	2015	2016	2017		2014	2015	2016	2017		2014	2015	2016	2017
Medicare					Medicare					Medicare				
Inpatient	\$47,356,671	\$66,632,934	\$54,292,504	\$31,786,806	Inpatient	\$38,351,479	\$36,321,147	\$31,786,806	\$36,141,249	Inpatient	-\$9,005,192	-\$30,311,787	#####	\$4,354,443
Outpatient	\$10,152,388	\$17,780,525	\$36,396,960	\$37,361,744	Outpatient	\$42,198,369	\$53,249,467	\$37,361,744	\$42,335,191	Outpatient	\$32,045,981	\$35,468,942	\$964,784	\$4,973,447
Medicaid					Medicaid					Medicaid				
Inpatient	\$421,219,961	\$165,739,966	\$627,747,541	\$45,098,744	Inpatient	\$52,653,233	\$60,923,957	\$47,148,744	\$59,744,592	Inpatient	-\$368,566,728	-\$104,816,009	#####	\$14,645,848
Outpatient	\$17,997,130	\$231,313,626	\$694,508,199	\$53,008,400	Outpatient	\$69,009,730	\$98,502,092	\$57,008,400	\$70,361,227	Outpatient	\$51,012,600	-\$132,811,534	#####	\$17,352,827
Other Public					Other Public					Other Public				
Inpatient	\$0	\$0	\$1,460,822	\$137,624,920	Inpatient	\$117,026,635	\$108,752,259	\$137,624,920	\$132,787,830	Inpatient	\$117,026,635	\$108,752,259	#####	-\$4,837,090
Outpatient	\$0	\$0	\$4,473,384	\$161,762,309	Outpatient	\$168,381,860	\$191,058,593	\$161,762,309	\$157,019,186	Outpatient	\$168,381,860	\$191,058,593	#####	-\$4,743,123
Private Insurance					Private Insurance					Private Insurance				
Inpatient	\$16,151,467	\$19,941,739	\$2,286,995	\$22,423,850	Inpatient	\$30,706,053	\$23,044,751	\$20,373,850	\$42,784,320	Inpatient	\$14,554,586	\$3,103,012	\$18,086,855	\$20,360,470
Outpatient	\$2,318,806	\$32,123,538	\$2,959,802	\$263,356,664	Outpatient	\$32,114,975	\$30,049,723	\$22,356,664	\$40,978,954	Outpatient	\$29,796,169	-\$2,073,815	\$19,396,862	-\$222,377,710
Private Pay					Private Pay					Private Pay				
Inpatient	\$1,193,024	\$3,299,619	\$20,578,700	\$4,827,838	Inpatient	\$3,051,289	\$3,096,282	\$4,827,838	\$3,462,238	Inpatient	\$1,858,265	-\$203,337	#####	-\$1,365,600
Outpatient	\$4,452,543	\$9,526,661	\$26,875,980	\$5,674,570	Outpatient	\$4,736,503	\$5,109,636	\$5,674,570	\$5,374,417	Outpatient	\$283,960	-\$4,417,025	#####	-\$300,153
Charity Care Expense					Charity Care Expense					Charity Care Expense				
Inpatient	\$0	\$84,517,794	\$120,407,153	\$93,611,583	Inpatient	\$57,842,132	\$99,171,905	\$105,027,934	\$87,711,971	Inpatient	\$57,842,132	\$14,654,111	#####	-\$5,899,612
Outpatient	\$0	\$139,459,056	\$126,486,927	\$187,403,550	Outpatient	\$108,070,298	\$149,757,288	\$198,543,972	\$185,685,544	Outpatient	\$108,070,298	\$10,298,232	\$72,057,045	-\$1,718,006
Total					Total					Total				
Inpatient	\$485,921,123	\$255,614,258	\$706,366,562	\$241,762,158	Inpatient	\$241,788,689	\$232,138,396	\$241,762,158	\$274,920,229	Inpatient	-\$244,132,434	-\$23,475,862	#####	\$33,158,071
Outpatient	\$34,920,867	\$290,744,350	\$765,214,325	\$521,163,687	Outpatient	\$316,441,437	\$377,969,511	\$284,163,687	\$316,068,975	Outpatient	\$281,520,570	\$87,225,161	#####	-\$205,094,712

<u>Ownership, Management and General Information</u>		<u>Patients by Race</u>		<u>Patients by Ethnicity</u>	
ADMINISTRATOR NAME:	Peter Daniels	White	3.6%	Hispanic or Latino:	3.1%
ADMINSTRATOR PHONE	312-864-5507	Black	93.8%	Not Hispanic or Latino:	96.7%
OWNERSHIP:	Cook County Government	American Indian	0.2%	Unknown:	0.2%
OPERATOR:	Cook County Health and Hospitals System	Asian	0.2%		
MANAGEMENT:	County	Hawaiian/ Pacific	0.0%	IDPH Number:	4549
CERTIFICATION:	None	Unknown	2.3%	HPA	A-03
FACILITY DESIGNATION:	General Hospital			HSA	6
ADDRESS	500 East 51st Street	CITY: Chicago	COUNTY: Suburban Cook (Chicago)		

Facility Utilization Data by Category of Service

<u>Clinical Service</u>	Authorized CON Beds 12/31/2014	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	79	25	0	1,234	4,644	673	4.3	14.6	18.4	58.3
0-14 Years				0	0					
15-44 Years				205	688					
45-64 Years				823	3,255					
65-74 Years				134	406					
75 Years +				72	295					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	11	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				0	0					
Transfers				0	0					
Obstetric/Gynecology	23	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	113			1,234	4,644	673	4.3	14.6	12.9	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	19.4%	60.8%	0.4%	4.7%	10.2%	4.5%	
	239	750	5	58	126	56	1,234
Outpatients	13.3%	54.2%	0.1%	3.6%	20.0%	8.8%	
	11895	48362	85	3242	17896	7819	89,299

<u>Financial Year Reported:</u>	12/1/2012 to	11/30/2013	<u>Inpatient and Outpatient Net Revenue by Payor Source</u>					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue ( \$ )	14.9%	19.6%	0.0%	2.1%	63.5%	100.0%		14,917,609	
	2,906,700	3,826,572	0	410,949	12,422,219	19,566,440	2,767,898		
Outpatient Revenue ( \$ )	8.8%	13.9%	0.0%	2.6%	74.7%	100.0%		Total Charity Care as % of Net Revenue	
	4,279,664	6,765,540	0	1,264,758	36,315,363	48,625,325	12,149,711	21.9%	

Birthing Data

Number of Total Births:	0
Number of Live Births:	0
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	6
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	2
CSections Performed:	0

Newborn Nursery Utilization

	Level I	Level II	Level II+
Beds	0	0	0
Patient Days	0	0	0
Total Newborn Patient Days			0
<u>Laboratory Studies</u>			
Inpatient Studies			26,912
Outpatient Studies			128,783
Studies Performed Under Contract			0

Organ Transplantation

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

**Ownership, Management and General Information**

**ADMINISTRATOR NAME:** Dr. John Jay Shannon  
**ADMINSTRATOR PHONE:** 312-864-5501  
**OWNERSHIP:** Cook County  
**OPERATOR:** John H. Stroger Hospital of Cook County  
**MANAGEMENT:** County  
**CERTIFICATION:** (Not Answered)  
**FACILITY DESIGNATION:** (Not Answered)  
**ADDRESS:** 500 East 51st Street

**Patients by Race**

White 2.6%  
 Black 95.2%  
 American Indian 0.5%  
 Asian 0.3%  
 Hawaiian/ Pacific 0.0%  
 Unknown 1.5%

**Patients by Ethnicity**

Hispanic or Latino: 2.3%  
 Not Hispanic or Latino: 97.7%  
 Unknown: 0.0%  
 IDPH Number: 4549  
 HPA A-03  
 HSA 6

**CITY:** Chicago

**COUNTY:** Suburban Cook (Chicago)

**Facility Utilization Data by Category of Service**

Clinical Service	Authorized CON Beds 12/31/2015	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
<b>Medical/Surgical</b>	79	25	19	665	2,468	791	4.9	8.9	11.3	35.7
0-14 Years				0	0					
15-44 Years				106	382					
45-64 Years				432	1,618					
65-74 Years				75	256					
75 Years +				52	212					
<b>Pediatric</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<b>Intensive Care</b>	6	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				0	0					
Transfers				0	0					
<b>Obstetric/Gynecology</b>	23	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
<b>Neonatal</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<b>Long Term Care</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<b>Swing Beds</b>			0	0	0		0.0	0.0		
<b>Acute Mental Illness</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<b>Rehabilitation</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<b>Long-Term Acute Care</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
<b>Facility Utilization</b>	<b>108</b>			<b>665</b>	<b>2,468</b>	<b>791</b>	<b>4.9</b>	<b>8.9</b>	<b>8.3</b>	

(Includes ICU Direct Admissions Only)

**Inpatients and Outpatients Served by Payor Source**

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
<b>Inpatients</b>	20.0%	58.3%	0.0%	6.3%	9.0%	6.3%	
	133	388	0	42	60	42	665
<b>Outpatients</b>	15.5%	56.5%	0.2%	5.2%	15.0%	7.7%	
	13521	49377	180	4545	13083	6692	87,398

**Financial Year Reported:** 12/1/2013 to 11/30/2014

**Inpatient and Outpatient Net Revenue by Payor Source**

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense	Total Charity Care Expense
<b>Inpatient Revenue ( \$ )</b>	17.1%	31.5%	0.0%	45.0%	6.3%	100.0%		9,442,662
	1,948,302	3,584,223	0	5,113,823	715,933	11,362,281	1,884,565	
<b>Outpatient Revenue ( \$ )</b>	6.3%	4.2%	1.9%	83.2%	4.5%	100.0%		Total Charity Care as % of Net Revenue
	825,477	549,726	247,923	10,981,880	593,711	13,198,717	7,558,097	38.4%

**Birthing Data**

Number of Total Births: 0  
 Number of Live Births: 0  
 Birthing Rooms: 0  
 Labor Rooms: 0  
 Delivery Rooms: 0  
 Labor-Delivery-Recovery Rooms: 0  
 Labor-Delivery-Recovery-Postpartum Rooms: 0  
 C-Section Rooms: 0  
 CSections Performed: 0

**Newborn Nursery Utilization**

Level I 0  
 Level II 0  
 Level II+ 0  
 Beds 0  
 Patient Days 0  
 Total Newborn Patient Days 0

**Organ Transplantation**

Kidney: 0  
 Heart: 0  
 Lung: 0  
 Heart/Lung: 0  
 Pancreas: 0  
 Liver: 0  
 Total: 0

**Laboratory Studies**

Inpatient Studies 5,307  
 Outpatient Studies 83,009  
 Studies Performed Under Contract 6,141

<u>Ownership, Management and General Information</u>		<u>Patients by Race</u>		<u>Patients by Ethnicity</u>	
ADMINISTRATOR NAME:	Doug Elwell	White	5.6%	Hispanic or Latino:	4.6%
ADMINSTRATOR PHONE:	(312) 864-7198	Black	91.4%	Not Hispanic or Latino:	95.4%
OWNERSHIP:	Cook County	American Indian	0.1%	Unknown:	0.0%
OPERATOR:	John H. Stroger Hospital of Cook County	Asian	0.4%		
MANAGEMENT:	County	Hawaiian/ Pacific	0.1%	IDPH Number:	4549
CERTIFICATION:	(Not Answered)	Unknown	2.3%	HPA	A-03
FACILITY DESIGNATION:	General Hospital			HSA	6
ADDRESS	500 East 51st Street	CITY:	Chicago	COUNTY:	Suburban Cook (Chicago)

**Facility Utilization Data by Category of Service**

<u>Clinical Service</u>	Authorized CON Beds 12/31/2016	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	79	25	18	736	2,962	1,063	5.5	11.0	13.9	44.0
0-14 Years				0	0					
15-44 Years				121	505					
45-64 Years				491	1,933					
65-74 Years				86	338					
75 Years +				38	186					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	6	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				0	0					
Transfers - Not included in Facility Admissions				0	0					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Total AMI	0			0	0	0	0.0	0.0	0.0	
Adolescent AMI		0	0	0	0	0	0.0	0.0		0.0
Adult AMI		0	0	0	0	0	0.0	0.0		0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	85			736	2,962	1,063	5.5	11.0	12.9	

**Inpatients and Outpatients Served by Payor Source**

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	19.2%	56.0%	0.0%	7.4%	13.3%	4.2%	
	143	417	0	55	99	31	745
Outpatients	9.2%	54.0%	0.5%	5.6%	29.3%	1.5%	
	5689	33462	281	3470	18193	908	62,003

<u>Financial Year Reported:</u>	12/1/2014 to	11/30/2015	<u>Inpatient and Outpatient Net Revenue by Payor Source</u>					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue ( \$ )	15.1%	68.2%	0.0%	14.6%	2.1%	100.0%		18,845,373	
	1,121,929	5,063,863	0	1,080,496	154,499	7,420,787	5,832,300		
Outpatient Revenue ( \$ )	3.1%	82.9%	0.0%	6.6%	7.4%	100.0%			
	2,076,410	55,012,419	0	4,375,925	4,898,494	66,363,248	13,013,073	25.5%	

**Birth Data**

Number of Total Births:	0
Number of Live Births:	0
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	0
CSections Performed:	0

**Newborn Nursery Utilization**

	Level I	Level II	Level II+
Beds	0	0	0
Patient Days	0	0	0
Total Newborn Patient Days			0
<b>Laboratory Studies</b>			
Inpatient Studies			15,689
Outpatient Studies			134,295
Studies Performed Under Contract			0

**Organ Transplantation**

Kidney:	
Heart:	
Lung:	
Heart/Lung:	
Pancreas:	
Liver:	
Total:	

<u>Ownership, Management and General Information</u>		<u>Patients by Race</u>		<u>Patients by Ethnicity</u>	
ADMINISTRATOR NAME:	Doug Elwell	White	4.9%	Hispanic or Latino:	4.3%
ADMINSTRATOR PHONE	312-864-6827	Black	93.0%	Not Hispanic or Latino:	95.7%
OWNERSHIP:	Cook County	American Indian	0.0%	Unknown:	0.0%
OPERATOR:	Cook County	Asian	0.5%		
MANAGEMENT:	County	Hawaiian/ Pacific	0.2%	IDPH Number:	4549
CERTIFICATION:		Unknown	1.4%	HPA	A-03
FACILITY DESIGNATION:	General Hospital			HSA	6
ADDRESS	500 East 51st Street	CITY: Chicago		COUNTY: Suburban Cook (Chicago)	

Facility Utilization Data by Category of Service

<u>Clinical Service</u>	<u>Authorized CON Beds 12/31/2017</u>	<u>Peak Beds Setup and Staffed</u>	<u>Peak Census</u>	<u>Admissions</u>	<u>Inpatient Days</u>	<u>Observation Days</u>	<u>Average Length of Stay</u>	<u>Average Daily Census</u>	<u>CON Occupancy Rate %</u>	<u>Staffed Bed Occupancy Rate %</u>
Medical/Surgical	79	25	17	587	2,892	1,362	7.2	11.7	14.8	46.6
0-14 Years				0	0					
15-44 Years				112	504					
45-64 Years				358	1,773					
65-74 Years				64	346					
75 Years +				53	269					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	6	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				0	0					
Transfers				0	0					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Total AMI	0			0	0	0	0.0	0.0	0.0	
Adolescent AMI		0	0	0	0	0	0.0	0.0		0.0
Adult AMI		0	0	0	0	0	0.0	0.0		0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	85			587	2,892	1,362	7.2	11.7	13.7	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	<u>Medicare</u>	<u>Medicaid</u>	<u>Other Public</u>	<u>Private Insurance</u>	<u>Private Pay</u>	<u>Charity Care</u>	<u>Totals</u>
Inpatients	20.3%	57.4%	0.0%	4.1%	11.1%	7.2%	
	119	337	0	24	65	42	587
Outpatients	18.8%	46.9%	0.0%	4.9%	16.6%	12.7%	
	19957	49854	26	5236	17609	13539	106,221

<u>Financial Year Reported:</u>	<u>12/1/2015 to</u>	<u>11/30/2016</u>	<u>Inpatient and Outpatient Net Revenue by Payor Source</u>				<u>Charity Care Expense</u>	<u>Total Charity Care Expense</u>
	<u>Medicare</u>	<u>Medicaid</u>	<u>Other Public</u>	<u>Private Insurance</u>	<u>Private Pay</u>	<u>Totals</u>	<u>Charity Care Expense</u>	<u>Total Charity Care as % of Net Revenue</u>
Inpatient Revenue ( \$ )	46.6%	15.1%	0.5%	29.2%	8.7%	100.0%		15,653,640
	389,991	126,378	4,236	244,456	72,674	837,735	1,565,345	
Outpatient Revenue ( \$ )	46.6%	15.1%	0.5%	29.2%	8.7%	100.0%		
	2,058,380	667,026	22,358	1,290,244	383,573	4,421,581	14,088,295	297.6%

Birthing DataNewborn Nursery UtilizationOrgan Transplantation

Number of Total Births:	0	Level I	Level II	Level II+	Kidney:	0
Number of Live Births:	0	Beds	0	0	Heart:	0
Birthing Rooms:	0	Patient Days	0	0	Lung:	0
Labor Rooms:	0	Total Newborn Patient Days		0	Heart/Lung:	0
Delivery Rooms:	0				Pancreas:	0
Labor-Delivery-Recovery Rooms:	0				Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0				Total:	0
C-Section Rooms:	0					
CSections Performed:	0					

Laboratory Studies

Inpatient Studies	6,973
Outpatient Studies	83,440
Studies Performed Under Contract	642

Ownership, Management and General Information		Patients by Race		Patients by Ethnicity	
ADMINISTRATOR NAME:	Peter Daniels	White	30.8%	Hispanic or Latino:	27.6%
ADMINSTRATOR PHONE	312-864-5507	Black	52.4%	Not Hispanic or Latino:	71.2%
OWNERSHIP:	Cook County	American Indian	3.3%	Unknown:	1.2%
OPERATOR:	John H. Stroger Hospital of Cook County	Asian	3.8%		
MANAGEMENT:	County	Hawaiian/ Pacific	0.1%	IDPH Number:	5272
CERTIFICATION:	None	Unknown	9.7%	HPA	A-02
FACILITY DESIGNATION:	General Hospital			HSA	6
ADDRESS	1901 West Harrison Street -	CITY: Chicago	COUNTY: Suburban Cook (Chicago)		

Facility Utilization Data by Category of Service										
Clinical Service	Authorized CON Beds 12/31/2014	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
<b>Medical/Surgical</b>	240	240	240	15,275	63,650	10,683	4.9	203.7	84.9	84.9
0-14 Years				0	0					
15-44 Years				4,055	16,723					
45-64 Years				8,329	35,126					
65-74 Years				1,868	7,619					
75 Years +				1,023	4,182					
<b>Pediatric</b>	40	14	14	494	1,653	543	4.4	6.0	15.0	43.0
<b>Intensive Care</b>	86	86	62	3,210	16,528	289	5.2	46.1	53.6	53.6
Direct Admission				2,557	12,469					
Transfers				653	4,059					
<b>Obstetric/Gynecology</b>	40	28	28	1,868	5,762	335	3.3	16.7	41.8	59.7
Maternity				1,182	3,801					
Clean Gynecology				686	1,961					
<b>Neonatal</b>	58	52	39	356	9,630	0	27.1	26.4	45.5	50.7
<b>Long Term Care</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<b>Swing Beds</b>			0	0	0		0.0	0.0		
<b>Acute Mental Illness</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<b>Rehabilitation</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<b>Long-Term Acute Care</b>	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	36					3417				
<b>Facility Utilization</b>	<b>464</b>			<b>20,550</b>	<b>97,223</b>	<b>15,267</b>	<b>5.5</b>	<b>308.2</b>	<b>66.4</b>	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source							
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
<b>Inpatients</b>	13.4%	54.9%	1.5%	3.3%	12.3%	14.5%	
	2761	11286	309	679	2537	2978	20,550
<b>Outpatients</b>	13.3%	43.8%	0.2%	3.1%	17.3%	22.4%	
	121921	401522	1377	28324	158421	204962	916,527

Financial Year Reported:		12/1/2012 to		11/30/2013		Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense 0
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals						
<b>Inpatient Revenue (\$)</b>	9.7%	86.7%	0.0%	3.3%	0.2%	100.0%						Total Charity Care as % of Net Revenue
	47,356,671	421,219,961	0	16,151,467	1,193,024	485,921,123	0					
<b>Outpatient Revenue (\$)</b>	29.1%	51.5%	0.0%	6.6%	12.8%	100.0%						
	10,152,388	17,997,130	0	2,318,806	4,452,543	34,920,867	0				0.0%	

Birthing Data			Newborn Nursery Utilization				Organ Transplantation		
Number of Total Births:	843		Level I	Level II	Level II+	Kidney:		0	
Number of Live Births:	823		Beds	26	8	Heart:		0	
Birthing Rooms:	0		Patient Days	0	0	Lung:		0	
Labor Rooms:	9		Total Newborn Patient Days			Heart/Lung:		0	
Delivery Rooms:	0					Pancreas:		0	
Labor-Delivery-Recovery Rooms:	0					Liver:		0	
Labor-Delivery-Recovery-Postpartum Rooms:	14		<b>Laboratory Studies</b>			Total:		0	
C-Section Rooms:	2		Inpatient Studies		954,370				
CSections Performed:	246		Outpatient Studies		1,691,844				
			Studies Performed Under Contract		55,101				

John H. Stroger reported Total Charity Care Cost of \$173,942,176. That is 33.4% of the reported Total Net Revenue of \$520,841,990.

