AGENDA
COMMUNITY HEALTH SERVICES BOARD
Cordova Center – Community Room A&B
March 9, 2017 at 7:00PM
REGULAR MEETING

AT CCMC, WE BELIEVE THAT HEALTHY PEOPLE CREATE A HEALTHY COMMUNITY.

Health Service Board

President:
Tim Joyce Term expires 03/17
Vice-President:
Josh Hallquist Term expires 03/18
Secretary:
James Wiese Term expires 03/19
Board members:
James Burton Term expires 03/19
Tom Bailer Term expires 03/17
Robert Beedle Term expires 03/18
David Allison Term expires 03/19

CCMC CEO/Administrator
Scot Mitchell

OPENING

1. Call to Order
2. Roll Call –Tim Joyce, Josh Hallquist, James Wiese, James Burton, David Allison, Tom Bailer, and Robert Beedle.
3. Establishment of a Quorum

A. APPROVAL OF AGENDA

B. CONFLICT OF INTEREST

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS

1. Audience Comments (limited to 3 minutes per speaker).
   Speaker must give name and agenda item to which they are addressing.
2. Guest Speaker

D. APPROVAL OF CONSENT CALENDAR

E. APPROVAL OF MINUTES

1. January 12, 2017 HSB Regular Meeting Minutes	Pages - 1-2
2. February 9, 2017 HSB Regular Meeting Minutes	Pages - 3-5

F. REPORTS OF OFFICER and ADVISORS

1. President's Report –	
2. CEO Report – March CEO Report Attached	Pages - 6-9
3. Finance Report – January Financial Report	Pages - 10-18
4. Nursing Report -	Pages - 19-21
5. QHR Report –	Pages
6. 340B Pharmacy Program Presentation -	Pages - 22-36

G. CORRESPONDENCE

H. ACTION ITEMS

1. FS 350 ~ Charity Care Policy	Pages – 37-46
2. Personnel Organization Plan	Pages – 47-48
3. 2017 Financial Statement Audit Proposal	Pages – 49-70
4. Integrated Pharmacy Services Agreement	Pages – 71-80
5. CCMC Check Signers	Pages – 81-82
6. 4th Quarter of 2016 Quality Improvement Report	Pages – 83-86

*Executive Session: Subjects that may be considered in executive session are: 1) Matters, immediate knowledge of which would clearly have an adverse effect upon the finances of the public entity; 2) Subjects that tend to prejudice the reputation and character of any person, provided that the person may request a public discussion; 3) Matters which by law, municipal charter, or ordinance are required to be confidential; 4) Matters involving consideration of governmental records that by law are not subject to public disclosure; 5) Direction to an attorney or labor negotiator regarding the handling of specific legal matters or labor negotiations.

I. DISCUSSION ITEMS

J. AUDIENCE PARTICIPATION (limited to 3 minutes per speaker)

Members of the public are given the opportunity to comment on matters which are within the subject matter jurisdiction of the Board and are appropriate for discussion in an open session.

K. BOARD MEMBERS COMMENTS

L. EXECUTIVE SESSION

M. ADJOURNMENT

*Executive Session: Subjects that may be considered in executive session are: 1) Matters, immediate knowledge of which would clearly have an adverse effect upon the finances of the public entity; 2) Subjects that tend to prejudice the reputation and character of any person, provided that the person may request a public discussion; 3) Matters which by law, municipal charter, or ordinance are required to be confidential; 4) Matters involving consideration of governmental records that by law are not subject to public disclosure; 5) Direction to an attorney or labor negotiator regarding the handling of specific legal matters or labor negotiations.

Minutes
Community Health Services Board
Cordova Center – Community Rooms A & B
January 12, 2017 at 7:00pm
Regular Meeting

CALL TO ORDER AND ROLL CALL –

Josh Hallquist called the HSB regular meeting to order at 7:00pm. Board members present: **Josh Hallquist, Tim Joyce (telephonically), David Allison, James Burton and Robert Beedle (arrived at 7:12pm).**
Tom Bailer and James Wiese were absent.
A quorum was established. 4 members present; 3 member absent.
CCMC staff present: Scot Mitchell, CEO; Lee Holter, CFO; Randy Apodaca, Director of Rehab Services; and Faith Wheeler-Jeppson, Executive Admin Assistant.

A. APPROVAL OF AGENDA
M/ Allison S/ Joyce "move to approve the agenda."
Vote on motion: 4 yeas, 0 nays, 3 absent.
Motion was approved.

B. CONFLICT OF INTEREST

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS
1. **Audience Participation** ~ None
2. **Guest Speaker** ~ None

D. APPROVAL OF CONSENT CALENDAR ~ None

E. APPROVAL OF MINUTES
M/ Allison S/ Joyce "move to approve the December 1, 2016 Special Meeting Minutes, December 8, 2016 Regular Meeting Minutes and the December 15, 2016 Special Meeting Minutes."
Vote on motion: 4 yeas, 0 nays, 3 absent.
Motion was approved.

F. REPORT OF OFFICERS AND ADVISORS
1. President's Report ~ I talked with Scot regarding the potential for doing a 6 month evaluation performance review for Scot. If the board is in agreement, I would like to have an Executive Session for our next meeting and conduct that performance review.
2. Administrator's Report ~ Scot Mitchell thanked the board for agreeing to do the performance review. My written report was in the packet, I tried to include a bunch of information that is going on nationally. The senate has already voted the first time for the repeal of the ACA. A lot of other things are going on, the process for approving some of Trump's cabinet started this week. My intentions are to try to keep you guys updated as things go. I'll continue to put out a weekly email as well. Tim, to your question about the UPS system, I have talked with Clay and he had a couple of updates. He hopes that by the end of this week to have the insurance claims in. Once the claim goes through he hopes to have some more information. He hopes that in about 20 days he will know whether or not it is even a viable option and it would take until the end of the year to have something in place. We will be having out Community Health Need Assessment meeting on January 8th at noon, we have facilitator from the National Rural Health Resource Center, and if any of you are available it would be great to have your input.

Robert Beedle arrived at 7:12 pm

3. Finance Report ~ Holter reported that financials for November are in the packet and hoped that they had all had a chance to go through the information. A few highlights for November, Days cash on hand was at 3.8, Net AR decreased $54K due to an increase in collections for November, Gross AR days are 70.2. The $3.1 Million dollar PERS liability remains the same. Year to date we show a loss of $708K as of November versus the YTD loss of $93K and the loss of the prior year November of $301K. A Charge Master review has been scheduled for the third week of June 2017
4. QHR Report ~ Ken Ward reported that we do continue to provide support at Scot and Lee's discretion, we've been a resource to Randy Apodaca as well. We've talked about the Cost Report, I put our HFR Coordinator David on that to assist Lee in any way we can.

G. CORRESPONDENCE ~ None

H. ACTION ITEMS

1. ADM 300 ~ Policy, Procedure, and Guideline Development and Review Approval.

M/ Beedle S/ Allison "move to approve the ADM 300 ~ Policy, Procedure, and Guideline Development and Review."

Vote on motion: 5 yeas, 0 nays, 2 absent (Bailer and Wiese).
Motion was approved.

I. DISCUSSION ITEMS ~ None

J. AUDIENCE PARTICIPATION ~ None

K. BOARD MEMBERS COMMENTS

Joyce ~ I am a bit concerned that it may take until the end of the year with the UPS.
Burton ~ No comment
Beedle ~ Thank you for all of your help in making it a success here.
Allison ~ Thank Staff as well, it's nice to have full time, year round local folks here.
Hallquist ~ My comment on the battery back-up is, at what point do we just want to do this?

L. ADJOURNMENT –

M/ Beedle S/ Allison "I move to adjourn the meeting."
Hallquist declared the meeting adjourned at 7:54pm

Prepared by: Faith Wheeler-Jeppson

Minutes
Community Health Services Board
Cordova Center – Community Rooms A & B
February 9, 2016 at 7:00pm
Regular Meeting

CALL TO ORDER AND ROLL CALL –

Tim Joyce called the HSB regular meeting to order at 7:00pm. Board members present: **Tim Joyce, Josh Hallquist, James Wiese, James Burton, David Allison, Tom Bailer, and Robert Beedle.**
A quorum was established. 7 members present; 0 members absent.
CCMC staff present: Scot Mitchell, CEO; Stephen Sundby, ED Sound Alternatives; Lee Holter, CFO; Kevin Byrd, Rad Tech and Faith Wheeler-Jeppson, Executive Admin Assistant.

A. APPROVAL OF AGENDA
M/ Allison S/ Bailer "move to approve the agenda."
Vote on motion: 7 yeas, 0 nays, 0 absent.
Motion was approved.

B. CONFLICT OF INTEREST ~ None

C. COMMUNICATIONS BY AND PETITIONS FROM VISITORS
1. **Audience Participation** ~ None
2. **Guest Speaker** ~ None

D. APPROVAL OF CONSENT CALENDAR ~ None

E. APPROVAL OF MINUTES

F. REPORT OF OFFICERS AND ADVISORS
1. President's Report ~ Joyce reported that he did talk with Scot over the last couple of weeks about the issues surrounding the CT scanner and the battery backup. What CEC originally thought that they could do over there, they can't so now we're back where we were. We'll have further discussion about that later on.
2. Sound Alternatives Quarterly Report ~ Stephen Sundby reported that they are going to do a continuation grant again. In March they will put out what we have to submit. They still don't know how much they're going to cut this year, which is not unusual, it will probably be June before we'll know. Last year they cut $28K, part of that was an across the board cut. I am speculating that they will do another percentage cut, along the same lines with the Medicaid expansion. The money that we get comes from the state, there are four core areas that it covers 1) Emergency Services which is on-call, 2) seriously mentally ill adults, 3) severely emotionally disturbed youth, and then 4) substance abuse. The money that comes for substance abuse comes from a federal block grant.
3. Administrator's Report ~ Scot Mitchell stated that as of yesterday we signed an agreement with a payor that will allow our clinic, hospital and ancillary services to do disability screening exams for Veterans through the VA program. We don't have a definite knowledge of how many patients we'll have from that, but it will be a new service. Another thing to let you know, the flu is prevalent in the community right now, in 3 days this week we had 6 confirmed cases of the flu. Last year we had no confirmed cases of the flu in Cordova.
4. Finance Report ~ Holter reported that everything in his report is pre-audit. On the Balance Sheet we ended up with 3.4 Days Cash on Hand, Income Statement should read that we are $52K over, we ended the year with a loss of $977K. Acute Care Patient days

are up, Swing Bed days are also up. ER visits in December were up, Clinic visits were also up over the prior month. Lab and Diagnostic were down, and PT and OT were up. Payroll increased as we have more permanent staff on the payroll. Utilities were up $2K compared to November, Repairs and Maintenance expenses for December came in just below the $8K monthly average. The 2017 Audit has been scheduled for the first week in April with information going to the cost report prepared the last week of April. A Charge master review has been scheduled for the third week in June 2017. Education will be provided to the department heads, administration and any board member who would like to attend.

5. QHR Report ~ Ron Vigus reported that QHR continues to provide help as needed, we have also been focusing efforts on helping the Compliance Officer reviewing CCMC's Compliance Program for the upcoming year.

G. CORRESPONDENCE ~ None

H. ACTION ITEMS

1. Community Health Needs Assessment Survey Approval

M/ Beedle S/ Bailer "move to approve the Community Health Needs Assessment Survey."
Vote on motion: Beedle; yea, Bailer; yea, Hallquist; yea, Allison; yea, Burton; yea, Wiese; yes, Joyce; yea
Motion was approved.

I. DISCUSSION ITEMS

1. CT Scanner UPS

Scot Mitchell reported that this issue predates him at the hospital, as Tim had mentioned earlier it's been back and forth over that last few months, we got a final "no vote" from CEC. The project that they were hoping that would address this need is not going to be able to address it based on what their engineers are looking at. Based on my written report we have done over 180 CT Scans in 2016, that is a lot of scans, that is a lot of dollars, almost $250,000 worth of revenue that came from that. We've also decreased the number of transfers out of CCMC to other facilities by about half. The dollars make a big difference, but the quality of care that we're able to provide with this machine is huge. I talked with Clay and he said that we're going to see a big decrease in the number of outages. They talked with their insurance provider to see if they could incur some of the cost associated with the outages last year, but they're saying that the costs we incurred can't be correlated to any of the outages. I'm coming to you today recommending that this go back to City Council to be included in this years capital from the City. We had talked about it during the budget process back in the fall and we need it, it is an important piece of equipment, the service is a big need for the community. We've shown results in the first year of utilization.

The board continued with a lengthy discussion regarding CCMC's need for the funds to purchase the CT Scanner UPS.

M/ Burton S/ Bailer "I move to recommend a UPS for the CT Scanner for CCMC be put on the Agenda for City Council at the next appropriate meeting."

Vote on motion: 7; yeas – 0; nay – 0 absent
Motion was approved.

J. AUDIENCE PARTICIPATION ~ None

K. BOARD MEMBERS COMMENTS

Wiese ~ John Harvill, thank you for putting in for the Health Service Board. Thank you staff.
Hallquist ~ Thank everybody for their time.
Bailer ~ Thank you everybody and Thank you John for stepping up.
Allison ~ We had 5 people sign up for the 5 seats. It's a heavy load for the staff, I just recommend that you make sure that the new folks get packets and get invited to any of the meetings between now and April. Thanks again staff.
Burton ~ I echo previous comments, I was glad to see that we had a full complement of board members for the next election. That's a good sign for the future.
Beedle ~ Thank you, I appreciate it. Thank you for all of your hard work.
Joyce ~ Thank you, I think you'll have a good board to work with. It'll be a lot of training in the beginning, but worth it.

Bailer asked for a five minute break

M/ Bailer S/ Beedle "I move to go into executive session for the CEO 6 month evaluation." at 8:40pm

Out of Executive 9:53pm

L. ADJOURNMENT –
M/ Beedle S/ Wiese "I move to adjourn the meeting."
Joyce declared the meeting adjourned at 9:53pm

Prepared by: Faith Wheeler-Jeppson

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CEO Report to the HSB

March 9, 2017 Meeting

Scot Mitchell, CEO

The Big Picture

There has been a great deal of activity with the new Administration in Washington, DC as pertains to healthcare. Despite all of this activity, not a lot of specifics have come out of the Capital in the past few weeks. As of my writing this report, there has been no bill introduced that would repeal and replace all of the ACA as President Trump has stated he wants to do. There is a draft House bill available, but it is a version from a couple weeks ago, so it may be outdated.

The Budget Reconciliation bill is still being addressed, albeit very slowly, by both chambers of Congress. In a normal year, we would be seeing the budget being delivered soon. As I've mentioned previously, the reconciliation process allows the Senate to make changes to the ACA that affect the federal budget with a simple majority vote. The changes that can be made this way will not accomplish everything the President has stated he wants, so we will have to see if Congress can work together to actually come up with a solution.

Dr. Tom Price has been confirmed by the Senate as the Secretary of Health and Human Services. He has been a staunch advocate for repealing the ACA in the past. Seema Verma, who is the nominee to head the Centers for Medicare and Medicaid Services is still awaiting her confirmation. Dr. David Shulkin has been confirmed as the Secretary of Veterans Affairs.

Status Updates

- The Alaska State Hospital and Nursing Home Association held its annual Legislative Fly-in in Juneau the first week of March. I had planned to attend, but decided to stay at the hospital due to the number of items needing my attention. I had originally scheduled in-person meetings with Representative Louise Stutes and Senator Gary Stevens for this trip, but instead I had a telephone conversation with

Senator Stevens and one of Representative Stutes' staff members. I expressed my concerns about how the State budget issues are negatively affecting CCMC, and the potential for additional cuts to Medicaid could be devastating. Senator Stevens advised me that there will probably be more cuts than what Governor Walker proposed in his budget for 2018. I also expressed my concerns for how much the PERS system adversely affects CCMC. Senator Stevens let me know that there have been discussions about the State reducing the 25% they match of our required contributions. This would add another harmful issue to our facility.

