AGENDA
CCMC AUTHORITY BOARD OF DIRECTORS
CCMC CONFERENCE ROOM
November 2, 2017 at 6:00PM
REGULAR MEETING

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

Board of Directors

Kristin Carpenter	exp. 3/20
April Horton	exp. 3/19
Sally Bennett	exp. 3/19
VACANT	exp. 3/18
Dorne Hawxhurst	exp. 3/18

CCMC CEO
Scot Mitchell

OPENING:

A. Call to Order
Roll Call – April Horton, Dorne Hawxhurst, Kristin Carpenter, and Sally Bennett
Establishment of a Quorum

B. APPROVAL OF AGENDA

C. CONFLICT OF INTEREST

D. COMMUNICATIONS BY AND PETITIONS FROM VISITORS (Speaker must give name and agenda item to which they are addressing.)
1. Audience Comments (limited to 3 minutes per speaker).
2. Guest Speaker

E. BOARD DEVELOPMENT
1. Funding Authorization Levels

F. APPROVAL OF CONSENT CALENDAR

G. APPROVAL OF MINUTES
1. 9-28-2017 Regular Meeting Minutes — Pages 1-3

H. REPORTS OF OFFICER and ADVISORS
1. Board Chair Report – Kristin Carpenter
2. CEO Report – Scot Mitchell, CEO — Pages 4-5
3. Finance Report – Lee Holter, CFO — Pages 6-18
4. Nursing Report – Tammy Pokorney, CNO — Pages 19-43
5. 2016 Audit Report – Shar Sheaffer, DZA — Pages 44-97

I. CORRESPONDENCE

J. ACTION ITEMS
1. Appointment of Board Member to fill vacant position

K. DISCUSSION ITEMS
1. Cordova Drug Acquisition Status
2. Upcoming Board Meeting Dates
3. CEO Evaluation Preparation — Pages 98-102

L. 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.

M. BOARD MEMBERS COMMENTS

N. EXECUTIVE SESSION

O. ADJOURNMENT

For a full packet, go to www.cityofcordova.net/government/boards-commissions/health-services-board

*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
CCMC Authority – Board of Directors
CCMC Admin Conference Room
September 28, 2017 at 6:00pm
Regular Meeting

CALL TO ORDER AND ROLL CALL –

Kristin Carpenter called the Board Meeting to order at 6:00pm.
Board members present: **April Horton, Dorne Hawxhurst, Kristin Carpenter,** and **Sally Bennett**
A quorum was established. 4 members present.
CCMC staff present: Scot Mitchell, CEO; Lee Holter, CFO; Tammy Pokorney, CNO, Dr. Blackadar, Medical Director; and Faith Wheeler-Jeppson, Executive Admin Assistant.
There were 2 community members in the audience.

A. APPROVAL OF AGENDA
Carpenter "move to approve the agenda as amended."
4 yeas, 0 nay
Motion passed.

B. CONFLICT OF INTEREST ~ None

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

D. BOARD DEVELOPMENT
1. **Organizational Scorecard**

Lee Holter provided a breakdown of the Organizational Scorecard handout that was provided at the meeting. The indicators are, Acute Patient Days, LTC Days, Adjusted Patient Days, FTE's, Labor $/Manhour, Paid Manhours/Adjusted Patient Days, Overtime, Days Cash on Hand, Days in AR, Average Payment Period, Operating Margin and Average Age of Plant.

E. APPROVAL OF CONSENT CALENDAR ~ None

F. APPROVAL OF MINUTES
M/Bennett S/Horton "move to approve the July 27, 2017 Regular Meeting Minutes".
4 yeas, 0 nay
Motion passed.

G. REPORT OF OFFICERS AND ADVISORS
1. **CEO's Report** ~ Scot Mitchell, CEO stated that his written report was in the packet. A few additional items that have happened since then, last week we had a couple of representatives from the State of Alaska Behavioral Health to do some training for Sound Alternatives staff. We've hired the new Executive Director for Sound

Alternatives and she will be starting on the 16th of October. He met with the CEO's of the small hospitals in Alaska at the ASHNHA Conference and we are going to look at how we can work together to improve on productivity, benchmarking, staffing, another area is utilization of swing beds. CCMC LTC received the Excellence in Quality Award from Mountain Pacific Quality Health at the ASHNHA Conference

2. **Finance Report** ~ Lee Holter, CFO review the financial information provided in the packet, a few highlights were that our PERS debt went up, in Other Revenue we are ahead of budget, Wages are below budget, Taxes and Benefits are below budget, Professional Salaries continues to be below budget, Supplies is above budget, so right now we have a positive bottom line.
3. **Nursing Report** ~ Tammy Pokorney, CNO reviewed her written report in the packet to the board. In addition to her report, Tammy reported that according to her report there were 3 travelers, but there will be a total of 5. Right after the first of the year there will be two more permanent staff in nursing, bringing the number of travelers down. LTC census is still at 10. Our priorities right now are staff development, because there is not a competency based program here right now we are creating one.

H. CORRESPONDENCE

1. A letter from Mrs. Diana Rubio.

I. ACTION ITEMS

1. **2016 CAH Periodic Evaluation – Annual Report**

M/Bennett S/Horton "I move that the CCMC Authority Board of Directors approves the 2016 CAH Periodic Evaluation – Annual Review."

4 yeas, 0 nays

Motion passed.

J. DISCUSSION ITEMS

1. Board Vacancy Process

Board candidate Amanda Wiese introduced herself to the board members and staff present at the meeting.

Board member election to fill the vacant seat will be on the November 2nd 2017 meeting.

K. AUDIENCE PARTICIPATION

David O'Brien read a letter presenting three possible scenarios to the board regarding the acquisition of some of the assets from Cordova Drug.

L. BOARD MEMBERS COMMENTS

Carpenter ~ Thank you Tammy and Amanda. And I would like to thank Scot for the hard work that he's doing.

Hawxhurst ~ None

Bennett ~ None

Horton ~ Have a good night

M. EXECUTIVE SESSION

M/Horton S/Hawxhurst "I move to go into Executive Session for matters which by law, municipal charter, or ordinance are required to be confidential."

Went into Executive Session at 7:59pm
Came out of Executive Session at 8:52pm

N. ADJOURNMENT

M/Hawxhurst S/Horton "I move to adjourn the meeting."
Carpenter declared the meeting adjourned at 8:53pm.

Prepared by: Faith Wheeler-Jeppson

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CEO Report to the CCMC Authority Board of Directors
November 2, 2017 Meeting
Scot Mitchell, CEO

The Big Picture

As mentioned last month, Congress revived its attempt to repeal and replace the Affordable Care Act (ACA) after they failed to come up with enough votes to pass the Better Care Reconciliation Act (BCRA), which would have allowed for a partial repeal of the Affordable Care Act (ACA), earlier this summer. The attempt last month was through the Graham-Cassidy-Heller-Johnson bill that was also pulled from consideration due to a lack of votes. Since the Republican controlled Senate does not have a filibuster-proof majority, they do not appear to be able to come up with enough votes to repeal the ACA as they have wanted. This means they will have to work with the Democrats to pass any healthcare legislation.

President Trump recently issued an Executive Order eliminating the cost-sharing reduction program component of the ACA. Several years ago the courts ruled that these payments to insurance companies were illegal because Congress never authorized them. These payments were to help low income people pay for their co-pays and deductibles. There now appears to be a bicameral agreement in Congress to make a few changes to the ACA that would address the following issues:

- Provide funding for the cost-sharing reduction payments through 2019.
- Relieve the individual mandate in ACA from 2017 – 2021.
- Exempt employers from penalties if they do not provide healthcare coverage to their employees based on the employer mandate in ACA.
- Increase the maximum contribution limit for Health Savings Accounts.

This agreement is very new and has not yet been submitted to either house of Congress. I will provide more updates on healthcare reform efforts as they become available.

Status Updates

- Dingus, Zarecor and Associates will be at the CCMC Authority Board meeting on November 2, 2017 to present the 2016 audit report to the Board. This is the first year that DZA has performed the audit of our financial statements, so it took a longer time than expected. There were several issues that caused the delay, which will be discussed in detail during their report.
- The Joint Commission was onsite October 10th and 11th for a recertification survey of Sound Alternatives. The survey went well, with only three areas of improvement cited. Two of the areas were on improving the documentation of the services provided, while the final suggestion was to use a different model for assessing the risk of suicide for clients. We have 60 days to submit a plan of

correction to The Joint Commission. Once that is approved, Sound Alternatives will have its accreditation for another three years.

- Lykia Lorenz recently started her role as the new Executive Director of Sound Alternatives. Lykia hit the ground running and has already started working on several key areas. She has made numerous contacts with State and association staff to help her with her new responsibilities. Lykia has a lot of energy and great ideas on how to expand the services offered by Sound Alternatives.
- Recently, Tammy Pokorney, CNO and I met with a representative from Alaska Regional Hospital to discuss areas of potential collaboration. We talked about bringing specialty physicians to CCMC for clinics, in several areas as identified by our Medical Staff and the community during our Community Health Needs Assessment last year. We also talked about utilizing Alaska Regional Hospital staff to help with education and training for nursing and other staff. We also talked about making sure that we receive appropriate swing bed patients back at CCMC after we refer patients to them. This is an exciting opportunity for us to expand the services we offer here in Cordova. We have scheduled a conference call with our Medical Staff and Alaska Regional Hospital staff to go into more detail about how this collaboration might be implemented.
- As we are looking for more ways to increase the financial sustainability of CCMC, one area commonly used in CAH facilities is swing beds. We've seen a significant bump in the utilization of intermediate swing beds this year. One way to further improve this program is using swing beds more for Medicare skilled patients. With this in mind, we are currently researching the potential to have a consultant help us refine our swing bed program so we can focus our energy on ways to improve that program.
- I have been working with Lee Holter, CFO and Tammy Pokorney, CNO to start the initial discussions for an organization-wide improvement plan. We had originally started working on this about a year ago, but had to postpone it until Tammy came on board as the Chief Nursing Officer. The main goal of this improvement plan is to come up with an obtainable strategic course to help CCMC get back into a financially sustainable situation, while continuing to improve the quality of care we provide to the citizens of Cordova. We are putting our thoughts to paper and will work with the Leadership Team and Medical Staff to prioritize a set of action items to meet the objective. This will be a multi-year project and involve every area of the facility. Once we have this plan in motion, I will take ideas from the plan and will work with the Board on developing an updated Strategic Plan for CCMC.
- Our retail pharmacy is moving closer to becoming a reality. While we had hoped to open by the end of October, we have now had to push that back to mid-November. The main reason for the delay is due to waiting on payor contracts to be returned to us so we can bill insurances for prescriptions. We still have a couple renovation projects to complete, which should be done shortly. We've had ongoing discussions with David O'Brien on possibly purchasing some of the assets of Cordova Drug, but we have not yet been able to reach a mutually agreeable arrangement.
- We've been having conversations with the City of Cordova on ways we can reduce the costs of health insurance coverage for both organizations. With the upcoming opening of our retail pharmacy, we have an opportunity to utilize the pharmacy to cut costs for the City, CCMC and our employees on the purchase of prescription medications. We are diligently striving to have this program in place by the new plan year that starts January 1, 2018.
- CCMC was recently awarded a grant of over $23,000 for purchasing communication equipment to be used during emergency situations. This grant is part of the Hospital Preparedness Program to help hospitals prepare for emergencies. Vivian Knop and Tammy Pokorney did the heavy lifting on submitting the grant after having several meetings with local police, fire, EMS and emergency planning folks from Cordova. The radios will be available to be used by all of these agencies to improve communication among all responders during disasters.

To the CCMC Health Services Board

September 2017 Financial Executive Summary

Statistics

Acute Care patient days increased by 4 in September from 12 in August. Swingbed days fell by 4 In September to 120 compared to 124 for August. Average Daily Census (ADC) increased to 4.5 days in September 4.4 in August.
There were 53 ER Visits in September versus 68 in August. PT procedures increased by 70 from August's level of 136 versus. Lab tests were down by 73 tests, with August having 410 tests versus 337 in September. X-ray tests dropped by 14 to 43 in September compared to 57 in August, while CT tests were 12 compared to 15 in August. September clinic visits were up by 72 visits in September compared to 284 in August, this includes nurse visits giving flu shots. Behavioral Health decreased by 37 visits in September compared to 109 in August.

Balance sheet

Cash decreased by $26K in September versus August's cash balance of $501K. Day's cash on hand at the end of September was 17.1 days compared to 18.2 days at the end of August.
Net AR Increased by $265K in September when compared to August. We are seeing constant improvement in AR due to the collect efforts by AVEC. Days in AR increased by 1.4 days in September from 80.1 days in August.
I have included the most recent slide showing AVEC's progress on AR by week.
Accounts payable increased by $168K in September from August's amount of $735,603. Payroll liabilities fell by $232K from August's amount of $342,320.
There was no increase in debt to the city in August. Only minor changes in the other amount of debt for September.

Income Statement

Gross revenue continued to decrease in September by $118K from August which had $1,124K, a good month but not as good as July was. All service line decreased in September except for an $8K increase in acute care.
Contractual adjustments increased in September due to an increased amount of uncollected Swingbed and the mix between the payers. Bad debt decreased significantly by $351K in September due to accounts collected and being shifted to collections.
Payroll decreased by $8K from August $339K for September. Payroll taxes and Benefits decreased by $18K August to September. Professional services increased $46K in September primarily due to one maintenance contract sending three quarterly invoices for $27K. Supplies expense decreased by $37K

in September. Rents and Leases returned to a near normal level for September. Maintenance and repair expenses Increased by $20K in September versus August, as summer maintenance projects continue in progress. Utilities were up a fuel for the winter was purchased
Travel decreased but recruitment and relocation went up for September as a pharmacist started and an ED for behavioral health was hired.
Overall expenses were down by $12K in September compared to July. We had a $294,358K operating profit for September.

Year to Date

Please note that the financials reflect the completed Audit.
YTD revenue for Nine months of operation is $1,145K over budget and exceeds last year by $1,921K. Continued high volume in Swing bed has helped this year. YTD net income for September, was $565K. It is encouraging, that YTD expenses remain below budget and lower than last year's YTD expenses. This of course will reduce our reimbursement from Medicare, due to increased Medicaid swingbed and lower expenses.

Activity and Projects

EHR
Work on E H R improvement is suspended after viewing 3 systems and then deciding that we could not get a new system installed in 2017 and need to stick with one system through 2018 so that we meet meaningful use Stage 3 criteria to avoid reimbursement penalties on future revenue. CMS has now decided to only require 90 days testing in 2018.

System problems are occurring with revenue being generated in a departments and the billing system trying to transfer the revenue to another department. I was able to celebrate some success with Healthland, in that they acknowledged that I was correct—that combining bills should not shift revenue between departments. They will fix the problem, however not any time soon, it will be next year, (I am not holding my breath)--if then.

Budget
Currently working with managers and Administration to get a 2018 budget to the board later this year. The managers have been actively involved with figuring their department's operating expenses budget.

Business Line Statements/Departmental Statements
This is a work in progress that keeps getting delayed. I am working on financial statements for our business lines, I.E., Sound Alternatives, Clinic, LTC in addition to the consolidated 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 billing, coding and Collections
AVEC staff continue working old open claims as well as coding new claims, they are totally responsible for coding and billing at this point, we still have to work on some rough spots in the process but they are doing well.

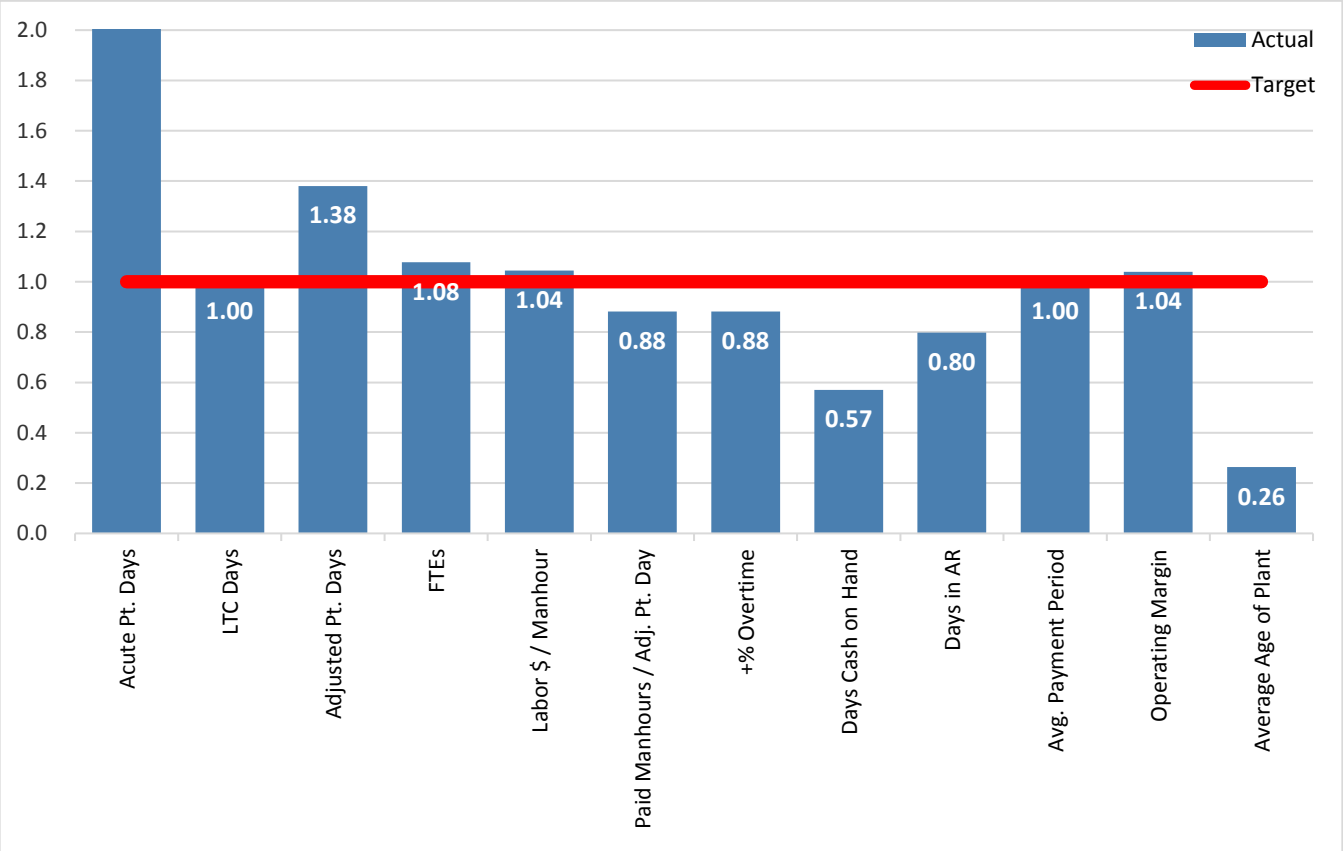
Respectfully submitted

Lee Holter
CFO

Monthly Financial Statements

SEPTEMBER 2017

Cordova Community Medical Center
Organizational Scorecard
September 2017



	September			August		
Indicator	Target	Actual	Score	Target	Actual	Score
Acute Pt. Days	431	1140	2.65	371	1004	2.71
LTC Days	2730	2730	1.00	2430	2430	1.00
Adjusted Pt. Days	1418	1958	1.38	1221	1732	1.42
FTEs	60	55.7	1.08	60	57.8	1.04
Labor $ / Manhour	35	33.52	1.04	35	35.16	1.00
Paid Manhours / Adj. Pt. Day	30	34	0.88	30	34.6	0.87
+% Overtime	3	3.4	0.88	3	4.4	0.68
Days Cash on Hand	30	17.1	0.57	30	18.2	0.61
Days in AR	65	81.5	0.80	65	80.1	0.81
Avg. Payment Period	30	30	1.00	30	39.6	0.76
Operating Margin	5	5.2	1.04	5	3.7	0.74
Average Age of Plant	7	26.6	0.26	7	30.1	0.23