<u>Ownership, Management and General Information</u>		<u>Patients by Race</u>		<u>Patients by Ethnicity</u>	
ADMINISTRATOR NAME:	Dr. John Jay Shannon	White	31.7%	Hispanic or Latino:	27.7%
ADMINSTRATOR PHONE	312-864-5504	Black	53.3%	Not Hispanic or Latino:	72.2%
OWNERSHIP:	Cook County	American Indian	1.9%	Unknown:	0.1%
OPERATOR:	John H Stroger Hospital of Cook County	Asian	3.6%		
MANAGEMENT:	County	Hawaiian/ Pacific	0.0%	IDPH Number:	5272
CERTIFICATION:	(Not Answered)	Unknown	9.5%	HPA	A-02
FACILITY DESIGNATION:	(Not Answered)			HSA	6
ADDRESS	1901 West Harrison Street -	CITY: Chicago		COUNTY: Suburban Cook (Chicago)	

**Facility Utilization Data by Category of Service**

<u>Clinical Service</u>	Authorized CON Beds 12/31/2015	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	240	240	240	16,136	62,365	12,529	4.6	205.2	85.5	85.5
0-14 Years				0	0					
15-44 Years				4,256	15,820					
45-64 Years				8,403	33,184					
65-74 Years				2,180	8,571					
75 Years +				1,297	4,790					
Pediatric	40	14	13	441	1,669	492	4.9	5.9	14.8	42.3
Intensive Care	86	86	73	4,000	19,974	453	5.1	56.0	65.1	65.1
Direct Admission				2,752	14,005					
Transfers				1,248	5,969					
Obstetric/Gynecology	40	26	26	1,850	5,829	276	3.3	16.7	41.8	64.3
Maternity				1,284	4,196					
Clean Gynecology				566	1,633					
Neonatal	58	52	35	338	9,217	0	27.3	25.3	43.5	48.6
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	22					2375				
Facility Utilization	464			21,517	99,054	16,125	5.4	315.6	68.0	

(Includes ICU Direct Admissions Only)

**Inpatients and Outpatients Served by Payor Source**

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	15.5%	47.9%	1.4%	4.5%	15.6%	15.1%	
	3328	10303	300	968	3359	3259	21,517
Outpatients	14.0%	42.8%	1.5%	5.4%	14.7%	21.6%	
	134101	409634	14688	51652	140450	206238	956,763

**Financial Year Reported:** 12/1/2013 to 11/30/2014 **Inpatient and Outpatient Net Revenue by Payor Source**

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense	Total Charity Care Expense
Inpatient Revenue ( \$ )	26.1%	64.8%	0.0%	7.8%	1.3%	100.0%		223,976,850
	66,632,934	165,739,966	0	19,941,739	3,299,619	255,614,258	84,517,794	
Outpatient Revenue ( \$ )	6.1%	79.6%	0.0%	11.0%	3.3%	100.0%		Total Charity Care as % of Net Revenue
	17,780,525	231,313,626	0	32,123,538	9,526,661	290,744,350	139,459,056	41.0%

**Birthing Data**

Number of Total Births:	902
Number of Live Births:	893
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	13
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	2
CSections Performed:	294

**Newborn Nursery Utilization**

	Level I	Level II	Level II+
Beds	26	0	0
Patient Days	1,927	0	0
Total Newborn Patient Days			1,927

**Organ Transplantation**

Kidney:	0
Heart:	0
Lung:	0
Heart/Lung:	0
Pancreas:	0
Liver:	0
Total:	0

**Laboratory Studies**

Inpatient Studies	961,397
Outpatient Studies	1,408,320
Studies Performed Under Contract	43,804

Ownership, Management and General Information		Patients by Race		Patients by Ethnicity	
ADMINISTRATOR NAME:	Doug Etwell	White	32.8%	Hispanic or Latino:	29.9%
ADMINSTRATOR PHONE:	(312) 864-7198	Black	52.3%	Not Hispanic or Latino:	70.0%
OWNERSHIP:	Cook County	American Indian	1.2%	Unknown:	0.1%
OPERATOR:	John H. Stroger Hospital of Cook County	Asian	3.8%		
MANAGEMENT:	County	Hawaiian/ Pacific	0.0%	IDPH Number:	5272
CERTIFICATION:	(Not Answered)	Unknown	9.9%	HPA	A-02
FACILITY DESIGNATION:	General Hospital			HSA	6
ADDRESS	1901 West Harrison Street -	CITY:	Chicago	COUNTY:	Suburban Cook (Chicago)

**Facility Utilization Data by Category of Service**

Clinical Service	Authorized CON Beds 12/31/2016	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	240	240	212	15,470	60,880	17,783	5.1	214.9	89.6	89.6
0-14 Years				4	4					
15-44 Years				4,204	16,027					
45-64 Years				7,936	31,137					
65-74 Years				2,099	8,914					
75 Years +				1,227	4,798					
Pediatric	26	14	13	426	1,635	614	5.3	6.1	23.6	43.9
Intensive Care	86	86	75	4,115	20,977	496	5.2	58.7	68.2	68.2
Direct Admission				2,919	15,325					
Transfers - Not included in Facility Admissions				1,196	5,652					
Obstetric/Gynecology	40	40	30	1,934	5,998	365	3.3	17.4	43.5	43.5
Maternity				1,448	4,655					
Clean Gynecology				486	1,343					
Neonatal	58	52	32	336	7,777	0	23.1	21.2	36.6	40.9
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Total AMI	0			0	0	0	0.0	0.0	0.0	
Adolescent AMI		0	0	0	0	0	0.0	0.0		0.0
Adult AMI		0	0	0	0	0	0.0	0.0		0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
<b>Facility Utilization</b>	<b>450</b>			<b>21,085</b>	<b>97,267</b>	<b>19,258</b>	<b>5.5</b>	<b>318.4</b>	<b>70.7</b>	

**Inpatients and Outpatients Served by Payer Source**

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	15.3%	47.3%	0.0%	4.6%	13.6%	19.2%	
	3218	9973	4	974	2875	4041	21,085
Outpatients	15.7%	39.5%	0.1%	5.8%	13.7%	25.4%	
	148385	374115	597	54684	129454	240629	947,864

Financial Year Reported:	12/1/2014 to	11/30/2015	Inpatient and Outpatient Net Revenue by Payer Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue ( \$ )	7.7%	88.9%	0.2%	0.3%	2.9%	100.0%		246,894,080	
	54,292,504	627,747,541	1,560,822	2,286,995	20,578,700	706,466,562	120,407,153		
Outpatient Revenue ( \$ )	4.8%	90.8%	0.6%	0.4%	3.5%	100.0%		Total Charity Care as % of Net Revenue	
	36,396,960	694,508,199	4,473,384	2,959,802	26,875,980	765,214,325	126,486,927	16.8%	

**Birth Data**

Number of Total Births:	897
Number of Live Births:	887
Birthing Rooms:	0
Labor Rooms:	9
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	9
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	2
CSections Performed:	283

**Newborn Nursery Utilization**

	Level I	Level II	Level II+
Beds	26	0	0
Patient Days	2,407	0	0
Total Newborn Patient Days			2,407

**Organ Transplantation**

Kidney:	
Heart:	
Lung:	
Heart/Lung:	
Pancreas:	
Liver:	
Total:	

**Laboratory Studies**

Inpatient Studies	1,054,599
Outpatient Studies	1,643,845
Studies Performed Under Contract	52,000

<u>Ownership, Management and General Information</u>		<u>Patients by Race</u>		<u>Patients by Ethnicity</u>	
ADMINISTRATOR NAME:	Douglas Elwell	White	32.8%	Hispanic or Latino:	29.7%
ADMINSTRATOR PHONE	312-864-6827	Black	53.1%	Not Hispanic or Latino:	70.3%
OWNERSHIP:	Cook County	American Indian	0.9%	Unknown:	0.0%
OPERATOR:	Cook County	Asian	3.6%		
MANAGEMENT:	County	Hawaiian/ Pacific	0.0%	IDPH Number:	5272
CERTIFICATION:		Unknown	9.6%	HPA	A-02
FACILITY DESIGNATION:	General Hospital			HSA	6
ADDRESS	1901 W. Harrison St	CITY:	Chicago	COUNTY:	Suburban Cook (Chicago)

<u>Facility Utilization Data by Category of Service</u>										
<u>Clinical Service</u>	Authorized CON Beds 12/31/2017	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate %	Staffed Bed Occupancy Rate %
Medical/Surgical	240	240	205	13,227	58,196	19,213	5.9	212.1	88.4	88.4
0-14 Years				0	0					
15-44 Years				3,546	15,305					
45-64 Years				6,691	28,919					
65-74 Years				1,842	8,695					
75 Years +				1,148	5,277					
Pediatric	26	14	9	201	689	332	5.1	2.8	10.8	20.0
Intensive Care	86	86	75	4,107	20,314	462	5.1	56.9	66.2	66.2
Direct Admission				3,006	15,232					
Transfers				1,101	5,082					
Obstetric/Gynecology	40	40	29	2,001	5,952	349	3.1	17.3	43.2	43.2
Maternity				1,532	4,682					
Clean Gynecology				469	1,270					
Neonatal	58	52	33	397	8,023	0	20.2	22.0	37.9	42.3
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds			0	0	0		0.0	0.0		
Total AMI	0			0	0	0	0.0	0.0	0.0	
Adolescent AMI		0	0	0	0	0	0.0	0.0		0.0
Adult AMI		0	0	0	0	0	0.0	0.0		0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	12					296				
Facility Utilization	450			18,832	93,174	20,652	6.0	311.9	69.3	

(Includes ICU Direct Admissions Only)

<u>Inpatients and Outpatients Served by Payor Source</u>							
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	15.8%	47.1%	0.0%	4.5%	14.2%	18.4%	
	2976	8869	1	841	2676	3469	18,832
Outpatients	15.8%	36.5%	0.1%	5.6%	15.5%	26.6%	
	147666	340868	482	51874	144709	248855	934,454

<u>Financial Year Reported:</u>		12/1/2015 to	11/30/2016	<u>Inpatient and Outpatient Net Revenue by Payor Source</u>				Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Expense		
Inpatient Revenue ( \$ )	13.1%	18.7%	56.9%	9.3%	2.0%	100.0%		281,015,133	
	31,786,806	45,098,744	137,624,920	22,423,850	4,827,838	241,762,158	93,611,583	Total Charity Care as % of Net Revenue	
Outpatient Revenue ( \$ )	13.1%	18.7%	56.9%	9.3%	2.0%	100.0%			
	37,361,744	53,008,400	161,762,309	26,356,664	5,674,570	284,163,687	187,403,550	53.4%	

<u>Birthing Data</u>		<u>Newborn Nursery Utilization</u>			<u>Organ Transplantation</u>	
Number of Total Births:	1,250	Level I	Level II	Level II+	Kidney:	0
Number of Live Births:	1,215	Beds	26	0	Heart:	0
Birthing Rooms:	0	Patient Days	2,340	0	Lung:	0
Labor Rooms:	0	Total Newborn Patient Days		2,340	Heart/Lung:	0
Delivery Rooms:	0				Pancreas:	0
Labor-Delivery-Recovery Rooms:	11	<u>Laboratory Studies</u>			Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0	Inpatient Studies		731,810	Total:	0
C-Section Rooms:	2	Outpatient Studies		1,603,670		
CSections Performed:	352	Studies Performed Under Contract		43,180		



# Cook County Health & Hospitals System

Financial Counseling Services

<b>Policy Title:</b> CareLink Financial Assistance Program Procedure	<b>Policy Number:</b>
<b>Date of Original Policy:</b> 4/17/2010 <b>Revised:</b> 11/1/2016	<input checked="" type="checkbox"/> Core Policy <input type="checkbox"/> Area Specific Policy
<b>Pages:</b> 16	

### Purpose:

To provide the guidelines for accessing financial assistance through CareLink for residents of Cook County.

### Scope:

The Cook County Health & Hospitals System mission is to provide a full range of high quality services to all the patients it serves. CCHHS will sponsor and administer a system wide financial assistance program, known as CareLink, herein referred to as "CareLink". CareLink is a program designed to assist those patients with income at or below 600% of the federal poverty guidelines as published annually in the federal register. CareLink is a financial assistance program for patients of CCHHS. A patient is eligible to apply for assistance for non-elective medical services under the CareLink program if they are:

- A resident of Cook County;
- Have an annual household income equal to or less than 600 % of federal poverty guidelines;
- Uninsured;
- Underinsured patients are defined as CCHHS patients covered by a private health insurance plan that has an active contract with CCHHS as an in-network provider. Patients with an HMO plan contracted with CCHHS AND who select CCHHS to serve as their Primary Care Provider, or patients with a PPO plan or traditional "fee-for-service, may apply for CareLink and receive a discount on the out-of-pocket costs associated with these plans, including deductibles and co-insurance. CareLink cost-sharing fees would be applicable.

For example, someone enrolled in an HMO plan contracted with CCHHS, but who has an annual deductible of \$6,600 and who has income below 600% FPL, may apply for CareLink to cover a portion of the out-of-pocket costs incurred at CCHHS.

CareLink will also be available on a temporary basis to existing CCHHS patients insured by a private health insurance plan that CCHHS currently only has a facility agreement with (and not a provider agreement).

Carelink is a payer of last resort. Carelink representatives must explore potential eligibility for other funding program sources (e.g., Medicaid, etc.) prior to certifying patients for eligibility. If a patient is potentially eligible for another financial assistance program(s) the patient must apply for assistance with the appropriate agency

and denied prior to being approved for Carelink Assistance. Any patient who fails or refuses to comply with this eligibility requirement is not eligible for Carelink assistance

### **Definitions:**

Fee-for-Service (FFS) Plans (non-PPO) - A traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse the patient after they have filed an insurance claim for each covered medical expense. When the patient needs medical attention, they visit the doctor or hospital of their choice.

Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO) - An FFS option that allows the patient to see medical providers who reduce their charges to the plan; the patient pay less money out-of-pocket when they use a PPO provider. When the patient visits a PPO they usually will not have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. For instance, lab work and radiology services from independent practitioners within the hospital may not be covered by the PPO agreement. Most networks are quite wide, but they may not have all the doctors or hospitals they want.

Health Maintenance Organization (HMO) - A health plan that provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service the patient receives and free the patient from completing paperwork or being billed for covered services. The patient's eligibility to enroll in an HMO is determined by where they live or, for some plans, where they work. Some HMOs are affiliated with or have arrangements with HMOs in other service areas for non-emergency care if the patient travels or are away from home for extended periods. Plans that offer reciprocity discuss it in their brochure.

- The HMO provides a comprehensive set of services - as long as the patient uses the doctors and hospitals affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and generally no deductible or coinsurance for in-hospital care.
- Most HMOs ask the patient to choose a doctor or medical group to be their primary care physician (PCP). The PCP provides general medical care. In many HMOs, a patient must get authorization or a "referral" from their PCP to see other providers. The referral is a recommendation by their physician for the patient to be evaluated and/or treated by a different physician or medical professional. The referral ensures that the patient sees the right provider for the care most appropriate to their condition.
- Care received from a provider not in the plan's network is not covered unless it is emergency care or the plan has a reciprocity arrangement.

HMO Plans Offering a Point of Service (POS) Product - In an HMO, the POS product lets the patient use providers who are not part of the HMO network. However, the patient pays more for using these non-network

providers. The patient usually pays higher deductibles and coinsurances than the patient pay with a plan provider. The patient will also need to file a claim for reimbursement, like in a FFS plan. The HMO plan wants the patient to use its network of providers, but recognizes that sometimes enrollees want to choose their own provider. Some plans are Point of Service (POS) plans and have features similar to both FFS plans and HMOs.

Consumer-Driven Health Plans (CDHP) - Describes a wide range of approaches to give the patient more incentive to control the cost of either their health benefits or health care. The patient has greater freedom in spending health care dollars up to a designated amount, and the patient receives full coverage for in-network preventive care. In return, the patient assumes significantly higher cost sharing expenses after they have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

High Deductible Health Plan (HDHP) - A High Deductible Health Plan is a health insurance plan in which the enrollee pays a deductible. HDHPs can have first dollar coverage (no deductible) for preventive care and higher out-of-pocket copayments and coinsurance for services received from non-network providers.

Health Savings Account (HSA) - A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pretax basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax-free, and that amount is available on a tax-free basis to pay medical costs. To open an HSA, the patient must be covered under a High Deductible Health Plan and cannot be eligible for Medicare or covered by another plan that is not a High Deductible Health Plan or a general purpose HCFSA or be dependent on another person's tax return. HSAs are subject to a number of rules and limitations established by the Department of Treasury.

Health Reimbursement Arrangement (HRA) - Health Reimbursement Arrangements are a common feature of Consumer-Driven Health Plans. They may be referred to by the health plan under a different name, such as Personal Care Account. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA. HRAs are similar to HSAs except an enrollee cannot make deposits into and HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

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## Section I. Program Overview

The Cook County Health & Hospitals System Mission is to provide a full range of high quality services to all the patients it serves. CCHHS will sponsor and administer a system-wide financial assistance program known as CareLink. This document established the requirements to determine eligibility for the CareLink program.

CareLink eligibility will be administered by the financial counseling services department. CCHHS will utilize federal poverty guidelines as published annually in the federal register as the basis for income eligibility thresholds.

CareLink is a financial assistance program for CCHHS patients who are uninsured or underinsured and ineligible for coverage through Medicaid or another public health care assistance programs. Someone who appears eligible for Medicaid MUST complete an application for Medicaid prior to OR at the same time a CareLink application is filed. Whenever possible and appropriate, financial counselors will use information provided in the Medicaid application in a patient's CareLink application.

Patients found ineligible for Medicaid because he/she has not cooperated with the application process will be found ineligible for CareLink.

Discounts on total charges for CareLink enrollees is on a sliding scale basis based on household income and the Federal Poverty Level:

- Uninsured patients with an annual income equal to or less than 250% of the Federal Poverty guidelines as established in the federal register annually are eligible for a 100% discount of total charges.
- Uninsured patients with an annual income greater than 250% of the federal poverty level but equal to or less than 350% of the current years Federal Poverty guidelines as established in the federal register annually are eligible for a 50% discount of total charges.
- Uninsured patients with an annual income greater than 350% of the federal poverty level but equal to or less than 600% of the current years Federal Poverty guidelines as established in the federal register annually are eligible for a 25% discount of total charges.
- Uninsured patients with an income above 600% are not eligible for assistance under the CareLink program.

### Patients with access to employer-sponsored health insurance

Patients with *access* to health insurance through his/her employer are **ineligible** for CareLink. However, the spouse or partner of the patient *may* be eligible for CareLink if the spouse or partner in question is unemployed or does not have access to his/her employer-sponsored health insurance, AND if the employer-sponsored insurance offered through the patient's employer is unaffordable. In this situation, unaffordable is a monthly premium for employee + spouse/partner defined as exceeding 9.5% of household income.

For example:

Jane is applying for CareLink for herself and her husband John. Their total monthly income is \$3,750.

Jane's employer offers her health insurance coverage at \$200/month. Regardless of whether Jane accepts this offer, Jane is ineligible for CareLink.

Jane's husband John works, but is not offered health insurance by his employer. Jane's employer offers family coverage for \$500/month (employee + spouse), which is over 13% of their household income. John may be found eligible for CareLink.

Please inform patients that while they may be found eligible for CareLink, this is not considered health insurance, and they may still be subject to a financial penalty for not having health insurance coverage when they file their taxes.

Households seeking to apply for CareLink under these circumstances are required to provide documentation that indicates the monthly premium for employee + spouse/partner coverage, which may also be referred to as family coverage. Acceptable documentation includes:

- Open enrollment flyer or other materials that includes the cost of employee + spouse/partner coverage, employer name, and date; or
- Letter from Human Resources on company letterhead that verifies the cost of employee + spouse/partner coverage with details about open enrollment.

**NOTE:** The affordability test is not necessary, if the patient states that they are not eligible to enroll in the spouse's employer-sponsored health insurance because they are ineligible noncitizen (do not have social security number) or employer does not offer spouse/family coverage, the patient is eligible to apply for CareLink.

#### Underinsured patients

Patients with certain private insurance coverage may be found eligible for CareLink, if CCHHS is considered an in-network provider with their HMO or if the patient has a PPO or traditional "fee-for-service". These patients are considered "underinsured" and may apply for CareLink to receive a partial discount on total out-of-pocket costs, excluding co-pays, which are not covered by the patient's private insurance (e.g. annual deductible or co-insurance).

- Underinsured patients with an annual income equal to or less than 250% of the Federal Poverty guidelines as established in the federal register annually are eligible for a 100% discount of total out-of-pocket costs, excluding co-pays.
- Underinsured patients with an annual income greater than 250% of the federal poverty level but equal to or less than 350% of the current years Federal Poverty guidelines as established in the federal register annually are eligible for a 50% discount of total out-of-pocket costs, excluding co-pays.
- Underinsured patients with an annual income greater than 350% of the federal poverty level but equal to or less than 600% of the current years Federal Poverty guidelines as established in the federal register

annually are eligible for a 25% discount of total out-of-pocket costs, excluding co-pays.

- Underinsured patients with an income above 600% are not eligible for assistance under the CareLink program.

CareLink cost-sharing fees are applicable regardless of whether someone is uninsured or underinsured.

Patients who have access to affordable employer-sponsored insurance are ineligible for CareLink.

#### Temporary CareLink policy to expire December 31, 2016

Through December 31, 2016, CareLink will provide temporary coverage to *existing* CCHHS patients insured by a private health insurance plan that CCHHS currently only has a facility agreement with. As of February 25, 2016, these plans include:

- Aetna
- Blue Cross Blue Shield HMOI

This temporary CareLink coverage is intended to provide CCHHS patients the opportunity to continue using CCHHS provider services while CCHHS works towards establishing a provider agreement with these health plans. Insured patients who may be eligible for temporary CareLink must be enrolled in a contracted HMO and who has selected CCHHS to serve as their Primary Care Provider or patients enrolled in a PPO.

Upon expiration of the patient's CareLink coverage, any visits to CCHHS providers that are not considered facility charges, would be the responsibility of the patient.

#### **Criteria Evaluated**

Any individual living in Cook County may apply for financial assistance or receive assistance in applying for state and federal assistance. It is not necessary for a person to have received medical services at a CCHHS facility.