- Governor Walker has submitted his proposed fiscal year 2018 budget to the State Legislature. His proposal includes cuts of $30 million to the Medicaid budget, with an additional $15 million shortfall not covered. There were several line items impacted that will reduce reimbursement to CCMC if enacted. As Senator Stevens advised me, we can expect the Legislature to make changes to the proposed budget before it is passed, so we will probably see additional cuts soon.
- ASHNHA recently provided us with some interesting data that outlines the payment cuts that CCMC has been subject to since the sequestration took effect in 2010. Since 2010, CCMC has had payment cuts of over $230,000 from the sequestration, with more than $700,000 additional cuts expected over the next nine years. Sequestration became a reality when Congress failed to pass a budget several years ago, resulting in a 2% cut to most components of the federal budget. These cuts have been part of the reasons for CCMC's financial struggles over the years.
- As I have mentioned previously, PERS conducted an audit a couple months ago, which was the first audit we've had since 2007. They found a few minor issues that we have addressed, but they also found a major one that was discovered in the 2007 audit that had never been addressed. The PERS staff are sending their report up the chain of command, and we expect that there will be a significant penalty from PERS due to the fact that the issue found in 2007 had not been addressed even after 10 years. We are working with PERS to try to make some additional changes to help reduce the burden PERS places on CCMC.
- As you know, I've been working with City Manager Alan Lanning on ways we can trim some costs off our employee health insurance. One method is to take advantage of the federal 340B pharmacy program. This is a program that has been around about 25 years now and it allows CAHs to get reduced costs for certain medications prescribed to our employees. I have invited two pharmacists to give a presentation on the benefits of the 340B program at the March 9, 2017 HSB meeting. They have reviewed our prescription drug costs for our employees from last year and estimate that we could save us as much as 40% to 50% on those expenses.
- As part of the City Strategic Planning process, it has discussed that there is a desire for CCMC to open a retail pharmacy. We are ready to move in that direction now. I have been working with a company that helps small hospitals with the 340B pharmacy program, as well as the operation of retail and hospital pharmacies. TranscendRx is owned by a group of Iowa hospitals, and they offer everything we would need to successfully implement the 340B pharmacy program and assist us with the planning and operation of a retail pharmacy. I will be asking the HSB for approval to enter into an integrated pharmacy services agreement with TranscendRx at the next meeting. I will need HSB approval since the costs of this agreement were not included in the 2017 budget, and as a result exceed what I am allowed to spend without HSB approval. The agreement would cost $25,000 upfront and $3,000 per month and would provide assistance for the 340B and retail pharmacy programs. We do not yet have a solid budget for the retail pharmacy, but due to time constraints, I would ask permission from the HSB to move forward with opening a retail pharmacy and provide the cost estimates once they become available. The TranscendRx staff will help us prepare a more solid start-up cost estimate after they have had a chance to review our current physical plant for a retail pharmacy location. Depending upon renovations needed at CCMC, we should be able to have a retail pharmacy operational within a few months.

- Two of our senior leaders at CCMC will be gone before the next HSB meeting. Stephen Sundby will be retiring as the Executive Director of Sound Alternatives on March 3rd. Randy Apodaca has accepted a new position in New Mexico and his last day will also be Mach 3rd. We will be having a potluck for both of them on March 3rd at 3:00 pm, and everyone is invited to attend.
- I have provided an updated organization chart for the personnel organization plan that the HSB is required to approve. I was making changes to this and had originally planned to present it to the HSB last month, but wanted to wait so I could include the changes needed after Stephen and Randy leave. We will also need to update the approved check signers list at this meeting since both Stephen and Randy were on that list.
- We will be asking the HSB to approve a new accounting firm to conduct the audit of the 2016 financial statements. The firm we used last year quoted $40,000 and the firm we are requesting approval for quoted $20,000. Travel expenses would be reimbursed at cost for either firm. Dingus, Zarecor & Associates is based out of Spokane Valley, Washington and is the firm we are requesting approval for. Lee Holter, CFO, has used DZA previously and highly recommends them.
- You are well aware of the request from CCMC to the City for the costs of purchasing and installing a UPS system for the CT scanner and radiology department. Our Radiology Technician, Kevin Byrd was able to get GE to come down on the cost of the system, which reduced the cost to about $117,000. I thought it would be good to provide you with more details on the benefit that the CT scanner has provided to the patients served by CCMC, and the community in general. CCMC performed 183 CT scans in 2016 and generated $238,940 in revenue from those tests. We estimate that by having the CT available in Cordova, we were able to save patients about $500,000 in air medical costs by reducing the transfers to Anchorage by one-third. Our CT scanner was available 92% of the time last year, which resulted in about 25 days without it being available. We know that we had eight ER patients who needed a CT but were not able to receive one due to it being down. This cost CCMC about $10,000 in lost charges due to it not being available. The CT scanner was a very good service to add to CCMC, and by adding the UPS system we will be able to reduce the down time this year.
- We will be bringing an updated charity care policy to the board for approval at this meeting. There have been some changes to federal standards since the CCMC policy was last reviewed in 2015, and we want to make sure we have a charity care policy that meets regulatory requirements as well as benefits those citizens in need.
- We are continuing our efforts to find a more effective EHR system to replace the Centriq system we currently have. As you are well aware, the current system is not helping us in our efforts to improve our overall operations and we now have a committee put together to help with this process. The committee is currently working with staff to develop a list of features needed for each department and will then use that information to draft a Request for Proposals to send to several EHR vendors. We hope to have the RFP ready to go soon.
- Last month Dr. Blackadar, Lisa Cuff, CNO and myself had a dinner meeting with the EMTs from the ambulance service at the hospital for a chance to get to know them better. Our goal moving forward is for our clinical staff to work closer with the EMTs to help improve the care patients receive prior to and upon their arrival to the emergency room at CCMC. We are developing a training program that will allow the EMTs and our nursing staff to train together which will help improve the quality of care provided by both.
- Representatives from the Alaska Department of Health and Social Services, the Alaska State Hospital and Nursing Home Association and Mountain-Pacific Quality Health visited CCMC last month. They were here to meet with staff to discuss how they might be able to help us meet the many quality reporting requirements put upon hospitals. This was the first time they have done a joint visit like this and it was helpful for our staff to meet the people they have been working with from a distance.

They found no major concerns, and provided some insight into how we can continue to improve our quality reporting efforts.

- We are currently exploring options to improve the radiology reading service we have at CCMC. We are trying to find a group of radiologists who can provide better service at a reduced cost from our current providers. We will need to credential and the board will have to approve privileges for any new radiologists, so more will be coming on this as the process unfolds.
- Since this is the last meeting for the Health Services Board, I want to pass along my thanks for everything that each of you have done to help CCMC. The hospital industry is the most highly regulated industry in our country, and it is not easy to understand the many issues facing hospitals now. As you well know, serving on a hospital board is not for the faint of heart, and on behalf of the employees, medical staff and volunteers I thank you for your service and commitment to CCMC and the community of Cordova!

Monthly Financial Statements

January 2017

To the CCMC Health Services Board

January 2017 Financial Executive Summary

Pre-Audit

Stats

Acute Care patient days increased to 32 from 17 Days in December. Swingbed days also increased to 64 versus 17 in December. Average daily census was 3.1 which was up from 1.1 in December.
The ER had a slight decrease in visits for January with 4 less than December. January clinic visits, while lower than in December by 11, set a new high mark for our Doctors for the month of January. Lab tests increased by 79 over December, while Diagnostic imaging saw an increase of 10 over the month of December. PT and OT procedures stayed relatively flat from December volumes.

Balance sheet

Please note that the financials presented are pre-audit and may be modified in the audit. Cash increased by $74K during January from December. Day's cash on hand at the end of January was 10.3 versus December which had 3.4 days.
Net AR increased by $201K over the prior month. Gross AR days for January were 66.8 compared to December which had 72.3.
AP increased $55K in January from December. Payroll liabilities increased $265K from the prior month. The $3.1 Mil dollar Long Term debt amount accounts for funds received from the city, with $918K received 2016.

Income Statement

January's Gross revenue was up by $182K over December. Acute care increased $51K, Swing Bed increased $126K, LTC (based on days) was the same, the Clinic decreased ($7K) and Outpatient increased $50K, additionally Behavioral Health saw a decrease of ($36K) in revenue.
Contractual adjustments increased in December by $188K, while Bad debt decreased $61K from the prior month.

Payroll decreased from the prior month by $5K. Payroll taxes and Benefits decreased in January by $55K. Professional services increased by $9K over December. As noted previously professional services decreased by year's end $130K from a high in June. Utilities were up $2K from December. (I remind the board there was an accounting change last year put the revenue for the UAC (Universal Access) funds offset into other Revenue.) The remaining expenses were similar to the prior month, except that recruitment dropped significantly in January from December.

Overall expenses were lower from December by $84K. Please note that expenses for January 2017 are $34,886 lower than January 2016.

Year to Date

Please note that the financials presented are pre-audit and may be modified in the audit.
January Net Income was $161,582 compared to ($269,116) in December a variance of $430,698.
For January the YTD is the same as the current month.

Activity and Projects

EHR
Work on E H R improvement continues, but is frustrating slow with setbacks. We are back on track with the internal system steering meeting and biweekly calls with Healthland technical support. There continue to be system problems, system work a rounds, and staff education issues to resolve. There are problems with clinical charting in Nursing, in the Physician Ordering module, in Medical records, to the billing module and to the GL. The system is not yet programed for the wasting of drugs, a reporting requirement that started January 1st for all hospitals.
The doctors are particularly frustrated with the Medical Necessity system when ordering labs as their choices do not coincide with what the lab sees (SNOMED codes vs. ICD10 codes.) SNOMED stands for (Systematized Nomenclature of Medicine) codes which were instituted for POE (Physician Order Entry) so hospitals could meet meaningful use requirements to get funds from the HITECH Act for their Electronic Medical Records systems. (ICD10 stands for International Classification of Diseases 10th revision.)
The New EHR replacement process has started, we have had two meetings and are collecting all of the departments needed functions to put into the RFP, which will go out to vendors, for them to respond with a quote for a system.

Budget
The 2017 monthly budget has been spread based prior history and loaded into the system. It now has been activated and is showing on the current financials.

Business Line Statements/Departmental Statements

I am working on financial statements for our business lines, I.E., Sound Alternatives, Clinic, LTC in addition to the Hospital Financials. These individual financial statements would roll into the total CCMC financial statement you get each month. Also working to set up Departmental statements so managers can see their monthly departmental operation against budget.

AR Balances

I have been able to review some of the accounts outstanding and get follow up done on some of the balances. The insurance company acknowledges they have all the information and will start processing the account for payment. In some cases they have come back and denied the claim for timely filing, because it sat too long untouched in their system. When that occurs we have to write an appeal and ask the insurance company to adjudicate in our favor as the claim was delivered timely-they just did not process it timely. It has been determined that I need an additional staff person, to do continuous in house follow up on patient's accounts and help hold the collection company to their contractual terms.

Other items

The Audit for 2016 has been scheduled for the first week in April with information going to the cost report preparer the last week of April. There will be lots of detailed reconciliations/schedules to be filled out for both the Auditors and the cost report during the first three months of the New Year.

A charge master review has been scheduled for the third week of June, 2017, this will be a review of charge codes, proper use of CPT codes for billing compliance and a pricing review. Education will be provided to the department heads, administration and any board members who would like to attend the general session.

Respectfully submitted

Lee Holter
CFO

Cordova Community Medical Center Statistics

	31	28	31	30	31	30	31	31	30	31	30	31		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Cumulative Total	Monthly Average
Hosp Acute+SWB Avg. Census		29												
FY 2017	3.1													3.1
FY 2016	0.8	1.9	1.6	2.0	1.6	2.2	1.2	0.3	0.7	1.1	0.5	1.1		1.3
FY 2015	1.1	0.2	2.0	2.3	2.5	2.2	0.9	1.5	0.8	0.5	0.9	0.1		1.2
Acute Admits														
FY 2017	9												9	9.0
FY 2016	6	8	3	8	9	5	7	5	6	10	6	8	81	6.8
FY 2015	1	1	4	6	5	2	5	1	5	5	3	1	39	3.3
Acute Patient Days														
FY 2017	32												32	32.0
FY 2016	16	15	18	22	26	20	11	10	18	22	15	17	210	17.5
FY 2015	2	3	7	8	16	3	10	2	11	6	7	2	77	6.4
SWB Admits														
FY 2017	5												5	5.0
FY 2016	2	2	0	2	1	3	1	0	1	2	1	2	17	1.4
FY 2015	1	1	3	3	2	0	0	3	1	1	0	0	15	1.3
SWB Patient Days														
FY 2017	64												64	64.0
FY 2016	10	40	32	37	24	46	25	0	3	11	1	17	246	20.5
FY 2015	31	3	55	60	60	62	18	45	12	10	19	0	375	31.3
CCMC LTC Admits														
FY 2017	0												0	0
FY 2016	1	0	0	0	0	0	2	0	0	0	0	0	3	0.3
FY 2015	0	0	0	1	1	2	1	2	2	1	0	0	10	0.8
CCMC LTD Resident Days														
FY 2017	310												310	310
FY 2016	310	290	310	297	310	298	292	310	300	310	300	310	3,637	303.1
FY 2015	310	280	308	287	307	300	274	273	388	309	300	310	3,646	304
CCMC LTC Avg. Census														
FY 2017	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		10.0
FY 2016	10.0	10.0	10.0	9.9	10.0	9.9	9.4	10.0	10.0	10.0	10.0	10.0		9.9
FY 2015	10.0	10.0	9.9	9.6	9.9	10.0	8.8	8.8	12.9	10.0	10.0	10.0		10.0
ER Visits														
FY 2017	49												49	49.0
FY 2016	52	45	52	52	59	79	85	74	51	55	37	53	694	57.8
FY 2015	23	46	49	40	104	73	104	97	47	56	37	39	715	59.6

Cordova Community Medical Center Statistics

	31 Jan	28 Feb	31 Mar	30 Apr	31 May	30 Jun	31 Jul	31 Aug	30 Sep	31 Oct	30 Nov	31 Dec	Cumulative	Monthly
Outpatient Registrations w/ER														
FY 2017	120												120	120
FY 2016									165	146	126	137	574	144
FY 2015													0	0
PT Procedures														
FY 2017	416												416	416
FY 2016	319	344	349	401	326	396	291	324	489	346	407	415	4,407	367
FY 2015	224	197	280	347	321	224	319	345	216	170	296	269	3,208	267
OT Procedures														
FY 2017	94												94	94
FY 2016	105	107	51	139	124	53	31	26	36	62	66	111	911	76
FY 2015	24	55	95	67	108	65	35	107	90	99	115	128	988	82
Lab Tests														
FY 2017	298												298	298
FY 2016	304	363	324	350	374	399	318	314	319	340	272	219	3,896	325
FY 2015	440	350	533	266	486	311	411	328	359	363	291	367	4,505	375
X-Ray Procedures														
FY 2017	47												47	47
FY 2016	60	52	64	56	76	71	63	74	52	44	42	37	691	58
FY 2015	27	27	66	68	59	56	99	84	47	34	37	44	648	54
CT Procedures														
FY 2017	7												7	7
FY 2016									15	25	17	13	70	
FY 2015													0	0
CCMC Clinic Visits														
FY 2017	212												212	212.0
FY 2016	178	197	170	203	222	191	205	231	343	227	203	223	2,593	216
FY 2015	141	151	157	196	204	190	224	270	164	194	131	160	2,182	182
Behavioral Hlth Visits														
FY 2017	70												70	70.0
FY 2016	94	100	103	104	89	75	58	39	56	47	80	122	967	81
FY 2015	94	90	73	97	37	68	112	49	106	70	71	76	943	79

Cordova Community Medical Center
Balance Sheet

ASSETS	1/31/2017	12/31/2016	1/31/2016
Current Assets			
Cash	282,988	108,722	176,865
Net Account Receivable	1,372,044	1,261,097	1,194,850
Third Party Receivable	-	-	0
Other Receivables	100,481	100,481	53,041
Prepaid Expenses	13,056	2,002	22,642
Inventory	153,284	169,201	139,147
Total Current Assets	**1,921,853**	**1,641,503**	**1,586,546**
Property, Plant & Equipment			
Land	122,010	122,010	122,010
Buildings	7,006,763	7,006,763	7,006,763
Equipment	6,759,816	6,759,816	6,526,416
Construction in Progress	1,077,323	1,060,094	1,060,094
Subtotal PP&E	14,965,911	14,948,682	14,715,283
Less Accumulated Depreciation	(10,196,705)	(10,106,135)	(9,642,061)
Total Property & Equipment	**4,769,206**	**4,842,547**	**5,073,222**
Other Assets			
PERS Deferred Outflow	929,979	929,979	929,979
Total Other Assets	**929,979**	**929,979**	**929,979**
Total Assets	**7,621,038**	**7,414,029**	**7,589,747**
LIABILITIES AND FUND BALANCE			
Current Liabilities			
Accounts Payable	641,065	586,585	1,113,741
Payroll & Related Liabilities	761,617	496,516	625,471
Third Party Settlement Payment	0	0	0
Interest & Other Payables	7,598	6,035	293
Long Term Debt-- City	3,100,976	3,100,976	2,182,460
Other Current Long Term Debt	125,797	132,146	137,630
Total Current Liabilities	**4,637,053**	**4,322,258**	**4,059,595**
Long Term Liabilities			
2015 Net Pension Liability	5,015,100	5,015,100	5,015,100
Total Long Term Liabilities	**5,015,100**	**5,015,100**	**5,015,100**
Total Liabilities	**9,652,153**	**9,337,358**	**9,074,695**
Net Position			
Unrestricted Fund Balance	2,769,539	2,769,539	2,769,539
Temporary Restricted Fund Balance	13,035	13,035	13,035
Pension Deferred Inflow	88,788	88,788	88,788
Prior Year Retained Earnings	(5,064,060)	(4,086,354)	(4,086,354)
Current Year Net Income	161,582	(708,338)	(269,957)
Total Net Position	**(2,031,115)**	**(1,923,329)**	**(1,484,949)**
Total Liabilities & Net Position	**7,621,038**	**7,414,029**	**7,589,747**