Cordova Community Medical Center
Balance Sheet

ASSETS	9/30/2017	8/31/2017	9/30/2016
Current Assets			
Cash	475,496	500,882	461,799
Net Account Receivable	1,656,612	1,391,718	1,252,274
Third Party Receivable	-	-	0
Other Receivables	83,394	83,394	100,481
Prepaid Expenses	50,152	47,869	6,727
Inventory	151,324	128,472	173,057
Total Current Assets	**2,416,978**	**2,152,334**	**1,994,338**
Property, Plant & Equipment			
Land	122,010	122,010	122,010
Buildings	7,006,762	7,006,762	7,006,763
Equipment	6,772,970	6,772,970	6,759,816
Construction in Progress	112,480	110,945	1,060,094
Subtotal PP&E	14,014,222	14,012,687	14,948,682
Less Accumulated Depreciation	(10,566,459)	(10,518,613)	(10,012,208)
Total Property & Equipment	**3,447,762**	**3,494,074**	**4,936,474**
Other Assets			
PERS Deferred Outflow	1,218,788	1,218,788	929,979
Total Other Assets	**1,218,788**	**1,218,788**	**929,979**
Total Assets	**7,083,529**	**6,865,196**	**7,860,791**
LIABILITIES AND FUND BALANCE			
Current Liabilities			
Accounts Payable	903,999	735,603	739,722
Payroll & Related Liabilities	109,870	342,329	432,950
Third Party Settlement Payment	0	0	0
Interest & Other Payables	14,195	14,183	4,247
Long Term Debt-- City	3,477,563	3,477,563	3,100,976
Other Current Long Term Debt	43,160	45,896	138,798
Total Current Liabilities	**4,548,787**	**4,615,575**	**4,416,693**
Long Term Liabilities			
2015 Net Pension Liability	6,907,864	6,907,864	5,015,100
Total Long Term Liabilities	**6,907,864**	**6,907,864**	**5,015,100**
Deferred Inflows of Resources			
Pension Deferred Inflow	77,000	77,000	88,788
Total Deferred Inflows	**77,000**	**77,000**	**88,788**
Total Liabilities	**11,533,651**	**11,600,439**	**9,520,581**
Net Position			
Unrestricted Fund Balance	2,460,523	2,460,523	2,769,539
Temporary Restricted Fund Balance	13,035	13,035	13,035
Prior Year Retained Earnings	(7,479,816)	(7,479,816)	(4,086,354)
Current Year Net Income	556,136	271,015	(356,011)
Total Net Position	**(4,450,122)**	**(4,735,243)**	**(1,659,791)**
Total Liabilities & Net Position	**7,083,528.88**	**6,865,195.67**	**7,860,791**

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

TOTAL

Gross A/R	0 - 30	31 - 60	61 - 90	91 - 120	121+	Totals		Sep Days In AR
Commercial	102,035	100,136	63,366	24,180	121,070	410,786	14.0%	
Medicare	275,968	16,283	79,303	4,952	87,825	464,331	15.9%	
Medicaid	491,154	14,489	82,113	133,537	287,301	1,008,593	34.5%	
Long Term Care	272,421	2,922	13	(524)	60,273	335,106	11.5%	
Other Govt payers	20,248	21,741	15,185	9,893	12,424	79,490	2.7%	
Extended Pymt Terms	-	-	15,419	21,651	197,662	234,732	8.0%	
Private Pay	15,066	57,442	64,365	26,765	63,623	227,261	7.8%	
Work Comp	7,746	49,112	23,378	14,313	69,957	164,506	5.6%	
Totals	1,184,638	262,125	343,142	234,767	900,135	2,924,807	100.0%	81.5
	40.5%	9.0%	11.7%	8.0%	30.8%	100.0%		
						(89,221)	Credit Balances	

Cordova Community Medical Center
Income Statement

September 2017						Year To Date				
Actual	Budget	Variance	Prior Yr	Variance		Actual	Budget	Variance	Prior Yr	Variance
					REVENUE					
72,989	169,892	(96,903)	92,293	(19,303)	**Acute**	765,010	1,243,183	(478,173)	587,598	177,412
246,130	25,195	220,935	19,648	226,481	**Swing Bed**	2,039,731	247,858	1,791,873	600,203	1,439,528
362,077	337,973	24,104	345,389	16,687	**Long Term Care**	3,287,487	3,217,479	70,008	3,164,895	122,592
108,111	66,205	41,906	57,879	50,232	**Clinic**	882,688	709,504	173,184	648,653	234,035
211,001	219,238	(8,237)	249,123	(38,122)	**Outpatients**	2,015,484	2,190,605	(175,121)	1,943,285	72,199
6,346	53,581	(47,235)	19,066	(12,720)	**Behavioral Health**	270,178	506,649	(236,471)	394,472	(124,294)
1,006,654	872,084	134,570	783,398	223,256	**Patient Services Total**	9,260,579	8,115,278	1,145,301	7,339,106	1,921,474
					DEDUCTIONS					
3,978	13,550	(9,572)	(30)	4,008	**Charity**	9,765	125,539	(115,774)	184,560	(174,794)
243,343	126,584	116,759	38,480	204,863	**Contractual Adjustments**	1,976,758	1,172,813	803,945	1,158,661	818,097
(287,738)	24,838	(312,576)	2,168	(289,907)	**Bad Debt**	258,112	230,126	27,986	290,187	(32,076)
(40,417)	164,972	(205,389)	40,619	(81,036)	**Deductions Total**	2,244,635	1,528,478	716,157	1,633,407	611,227
					COST RECOVERIES				-	
83,624	61,732	21,892	-	83,624	**Grants**	336,402	383,025	(46,623)	389,989	(53,587)
93,754	146,480	(52,726)	82,475	11,280	**In-Kind Contributions**	831,814	908,841	(77,027)	1,084,605	(252,791)
2,850	23,311	(20,461)	66,545	(63,695)	**Other Revenue**	383,658	144,637	239,021	692,069	(308,411)
180,228	231,523	(51,295)	149,019	31,209	**Cost Recoveries Total**	1,551,874	1,436,503	115,371	2,166,664	(614,789)
1,227,299	**938,635**	**288,664**	**891,799**	**335,500**	**TOTAL REVENUES**	**8,567,819**	**8,023,303**	**544,516**	**7,872,362**	**695,457**
					EXPENSES					
339,103	482,661	(143,558)	296,696	42,407	**Wages**	2,994,016	3,217,723	(223,707)	2,586,089	407,927
129,254	245,811	(116,557)	98,577	30,677	**Taxes & Benefits**	1,330,214	1,638,732	(308,518)	1,554,370	(224,156)
175,341	142,467	32,874	207,182	(31,840)	**Professional Services**	1,286,111	1,327,159	(41,048)	1,872,015	(585,904)
9,563	2,307	7,256	576	8,987	**Minor Equipment**	34,261	20,763	13,498	26,695	7,566
32,756	34,428	(1,672)	30,110	2,646	**Supplies**	425,385	312,549	112,836	307,169	118,216
30,106	2,204	27,902	3,551	26,554	**Repairs & Maintenance**	82,938	19,836	63,102	63,272	19,666
9,543	9,142	401	15,499	(5,956)	**Rents & Leases**	104,799	82,278	22,521	137,723	(32,925)
111,069	97,962	13,107	100,391	10,677	**Utilities**	960,954	910,844	50,110	918,374	42,579
6,147	3,742	2,405	2,019	4,129	**Travel & Training**	64,498	33,696	30,802	33,840	30,658
14,595	19,113	(4,518)	14,355	241	**Insurances**	145,395	163,939	(18,544)	140,906	4,489
19,137	4,167	14,970	10,112	9,025	**Recruit & Relocate**	57,477	37,503	19,974	63,752	(6,275)
47,846	43,750	4,096	46,083	1,763	**Depreciation**	415,039	393,750	21,289	411,310	3,729
8,481	12,224	(3,743)	7,101	1,380	**Other Expenses**	101,872	110,016	(8,144)	112,857	(10,985)
932,941	**1,099,978**	**(167,037)**	**832,252**	**100,689**	**TOTAL EXPENSES**	**8,002,959**	**8,268,788**	**(265,829)**	**8,228,373**	**(225,414)**
294,358	(161,343)	455,701	59,547	234,811	**OPERATING INCOME**	564,860	(245,485)	810,345	(356,011)	920,871
10			-		Restricted Contributions	525			-	
294,368	**(161,343)**	**455,711**	**59,547**	**234,821**	**NET INCOME**	**565,385**	**(245,485)**	**810,870**	**(356,011)**	**921,396**

Cordova Community Medical Center Statistics

Change each month 8

	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 ADC	3.1	3.8	4.5	4.5	4.5	3.1	5.3	4.4	4.5					4.2
FY 2016	0.8	1.9	1.3	2.0	1.7	2.2	1.2	0.3	0.7	1.1	0.5	1.0		1.2
FY 2015	1.1	0.2	2.0	2.3	2.0	2.7	0.9	1.5	0.7	0.5	0.9	0.1		1.2
Acute Admits														
FY 2017	9	7	7	5	4	1	10	6	6				55	6.9
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	22	29	23	28	2	49	12	16				213	26.6
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	3	2	1	2	0	1	0	0				14	1.8
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	84	109	111	111	90	114	124	120				927	115.9
FY 2016	9	40	23	37	28	46	25	0	3	11	1	14	237	19.8
FY 2015	31	3	55	60	46	78	18	45	11	11	19	0	377	31.4
CCMC LTC Admits														
FY 2017	0	0	0	0	0	0	0	0	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	280	310	300	310	300	310	310	300				2,730	341
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	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	0.0	0.0	0.0		11.3
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	35	47	49	53	55	75	68	53				484	60.5
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

Change each month 8

	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	111	138	293	136	146	177	168	145				1,434	179
FY 2016	120	117	131	342	159	164	160	172	165	146	126	137	1,939	485
FY 2015													0	0
PT Procedures														
FY 2017	416	322	497	399	327	296	343	136	206				2,942	368
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	38	0	0	0	0	0	0	0				132	17
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	322	284	304	318	283	435	410	337				2,991	374
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	43	37	29	42	63	72	57	43				433	54
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	13	14	12	14	22	15	12				116	15
FY 2016		7	16	14	15	24	20	14	15	25	17	13	180	16
FY 2015													0	0
CCMC Clinic Visits														
FY 2017	212	175	197	188	248	239	217	284	356				2,116	264.5
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	98	71	90	88	100	85	109	72				783	97.9
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 - ATB Weekly Comparison

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER 10232017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	274	394	294	126	112	187	156
Balance	$339,164.61	$242,627.15	$166,655.23	$101,010.44	$60,629.49	$144,312.67	$91,794.90
AR %	30%	21%	15%	9%	5%	13%	8%
	0 to 90 days AR % - 65%			90 + days AR % - 35%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER 10162017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	369	377	292	124	112	186	158
Balance	$195,465.41	$255,326.55	$159,500.39	$90,159.21	$59,243.04	$145,758.12	$95,437.13
AR %	20%	26%	16%	9%	6%	15%	10%
	0 to 90 days AR % - 61%			90 + days AR % - 39%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER 10092017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	293	374	280	114	113	178	161
Balance	$181,501.84	$226,318.04	$167,512.96	$92,425.76	$71,447.45	$116,306.81	$96,807.95
AR %	19%	24%	18%	10%	8%	12%	10%
	0 to 90 days AR % - 60%			90 + days AR % - 40%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER 10022017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	368	374	261	140	134	177	154
Balance	$265,582.70	$202,067.39	$161,909.61	$77,290.33	$74,061.40	$121,601.71	$85,080.52
AR %	27%	20%	16%	8%	7%	12%	9%
	0 to 90 days AR % - 64%			90 + days AR % - 36%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 09262017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	353	365	253	148	142	180	162
Balance	$256,085.92	$228,110.44	$169,977.10	$68,155.67	$78,964.55	$126,227.67	$88,376.45
AR %	25%	22%	17%	7%	8%	12%	9%
	0 to 90 days AR % - 64%			90 + days AR % - 36%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 09192017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	391	373	226	144	154	183	167
Balance	$235,684.33	$220,078.82	$153,698.11	$60,363.52	$82,507.40	$126,138.61	$90,383.28
AR %	24%	23%	16%	6%	9%	13%	9%
	0 to 90 days AR % - 63%			90 + days AR % - 37%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 09122017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	385	358	210	144	139	196	172
Balance	$202,675.94	$224,140.06	$156,776.28	$47,239.85	$89,293.80	$132,166.57	$90,414.98
AR %	21%	24%	17%	5%	9%	14%	10%
	0 to 90 days AR % - 62%			90 + days AR % - 38%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 09052017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	364	356	202	149	144	234	182
Balance	$253,257.13	$262,871.17	$116,951.33	$89,207.19	$96,126.67	$166,794.32	$96,332.42
AR %	23%	24%	11%	8%	9%	15%	9%
	0 to 90 days AR % - 59%			90 + days AR % - 41%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08282017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	340	302	197	127	147	231	182
Balance	$249,368.28	$241,404.34	$87,005.84	$80,018.09	$100,335.26	$165,667.23	$95,051.39
AR %	24%	24%	9%	8%	10%	16%	9%
	0 to 90 days AR % - 57%			90 + days AR % - 43%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08212017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	344	265	183	132	156	222	174
Balance	$268,619.79	$208,559.83	$80,714.83	$95,995.72	$104,707.18	$147,054.42	$90,141.25
AR %	27%	21%	8%	10%	11%	15%	9%
	0 to 90 days AR % - 56%			90 + days AR % - 44%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08142017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	329	254	180	137	199	254	199
Balance	$283,341.87	$178,789.89	$67,460.23	$101,113.38	$116,284.81	$169,144.63	$96,618.19
AR %	28%	18%	7%	10%	11%	17%	10%
	0 to 90 days AR % - 52%			90 + days AR % - 48%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 08072017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	297	220	173	138	212	260	191
Balance	$263,787.12	$129,933.07	$81,453.63	$95,735.20	$115,942.33	$172,958.35	$93,177.18
AR %	28%	14%	9%	10%	12%	18%	10%
	0 to 90 days AR % - 50%			90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07172017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	321	246	158	123	204	272	179

Balance	$233,047.46	$136,041.18	$111,685.67	$52,043.30	$143,808.28	$171,921.47	$89,879.21
AR %	25%	14%	12%	6%	15%	18%	10%
	0 to 90 days AR % - 51%			90 + days AR % - 49%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07102017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	261	253	157	119	194	290	163
Balance	$161,435.68	$119,009.72	$111,588.67	$67,289.17	$123,063.88	$179,174.75	$81,966.90
AR %	19%	14%	13%	8%	15%	21%	10%
	0 to 90 days AR % - 46%			90 + days AR % - 54%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 07032017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	287	241	171	126	174	308	152
Balance	$158,402.75	$171,984.46	$119,115.33	$82,499.78	$124,412.41	$169,894.68	$77,005.96
AR %	18%	19%	13%	9%	14%	19%	9%
	0 to 90 days AR % - 50%			90 + days AR % - 50%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 06262017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	284	236	177	146	166	341	181
Balance	$194,397.30	$140,058.70	$125,250.26	$88,857.41	$131,910.05	$182,499.31	$79,870.87
AR %	21%	15%	13%	9%	14%	19%	8%
	0 to 90 days AR % - 49%			90 + days AR % - 51%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 06192017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	267	236	175	156	153	351	179
Balance	$165,205.39	$171,098.47	$205,909.53	$101,031.72	$123,858.03	$187,394.41	$71,235.45
AR %	16%	17%	20%	10%	12%	18%	7%
	0 to 90 days AR % - 53%			90 + days AR % - 47%			

AGING ANALYSIS FOR AVEC RESPONSIBLE PAYER - 06092017							
Age	0-30	31-60	61-90	91-120	121-180	181-365	365+
Count	250	259	189	163	154	361	193
Balance	$153,011.67	$192,763.53	$222,889.32	$105,800.41	$123,286.52	$193,886.77	$74,063.02
AR %	14%	18%	21%	10%	12%	18%	7%
	0 to 90 days AR % - 53%			90 + days AR % - 47%			

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

Date: October 25, 2017
To: CCMC Authority Board of Directors
From: Chief Nursing Officer, Tammy Pokorney, RN
RE: Nursing Report

October 2017 Nursing Activity Update:

1. Caregiver openings –nursing positions are filled or allocated with offers for personnel. The nursing staff is now all RN with ongoing training in trauma and community specific care-focused seasonally as well as long term care to optimize our travelers as well as progress in education.

2. LTC census is 10 residents. Currently, we have 5 Swing beds occupied. Highest census was 18.

3. Priorities remain staff development, infection control, internal quality measures with quantifiable outcomes, and technology integration where applicable. We are making headway in our technology selections and look forward to becoming fully automated for nursing care, policy oversight, and human resource functions with education and payroll integrated as well.

4. Attached is the quality report for:
    a. Abaqis for Long Term Care.
    b. Partnership for Patients.
    c. Mountain Pacific report on Reducing Healthcare-Acquired Conditions in Nursing Homes.

Please let me know if there are any questions.