Applicants must meet eligibility requirements to be eligible. Program eligibility determinations are based on analysis of the following criteria:

- Established Cook County Residence
- Analysis of Third Party Funding Sources
- Identification
- Family Size
- Income
- Ineligible for Medicaid, including ACA expansion, All Kids, Moms & Babies, FamilyCare, or AABD/SPD
- Access to affordable private insurance through an employer

It is the applicant's responsibility to present required documentation to substantiate the criteria above.

Applicants who refuse to provide this documentation are not eligible. Applicants will be made aware that independent verification is a part of the eligibility process. Applicants are **required to provide written attestation** to the validity and accuracy of information provided.

**Patient Financial Obligations – Cost-sharing fees (*future implementation date*)**

CareLink participants are subject to cost-sharing fees at the point of service of the following amounts:

- For CareLink enrollees with income below 250% FPL, a \$5 cost-sharing fee shall be applied per non-dental outpatient visit, with a maximum of up to \$10 for two or more non-dental outpatient visits taking place in one day. Outpatient visits include visits to the Emergency Department that DO NOT result in an inpatient hospital admission.
- For CareLink enrollees with income 250-600% FPL, a \$10 cost-sharing fee shall be applied per non-dental outpatient visit, with a maximum of up to \$20 for two or more non-dental outpatient visits in one day. Outpatient visits include visits to the Emergency Department that DO NOT result in an inpatient hospital admission.
- \$25 cost-sharing fee per dental visit applied to CareLink enrollees of all income levels.
- \$2 cost-sharing fee per prescription, with a max of \$8 for four or more prescriptions picked up in one day applied to CareLink enrollees of all income levels.

**Right to Appeal Process**

Every applicant will be afforded the right to appeal any decision related to program eligibility. The applicant’s right to appeal is addressed at the end of this policy.

**Section II. Patient Identity Procedures**

**Documentation**

In all cases, the applicant should be asked to provide a picture ID. If picture ID is not available, other forms of Identification are sufficient proof of applicant identification. The following may be used to establish the identity of the applicant. Patients are required to present two acceptable forms of Identification when applying for CareLink assistance.

**Required forms of ID: 1 item from list A, or 2 items from list B.**

List (A) Photo Identification

- Valid Passport
- Permanent Resident Card (green card)
- Naturalization/Citizenship papers with picture

List (B) Other Forms of Identification

- Government issued photo ID i.e. State Driver’s license or State Identification Card; Valid Foreign consulate identification card; Worker’s permit identification with picture; Foreign voter’s registration card with picture; Student picture ID

**NOTE:** (*If applicant does not have one of the photo identification listed in List A, one of these other photo IDs. Is required*)

- Birth record
- Certificate of Citizenship
- Notice to Appear
- Form I-94, Departure Record
- Naturalization Certificate without picture
- Form I-797, Notice of Action
- Travel Documents issued by U. S. Citizenship and Immigration Service
- Adoption records
- Social Security card
- SSI/RSDI award letter
- Voter registration card
- Referral letters from state or local agencies on agency letterhead. (Examples: Any local entity such as a church, hospital or clinic NOT part of CCHHS, nonprofit, neighborhood or community organization, shelter, a court or other government agency.)

### **Section III. Cook County Residency Requirements**

#### **Cook County Residents**

Persons applying for CareLink assistance must reside in Cook County at the time of service, **and** at the time of application. An applicant can be considered as living in Cook County in the following situations:

- The applicant is living in a home or fixed place of residence located in Cook County.
- An applicant with no fixed residence declaring intent to remain and live in Cook County.
- Immigration status is not a factor in determining CareLink eligibility provided all other eligibility criteria is met
- Patients residing at a domestic violence shelter in Cook County

#### **Residency Documentation**

##### **Accepted Proof**

All residency documentation must be in the name of the applicant or a member of the household unit (as defined in Section IV – Household Composition of this policy). The documentation must contain the address used or declared by the applicant to establish residency.

**Requirement at application:** At least 1 of the following items must be used to verify Cook County residency:

##### **Proof of residency**

- Mortgage statement dated within 30 days of the interview date
- Current lease/rental agreement
- Deed or sales contract for home purchase
- Utility bill dated within 30 days of the interview date
- Public or private school enrollment records

- Receipt of payment of property tax
- Written referral letter from a shelter, church, or nonprofit on organizational letterhead
- Documentation of release from a Department of Corrections Facility to a Cook County address
- Award letter from a federal or state agency (for example, Disability Award or Food Stamps) dated within previous 60 days
- Voter registration card
- Automobile registration
- Business mail, such as a bank statement, credit card bill or hospital bill from a non-CCHHS facility, addressed to the applicant or member of the household unit dated within the last 60 days

**No Fixed Residence, Homeless**

The applicant must complete a statement as to their homeless situation in situations where verifiable proof does not exist. The applicant must have also substantiated the reason for the lack of proof of residency.

**Non- Cook County Residents**

Persons not considered Cook County residents include the following persons:

- An applicant who resides outside the boundaries of Cook County limits
- An applicant who is an inmate, patient, or resident of an institution operated by a state or federal agency

**Section IV. Household Composition Requirements**

**Household**

Eligibility is based on a household. A household, for purposes of determining CareLink eligibility, consists of a person living alone or persons living together where one or more individuals have a legal responsibility for the support of the others; even when more than one household resides together. The income of included household members is considered when determining eligibility.

Examples of a household include:

- Single adults 18 or older, not attending school
- Parents and minor children
- A legally married couple or a couple in a civil union
- Caregiver relatives (aunt, uncle, grandparent) caring for minor children

**Excluded Household Members**

Certain individuals living in an otherwise eligible household are not considered part of the household. This includes individuals who are receiving

- A household member not living in the household
- Incarcerated household members

The income of these household members is not considered when determining eligibility.

## **Separate Households Living Together**

Separate households living together include any individual (or family) living together with another household unit and that individual (or family) has no legal responsibility for members of the other household unit. In these instances, the separate household person (or family) is not considered a part of household unit applying for CareLink assistance.

The incomes of separate households living together are not counted when determining eligibility.

CCHHS may ask for additional documentation to verify information provided in the CareLink application.

## **Section V. Income Guidelines**

Income is any type of recurring payment that is received by any household member applying for assistance. Household income is verified and compared to the Federal Poverty Income Level chart to determine eligibility.

### **Types of Income**

For CareLink assistance purposes there are two main categories of income that are to be assessed when determining eligibility. Types of income are “Countable Income” and “Exempt Income”. The income of the applicant and applicable household members must be considered when determining eligibility. For the purposes of determining eligibility, income is either counted or exempt.

### **Countable Income**

- Wages, salaries, bonuses and/or tips, received via paycheck or cash
- Self-employment, business, and farm income after deduction of business expenses (including depreciation and capital losses)
- Alimony payments
- Social Security Disability Insurance or retirement award letter
- Dividends, interest, and royalties
- Pensions and annuities, including investment income
- Railroad retirement
- Private or insurance disability payments
- Regular cash support from family/others not living in the applicant household
- Education/training stipends (specified for living expenses)
- Income from rental property
- Lump sum payments (counted only if received more than one in year, and only counts in the month received)
- Unemployment benefits

### **Exempt Income**

Exempt income is income or payments received by the applicant or a household member but not counted towards the household’s eligibility determination. Examples of Exempt Income may include:

- Supplemental Security Income (SSI) payments
- Dependent student/child earned income
- Temporary Assistance for Needy Families (TANF) or Foster Care

- Crime Victims Emergency Assistance
- Tax refunds
- Reimbursement of expenses (e.g., mileage, etc.)
- Employment income received by a full-time high school student
- Irregular Payments from family and friends of \$50.00 or less and not received regularly

Exempt income ***is not*** counted when determining eligibility.

## Section VI. Income Determination Process

### Calculating Income

Income determination for eligibility is based on verified gross monthly income. Not every applicant or household member receives income on a once monthly basis. Often a household's income must be converted from a non-monthly amount into a monthly amount. Converting Income to Monthly Values

The following table lists the different conversion formulas to be used when converting income to a monthly amount.

If the applicant or household member receives income ...	Then convert the income to a monthly amount by...
Weekly	Multiplying weekly average by 4.33
Every Other Week	Multiplying bi-weekly average by 2.17
Twice Monthly	Multiplying twice monthly average by 2
Once Monthly	Multiplying once monthly average by 1
Yearly (Self-employed)	Dividing previous tax years gross income by 12

### Documenting Income

All household income, counted or exempted, must be verified and documented. An applicant's statement of income will not be accepted as income verification.

### Employment Income Verification

An applicant's or household member's most recent paycheck stubs are the preferred method of verifying Employment Income. Acceptable forms of income verification may include:

Income Frequency	Pay Stubs Required
Weekly	4 Payroll check stubs, dated within last 30 days, if employed full-time and paid weekly.
Every Two Weeks or Bi-monthly	2 Payroll check stubs dated within last 30 days, if employed full-time and paid every

	two weeks or bi-monthly.
Once Monthly	2 Payroll check stubs, dated within last 60 days, if employed full-time and paid once monthly.
Employed Part-time or if hours vary	4 Payroll check stubs, dated within last 60 days, if employed part-time or if hours vary.

**Other forms of acceptable Income verification include:**

Required at application, if payroll check stubs are not available or the applicant is not employed.

- Written verification from employer on company letterhead; notarized typed/handwritten acceptable
- If self-employed, 30 days’ ledger of income/expenses
- Complete copy of prior year’s federal tax forms filed (self-employed only)
- Unemployment benefits statement or letter from the Illinois Dept. of Employment Security
- Retirement, Survivors, Disability Insurance (RSDI) award letters
- Short or long term disability statements
- Supplemental Security Income Award letters (SSI)
- Statement of dividends, interest and royalties
- Education/training stipends (specified for living expenses)
- Pensions and annuities statements
- Veteran’s Administration Benefits
- Worker’s Compensation letter
- Notarized letter indicating amount and source of financial assistance, that should include any regular cash support from family/others not living in the applicant household or in-kind support for room and board or other living expenses
- Notarized letter from non-legally responsible adults living in the same household as the patient providing in-kind support for room and board
- Income from rental property
- Farming income
- Child support payments or support verification letter
- Alimony support records or cancelled checks
- Odd jobs such as babysitting, cleaning houses, or mowing lawns, and day labor
- Lump Sum Payments (Counted only if received more than once in year, and only counts in the month received)

**Section VII. Application Process**

**Applicant Rights & Responsibilities**

Residents of Cook County have the right to submit an application for review and eligibility determination. Each applicant should be treated with dignity and respect during an interview for potential program eligibility. Before completing the eligibility interview, Financial Counselors must:

- Ensure the applicant has a thoroughly completed application with all required supporting documentation.
- Review rights and responsibilities.
- Confirm the applicant understands the rights and responsibilities.
- Explain the program's eligibility and verification requirements.

### **Application Submission**

Applicants must complete the "Application for CareLink" as part of the eligibility review process. The applicant or authorized representative can request an application in person or by telephone. All applications must be completed and signed by the applicant or a representative.

Note: CCHHS employees/contracted employees may assist with the completion of the application in situations where the applicant cannot reasonably complete the application him/herself, but the applicant or representative must sign the application attesting to its accuracy.

Patients may complete a CareLink application *prior* to receiving a service at CCHHS.

A patient who applies for CareLink *after* receiving a service from CCHHS may have CareLink retroactively cover all or a portion of that service, if a CareLink application is completed and approved within 90 days of that service.

**A CareLink application must be completed within 30 calendar days of initiation. This includes the paper application, the submission of any necessary documentation, and an interview with a financial counselor. Incomplete applications or applications missing the necessary supporting documentation will be considered pending for a period of up to 30 calendar days from the initial date of application. On the 31<sup>st</sup> day, an incomplete pending application will be denied. Denied applications and all supporting documentation will be returned to the applicant at time of denial and the patient will be provided with an "Eligibility Determination Notice" as well as instructions on how to re-apply for assistance.**

### **Face-to-Face Interview**

A face-to-face interview with a financial counselor is part of the CareLink application process. Face-to-face interviews are available with financial counselors at multiple sites throughout CCHHS. An application cannot be completed or approved until a face-to-face application occurs.

### **Supporting Documentation**

It is the responsibility of the applicant or representative to provide any and all supporting documents identified as necessary to determine eligibility during the interview. Failure to provide appropriate documents in the 30-day application window will result in denial and require a new CareLink application to be filed. The applicant will be responsible for re-scheduling another appointment once they have secured all required documentation.

## **Other Funding Program Sources**

CareLink is the payer of last resort. Financial Counselors must explore potential eligibility for other funding program sources (e.g., Medicaid, Crime Victims, etc.) prior to certifying patients for eligibility. If a patient is potentially eligible for another financial assistance program(s) the patient **must** apply for assistance with the appropriate agency and denied prior to being approved for CareLink Assistance.

Patients should be informed about their responsibility to apply for Medicaid or related programs if they appear to be eligible. Any patient who fails or refuses to comply with this eligibility requirement will be deemed ineligible for CareLink. Accounts on patients who have applied for assistance through other funding sources will remain financially classified as “Self-Pay” until final disposition is reached on applications for assistance with the other funding sources.

At CCHHS’ management discretion applicants pending eligibility for Supplemental Security Income (SSI) assistance may be processed for CareLink assistance based on several factors. This might include consideration of the length of time it currently takes the Social Security Administration to process and approve claims for SSI, high account balances, and account aging. Another consideration would include the applicant’s SSI claim and the current level of appeal with SSA.

## **Disposition of Application at Interview**

The “Notice of Eligibility Determination” is the applicant's notice of eligibility status. At the end of the application review/face-to-face interview with the patient the financial counselor will have reached one of three outcome options. This includes:

- Approved Application
- Denied Application
- Pending

## **Approved Application**

The financial counselor will complete the “Notice of Eligibility Determination” letter informing the applicant of their eligibility (or continuing eligibility for recipients reapplying to extend their benefits). The “Notice of Eligibility Determination” letter will contain the following:

- Applicant’s name
- Medical record number
- Effective beginning and ending dates of CareLink eligibility (Eligibility Coverage Period)
- Level of Assistance (e.g., 100% or a partial discount)
- Effective date of the decision
- The right to appeal
- The right to re-apply

The financial counselor will advise the household about their right to appeal the decision if there are concerns about the amount of eligibility provided. Additionally, remind the recipient they are required to report any change in their residency, household composition, or income. Explain that failure to do so will result in termination of coverage dating back to the date of the unreported change.

### **Denied Application**

The financial counselor will complete the “Notice of Eligibility Determination” letter informing the applicant of their denial. The “Notice of Eligibility Determination” letter will contain the following:

- Applicant’s name
  - Medical record number
  - Specific reason for denial; as listed below.
  - Effective date of the decision
  - The right to appeal
  - The right to re-apply
- 
- i. Incomplete application or missing/invalid supporting documentation
  - ii. Residency outside Cook County, Illinois
  - iii. Failure to keep face-to-face interview appointment
  - iv. Income exceeds program limits for applicant’s household unit size
  - v. Access to employer-sponsored health insurance coverage
  - vii. Applicant’s identification not established
  - 8. Non-Compliance (Not completing the requirement to apply for other funding program sources)
  - 9. Failure to report changes in “Residency, Household Composition, or Income”.

## **Section VIII. Eligibility Periods**

### **12-Month Eligibility Period**

Once a patient is found eligible for CareLink, he/she will have CareLink eligibility for up to 12 months from the month they are first approved. However, CareLink participants are required to report changes in family income, family size, insurance changes, or address to CCHHS Financial Counselors within 30 days of the changes occurring. Failure to report changes may result in cancellation of CareLink eligibility and billing for future CCHHS services.

CareLink enrollees may be subject to review of their case sooner than 12 months, in the event that they may be eligible for private insurance on the Marketplace during the Open Enrollment Period or through his/her employer.

### **Retroactive Eligibility**

Retroactive eligibility may be allowed for up to 90 days prior to the date of approval, provided the patient has met all eligibility criteria during that time frame. Retroactive eligibility applies only to the patient's self-pay account(s) or balances.

## **Section IX. Complaints, Grievances, and Appeals**

### **Overview**

- Applicant disagreements regarding denials should be addressed to the financial counselor completing the denial.
- If the applicant is not satisfied with the explanation or reason, the applicant may file an appeal by contacting the CareLink Advocate Direct Supervisor where the interview took place. The financial counselor or supervisor upon receipt of notice of appeal, either written or verbal must schedule an appointment with the applicant to hear their appeal within 2 business days. The applicant may be required to present additional documentation in compliance with this policy for the appeal process.
- The CareLink Advocate Direct Supervisor will review the patient's CareLink application and all supporting documentation and determine if the appeal hearing is necessary in order to reach a favorable decision. If the hearing is necessary, it should take place as scheduled. If not the hearing is cancelled and the patient notified of the favorable outcome. The patient must be notified of the CareLink Advocate Supervisor's decision no later than 5 business days following the appeal hearing.
- If the applicant is not satisfied with the financial counseling supervisor's decision the applicant will be referred to the Patient Access Director for further review. The Patient Access Director will review the file and render a final decision in writing and notify the applicant within 10 business days from the date the appeal was referred. The Patient Access Director may request that the patient provide additional documentation to assist in resolving the dispute.

If the applicant is not satisfied with the financial counseling director's decision the applicant's file will be referred to the Chief Financial Officer of the facility for final resolution.



# Cook County Health & Hospitals System

Financial Counseling Services

<b>Policy Title:</b> Financial Assistance Program Procedure		<b>Policy Number:</b>
<b>Date of Original Policy:</b> 4/17/2010 <b>Revised:</b> February 26, 2016	<input checked="" type="checkbox"/> Core Policy <input type="checkbox"/> Area Specific Policy	<b>Pages:</b> 16

### Purpose:

To provide the guidelines for accessing financial assistance through CareLink for residents of Cook County.

### Scope:

The Cook County Health & Hospitals System mission is to provide a full range of high quality services to all the patients it serves. CCHHS will sponsor and administer a system wide financial assistance program, known as CareLink, herein referred to as "CareLink". CareLink is a program designed to assist those patients with income at or below 600% of the federal poverty guidelines as published annually in the federal register. CareLink is a financial assistance program for patients of CCHHS. A patient is eligible to apply for assistance for non-elective medical services under the CareLink program if they are:

- A resident of Cook County;
- Have an annual household income equal to or less than 600 % of federal poverty guidelines;
- Uninsured;
- Underinsured patients are defined as CCHHS patients covered by a private health insurance plan that has an active contract with CCHHS as an in-network provider. Patients with an HMO plan contracted with CCHHS AND who select CCHHS to serve as their Primary Care Provider, or patients with a PPO plan or traditional "fee-for-service, may apply for CareLink and receive a discount on the out-of-pocket costs associated with these plans, including deductibles and co-insurance. CareLink cost-sharing fees would be applicable.

For example, someone enrolled in an HMO plan contracted with CCHHS, but who has an annual deductible of \$6,600 and who has income below 600% FPL, may apply for CareLink to cover a portion of the out-of-pocket costs incurred at CCHHS.

CareLink will also be available on a temporary basis to existing CCHHS patients insured by a private health insurance plan that CCHHS currently only has a facility agreement with (and not a provider agreement).

CareLink is a payer of last resort. CareLink representatives must explore potential eligibility for other funding program sources (e.g., Medicaid, etc.) prior to certifying patients for eligibility. If a patient is potentially eligible for another financial assistance program(s) the patient must apply for assistance with the appropriate agency and denied prior to being approved for CareLink Assistance. Any patient who fails or refuses to comply with this eligibility requirement is not eligible for

**Definitions:**

Fee-for-Service (FFS) Plans (non-PPO) - A traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse the patient after they have filed an insurance claim for each covered medical expense. When the patient needs medical attention, they visit the doctor or hospital of their choice.

Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO) - An FFS option that allows the patient to see medical providers who reduce their charges to the plan; the patient pay less money out-of-pocket when they use a PPO provider. When the patient visits a PPO they usually will not have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. For instance, lab work and radiology services from independent practitioners within the hospital may not be covered by the PPO agreement. Most networks are quite wide, but they may not have all the doctors or hospitals they want.

Health Maintenance Organization (HMO) - A health plan that provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service the patient receives and free the patient from completing paperwork or being billed for covered services. The patient's eligibility to enroll in an HMO is determined by where they live or, for some plans, where they work. Some HMOs are affiliated with or have arrangements with HMOs in other service areas for non-emergency care if the patient travels or are away from home for extended periods. Plans that offer reciprocity discuss it in their brochure.

- The HMO provides a comprehensive set of services - as long as the patient uses the doctors and hospitals affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and generally no deductible or coinsurance for in-hospital care.
- Most HMOs ask the patient to choose a doctor or medical group to be their primary care physician (PCP). The PCP provides general medical care. In many HMOs, a patient must get authorization or a "referral" from their PCP to see other providers. The referral is a recommendation by their physician for the patient to be evaluated and/or treated by a different physician or medical professional. The referral ensures that the patient sees the right provider for the care most appropriate to their condition.
- Care received from a provider not in the plan's network is not covered unless it is emergency care or the plan has a reciprocity arrangement.

HMO Plans Offering a Point of Service (POS) Product - In an HMO, the POS product lets the patient use providers who are not part of the HMO network. However, the patient pay more for using these non-network providers. The patient usually pay higher deductibles and coinsurances than the patient pay with a plan

provider. The patient will also need to file a claim for reimbursement, like in a FFS plan. The HMO plan wants the patient to use its network of providers, but recognizes that sometimes enrollees want to choose their own provider. Some plans are Point of Service (POS) plans and have features similar to both FFS plans and HMOs.

Consumer-Driven Health Plans (CDHP) - Describes a wide range of approaches to give the patient more incentive to control the cost of either their health benefits or health care. The patient has greater freedom in spending health care dollars up to a designated amount, and the patient receives full coverage for in-network preventive care. In return, the patient assume significantly higher cost sharing expenses after they have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

High Deductible Health Plan (HDHP) - A High Deductible Health Plan is a health insurance plan in which the enrollee pays a deductible. HDHPs can have first dollar coverage (no deductible) for preventive care and higher out-of-pocket copayments and coinsurance for services received from non-network providers.