Cordova Community Medical Center
Gross AR Aging and Days in AR
January 2017

TOTAL **Gross A/R**	0 - 30	31 - 60	61 - 90	91 - 120	121+	Totals		Jan Days In AR
Commercial	110,369	76,735	47,140	31,351	139,288	404,883	22.5%	
Medicare	121,130	47,972	13,922	13,510	93,042	289,577	16.1%	
Medicaid	25,158	51,773	18,002	10,158	84,203	189,294	10.5%	
Other Govt payers	37,002	17,176	10,027	3,141	34,380	101,726	5.7%	
Extended Pymt Terms	-	1,157	2,182	847	68,244	72,429	4.0%	
Private Pay	31,484	20,613	26,997	45,760	188,124	312,977	17.4%	
Long Term Care	264,827	(32,006)	7,355	1,648	105,610	347,434	19.3%	
Work Comp	12,404	12,160	12,483	6,228	35,137	78,412	4.4%	
Totals	602,372	195,581	138,108	112,642	748,027	1,796,731	100.0%	66.8
	33.5%	10.9%	7.7%	6.3%	41.6%	100.0%		
						95,953	Credit Balances	

Cordova Community Medical Center
Income Statement

	January 2017					Year To Date				
REVENUE	Actual	Budget	Variance	Prior Yr	Variance	Actual	Budget	Variance	Prior Yr	Variance
Acute	132,729	30,839	101,890	22,709	110,020	132,729	30,839	101,890	22,709	110,020
Swing Bed	169,254	92,045	77,209	-	169,254	169,254	92,045	77,209	-	169,254
Long Term Care	358,083	346,378	11,705	337,604	20,479	358,083	346,378	11,705	337,604	20,479
Clinic	66,066	63,293	2,773	63,207	2,858	66,066	63,293	2,773	63,207	2,858
Outpatients	210,417	188,520	21,897	146,497	63,920	210,417	188,520	21,897	146,497	63,920
Behavioral Health	20,032	48,254	(28,222)	35,581	(15,548)	20,032	48,254	(28,222)	35,581	(15,548)
Patient Services Total	956,581	769,329	187,252	605,598	350,983	956,581	769,329	187,252	605,598	350,983
DEDUCTIONS										
Charity	-	21,804	(21,804)	3,790	(3,790)	-	21,804	(21,804)	3,790	(3,790)
Contractual Adjustments	320,840	94,385	226,455	158,506	162,334	320,840	94,385	226,455	158,506	162,334
Bad Debt	75,164	18,576	56,589	10,825	64,339	75,164	18,576	56,589	10,825	64,339
Deductions Total	396,004	134,764	261,240	173,121	222,883	396,004	134,764	261,240	173,121	222,883
COST RECOVERIES						-	-		-	
Grants	83,774	40,808	42,966	(492)	84,266	83,774	40,808	42,966	(492)	84,266
In-Kind Contributions	93,754	101,454	(7,699)	87,856	5,899	93,754	101,454	(7,699)	87,856	5,899
Other Revenue	323,126	63,288	259,839	70,167	252,960	323,126	63,288	259,839	70,167	252,960
Cost Recoveries Total	500,655	205,549	295,106	157,530	343,125	500,655	205,549	295,106	157,530	343,125
TOTAL REVENUES	**1,061,232**	**840,114**	**221,118**	**590,007**	**471,225**	**1,061,232**	**840,114**	**221,118**	**590,007**	**471,225**
EXPENSES										
Wages	333,077	294,439	38,639	304,206	28,871	333,077	294,439	38,639	304,206	28,871
Taxes & Benefits	168,765	201,960	(33,195)	60,766	107,998	168,765	201,960	(33,195)	60,766	107,998
Professional Services	147,903	180,625	(32,723)	188,805	(40,902)	147,903	180,625	(32,723)	188,805	(40,902)
Minor Equipment	2,556	1,448	1,108	1,636	919	2,556	1,448	1,108	1,636	919
Supplies	32,932	36,269	(3,337)	126,994	(94,062)	32,932	36,269	(3,337)	126,994	(94,062)
Repairs & Maintenance	19,993	8,798	11,195	5,259	14,734	19,993	8,798	11,195	5,259	14,734
Rents & Leases	9,978	10,197	(219)	9,641	337	9,978	10,197	(219)	9,641	337
Utilities	110,469	47,300	63,170	144,388	(33,918)	110,469	47,300	63,170	144,388	(33,918)
Travel & Training	3,851	4,341	(490)	3,928	(77)	3,851	4,341	(490)	3,928	(77)
Insurances	16,836	17,221	(385)	35,019	(18,183)	16,836	17,221	(385)	35,019	(18,183)
Recruit & Relocate	145	7,838	(7,693)	8,126	(7,981)	145	7,838	(7,693)	8,126	(7,981)
Depreciation	45,285	22,361	22,924	38,951	6,334	45,285	22,361	22,924	38,951	6,334
Other Expenses	7,860	9,151	(1,291)	6,816	1,043	7,860	9,151	(1,291)	6,816	1,043
TOTAL EXPENSES	**899,650**	**841,946**	**57,703**	**934,536**	**(34,886)**	**899,650**	**841,946**	**57,703**	**934,536**	**(34,886)**
OPERATING INCOME	161,582	(1,832)	163,414	(344,529)	506,111	161,582	(1,832)	163,414	(344,529)	506,111
Restricted Contributions				-					-	
NET INCOME	**161,582**	**(1,832)**	**163,414**	**(344,529)**	**506,111**	**161,582**	**(1,832)**	**163,414**	**(344,529)**	**506,111**

Nursing Report
March 10, 2017
Chief Nursing Officer
Lisa Cuff, DNP, MSN, RN

It has been a busy 4 months since my arrival to Cordova at the end of October 2016. Since this is my first report to the board, I have organized this report based upon my assessment and further divided into specific nursing related categories.

Nursing Leadership

The focus of nursing leadership at CCMC is to create stability and rebuild the foundation for the nursing department to ensure the current American Nurse Association (ANA) standards of practice, evidence-based practice guidelines are implemented, and to support current federal and state regulations. The resulting impact of rebuilding the Nursing Department infrastructure will be improved quality of care, improved patient satisfaction, and improved employee satisfaction.

Following the state survey results it became apparent the need for a fulltime Long Term Care Director of Nursing (DON). The regulations are specific in regards to the number of hours the DON spends in administrative and care direction for Long Term Care as well as the hours mandated for the critical access hospital. Shortly following the survey, we contracted a LTC DON with significant experience in long-term care and in the survey process. The interim LTC DON remains with the agreement to stay until a qualified replacement is hired.

Additional support positions identified include the following new positions. Interviews will begin in the near future for both positions.

1. Quality Improvement/Clinical Practice Educator/Registered Nurse Case Manager
2. Infection Preventionist/Wound Care Specialist/Risk Management/Occupational Health Nurse

Nurse Staffing

Changes to the nurse-staffing plan created prior to my arrival, went through a difficult transition from November to current. The previous staffing plan included a unit clerk for each shift. Through situational and direct assessment, the need to remove this position from our staffing plan was evident within the first 2 weeks of my assessment. Although a difficult transition, the result provided conclusive evidence that many duties allocated to the nursing department (RN, LPN, and CNA/Unit clerk) were non-nursing duties, taking away from time spent with patient's and residents. This assessment also provided the evidence needed to make changes to the level of staffing based on acuity. The current staffing plan consists of two licensed staff and two CNA's per shift, with a mid-shift CNA to provide the needed support to comply with current staffing standards for quality care excellence. The staffing goal to identify an acuity model to ensure the appropriate number of licensed nurses assigned with the increase in acuity

vs. volume is in the process of research and development with an emphasis on rural health nursing ratios appropriate for CCMC. The goal is to implement the new staffing matrix before or by June 2017.

We continue to seek out permanent nursing staff to join the CCMC nursing team. We currently have three fulltime permanent RN's, two travel RN's, three travel LPN's, and zero travel CNA's. Continued efforts for recruiting current travel nurses is ongoing with positive feedback and potential to consider fulltime permanent status. The CCMC team consistently seeks out ways to improve recruitment and retention through the efforts of the recruitment and retention committee. The goal to reduce travel nurse use to 25% or less by 08/2017, and less than 10% by year's end will promote the nursing quality and dedication to care described in the new CCMC Nursing Professional Practice Model currently in the development and implementation process.

Nursing Department Education Plan

The assessment process during my first 4 months revealed issues within the education plan for the Nursing Department. Continued skills and evidence-based practice education lacks the robust need of the rural environment. As nurse generalists this is even harder to maintain. Using a professional development model for competency driven care, the nursing department will launch an annual education calendar each December. Working closely with the quality improvement team, areas identified as improvement needs will be scheduled as ongoing education and competency training. Because of the nature of the rural environment, the need for continued Trauma/Emergency nursing to maintain skill level and regulatory requirements is needed. A recent meeting with the EMS system initiated collaborative correspondence to improve and meet educational needs for both CCMC and EMS. This collaboration will result in improved communication, expectations, and maintaining skill levels appropriate for the individual scope of practice. In addition to the trauma/emergency training, continued support through education for a variety of nursing skills, nursing specialties, and regulatory compliance knowledge will be provided. The education calendar for 2016 will be available beginning May 2016 to allow the adjustment of the Clinical Practice Educator position. In the interim, clinical education is being provided through our online learning platform, and in-services provided by nursing leadership.

Following the community health needs assessment, nursing leadership is working on a community health education program to assist in addressing the health needs of our community. The community health education program is currently being developed for a targeted implementation date to coincide with the community health fair. The goal of this program is to connect CCMC's nursing staff with the community as healthcare advocates and provide a program that promotes health and longevity.

Equipment needs

As with any profession, the need for adequate equipment to do the job is essential for success. We continue to evaluate the status of equipment that may need replacing due to acceptable wear and tear and number of years in use, the ability to meet the national standards of care, and the ability to meet current national quality standards.

Nursing Department 2017 Plan

Throughout 2017, the nursing department at CCMC will be implementing many changes to contribute to positive patient outcomes by using evidence-based practice guidelines and standards. The standards of practice created by the American Nurses Association (ANA), the Emergency Nurses Association (ENA), and the American Association of Critical Care Nurses (AACN) will be the focus to increase quality and satisfaction for the care provided by CCMC's Nursing Department. The first step is the development and implementation of the CCMC Nursing Department Mission, Vision, and Values, which will carry through to the Nursing Professional Practice Model. The Nursing Department must be structured to support the mission, vision, and values of CCMC. This provides the foundation for our nursing staff to implement nursing care in a structured, evidence-based, holistic delivery model. Within the healthcare profession, the need to identify how we view ourselves, how the community views us, how we care for our patients, co-workers and ourselves is essential for health and healing. The implementation of the American Association of Critical Care Nurses (AACN) Healthy Work Environment Standards provides the construct to accomplish this mission. This initiative is projected to begin May 2017.

As we move through the next several months, records of change management strategies and results will be maintained for potential contribution to rural health nursing through professional nursing research projects. The world of healthcare continues to change. Contributing to rural healthcare research will assist in elevating the voice of rural nurses who advocate for our communities.

I look forward to updating you on our progress throughout 2017.

Thank you,

Lisa Cuff, DNP, MSN, RN
Chief Nursing Officer

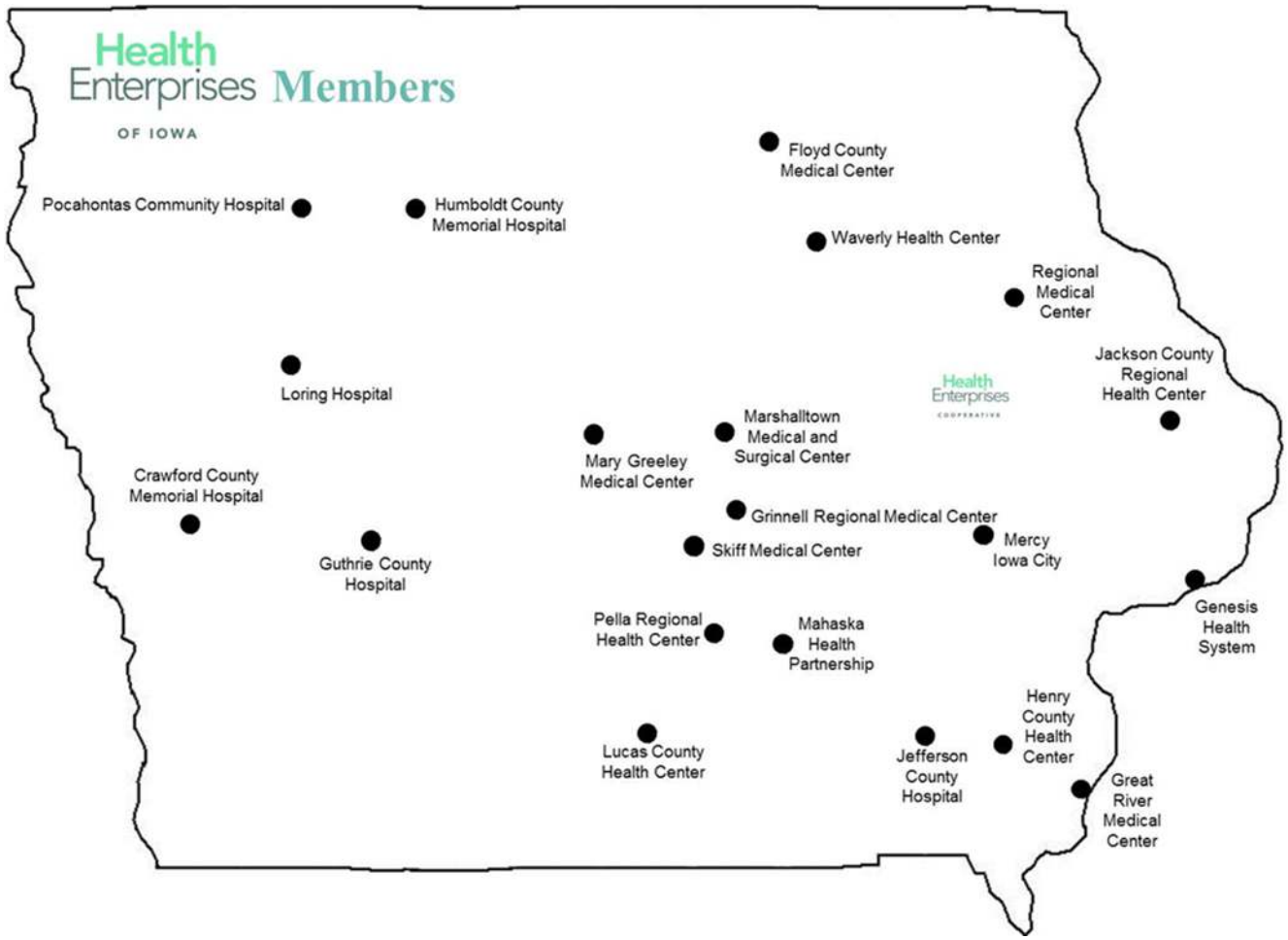
HEALTH ENTERPRISES

Cordova Hospital Board Meeting: Intro to 340B

Presented by Aaron K. Lott Pharm. D.
Executive Director of Pharmacy Services

March 2017

WHO WE ARE


Health Enterprises Members
OF IOWA
Floyd County Medical Center
Pocahontas Community Hospital
Humboldt County Memorial Hospital
Waverly Health Center
Regional Medical Center
Jackson County Regional Health Center
Loring Hospital
Health Enterprises
Marshalltown Medical and Surgical Center
Mary Greeley Medical Center
Crawford County Memorial Hospital
Grinnell Regional Medical Center
Mercy Iowa City
Skiff Medical Center
Guthrie County Hospital
Genesis Health System
Pella Regional Health Center
Mahaska Health Partnership
Henry County Health Center
Lucas County Health Center
Jefferson County Hospital
Great River Medical Center

Health Enterprises Overview

Current Services

- 340B Auditing, compliance and implementation
- 340B entity owned retail pharmacy implementation
- Pharmacy Benefits Management (PBM)
- Specialty Pharmacy
- Rehabilitation Therapies
- Anesthesia
- Group Purchasing
- Mobile Services

Information Covered Today

- 340B Program Basics
- Compliance Trends
- Preparation for Audits
- 340B Program Updates
- Summary