Tammy Pokorney
CNO

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Washington State Hospital Association

Cordova Community Medical Center

Patient Safety Trend Report

August 2017 Release

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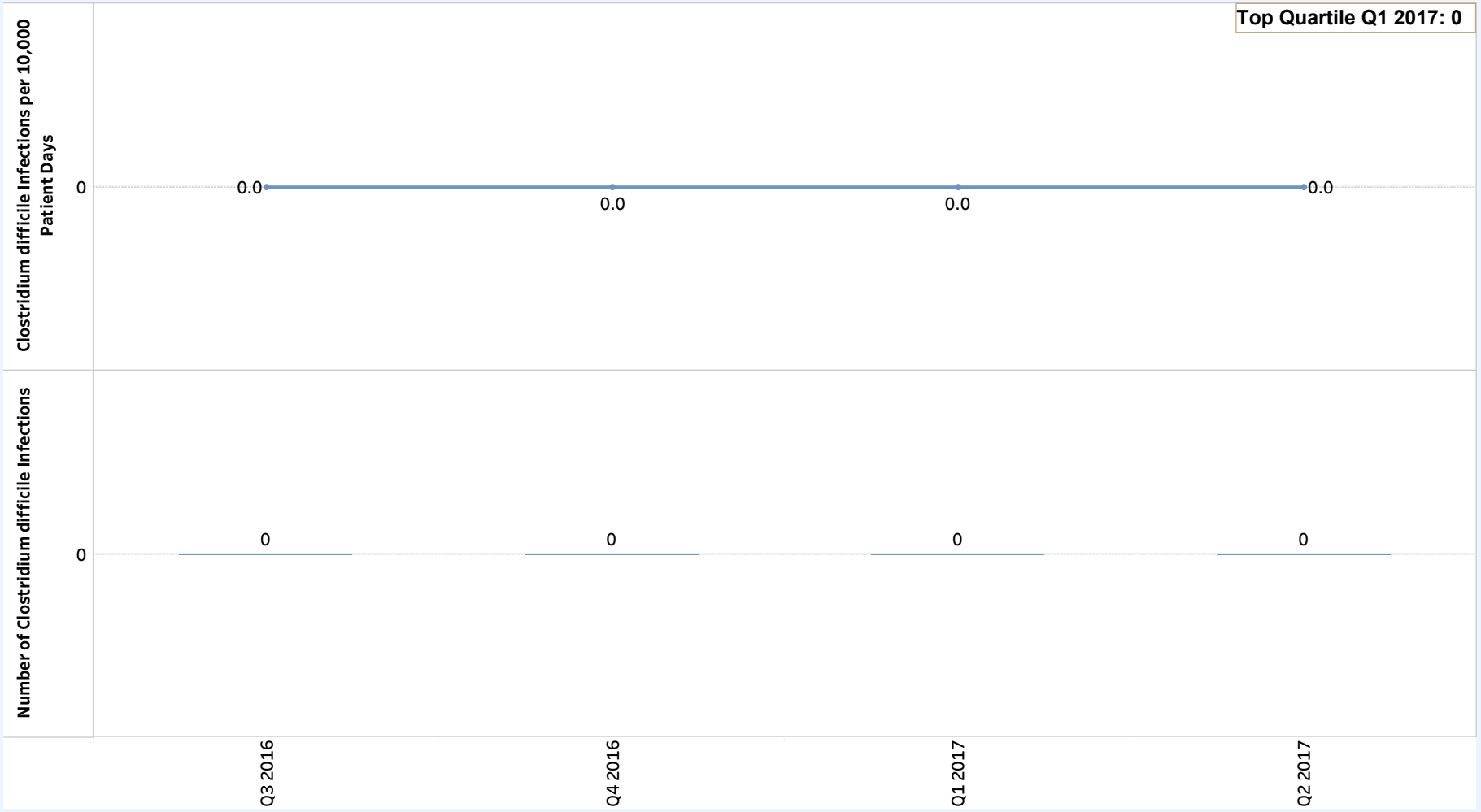
Clostridium *difficile* Infection (CDI) Rate



Definition: Facility CDI Healthcare Facility-Onset Incidence Rate = Number of all healthcare facility-onset (HO) Clostridium difficile infections (CDI) laboratory-identified (LabID) events per month in the facility / number of patient days for the facility x 10,000.
Data source: Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN).

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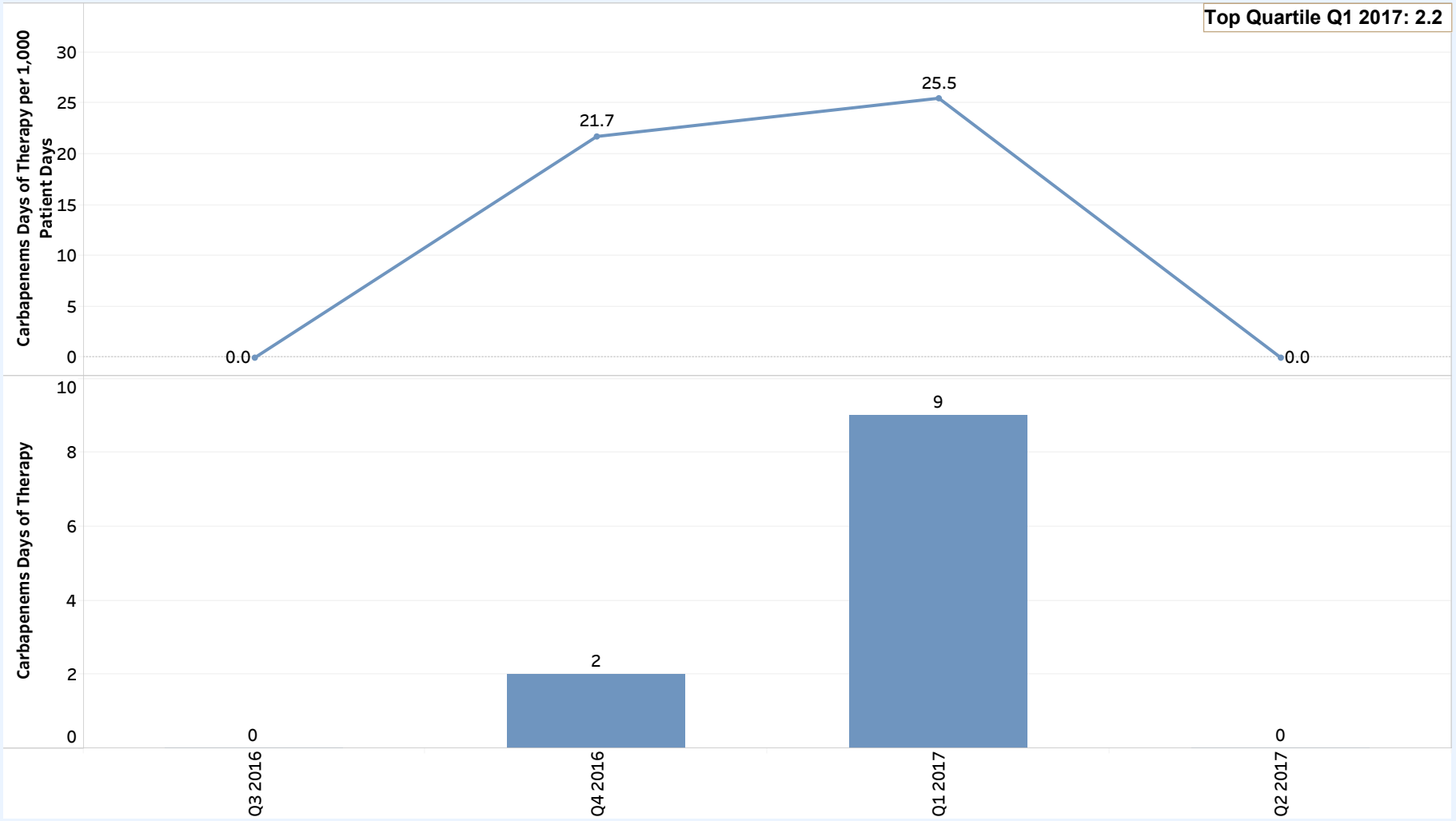
Antimicrobial Stewardship (ASP) Carbapenems Days-of-Therapy



Defintion: Total number of days of therapy per 1,000 patient days (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS), CDC NHSN.

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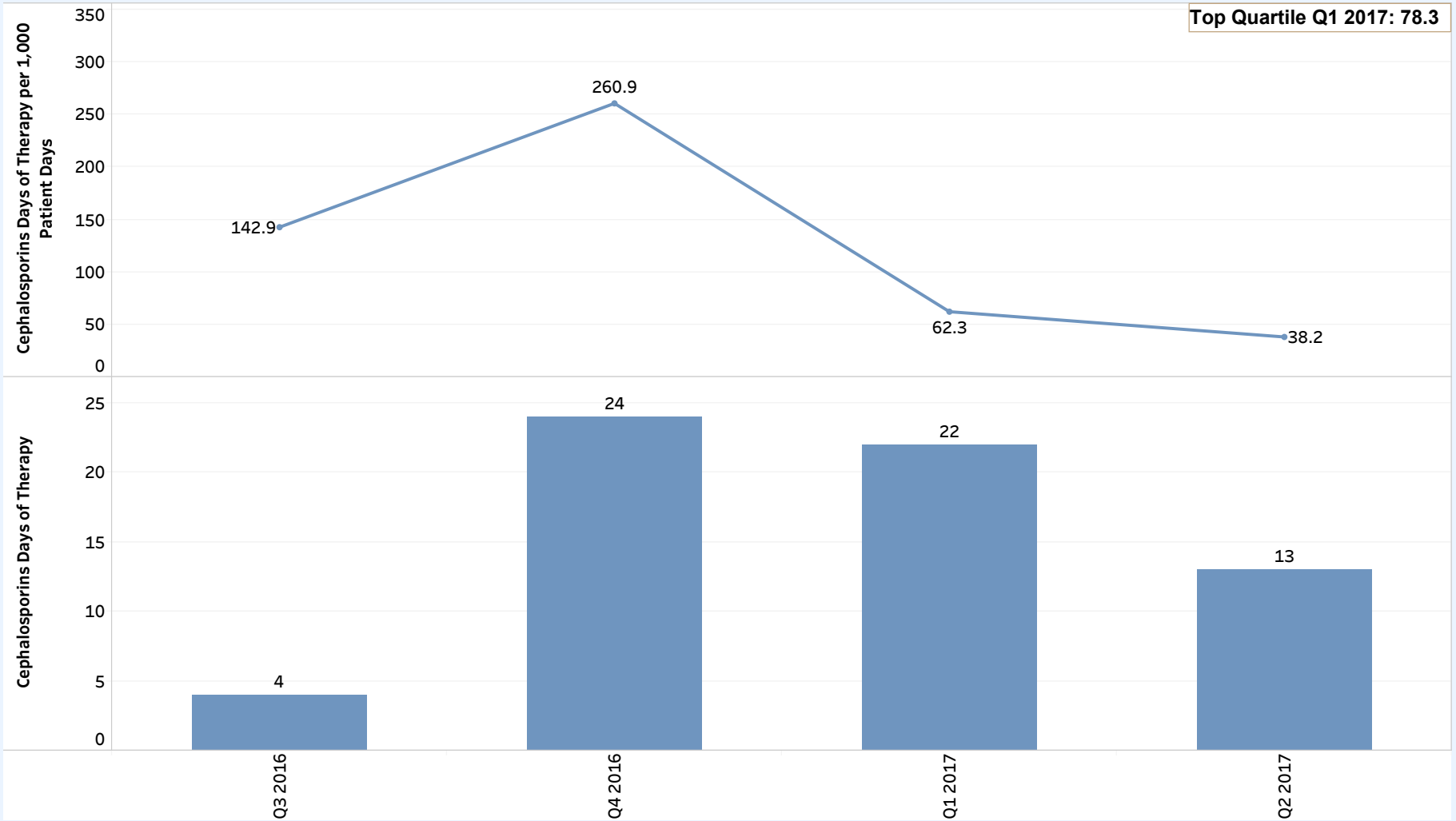
Antimicrobial Stewardship (ASP) Cephalosporins Days-of-Therapy



Defintion: Total number of days of therapy per 1,000 patient days (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS), CDC NHSN.

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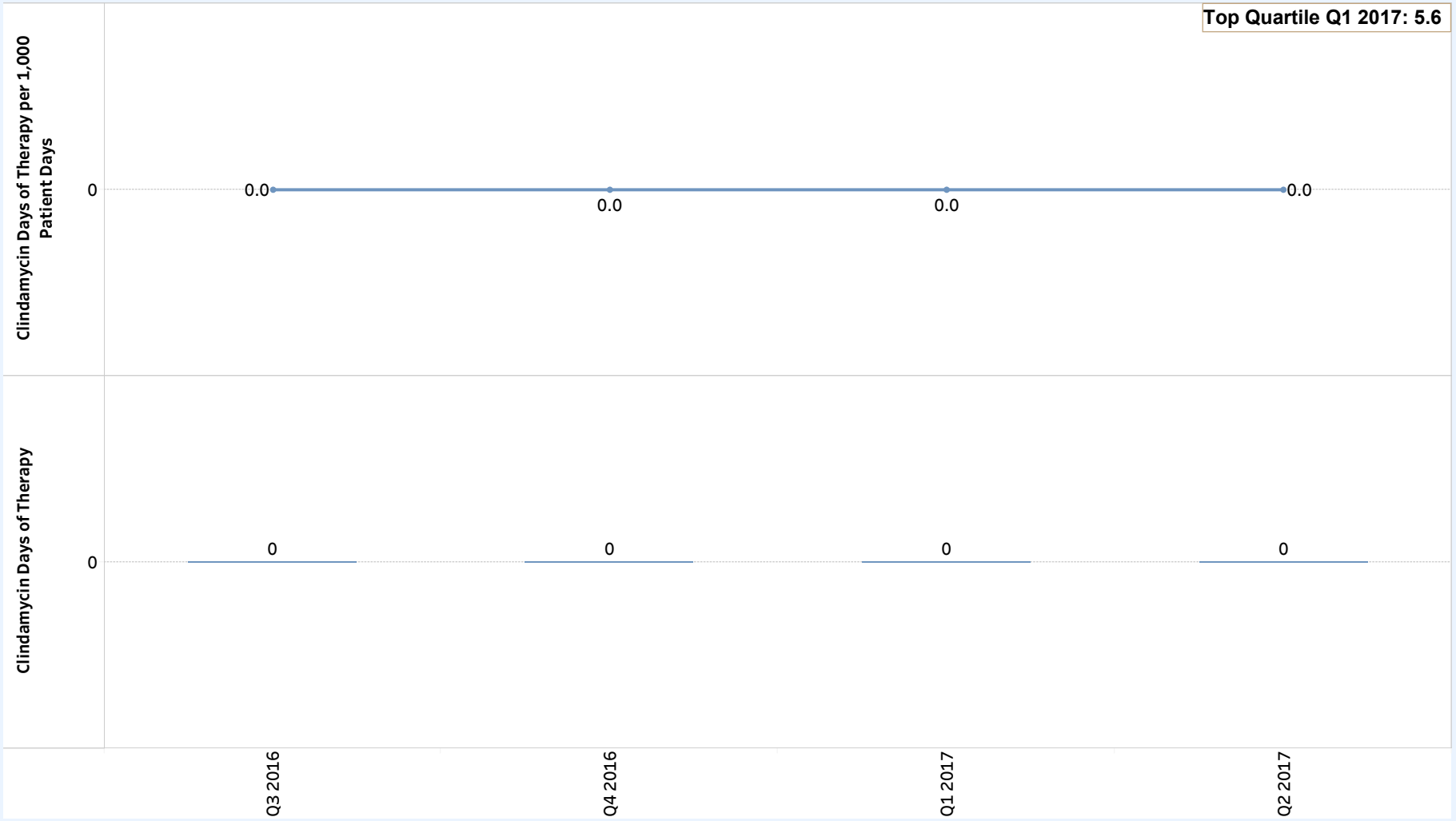
Antimicrobial Stewardship (ASP) Clindamycin Days-of-Therapy



Defintion: Total number of days of therapy per 1,000 patient days (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS), CDC NHSN.

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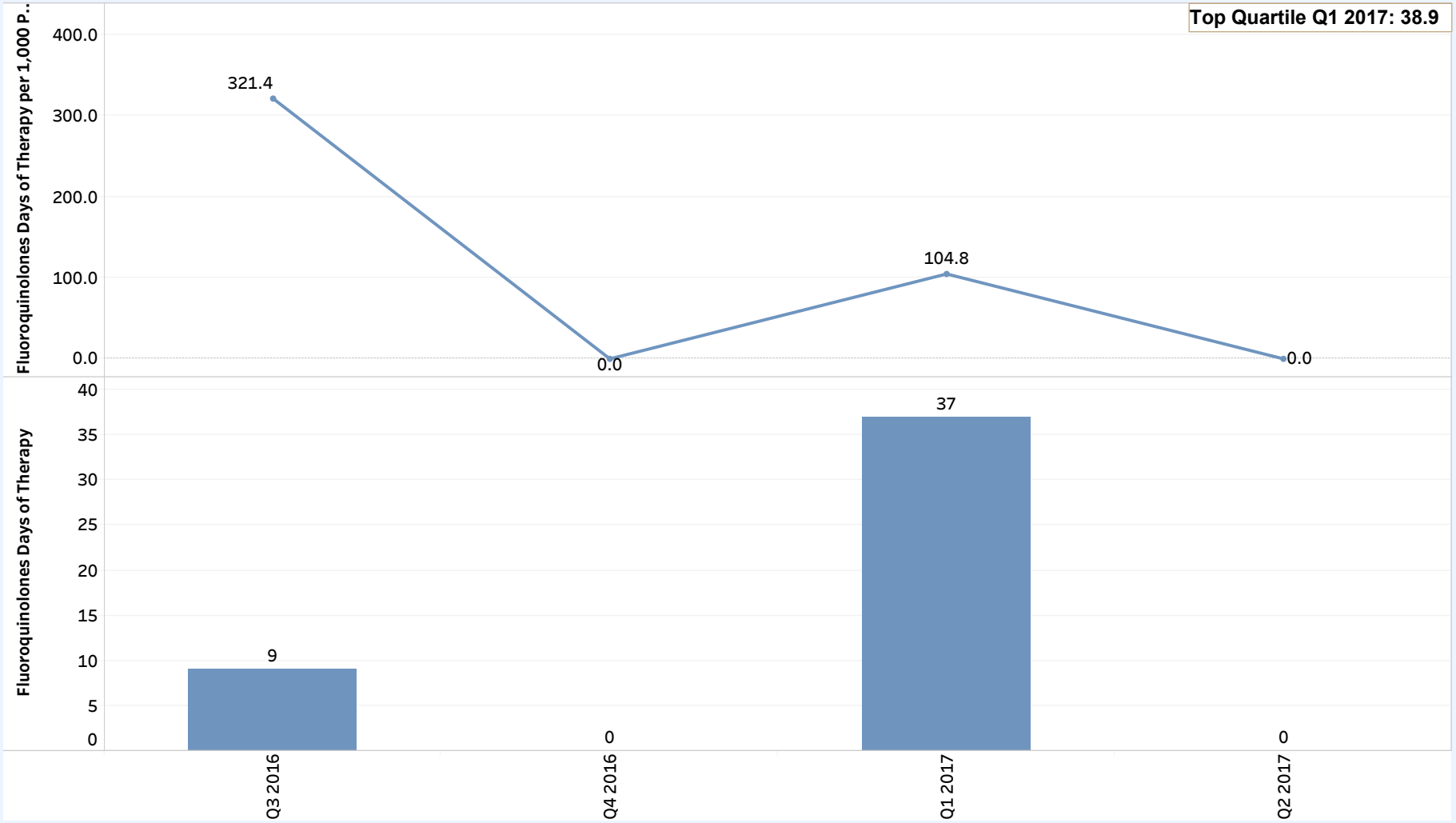
Antimicrobial Stewardship (ASP) Fluoroquinolones Days-of-Therapy



Defintion: Total number of days of therapy per 1,000 patient days (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS), CDC NHSN.