Health Savings Account (HSA) - A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pretax basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax-free, and that amount is available on a tax-free basis to pay medical costs. To open an HSA, the patient must be covered under a High Deductible Health Plan and cannot be eligible for Medicare or covered by another plan that is not a High Deductible Health Plan or a general purpose HCFSAs or be dependent on another person's tax return. HSAs are subject to a number of rules and limitations established by the Department of Treasury.

Health Reimbursement Arrangement (HRA) - Health Reimbursement Arrangements are a common feature of Consumer-Driven Health Plans. They may be referred to by the health plan under a different name, such as Personal Care Account. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA. HRAs are similar to HSAs except an enrollee cannot make deposits into and HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

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## Section I. Program Overview

The Cook County Health & Hospitals System Mission is to provide a full range of high quality services to all the patients it serves. CCHHS will sponsor and administer a system-wide financial assistance program known as CareLink. This document established the requirements to determine eligibility for the CareLink program.

CareLink eligibility will be administered by the financial counseling services department. CCHHS will utilize federal poverty guidelines as published annually in the federal register as the basis for income eligibility thresholds.

CareLink is a financial assistance program for CCHHS patients who are uninsured or underinsured and ineligible for coverage through Medicaid or another public health care assistance programs. Someone who appears eligible for Medicaid MUST complete an application for Medicaid prior to OR at the same time a CareLink application is filed. Whenever possible and appropriate, financial counselors will use information provided in the Medicaid application in a patient's CareLink application.

Patients found ineligible for Medicaid because he/she has not cooperated with the application process will be found ineligible for CareLink.

Discounts on total charges for CareLink enrollees is on a sliding scale basis based on household income and the Federal Poverty Level:

- Uninsured patients with an annual income equal to or less than 250% of the Federal Poverty guidelines as established in the federal register annually are eligible for a 100% discount of total charges.
- Uninsured patients with an annual income greater than 250% of the federal poverty level but equal to or less than 350% of the current years Federal Poverty guidelines as established in the federal register annually are eligible for a 50% discount of total charges.
- Uninsured patients with an annual income greater than 350% of the federal poverty level but equal to or less than 600% of the current years Federal Poverty guidelines as established in the federal register annually are eligible for a 25% discount of total charges.
- Uninsured patients with an income above 600% are not eligible for assistance under the CareLink program.

### Patients with access to employer-sponsored health insurance

Patients with *access* to health insurance through his/her employer are **ineligible** for CareLink. However, the spouse or partner of the patient *may* be eligible for CareLink if the spouse or partner in question is unemployed or does not have access to his/her employer-sponsored health insurance, AND if the employer-sponsored insurance offered through the patient's employer is unaffordable. In this situation, unaffordable is a monthly premium for employee + spouse/partner defined as exceeding 9.5% of household income.

For example:

Jane is applying for CareLink for herself and her husband John. Their total monthly income is \$3,750.

Jane's employer offers her health insurance coverage at \$200/month. Regardless of whether Jane accepts this offer, Jane is ineligible for CareLink.

Jane's husband John works, but is not offered health insurance by his employer. Jane's employer offers family coverage for \$500/month (employee + spouse), which is over 13% of their household income. John may be found eligible for CareLink.

Please inform patients that while they may be found eligible for CareLink, this is not considered health insurance, and they may still be subject to a financial penalty for not having health insurance coverage when they file their taxes.

Households seeking to apply for CareLink under these circumstances are required to provide documentation that indicates the monthly premium for employee + spouse/partner coverage, which may also be referred to as family coverage. Acceptable documentation includes:

- Open enrollment flyer or other materials that includes the cost of employee + spouse/partner coverage, employer name, and date; or
- Letter from Human Resources on company letterhead that verifies the cost of employee + spouse/partner coverage with details about open enrollment.

**NOTE:** The affordability test is not necessary, if the patient states that they are not eligible to enroll in the spouse's employer-sponsored health insurance because they are ineligible noncitizen (do not have social security number) or employer does not offer spouse/family coverage, the patient is eligible to apply for CareLink.

#### Underinsured patients

Patients with certain private insurance coverage may be found eligible for CareLink, if CCHHS is considered an in-network provider with their HMO or if the patient has a PPO or traditional "fee-for-service". These patients are considered "underinsured" and may apply for CareLink to receive a partial discount on total out-of-pocket costs, excluding co-pays, which are not covered by the patient's private insurance (e.g. annual deductible or co-insurance).

- Underinsured patients with an annual income equal to or less than 250% of the Federal Poverty guidelines as established in the federal register annually are eligible for a 100% discount of total out-of-pocket costs, excluding co-pays.
- Underinsured patients with an annual income greater than 250% of the federal poverty level but equal to or less than 350% of the current years Federal Poverty guidelines as established in the federal register annually are eligible for a 50% discount of total out-of-pocket costs, excluding co-pays.
- Underinsured patients with an annual income greater than 350% of the federal poverty level but equal to or less than 600% of the current years Federal Poverty guidelines as established in the federal register annually are eligible for a 25% discount of total out-of-pocket costs, excluding co-pays.

- Underinsured patients with an income above 600% are not eligible for assistance under the CareLink program.

CareLink cost-sharing fees are applicable regardless of whether someone is uninsured or underinsured.

Patients who have access to affordable employer-sponsored insurance are ineligible for CareLink.

#### Temporary CareLink policy to expire December 31, 2018

Through December 31, 2018, CareLink will provide temporary coverage to *existing* CCHHS patients insured by a private health insurance plan that CCHHS currently only has a facility agreement. As of January 18, 2018, these plans include:

- Aetna
- Blue Cross Blue Shield HMOI

This temporary CareLink coverage is intended to provide CCHHS patients the opportunity to continue using CCHHS provider services while CCHHS works towards establishing a provider agreement with these health plans. Insured patients who may be eligible for temporary CareLink must be enrolled in a contracted HMO and who has selected CCHHS to serve as their Primary Care Provider or patients enrolled in a PPO.

Upon expiration of the patient's CareLink coverage, any visits to CCHHS providers that are not considered facility charges, would be the responsibility of the patient.

#### **Criteria Evaluated**

Any individual living in Cook County may apply for financial assistance or receive assistance in applying for state and federal assistance. It is not necessary for a person to have received medical services at a CCHHS facility.

Applicants must meet eligibility requirements to be eligible. Program eligibility determinations are based on analysis of the following criteria:

- Established Cook County Residence
- Analysis of Third Party Funding Sources
- Identification
- Family Size
- Income
- Ineligible for Medicaid, including ACA expansion, All Kids, Moms & Babies, FamilyCare, or AABD/SPD
- Access to affordable private insurance through an employer

It is the applicant's responsibility to present required documentation to substantiate the criteria above.

Applicants who refuse to provide this documentation are not eligible. Applicants will be made aware that independent verification is a part of the eligibility process. Applicants are **required to provide written attestation** to the validity and accuracy of information provided.

**Patient Financial Obligations – Cost-sharing fees (*future implementation date*)**

CareLink participants are subject to cost-sharing fees at the point of service of the following amounts:

- For CareLink enrollees with income below 250% FPL, a \$5 cost-sharing fee shall be applied per non-dental outpatient visit, with a maximum of up to \$10 for two or more non-dental outpatient visits taking place in one day. Outpatient visits include visits to the Emergency Department that DO NOT result in an inpatient hospital admission.
- For CareLink enrollees with income 250-600% FPL, a \$10 cost-sharing fee shall be applied per non-dental outpatient visit, with a maximum of up to \$20 for two or more non-dental outpatient visits in one day. Outpatient visits include visits to the Emergency Department that DO NOT result in an inpatient hospital admission.
- \$25 cost-sharing fee per dental visit applied to CareLink enrollees of all income levels.
- \$2 cost-sharing fee per prescription, with a max of \$8 for four or more prescriptions picked up in one day applied to CareLink enrollees of all income levels.

**Right to Appeal Process**

Every applicant will be afforded the right to appeal any decision related to program eligibility. The applicant's right to appeal is addressed at the end of this policy.

**Section II. Patient Identity Procedures**

**Documentation**

In all cases, the applicant should be asked to provide a picture ID. If picture ID is not available, other forms of Identification are sufficient proof of applicant identification. The following may be used to establish the identity of the applicant. Patients are required to present two acceptable forms of Identification when applying for CareLink assistance.

**Required forms of ID: 1 item from list A, or 2 items from list B.**

List (A) Photo Identification

- Valid Passport
- Permanent Resident Card (green card)
- Naturalization/Citizenship papers with picture
- Military ID with picture

List (B) Other Forms of Identification

- Government issued photo ID i.e. State Driver's license or State Identification Card; Valid Foreign consulate identification card; Worker's permit identification with picture; Foreign voter's registration card with picture; Student picture ID

- Birth record
- Certificate of Citizenship
- Notice to Appear
- Form I-94, Departure Record
- Naturalization Certificate without picture
- Form I-797, Notice of Action
- Travel Documents issued by U. S. Citizenship and Immigration Service
- Adoption records
- Social Security card
- SSI/RSDI award letter
- Voter registration card
- Referral letters from state or local agencies on agency letterhead. (Examples: Any local entity such as a church, hospital or clinic NOT part of CCHHS, nonprofit, neighborhood or community organization, shelter, a court or other government agency.)

### **Section III. Cook County Residency Requirements**

#### **Cook County Residents**

Persons applying for CareLink assistance must reside in Cook County at the time of service, **and** at the time of application. An applicant can be considered as living in Cook County in the following situations:

- The applicant is living in a home or fixed place of residence located in Cook County.
- An applicant with no fixed residence declaring intent to remain and live in Cook County.
- Immigration status is not a factor in determining CareLink eligibility provided all other eligibility criteria is met
- Patients residing at a domestic violence shelter in Cook County

#### **Residency Documentation**

##### **Accepted Proof**

All residency documentation must be in the name of the applicant or a member of the household unit (as defined in Section IV – Household Composition of this policy). The documentation must contain the address used or declared by the applicant to establish residency.

**Requirement at application:** At least 1 of the following items must be used to verify Cook County residency:

##### **Proof of residency**

- Mortgage statement dated within 30 days of the interview date
- Current lease/rental agreement
- Deed or sales contract for home purchase

- Utility bill dated within 30 days of the interview date
- Public or private school enrollment records
- Receipt of payment of property tax
- Written referral letter from a shelter, church, or nonprofit on organizational letterhead
- Documentation of release from a Department of Corrections Facility to a Cook County address
- Award letter from a federal or state agency (for example, Disability Award or Food Stamps) dated within previous 60 days
- Voter registration card
- Automobile registration
- Business mail, such as a bank statement, credit card bill or hospital bill from a non-CCHHS facility, addressed to the applicant or member of the household unit dated within the last 60 days

#### **No Fixed Residence, Homeless**

The applicant must complete a statement as to their homeless situation in situations where verifiable proof does not exist. The applicant must have also substantiated the reason for the lack of proof of residency.

#### **Non- Cook County Residents**

Persons not considered Cook County residents include the following persons:

- An applicant who resides outside the boundaries of Cook County limits
- An applicant who is an inmate, patient, or resident of an institution operated by a state or federal agency

### **Section IV. Household Composition Requirements**

#### **Household**

Eligibility is based on a household. A household, for purposes of determining CareLink eligibility, consists of a person living alone or persons living together where one or more individuals have a legal responsibility for the support of the others; even when more than one household resides together. The income of included household members is considered when determining eligibility.

Examples of a household include:

- Single adults 18 or older, not attending school
- Parents and minor children
- A legally married couple or a couple in a civil union
- Caregiver relatives (aunt, uncle, grandparent) caring for minor children

#### **Excluded Household Members**

Certain individuals living in an otherwise eligible household are not considered part of the household. This includes individuals who are receiving

- A household member not living in the household
- Incarcerated household members

The income of these household members is not considered when determining eligibility.

### **Separate Households Living Together**

Separate households living together include any individual (or family) living together with another household unit and that individual (or family) has no legal responsibility for members of the other household unit. In these instances the separate household person (or family) is not considered a part of household unit applying for CareLink assistance.

The incomes of separate households living together are not counted when determining eligibility.

CCHHS may ask for additional documentation to verify information provided in the CareLink application.

## **Section V. Income Guidelines**

Income is any type of recurring payment that is received by any household member applying for assistance. Household income is verified and compared to the Federal Poverty Income Level chart to determine eligibility.

### **Types of Income**

For CareLink assistance purposes there are two main categories of income that are to be assessed when determining eligibility. Types of income are “Countable Income” and “Exempt Income”. The income of the applicant and applicable household members must be considered when determining eligibility. For the purposes of determining eligibility, income is either counted or exempt.

### **Countable Income**

- Wages, salaries, bonuses and/or tips, received via paycheck or cash
- Self-employment, business, and farm income after deduction of business expenses (including depreciation and capital losses)
- Alimony payments
- Social Security Disability Insurance or retirement award letter
- Dividends, interest, and royalties
- Pensions and annuities, including investment income
- Railroad retirement
- Private or insurance disability payments
- Regular cash support from family/others not living in the applicant household
- Education/training stipends (specified for living expenses)
- Income from rental property
- Lump sum payments (counted only if received more than one in year, and only counts in the month received)
- Unemployment benefits

### **Exempt Income**

Exempt income is income or payments received by the applicant or a household member but not counted towards the household’s eligibility determination. Examples of Exempt Income may include:

- Supplemental Security Income (SSI) payments

- Dependent student/child earned income
- Temporary Assistance for Needy Families (TANF) or Foster Care
- Crime Victims Emergency Assistance
- Tax refunds
- Reimbursement of expenses (e.g., mileage, etc.)
- Employment income received by a full-time high school student
- Irregular Payments from family and friends of \$50.00 or less and not received regularly

Exempt income ***is not*** counted when determining eligibility.

## Section VI. Income Determination Process

### Calculating Income

Income determination for eligibility is based on verified gross monthly income. Not every applicant or household member receives income on a once monthly basis. Often a household's income must be converted from a non-monthly amount into a monthly amount. Converting Income to Monthly Values

The following table lists the different conversion formulas to be used when converting income to a monthly amount.

If the applicant or household member receives income ...	Then convert the income to a monthly amount by...
Weekly	Multiplying weekly average by 4.33
Every Other Week	Multiplying bi-weekly average by 2.17
Twice Monthly	Multiplying twice monthly average by 2
Once Monthly	Multiplying once monthly average by 1
Yearly (Self-employed)	Dividing previous tax years gross income by 12

### Documenting Income

All household income, counted or exempted, must be verified and documented. An applicant's statement of income will not be accepted as income verification.

### Employment Income Verification

An applicant's or household member's most recent paycheck stubs are the preferred method of verifying Employment Income. Acceptable forms of income verification may include:

Income Frequency	Pay Stubs Required
Weekly	2 Payroll check stubs, dated within last 30 days, if employed full-time and paid weekly.

Every Two Weeks or Bi-monthly	2 Payroll check stubs dated within last 30 days, if employed full-time and paid every two weeks or bi-monthly.
Once Monthly	2 Payroll check stubs, dated within last 60 days, if employed full-time and paid once monthly.
Employed Part-time or if hours vary	4 Payroll check stubs, dated within last 60 days, if employed part-time or if hours vary.

**Other forms of acceptable Income verification include:**

Required at application, if payroll check stubs are not available or the applicant is not employed.

- Written verification from employer on company letterhead
- If self-employed, 30 days ledger of income/expenses
- Complete copy of prior year’s federal tax forms filed
- Unemployment benefits statement or letter from the Illinois Dept. of Employment Security
- Retirement, Survivors, Disability Insurance (RSDI) award letters
- Short or long term disability statements
- Supplemental Security Income Award letters (SSI)
- Statement of dividends, interest and royalties
- Education/training stipends (specified for living expenses)
- Pensions and annuities statements
- Veteran’s Administration Benefits
- Worker’s Compensation letter
- Notarized letter indicating amount and source of financial assistance, that should include any regular cash support from family/others not living in the applicant household or in-kind support for room and board or other living expenses
- Notarized letter from non-legally responsible adults living in the same household as the patient providing in-kind support for room and board
- Income from rental property
- Farming income
- Child support payments or support verification letter
- Alimony support records or cancelled checks
- Odd jobs such as babysitting, cleaning houses, or mowing lawns, and day labor
- Lump Sum Payments (Counted only if received more than once in year, and only counts in the month received)

**Section VII. Application Process**

**Applicant Rights & Responsibilities**

Residents of Cook County have the right to submit an application for review and eligibility determination. Each applicant should be treated with dignity and respect during an interview for potential program eligibility. Before completing the eligibility interview, Financial Counselors must:

- Ensure the applicant has a thoroughly completed application with all required supporting documentation.
- Review rights and responsibilities.
- Confirm the applicant understands the rights and responsibilities.
- Explain the program's eligibility and verification requirements.

### **Application Submission**

Applicants must complete the "Application for CareLink" as part of the eligibility review process. The applicant or authorized representative can request an application in person or by telephone. All applications must be completed and signed by the applicant or a representative.

Note: CCHHS employees/contracted employees may assist with the completion of the application in situations where the applicant cannot reasonably complete the application him/herself, but the applicant or representative must sign the application attesting to its accuracy.

Patients may complete a CareLink application *prior* to receiving a service at CCHHS.

A patient who applies for CareLink *after* receiving a service from CCHHS may have CareLink retroactively cover all or a portion of that service, if a CareLink application is completed and approved within 90 days of that service.

**A CareLink application must be completed within 30 calendar days of initiation. This includes the paper application, the submission of any necessary documentation, and an interview with a financial counselor. Incomplete applications or applications missing the necessary supporting documentation will be considered pending for a period of up to 30 calendar days from the initial date of application. On the 31<sup>st</sup> day, an incomplete pending application will be denied. Denied applications and all supporting documentation will be returned to the applicant at time of denial and the patient will be provided with an "Eligibility Determination Notice" as well as instructions on how to re-apply for assistance.**

### **Face-to-Face Interview**

A face-to-face interview with a financial counselor is part of the CareLink application process. Face-to-face interviews are available with financial counselors at multiple sites throughout CCHHS. An application cannot be completed or approved until a face-to-face application occurs.

### **Supporting Documentation**

It is the responsibility of the applicant or representative to provide any and all supporting documents identified as necessary to determine eligibility during the interview. Failure to provide appropriate documents

in the 30-day application window will result in denial and require a new CareLink application to be filed. The applicant will be responsible for re-scheduling another appointment once they have secured all required documentation.

### **Other Funding Program Sources**

CareLink is the payer of last resort. Financial Counselors must explore potential eligibility for other funding program sources (e.g., Medicaid, Crime Victims, etc.) prior to certifying patients for eligibility. If a patient is potentially eligible for another financial assistance program(s) the patient **must** apply for assistance with the appropriate agency and denied prior to being approved for CareLink Assistance.

Patients should be informed about their responsibility to apply for Medicaid or related programs if they appear to be eligible. Any patient who fails or refuses to comply with this eligibility requirement will be deemed ineligible for CareLink. Accounts on patients who have applied for assistance through other funding sources will remain financially classified as “Self-Pay” until final disposition is reached on applications for assistance with the other funding sources.

At CCHHS’ management discretion applicants pending eligibility for Supplemental Security Income (SSI) assistance may be processed for CareLink assistance based on several factors. This might include consideration of the length of time it currently takes the Social Security Administration to process and approve claims for SSI, high account balances, and account aging. Another consideration would include the applicant’s SSI claim and the current level of appeal with SSA.

### **Disposition of Application at Interview**

The “Notice of Eligibility Determination” is the applicant's notice of eligibility status. At the end of the application review/face-to-face interview with the patient the financial counselor will have reached one of three outcome options. This includes:

- Approved Application
- Denied Application
- Pending

### **Approved Application**

The financial counselor will complete the “Notice of Eligibility Determination” letter informing the applicant of their eligibility (or continuing eligibility for recipients reapplying to extend their benefits). The “Notice of Eligibility Determination” letter will contain the following:

- Applicant’s name
- Medical record number

- Effective beginning and ending dates of CareLink eligibility (Eligibility Coverage Period)
- Level of Assistance (e.g., 100% or a partial discount)
- Effective date of the decision
- The right to appeal
- The right to re-apply

The financial counselor will advise the household about their right to appeal the decision if there are concerns about the amount of eligibility provided. Additionally, remind the recipient they are required to report any change in their residency, household composition, or income. Explain that failure to do so will result in termination of coverage dating back to the date of the unreported change.

### **Denied Application**

The financial counselor will complete the “Notice of Eligibility Determination” letter informing the applicant of their denial. The “Notice of Eligibility Determination” letter will contain the following:

- Applicant’s name
  - Medical record number
  - Specific reason for denial; as listed below.
  - Effective date of the decision
  - The right to appeal
  - The right to re-apply
- i. Incomplete application or missing/invalid supporting documentation
  - ii. Residency outside Cook County, Illinois
  - iii. Failure to keep face-to-face interview appointment
  - iv. Income exceeds program limits for applicant’s household unit size
  - v. Access to employer-sponsored health insurance coverage
  - vii. Applicant’s identification not established
  8. Non-Compliance (Not completing the requirement to apply for other funding program sources)
  9. Failure to report changes in “Residency, Household Composition, or Income”.

## **Section VIII. Eligibility Periods**

### **12-Month Eligibility Period**

Once a patient is found eligible for CareLink, he/she will have CareLink eligibility for up to 12 months from the

month they are first approved. However, CareLink participants are required to report changes in family income, family size, insurance changes, or address to CCHHS Financial Counselors within 30 days of the changes occurring. Failure to report changes may result in cancellation of CareLink eligibility and billing for future CCHHS services.

CareLink enrollees may be subject to review of their case sooner than 12 months, in the event that they may be eligible for private insurance on the Marketplace during the Open Enrollment Period or through his/her employer.