HEALTH ENTERPRISES

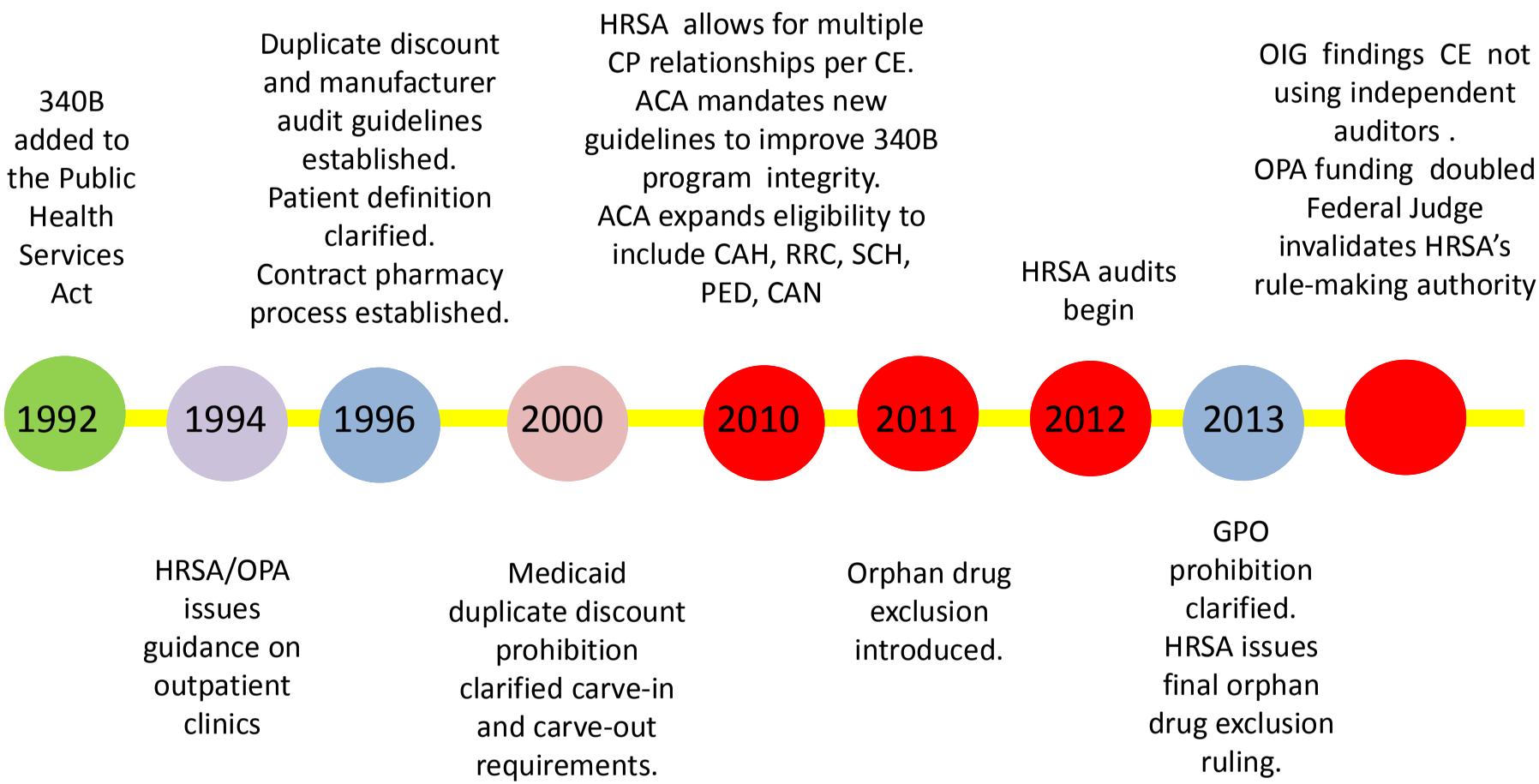
340B Program Basics

- Definition
  - The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices.

- Purpose
  - Enable covered entities to stretch scarce Federal resources as far as possible.

- End result covered entities use savings to:
  - Reduce price of pharmaceuticals for patients
  - Expand services offered to patients
  - Provide services to more patients

340B Program Basics



340B Program Basics

- Steps for Enrollment
  - Determine eligibility
  - Complete appropriate forms
  - Submit forms during quarterly open enrollment periods

Register	**Start Date**
January 1-15	April 1
April 1-15	July 1
July 1-15	October 1
October 1-15	January 1

  - OPA verifies forms and eligibility
  - Await decision from OPA

- Participation
  - Once enrolled set up a 340B account with your wholesaler
  - If contract relationships will exist and the wholesaler is different than your own you will need to fill out a 340B account application for that wholesaler
  - Will you use a 3rd party software vendor?

Compliance

Key Components for Compliance Programs

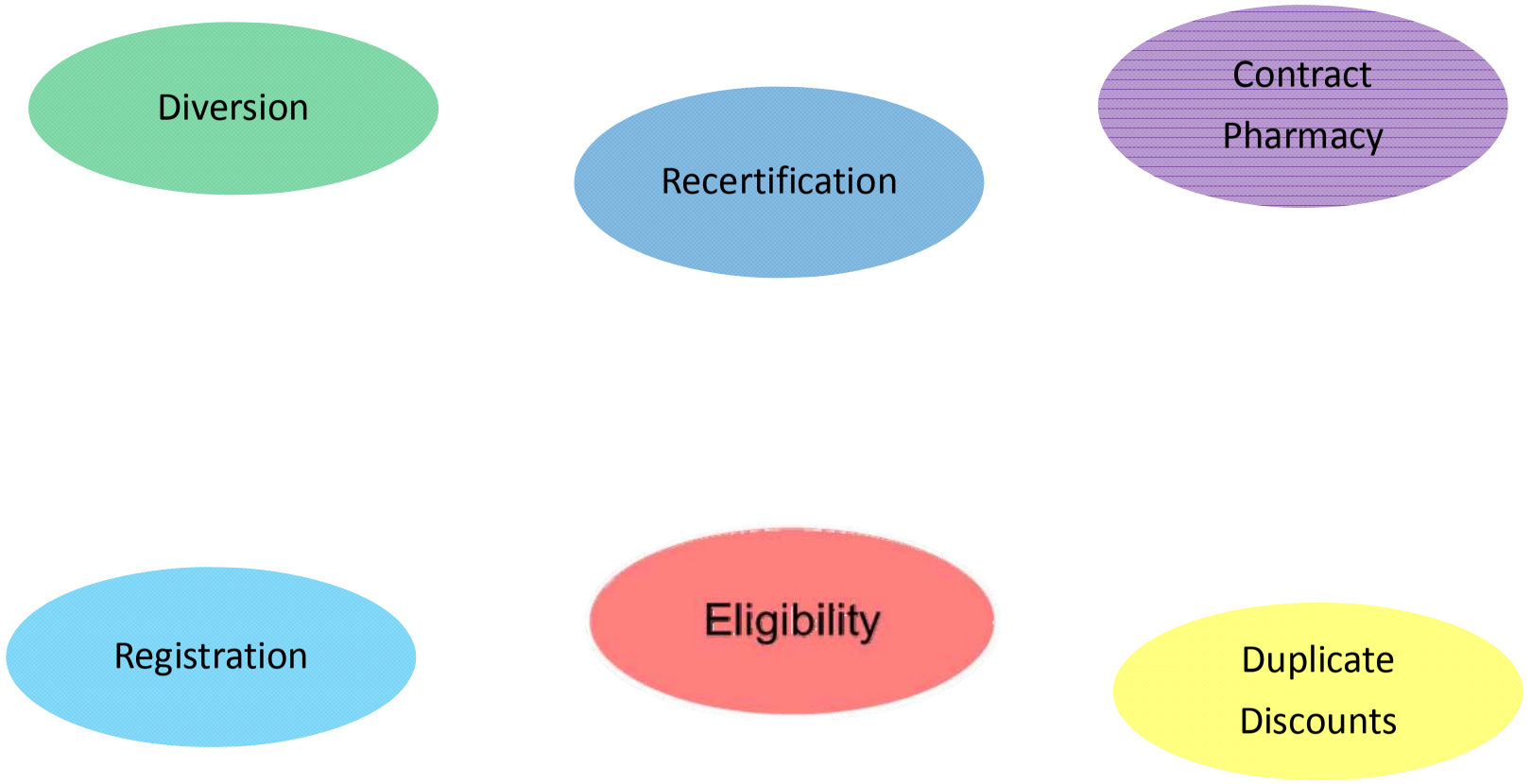
1. Designating a Compliance Officer and Committee
2. Developing written Policies and Procedures
3. Conducting Effective Training
4. Developing Effective Lines of Communication
5. Enforcing Standards through well publicized Disciplinary Guidelines
6. Performing audits and monitoring risk areas
7. Responding to detected offenses and developing Corrective Action Initiatives

Source: OIG 1998; 2005

HEALTH ENTERPRISES

Compliance

Key Compliance Areas



HEALTH ENTERPRISES

Compliance

Key Compliance Areas

- Eligibility
  - Hospital must be
    - owned and operated by state or local government
    - formally granted governmental powers
    - or a private (non-profit hospital) under contract with state or local government
    - Or
      - A critical access hospital
      - A disproportionate share hospital, meeting a DSH %
        - 8% if sole community or rural referral center
        - 11.75% for all other hospitals, including free-standing children's hospitals and cancer hospitals

HEALTH ENTERPRISES

Compliance

Key Compliance Areas

- Registration
  - Covered entity must register with HRSA and all eligible offsite locations that use 340B drugs
  - Each individual location (clinic or offsite outpatient dept.) must be registered separately registered
  - Authorizing official will submit information through annual recertification process

- Recertification
  - Required for all hospital types or CE will be removed from the program
  - Authorizing official must attest to eight questions after reading the following statement:

"As an Authorized Official, I acknowledge the 340B covered entity's responsibility to abide by and further certify on behalf of the covered entity that:

Link to recertification instructions:
http://opanet.hrsa.gov/opa/Manuals/OPA%20Database%20Guide%20for%20Public%20Users%20-%20Recertification.pdf

HEALTH ENTERPRISES

Compliance

Key compliance areas

- **Diversion**
  - Drugs can only be used on an outpatient basis for covered entity's patient
    - Must maintain patients health care record
    - Must maintain responsibility for individuals care via relationship with health professional
    - HRSA's most recent definition of a patient is from 1996

- **Duplicate discounts**
  - 340B law prohibits application of both 340B discount and rebate from Medicaid on the same drug claim
  - Recommendation to my members -"carve out" do not even submit data when Medicaid billing code is present. In most circumstances the small amount of savings realized is not worth the risk of non-compliance

HEALTH ENTERPRISES

Compliance

Key Compliance Areas

- **Contract Pharmacy**
  - Currently no limit on the number of relationships
    - One entity has over 300+ relationships
  - Hospitals bears **FULL** responsibility for compliance and must monitor contract pharmacies
    - The current HRSA language states that is an expectation that covered entities with contract pharmacy relationships will have an annual independent audit of their program done annually
  - Speculation that mega-reg will limit number of CP relationships a CE can have

Hospital Owned Retail

CAH Profile

- 2 contract pharmacy relationships
- 3 child sites in other towns
- July financials for hospital owned retail pharmacy
  - 3rd Party Sales Report
  - Total Rxs = 2832
  - COGs $119,066.50
  - Adjudicated Amount $140,948.08
  - Profit = $21,881.58 // 15.5%

  - 340b Margin Report
  - Total 340b Rxs = 1353
  - Cost of 340b Drugs = $12,922.55
  - Enhanced Margin Profit = $36,377.60 // 73.8%

- Total Gross Profit = $21,881.58 + 36,377.60 = $58,259.18

HEALTH ENTERPRISES

Questions

Jon Thompson

Operations Manager

jthompson@transcendrx.com

Aaron Lott

Executive Director of Pharmacy Services

alott@healthenterprises.org

Cordova Community
MEDICAL CENTER

Memorandum

To: Health Services Board
From: Scot Mitchell, FACHE, CCMC CEO
Subject: Charity Care/Discounted Fees Policy
Date: March 6, 2017

Suggested Motion: "I move to approve the revised Charity Care/Discounted Fees Policy, number FS 350."

SUBJECT: Charity Care/Discounted Fees **DEPARTMENT: Financial Services** **Original Approval Date: 08/1/2001** **Approved by:** Scot Mitchell, CEO	FS 350	
	☐ New ☒ Revised	**Date:** 03/09/2017
	Page 1 of 2	

Policy:

In keeping with the philosophy and mission of the Cordova Community Medical Center (CCMC), medically necessary health care services are available to all individuals, regardless of the ability to pay. CCMC assists persons with financial need, (as determined by family incomes relative to the Health and Human Services federal poverty guidelines for Alaska,) by waiving all or part of the charges for services provided by CCMC based on a sliding payment scale.

Procedure:

The patient must meet the following criteria to be eligible for an allowance under the Charity Care/Discounted Fee policy:

The service(s) being considered must be medically necessary; elective procedures are excluded.

The patient must be a Self-Pay patient or have a self-pay balance on the account following application of any available assistance/insurance programs. Deductibles and coinsurance under the Medicare and Medicaid programs may be considered for financial assistance.

The patient's family income must be equal to or below 200% of the Federal Poverty Level at the time of application.

A. The patient must demonstrate an effort to qualify for other programs that would assist in repaying the hospital charges, (i.e. Medicaid).
B. In the case of a minor patient, the responsible party must meet the above criteria to qualify.

1. CCMC will bill for services rendered at the usual and customary rate following standard billing practices. Financial assistance from CCMC is secondary to all other financial resources available to the patient, including insurance, government programs and third-party payers. These sources include, but are not limited to: Veteran's Administration, Worker's Compensation, Native Health Services and Third Party Insurance. The patient may not withhold information regarding enrollment in or eligibility for these resources/programs.

SUBJECT: Charity Care/Discounted Fees **DEPARTMENT: Financial Services** **Original Approval Date: 08/1/2001** **Approved by:** Scot Mitchell, CEO	FS 350	
	☐ New ☒ Revised	**Date:** 03/09/2017
	Page 2 of 2	

The patient must submit a completed Charity Care/Discounted Fee application and all required verification documents within 30 days of receiving a statement from CCMC for the date of service.

2. The CCMC Chief Financial Officer (CFO) will review the application within 15 days of receipt and notify the applicant of the result in writing. Late applications will be considered at the discretion of the CEO or CFO.
3. Upon approval, the billing office will apply the sliding fee discount to the appropriate charges. At a minimum, the patient will owe $30 for visits with a medical provider and $20 each for laboratory, radiology, and other medically necessary services.
4. Because financial situations can change, the patient must re-apply for each eligible visit.

Attachments:
Charity Care/Discounted Fee Application (3 pages)
Charity Care/Discounted Fee Information Sheet
2017 HHS Poverty Guidelines

Cross – Reference:

QMC Approval Date: 02/28/2017

HSB Approval Date: 03/09/2017

Revision History:
08/01/2001: Original Approval
05/30/2015: Updated Policy
03/09/2017: Updated FPL levels and minor revisions

CEO Signature _____ **Date** _____
Department Manager Signature_____ **Date** _____

Review Signature _____ **Date** _____
Review Signature _____ **Date** _____
Review Signature _____ **Date** _____
Review Signature _____ **Date** _____

Cordova Community
MEDICAL CENTER
P: (907) 424-8000 | F: (907) 424-8116
P.O. Box 160 | 602 Chase Ave., Cordova, AK 99574-0160

Charity Care/Discounted Fee Information

The information you provide is confidential. We use it only to evaluate if you are eligible for a discount.

How does the program work?
We will not deny you necessary care due to an inability to pay at the time of Service. If you have insurance or other medical benefits such as Medicare, Medicaid, coverage under a Native Corporation, or the Veteran's Administration, we will bill them first. If you have medical insurance or are eligible for any other medical benefits, you must tell us. If we find a potential payments source, but you didn't tell us, we will deny your application for a discount. If you do not have insurance, or if your insurance or other benefit doesn't pay the full amount, the amount left over becomes "self-pay". This means you are responsible for paying the unpaid balance. We may be able to offer financial assistance to help you pay the balance.

First, if you do not already have Medicaid, you must apply for it, or prove that you applied and were rejected. You must do this before you can apply to CCMC for a discount on the amount you owe.

You will receive a statement from CCMC for the services you received. When you do, you have 30 days to apply for a discount. To apply, complete a Charity Care/Discounted Fees Application and gather all the requested validation paperwork. Bring or mail the entire packet to CCMC. Remember, you only have 30 days from the date of your first statement to submit a complete application if you want to be considered for charity care or discounted fees.

Why does CCMC need to know my household income and our assets?
Eligibility for a discount at CCMC is based up a family's relationship to the Federal Poverty Guidelines. We must be able to prove that any patient who receives charity care or discounted fees from us, meets the stated guidelines.

Why must I tell you about my medical insurance and about other benefits I may have?
When you receive medical services at CCMC, we are required by Federal Regulations, to charge you the "usual and customary rate", regardless of your financial situation. We can't charge you less, but will not turn you away if you require medical care and are unable to pay this usual and customary rate. CCMC does this because we are required to charge all patients the same amount for the same service. We apply the discount after we receive all the payments from insurance companies and others. Payments from these sources lower the amount you owe. If we approve your request for a discount, we calculate the discount as a percentage of the total you owe, so you want your self-pay balance to be as low as possible. We cannot apply payments from insurance and benefits programs to a discounted balance, because the hospital/clinic can be fined or lose participation in reimbursement contracts for not charging everyone the same.

What do I need to re-apply?
Financial situations change, so you will need to reapply every six months or whenever your personal or financial situation changes. Before you reapply, we encourage you to contact the Billing Office to see what paperwork we need. In some cases, we may only require that you send updated paperwork that we can attach to a previously filed application, rather than a new application.