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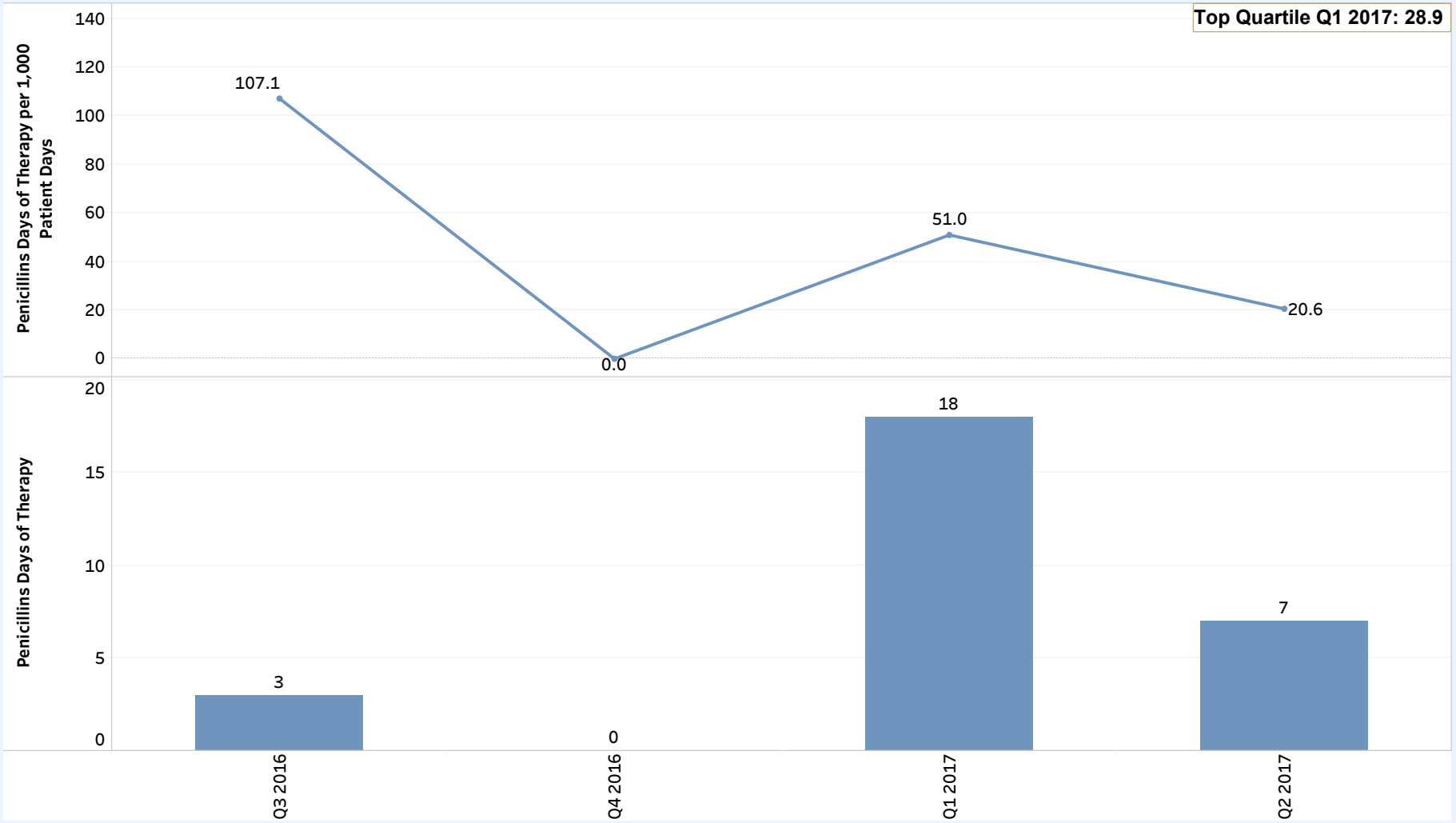
Antimicrobial Stewardship (ASP) Penicillins Days-of-Therapy



Defintion: Total number of days of therapy per 1,000 patient days (Carbapenems, Cephalosporins, Clindamycin, Fluoroquinolones, Penicillins).
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS), CDC NHSN.

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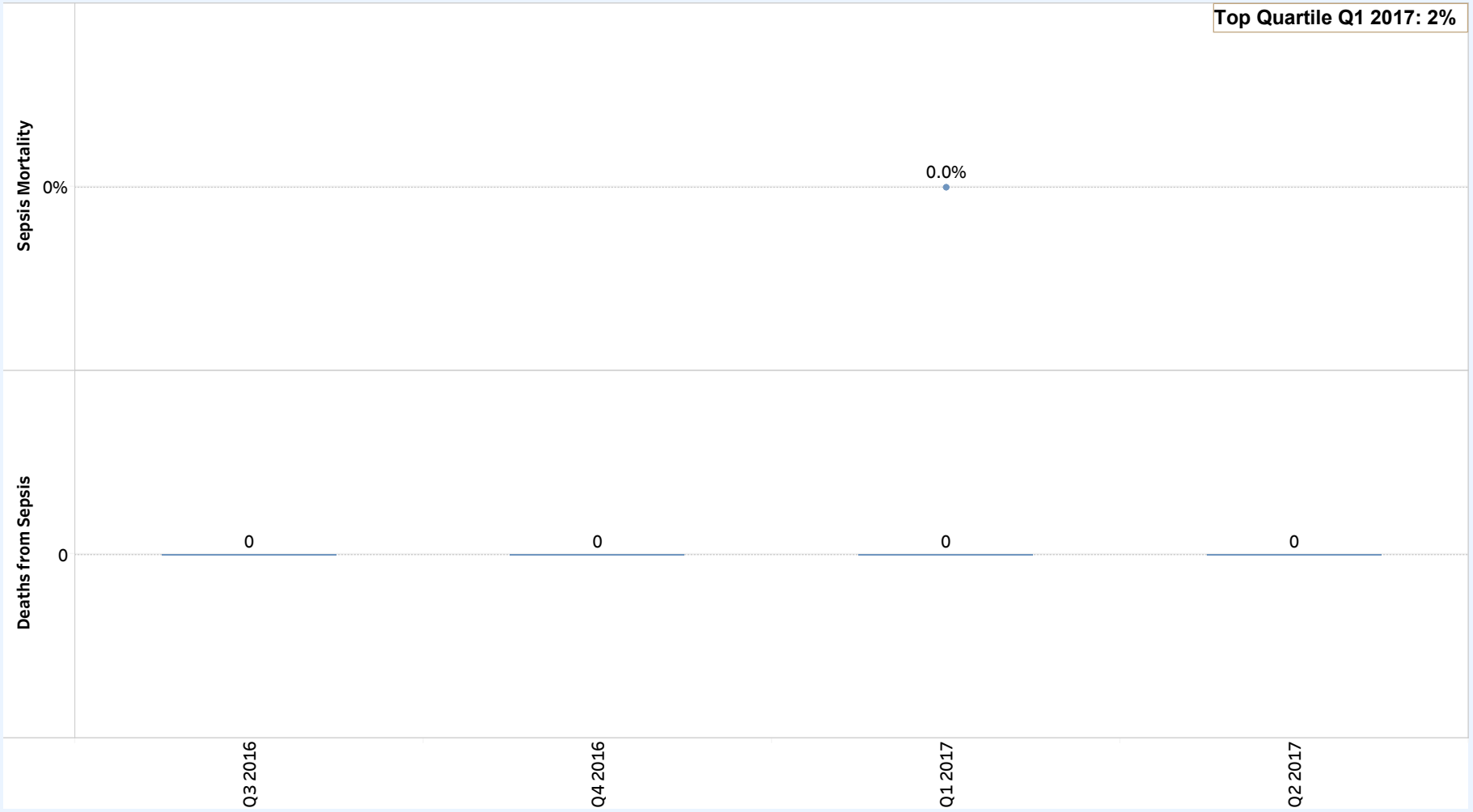
Severe Sepsis and Septic Shock Mortality Rate



Definition: Hospital deaths related to Severe Sepsis and Septic Shock (All Ages) from the number of patients diagnosed with Severe Sepsis and Septic Shock (Excludes Comfort Care Patients) (with ICD-9 or ICD-10 codes).
Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS).

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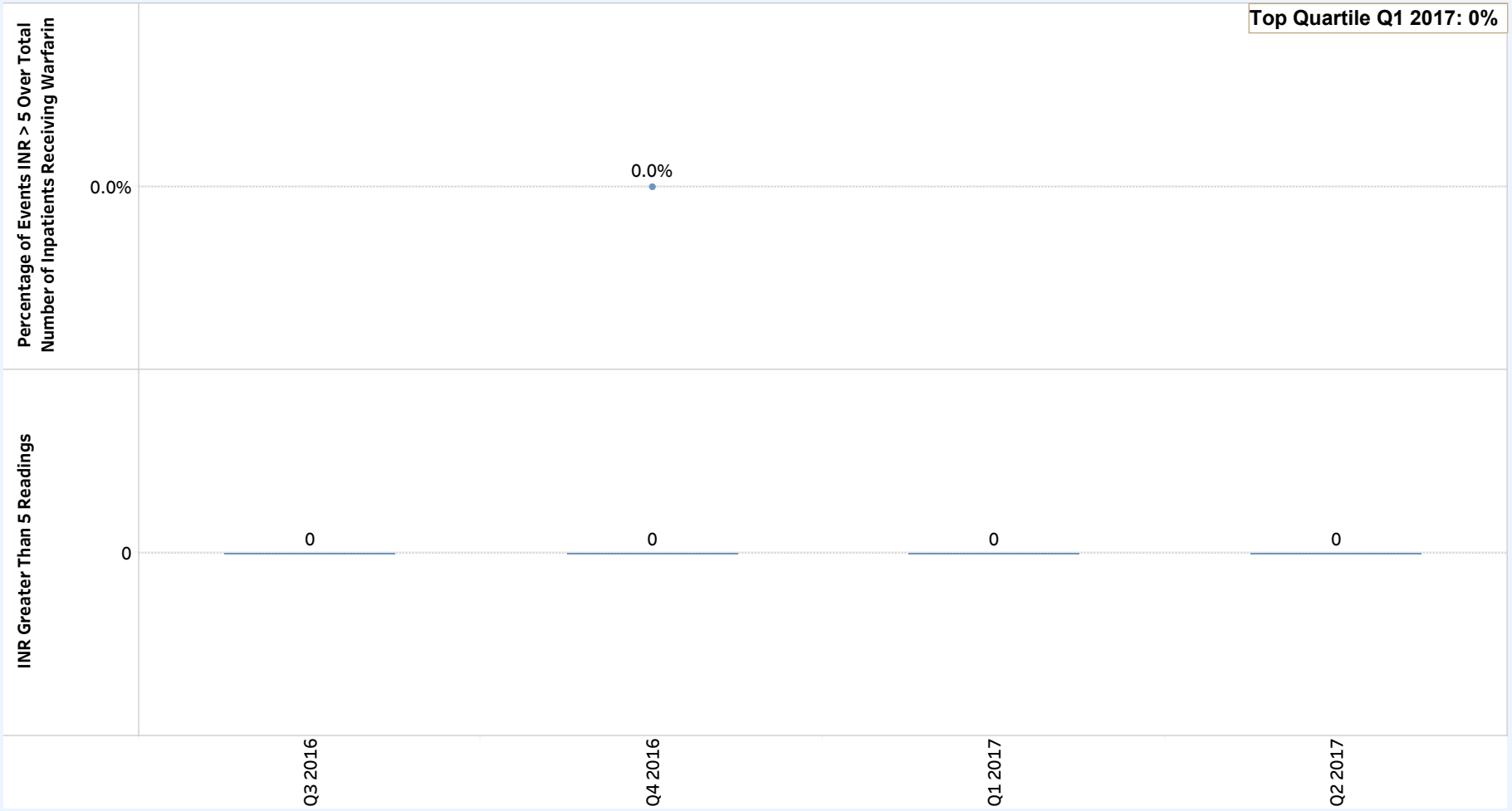
Adverse Drug Events Anticoagulants: Option 1



Definition: Number of patient events with an INR >5 after any warfarin administration (for patients cared for in an inpatient area) over the number of patients (cared for in an inpatient area) on warfarin. A patient that has multiple elevated INRs will be counted as one event until it drops below 3.5 and rises above 5 again. Exclusions: emergency department readings, patients admitted for trauma, patients with liver failure diagnosis, and patients given argatroban before warfarin.
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System.

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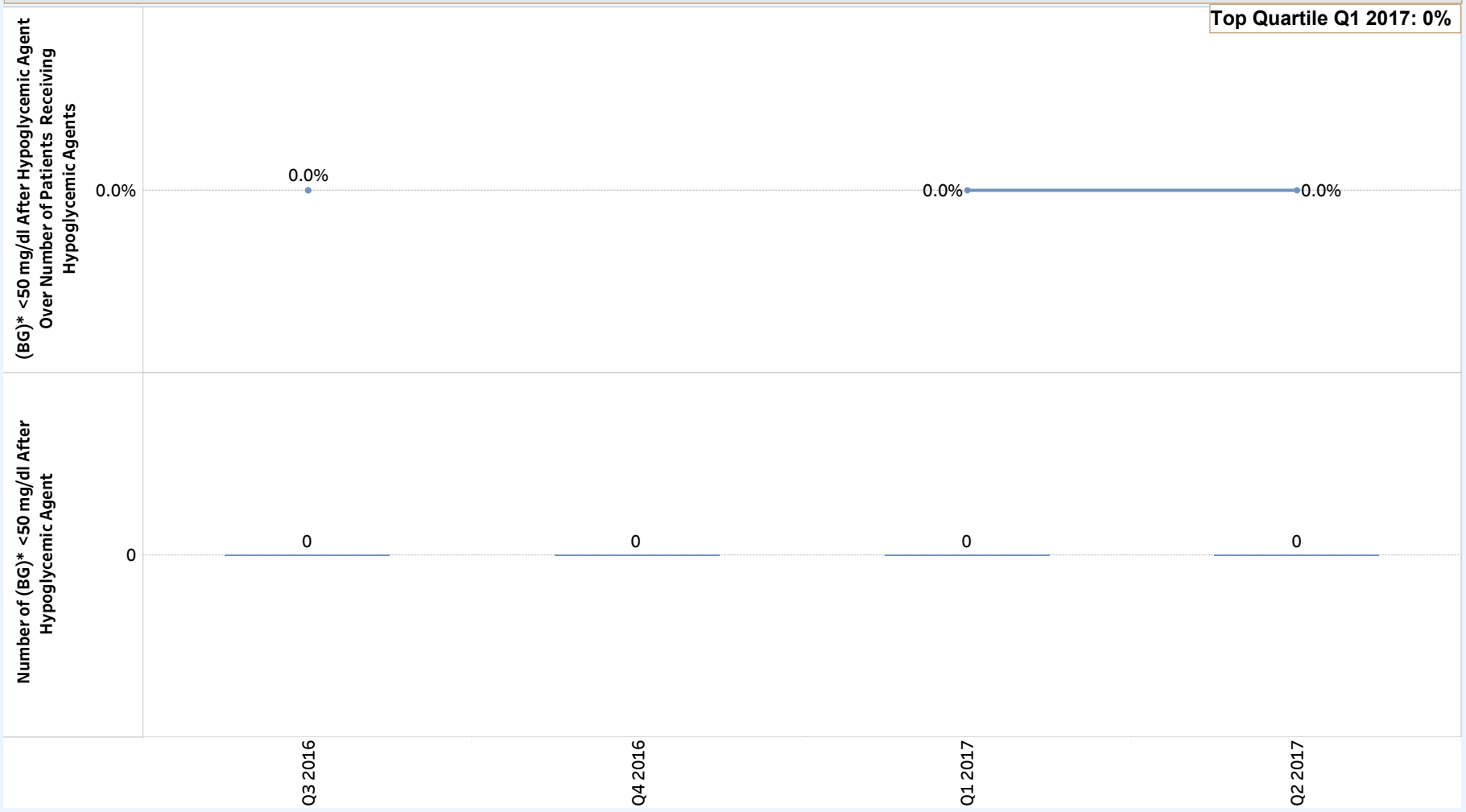
Patient Safety Trend Report - August 2017 Release

Adverse Drug Events Hypoglycemic Agent: Option 1



Definition: Number of patient blood glucose (BG)* levels of <50 mg/dl after any hypoglycemic agent administration (patients cared for in an inpatient area) over the number of patients (cared for in an inpatient area) receiving hypoglycemic agents (oral & insulin).
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System.