### **Retroactive Eligibility**

Retroactive eligibility may be allowed for up to 90 days prior to the date of approval, provided the patient has met all eligibility criteria during that time frame. Retroactive eligibility applies only to the patient's self-pay account(s) or balances.

## **Section IX. Complaints, Grievances, and Appeals**

### **Overview**

- Applicant disagreements regarding denials should be addressed to the financial counselor completing the denial.
- If the applicant is not satisfied with the explanation or reason, the applicant may file an appeal by contacting the CareLink Advocate Direct Supervisor where the interview took place. The financial counselor or supervisor upon receipt of notice of appeal, either written or verbal must schedule an appointment with the applicant to hear their appeal within 2 business days. The applicant may be required to present additional documentation in compliance with this policy for the appeal process.
- The CareLink Advocate Direct Supervisor will review the patients CareLink application and all supporting documentation and determine if the appeal hearing is necessary in order to reach a favorable decision. If the hearing is necessary it should take place as scheduled. If not the hearing is cancelled and the patient notified of the favorable outcome. The patient must be notified of the CareLink Advocate Supervisor's decision no later than 5 business days following the appeal hearing.
- If the applicant is not satisfied with the financial counseling supervisor's decision the applicant will be referred to the Patient Access Director for further review. The Patient Access Director will review the file and render a final decision in writing and notify the applicant within 10 business days from the date the appeal was referred. The Patient Access Director may request that the patient provide additional documentation to assist in resolving the dispute.

If the applicant is not satisfied with the financial counseling director's decision the applicants file will be referred to the Chief Financial Officer of the facility for final resolution.



Subject : Financial Counseling		Category: Revenue Cycle Operations Patient Access Registration	
Title: Illinois Rural Uninsured and the Hospital Uninsured Patient Discount Act (HUPDA)		Page: 1 of 40	Policy #: NEW
		Approval Date: 12/15/2011	Posting Date: 12/15/2011

**PURPOSE:**

To establish guidelines for offering medical discounts for uninsured patients who reside within the state of Illinois but outside of Cook County.

**AFFECTED AREAS:**

Procedure applies to all Cook County Health and Hospitals System (CCHHS) areas including, but not limited to, the following:

- Any representative at the Health Systems facilities John H. Stroger, Jr. Hospital, Oak Forest Hospital, Provident Hospital, Ambulatory & Community Health Network (ACHN), and the Ruth M. Rothstein Core Center
- Patient Financial Services, Reimbursement
- Patient Access, Registrations
- Pharmacy
- Laboratory
- Radiology
- Contractor that conducts business within CCHHS.

**POLICY:**

Stated or guidance via the Illinois Act and law: Illinois Rural Uninsured and the Hospital Uninsured Patient Discount Act (Public Act 95-0965) (HUPDA, as identified via this document) offers discounts and capitates (thresholds) for all hospital bills for uninsured patients and residents in Illinois. Effective 4/1/2009, hospital charges to eligible uninsured cannot exceed the costs of the services plus 35 percent. This law also places an annual cap on the amount of money hospitals can collect for services from eligible uninsured patients to no more than 25 percent of a patient's family income per year. (See Appendix A for the complete Act).

**DEFINITIONS:**

- Cost to charge ratio: the ratio of a hospital's costs to its charges taken from its most recently filed Medicare cost reports (CMS 2552-96 Worksheet C, Part I, PPS Inpatient Ratios).
- Critical Access Hospital: a hospital that is designated as such under the federal Medicare rural Hospital Flexibility Program
- Family Income: the sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support

- **Federal poverty income guidelines:** the poverty guidelines updated periodically in the Federal Register by the United States department of Health and Human Services under authority of 42 U.S.C. 9902 (2)
- **Health care services:** any medically necessary inpatient or outpatient hospital services, including pharmaceuticals or supplies provided by a hospital to a patient
- **Hospital:** any facility or institution required to be licensed pursuant to the Hospital Licensing Act or operated under the University of Illinois Hospital Act
- **Illinois resident:** a person who lives or intends to live in Illinois indefinitely, in the foreseeable future (i.e. one year or more, and/or no plans to relocate to another state). Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirements under this Act
- **Medically necessary:** any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A "medically necessary" service does not include any of the following:
  1. Non-medical services such as social and vocational services
  2. Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity
- **Rural hospital:** a hospital that is located outside a metropolitan statistical area
- **Uninsured discount:** a hospital's charges multiplied by the uninsured discount factor
- **Uninsured discount factor:** 1.0 less the product of a hospital's cost to charge ratio multiplied by 1.35
- **Uninsured patient:** an Illinois resident who is a patient of a hospital and is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance, or other third party liability

**PROCEDURE:**

**Responsible Party**

Any Representative/  
Supervisor/Manager  
in Patient Financial  
Services

**Guidelines**

**Section I. Program Overview**

The Cook County Health & Hospitals System (CCHHS) mission is to provide a full range of high quality services to all the patients it serves. CCHHS will sponsor and administer a system wide Hospital Uninsured Patient Discount Act known as "HUPDA" to non-Cook County residents. Cook County residents are

eligible and encouraged to apply to the Cook County Health & Hospital System's Carelink program. (See prevailing and Cook County Board Approved: CCHHS Carelink Procedure 03.14.2011 for additional details).

#### Program Guidelines

The HUPDA Procedure will comply with all state laws and precedent set by The State of Illinois General Assembly. The Attorney General is responsible for administering and ensuring compliance with this Act, including the development of any rules necessary for the implementation and enforcement of this Act.

Cook County Health & Hospital System is defined as a Critical Access Hospital under this Act. HUPDA eligibility will be administered by Patient Financial Services department. However, Patient Access Services will be responsible for collecting monies due at time of service (as applicable), and validating their current insurance/financial information at the time of service (typical registration process) for all qualified patients as listed via the computer systems.

CCHHS will utilize federal poverty guidelines as published annually in the (US) Federal Register as the basis for income eligibility thresholds. (See prevailing Federal Poverty Guidelines for additional details, as listed yearly via the U.S. Federal Register the 3rd week of January- website: [aspe.hhs.gov](http://aspe.hhs.gov).)

As defined by the Act: A Critical Access Hospital shall provide a discount from its charges to any uninsured patient who applies for a discount and has annual family income of not more than 300% of the federal poverty income guidelines for all medically necessary health care services exceeding \$300.00 in any one inpatient admission or outpatient visit/encounter.

CCHHS honors the discount for all medically necessary health care services exceeding \$300.00 in any one inpatient admission or outpatient encounter, a hospital shall not collect from an uninsured patient, deemed eligible under eligibility subsection, more than its charges less the amount of the uninsured discount.

The maximum amount that may be collected in a twelve (12) month period for health care services provided by the hospital from a patient determined by that hospital to be eligible is 25% of the patient's gross family income, and is subject to the patient's continued eligibility under this Act. The twelve (12) month period to which the maximum amount applies shall begin on the first date, after the effective date of this Act, an uninsured patient receives health care services that are determined to be eligible for the uninsured discount at that hospital.

To be eligible to have this maximum amount applied to subsequent charges, the uninsured patient shall inform the hospital in subsequent inpatient admissions or outpatient encounters that the patient has previously received

health care services from that hospital and was determined to be entitled to the uninsured discount (HUPDA).

#### **Criteria Evaluated**

Applicants must meet all eligibility requirements to be eligible (see Section II through Section VI below for additional details). Program eligibility determinations are based on analysis of the following criteria, as defined by the Act. The criteria is summarized below

- Established Illinois Residence
- Analysis of Third Party Funding Sources
- Valid proof of Identification
- Family Size
- Household Income/Resources as deemed necessary

To qualify for HUPDA, these are the resulting qualifications of the analysis.(see Section II through Section VI, below for additional details):

- Effective 4/1/2009, hospital charges to eligible uninsured cannot exceed the costs of the service plus 35 percent
- Must have no insurance coverage under any health benefit plan (includes partial and whole plans)
- Must provide verification of Illinois residency
- Patient will apply or has applied for public program coverage, Medicare or Medicaid, if the patient is likely to be eligible
- Must have a family income and assets of not more than 300 percent for the federal poverty level CCHHS for all medically necessary health care services exceeding \$300.00 in any one inpatient admission or outpatient encounter
- The law also puts an annual cap on the amount of money hospitals can collect for services (*See Patient Financial Obligations below*)
- Must apply and complete application for a discount within sixty (60) days of hospital discharge or service Hospital obligation to an uninsured patient who fails to provide requested documentation within thirty (30) days of request will cease

It is the applicant's responsibility to present required documentation to substantiate the criteria above. Applicants who refuse to provide this documentation are not eligible for additional consideration. Applicants will be made aware that independent verification, such as income and assets review, may be part of the eligibility process. Applicants are required to provide written attestation to the validity and accuracy of the information. The provision of false or misleading information by an applicant may result in CCHHS pursuing legal action against the applicant.

### **Patient Financial Obligations**

The HUPDA law places an annual cap on the amount of money a hospital can collect for services from eligible uninsured patients to no more than 25% of patient's family gross income per year if a payment plan is necessary. The minimum value to receive the HUPDA discount, as described by the law, are inpatient or outpatient services greater than \$300.00. The ability or inability to meet HUPDA uninsured Act guidelines, and the patient's financial obligations does not affect eligibility or ability to receive healthcare services. However, failure to satisfy obligations will result in enforcement of CCHHS standard collections efforts.

CCHHS will base the discount on per service/encounter charges. The Charges are discounted to a maximum of 135% of cost by applying the Cost of Charge Ratio from most recently filed Medicare Cost Report. (See prevailing Medicare Cost Report, Worksheet C as issued or provided by the Illinois Attorney General's Office for additional details).

### **Right to Appeal Process**

Every applicant will be afforded the right to appeal any decision related to program eligibility. The applicant's right to appeal is addressed via Appendix A - HUPDA Act.

## **Section II. Patient Identity Procedures**

### **Documentation:**

In all cases, the applicant will be asked to provide a picture ID. If picture ID is not available, other forms of identification are sufficient proof of applicant identification. The following may be used to establish the identity of the applicant. Patients are required to present two acceptable forms of identification when applying for HUPDA (see List A and B, below for details).

### **Required forms of ID:**

#### **CCHHS List (A) Photo Identification Requirement**

- Valid Illinois photo ID from the Secretary of State Office
- Valid domestic or foreign driver's license
- Military ID
- Passport/Student picture ID
- Employee picture identification card
- Workers' permit identification with picture

#### **CCHHS List (B) Other Forms of Identification Requirements:**

- Immigration documentation
- Social Security card

- SSI/RSDI Award Letter
- Birth certificate
- Wage stubs
- Referral letters from state or local agencies on agency letterhead (Examples: Any local entity such as a church, hospital, shelter, a court or government agency.)
- Or any document listed via Section III.

### **Section III. Illinois Residency Requirements:**

Illinois resident verification is required. Acceptable verification of Illinois residency shall include one of the following, in addition to the identification items listed above via Section II:

- a recent residential utility bill
- a housing lease agreement
- a vehicle registration card
- a voter registration card
- mail addressed to the uninsured patient at an Illinois address from a government or other credible source;
- a statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or a letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility.

Hospital obligations toward an individual uninsured patient under this Act shall cease if that patient unreasonably fails or refuses to provide the hospital with information or documentation requested under Section II through Section VI or to apply for coverage under public programs when requested within thirty (30) days of the hospital's request.

### **Section IV. Household Composition Requirements**

Eligibility is based on a household. A household, for purposes of determining HUPDA eligibility, consists of a person living alone or persons living together where one or more individuals have a legal responsibility for the support of the others; even when more than one household resides together. The income of included household members is considered when determining eligibility.

Examples of a household include:

- Single adult 18 or older, not attending school
- Parents and minor children
- Legally married couples
- Registered Domestic Partners
- Civil Union Partners

#### Excluded Household Members

- Certain individuals living in an otherwise eligible household are not considered part of the household for the purposes of considering income. This includes individuals who are: Receiving Assistance to Needy Families (TANF); Receiving Supplemental Security Income (SSI);
- a household member not living in the household; or are
- Currently incarcerated.

#### Minors as Household Members

A minor is any person who has not reached the age of 18, and is not, or has never been married. A household member's status is no longer in effect on the first day of the month following the month of;

- Their 18th birthday, or
- their high school graduation. The household member must expect to graduate from high school before their 19th birthday.

#### Marriage, Separation & Divorce

**Marriage:** Two individuals who have made a legal or informal declaration of marriage. The marriage must hold to the legal, acceptable standard in the State of Illinois (at the time of application).

**Separation:** Two individuals who were previously legally married or in a Civil Union and who no longer reside in the same household.

**Divorce:** Two individuals who have dissolved the marriage agreement.

**Civil Union:** A legal union of a same-sex couple, sanctioned by a civil authority.

#### Separate Households Living Together

Separate households living together include any individual (or family) living together with another household unit and that individual (or family) has no legal responsibility for members of the other household unit. In these instances the separate household person (or family) is not considered a part of household unit applying for HUPDA assistance.

Examples of a separate household include:

- Single adults 18 or older living together
- Parents living with adult children
- Two legally married couples living together

The incomes of separate households living together are not counted when determining eligibility.

#### Documentation

The following information can be used to document dependency status,

marriage, separation or divorce.

#### Dependency

Dependency can be established by presenting 1 of the following documents containing the household member's name:

- Birth certificate
- Hospital or public health records of birth
- Local, state, federal government or military record
- School or day care records
- Court-ordered guardianship/conservatorship
- Immigration and Naturalization Service records

#### Marriage, Separation & Divorce

##### Marriage

- Marriage license
- Matrimonial or marriage certificate
- Verbal declaration of marriage
- Bureau of Vital Statistics Declaration of Informal Marriage Form
- Current joint income tax return
- Documentation of a Civil Union as sanctioned by a civil authority

##### Separation

- Verbal declaration of separation from a spouse made at the beginning of the interview, otherwise both incomes should be used to determine eligibility
- School or day care records showing separate households for the parents or caretakers.

##### Divorce

- Divorce decree

#### Section V. Income Guidelines

Income is any type of recurring payment that is received by any household member applying for assistance. Household income is verified and compared to the Federal Poverty Income Level chart to determine eligibility. Acceptable family income documentation shall include any one of the following:

- a copy of the most recent tax return;
- a copy of the most recent W-2 form and 1099 forms;
- copies of the 2 most recent pay stubs;
- written income verification from an employer if paid in cash; or
- as applicable, credit reporting information,

An uninsured patient who is requesting an uninsured discount must certify the

existence of assets owned by the patient and to provide documentation of the value of such assets.

Acceptable documentation may include statements from financial institutions or some other third party verification of an asset's value. If no third party verification exists, then the patient shall certify as to the estimated value of the asset.

### **Types of Income**

For HUPDA assistance purposes there are two main categories of income that are to be assessed when determining eligibility. Types of income are "Countable Income" and "Exempt Income". The income of the applicant and applicable household members must be considered when determining eligibility. For the purposes of determining eligibility, income is either counted or exempt. The definition of wages for this purpose is gross wages.

### **Countable Income**

- Gross Wages, Salaries, & Tips
- Commissions
- Bonuses
- Alimony support
- Child support payments
- Retirement Survivors Disability Insurance (RSDI). These are benefits from the Social Security Administration
- Dividends, interest and royalties
- Pensions and annuities
- Veteran's Administration Benefits
- Worker's Compensation
- Regular cash support from family/others not living in the applicant household
- Education/training stipends (specified for living expenses)
- Income from rental property
- Farming income
- Odd jobs such as babysitting, cleaning houses, or mowing lawns, and day labor
- Lump Sum Payments (Counted only if received more than one in year, and only counts in the month received)
- Unemployment Insurance

### **Exempt Income**

Exempt income is income or payments received by the applicant or a household member but not counted towards the household's eligibility determination. Examples of Exempt Income may include:

- Supplemental Security Income (SSI) payments
- Dependent student/child earned income

- Temporary Assistance for Needy Families (TANF) or Foster Care
- Crime Victims Emergency Assistance
- Tax refunds
- Reimbursement of expenses (e.g., mileage, etc.)
- Employment income received by a full-time high school student
- Irregular Payments from family and friends of \$50.00 or less and not received regularly (once a month)

Exempt income is not counted when determining eligibility.

### Section VI. Income Determination Process

#### Calculating Income

Income determination for eligibility is based on verified gross yearly income. Not every applicant or household member receives income on a once monthly basis. Often a household's income must be converted from a non-monthly amount into a monthly amount.

#### Converting Income to Monthly Values

The following table lists the different conversion formulas to be used when converting income to a monthly amount.

If the applicant or household member receives income ...	Then convert the income to a yearly amount by...
Weekly	Multiplying weekly average by 52
Every Other Week	Multiplying bi-weekly average by 26
Twice Monthly	Multiplying twice monthly average by 24
Once Monthly	Multiplying once monthly average by 12
Yearly (Self employed)	As listed

#### Documenting Income

All household income, counted or exempted, must be verified and documented. An applicant's statement of income will not be accepted as income verification.

#### Employment Income Verification

An applicant's or household member's most recent paycheck stubs are the preferred method of verifying Employment Income.

Income Frequency	Pay Stubs Required
Weekly	Two (2) Payroll check stubs, dated within last 30 days, if employed full-time and paid weekly.
Every Two Weeks or Bi-monthly	Two (2) Payroll check stubs dated within last 30 days, if employed full-time and paid every two weeks or bi-monthly.
Once Monthly	Two (2) Payroll check stubs, dated within last 60 days, if employed full-time and paid once monthly.
Employed Part-time or if hours vary	Four (4) Payroll check stubs, dated within last 60 days, if employed part-time or if hours vary.

Other forms of acceptable Income verification include (Required at application, if payroll check stubs are not available or the applicant is not employed):

- Written verification from employer on company letterhead
- Child support payments or support verification letter
- Unemployment benefits statement or letter from the Illinois Dept. of Employment Security
- Alimony support records or cancelled checks
- Retirement, Survivors, Disability Insurance (RSDI) award letters
- Supplemental Security Income Award letters (SSI)
- Statement of dividends, interest and royalties
- Education/training stipends (specified for living expenses)
- Pensions and annuities statements
- Veteran's Administration Benefits
- Worker's Compensation letter
- Complete copy of prior years Federal tax filed

**Organization Financial Requirements**

CCHHS will submit to the Attorney General's office, Worksheet C Part I from its most recently filed Medicare Cost Report with the Attorney General within sixty (60) days after the effective date of this Act and thereafter shall file each subsequent Worksheet C Part I with the Attorney General within thirty (30) days of filing its Medicare Cost Report with the hospital's fiscal intermediary.

**Section VII. Third Party Funding Sources**

**Patient Third Party Funding Access**

#### **Enrollment in Employer-Sponsored Health Insurance**

Applicants who are eligible for an employer-sponsored health plan at the time of application may not be considered for the HUPDA discount. If an individual chooses not to pay the insurance premiums, then this will be considered during the HUPDA application process.

HUPDA is specific to uninsured or underinsured patients (lacking hospital/inpatient and physician/outpatient medical coverage, i.e. dental plan only) and it cannot be combined with Third Party Funding sources.

#### **Enrollment in Other Funding Programs**

Applicants who are enrolled in a funding program not sponsored by an employer such as Medicare and Medicaid at the time of application may be eligible for HUPDA assistance as a secondary or tertiary funding source.

### **Section VIII. Application Process**

#### **Applicant Rights & Responsibilities**

Residents of Illinois have the right to submit an application for review and eligibility determination. Each applicant will be treated with dignity and respect during an interview for potential program eligibility. Before completing the eligibility interview, the Patient Financial Services Representatives must:

- Ensure the applicant has a thoroughly completed application with all required supporting documentation.
- Review rights and responsibilities.
- Confirm the applicant understands the rights and responsibilities.
- Explain the program's eligibility and verification requirements.

#### **Conflict of Interest**

Patient Financial Services Representatives must not process a charity-based program application if a conflict of interest exists. A conflict of interest is defined as situations where an employee/contracted employee and the applicant are in a personal relationship; situations in which the applicant is the employee's/contracted employee roommate, relative or acquaintance.

Examples include:

- Father or mother (parent or guardian)
- Grandfather or grandmother
- Brother or sister
- Uncle or aunt
- First cousin
- Nephew or niece
- Stepfather or stepmother
- Stepbrother or stepsister

- Neighbor
- Business Associate
- Acquaintance
- Husband or wife
- Domestic or civil union partner

The conflict of interest relationship restriction extends up to:

- The spouse of the listed relatives, even after the marriage has ended in death or divorce;
- The degree of "great-great" for uncles/aunts and nephews/nieces; and
- The degree of "great-great-great" for grandparents.

The conflict of interest also extends to include the spouse of the listed relatives even when the married couple (listed relative and spouse) is "separated." The Representative should inform their immediate supervisor of the potential conflict of interest and request that another Representative determine the applicant's eligibility. Similarly, management staff must defer to another member of management if a potential conflict of interest at any point during the process.

#### **Application Submission**

Applicants must complete the "Application for CareLink/HUPDA" as part of the eligibility review process. The applicant or authorized representative can request an application in person or by telephone. All applications must be completed and signed by the applicant or a representative.

Note: CCHHS employees/contracted employees may assist with the completion of the application in situations where the applicant cannot reasonably complete the application him/herself, but the applicant or representative must sign the application attesting to its accuracy. All applications for assistance through the HUPDA must be submitted complete and with all supporting documentation in order to be scheduled for a face to face interview appointment. Incomplete applications or applications missing the necessary supporting documentation may be denied. Denied applications and all supporting documentation will be returned to the applicant at time of denial and the patient will be provided with an "HUPDA Discount Notice" as well as instructions on how to re-apply for assistance, however the patient's application timeframe may not be revised (60 days to apply post discharge or date of service and 30 days to fulfill the requirements), to accommodate missing data elements.