CCMC will charge you a nominal fee.
CCMC requires that patients who are otherwise eligible for a 100% discount pay a nominal fee of $30.00 for clinic visits with a medical provider and $20.00 each for approved laboratory, radiology, or mental health services.

What charges cannot be considered for discounts (excluded charges)?

CCMC's Charity Care/Discounted Fees Policy only applies to medically necessary services as determined by a medical provider. If you are seen in the ER of after-hours for a condition that is not an emergency, those charges will not be eligible for a discount.

Cordova Community
MEDICAL CENTER
P: (907) 424-8000 | F: (907) 424-8116
P.O. Box 160 | 602 Chase Ave., Cordova, AK 99574-0160

Charity Care/Discounted Fees Application

CCMC's policy is to provide medically necessary services regardless of a patient's ability to pay. Discounts are offered based upon family income and size. Please fill in the following areas and return this form and copies of information listed on the verification checklist to CCMC. Our staff will review your application to determine if you or members of your family are eligible for a discount. You must submit a completed application (including verification) within 30 days of receiving a statement from CCMC for the date of service.

Discounts, if approved, apply only to medically necessary services received from CCMC, but not those services received through an affiliate entity, such as some visiting providers, outside processing or consultation, patient transport, or other such services. In the hope that your financial situation improves, discounts apply only to current self-pay balances, not future services. This form must be completed every six (6) months, or if there are changes in personal Finances. Discounts will only be considered after all other medical benefits have been applied.

Applicant Information

Name		Date of Service		Amount Owed
Street/PO Box	City	State	Zip	Phone

Household Information: Please complete the following for the head of household, spouse and dependent children under the age of 18 living in the patient's household.

Name	Date of Birth	Relationship to Applicant	Place of Employment	Is The Job Seasonal?
HEAD OF HOUSEHOLD				

Household Assets: Please complete the following for you, your spouse, and your dependents.

Financial Assets	Head of Household	Spouse	Dependents	Total
Amount in Checking/Savings Accounts				
Other Liquid Assets (please explain) Boats, ATVs, Vehicles, Etc.				
Total Value of Assets				

Monthly Household Income

Please complete the following for you, your spouse, and your dependents.

Source	Self	Spouse	Dependents	Total
Gross wages, salaries, tips, etc.				
Social Security, pension, annuity, veteran's benefits, public assistance, unemployment				
Alimony, child support, foster care, military family allowances and allotments				
Self-Employed Income				
Rent, interest, dividend and other income				
Alaska Permanent Fund				
Worker's Comp, Disability				
Other income (please explain)				
Total Income				

Access to Medical Benefits

Check all that apply for each member of your household.

Insurance or Benefit Eligibility	Self	Spouse	Dependents	Total
Third Party Insurance Plan(s)				
Tricare				
Medicaid				
Medicare				
Native Benefits				
Veterans Benefits				

Verification Checklist

Attach copies of ALL items listed below for each household member	Office Use Only	
	YES	NO
Identification: Driver's license, state ID card, birth certificate, employment ID, passport, social security card		
Income: Prior year tax return, three most recent pay stubs		
Insurance/Medical Benefits: Insurance card(s)		
Medicaid: Application made or evidence of rejection		

Applicant Certification (or Parent/Legal Guardian if Applicant is a minor):
I certify that the information provided is correct and that I have fully disclosed all requested information.

Signature _____ Printed Name _____ Date _____

Office Use Only	Applicable Balance _____
Patient Name_____	Discount _____
Date of Service_____	Approved By_____

CCMC Sliding Scale

2017

Alaskan Poverty Scale

Family Size		Annualized Income Level relative to Poverty Guideline							
Persons In Family	<= 100% Poverty Level		> 100% and <= 150%		> 150% and <= 200%		> 200% and <= 250%		> 250%
1	0	$14,840	14,841	22,260	22,261	29,682	29,683	37,103	37,104
2	0	$20,020	20,021	30,030	30,031	40,042	40,043	50,053	50,054
3	0	$25,200	25,201	37,800	37,801	50,402	50,403	63,003	63,004
4	0	$30,380	30,381	45,570	45,571	60,762	60,763	75,953	75,954
5	0	$35,560	35,561	53,340	53,341	71,122	71,123	88,903	88,904
6	0	$40,740	40,741	61,110	61,111	81,482	81,483	101,853	101,854
7	0	$45,920	45,921	68,880	68,881	91,842	91,843	114,803	114,804
8	0	$51,120	51,121	76,680	76,681	102,242	102,243	127,803	127,804
Discount %	Nominal Fee (see guidelines)		75%		50%		25%		0%

Discounted fees only apply to services provided in-house by CCMC.

Medical: Nominal fees are applied for each visit for all in-house CCMC services

Pharmacy: Samples are provided, when available, without charge

Lab & X-ray: Reference lab tests and consulting radiology interpretations are excluded.

Nominal fees: Minimum payment

2017 Poverty Guidelines

Persons in Family	Alaska
1	$14,840
2	20,020
3	25,200
4	30,380
5	35,560
6	40,740
7	45,920
8	51,120
For each additional person over 8, add	5,200

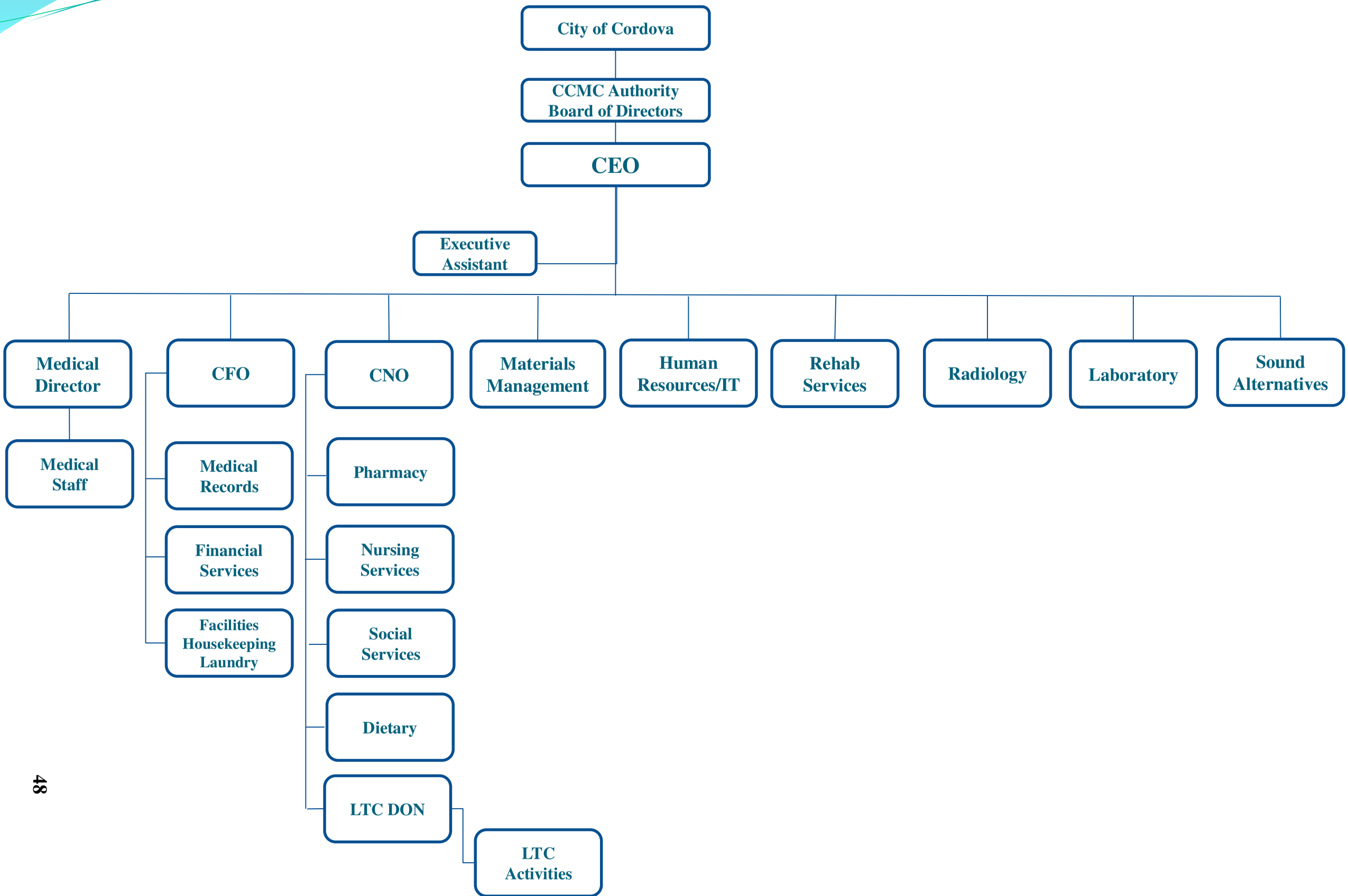
http://aspe.hhs.gov/poverty/15poverty.cfm#guidelines

Memorandum

To: Health Services Board
From: Scot Mitchell, FACHE, CCMC CEO
Subject: Personnel Organization Plan
Date: March 6, 2017

Suggested Motion: "I move to approve the updated Personnel Organization Plan."

CCMC Organizational Chart 2017



Cordova Community
MEDICAL CENTER

Memorandum

To: Health Services Board
From: Scot Mitchell, FACHE, CCMC CEO
Subject: CCMC 2016 Financial Statement Audit
Date: March 6, 2017

Suggested Motion: "I move to approve the proposal from Dingus Zarecor & Associates, PLLC to perform the audit of the 2016 CCMC financial statement for a cost of $20,000 plus out-of-pocket expenses to be billed at actual cost."

Cordova Community Medical Center

Proposal to Provide Services

February 2017

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Table of Contents:

The following is a description of our firm, our qualifications, the services we provide, our proposed prices, and references.

Proposal Highlights

- We are critical access hospital specialists, and the majority of our clients are critical access hospitals. The remaining clients are other healthcare and public sector organizations.
- DZA will provide an in-person presentation to the Health Services Board that includes a financial indicators report.
- DZA carefully plans each engagement to ensure timely delivery of the audited financial statements and Medicare cost report.
- DZA prides itself on exceptional communication with hospital management and Health Services Board throughout the audit process.
- An experienced Medicare cost report preparer will make a site visit as part of the preparation process. Additionally, the Medicare cost report will be reviewed by both the owner primarily responsible for the Medicare cost report and also a second owner.
- DZA provides a letter of recommendations with every financial statement audit and Medicare cost report.
- DZA does not charge for routine questions throughout the year unless a project is requested.
- We understand that when you have questions, a quick response is vital. We are very responsive to time-sensitive requests.

Capability of our Team

Focus and Services Provided

Dingus, Zarecor & Associates PLLC (DZA) is a certified public accounting firm located in Spokane Valley, Washington. DZA primarily serves critical access hospitals; we also serve hospitals, nursing homes, rural health clinics, federally qualified health centers, home health agencies, hospice agencies, assisted living facilities, retirement communities, and other public sector organizations in the western United States. A complete list of clients by sector is included in this proposal. Our staff spends over 75% of their time providing services to critical access hospitals. DZA works with critical access hospitals in the Northwest. DZA provides audit, cost report, or both services for approximately 75 hospitals; of these hospitals, approximately 65 are critical access hospitals.

DZA has served critical access hospitals as its core business since the firm's beginning in 2003. Our owners and staff stay informed about regional and national critical access hospital issues through national training and focused research. DZA will use the insights and knowledge of two experienced owners in every aspect of the work performed for Cordova Community Medical Center (the Center).

DZA has 28 professional staff members and five support staff members. As a firm with a niche focus, all of our employees are well versed in financial and reimbursement-specific issues that affect critical access hospitals.

Capability of our Team (Continued)

Focus and Services Provided (continued)

DZA provides the following services:

- Audit, review, and compilation of financial statements
- Medicare and Medicaid cost report preparation
- Medicare and Medicaid reimbursement consulting
- IRS Form 990 and 990T tax return preparation
- Retirement plan audits
- Uniform guidance single audits
- General business consulting for healthcare organizations
- Feasibility studies

DZA also provides the following consulting services:

- Critical access hospital interim settlement estimates
- Reimbursement strategies for critical access hospitals
- Rural health clinic financial feasibility studies
- Medicare appeals
- Assistance with facility Medicare enrollment
- Disproportionate share survey reporting
- Analysis of the impact of Medicare regulation changes on reimbursement
- Analysis of the effect of operational changes on Medicare and Medicaid reimbursement
- Budgeting assistance
- Contractual allowance estimates
- Third-party settlement estimates
- Internal control system reviews
- Analysis of the effect of new accounting pronouncements
- Board education
- Wage index reviews
- Occupational mix preparation and related consulting
- Service line profitability analysis

DZA also has excellent referral relationships with organizations that provide additional consulting services such as business office consulting and revenue cycle reengineering.

Commitment to Client Service

DZA is committed to providing high-quality service to critical access hospitals at an affordable price.

Our commitment is achieved as follows:

An experienced auditor will be directly involved in each engagement. We realize the skills and experience of the engagement team working directly with your organization is important to you. A manager will be on-site for one to two days during fieldwork. An in-charge auditor with at least five to eight years of experience auditing critical access hospitals will be on-site throughout the audit.

An experienced cost report preparer will be directly involved in each engagement and will make a site visit. An experienced cost report preparer, typically an owner, will be on-site one to two days as part of the cost report preparation process. We believe a site visit is critical to optimizing reimbursement and understanding the critical access hospital's operations.

Capability of our Team (Continued)

Commitment to Client Service (continued)

DZA is a firm primarily focused on critical access hospitals and other healthcare and public sector organizations. As a result, DZA personnel are highly qualified to serve critical access hospitals. Our team are specialists, not generalists. Our staff has training and experience relevant to your needs.

DZA personnel receive training directly related to critical access hospitals, hospitals, and other healthcare and public sector organizations. Our staff attend various relevant healthcare association educational sessions and national healthcare educational programs. The staff assigned to your engagement will have received healthcare organization training and are directly supervised by owners with at least fifteen years of experience with critical access hospitals.

DZA is committed to quality. All work products prepared by our firm are carefully reviewed by personnel with over fifteen years of experience. Our Medicare cost reports are reviewed by both the owner responsible for the engagement and a second owner to provide an objective review for compliance and reimbursement strategies.

Two owners are assigned to each hospital. At DZA, we understand that continuity and client services are important to you. DZA's owners are a team and believe that utilizing each other's strengths makes for the best client service. Each hospital is assigned a primary and secondary owner contact. Hospitals are welcome to call either contact at any time. The primary owner is directly involved in each engagement. While each hospital is assigned two owners, hospitals commonly communicate with all four owners.

DZA recognizes that our people are our greatest resource. DZA is a professional service firm, and it is our people and their knowledge that is important to you. We hand-pick the best in-charge accountant to fit your needs based on their experience. An owner is involved at all stages of the engagement and ensures each engagement is timely, efficient, and accurate.

DZA is committed to being the best value for your organization. DZA provides your organization with professional and knowledgeable staff at an affordable price.

Open, Ongoing Communication

We want our relationship to be open and ongoing. We have many clients who are in contact with us nearly weekly to discuss issues large and small. We welcome emailed questions and clarification; we respond quickly to these important inquiries. We do not charge for this ongoing communication, unless a significant project or research is requested. We believe continuous communication throughout the year is necessary to provide high-quality audit and cost report preparation services.

We also add value to the relationship by passing relevant information on to our clients as we learn it via e-mails or telephone calls. When attending educational or other meetings, we continually think about how the topic being discussed applies to our clients.

Board Presentation

We will provide a financial indicators report to management and the Health Services Board with historical and benchmark comparisons. This report will be delivered, along with the financial statements and other reports, at the annual audit presentation to the Health Services Board. We have found the financial indicators are appreciated by Boards, as it allows them to see the hospital's financial condition in a more visual fashion.

Capability of our Team (Continued)

Audit Approach and Use of Technology

We use a risk-based audit approach. We start by scheduling our audit and cost report issuance dates with management. We then schedule our completion date to be two weeks before the actual issuance date. This allows management time to review the draft cost report and financial statements. Based on these agreed-upon dates, we then schedule interim and final fieldwork. Interim fieldwork is used to develop the audit plan; the in-charge auditor will directly contact one or two Board members during this time.

We will communicate required documents and schedules to the finance staff well in advance of year-end to allow them to incorporate the creation of these documents into their year-end closing procedures.

Audit procedures start in the office and final fieldwork will be used to finalize and test audit items. Since we view the audit and cost report as a complete project, all projects will be performed simultaneously.

DZA uses paperless software to facilitate use of client data and record retention. The implementation of paperless software allows us to be efficient and timely in our audits and cost reports.

We utilize a secure portal to exchange information with our clients to ensure that information can be easily and securely shared.

Improved Cost Report Reimbursement

DZA is unique among public accounting firms in having two experienced owners review each cost report. The second owner serves as a detached observer whom objectively identifies reimbursement opportunities on the cost report. This approach has lead to many improvements in reimbursement opportunities for all DZA clients.

DZA also provides a management letter with each Medicare cost report that provides the Center with additional proactive reimbursement recommendations to implement for future cost reports.