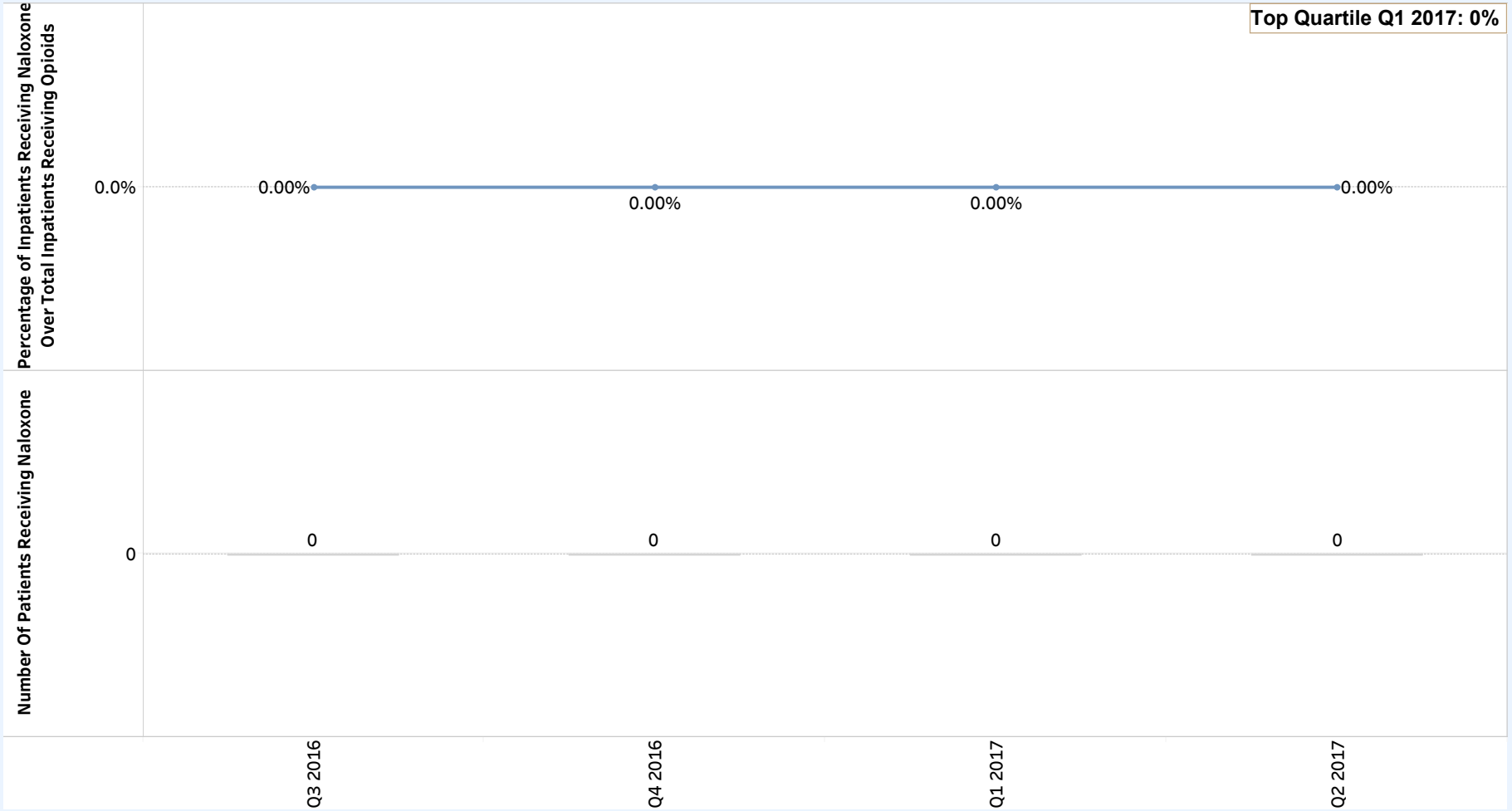
Partnership for Patients

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Washington State Hospital Association

Cordova Community Medical Center
Patient Safety Trend Report - August 2017 Release

Adverse Drug Events Opioids: Option 1



Definition: Number of patients (cared for in an inpatient area) who received naloxone after any opioid administration over number of patients (cared for in an inpatient area) receiving opioids. Exclusions: naxolone given in PACU and procedural areas, given (via IV infusion) for epidural-related itching symptoms,all doses given in the ED or within 24 hours of admission for a diagnosis of suicide attempt, opiate abuse, dependence, poisoning, or overdose.
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System.

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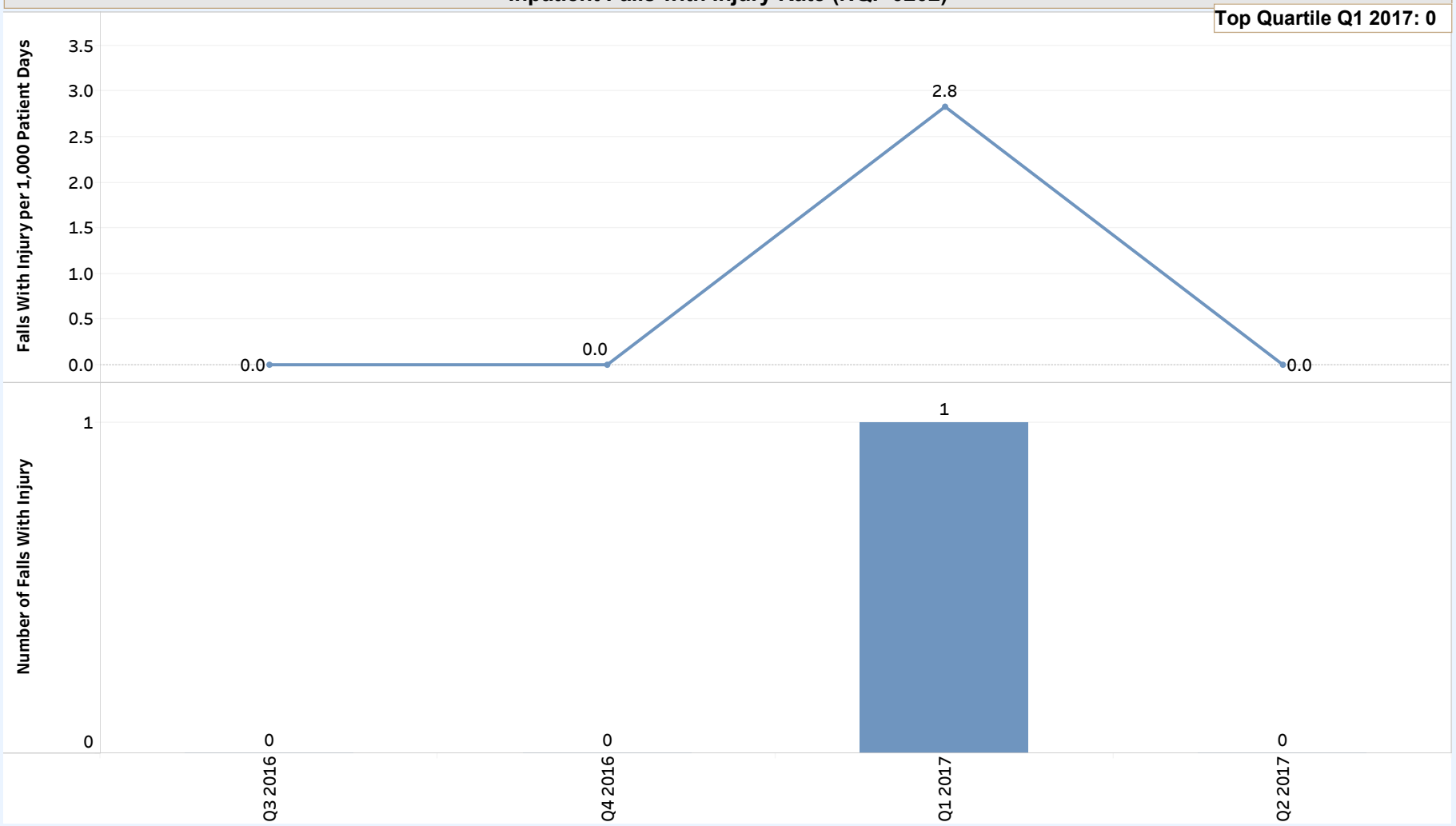
Washington State Hospital Association

Cordova Community Medical Center
Patient Safety Trend Report - August 2017 Release

Inpatient Falls with Injury Rate (NQF 0202)



Definition: National Database of Nursing Quality Indicators/Collaborative Alliance for Nursing Outcomes (CALNOC) and NQF 0202, falls with an injury level of minor or greater per 1,000 patient days.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS) and CALNOC.

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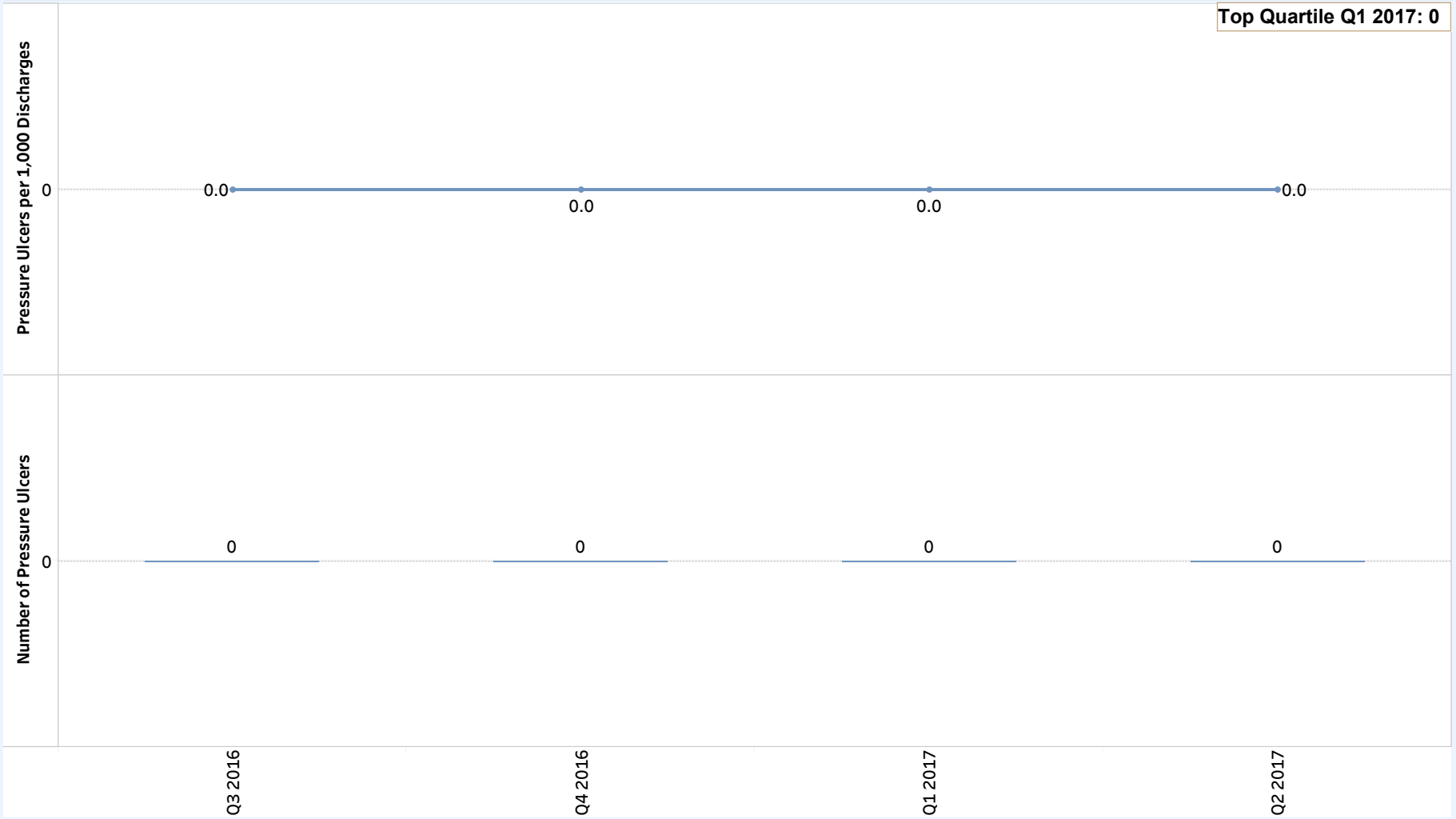
Washington State Hospital Association

Cordova Community Medical Center
Patient Safety Trend Report - August 2017 Release

Hospital-Acquired Pressure Ulcers Rate (AHRQ PSI-03)



Definition: AHRQ PSI-03, number of pressure ulcers stage III, IV, or unstageable per 1,000 medical and surgical discharges.
Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS).

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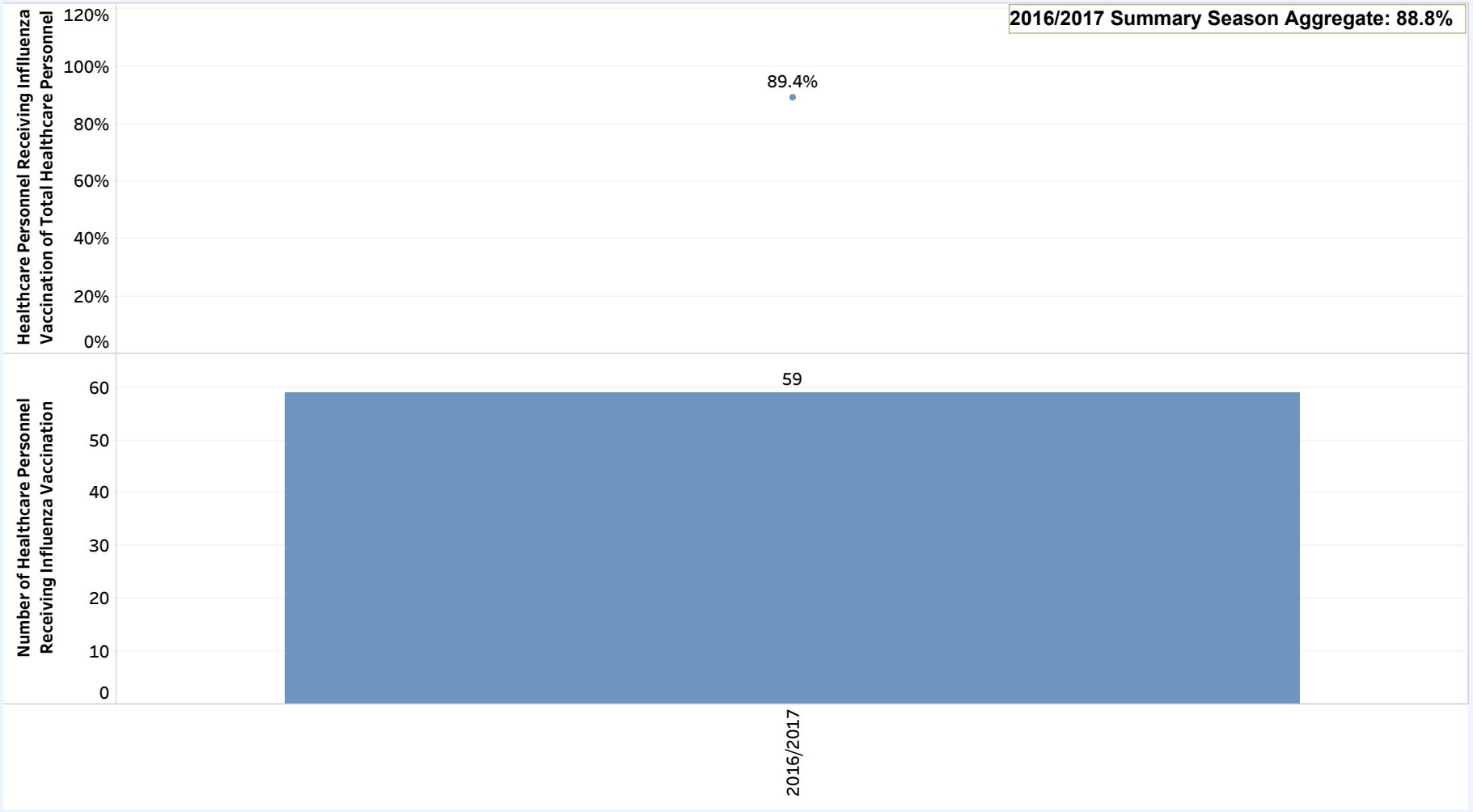
Washington State Hospital Association

Cordova Community Medical Center
Patient Safety Trend Report - August 2017 Release

Influenza Immunization of Healthcare Personnel



Definition: Healthcare Personnel receiving influenza vaccine out of those who are physically present in the Healthcare facility for at least one working day between October 1st and March 31st of the following year (Excludes total number of Healthcare Personnel with contraindication).
Data Source: CDC NHSN.

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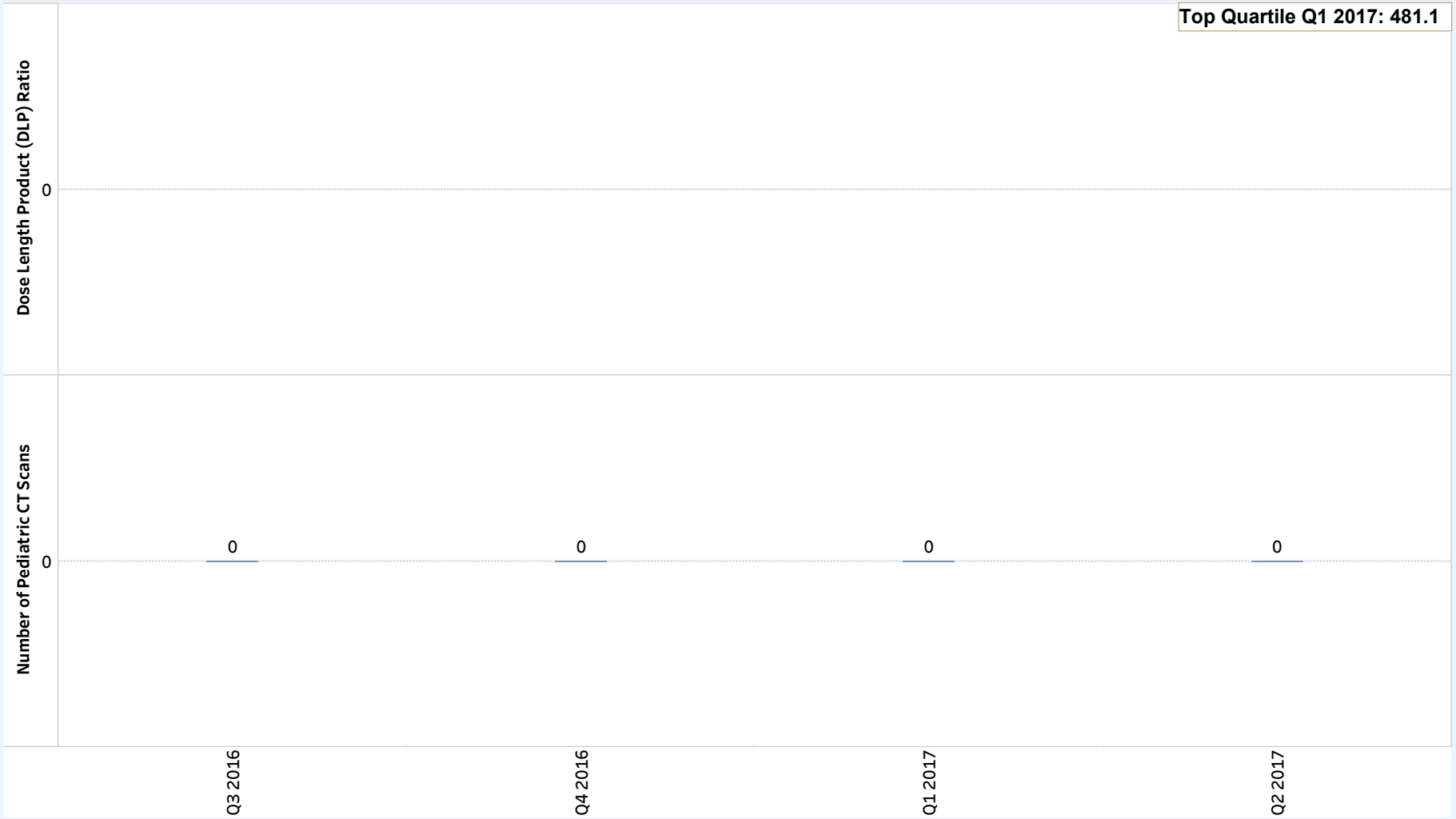
Washington State Hospital Association

Cordova Community Medical Center
Patient Safety Trend Report - August 2017 Release

Undue Exposure to Radiation: Radiology Dosage Per Pediatric Head CT



Definition: Total dose length product (DLP) for all head CTs divided by number of head CTs for pediatric patients.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS).