#### **Face to Face Interview**

The interview process is a face to face interview with the applicant. Eligibility determination will only be conducted if the application packet is 100% complete, and all supporting documents attached. Patient Financial Services Representatives are the designated staff responsible for eligibility determination process; quality review of their HUPDA processes will be performed often to assure adherence to the prevailing procedure and process.

### Supporting Documentation

It is the responsibility of the applicant or representative to provide any and all supporting documents identified as necessary to determine eligibility during the interview. Failure to provide the appropriate documents may result in denial. The applicant will be responsible for re-scheduling another appointment once they have secured all required documentation, however this information must be submitted within sixty (60) days post discharge and a maximum of thirty (30) days to fulfill the requirements upon the discovery of the missing elements. However, a maximum of two (2) attempts at extension of the previously disclosed outstanding need will be allowed.

### Other Funding Program Sources

Financial Assistance via HUPDA is a payer of last resort. Patient Financial Services Representatives must explore (or refer the patient) potential eligibility for other funding program sources (e.g., Medicaid, Medicare, etc.) prior to certifying patients for HUPDA eligibility. If a patient is potentially eligible for another financial assistance program(s) the patient must apply for assistance with the appropriate agency and denied prior to being approved for CCHHS HUPDA discount. Any patient who fails or refuses to comply with this eligibility requirement is not eligible for assistance. Accounts on patients who have applied for assistance through other funding sources will remain financially classified as "Self-Pay" until final disposition is reached on applications for assistance with the other funding sources. At CCHHS' management discretion applicants pending eligibility for Supplemental Security Income (SSI) assistance may be processed for assistance based on several factors. This might include consideration of the length of time it currently takes the Social Security Administration (SSA) to process and approve claims for SSI, high account balances, and account aging. Another consideration would include the applicant's SSI claim and the current level of appeal with SSA.

### Disposition of Application at Interview

The "Notice of HUPDA Determination" is the applicant's notice of eligibility status. At the end of the application review/ face to face interview with the patient, the Representative and the calculation of the discount and/or payment plan.

The Representative will complete the "Notice of HUPDA Eligibility Determination" letter informing the applicant of their eligibility (or continuing eligibility for recipients reapplying to extend their benefits). The "Notice of HUPDA Determination" letter will contain the following:

- Applicants name
- Medical record number
- Level of Discount and/or Payment Plan Arrangement based on the Program Guidelines listed in Section I.
- Effective date of the decision
- Timeframe for Eligibility

The Representative will advise the household about their right to appeal the decision if there are concerns about the amount of eligibility provided. Additionally, remind the patient they are required to report any change in their residency, household composition, or income. Explain that failure to do so will result in standard CCHHS collection efforts, which may ultimately lead to collection agency actions.

#### Continuing Eligibility Reviews

Each time a recipient of the HUPDA discount presents for services at CCHHS, registration staff must conduct insurance verification and/or a mini-review of payer data during the usual course of registration processes. This review is designed to determine if any changes have occurred in the recipient's circumstances that would affect HUPDA eligibility. Continuing Eligibility Reviews may also be conducted as part of the pre-registration for scheduled services. These changes include but are not limited to:

- Residency
- Income
- Employment
- Household composition
- Financial Resources
- Access to Employer group health coverage

Registration and Patient Financial Services staff are required to conduct the continuing eligibility review questions in an open ended question format, meaning the patient must provide responses with more than a YES or NO response. Example; instead of asking the patient "Do you still reside at 1313 Mockingbird Lane?" the registrar would ask the question "Can you please verify the address we currently have on file for you?"

When a status change is identified during the mini-review the patient will be directed to contact Patient Financial Services department and team who will interview the patient to determine if the status change affects program eligibility. This must occur prior to services being rendered, if possible. If not possible, this should be accomplished prior to the patient being discharged. Patient Financial Services Representatives are responsible for explaining to the patient that failure to see a Patient Financial Services Representative could result in

termination of their HUPDA eligibility, the discount will be removed, and usual "Self Pay" processes will commence which may culminate in collection agency efforts.

### **Section IX. Eligibility Periods**

#### **Eligibility**

Eligibility can remain in effect for a period of twelve (12) consecutive months. Patient is responsible for notifying CCHHS of the dates of service/accounts to be considered. The eligibility date may vary based on the accounts submitted for the HUPDA coverage, however this time frame may not exceed one (1) year, twelve (12) consecutive months or three hundred sixty-five (365) days from the most current account date.

#### **Retroactive Eligibility**

Retroactive eligibility applies only to the patient's self-pay account(s) or balances.

Retroactive eligibility is possible provided that all visits have been disclosed during the HUPDA processes. If a patient needs to be considered for service dates beyond/older than the most current date of service/account, this is possible however it will impact future eligibility time frame. A patient will be considered for HUPDA discount for a continuous 1 year (365 days). Sufficient documentation (as outlined via this procedure) is required to reflect and indicate the need during the period. Patient's eligibility will be reviewed with each inpatient and/or outpatient admission

### **Section X. Complaints, Grievances, and Appeals**

#### **Overview**

Complaints and grievances should be directed to the Patient Financial Services department, particularly if these are outside of the HUPDA discount guidance. There are escalation processes within the department which include Patient Financial Services Management and the System Director of Patient Financial Services. All final decisions will result in a letter issued by CCHHS addressing the concerns.

If the complaints are not remedied by Patient Financial Services, the Senior Director of the Revenue Cycle and/or the System Chief Financial Officer of CCHHS, the Illinois Attorney General's Office may intervene on the patient's behalf.

The Attorney General is responsible for administering and ensuring compliance with this Act, including the development of any rules necessary for the

implementation and enforcement of this Act.

The Attorney General will conduct an investigation, request documentation and report of the events to assure compliance and/or address any complaints. If CCHHS has corrective action measures to administer, the patient and CCHHS will be advised of the results.

The Attorney General may seek the assessment of a civil monetary penalty not to exceed \$500.00 per violation in any action filed under this Act where a hospital, by pattern or practice, knowingly violates this Act.

In the event a court grants a final order of relief against any hospital for a violation of this Act, the Attorney General may, after all appeal rights have been exhausted, refer the hospital to the Illinois Department of Public Health for possible adverse licensure action under the Hospital Licensing Act.

**Guidelines/Action Steps:**

1. Out of county patient contacts CCHHS (in person, mail, telephone, facsimile, or other electronic means) or notifies the registrar during the registration process that that they will need assistance with their medical bills.
  - a. If patient contacts CCHHS, the Customer Service Representative in PFS provides a HUPDA packet and/or advised of the HUPDA requirements.
  - b. If the patient contacts/inquires while at Patient Access Services, the corresponding team member will refer the patient to Financial Counseling utilizing the packet information.
2. If patient is unable to visit the facility, this interview may be conducted by telephone provided the patient has submitted all required documentation prior to the telephone interview; the documentation should also indicate the patient's interest in qualifying for the HUPDA discount. Patient's signatures will obtained/requested at the end of the interview process, or if the documents are mailed in, the patient's signature will be validated with the copies of the identification items as listed in Section II. List (A)
3. Patient (or submitted documentation) is received via in-person or

**Responsible Party**

Patient Financial  
Services and  
Patient Access  
Services  
Representatives

Financial  
Counselors and Self  
Pay  
Representatives

telephone contact. The HUPDA packet is reviewed for completeness. The checklist is based on items listed in Section I through VI:

- Illinois Residency
  - Income
  - Employment
  - Household composition/Resources
  - Access to Employer group health coverage
- a. Is the documentation complete?
    - i. No. The patient must be rescheduled and provided the list of items that are missing.
    - ii. Yes. Proceed to the next step.
  4. The documents received will be scanned into the patient's Financial Record and/or highest dollar value account/visit.
  5. A review of the documentation will be performed. Pertinent data will be reviewed to assure that the patient meets the critical guidelines established by HUPDA.
    - a. Is the patient's income (household) more than 300% of the Federal Poverty Guidelines?
      - i. Yes. Patient does not qualify for HUPDA, standard collection efforts will apply and a payment plan should be arranged that are within the standard CCHHS collections guidelines.
      - ii. No. The patient is qualified for HUPDA. Proceed to next step.
  6. When approved, the Financial Counselor will calculate the patient's responsibility portion based on the HUPDA guidelines, not to exceed 25% of the patient's (household) annual income. The Counselor will utilize the HUPDA Calculator (otherwise called the HUPDA packet) to determine the discount and payment arrangement. (See the CCHHS HUPDA Calculator for additional details. This is also listed via Appendix C). The final determination of the eligibility will be quality reviewed and/or approved by the Lead/Supervisor/Manager to assure compliance with the HUPDA law and guidelines as detailed within this Procedure. A letter will given to the patient advising them of:
    - a. The effective dates of HUPDA;
    - b. They (the patient) is responsible for notifying Patient Financial Services when their bill is over \$300 for a discount to be calculated on their bill and a payment arrangement to be made; and
    - c. If the balance of the bill is under \$300 the patient will receive no discount but may contact Patient Financial Services to set up a payment plan.
  7. The HUPDA Calculator, "Notice of HUPDA Determination" letter and Payment Arrangement Agreement will be scanned into the Imaging

Financial Counselor  
and Patient Access  
leadership team

System.

Patient Financial  
Services Customer  
Service and Self  
Pay

Patient Access  
Services  
Representatives

Patient Financial  
Services Customer  
Service and Self  
Pay Representative,  
Supervisor and/or  
Manager

Patient Access  
Service  
Representative

8. If the patient's charges exceed \$300.00, patient contacts Patient Financial Services and determine what discount is to be applied. A payment plan for the remaining balance will then be determined.
  - For charges less than \$300.00, standard CCHHS collection efforts will prevail. These services would not qualify for HUPDA consideration, standard rates and collection procedures would apply.
9. Post quality review, the accounts contained with the HUPDA packet will be updated to the correct Transaction and Activity Codes for the discount and payment plan to be placed on the account(s). The payment plan processes and system Comments will document the time frame for the payment plan arrangements and the HUPDA eligibility, respectively. The "Notice of HUPDA Determination" letter and Payment Arrangement Agreement will be prepared.
10. The patient will be contacted and advised of their responsibilities based on the HUPDA Calculator results utilizing the CCHHS Payment Plan Agreement terms. (See *Financial Payment Plan Agreement Procedure for additional details; a prevailing CCHHS Payment Plan table is outlined via Appendix B.*) If the patient expresses concerns regarding the arrangements, return to Step 8 above and the Supervisor will assist in considering alternative arrangements, as applicable (i.e. increase timeframe of the arrangement). (See *the HUPDA Calculator for additional details*).
11. The patient will be provided "Notice of HUPDA Determination" letter within seven (7) days of their Face to Face/Telephone review of account(s). It will list the payment arrangements and the patient will have 30 days to return the payment arrangement documents and the first payment, if these documents were not previously provided to the patient and the initial payment collected.
12. Upon each future visit, the patient will be required to present the "Notice of HUPDA Determination" and/or insurance information and a mini-review of insurance information (if any), standard within the registration processes, may capture new information that may impact the patient's HUPDA eligibility. If the patient is uninsured or underinsured, the patient will be registered / admitted as "Self Pay"; the HUPDA information will be noted on the account during the visit. If the patient has insurance, HUPDA will not apply and the patient's insurance carrier will be billed according to prevailing contractual rates. As appropriate, with each registration, a patient may have a

responsibility portion at the point of service for insurance/payer amounts due. (See Admission/Registration Procedures for additional details).

13. Patient must notify (telephone or mail) the Patient Financial Services department (post each visit) in order for the HUPDA discount to apply. New agreed upon payment arrangement terms will also apply to all new visits. If the patient defaults on the prevailing agreed upon HUPDA-related payment arrangements three (3) times during the payment arrangement time frame the discount will be removed, and usual/standard "Self Pay" processes will commence which may culminate in collection agency efforts.

**JOB AIDS:**

- HUPDA calculator in Excel

**POLICY UPDATE SCHEDULE:** Review within one year from approval date

**CROSS REFERENCES:**

- Cook County Board Approved: CCHHS CareLink Procedure 03.14.2011
- Payment Plan Arrangement Agreement Procedure
- HUPDA Calculator

**RELEVANT REGULATORY OR OTHER REFERENCES:**

- Illinois Rural Uninsured and the Hospital Uninsured Patient Discount Act (Public Act 95-0965) (HUPDA) *See Appendix A*
- Medicare Cost Report, CMS 2552-96 Worksheet C, Part I, PPS Inpatient Ratios
- Federal Register, Federal Poverty Guidelines

**APPROVAL PARTIES:**

**SIGNATURE ON FILE**

System Director, Patient Access

**12/15/2011**

Date

**SIGNATURE ON FILE**

System Chief Financial Officer

**12/15/2011**

Date

**APPENDIX:**

- A - Illinois Rural Uninsured and the Hospital Uninsured Patient Discount Act (Public Act 95-0965) (HUPDA)
- B - CCHHS Payment Plan Terms
- C.1 - HUPDA Checklist
- C.2 - HUPDA Income Calculator
- C.3 - HUPDA Worksheet
- C.4 - HUPDA Determination

**Appendix A**

**Illinois Rural Uninsured and the Hospital Uninsured Patient Discount Act (Public Act 95-0965) (HUPDA)**

**Public Act 095-0965**

SB2380 Enrolled

LRB095 19723 KBJ 46088 b

AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Hospital Uninsured Patient Discount Act.

Section 5. Definitions. As used in this Act:

"Cost to charge ratio" means the ratio of a hospital's costs to its charges taken from its most recently filed Medicare cost report (CMS 2552-96 Worksheet C, Part I, PPS Inpatient Ratios).

"Critical Access Hospital" means a hospital that is designated as such under the federal Medicare Rural Hospital Flexibility Program.

"Family income" means the sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support.

"Federal poverty income guidelines" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

"Health care services" means any medically necessary inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a

patient.

"Hospital" means any facility or institution required to be licensed pursuant to the Hospital Licensing Act or operated under the University of Illinois Hospital Act.

"Illinois resident" means a person who lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this Act.

"Medically necessary" means any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A "medically necessary" service does not include any of the following:

- (1) Non-medical services such as social and vocational services.
- (2) Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.

"Rural hospital" means a hospital that is located outside a metropolitan statistical area.

"Uninsured discount" means a hospital's charges multiplied by the uninsured discount factor.

"Uninsured discount factor" means 1.0 less the product of a hospital's cost to charge ratio multiplied by 1.35.

"Uninsured patient" means an Illinois resident who is a patient of a hospital and is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability.

#### Section 10. Uninsured patient discounts.

##### (a) Eligibility.

- (1) A hospital, other than a rural hospital or Critical Access Hospital, shall provide a discount from its charges to any uninsured patient who applies for a discount and has family income of not more than 600% of the federal poverty income guidelines for all medically necessary health care services exceeding \$300 in any one inpatient admission or

outpatient encounter.

(2) A rural hospital or Critical Access Hospital shall provide a discount from its charges to any uninsured patient who applies for a discount and has annual family income of not more than 300% of the federal poverty income guidelines for all medically necessary health care services exceeding \$300 in any one inpatient admission or outpatient encounter.

(b) Discount. For all health care services exceeding \$300 in any one inpatient admission or outpatient encounter, a hospital shall not collect from an uninsured patient, deemed eligible under subsection (a), more than its charges less the amount of the uninsured discount.

(c) Maximum Collectible Amount.

(1) The maximum amount that may be collected in a 12 month period for health care services provided by the hospital from a patient determined by that hospital to be eligible under subsection (a) is 25% of the patient's family income, and is subject to the patient's continued eligibility under this Act.

(2) The 12 month period to which the maximum amount applies shall begin on the first date, after the effective date of this Act, an uninsured patient receives health care services that are determined to be eligible for the uninsured discount at that hospital.

(3) To be eligible to have this maximum amount applied to subsequent charges, the uninsured patient shall inform the hospital in subsequent inpatient admissions or outpatient encounters that the patient has previously received health care services from that hospital and was determined to be entitled to the uninsured discount.

(4) Hospitals may adopt policies to exclude an uninsured patient from the application of subdivision (c) (1) when the patient owns assets having a value in excess of 600% of the federal poverty level for hospitals in a metropolitan statistical area or owns assets having a value in excess of 300% of the federal poverty level for Critical Access Hospitals or hospitals outside a metropolitan statistical area, not counting the following assets: the uninsured patient's primary residence;

personal property exempt from judgment under Section 12-1001 of the Code of Civil Procedure; or any amounts held in a pension or retirement plan, provided, however, that distributions and payments from pension or retirement plans may be included as income for the purposes of this Act.

(d) Each hospital bill, invoice, or other summary of charges to an uninsured patient shall include with it, or on it, a prominent statement that an uninsured patient who meets certain income requirements may qualify for an uninsured discount and information regarding how an uninsured patient may apply for consideration under the hospital's financial assistance policy.

Section 15. Patient responsibility.

(a) Hospitals may make the availability of a discount and the maximum collectible amount under this Act contingent upon the uninsured patient first applying for coverage under public programs, such as Medicare, Medicaid, AllKids, the State Children's Health Insurance Program, or any other program, if there is a reasonable basis to believe that the uninsured patient may be eligible for such program.

(b) Hospitals shall permit an uninsured patient to apply for a discount within 60 days of the date of discharge or date of service.

(1) Income verification. Hospitals may require an uninsured patient who is requesting an uninsured discount to provide documentation of family income. Acceptable family income documentation shall include any one of the following:

- (A) a copy of the most recent tax return;
- (B) a copy of the most recent W-2 form and 1099 forms;
- (C) copies of the 2 most recent pay stubs;
- (D) written income verification from an employer if paid in cash; or
- (E) one other reasonable form of third party income verification deemed acceptable to the hospital.

(2) Asset verification. Hospitals may require an uninsured patient who is requesting an uninsured discount to certify the existence of assets owned by the patient and to provide documentation of the value of such assets.

Acceptable documentation may include statements from financial institutions or some other third party verification of an asset's value. If no third party verification exists, then the patient shall certify as to the estimated value of the asset.

(3) Illinois resident verification. Hospitals may require an uninsured patient who is requesting an uninsured discount to verify Illinois residency. Acceptable verification of Illinois residency shall include any one of the following:

(A) any of the documents listed in paragraph (1);  
(B) a valid state-issued identification card;  
(C) a recent residential utility bill;  
(D) a lease agreement;  
(E) a vehicle registration card;  
(F) a voter registration card;  
(G) mail addressed to the uninsured patient at an Illinois address from a government or other credible source;

(H) a statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or

(I) a letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility.

(c) Hospital obligations toward an individual uninsured patient under this Act shall cease if that patient unreasonably fails or refuses to provide the hospital with information or documentation requested under subsection (b) or to apply for coverage under public programs when requested under subsection (a) within 30 days of the hospital's request.

(d) In order for a hospital to determine the 12 month maximum amount that can be collected from a patient deemed eligible under Section 10, an uninsured patient shall inform the hospital in subsequent inpatient admissions or outpatient encounters that the patient has previously received health care services from that hospital and was determined to be entitled to the uninsured discount.

(e) Hospitals may require patients to certify that all of the information provided in the application is true. The application may state that if any of the information is untrue, any discount granted to the patient is forfeited and the

patient is responsible for payment of the hospital's full charges.

Section 20. Exemptions and limitations.

(a) Hospitals that do not charge for their services are exempt from the provisions of this Act.

(b) Nothing in this Act shall be used by any private or public health care insurer or plan as a basis for reducing its payment or reimbursement rates or policies with any hospital. Notwithstanding any other provisions of law, discounts authorized under this Act shall not be used by any private or public health care insurer or plan, regulatory agency, arbitrator, court, or other third party to determine a hospital's usual and customary charges for any health care service.

(c) Nothing in this Act shall be construed to require a hospital to provide an uninsured patient with a particular type of health care service or other service.

(d) Nothing in this Act shall be deemed to reduce or infringe upon the rights and obligations of hospitals and patients under the Fair Patient Billing Act.

(e) The obligations of hospitals under this Act shall take effect for health care services provided on or after the first day of the month that begins 90 days after the effective date of this Act or 90 days after the initial adoption of rules authorized under subsection (a) of Section 25, whichever occurs later.

Section 25. Enforcement.

(a) The Attorney General is responsible for administering and ensuring compliance with this Act, including the development of any rules necessary for the implementation and enforcement of this Act.

(b) The Attorney General shall develop and implement a process for receiving and handling complaints from individuals or hospitals regarding possible violations of this Act.

(c) The Attorney General may conduct any investigation deemed necessary regarding possible violations of this Act by any hospital including, without limitation, the issuance of subpoenas to:

(1) require the hospital to file a statement or report or answer interrogatories in writing as to all information relevant to the alleged violations;

(2) examine under oath any person who possesses knowledge or information directly related to the alleged violations; and

(3) examine any record, book, document, account, or paper necessary to investigate the alleged violation.

(d) If the Attorney General determines that there is a reason to believe that any hospital has violated this Act, the Attorney General may bring an action in the name of the People of the State against the hospital to obtain temporary, preliminary, or permanent injunctive relief for any act, policy, or practice by the hospital that violates this Act. Before bringing such an action, the Attorney General may permit the hospital to submit a Correction Plan for the Attorney General's approval.

(e) This Section applies if:

(1) A court orders a party to make payments to the Attorney General and the payments are to be used for the operations of the Office of the Attorney General; or

(2) A party agrees in a Correction Plan under this Act to make payments to the Attorney General for the operations of the Office of the Attorney General.

(f) Moneys paid under any of the conditions described in subsection (e) shall be deposited into the Attorney General Court Ordered and Voluntary Compliance Payment Projects Fund. Moneys in the Fund shall be used, subject to appropriation, for the performance of any function, pertaining to the exercise of the duties, to the Attorney General including, but not limited to, enforcement of any law of this State and conducting public education programs; however, any moneys in the Fund that are required by the court to be used for a particular purpose shall be used for that purpose.

(g) The Attorney General may seek the assessment of a civil monetary penalty not to exceed \$500 per violation in any action filed under this Act where a hospital, by pattern or practice, knowingly violates Section 10 of this Act.