DZA Differentiates Itself from Others Through Our Processes

An owner is directly involved in all stages of the engagement — from pre-planning, to the presentation of the financial statement audit to the Health Services Board. Our best practices are continually monitored and updated. We find that spending time planning the project allows us to complete the project timely, efficiently, and accurately. Planning includes the owner, in-charge accountant, and staff accountant. An in-charge accountant is assigned to each hospital and is closely monitored by the primary owner. DZA believes that project management begins with our internal procedures and best practices. Our employees have a framework to follow which allows owners to better monitor and track the progress of each financial statement audit and Medicare cost report preparation.

DZA Staff Biographies

Tom Dingus, CPA, Owner
tdingus@dzacpa.com

Background
Tom established DZA and is a graduate of Central Washington University.

Healthcare Experience
Tom has worked directly with rural and critical access hospitals, other hospitals, nursing homes, rural health clinics, community health centers, hospices, assisted living facilities, home health agencies, foundations, and other public sector organizations for over 25 years. He has served the financial reporting, IRS Form 990, and Medicare/Medicaid reimbursement needs of these organizations.

Healthcare Industry Involvement
Tom is a former president of the Washington/Alaska Chapter of Healthcare Financial Management Association (HFMA). He served as an officer and board member for ten years. He received HFMA's Medal of Honor in 2003 and previously had been awarded HFMA's Muncie Gold Merit Award. He regularly presents at numerous HFMA and other healthcare association educational meetings on various healthcare, reimbursement, IRS Form 990, and accounting topics.

Luke Zarecor, CPA, FHFMA, Owner
lmzarecor@dzacpa.com

Background
Luke helped to establish DZA more than ten years ago. After receiving his bachelor's and master's degrees in accounting from Brigham Young University, Luke has worked exclusively with healthcare organizations.

Healthcare Industry Experience
Luke has worked exclusively with healthcare organizations during the past 17 years. Luke works directly with critical access hospitals, other hospitals, nursing homes, rural health clinics, federally qualified health centers, assisted living facilities, hospices, and home health agencies. Luke serves both the financial reporting and Medicare/Medicaid reimbursement needs of these organizations.

Luke is a former president of the Idaho Chapter of HFMA, has served as the regional executive of Region 10 for HFMA, and has regularly attended healthcare association conferences during the past twelve years. Luke has received the Muncie Gold Merit Award from HFMA, the HFMA Founders Medal of Honor Award, and is a Fellow of HFMA (FHFMA).

Shar Sheaffer, CPA, Owner
ssheaffer@dzacpa.com

Background
Shar is a graduate of Eastern Washington University and serves as DZA's Director of Reimbursement.

Healthcare Industry Experience
Working exclusively with healthcare organizations for over 15 years, Shar specializes in consulting with critical access hospitals and other hospitals about reimbursement issues. The reimbursement landscape is ever-changing, and Shar educates staff and clients about those modifications. She assists critical access hospitals, other hospitals, nursing homes, rural health clinics, community health centers, and home health agencies with reimbursement, financial reporting, and consulting needs.

Community & Professional Involvement
Shar is a former President of the Montana Chapter of HFMA, and she has received the Muncie Gold Merit Award from HFMA. Shar frequently speaks on reimbursement topics at numerous HFMA and other healthcare conferences.

DZA Staff Biographies (Continued)

Shaun Johnson, CPA, Owner
sjohnson@dzacpa.com

Background
Shaun is a graduate of Whitworth University.

Healthcare Industry Experience
For over 15 years, Shaun has worked directly with hospitals, nursing homes, rural health clinics, community health centers, hospices, assisted living facilities, home health agencies, foundations, and other public sector organizations. He has served the financial reporting, IRS Form 990, and Medicare/Medicaid reimbursement needs of these organizations. Shaun has also attended numerous healthcare and public sector training seminars.

Shaun is the past-President of the Wyoming Chapter of HFMA and in 2016 received the Follmer Bronze Merit Award from HFMA.

Community & Professional Involvement
Shaun is a former President of the Spokane Chapter of the Washington Society of Certified Public Accountants (WSCPA) Board of Directors and is a former chairperson of the Spokane Chapter of WSCPA Fall Series CPE Committee.

Alanna Lakey, Manager
alakey@dzacpa.com

Background
Alanna is a graduate of Whitworth University.

Experience
Alanna works with healthcare and other public sector organizations. She has served as the in-charge auditor on numerous engagements and specializes in single audits. In addition, Alanna is a member of Oregon Chapter of HFMA.

Abby Smith, CPA, Manager
asmith@dzacpa.com

Background
Abby is a graduate of Gonzaga University.

Healthcare Experience
Abby works exclusively with healthcare and other public sector organizations. She has over ten years of experience auditing and preparing cost reports for hospitals. She has served as the manager on numerous engagements. Abby has attended national cost report preparation seminars along with several other relevant continuing professional education courses. Abby is the Chair of the Spokane Chapter of the WSCPA, is a public hospital district commissioner, and serves as the treasurer on that board.

Jeannette Ring, CPA, Manager
jring@dzacpa.com

Background
Jeannette is a graduate of Central Washington University.

Healthcare Experience
Jeannette has over ten years of experience in reimbursement and consulting services and works exclusively with healthcare organizations, specializing in Medicare/Medicaid reimbursement. She has attended several hospital reimbursement seminars along with other relevant continuing professional education courses. Jeannette also trains DZA staff on Medicare cost report preparation and strategies.

DZA Staff Biographies (Continued)

Joe Lodge, CPA, Manager
jlodge@dzacpa.com

Background
Joe received both his bachelor's and master's degrees in Accounting from Brigham Young University.

Healthcare Experience
Joining the firm nine years ago, Joe works exclusively within the healthcare industry and has completed several related continuing professional education courses. Joe serves as the in-charge on numerous healthcare organization engagements, utilizing his experience auditing and preparing cost reports for critical access hospitals. In addition, Joe is a member of the Idaho Chapter of HFMA.

Kami Matzek, CPA, Manager
kmatzek@dzacpa.com

Background
Kami is a graduate of Eastern Washington University.

Healthcare Experience
With eight years of experience auditing and preparing cost reports for critical access hospitals, Kami works exclusively with healthcare and other public sector organizations and has served as the in-charge on numerous engagements. Kami is currently a board member of the Washington/Alaska of HFMA.

Rikki Patch, CPA, Manager
rpatch@dzacpa.com

Background
Rikki has a bachelor's degree from Montana Tech and a master's degree from the University of Montana.

Experience
Rikki works exclusively with healthcare and other public sector organizations and has attended several relevant continuing professional education courses. She has served as the manager on numerous healthcare organization engagements and is DZA's IRS Form 990 specialist.

Tristi Cohelan, Manager
tcohelan@dzacpa.com

Background
Tristi has bachelors' degrees in both Professional Accounting and Management Information Systems from Eastern Washington University.

Experience
For over ten years, Tristi has worked with exclusively with healthcare organizations and is an experienced Medicare/Medicaid cost report preparer. She assists critical access hospitals, hospitals, nursing homes, rural health clinics, and community health centers with reimbursement, financial reporting, and consulting needs. Tristi has attended national cost report preparation seminars along with several other relevant continuing professional education courses.

Proposed Price

Our proposed prices are as follows:

	2016	2017	2018
Financial statement audit	$ 20,000	$ 20,000	$ 21,000
Medicare cost report preparation	8,500	8,500	8,750
Total	28,500	28,500	29,750
Total if awarded both	$ 27,500	$ 27,500	$ 28,750

We typically do not increase our prices by more than three percent a year.

Our price quotes are based on the anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during performance of the requested services. If significant additional time is necessary, we will discuss it with you and arrive at a new fee estimate before we incur the additional costs.

Our out-of-pocket costs will be billed at actual. We do not charge for routine consultations or questions during the year, and we encourage and welcome ongoing communication. Projects or research is billed at our standard rates which vary based on the individual providing the services.

Contact Information

Dingus, Zarecor & Associates PLLC
12015 East Main
Spokane Valley, Washington 99206

Telephone: 509.321.9485
Fax: 509.242.0877
E-mail: ssheaffer@dzacpa.com

References

Steve Febus, CFO
Pullman Regional Hospital
Pullman, Washington
Telephone: 877.446.0473
E-mail: steve.febus@pullmanregional.org

Hilary Whittington, CFO
Jefferson Healthcare
Port Townsend, Washington
Telephone: 360.385.2200
E-mail: hwhitting@jgh.org

Leslie Crane, CFO
Bear Lake Memorial Hospital
Montpelier, Idaho
Telephone: 208.847.4406
E-mail: leslie.crane@blmhospital.com

Current Firm Client List

Critical Access Hospitals

- Bear Lake Memorial Hospital *(hospital, rural health clinics, home health agency, nursing home, and assisted living facility)*
- Bingham Memorial Hospital *(hospital, rural health clinics, nursing home, and graduate medical educational program)*
- Blue Mountain Hospital *(hospital, rural health clinic, and home health agency)*
- Boundary Community Hospital *(hospital, rural health clinic, and skilled nursing facility)*
- Cascade Medical Center *(hospital and rural health clinic)*
- Columbia Basin Hospital *(hospital, rural health clinic, nursing home, and assisted living facility)*
- Columbia County Health System *(hospital, rural health clinics, and nursing home)*
- Columbia Memorial Hospital *(hospital and rural health clinic)*
- Community Hospital of Anaconda *(hospital, home health agency, nursing home, and hospice)*
- Coulee Medical Center *(hospital and rural health clinics)*
- Curry Health District *(hospital and rural health clinic)*
- East Adams Rural Hospital *(hospital, rural health clinics, and nursing home)*
- Good Shepherd Medical System *(hospital, rural health clinics, home health agency, and hospice)*
- Grand River Hospital District *(hospital and rural health clinics)*
- Grande Ronde Hospital *(hospital, rural health clinics, and home health agency)*
- Jefferson Healthcare *(hospital, rural health clinics, home health agency, and hospice)*
- Kittitas Valley Healthcare *(hospital, rural health clinics, home health agency, and hospice)*
- Klickitat Valley Health *(hospital, rural health clinic, home health agency, and graduate medical education program)*
- Kremmling Memorial Hospital District *(hospital and rural health clinic)*
- Lost Rivers Medical Center *(hospital and rural health clinics)*
- Lower Umpqua Hospital *(hospital and rural health clinic)*
- Marias Medical Center *(hospital and nursing home)*
- Mendocino Coast Hospital District *(hospital, rural health clinic, and home health agency)*
- Mineral Community Hospital *(hospital and assisted living facility)*
- Minidoka Memorial Hospital *(hospital, rural health clinic, home health agency, nursing home, and hospice)*
- Moab Regional Hospital *(hospital and hospice)*
- Morton General Hospital *(hospital and rural health clinics)*
- Newport Community Hospital *(hospital, rural health clinic, nursing home, and assisted living facility)*
- Niobrara Health and Life Center *(hospital and rural health clinic)*
- Nor-Lea Hospital District *(hospital and rural health clinics)*
- North Canyon Medical Center *(hospital and rural health clinic)*

Current Firm Client List (Continued)

Critical Access Hospitals *(continued)*

- North Runnels Hospital *(hospital, rural health clinic, and home health agency)*
- North Valley Hospital – Washington (*hospital and nursing home)*
- Odessa Memorial Healthcare Center *(hospital, rural health clinic, and assisted living facility)*
- Oneida County Hospital *(hospital, rural health clinics, and nursing home)*
- Orchard Hospital *(hospital, rural health clinics, and nursing home)*
- Pioneers Medical Center *(hospital, rural health clinic, home health agency, and nursing home)*
- Plains Memorial Hospital *(hospital and rural health clinic)*
- PMH Medical Center *(hospital and rural health clinic)*
- Prowers Medical Center *(hospital and rural health clinic)*
- Pullman Regional Hospital *(hospital and rural health clinic)*
- Quincy Valley Medical Center (*hospital and rural health clinic)*
- Shoshone Medical Center *(hospital)*
- Sierra Vista Hospital *(hospital and rural health clinic)*
- Skyline Community Hospital *(hospital)*
- St. Vincent Hospital *(hospital)*
- Star Valley Medical Center *(hospital and nursing home)*
- Steele Memorial Hospital *(hospital and rural health clinic)*
- Summit Pacific *(hospital and rural health clinics)*
- Sunnyside Community Hospital *(hospital and rural health clinics)*
- Syringa General Hospital *(hospital, rural health clinic, home health agency, and hospice)*
- Teton Valley Hospital *(hospital and rural health clinics)*
- The Memorial Hospital *(hospital and rural health clinics)*
- Three Rivers Hospital *(hospital)*
- Wallowa Memorial Hospital *(hospital, rural health clinic, and home health agency)*
- Walter Knox Memorial Hospital *(hospital and rural health clinic)*
- Weiser Valley Hospital District *(hospital and rural health clinic)*
- Whitman Hospital and Medical Center *(hospital)*
- Willapa Harbor Hospital *(hospital and rural health clinic)*

Hospitals

- Gila Regional Medical Center *(hospital)*
- Guadalupe County Hospital *(hospital)*
- Idaho Doctors Hospital *(hospital)*
- Kootenai Health *(hospital and graduate medical educational program)*

Current Firm Client List (Continued)

Hospitals

- Lubbock Heart & Surgical Hospital *(hospital)*
- Madison Memorial Hospital *(hospital)*
- Mountain View Hospital *(hospital and rural health clinic)*
- Samaritan Healthcare *(hospital and rural health clinic)*
- Trios Health *(hospital, home health agency, and graduate medical educational program)*

Federally Qualified Health Centers

- Adams County Community Health Center *(federally qualified health center)*
- Clackamas County Public Health*(federally qualified health center)*
- Community Action Partnership of Western Nebraska *(federally qualified health center)*
- Council Community Health Center*(federally qualified health center)*
- Family Health Centers *(federally qualified health center)*
- Family Medicine Residency of Idaho, Inc. *(federally qualified health center and graduate medical education program)*
- HealthWorks*(federally qualified health center)*
- Hi-Desert Medical Center*(federally qualified health center)*
- Mattawa Community Medical Clinic *(federally qualified health center)*
- Northeast Washington Health Programs Association *(federally qualified health centers and assisted living facility)*
- Operation Samahan, Inc. *(federally qualified health center)*
- Shoalwater Bay Indian Tribe *(federally qualified health center)*
- The N.A.T.I.V.E. Project *(federally qualified health center)*

Other Healthcare Organizations

- Borger Medical Clinic *(rural health clinic)*
- Colville Tribal Convalescent Center *(nursing home)*
- Eunice Hospital District *(clinic)*
- Hands of Hope *(hospice)*
- Hospice of Spokane *(hospice)*
- Kittitas County Public Hospital District No. 2 *(ambulance)*
- Mary's Woods at Marylhurst *(retirement community and skilled nursing facility)*
- Rockwood Retirement Communities *(retirement communities, nursing home, and assisted living facility)*
- Salmon River Health Clinic *(rural health clinic)*

Appendix A – DZA Newsletter

Final MOON Released

CMS has released the final version of the Medicare Outpatient Observation Notice (M.O.O.N.). Hospitals and critical access hospitals are required to provide this form to all Medicare patients who have been in observation status for more than 24 hours starting March 8, 2017. Early implementation is allowed.

A copy of the final form can be found on www.cms.gov.

For more information on the rules surrounding this form visit www.conta.cc/2bcaxrq.

Change in the President of the United States of America

In January, Donald Trump will be sworn in as the President of the United States of America. As part of his platform, he (as well as the Republicans in Congress) has pledged to repeal the Affordable Care Act (ACA). The repeal of the ACA will significantly affect many hospitals.

The ACA began as a concept from the Heritage Foundation, a politically conservative think tank. It was thought by conservatives at the time to be a good alternative to a single payor system.

The Republican's issue with the law appears to be the individual mandate. The ACA is a robust law with many changes. Below are a few highlights from the ACA.

1. Expanded 340B covered facilities to include critical access hospitals. It also expanded 340B covered facilities to include rural referral centers and sole community hospitals as covered entities at a lower disproportionate share percentage.
2. Removed lifetime limits for insurance coverage. For those with chronic illnesses, the lifetime limit can come rather quickly.
3. Allows for parents to keep their children on health insurance up to the age of 26. This provision expanded the number of college age children who have insurance coverage.
4. It allows states to expand Medicaid.
5. Prohibits insurance plans from rescinding insurance due to a mistake on the application form (fraud is another story).
6. Added wellness visits as covered services for Medicare beneficiaries.
7. Established a PPS payment system for federally qualified health centers (FQHCs).
8. Added non-provider time to allowable resident time for graduate medical education (GME) and indirect medical education (IME). This increased the FTEs that a teaching hospital could report and as long as the FTEs were not greater than the FTE cap, payment is increased.

12015 East Main Avenue | Spokane Valley, WA 99206 | 509.242.0874 | www.dzacpa.com

9. Increased Medicaid prescription drug rebates from 15.1% to 23.1%.
10. Requires health insurance companies to report the percentage of total premium revenue spent on clinical services and the percent spent on administrative costs.
11. Requires health insurance companies to cover preventative health services without cost sharing (no copay).
12. It established the readmissions reduction, value-based purchasing, and hospital acquired conditions programs.
13. It changed how hospitals are paid for disproportionate share by Medicare (added the uncompensated care calculation).
14. It includes the mental health parity act which essentially requires insurers to cover mental health issues on the same level as other outpatient continuing services (like physical therapy).