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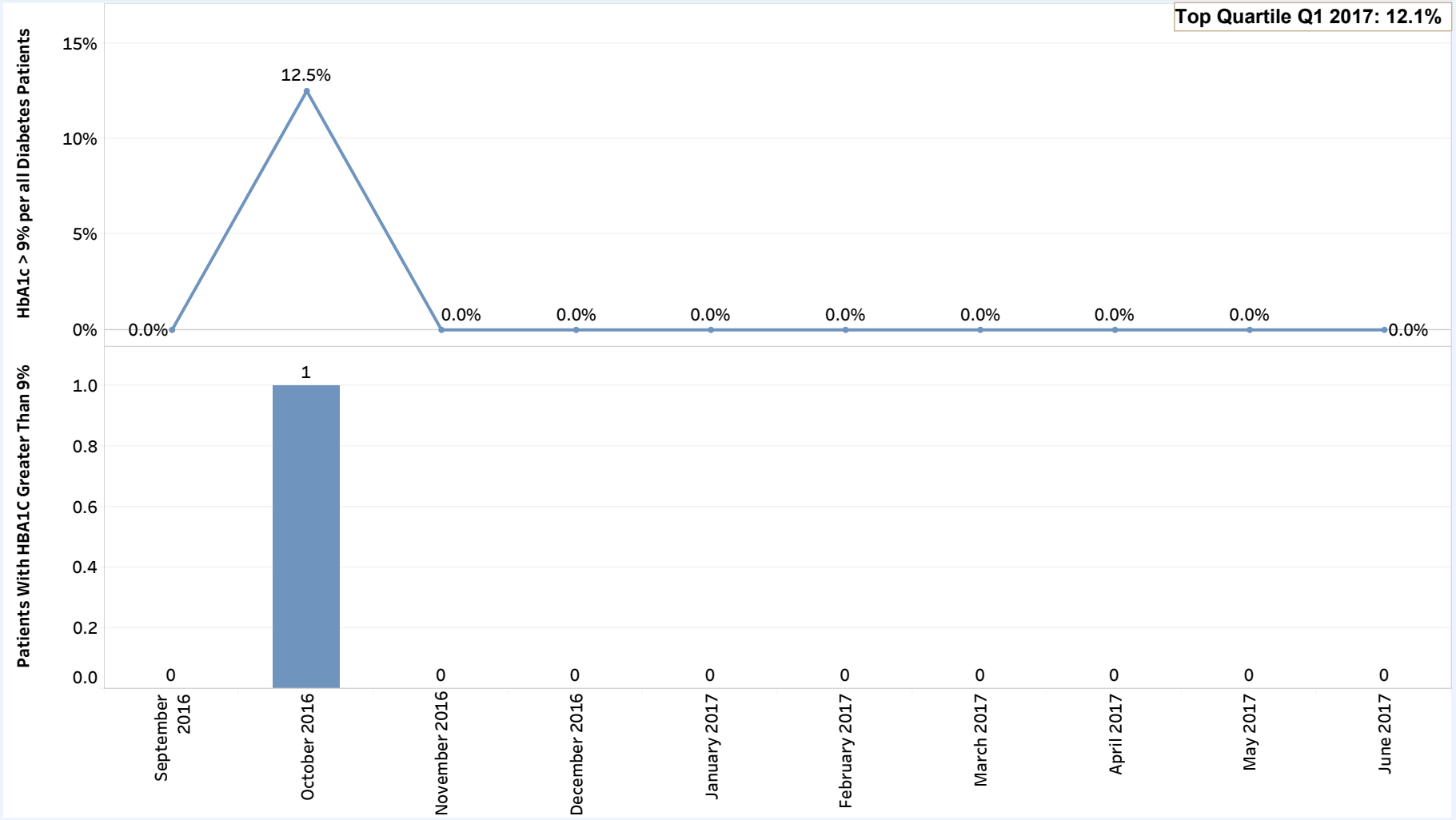
Washington State Hospital Association

Cordova Community Medical Center
Patient Safety Trend Report - August 2017 Release

Population Health: Diabetic Care (Critical Access Hospitals Only)



Definition: Number of patients with HbA1c levels > 9% per all diabetes patients.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS).

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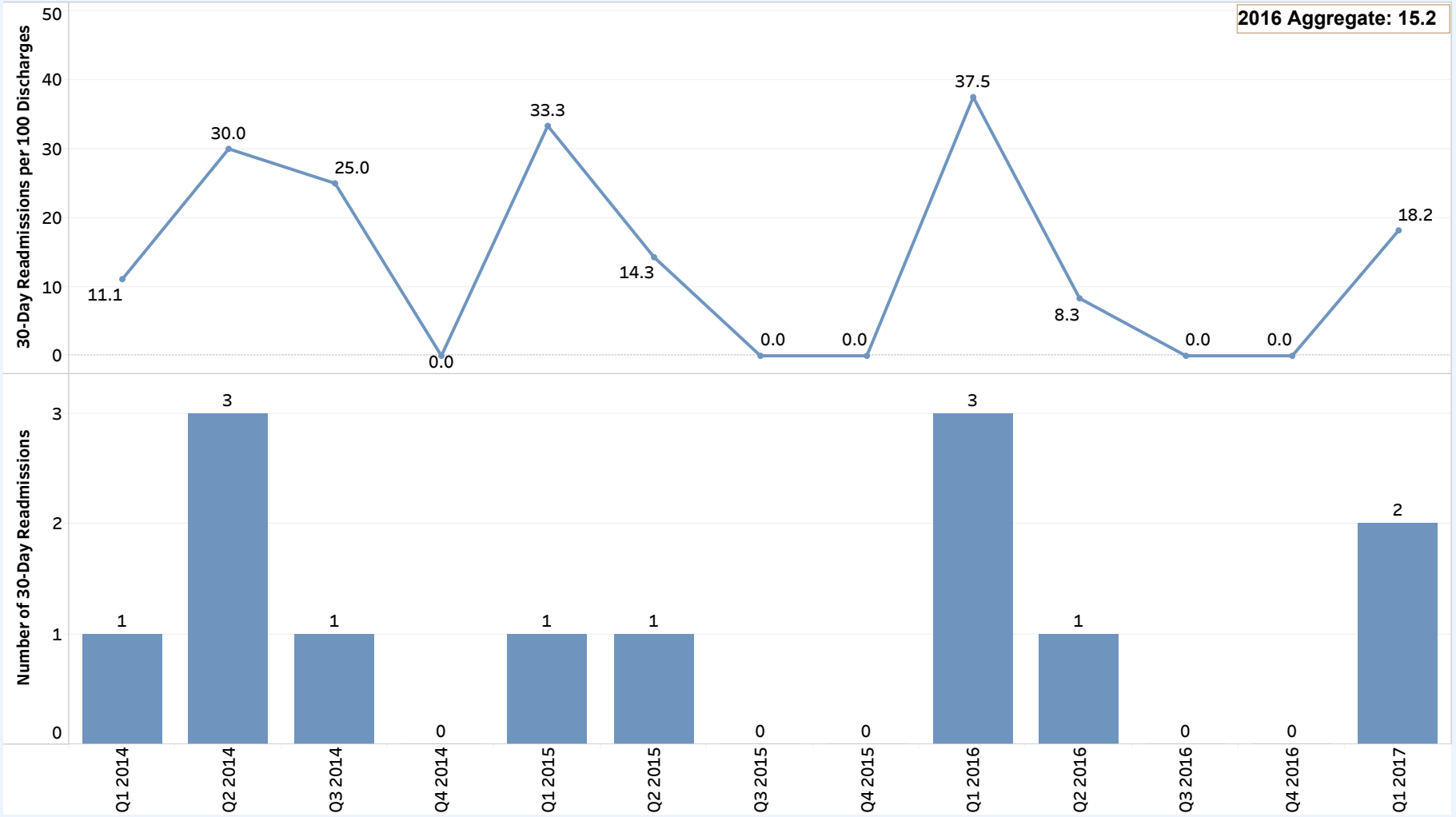
Washington State Hospital Association

Cordova Community Medical Center
Patient Safety Trend Report - August 2017 Release

30-Day Medicare FFS Readmissions



Definition: Number of 30-Day Medicare FFS readmissions per 100 live discharges.
Data Source: Qualis Health and Mountain-Pacific Quality Health.

MDS 3.0 Report

025028: Cordova Community Medical Center Long-Term Care, Cordova, AK

Report Filter:

- Analysis Period End Date: **24-Oct-2017**
- Random Sample: **None**
- Resident Group(s): **Swing Beds**
  LTC

Residents included: 10

Accidents

Accident Hazards - Wandering to a Dangerous Place (Most Recent FULL MDS) (QP298)

Activities of Daily Living

Incidence of Decline in ADLs (Previous & Most Recent (excl.Adm.) MDS) (QP290)

Bed Mobility

Transfer

Locomotion on Unit

Locomotion off Unit

Dressing

Eating

Toileting

Behavioral and Emotional Status

Increase in Physical Abuse (Admission-90 MDS) (QP043a)

Increase in Resistance to Care (Admission-90 MDS) (QP106a)

Increase in Resistance to Care (Previous-Most Recent MDS) (QP106b)

Dental Status and Services

Oral/Dental Problems (Most Recent FULL MDS) (QP217)

Broken Denture

No Natural Teeth

Abnormal mouth tissue

Obvious cavity

Inflamed, bleeding gums

Mouth, facial pain

Hearing and Vision

Lack of Corrective Action for Visual Problems (Most Recent MDS) (QP213)

Lack of Corrective Action for Auditory Problems (Most Recent MDS) (QP214)

Hydration

Prevalence of Dehydration (Most Recent MDS) (QP015)

Dehydration

Volume Depletion

Infections (non-UTI related)

Wound Infection (Most Recent MDS) (QP061)

Nutrition

Prevalence of Weight Loss (Most Recent MDS) (QP013)

Physical Restraints

Prevalence of a Daily Device (Most Recent MDS) (QP022)

Trunk Restraint (In Bed)

Limb Restraint (In Bed)

Trunk Restraint (In Chair)

Limb Restraint (In Chair)

Chair Prevents Rising

Pressure Ulcers

Prevalence of Stage 1-4 Pressure Ulcers (High Risk) (Most Recent MDS) (QP024_H)

Pressure Ulcer

Additional Active Diagnoses - 707/E86.9

Prevalence of Stage 1-4 Pressure Ulcers (Low Risk) (Most Recent MDS) (QP024_L)

Pressure Ulcer

Additional Active Diagnoses - 707/L89

Range of Motion

Incidence of Decline in Functional Range of Motion (Previous-Most Recent MDS) (QP018)

Range of Motion in Upper Extremities

Range of Motion in Lower Extremities

Tube Feeding

Prevalence of Tube Feeding (Most Recent MDS) (QP014)

Urinary Catheter, Incontinence and Infection

Prevalence of Indwelling Catheters (Most Recent MDS) (QP010)

Prevalence of Urinary Tract Infections (Most Recent MDS) (QP012)

Continence Decline Since Admission (Admission-90 MDS) (QP047)

Residents With Flagged Assessments

QCLI: Accident Hazards - Wandering to a Dangerous Place (Most Recent FULL MDS) (QP298)

Name	Identifier	Room Number	Assessment Date(s)
Wandering			
No residents were flagged for this care area.			

QCLI: Incidence of Decline in ADLs (Previous & Most Recent (excl.Adm.) MDS) (QP290)

Name	Identifier	Room Number	Assessment Date(s)
Bed Mobility			
No residents were flagged for this care area.			
Transfer			
No residents were flagged for this care area.			

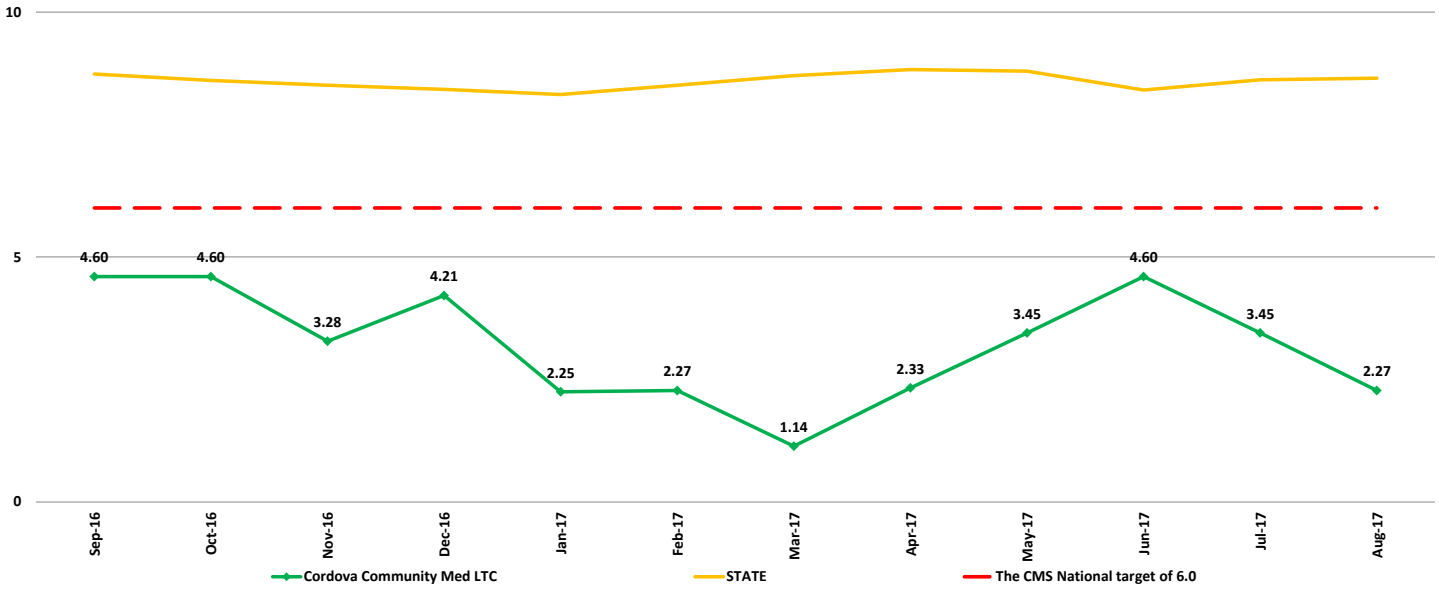
Reducing Healthcare-Acquired Conditions in Nursing Homes

Proxy Composite Score Report, Data through August 2017

Cordova Community Med LTC

Your Facility's Current Score **2.27**
Your State's Current Score **8.65**

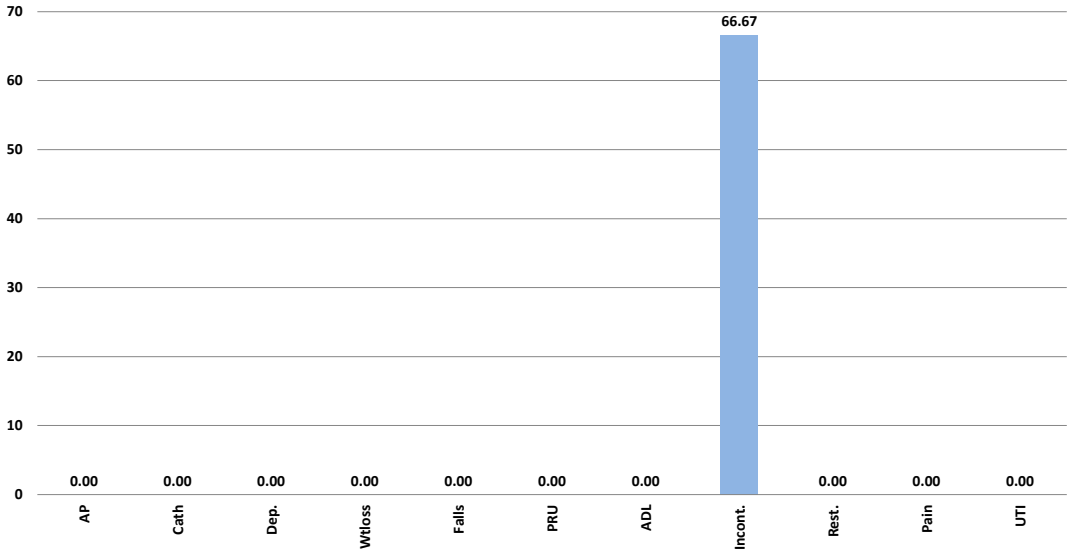
Proxy-Composite Score for your nursing center over time



Month	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	AVG
Numerator	4	4	2	4	2	2	1	2	3	4	3	2	2.8
Denominator	87	87	61	95	89	88	88	86	87	87	87	88	85.8
Composite Rate	4.60	4.60	3.28	4.21	2.25	2.27	1.14	2.33	3.45	4.60	3.45	2.27	3.20

Proportion of the proxy-composite score from each measure for the most current time frame.