(h) In the event a court grants a final order of relief against any hospital for a violation of this Act, the Attorney General may, after all appeal rights have been exhausted, refer the hospital to the Illinois Department of Public Health for possible adverse licensure action under the Hospital Licensing Act.

(i) Each hospital shall file Worksheet C Part I from its

most recently filed Medicare Cost Report with the Attorney General within 60 days after the effective date of this Act and thereafter shall file each subsequent Worksheet C Part I with the Attorney General within 30 days of filing its Medicare Cost Report with the hospital's fiscal intermediary.

Section 30. Home rule. A home rule unit may not regulate hospitals in a manner inconsistent with the provisions of this Act. This Section is a limitation under subsection (i) of Section 6 of Article VII of the Illinois Constitution on the concurrent exercise by home rule units of powers and functions exercised by the State.

Section 90. The Comprehensive Health Insurance Plan Act is amended by changing Section 2 as follows:

(215 ILCS 105/2) (from Ch. 73, par. 1302)

Sec. 2. Definitions. As used in this Act, unless the context otherwise requires:

"Plan administrator" means the insurer or third party administrator designated under Section 5 of this Act.

"Benefits plan" means the coverage to be offered by the Plan to eligible persons and federally eligible individuals pursuant to this Act.

"Board" means the Illinois Comprehensive Health Insurance Board.

"Church plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Continuation coverage" means continuation of coverage under a group health plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal or State law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Sections 367.2, 367e, and 367e.1 of the Illinois Insurance Code, or any other similar requirement in another State.

"Covered person" means a person who is and continues to remain eligible for Plan coverage and is covered under one of the benefit plans offered by the Plan.

"Creditable coverage" means, with respect to a federally eligible individual, coverage of the individual under any of

the following:

- (A) A group health plan.
- (B) Health insurance coverage (including group health insurance coverage).
- (C) Medicare.
- (D) Medical assistance.
- (E) Chapter 55 of title 10, United States Code.
- (F) A medical care program of the Indian Health Service or of a tribal organization.
- (G) A state health benefits risk pool.
- (H) A health plan offered under Chapter 89 of title 5, United States Code.
- (I) A public health plan (as defined in regulations consistent with Section 104 of the Health Care Portability and Accountability Act of 1996 that may be promulgated by the Secretary of the U.S. Department of Health and Human Services).
- (J) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).
- (K) Any other qualifying coverage required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or regulations under that Act.

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in Section 2791(c) of title XXVII of the Public Health Service Act (42 U.S.C. 300 gg-91), nor does it include any period of coverage under any of items (A) through (K) that occurred before a break of more than 90 days or, if the individual has been certified as eligible pursuant to the federal Trade Act of 2002, a break of more than 63 days during all of which the individual was not covered under any of items (A) through (K) above.

Any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in determining if there has been a break of more than 90 days in any credible coverage.

"Department" means the Illinois Department of Insurance.

"Dependent" means an Illinois resident: who is a spouse; or who is claimed as a dependent by the principal insured for

purposes of filing a federal income tax return and resides in the principal insured's household, and is a resident unmarried child under the age of 19 years; or who is an unmarried child who also is a full-time student under the age of 23 years and who is financially dependent upon the principal insured; or who is a child of any age and who is disabled and financially dependent upon the principal insured.

"Direct Illinois premiums" means, for Illinois business, an insurer's direct premium income for the kinds of business described in clause (b) of Class 1 or clause (a) of Class 2 of Section 4 of the Illinois Insurance Code, and direct premium income of a health maintenance organization or a voluntary health services plan, except it shall not include credit health insurance as defined in Article IX 1/2 of the Illinois Insurance Code.

"Director" means the Director of the Illinois Department of Insurance.

"Effective date of medical assistance" means the date that eligibility for medical assistance for a person is approved by the Department of Human Services or the Department of Healthcare and Family Services, except when the Department of Human Services or the Department of Healthcare and Family Services determines eligibility retroactively. In such circumstances, the effective date of the medical assistance is the date the Department of Human Services or the Department of Healthcare and Family Services determines the person to be eligible for medical assistance.

"Eligible person" means a resident of this State who qualifies for Plan coverage under Section 7 of this Act.

"Employee" means a resident of this State who is employed by an employer or has entered into the employment of or works under contract or service of an employer including the officers, managers and employees of subsidiary or affiliated corporations and the individual proprietors, partners and employees of affiliated individuals and firms when the business of the subsidiary or affiliated corporations, firms or individuals is controlled by a common employer through stock ownership, contract, or otherwise.

"Employer" means any individual, partnership, association, corporation, business trust, or any person or group of persons acting directly or indirectly in the interest of an employer in relation to an employee, for which one or more persons is gainfully employed.

"Family" coverage means the coverage provided by the Plan for the covered person and his or her eligible dependents who also are covered persons.

"Federally eligible individual" means an individual resident of this State:

(1) (A) for whom, as of the date on which the individual seeks Plan coverage under Section 15 of this Act, the aggregate of the periods of creditable coverage is 18 or more months or, if the individual has been certified as eligible pursuant to the federal Trade Act of 2002, 3 or more months, and (B) whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

(2) who is not eligible for coverage under (A) a group health plan (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), (B) part A or part B of Medicare due to age (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002), or (C) medical assistance, and does not have other health insurance coverage (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002);

(3) with respect to whom (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002) the most recent coverage within the coverage period described in paragraph (1) (A) of this definition was not terminated based upon a factor relating to nonpayment of premiums or fraud;

(4) if the individual (other than an individual who has been certified as eligible pursuant to the federal Trade Act of 2002) had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation

coverage, has exhausted such continuation coverage under such provision or program.

However, an individual who has been certified as eligible pursuant to the federal Trade Act of 2002 shall not be required to elect continuation coverage under a COBRA continuation provision or under a similar state program.

"Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with that plan.

"Group health plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Governmental plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, non-profit health care service plan contract, health maintenance organization or other subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. Health insurance coverage shall not include short term, accident only, disability income, hospital confinement or fixed indemnity, dental only, vision only, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization and a voluntary health services plan) that is authorized to transact health insurance business in this State. Such term does not include a group health plan.

"Health Maintenance Organization" means an organization as defined in the Health Maintenance Organization Act.

"Hospice" means a program as defined in and licensed under

the Hospice Program Licensing Act.

"Hospital" means a duly licensed institution as defined in the Hospital Licensing Act, an institution that meets all comparable conditions and requirements in effect in the state in which it is located, or the University of Illinois Hospital as defined in the University of Illinois Hospital Act.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance.

"Insured" means any individual resident of this State who is eligible to receive benefits from any insurer (including health insurance coverage offered in connection with a group health plan) or health insurance issuer as defined in this Section.

"Insurer" means any insurance company authorized to transact health insurance business in this State and any corporation that provides medical services and is organized under the Voluntary Health Services Plans Act or the Health Maintenance Organization Act.

"Medical assistance" means the State medical assistance or medical assistance no grant (MANG) programs provided under Title XIX of the Social Security Act and Articles V (Medical Assistance) and VI (General Assistance) of the Illinois Public Aid Code (or any successor program) or under any similar program of health care benefits in a state other than Illinois.

"Medically necessary" means that a service, drug, or supply is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided. When specifically applied to a confinement it further means that the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient. A service, drug, or supply shall not be medically necessary if it: (i) is investigational, experimental, or for research purposes; or (ii) is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider; or (iii) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or (iv) could have been omitted without adversely affecting the covered person's condition or the quality of medical care; or (v) involves the use of a medical

device, drug, or substance not formally approved by the United States Food and Drug Administration.

"Medical care" means the ordinary and usual professional services rendered by a physician or other specified provider during a professional visit for treatment of an illness or injury.

"Medicare" means coverage under both Part A and Part B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395, et seq.

"Minimum premium plan" means an arrangement whereby a specified amount of health care claims is self-funded, but the insurance company assumes the risk that claims will exceed that amount.

"Participating transplant center" means a hospital designated by the Board as a preferred or exclusive provider of services for one or more specified human organ or tissue transplants for which the hospital has signed an agreement with the Board to accept a transplant payment allowance for all expenses related to the transplant during a transplant benefit period.

"Physician" means a person licensed to practice medicine pursuant to the Medical Practice Act of 1987.

"Plan" means the Comprehensive Health Insurance Plan established by this Act.

"Plan of operation" means the plan of operation of the Plan, including articles, bylaws and operating rules, adopted by the board pursuant to this Act.

"Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, registered pharmacist acting within the scope of that registration, or any other person or entity licensed in Illinois to furnish medical care.

"Qualified high risk pool" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Resident" means a person who is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in this State that remains that person's principal residence and from which that person is absent only for temporary or transitory purpose.

"Skilled nursing facility" means a facility or that portion of a facility that is licensed by the Illinois Department of Public Health under the Nursing Home Care Act or a comparable

licensing authority in another state to provide skilled nursing care.

"Stop-loss coverage" means an arrangement whereby an insurer insures against the risk that any one claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount.

"Third party administrator" means an administrator as defined in Section 511.101 of the Illinois Insurance Code who is licensed under Article XXXI 1/4 of that Code.

(Source: P.A. 92-153, eff. 7-25-01; 93-33, eff. 6-23-03; 93-34, eff. 6-23-03; 93-477, eff. 8-8-03; 93-622, eff. 12-18-03.)

Section 99. Effective date. This Act takes effect upon becoming law, except that Sections 1 through 30 take effect 90 days after becoming law.

**Effective Date: 9/23/2008**

<http://ilga.gov/legislation/publicacts/fulltext.asp?Name=095-0965&GA=095>

**Appendix B**  
OCHHS Payment Plan Terms

Minimum Charges	Maximum Charges	Months
\$ 300.00	\$ 499.99	12
\$ 500.00	\$ 999.99	18
\$ 1,000.00	\$ 2,499.99	24
\$ 2,500.00	\$ 3,999.99	36
\$ 4,000.00	\$ 5,999.99	48
\$ 6,000.00	\$ 7,999.99	60
\$ 8,000.00	\$ 11,999.99	72
\$ 12,000.00	\$ 24,999.99	84
\$ 25,000.00	above	96
Special Circumstance	MAX	136

### Appendix C.1 HUPDA Checklist

0000

**HUPDA Checklist**

This form must be part of a packet for consideration.

**Proposed by Patient:**

\_\_\_\_\_

**Date of Service:**

\_\_\_\_\_

**Account Number(s):**

\_\_\_\_\_

**Medical Record Number:**

\_\_\_\_\_

**Facility:**

\_\_\_\_\_

**Check all that apply; check the applicable items:**

- Medicaid**
  - Certificate of Eligibility (COE) is on record
  - COE is in compliance
  - COE is in compliance with the Department of Health Services (DHS) requirements
  - Valid domicile or residence in Illinois
  - Valid ID
  - Properly assigned patient ID
  - Complete patient identification
  - Address of patient is correct
- Other Insurance**
  - If the policy is active
  - COE is in compliance with the Department of Health Services (and proof of compliance)
  - Complete identification
  - Proof of policy and
  - Policy is active
  - Policy is not a health maintenance organization (HMO) or a preferred provider organization (PPO) plan
  - Policy is not a Medicare or Medicaid plan
  - Policy is not a self-insured plan
  - Policy is not a health maintenance organization (HMO) or a preferred provider organization (PPO) plan
  - Policy is not a Medicare or Medicaid plan
  - Policy is not a self-insured plan
- Other Insurance**
  - Not addressed by the insurance policy; must show address from a government or other reliable source
  - Address must be the primary residence of the patient; other addresses of the patient must be provided with date of occupancy, or a letter from the insurance carrier or other reliable facility with date of occupancy of the facility

**Household composition:**

- Single adult 18 or older, not attending school
  - Parents and/or other adults
  - Legally married couple
  - Single parent with dependent child(ren)
  - Child Care Provider
  - Other: \_\_\_\_\_
- Indicate the number of persons in the household for the policy period.

**Income Requirements:**

- If the policy is active
  - A copy of the most recent tax return
  - A copy of the most recent 90-day and 1-year bank
  - Copies of the 3 most recent pay stubs
  - Other income verification forms as requested by the facility
  - Other documents: \_\_\_\_\_
- An affidavit of patient liability regarding an estimated amount must verify the existence of assets owned by the patient and to provide documentation of the value of such assets.
- Acceptable documentation may include statements from financial institutions or assets other than proof verification of an assets value, if verified only with the patient. Note the patient's liability on the estimated value of the asset.

**Other:**

- Other insurance (policy number)? Other insurance? (Please describe)
- \_\_\_\_\_
- \_\_\_\_\_

Confidential Form - By completion process only

### Appendix C.2 HUPDA Income Calculator

CCY98  
HUPDA Income Calculator

INCOME CALCULATOR									
<p>NAME: _____</p> <p>ADDRESS: _____</p> <p>CITY: _____ STATE: _____ ZIP: _____</p>									
INCOME	RESOURCES								
<p>Wages/Employer Commodities/Bonus Oid Job Farming Income RRM Benefits MA Benefits Pensions/Annuities Workers Comp Rental Property Income Education Stipends Dividends/Interest/Royalties Lump sum payments in past year (multiple) Alimony Child Support Payments Cash Support</p>	<p>Checking Savings CDs Money Market Account IRA Annuities Stocks Bonds</p>								
<p>UI Unemployment Payments TANF Payments Child Victim Assistance Child Support Tort Awards Alimony Reimbursement High School student income Dependent student earned income Lump sum received annual year Irregular family assistance (952)</p>	<p>401K (E-401K) Keogh Plan State/Local Employee Pension (SEP) Primary Vehicle</p> <p>Value of All Vehicles</p>								
	<table border="1"> <tr> <td></td> <td>\$0</td> </tr> <tr> <td></td> <td>\$0</td> </tr> <tr> <td></td> <td>\$0</td> </tr> <tr> <td></td> <td>\$0</td> </tr> </table>		\$0		\$0		\$0		\$0
	\$0								
	\$0								
	\$0								
	\$0								

Continental Bank For discussion purposes only



### Appendix C.4 HUPDA Determination

CCMS  
HUPDA Calculator  
Payment Plan Determination and Information

Prepared for: \_\_\_\_\_  
 Dates of Service: \_\_\_\_\_  
 Account Number(s): \_\_\_\_\_  
 Facility: \_\_\_\_\_  
 Medical Record Number: \_\_\_\_\_

Notice of HUPDA Determination

Section A Hospital Charges Calculation for HUPDA (charges need to exceed \$300.00)		Amount
<b>A.1 Hospital Charge 1</b>	Hospital Charges Considered/Generated at which Facility? (Select the facility)	\$ 300.00
	REVISED HOSPITAL CHARGE 1 WITH HUPDA DISCOUNT	\$ 287.20
If additional facilities need to be considered, please use the following:		
<b>A.2 Hospital Charge 2</b>	Hospital Charges Considered/Generated at which Facility?	\$ 10.00
	REVISED HOSPITAL CHARGE 2 WITH HUPDA DISCOUNT	\$ 7.81
<b>A.3 Hospital Charge 3</b>	Hospital Charges Considered/Generated at which Facility?	\$ 5.00
	REVISED HOSPITAL CHARGE 3 WITH HUPDA DISCOUNT	\$ 3.46

Are the charges (Hospital Charge 1 thru 3) greater than \$300.00 to meet HUPDA guidelines? **Yes**

Section B The Patient's Family Income	
Gross Family Income (i.e. based on yearly W-2 information or provided forms)	\$ 20,000.00
Total persons in the Patient's Family (household)	1
Does the patient meet the Income Guidelines for HUPDA?	<b>Yes</b>

Section C HUPDA Considerations	
Maximum % of the Patient's Income to be allocated to visit(s) (per HUPDA)	25%
The payment plan can not exceed (per year) via HUPDA/affordability:	\$ 5,000.00
Maximum Payment Per Month (per HUPDA)	\$ 416.67

Payment Plan Determination		Patient Payment Plan (Interest Free)	
Information listed is based on HUPDA terms and outlined in Section A through C)			
Calculating Charges/HUPDA Allowance for Payment Plan processes:			
Member of Month to Finance Patient's Balance (based on Hospital's Policies on Balance)	\$ 278.87	12 Months	
Monthly Patient Payment Plan Amount		\$ 23.22	Payment Amount
The HUPDA discount may apply within the following time frame (unless eligibility changes):			
Patient's % allocated to actual hospital's medical payments		<b>Yes</b>	
Is the Monthly Payment Amount Greater than the Maximum Payment Allowed per HUPDA?			
		<b>No</b>	(If yes, coordinate with the Worksheet information)

Patient agrees to pay according to terms. A default of three (3) payments may result in removal of account, and standard CCMS collection processes will apply. Additional charges will be considered.  
 If CCMS is notified directly within 60 days of discharge and 30 days to submit information of the matter however a new payment plan may apply.  
 Patient must notify Patient Financial Services for each visit to be considered for the HUPDA discount.

For Office Use Only: If other calculations are needed, please see the Worksheet.

Only make data entries via icons listed in Red and within a cell. Blue icons are calculations based on data entries.

# INCOME CALCULATOR

Name	
County of Residence	
HHS/SHS/HS/MS/MSME	

## INCOME

Wages/ Salary/ Tips	
Unemployment Payments	
Commissions/ Bonus	
Odd Jobs	
Farming Income	
FSD/ Benefits	
VA Benefits	
Pensions/ Annuities	
Workers Comp	
Rental Property Income	
Education Stipends	
Dividends/ Interest/ Royalties	
Lump sum payments in past year (multiple)	
Alimony	
Child Support Payments	
Cash Support	
SSI	
TANF Payments	
Crime Victim Assistance	
Child Support (not on a payment plan)	
Tax Refunds	
Mileage Reimbursement	
High School student Income	
Dependent student earned Income	
Lump sum received once/ year	
Irregular family assistance <\$50	

## RESOURCES

Checking	
Savings	
CDs	
Money Market account	
IRA	
Annuities	
Stocks	
Bonds	
401(K) & 403(B)	
Keogh Plan	
Simplified Employee Pension (SEP)	
Primary Vehicle	
Value of Add'l Vehicles	

Total of all resources	\$0
Total of all resources	\$0
Amount available for MSME	\$0
Household Size	0

**HUPDA Checklist**

These items must be in a packet for consideration.

Prepared for (Patient): \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Account Number(s): \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Facility: \_\_\_\_\_

Due to Patient: \_\_\_\_\_

Accounting by for: \_\_\_\_\_

Consideration: \_\_\_\_\_

(Check as completed; circle the outstanding items)

Identification \_\_\_\_\_

One item from List A and B are required.

1 of the following is required

CCHHS List (A) Photo Identification Requirement \_\_\_\_\_

Valid Illinois photo ID from the Secretary of State Office \_\_\_\_\_

Valid domestic or foreign driver's license \_\_\_\_\_

Military ID \_\_\_\_\_

Passport/Student picture ID \_\_\_\_\_

Employee picture identification card \_\_\_\_\_

Workers' permit identification with picture \_\_\_\_\_

1 of the following is required

CCHHS List (B) Other Forms of Identification Requirements (and proof of Residency)

Immigration documentation \_\_\_\_\_

Social Security card \_\_\_\_\_

SS/RSDI Award Letter \_\_\_\_\_

Birth certificate \_\_\_\_\_

Wags etubs \_\_\_\_\_

Referral letters from state or local agencies on agency letterhead (Examples: Any local entity such as a church, hospital, shelter, a court or government agency); \_\_\_\_\_

a recent residential utility bill \_\_\_\_\_

a housing lease agreement \_\_\_\_\_

a vehicle registration card \_\_\_\_\_

a voter registration card \_\_\_\_\_

mail addressed to the uninsured patient at an Illinois address from a government or other credible source; \_\_\_\_\_

a statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or a letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility. \_\_\_\_\_

Household composition

Single adult 18 or older, not attending school \_\_\_\_\_

Parents and minor children \_\_\_\_\_

Legally married couples \_\_\_\_\_

Registered Domestic Partners \_\_\_\_\_

Civil Union Partners \_\_\_\_\_

Exclusions: Persons of which the patient/guarantor is not financially responsible for, i.e. Divorce, Roommate \_\_\_\_\_

Determination of the persons in the household for the patient/guarantor? \_\_\_\_\_

Income Requirements

1 of the following is required

a copy of the most recent tax return; \_\_\_\_\_

a copy of the most recent W-2 form and 1099 forms; \_\_\_\_\_

copies of the 2 most recent pay stubs; \_\_\_\_\_

written income verification from an employer if paid in cash; \_\_\_\_\_

Other Resources: \_\_\_\_\_

An uninsured patient who is requesting an uninsured discount must certify the existence of assets owned by the patient and to provide documentation of the value of such assets. \_\_\_\_\_

Acceptable documentation may include statements from financial institutions or some other third party verification of an asset's value. If no third party verification exists, then the patient shall certify, as to the estimated value of the asset. \_\_\_\_\_

Other

Applied for Medicare and/or Medicaid? Other Assistance? (Please describe) \_\_\_\_\_

When? \_\_\_\_\_

Medicare/Medicaid Recipient Number: \_\_\_\_\_

Applied for Crime Victims? (Patient must enroll in HUPDA and submit that information to the Attorney General.) \_\_\_\_\_

20

Prepared for:  
 Dates of Service:  
 Account Number(s):  
 Facility:

Medical Record Number:

Approved time frame:

**Notice of HUPDA Pre-Determination**

**Hospital Charges Calculation for HUPDA (charges need to exceed \$300.00)**  
 To be determined when all Charges are listed on the account(s) or a Statement is received.

Amount  
 Pending

**The Patient's Family Income**

Gross Family Income (i.e. based on yearly W-2 information or provided items/income calculator)  
 Total persons in the Patient's Family (household)  
 Does the patient meet the Income Guideline for HUPDA?

\$	20,000.00
	1
	Yes

**HUPDA Considerations**

Maximum % of the Patient's Income to be allocated to visit(s) (per HUPDA)  
 The payment plan can not exceed (per year via HUPDA/Affordability):  
 Maximum Payment Per Month (per HUPDA)

25%	\$	5,000.00
	\$	416.67

**Patient Payment Plan (Interest Free)**

To be determined when all Charges are listed on the account(s) or a Statement is received.