Please consider writing your state's congressional leaders to help them understand the effect a full repeal of the ACA will have on your hospital. For critical access hospitals, emphasis should be placed on requesting that you remain a covered entity with regards to the 340B discount drug program.

21st Century Cures Act

President Obama signed into law the 21st Century Cures Act on December 13, 2016. Highlights from the law follow:

Outpatient Supervision in Small Rural Hospitals – Hospitals are required to have physician supervision for all outpatient therapeutic services except for services listed on CMS' website as exemptions.

Small rural hospitals and critical access hospital have been operating under an exception to the enforcement of this rule. The exception for these facilities has been extended through the end of 2016.

The exception to the enforcement rules has been on-going for several years. In this portion of the law, Congress requests that the Medicare Payment Advisory Commission (MedPAC) report on the effect the exception has on "access to health care by Medicare beneficiaries, on the economic impact and the impact upon hospital staffing needs, and on the quality of health care furnished to such beneficiaries."

Off-campus Provider-based Locations – The Bipartisan Budget Act of 2015 (the Budget Act) requires site-neutral payments for new off-campus provider-based locations. The reading of the Budget Act states only off-campus locations that were billing as provider-based before November 2, 2015, would be grandfathered and paid under the hospital level payment system. For a full summary of the rule including CMS' interpretation of the law, please see a previous DZA newsletter by visiting www.conta.cc/2ftvigd.

Section 16001 of the 21st Century Cures Act adds additional language to the existing law:

- Grandfathered off-campus sites now also include those sites that had submitted attestation to their Medicare Administrative Contractor for a location before December 2, 2015. These sites are "deemed" to have met the requirement to be billing as provider-based as of November 2, 2015.
- For services provided January 1, 2018, and thereafter, an off-campus provider-based location may be grandfathered in under the hospital level payment system if they comply with each of the following:

- The hospital sends CMS an attestation by February 11, 2017, (received by CMS date) that the department location met the provider-based requirements
- The department location is included as a location on the hospital's enrollment form (i.e. included as a location in PECOS).
- The hospital's CEO or COO certifies to CMS in writing that the hospital had a "binding written agreement with an outside unrelated party for the actual construction" of the off-campus department location. Please note that the certification must be **received** by CMS on or before February 11, 2017, and signed by either the **CEO or COO** of the hospital. The CFO or reimbursement manager cannot certify for this purpose.

Extension of the Rural Community Hospital Demonstration Program – The rural community hospital demonstration program allows for small rural hospitals that do not meet the requirements to be a critical access hospital an alternative payment methodology. Specifically, a potential hospital has fewer than 51 beds and is located in a rural area in one of the 20 states with low population density.

The extension of this program also expands the eligible hospitals to any state, but priority will be given to hospitals in one of the 20 low population density states.

The alternative payment is a cost per discharge for inpatient services based on the cost per discharge from the first cost report while under the program. Subsequent years are paid this cost-per-discharge inflated using the PPS market basket updates.

The program has been extended for five years. Applications for interested hospitals will be available on CMS' website shortly.

If you are a small rural hospital, we recommend contacting your DZA representative to talk about the feasibility of this program.

Telehealth Services – CMS and MedPAC have been charged with providing Congress with information on how telehealth services are utilized. Specifically, MedPAC is to report on the telehealth services that Medicare covers and the telehealth services that other insurers cover. Telehealth services allowed by other insurers but not Medicare will then be analyzed to see if they too should be part of Medicare-covered services.

Congress also indicated they believe the current telehealth originating sites (the location of the patient) should be expanded.

Additional movement on allowable telehealth services will be forthcoming based on these reports. However, the reports do not seem to address adding RHCs as a distant site (site of the physician) location.

Medicare Price Transparency – Starting in 2018, Congress has mandated that CMS provide beneficiaries with a website where they can look up services that will be provided in either a hospital outpatient setting or an ambulatory surgical center (ASC). For each service, based on the location, it should tell the patient the approximate Medicare payment and the approximate amount that will be the patient's responsibility.

While providing information to Medicare beneficiaries is certainly a good idea, there is concern about the effect this will have on critical access hospitals. Coinsurance at a critical access hospital is based on charge and not fee schedule. Therefore, patients looking up an area may have the wrong idea of what their cost-sharing will be. Additional review of this part of the law will be necessary.

If you have questions or require additional information, please call me at 509.321.9485.

Articles by:

Shar Sheaffer
CPA, Owner
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Appendix B – Peer Review Report

arnett foster toothman pllc
CPAs & Advisors

SYSTEM REVIEW REPORT

May 7, 2014

To the Owners of
Dingus, Zarecor & Associates PLLC
and the Peer Review Committee of the Washington Society of Certified Public Accountants

We have reviewed the system of quality control for the accounting and auditing practice of Dingus, Zarecor & Associates PLLC (the firm) in effect for the year ended November 30, 2013. Our peer review was conducted in accordance with the Standards for Performing and Reporting on Peer Reviews established by the Peer Review Board of the American Institute of Certified Public Accountants. As a part of our peer review, we considered reviews by regulatory entities, if applicable, in determining the nature and extent of our procedures. The firm is responsible for designing a system of quality control and complying with it to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Our responsibility is to express an opinion on the design of the system of quality control and the firm's compliance therewith based on our review. The nature, objectives, scope, limitations of, and the procedures performed in a System Review are described in the standards at www.aicpa.org/prsummary.

As required by the standards, engagements selected for review included engagements performed under *Government Auditing Standards*; and audits of employee benefit plans.

In our opinion, the system of quality control for the accounting and auditing practice of Dingus, Zarecor & Associates PLLC in effect for the year ended November 30, 2013, has been suitably designed and complied with to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Firms can receive a rating of *pass*, *pass with deficiency(ies)* or *fail*. Dingus, Zarecor & Associates PLLC has received a peer review rating of *pass*.

ARNETT FOSTER TOOTHMAN PLLC

Arnett Foster Toothman PLLC

101 Washington Street East | P.O. Box 2629
Charleston, WV 25329
304.346.0441 | 800.642.3601

Cordova Community
MEDICAL CENTER

Memorandum

To: Health Services Board
From: Scot Mitchell, FACHE, CCMC CEO
Subject: TranscendRx
Date: March 6, 2017

- **Suggested Motion:** "I move to authorize the CEO to enter into an Integrated Pharmacy Services Agreement with TranscendRx with an initial service fee of $25,000 and an additional monthly maintenance fee of $3,000 per month."

AGREEMENT FOR THE IMPLEMENTATION AND ONGOING CONSULTING OF INTEGRATED PHARMACY SERVICES

This Agreement for the Management of Pharmaceutical Services (**"Agreement"**) is between CORDOVA COMMUNITY MEDICAL CENTER and transcendRx, LLC, an Iowa limited liability company ("**TRX**"). Cordova Community Medical Center and TRX may each be referred to herein as a "**Party**" and collectively as the "**Parties**." The Effective Date of this Agreement is March 1, 2017.

RECITALS

A. The CORDOVA COMMUNITY MEDICAL CENTER has determined that it is in their best interest that Pharmaceutical Services (defined below) be implemented and managed by an outside third- party;

B. CORDOVA COMMUNITY MEDICAL CENTER desires to engage TRX to provide the Pharmaceutical Services for CORDOVA COMMUNITY MEDICAL CENTER in accordance with the terms of this Agreement;

C. TRX desires to provide the Pharmaceutical Services in accordance with the terms of this Agreement; and

D. The Parties have agreed that TRX shall assume the implementation, administration, and continued support of pharmaceutical services for CORDOVA COMMUNITY MEDICAL CENTER.

NOW, THEREFORE, in consideration of the foregoing, and the respective covenants and agreement of the Parties contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

1. Definitions. As used in this Agreement, the following terms shall have the following respective meanings:

"**Initial Term**" shall have the meaning given such term in Section 7.

"**Key Personnel**" shall mean those individuals identified in Section 2.3 and other such persons as are designated from time to time in a writing signed by TRX and CORDOVA COMMUNITY MEDICAL CENTER.

"**Pharmaceutical Services**" or "**Services**" means those services detailed in Schedule 1 to this Agreement.

2. Obligations of TRX.

2.1 Standards for Performance. TRX shall perform all of its Services in good faith in a manner believed by TRX to be in the best interests of CORDOVA COMMUNITY MEDICAL CENTER in accordance with (a) the terms of this Agreement and (b) the practices, methods, standards and procedures that are generally accepted and followed by providers of pharmaceutical services.

2.2 Duties of TRX. During the term of this Agreement, TRX shall provide the Services. TRX may from time to time employ third party(s) to fulfill its obligations as outlined in this Agreement.

2.3 Key Personnel of TRX. TRX shall provide the Services called for pursuant to this Agreement through the efforts of its Key Personnel. All employees of TRX providing services to CORDOVA COMMUNITY MEDICAL CENTER pursuant to this Agreement shall be and remain employees of TRX. CORDOVA COMMUNITY MEDICAL CENTER and TRX acknowledge and agree that for purposes of this Agreement, [_____] is designated as "**Key Personnel**."

2.4 Management Policy; Employees. Notwithstanding anything to the contrary in this Agreement, the property, funds, affairs, hiring of pharmacy employees and the management of the business and employees of CORDOVA COMMUNITY MEDICAL CENTER shall continue to be the responsibility of the Board of Directors and management of CORDOVA COMMUNITY MEDICAL CENTER. With respect to the on-going operations of CORDOVA COMMUNITY MEDICAL CENTER, TRX shall be guided by and adhere to any policies established by the Board of Directors of CORDOVA COMMUNITY MEDICAL CENTER in performing the Services.

2.5 Limitations. TRX shall have no authority to take any actions, or to perform any duties, except as expressly set forth in this Agreement or as otherwise expressly authorized in writing by CORDOVA COMMUNITY MEDICAL CENTER. Without limiting the generality of the foregoing, TRX shall not:

(a) enter into any contract or other commitment on behalf of CORDOVA COMMUNITY MEDICAL CENTER without the prior written approval of management of CORDOVA COMMUNITY MEDICAL CENTER;

(b) receive, disburse, transfer, deposit, withdraw or otherwise exercise authority over any of the cash, cash equivalents, cash accounts or similar financial assets of CORDOVA COMMUNITY MEDICAL CENTER;

(c) create or permit to exist any security interests, liens, encumbrances, charges, claims or demands against any of the assets of CORDOVA COMMUNITY MEDICAL CENTER, except those arising as a matter of law resulting from authorized actions of TRX; or

(d) take any action outside of the normal and ordinary course in the performance of the Pharmaceutical Services.

2.6 No Services Until Effective Date. Notwithstanding anything to the contrary in this Agreement, TRX shall not have any duty to, and shall not be required to, provide any Services until the Effective Date.

3. Obligations of CORDOVA COMMUNITY MEDICAL CENTER

CORDOVA COMMUNITY MEDICAL CENTER shall not knowingly violate, or knowingly direct TRX to violate, any federal, state or local law, ordinance, rule, regulation or permit applicable to pharmaceutical services. CORDOVA COMMUNITY MEDICAL CENTER shall reasonably assist TRX in the performance of its duties under this Agreement by providing, without limitation, the following:

(a) an accurate and complete copy of any and all contracts, permits and other obligatory instruments of CORDOVA COMMUNITY MEDICAL CENTER that are related to TRX's duties under this Agreement;

(b) a written review and evaluation of TRX's overall performance hereunder, in a form and content reasonably agreed upon by CORDOVA COMMUNITY MEDICAL CENTER and TRX, at such times as reasonably agreed upon by CORDOVA COMMUNITY MEDICAL CENTER and TRX, but no less than annually;

(c) inventory, multi-dose packaging equipment, infrastructure, office space and access to office equipment as set forth in Section 6 of this Agreement;

(d) the medications required by TRX to fill all prescriptions on a timely basis with the expectation that CORDOVA COMMUNITY MEDICAL CENTER will adjudicate all medications through the 340B drug pricing program;

(e) designate a primary contact to support the engagement in the following manner:

(i) Function as the liaison between our team and Cordova Community Medical Center staff;

(ii) Act as the official spokesperson for the effort;

(iii) Assist with removing potential barriers;

(iv) The liaison shall receive support from Executives, Directors and staff when assistance is needed in order to support the engagement; and

(f) employ and manage the employees necessary to operate its pharmacy business.

4. Non-Competition and Non-Solicitation.

(a) CORDOVA COMMUNITY MEDICAL CENTER and TRX agree not to recruit or retain for employment individuals solely employed by the other Party during and for a period of 12 months after the termination of this Agreement unless agreed to by both Parties.

(b) TRX agrees not to provide or manage pharmacy services within a 15 mile radius of now existing CORDOVA COMMUNITY MEDICAL CENTER hospital and clinic sites unless expressly agreed to by CORDOVA COMMUNITY MEDICAL CENTER.

(c) If, for any reason, the covenants provided for above shall be deemed too extensive and therefore unreasonable, such covenants shall be reinterpreted to requalify

the limitations provided therein so as to make said covenants enforceable, as long as the modifications to be made will not substantially defeat the original purposes of the parties hereto.

5. Right of First Refusal. CORDOVA COMMUNITY MEDICAL CENTER hereby grants to TRX a right of first refusal to provide pharmaceutical services to each of CORDOVA COMMUNITY MEDICAL CENTER's subsidiaries and affiliates at the same price and on the same terms and conditions as stated within this Agreement during the term of this Agreement.

6. Space, Equipment, Furniture, Inventory, Staffing, Etc. Unless otherwise provided for in a separate agreement, all inventory, multi-dose packaging equipment, hardware and software infrastructure, CORDOVA COMMUNITY MEDICAL CENTER employees, office space, and office equipment necessary to support TRX's performance of Services for CORDOVA COMMUNITY MEDICAL CENTER hereunder shall be provided and paid for by CORDOVA COMMUNITY MEDICAL CENTER.

7. Term. The term of this Agreement shall commence on the Effective Date and term five years after the first integrated pharmacy prescription is dispensed. This Agreement will be reviewed and revised as necessary no less than 180 days prior to the termination date for renewal. Either Party may terminate this Agreement for a material breach by the other Party which is not cured within the shorter of thirty (30) days after the receipt by the breaching Party of written notice and reasonable description of the breach or when it becomes evident that cure within the thirty (30) day period is impossible. Furthermore, either Party may terminate this Agreement if the other party (i) terminates or suspends its business, (ii) becomes subject to any bankruptcy or insolvency proceeding, or (iii) is wound up or liquidated, voluntarily or otherwise.

8. Compensation

8.1 Initial Service Fee. CORDOVA COMMUNITY MEDICAL CENTER acknowledges the significant time and cost that TRX will incur in order to commence implementation as well as performing Services under this Agreement and hereby agrees to pay a Service Fee of $25,000.00 to TRX upon execution of this Agreement.

8.2 Monthly Maintenance Service Fee. For each year during the term of this Agreement, CORDOVA COMMUNITY MEDICAL CENTER shall pay TRX a fixed Service Fee of $3,000.00 per month. TRX will provide CORDOVA COMMUNITY MEDICAL CENTER ongoing support outlined in Schedule 1. CORDOVA COMMUNITY MEDICAL CENTER agrees to pay each invoice within 30 days of receipt.

8.3 Payment Terms. CORDOVA COMMUNITY MEDICAL CENTER agrees to pay each invoice within 30 days of receipt and will reimburse transcendRx for any travel, lodging, and meal expenses for on-site support..

9. Documents and Data. All documents, intellectual property and materials prepared or developed by TRX in connection with the Services shall remain the property of TRX. To the extent that exclusive title and/or ownership rights in any intellectual property may not originally vest in TRX as contemplated hereunder, CORDOVA COMMUNITY MEDICAL CENTER hereby irrevocably assigns, transfers and conveys to TRX all right, title and interest therein. CORDOVA COMMUNITY MEDICAL CENTER shall provide to TRX and/or any TRX designee, all reasonable assistance and execute all documents necessary to assist and/or enable TRX to perfect, preserve, register and/or record its rights in any such intellectual property. The Parties expressly understand and agree that title to any

intellectual property resulting from the performance of Services under this Agreement shall automatically vest in TRX.

10. Standard of Care; Indemnification.

10.1 TRX to Act in Cordova Community Medical Center's Best Interest. In performing the Services hereunder, TRX and its employees and agents shall perform their duties in a manner reasonably believed by them to be in the best interest of CORDOVA COMMUNITY MEDICAL CENTER and with such care as an ordinarily prudent person in a like position would use under similar circumstances. Neither TRX nor its officers, directors, employees or agents shall be liable to CORDOVA COMMUNITY MEDICAL CENTER HEALTH CENTER for any liability or loss suffered by CORDOVA COMMUNITY MEDICAL CENTER as a result of any action or omission by TRX or its officers, directors, or employees in performing the services or providing products hereunder, except that TRX shall be liable to CORDOVA COMMUNITY MEDICAL CENTER to the extent, but only to the extent, of any direct, as opposed to consequential, special or punitive damages suffered by CORDOVA COMMUNITY MEDICAL CENTER which are caused by the willful misconduct of TRX or its officers, directors, employees, or agents, or by a material and continuing default by TRX of its obligations hereunder after written notice of such material and continuing default provided by CORDOVA COMMUNITY MEDICAL CENTER to TRX. TRX and Cordova Community Medical Center agree to abide by the HIPPA compliant rules outlined in Section III of the executed Business Associate Agreement.