Proportion of the Proxy-Composite score from each measure: The *Proxy-composite Score* is comprised of 11 National Quality Forum-Endorsed long-stay quality measures. Which one(s) are driving your score? Look for the measure(s) with the highest percentages. Lower is better.



AP	Cath	Dep.	Wtloss	Falls	PRU	ADL	Incont.	Rest.	Pain	UTI
0	0	0	0	0	0	0	2	0	0	0
9	8	9	10	10	9	6	3	10	4	10
0.00	0.00	0.00	0.00	0.00	0.00	0.00	66.67	0.00	0.00	0.00

Data is from the MDS 3.0 and is presented over time in rolling 6 month time spans with the 'month' reflecting the end of the time period. For example, the data for the month of July is reflective of the time period of February 1 through July 31. The data for the proportions graph shown to the right and for your facility's current ***Proxy-Composite score***, is the most recent 6 month time frame available at the time of the report.

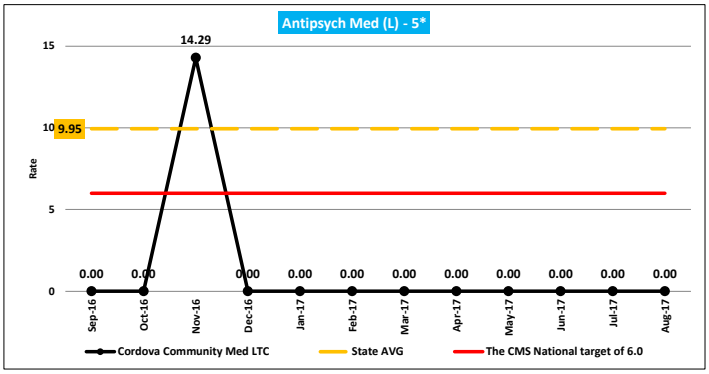
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

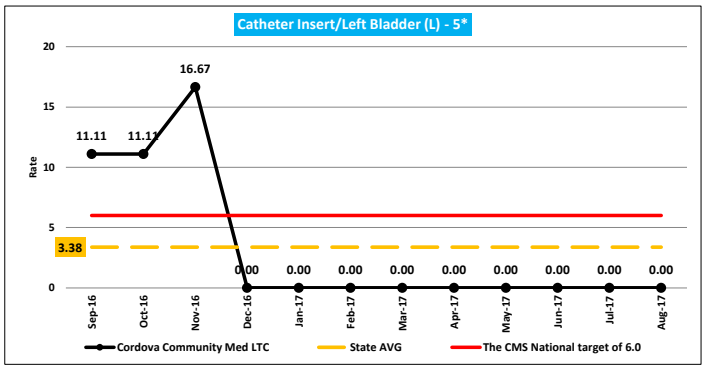
Developed by Mountain-Pacific Quality Health, the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Alaska, Hawaii and the U.S. Pacific Territories of Guam and American Samoa and the Commonwealth of the Northern Mariana Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy. 11SOW-MPQHF-AS-C2-17-206

Cordova Community Med LTC

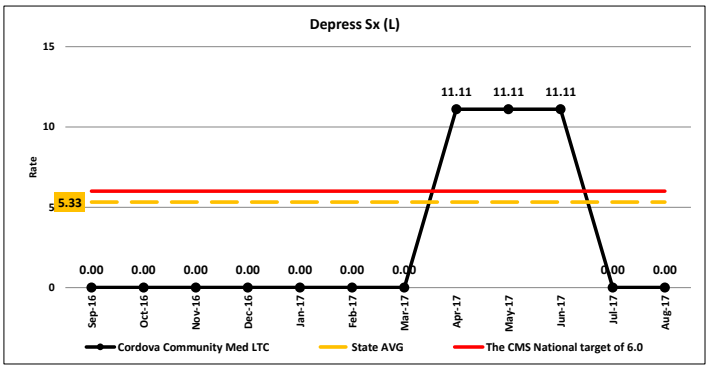
These graphs represent your facility's rates over time for each of the 11 long-stay quality measures that make up the *Proxy-Composite score* . Look for those measures with the higher scores to know where to focus your efforts - remember lower is better. Contact Mountain-Pacific Quality Health for any resources or assistance you might need to lower your scores.



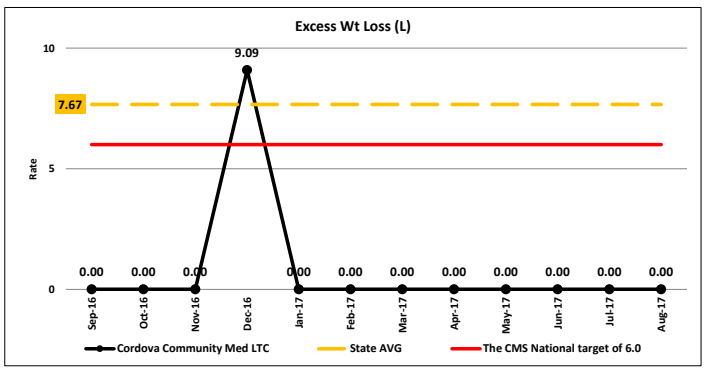
Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
0	0	1	0	0	0	0	0	0	0	0	0
9	9	7	10	9	9	9	9	9	9	9	9
0.00	0.00	14.29	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



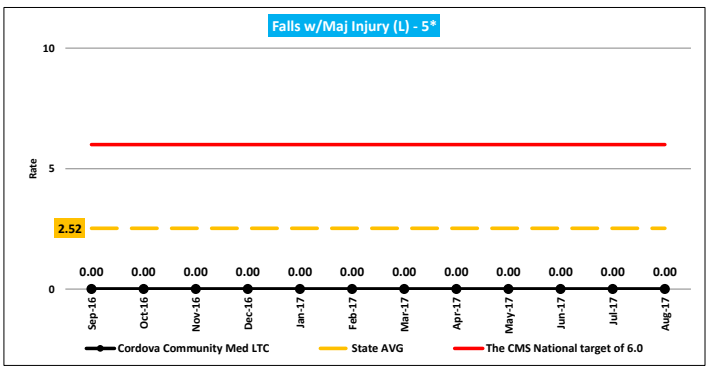
Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
1	1	1	0	0	0	0	0	0	0	0	0
9	9	6	9	8	8	8	8	8	8	8	8
11.11	11.11	16.67	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



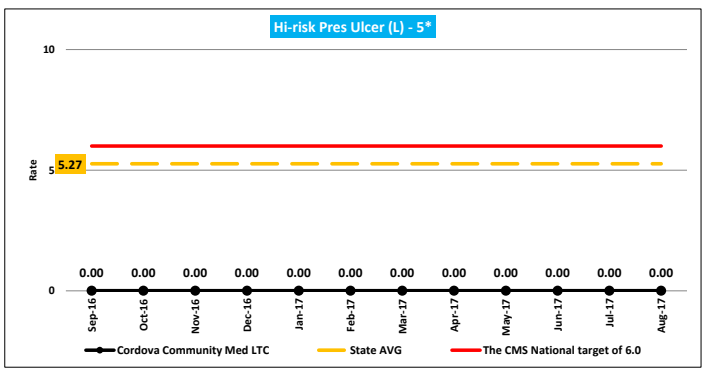
Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
0	0	0	0	0	0	0	1	1	1	0	0
8	8	6	9	9	9	9	9	9	9	9	9
0.00	0.00	0.00	0.00	0.00	0.00	0.00	11.11	11.11	11.11	0.00	0.00



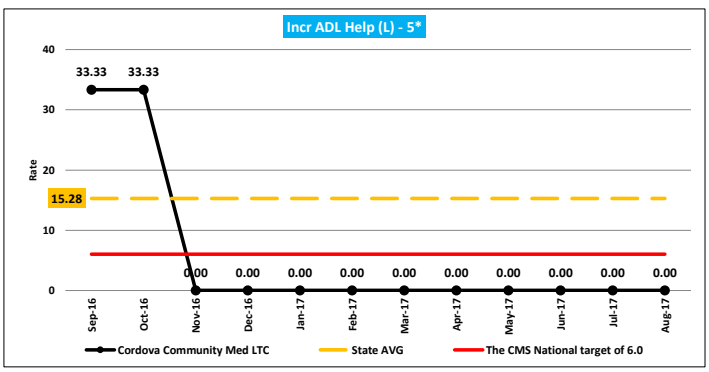
Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
0	0	0	1	0	0	0	0	0	0	0	0
10	10	7	11	10	10	10	10	10	10	10	10
0.00	0.00	0.00	9.09	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



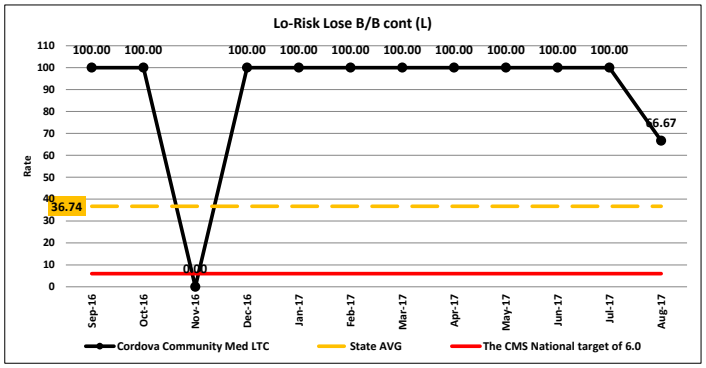
Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
0	0	0	0	0	0	0	0	0	0	0	0
10	10	8	11	10	10	10	10	10	10	10	10
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



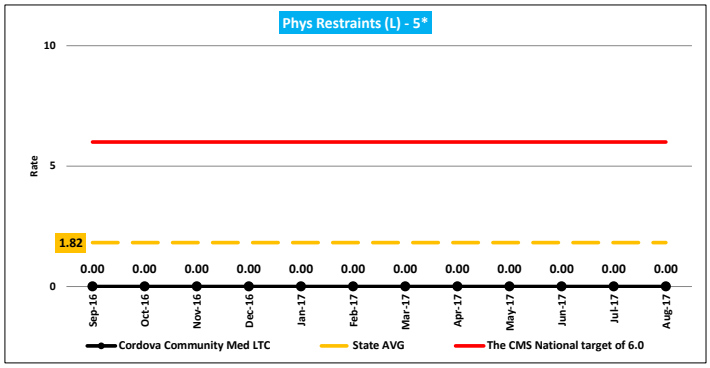
Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
0	0	0	0	0	0	0	0	0	0	0	0
9	9	7	10	9	9	9	9	9	9	9	9
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



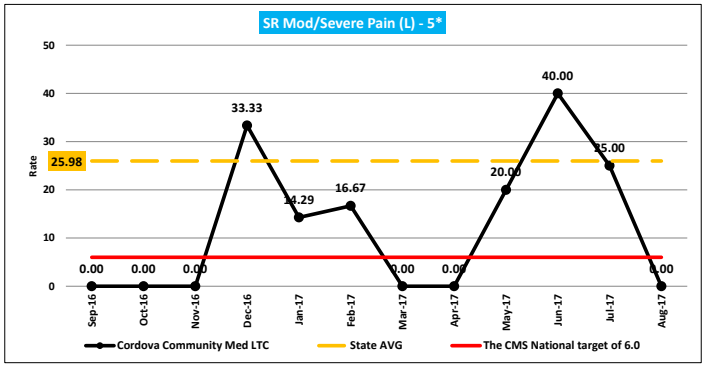
Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
2	2	0	0	0	0	0	0	0	0	0	0
6	6	3	6	6	6	6	6	6	6	6	6
33.33	33.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



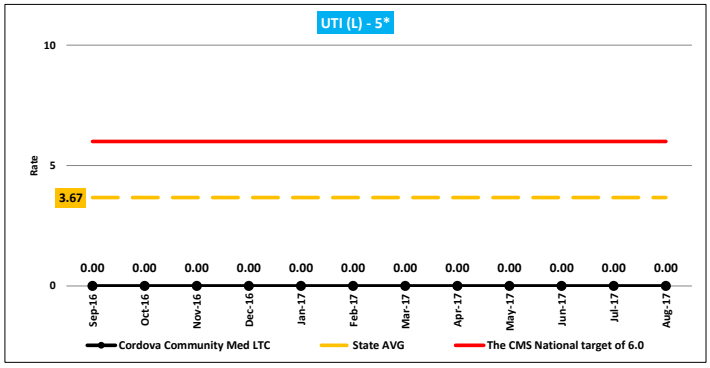
Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
1	1	0	1	1	1	1	1	1	1	2	2
1	1	0	1	1	1	1	1	1	1	2	3
100.00	100.00	#DIV/0!	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	66.67



Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
0	0	0	0	0	0	0	0	0	0	0	0
10	10	8	11	10	10	10	10	10	10	10	10
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00



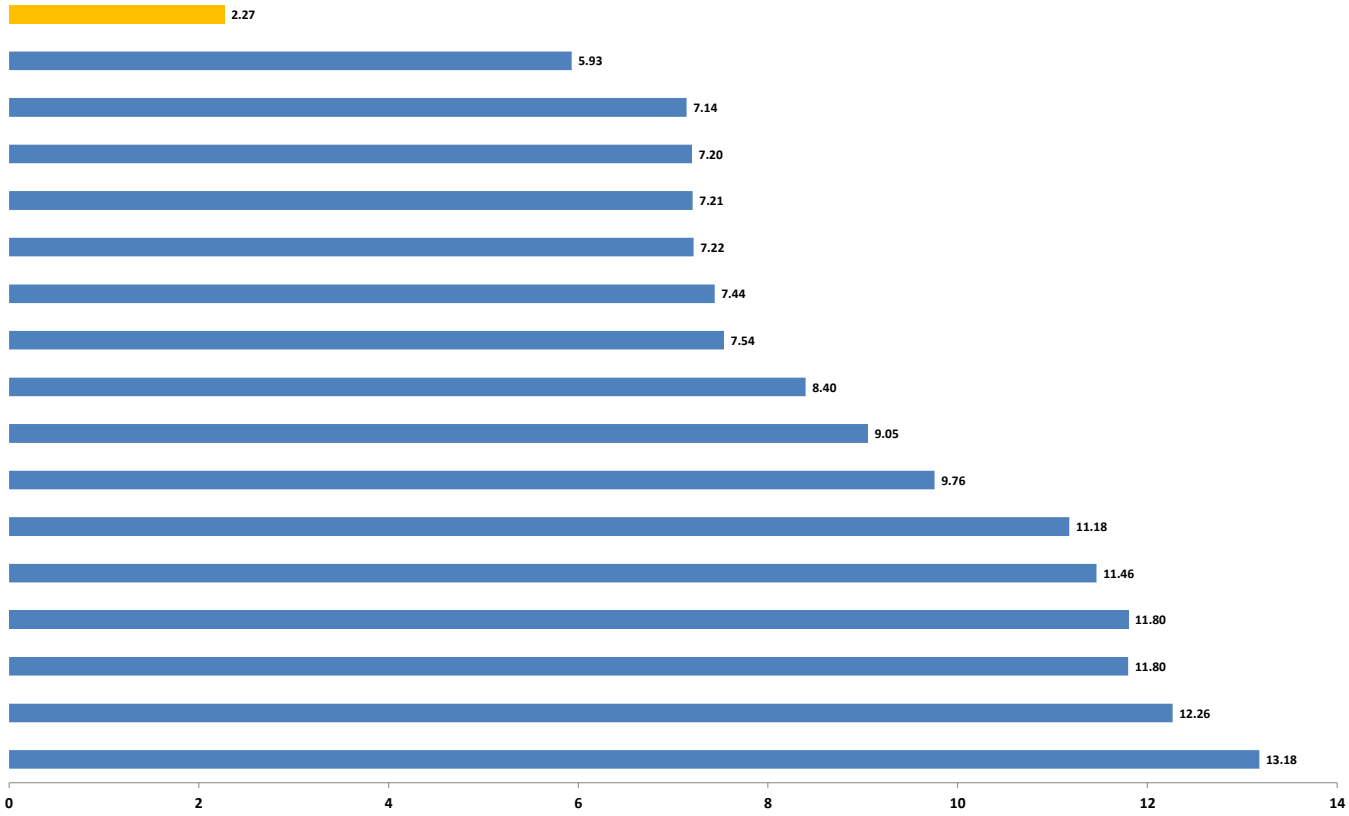
Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
0	0	0	2	1	1	0	0	1	2	1	0
5	5	2	6	7	6	6	4	5	5	4	4
0.00	0.00	0.00	33.33	14.29	16.67	0.00	0.00	20.00	40.00	25.00	0.00



Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
0	0	0	0	0	0	0	0	0	0	0	0
10	10	7	11	10	10	10	10	10	10	10	10
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

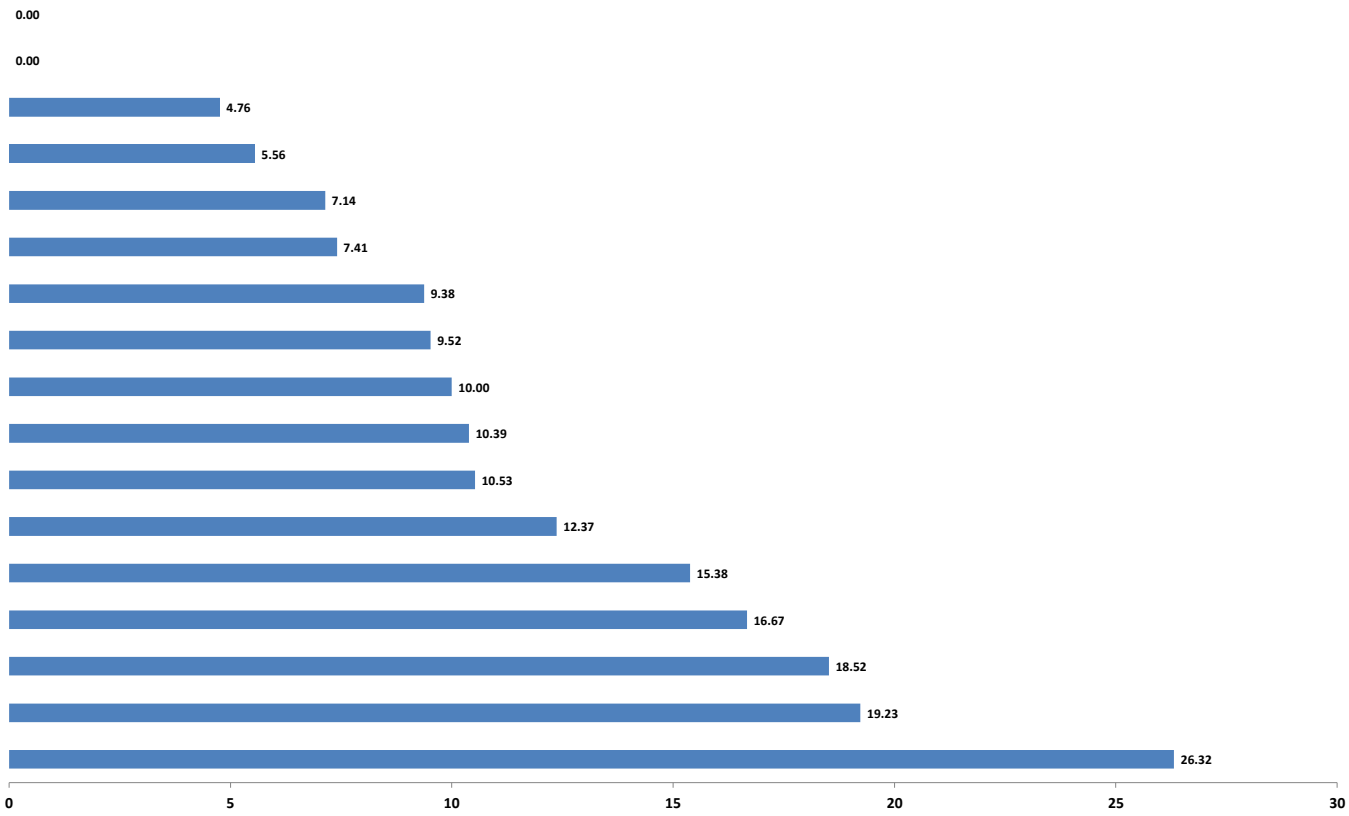
Cordova Community Med LTC

This ranking shows your facility's current *Proxy-Composite* score in relation to all of the nursing facilities in your state:



Cordova Community Med LTC

This ranking shows your facility's current *Anti-Psychotic Medication* score in relation to all of the nursing facilities in your state:



Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska

Basic Financial Statements and
Independent Auditors' Reports

December 31, 2016

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
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DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Cordova Community Health Services Board
Cordova Community Medical Center
A Component Unit of the City of Cordova, Alaska
Cordova, Alaska

In planning and performing our audit of the financial statements of Cordova Community Medical Center, a component unit of the City of Cordova (the Center) as of and for the year ended December 31, 2016, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to the financial audits contained in *Government Auditing Standards*, we considered the Center's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Center's internal control. Accordingly, we do not express an opinion on the effectiveness of the Center's internal control.