Patient agrees to pay according to terms. A default of three (3) payments may result in removal of discount, and standard CCHHS collection processes will apply. Additional charges will be considered if CCHHS is notified timely (within 60 days of discharge and 30 days to submit information) of the matter however a new payment plan may apply. Patient must notify Patient Access Services-Financial Counseling team for each visit to be reconsidered with the HUPDA discount.

This is a pre-determination. Patient must contact CCHHS Patient Access Services at ( ) after each visit to determine the discount and payment plan terms.

Financial Counselor  
 Signature:

Date:

For Office Use Only: Only make data entries via items listed in Red and within a cellblock; Blue items are calculations based on data entries.

Prepared for:  
Dates of Service:  
Account Number(s):  
Facility:

Medical Record Number:

**Notice of HUPDA Determination**

**Section A: Hospital Charges Calculation for HUPDA (charges need to exceed \$300.00)**

**A.1: Hospital Charge 1**  
 Hospital Charges Considered/Generated at which Facility? (Select the facility)  
 REVISSED HOSPITAL CHARGE 1 WITH HUPDA DISCOUNT  
 Facility: \_\_\_\_\_ Amount: \$ 20,000.00  
 Special Rate: \$

**A.2: Hospital Charge 2**  
 Hospital Charges Considered/Generated at which Facility?  
 REVISSED HOSPITAL CHARGE 2 WITH HUPDA DISCOUNT  
 Facility: \_\_\_\_\_ Amount: \$ 16,000.00  
 Special Rate: \$

**A.3: Hospital Charge 3**  
 Hospital Charges Considered/Generated at which Facility?  
 REVISSED HOSPITAL CHARGE 3 WITH HUPDA DISCOUNT  
 Facility: Stroger \_\_\_\_\_ Amount: \$  
 Special Rate: \$

Are the charges (Hospital Charge 1 thru 3) greater than \$300.00 to meet HUPDA guidelines? **Yes.**

**Section B: The Patient's Family Income**

Gross Family Income (i.e., based on yearly W-2 Information or provided items/Income Calculator)  
 Total persons in the Patient's Family (household)  
 Does the patient meet the Income Guideline for HUPDA?

\$	45,000.00
	4
	Yes

**Section C: HUPDA Considerations**

Maximum % of the Patient's Income to be allocated to visit(s) (per HUPDA)  
 The payment plan can not exceed (per year) via HUPDA/affordability:  
 Maximum Payment Per Month (per HUPDA)

\$	25%
\$	1,250.00
\$	937.50

**Payment Plan Determination**

Patient Payment Plan (Interest Free)  
 (Information listed is based on HUPDA terms and outlined via Section A through C)  
 Outstanding Charges/HUPDA Balance for Payment Plan processes:  
 \$ 16,000.00

Number of Months to Finance Patient's Balance (based on Hospital's Policies on Balance): 84 Months

Monthly Patient Payment Plan Amount

\$ 190.48 Payment Amount

The HUPDA discount may apply within the following time frame (unless eligibility changes):

Patient's % allocated to actual hospital's medical payments  
 is the Monthly Payment Amount Greater than the Maximum Payment Allowed per HUPDA (\*except Special Rate)?

\$	5.1%
----	------

No (If yes\*, coordinate with the Worksheet information).

Patient agrees to pay according to terms. A default of three (3) payments may result in removal of discount, and standard CCHHS collection processes will apply. Additional charges will be considered if CCHHS is notified timely (within 60 days of discharge and 30 days to submit information) of the matter however a new payment plan may apply. Patient must notify Patient Access Services for each visit to be reconsidered with the HUPDA discount.

**For Office Use Only:** If other calculators are needed, please see the Worksheet.  
 Only make data entries via items listed in Red and within a callblock; Blue items are calculations based on data entries.

DO NOT WRITE THIS IS THE WORKSHEET.

Section A Hospital Charges Calculation for HUPDA  
Hospital Charge (charges) need to exceed \$300.00  
Hospital Charge Condition/Service at which Facility?  
Medicare Cost Report Rate (Cost Forward pending as of 09/01/2011)  
Medicare Cost Report Rate (Provider) pending as of 09/01/2011  
Special Rate (No Income)  
Calculation based on the Rate

Section A.1  
Special Rate  
0.001  
0.000  
1.000  
CCRHIS Factor (up 1.50 per HUPDA)  
REVERSED HOSPITAL CHARGES WITH HUPDA DISCOUNT

Section A.2  
Additional Charges to Consider or Different Facility:  
Special Rate  
\$ 20,000.00  
\$ 10,000.00  
\$ 10,000.00

Section A.3  
Additional Charges to Consider or Different Facility:  
Special Rate  
\$ .5  
\$ .5

**B** Income Determinations based on HUPDA guidelines  
 Income Guidelines (covered up to 80% of Federal Poverty Guidelines (FPG)  
 FPG Current Rate (based on 2003) \$10,890.00  
 additional income in the household, as defined by procedure (if a listed per FPG) 3,820.00  
 Total in the Patient's Family 16,710.00

1	\$	10,890.00
0	\$	3,820.00
	\$	65,240.00
	\$	20,000.00

**C** Max Income Limit to be considered by HUPDA  
 The Patient's Family Income  
 Gross Family Income (based on yearly W-2 information or provided Items/Income Calculator)  
 Total Income in the Patient's Family (household)  
 Does the patient meet the income guidelines for HUPDA? Yes

Revised Patient Payment Plan (Revised Fee)  
 Maximum % of the Patient's Income to be allocated to visit(s) (per HUPDA)  
 The payment plan can not exceed the maximum HUPDA/visitability.  
 Maximum Payment Per Month (per HUPDA)  
 Outstanding Charges/HUPDA Balance for Payment Plan procedure:  
 .Number of Months to Finance Patient's Balance (based on Hospital's Policies on Balance):  
 Monthly Patient Payment Plan Amount  
 Patient's % allocated to actual hospital's medical payments

Is the Monthly Payment Amount Greater than the Maximum Payment Allowed per HUPDA?  
 If the patient's income has changed, start the process completely.  
 Option 1 Same payment amount; change in the number of months.  
 New total charges under HUPDA.  
 Revised Patient Payment Amount  
 Revised new Number of Months to Finance Patient's Balance:  
 Revised Patient's % allocated to hospital's medical payments  
 This will not impact the maximum payment allowable.  
 If there is a residual value in the months (i.e. 12.45, the last statement will reflect the residual value, which should be less than the Payment Plan Amount if all payments paid to terms)

Option 2 Revision to payment, same payment plan period  
 New total charges under HUPDA  
 Revised monthly payment amount  
 Number of months to finance Patient's Balance:  
 Revised Patient's % allocated to hospital's medical payments

Assume this % is less than maximum of the Patient's Income per HUPDA  
 Special Circumstances (revision as allowed by Management):  
 Payment Plan: can only be extended to the next period as a courtesy  
 Payment Plan Exception:

Only Upon Request (patient may have other medical bills elsewhere)  
 Months  
 Special Payment Amount



**B** Income Determinations based on HUPDA Guidelines.  
 Income Guidelines (covered up to 800% of Federal Poverty Guidelines (FPG))  
 FPG Current Rate (head of household)  
 Total in the Patient's Family

1 10,890.00  
 2 3,630.00  
 3 154,100.00  
 4 45,000.00

Max. Income Limit to be considered by HUPDA  
 The Patient's Family Income  
 Gross Family Income (i.e. based on yearly W-2 information or provided items/income calculator)  
 Total persons in the Patient's Family (household)  
 Does the patient meet the income guideline for HUPDA? Yes

**C** Patient Payment Plan (Interest Free)  
 Maximum % of the Patient's Income to be allocated to visit (per HUPDA)  
 The payment plan can not exceed (per year) via HUPDA/allowability:  
 Maximum Payment Per Month (per HUPDA)  
 Outstanding Charges/HUPDA Balance for Payment Plan processes:  
 Number of Months to Finance Patient's Balance (Based on Hospital's Policies on Balance)  
 Monthly Patient Payment Plan Amount  
 Patient's % allocated to actual hospital's medical payments  
 Is the Monthly Payment Amount Greater than the Maximum Payment Allowed per HUPDA (except Special Rate)? No (If Yes, see section C1)

25% 11,250.00  
 837.50  
 16,000.00  
 84 190.48  
 5.1%  
 190.48  
 190.48

**C1** Only if the Payment Amount is Greater than the Maximum Allowed Patient will make payments for the following # of months  
 At the following rate

Do not use Section C1  
 17 837.50  
 Months Payment Amount

**C2** Revised patient Payment Plan (with the addition of new visit/retirement facilities)  
 If the patient's income has changed, that the previous company.  
 Option 1: Same payment amount, change in the number of months  
 New total charged under HUPDA  
 Monthly Payment Amount  
 Revised new Number of Months to Finance Patient's Balance:  
 Revised Patient's % allocated to hospital's medical payments  
 This will not impact the maximum payment allowable.  
 If there is a residual value in the table (i.e. 12.45), the last statement will reflect the residual value, which should be less than the Payment Plan Amount if all payments paid to terms

Option 2: Revision in payment; same payment plan period  
 New total charges under HUPDA  
 Revised monthly payment amount  
 Number of Months to Finance Patient's Balance:  
 Revised Patient's % allocated to hospital's medical payments

16,000.00  
 84.00 190.48  
 5.1%  
 190.48  
 190.48  
 5.1%  
 190.48  
 190.48

**C3** Assume this % is less than maximum of the Patient's Income per HUPDA  
 Special circumstances (exceptions as offered by Management):  
 Payment Plan can only be extended to the next period as a Courtesy Payment Plan Exception.

Less than HUPDA maximum  
 Only Upon Request (patient may have other medical bills elsewhere)  
 136  
 117.65  
 Months Special Payment Amount

Only use the Months and Payment Amount that have number values below, then type in the other:  
 Months Months Calc. Pmt Calc. Payment  
 84 0 Do not use this row for monthly payment. VALUE \$ 190.48  
 84 84 \$ 190.48 \$ 190.48



**HUPDA Calculator**

The HUPDA Checklist should be provided to the patient. The patient must present within 60 days with this information prior to consideration.

Once the patient has satisfied all of the requirements of the HUPDA Checklist, then team member should data process the information via the Data Entry/HUPDA Determination sheet.

Via the Data Entry/HUPDA Determination sheet, complete only the red font cells as indicated. Note that the facility is a drop down. Also look for BLOCK cells (cells that have borders), put in the appropriate monies as indicated in the question/inquiry on the left. If some BLOCK cells are not needed (example A.2 and A.3) then place a zero only. Blue font items are calculations and should not be altered or accessed for the formula to work correctly.

**A block cell**  
(type information  
these boxes or

The Worksheet and the Income Calculators are not to be distributed to the patient. They are calculators and have the formulas that support the Data Entry/HUPDA determination sheet.







**Income Guidelines** based on HUPDA Guidelines  
 Income Guidelines (capped up to 800% of Federal Poverty Guidelines (FRG))  
 FRG Current (Year of household)  
 Total in the household, as defined by procedure (as listed per FRG)  
 Total in the Patient's Family

Max Income Limit to be considered by HUPDA

The Patient's Family Income  
 Gross Family Income (i.e. based on yearly W-2 information or provided Income Tax Return)  
 Total income in the Patient's Family (Annually)  
 Does the patient meet the Income Guidelines for HUPDA?

Patient Payment Plan (Interest Free)  
 Maximum % of the Patient's income to be allocated to verify (per HUPDA)  
 The payment plan can not exceed (per Year via HUPDA/Mortality):

Monthly Payment per Month (per HUPDA)  
 Number of Months to Finance Patient's Balance (based on Hospital practice on Balance):

Monthly Patient Payment Plan Amount  
 Patient's % allocated to total hospital's medical payments

Is the Monthly Payment Amount Greater than the Maximum Payment Allowed per HUPDA?

Only if the Payment Amount is Greater than the Maximum Allowed Patient will make payments for the following # of months:  
 At the following rate:

Revised Patient Payment Plan (with the addition of new rehabilitation facilities)  
 If the patient's income has changed, start the process completely:  
 Option 1 Same payment amount, change in the number of months  
 New total charged under HUPDA  
 Monthly Payment Amount

Revised new Number of Months to Finance Patient's Balance  
 Revised Patient's % allocated to hospital's medical payments  
 This will not impact the maximum payment allowed.  
 If there is a residual value in the months (i.e. 12.45, the last statement will reflect the residual value, which should be less than the Payment Plan Amount if all payments paid to terms)

Option 2 Revision in payment, same payment plan period  
 New total charges under HUPDA:  
 Revised monthly payment amount  
 Number of Months to Finance Patient's balance:  
 Revised Patient's % allocated to hospital's medical payments

Assure this % is less than maximum of the Patient's Income per HUPDA

Special Circumstances (exclusion as advised by Management):  
 Payment Plan can only be extended to the next period as a courtesy  
 Payment Plan Exception:

Only Upon Request (patient may have other medical bills elsewhere)  
 Months  
 Special Payment Amount

1	10,800.00
0	3,250.00
1	65,940.00
1	20,000.00

25%	5,000.00
	418.57
	10,000.00

\$ 10,000.00

Section DO NOT DISTRIBUTE. THIS IS THE WORKSHEET.

HUPDA Payroll Calculator

Section A1  
 Hospital Charges (as reported to external (3000.00)  
 Hospital Charges Considered/added as in which Facility?  
 Medicare Cost Report Basis (Date/Policy) pending as of 08/01/2011  
 Medicare Cost Report Basis (Date/Policy) pending as of 08/01/2011  
 Special Rate (no fraction)  
 Calculation based on the Ratio

REVENUE HOSPITAL CHARGES WITH HUPDA DISCOUNT

Special Rate 0.951  
 1.000

20,000.00  
 18,000.00

Section A2  
 Additional Charges to Consider or Different Facility:  
 Special Rate \$

\$ -  
 \$ -

Section A3  
 Additional Charges to Consider or Different Facility:  
 Special Rate \$

\$ -  
 \$ -

Prepared for:  
Dates of Service:  
Account Number(s):  
Facility:

Medical Record Number:

Notice of HUPDA Determination

Section A Hospital Charges Calculation for HUPDA (charges need to exceed \$300.00)

A.1 Hospital Charge 1  
Hospital Charges Considered/Generated at which Facility? (Select the facility)  
Special Rate \$ 20,000.00  
REVISD HOSPITAL CHARGE 1 WITH HUPDA DISCOUNT \$ 16,000.00

If additional facilities need to be considered, please use the following:

A.2 Hospital Charge 2  
Hospital Charges Considered/Generated at which Facility?  
Special Rate \$  
REVISD HOSPITAL CHARGE 2 WITH HUPDA DISCOUNT \$

A.3 Hospital Charge 3  
Hospital Charges Considered/Generated at which Facility?  
Special Rate \$  
REVISD HOSPITAL CHARGE 3 WITH HUPDA DISCOUNT \$

Are the charges (Hospital Charge 1 thru 3) greater than \$300.00 to meet HUPDA guidelines? Yes

Section B The Patient's Family Income

Gross Family Income (i.e. based on yearly W-2 information or provided items/income calculator)  
Total persons in the Patient's Family (household)  
Does the patient meet the Income Guidelines for HUPDA?  
\$ 45,000.00  
4  
Yes

Section C HUPDA Considerations

Maximum % of the Patient's Income to be allocated to visits (per HUPDA)  
The payment plan can not exceed (per year) via HUPDA/Affordability:  
Maximum Payment Per Month (per HUPDA)  
25%  
\$ 11,250.00  
\$ 937.50

Patient Payment Plan (Interest Free)  
(Information listed is based on HUPDA terms and outlined via Section A through C)  
Outstanding Charges/HUPDA Balance for Payment Plan processes:  
\$ 16,000.00

Number of Months to Finance Patient's Balance (based on Hospital's Policies on Balance): 84 Months

Monthly Patient Payment Plan Amount \$ 190.48 Payment Amount

The HUPDA discount may apply within the following time frame (unless eligibility changes):  
Patient's % allocated to actual hospital's medical payments:  
Is the Monthly Payment Amount Greater than the Maximum Payment Allowed per HUPDA (\*except Special Rate)?  
5.1% No

(If Yes, coordinate with the Worksheet information)

Patient agrees to pay according to terms. A default of three (3) payments may result in removal of discount and standard CCHHS collection processes will apply. Additional charges will be considered if CCHHS is notified timely (within 60 days of discharge and 30 days to submit information) of the matter; however, a new payment plan may apply. Patient must notify Patient Access Services for each visit to be reconsidered with the HUPDA discount.

For Office Use Only: If other calculators are needed, please see the Worksheet. Only make data entries via items listed in Red and within a callblock. Blue items are calculations based on data entries.

Prepared for:  
Dates of Service:  
Account Number(s):  
Facility:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Record Number:

\_\_\_\_\_  
\_\_\_\_\_

Approved time frame:

**Notice of HUPDA Pre-Determination**

**Section A**

**Hospital Charges Calculation for HUPDA (charges need to exceed \$300.00)**  
To be determined when all charges are listed on the account(s) or a Statement is received.

Amount:  
Pending

**Section B**

**The Patient's Family Income**

Gross Family Income (i.e. based on yearly W-2 Information or provided Items/Income Calculator)  
Total persons in the Patient's Family (household)  
Does the patient meet the Income Guidelines for HUPDA?

\$	20,000.00
	1
	Yes

**Section C**

**HUPDA Considerations**

Maximum % of the Patient's Income to be allocated to visit(s) (per HUPDA) 25%  
The payment plan can not exceed (per year via HUPDA)/Affordability: \$ 5,000.00  
Maximum Payment Per Month (per HUPDA) \$ 416.67

**Payment Plan Determination**

**Patient Payment Plan (Interest Free)**  
To be determined when all Charges are listed on the account(s) or a Statement is received.

Patient agrees to pay according to terms. A default of three (3) payments may result in removal of discount, and standard CCHHS collection processes will apply. Additional charges will be considered if CCHHS is notified timely (within 60 days of discharge and 30 days to submit information) of the matter however a new payment plan may apply. Patient must notify Patient Access Services-Financial Counseling team for each visit to be reconsidered with the HUPDA discount.

**This is a pre-determination. Patient must contact CCHHS Patient Access Services at ( ) after each visit to determine the discount and payment plan terms.**

Financial Counselor  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**For Office Use Only:** Only make data entries via items listed in Red and within a callblock; Blue items are calculations based on data entries.

**HUPDA Checklist**  
These items must be a packet for consideration.

Prepared for (Patient):

Dates of Service:

Account Number(s):

Medical Record Number:

Facility:

Due to Patient

Accounting by for

Consideration:

(Check as complete; date the outstanding items) identification

One item from List A and B are required.

1 of the following is required:

CCHHS List (A) Photo Identification Requirement

Valid Illinois photo ID from the Secretary of State Office

Valid domestic or foreign driver's license

Military ID

Passport/Student picture ID

Employee picture identification card

Workers' permit identification with picture

1 of the following is required

CCHHS List (B) Other Forms of Identification Requirements (and proof of Residency)

Immigration documentation

Social Security card

SSI/RSDI Award Letter

Birth certificate

Wage stubs

Referral letters from state or local agencies on agency letterhead (Example: Any local entity such as a church, hospital, shelter, a court or government agency.)

a recent residential utility bill

a housing lease agreement

a vehicle registration card

a voter registration card

mail addressed to the uninsured patient at an Illinois address from a government or other credible source;

a statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or a letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility.

Household composition

Single adult 18 or older, not attending school

Parents and minor children

Legally married couples

Registered Domestic Partners

Civil Union Partners

Excisions: Persons of which the patient/guardian is not financially responsible for; i.e. Divorce, Roommate

Determination of the persons in the household for the patient/guardian?

Income Requirements

1 of the following is required

a copy of the most recent tax return;

a copy of the most recent W-2 form and 1099 forms;

copies of the 2 most recent pay stubs;

written income verification from an employer if paid in cash;

Other Resources:

An uninsured patient who is requesting an uninsured discount must certify the existence of assets owned by the patient and to provide documentation of the value of such assets.

Acceptable documentation may include statements from financial institutions or some other third party verification of an asset's value. If no third party verification exists, then the patient shall certify as to the estimated value of the asset.

Other

Applied for Medicare and/or Medicaid? Other Assistance? (Please describe).

When?

Medicare/Medicaid Recipient Number:

Applied for Crime Victims? (Patient must enroll in HUPDA and submit that information to the Attorney General.)

# INCOME CALCULATOR

NAME  
 COUNTY OF RESIDENCE  
 HOUSEHOLD SIZE

## INCOME

INCOME SOURCE	AMOUNT
Wages/ Salary/Tips	
Unemployment Payments	
Commissions/ Bonus	
Odd Jobs	
Farming Income	
RSDI Benefits	
VA Benefits	
Pensions/ Annuities	
Workers Comp	
Rental Property Income	
Education Stipends	
Dividends/ Interest/ Royalties	
Lump sum payments in past year (multiple)	
Alimony	
Child Support Payments	
Cash Support	
SSI	
TANF Payments	
Crime Victim Assistance	
Child Support (not on a payment plan)	
Tax Refunds	
Mileage Reimbursement	
High School student income	
Dependent student earned income	
Lump sum received once/ year	
Irregular family assistance <\$50	

## RESOURCES

Checking	
Savings	
CDS	
Money Market account	
IRA	
Annuities	
Stocks	
Bonds	
401(K) & 403(B)	
Kaohg Plan	
Simplified Employee Pension (SEP)	
Primary Vehicle	
Value of Addl Vehicles	

RESOURCE	VALUE
Report Equities (EQUITY VALUE)	\$0
Report of State Vehicle Resources	\$0
AVAILABILITY OF VEHICLES	\$0
HOUSEHOLD SIZE	0

## HUPDA Calculator

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A block cell  
(type information in  
these boxes only)



Event Facility:

C

HUPDA is 

G