10.2 CORDOVA COMMUNITY MEDICAL CENTER to Indemnify TRX. CORDOVA COMMUNITY MEDICAL CENTER agrees to indemnify and hold TRX, and its officers, directors, employees and agents, harmless from all liabilities, loss, costs and damages, including reasonable legal fees, arising directly or indirectly from or in connection with TRX's performance of Services under this Agreement, provided, that TRX has satisfied its standard of care as set forth in Section 10.1. The indemnities and obligations set forth in this Agreement will continue in full force and effect after the expiration or termination of this Agreement.

11. Independent Contractor Status. TRX and its employees and agents shall be deemed independent contractors with full control over the manner and method of performance hereunder, except as otherwise provided in Section 2 hereof. During the term of this Agreement, any of the employees or agents of TRX who are rendering services to CORDOVA COMMUNITY MEDICAL CENTER in performance of TRX's obligations hereunder, shall remain employees or agents, as the case may be, of TRX, and shall continue to be paid by TRX and enjoy the benefits to which they are entitled as employees or agents of TRX, unless otherwise provided in any separate agreement covering the services of such employee.

12. Separate Entities. TRX and CORDOVA COMMUNITY MEDICAL CENTER are separate entities and nothing in this Agreement or otherwise shall be construed to create any rights of liabilities of any party hereto for any rights, privileges, duties or liabilities of any other party hereto, except to the extent otherwise provided in this Agreement or in any other agreement among the parties hereto, and shall create no partnership or joint-venture between the parties.

13. Additional Agreement of the Parties. TRX acknowledges and agrees that TRX may enter into contracts for the management of other pharmaceutical services in addition to those owned, leased or operated by CORDOVA COMMUNITY MEDICAL CENTER abiding by the agreed non-compete distance of 15 miles.

14. [Reserved].

15. Dispute Resolution. Any dispute between the Parties to this Agreement arising out of the breach of this Agreement by either Party, or any aspect of the relationship created by this Agreement, shall be resolved first by non-binding mediation, and if not resolved by non-binding mediation, then by binding arbitration under the Commercial Arbitration Rules of the American Arbitration Association. The arbitration hearing shall take place in Iowa City, Iowa.

Notification

transcendRx: To the extent notice is required to be provided by Cordova Community Medical Center to transcendRx under any provision in this Agreement, notice shall be provided to:

Aaron Lott
Executive Director
5825 Dry Creek Ln NE
Cedar Rapids, IA 52402

Cordova Community Medical Center. To the extent notice is required to be provided by transcendRx to Cordova Community Medical Center under any provision in this Agreement, notice shall be provided to:

_____
_____
_____
_____

16. Confidentiality. The Parties agree to each hold confidential and proprietary, for a period of five years (5) from the date of disclosure, but in any event for the duration of this Agreement, except as may be reasonably necessary from time to time to perform the Services hereunder, any proprietary or trade secret information supplied to the other, or designated as confidential. The provisions of this Section 16 shall not apply to information within any one of the following categories or any combination thereof: (a) information which was in the public domain prior to the receipt thereof or which subsequently becomes part of the public domain by publication or otherwise except by the recipient's wrongful act; (b) information which the recipient demonstrates was lawfully in his possession prior to receipt thereof through no breach of any confidentiality obligation; (c) information received from a third party having no obligation of confidentiality with respect thereto; or (d) information required to be divulged pursuant to law or court order. The Parties further agree to require its contractors, subcontractors, employees, agents to enter into such appropriate nondisclosure agreements relative to such confidential information, prior to their receipt thereof.

17. Miscellaneous.

17.1 Entire Agreement and Modification. All previous communications between the Parties hereto, either verbal or written, with reference to the subject matter of this Agreement are hereby abrogated. No amendment, modification or waiver of, or consent with respect to any

provision of this Agreement shall be effective unless the same shall be in writing and signed by both Parties and then any such amendment, modification, waiver or consent shall be effective only in the specific instance and for the specific purpose for which given.

17.2 Severability Clause. If any provision of this Agreement shall be found invalid or unenforceable, in whole or in part, by a court of competent jurisdiction, then such provision shall be deemed to be modified or restricted to the extent and in a manner necessary to render the same valid and enforceable, or if that is not possible, such provision shall be stricken and deleted from this Agreement, as the case may require, and this Agreement shall then be construed and enforced to the maximum extent permitted by law and with the purpose to achieve the fundamental intent of the parties.

17.3 Waiver. Any waiver at any time by either Party of its rights with respect to a default under this Agreement, or with respect to any other matters arising in connection with this Agreement, shall be in writing and shall not be deemed a waiver with respect to any subsequent default or other matter.

17.4 Binding Effect. This Agreement is binding upon the Parties hereto and their respective executors, administrators, heirs, assigns and successors in interest.

17.5 Choice of Law. This Agreement shall be construed and interpreted in accordance with the laws of the State of Iowa and excluding any choice of law rules, which may direct the application of laws of another jurisdiction.

17.6 Captions and Headings. The captions and headings appearing in this Agreement are inserted merely to facilitate reference and shall have no bearing upon the interpretation of the provisions contained in this Agreement.

17.7 **Agreement Drafted Jointly**. The Parties agree that neither Party shall be deemed solely responsible for drafting all or any portion of this Agreement, and in the event of a dispute, responsibilities for any ambiguities arising from any provision of the Agreement shall be shared equally between both Parties.

17.8 Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the Parties and their successors and permitted assigns. Neither CORDOVA COMMUNITY MEDICAL CENTER nor TRX may assign this Agreement or any rights or obligations hereunder without the prior written consent of the other.

[***Signature Page Follows]***

IN WITNESS WHEREOF, this Agreement has been executed and delivered by the duly authorized officers or representatives of each of the parties hereto, as of the date set forth above.

CORDOVA COMMUNITY MEDICAL CENTER

By:_____
Its: _____

TRX, LLC

By:_____
Aaron K. Lott, Executive Director of Pharmacy Services

Schedule 1

Pharmaceutical Services

During the term of this Agreement, TRX shall provide to CORDOVA COMMUNITY MEDICAL CENTER the following services:

1-1 Independent pharmacy buyout negotiation if applicable

1-2 Coordination and filling of all outpatient, discharged patient, and inpatient prescriptions at the retail location;

1-3 Coordination, implementation, and ongoing provision of pharmacy application interfacing with Cordova Community Medical Center's equipment;

1-4 Coordinate and report on measurement indicators as agreed to between the Parties, including readmissions, discharge satisfaction ratings, star ratings, and increase in 340B outpatient prescriptions; and

1-5 Obtaining all appropriate licenses (pharmacy license, CSA, DEA, etc)

1-6 Determining feasibility with current conditions – contract pharmacy status

1-7 Reviewing patient, clinic and physician eligibility determinations made by the client hospital.

1-8 Reviewing policies and procedures in place at the client hospital, and suggesting changes or additions.

1-9 Identifying areas for formulary optimization within the program

1-10 Identifying and assist in obtaining appropriate state/federal licenses needed to commence operations

1-11 Negotiating 3rd party contracts and PSAO to include negotiation of aggressive Cost of Goods (COGs) with wholesaler for retail pharmacy

1-12 Assist in establishing a retail pharmacy to include selection and training of software, POS, and SIGIS

1-13 Utilizing hospital information system to facilitate communication

1-14 Transitional care programming to include LTC / Hospital and Clinic Quality Measures

1-15 Hospital Integration w/outpatient departments; Disease management clinics

1-16 Submit report each month detailing the prescriptions filled by Cordova Community Medical Center Health Center during the preceding month

1-17 Provide input to design pharmacy build-out in hospital to maximize efficiency

1-18 Assist in recruitment of pharmacist in charge

Memorandum

To: Health Services Board
From: Scot Mitchell, FACHE, CCMC CEO
Subject: Resolution to update CCMC Authorized Check Signers
Date: March 1, 2017

In light of recent staffing changes at CCMC it is necessary to update the Resolution Authorizing CCMC Check Signers to reflect those changes:

To remove the following individuals as authorized check signers:

SA Director	Stephen Sundby
Dir. Of Rehab Svcs.	Randy Apodaca

To add the following CCMC Employees as authorized check signers:

CNO	Lisa Cuff

The updated list of CCMC authorized check signers will be as follows:

CEO	Scot Mitchell
CNO	Lisa Cuff
HSB President	Tim Joyce
HSB Vice-President	Josh Hallquist
HSB Secretary	James Wiese

Suggested Motion: "I move to approve the Resolution of the Cordova Health Services Board designating the representatives authorized for signing checks, non-check payroll tax payment, and cash transfers for Cordova Community Medical Center."

Community Health Services Board
Resolution

A RESOLUTION OF THE CORDOVA COMMUNITY HEALTH SERVICES BOARD OF THE CORDOVA COMMUNITY MEDICAL CENTER DESIGNATING THE RESPRESENTATIVES AUTHORIZED FOR SIGNING CHECKS, NON-CHECK PAYROLL TAX PAYMENT, AND CASH TRANSFERS FOR CORDOVA COMMUNITY MEDICAL CENTER.

WHEREAS, the Cordova Community Medical Center checking accounts for the general fund, payroll fund, grant fund and nursing home patient trust accounts, require two (2) signatures; and

WHEREAS, CCMC investment accounts, funded depreciation accounts, and malpractice trust accounts require the Administrator and one (1) Board Officer's original signatures, and

THERFORE, BE IT RESOLVED THAT,

1. All checks issued require two signatures; at least one (1) Health Service Board Officer's signature, and that non-check electronic payments and cash transfers from the general checking account to the payroll checking account should be signed off by at least one HSB officer and another authorized signer;

2. The Health Services Board authorizes the following individuals only to act as check signers on the above-mentioned accounts:

CEO	Scot Mitchell
CNO	Lisa Cuff
HSB President	Tim Joyce
HSB Vice-President	Josh Hallquist
HSB Secretary	James Wiese

PASSED and approved this 9th day of March 2017.

Board Signature: _____ Date: _____

Memorandum

To: Health Services Board
From: Scot Mitchell, FACHE, CCMC CEO
Subject: 4th Quarter 2016 Quality Improvement Report
Date: March 6, 2017

- **Suggested Motion:** "I move to accept the 4th Quarter 2016 Quality Improvement Report."

Cordova Community
MEDICAL CENTER
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Q4 2016 Quality Improvement Report
March 2, 2017

Q3 and Q4 2016 was a busy time for the CCMC Quality Committee and Staff as we worked to revitalize our Quality Improvement (QI) program. As part of that revitalization process we continued holding monthly QI committee meetings, even though the requirement is only quarterly, in order to bolster program development. In Q4 we finalized our 2017 Quality Plan, which was approved by the board at the December 2016 HSB meeting. You will see our progress on the 2017 Quality Plan in future quarterly reports.

Also during this timeframe, each hospital department initiated one or more Quality Improvement projects. Below is a summary of these ongoing projects:

- **Medical Staff:**
  Objective: The medical staff set out to monitor and improve care for inpatients in 4 key areas of patient care: smoking, substance abuse, DVT prevention and congestive heart failure.

  Process: We searched through CMS requirement for monitoring and reporting their patient care goals. We tried to identify 4 areas that applied to CCMC's patient population. We identified smoking, substance abuse, DVT prevention and congestive heart failure as metrics that would apply to us. We then had an independent person pull data from all admission records. Her default was to list any possible item that was not done as missed. All items that were missed were than reviewed by Dr. Blackadar to ensure they were applicable. For example not using DVT prophylaxis on an infant would not be listed as an error. The data was logged and tracked for 3 months.

  Outcomes: Of the 4 categories the CHF requirements had been deleted by CMS as they change reporting systems so this method was not tracked. There were 41 admissions with a 9% error rate for all 3 measures combined in the patients.

  Future efforts: The results and charts will be discussed at the next medical staff meeting and strategies for improvement decided upon. We will continue to track these measures.

- **Radiology:** Average time to complete X-ray and CT exams was determined. As a result of this study, radiology will change patient scheduling from every 60 minutes to every 30 minutes. Efficiency of new schedule will be monitored ongoing.
- **Maintenance:** Conducted improvement study regarding work order completion turnaround times. Study found that major lags in turnaround times were caused when no written work order was provided or there was no indication of urgency on the work order. Changes to the work order process are being made and effectiveness will be monitored.
- **Environmental Services:** The efficiency and effectiveness of cleaning process in various hospital areas was study. The study examined elements such as time it takes to clean an area, time required to respond to non-scheduled cleaning requests, the level of cleaning required for infection prevention, and many more elements. Staff are considering changes to the cleaning schedule that could speed up the time required to clean an area and decrease the number of times the area needs to be cleaned in a day. Study is ongoing.
- **Laboratory:** Turnaround times for STAT send-out labs were studied and a new process was implemented to decrease shipping and processing times for lab specimens. Results of the new process are currently being studied and preliminary indications are that turnaround times will be shortened by better than 50%.
- **Rehabilitation Services:** PT and OT documentation was studied to ensure that patient notes contained all elements required by CMS. The combined PT/OT error rate was less than 1%.
- **Materials Management:**
    - STAT orders – Studies monitoring the frequency and costs associated with STAT orders for materials and pharmaceuticals are ongoing. It was determined that staff education was needed for understanding ASAP orders versus STAT orders. Monitoring is ongoing.
    - Unsecured sharps and pharmaceuticals – A 3 month study determined that there was significant room for improvement in this area. Multiple steps were taken to better secure these items. A re-study will be conducted now that all improvements have been implemented.
- **Dietary:**
    - The Food Services revised five cycles of weekly meal plans to better reflect Resident/Patient preferences and nutritional requirements. Improvements will be monitored ongoing.
    - Patient food temperatures – Meal temperature were found to be less than optimal in many instances. Multiple improvement strategies were implemented. This study is ongoing, but early indications are that temperatures are being maintained in the optimal range.
- **Sound Alternatives:** Sound Alternatives is measuring the time between services provided and the documentation for those services. It is generally considered, the shorter the time of this occurrence the more accurate the documentation of the services provided. In addition, it improves the billing process by reducing the time between service provision and client billing. The desired outcome is for the documentation to be completed within 2 days (48 hours.) The data collected through January 2017 are reflected in the attached graph. As more data is collected it will be presented as monthly data to increase the N for each data point. The mean through January 2017 is 89% compliance. Our current goal is 90% compliance and will be adjusted up as the goals are met.

- **Human Resources:**
    - Employee Turnover – Employee turnover and associated costs continue to be tracked.
- **Administration:**
    - Housing – monitoring usage and costs of employee housing.
    - Policies and procedures – monitoring completion of P&P review and revision per regulatory requirements.
- **Social Services:** Studying Resident satisfaction/comfort with their personal rooms. Based on satisfaction survey results, improvements were made to the room. Following improvements, satisfaction increased by as much as 100% in many areas.
- **Medical Records:** Chart completion and accuracy was studied. It was found that in Q4 2016, 275 record corrections were needed. This was an increase of 102 errors over the previous quarter. This study is ongoing.

At our September QI meeting we required that each department identify and begin work on at least one QI project through the end of this year. Each department will be required to add one additional project each of the first two quarters in 2017 with a goal of each department maintaining three projects, ongoing. The nature and length of each of these projects will vary, but they will all be driven by some combination of the following core elements of healthcare Quality from the Institute of Medicine:

- **Care should be safe:** Patients should not be harmed by the care that is intended to help them.
- **Care should be effective:** Services should be provided based on scientific knowledge to those who could benefit and we should refrain from providing services to those not likely to benefit.
- **Care should be patient-centered:** Care should be respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Care should be timely:** Reducing waits and sometimes harmful delays for both those who receive care and those who give care.
- **Care should be efficient:** Care should avoid waste, including waste of equipment, supplies, ideas and energy.
- **Care should be equitable:** Care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

In addition to the department-specific projects, we have initiated efforts to meet other facility-wide quality reporting requirements. For example, we are now reporting on 11 measures in a quality collaborative between the Alaska State Hospital and Nursing Home Association (ASHNHA) and the Washing State Hospital Association (WSHA). This collaborative is called Partnership for Patients and is aimed at improving patient and staff safety and care. The data sharing through Partnership for Patients will also allow us to benchmark our performance amongst our peers in the two participating states.

In the coming weeks we will be partnering with the QI program at Sitka Community Hospital to receive training on how to program custom data reports in Centriq, our EMR. These reports will allow us to abstract larger amounts of Quality-related data at a faster rate. This will improve the accuracy and ease the time demands of the Quality reporting process. Further, the programming skills could be applied to building custom reports in other departments (e.g., Finance, Medical Records, Infection Control, Employee Health, etc…).