However, during our audit, we became aware of several matters that are opportunities for strengthening internal controls and operating efficiency. This letter does not affect our report dated September 22, 2017, on the financial statements of the Center. We will review the status of the comments during our next audit engagement. Our comments are summarized as follows:

Internal Controls – Internal controls are deterrents to fraud. The following internal control structure comments should be considered along with available resources, the cost, benefits of the particular control, and other mitigating controls. The inability to optimally segregate incompatible duties increases the importance of management's and the Health Services Board's oversight in the internal control process. Although nothing has come to our attention that would lead us to believe fraud has occurred, we recommend the following procedures to help minimize the risk of errors and fraud in your organization:

- Department statistics and patient days are not reconciled to revenue reports. Reconciling department statistics and patient days to revenue reports is a key control to ensure that revenue is properly stated. By not reconciling, a misstatement, whether to due to error or fraud, could go undetected. It is also a key control of the charge capture process. By not reconciling the Center could miss recognizing charges. We recommend reconciling department statistics and patient days to revenue reports as part of the month close process to ensure revenue is properly presented to the Health Services Board.
- Administrative adjustments to patient accounts are not reviewed. Reviewing administrative adjustments to patient accounts is a key control to ensure the adjustments made to the patient's account is properly authorized. By not reviewing these adjustments, there is a risk that improper adjustments are made. We recommend reviewing administrative adjustments to patient accounts on a monthly basis to ensure policies and procedures surrounding administrative adjustments are properly followed.

Patient Accounts Receivable –

- The allowance for contractual adjustments was not updated at year-end. Not updating the allowance for contractual adjustments at year-end increases the risk that net patient accounts receivable is materially misstated. Also, there was not an accounts receivable allowance related to the long-term care unit (LTCU) accounts receivable. We recommend updating the contractual adjustments allowance and developing an allowance for the LTCU accounts receivable as part of the month close process to ensure financial statements are fairly presented.

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Grant Revenue –

The Center receives a significant amount of grant revenue from the State of Alaska to support the behavioral health and dietary programs. Under Alaska state law, if the Center were to receive more than $500,000 in aggregate state grants the Center would be subject to a state single audit. A state single audit is a compliance audit with the findings presented as part of the financial statements. In 2016, the Center received $479,312 in state grants. Grant revenue was not tracked efficiently and therefore management was not aware of how close the Center came to being subject to a state single audit. We recommend the Center designate an individual to track all grants from application to receipt to ensure the Center is compliant with state law and grant agreements.

We wish to thank the Chief Financial Officer and the department managers for their support and assistance during our audit.

This communication is intended solely for the information and use of management, the Cordova Community Health Services Board, and others within the Center and is not intended to be, and should not be, used by anyone other than these specified parties.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
September 22, 2017

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

INDEPENDENT AUDITORS' REPORT

Cordova Community Health Services Board
Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Cordova, Alaska

Report on the Financial Statements

We have audited the accompanying financial statements of Cordova Community Medical Center, a component unit of the City of Cordova, Alaska (the Center) as of and for the year ended December 31, 2016, and the related notes to the financial statements, which collectively comprise the Center's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Center as of December 31, 2016, and the changes in financial position and cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Accounting principles generally accepted in the United States of America require that the schedule of proportionate share of net pension liability and schedule of the Center's contributions to the State of Alaska Public Employees' Retirement System (PERS) – Defined Benefit Pension Plan (DB Plan) on pages 26 and 27 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated September 22, 2017, on our consideration of the Center's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Center's internal control over financial reporting and compliance.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
September 22, 2017

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Statement of Net Position
December 31, 2016

ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		**2016**
Current assets		
Cash and cash equivalents	**$**	**96,239**
Receivables:		
Patient accounts, net of estimated uncollectibles of $357,112		**997,092**
Other		**83,392**
Third-party payor settlements		**16,081**
Inventories		**138,786**
Prepaid expenses		**8,883**
Total current assets		**1,340,473**
Noncurrent assets		
Capital assets, net		**3,754,397**
Total assets		**5,094,870**
Deferred outflows of resources, pension plan		**1,218,788**
Total assets and deferred outflows of resources	**$**	**6,313,658**

See accompanying notes to basic financial statements.

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Statement of Net Position (Continued)
December 31, 2016

LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		**2016**
Current liabilities		
Accounts payable	**$**	**556,816**
Accrued payroll and related liabilities		**298,788**
Accrued vacation		**222,126**
Electronic health records incentive payable		**99,058**
Current maturities of capital lease obligations		**32,287**
Notes payable, current		**3,093,127**
Total current liabilities		**4,302,202**
Noncurrent liabilities		
Capital lease obligations, less current maturities		**41,850**
Net pension liability		**6,907,864**
Total noncurrent liabilities		**6,949,714**
Total liabilities		**11,251,916**
Deferred inflows of resources, pension plan		**77,000**
Total liabilities and deferred inflows of resources		**11,328,916**
Net position (deficit)		
Net investment in capital assets		**3,680,260**
Unrestricted		**(8,708,553)**
Restricted		**13,035**
Total net position (deficit)		**(5,015,258)**
Total liabilities, deferred inflows of resources, and net position (deficit)	**$**	**6,313,658**

See accompanying notes to basic financial statements.

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Statement of Revenues, Expenses, and Changes in Net Position
Year Ended December 31, 2016

		2016
Operating revenues		
Net patient service revenue, net of provision for bad debts of $387,759	$	**7,287,538**
Electronic health records incentive (payback)		**(99,058)**
Grants		**479,312**
PERS on-behalf contribution		**131,217**
Universal service fund assistance		**962,530**
Other		**61,358**
Total operating revenues		**8,822,897**
Operating expenses		
Salaries and wages		**3,581,372**
Employee benefits		**3,525,387**
Supplies		**476,394**
Professional fees and purchased services		**2,391,901**
Equipment leases and rentals		**184,596**
Repairs and maintenance		**97,010**
Depreciation and amortization		**550,521**
Utilities		**1,241,637**
Insurance		**192,873**
Other expenses		**307,516**
Total operating expenses		**12,549,207**
Operating loss		**(3,726,310)**
Nonoperating revenues (expenses)		
Interest income		**17**
Interest expense		**(5,657)**
Total nonoperating expenses, net		**(5,640)**
Transfers in		
Utility costs waived by the City of Cordova		**28,135**
Capital equipment paid for by the City of Cordova		**223,589**
Total transfers in		**251,724**
Gain on debt forgiveness		**77,764**
Change in net position		**(3,402,462)**
Net position (deficit), beginning of year (restated)		**(1,612,796)**
Net position (deficit), end of year	**$**	**(5,015,258)**

See accompanying notes to basic financial statements.

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Statement of Cash Flows
Year Ended December 31, 2016

		2016
Increase (Decrease) in Cash and Cash Equivalents		
Cash flows from operating activities		
Receipts from and on behalf of patients	$	**7,465,895**
Grants		**479,312**
Other receipts		**305,178**
Electronic health records incentive		**571,921**
Payments to suppliers		**(4,137,360)**
Payments to or on behalf of employees		**(5,443,898)**
Net cash used in operating activities		**(758,952)**
Cash flows from noncapital financing activities		
Proceeds from notes payable		**910,667**
Cash flows from capital and related financing activities		
Purchase of capital assets		**(27,039)**
Principal payments on capital lease obligations		**(24,563)**
Interest payments on capital lease obligations		**(5,657)**
Net cash used in capital and related financing activities		**(57,259)**
Cash flows from investing activities		
Interest income		**17**
Net increase in cash and cash equivalents		**94,473**
Cash and cash equivalents, beginning of year		**1,766**
Cash and cash equivalents, end of year	**$**	**96,239**

See accompanying notes to basic financial statements.

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Statement of Cash Flows (Continued)
Year Ended December 31, 2016

		2016
Reconciliation of Operating Loss to Net Cash Used in Operating Activities		
Operating loss	**$**	**(3,726,310)**
Adjustments to reconcile operating loss to net cash used in operating activities		
Depreciation and amortization		**550,521**
Utility costs waived by the City of Cordova		**28,135**
Gain on forgiveness of debt		**77,764**
Provision for bad debts		**387,759**
(Increase) decrease in assets:		
Patient accounts receivable		**(429,721)**
Third-party payor settlements		**220,319**
Other receivables		**112,603**
Electronic health records incentive receivable		**571,921**
Inventories		**(3,412)**
Prepaid expenses		**13,759**
Deferred outflows of resources, pension plan		**(288,809)**
Increase (decrease) in liabilities:		
Accounts payable		**(324,209)**
Accrued payroll and related liabilities		**41,725**
Accrued vacation		**28,969**
Electronic health records incentive payable		**99,058**
Net pension liability		**1,892,764**
Deferred inflows of resources, pension plan		**(11,788)**
Net cash used in operating activities	**$**	**(758,952)**

See accompanying notes to basic financial statements.

1. Reporting Entity and Summary of Significant Accounting Policies:

a. Reporting Entity

Cordova Community Medical Center (the Center) operates a 23-bed critical access hospital. The Center provides inpatient and outpatient care, as well as long-term swing bed nursing facility services and the related ancillary procedures (laboratory, imaging, therapy, etc.) associated with those services. The Center is owned by the City of Cordova, Alaska (the City of Cordova) and is operated by the City Council sitting as the Community Health Services Board (the Board). For this reason, the Center is considered to be a component unit of the City of Cordova and is included in its annual financial statements. Subsequent to December 31, 2016, the community elected five community members to serve as the board of directors for the Center.

b. Summary of Significant Accounting Policies

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions which affect the reported amounts of assets, liabilities, deferred inflows of resources, deferred outflows of resources, and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise fund accounting – The Center's accounting policies conform to accounting principles generally accepted in the United States of America as applicable to proprietary funds of governments. The Center uses enterprise fund accounting. Revenue and expenses are recognized on the accrual basis using the economic resources measurement focus.

Cash and cash equivalents – Cash and cash equivalents include investments in highly liquid debt instruments with an original maturity of three months or less.

Inventories – Inventories are stated at cost using the first-in, first-out method. Inventories consist of pharmaceutical, medical-surgical, and other supplies used in the operation of the Center.

Prepaid expenses – Prepaid expenses are expenses paid during the fiscal year relating to expenses incurred in future periods. Prepaid expenses are amortized over the expected benefit period of the related expense.

Pensions – For purposes of measuring the net pension liability and pension expense, information about the fiduciary net position of the Alaska Public Employees' Retirement System (PERS) and additions to/deductions from PERS's fiduciary net position have been determined on the same basis as they are reported by PERS, and assuming the State's pension support under AS39.35.280 is a "Special Funding Situation" as defined by Governmental Accounting Standards Board (GASB) 68. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

1. Reporting Entity and Summary of Significant Accounting Policies (continued):

b. Summary of Significant Accounting Policies (continued)

Compensated absences – The Center operates a paid time off (PTO) employee leave program to provide time off for rest, personal needs, and illness. Only regular full-time and part-time employees are eligible for PTO. PTO benefits accrue time that may be used for vacation or personal purposes up to 320 hours. Paid days off are accrued when incurred and reported as a liability.

Net position – Net position of the Center is classified into three components. *Net investment in capital assets* consists of capital assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted net position* is composed of assets that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the Center. *Unrestricted net position* is composed of remaining net position that does not meet the definition of *net investment in capital assets* or *restricted.*

Restricted resources – When the Center has both restricted and unrestricted resources available to finance a particular program, it is the Center's policy to use restricted resources before unrestricted resources.

Operating revenues and expenses – The Center's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions, including grants for specific operating activities, associated with providing healthcare services — the Center's principal activity. Nonexchange revenues, including taxes and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide healthcare services, other than financing costs.

Grants and contributions – From time to time, the Center receives grants from the state of Alaska and others, as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Grants that are unrestricted, or that are restricted to a specific operating purpose, are reported as operating revenues. Grants that are used to subsidize operating deficits are reported as nonoperating revenues. Contributions, except for capital contributions, are reported as nonoperating revenues. Amounts restricted to capital acquisitions are reported after nonoperating revenues and expenses.

Transfers – Transfers between the primary government and component unit are required when revenue is generated in one fund and expenditures are paid from another fund.

Subsequent events – Subsequent events have been reviewed through September 22, 2017, the date on which the financial statements were available to be issued.

2. Restatement:

The Center has restated beginning net position to correct misstated grant revenue, payroll and other liabilities, grants receivable, electronic health records incentive revenue, and construction in progress. As a result, the Center's beginning net position balance has been decreased by $309,018 to reflect this cumulative change. The impact on beginning net position is as follows:

Net position (deficit) at December 31, 2015, as previously reported	**$**	**(1,303,778)**
Correction of grant receivables, other liabilities, and grant revenue		**133,740**
Correction of electronic health records incentive revenue		**571,921**
Correction of construction in progress		**(1,060,095)**
Correction of payroll liability		**45,416**
Net position (deficit) at December 31, 2015, as restated	**$**	**(1,612,796)**

3. Bank Deposits:

Custodial credit risk is the risk that, in the event of a depository institution failure, the Center's deposits may not be returned to it. The Center does not have a deposit policy for custodial credit risk.

The Center is authorized to invest in U.S. Treasury obligations, U.S. government agency securities and instrumentalities of government-sponsored corporations, State of Alaska obligations, certificates of deposit with commercial banks, repurchase agreements, and investments through the Alaska Municipal League Investment Pool.

4. Patient Accounts Receivable:

Patient accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectability of patient accounts receivable, the Center analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the Center analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which include both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Center records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts.

4. Patient Accounts Receivable (continued):

The Center's allowance for uncollectible accounts for self-pay patients has not changed significantly from the prior years. The Center does not maintain a material allowance for uncollectible accounts from third-party payors, nor did it have significant writeoffs from third-party payors.

Patient accounts receivable reported as a current asset by the Center consisted of these amounts:

		2016
Receivables from patients and their insurance carriers	$	**756,518**
Receivable from Medicare		**238,710**
Receivable from Medicaid		**358,976**
Total patient accounts receivable		**1,354,204**
Less allowance for uncollectible accounts		**357,112**
Patient accounts receivable, net	$	**997,092**

5. Capital Assets:

Capital assets are assets with an individual cost of more than $5,000 and an estimated useful life in excess of two years. Such assets are recorded at historical cost if purchased or constructed. Donated capital assets are stated at their estimated fair value at the date of donation. The costs of normal maintenance and repairs that do not add to the value of the asset or materially extend asset lives are charged to operations as incurred. Gains or losses on sales and retirements are included in nonoperating revenues and expenses. Depreciation is provided over the estimated useful lives of assets as determined from the American Hospital Association's published tables and management's estimate by the straight-line method using these asset lives:

Buildings	5 to 40 years
Fixed equipment	5 to 20 years
Major movable equipment	4 to 20 years

5. Capital Assets (continued):

Capital asset additions, retirements, transfers, and balances were as follows:

	December 31, 2015	Additions	Retirements	Transfers	December 31, 2016
Capital assets not being depreciated					
Land	$ 122,010	$ -	$ -	$ -	**$ 122,010**
Construction in progress	-	17,228	-	-	**17,228**
Total capital assets not being depreciated	122,010	17,228	-	-	**139,238**
Capital assets being depreciated					
Buildings	7,006,762	-	-	-	**7,006,762**
Fixed equipment	3,613,162	-	-	-	**3,613,162**
Major movable equipment	2,913,254	233,400	-	-	**3,146,654**
Total capital assets being depreciated	13,533,178	233,400	-	-	**13,766,578**
Less accumulated depreciation for					
Buildings	4,556,860	182,178	-	-	**4,739,038**
Fixed equipment	3,525,718	18,722	-	-	**3,544,440**
Major movable equipment	1,518,320	349,621	-	-	**1,867,941**
Total accumulated depreciation	9,600,898	550,521	-	-	**10,151,419**
Total capital assets being depreciated, net	3,932,280	(317,121)	-	-	**3,615,159**
Capital assets, net	$ 4,054,290	$ (299,893)	$ -	$ -	**$ 3,754,397**

6. Capital Lease Obligations:

A schedule of changes in the Center's capital lease obligations follows:

	Balance December 31, 2015	Additions	Reductions	Balance December 31, 2016	Amount Due Within One Year
Capital lease obligations	$ 98,700	$ -	$ (24,563)	$ 74,137	**$** 32,287

Capital lease obligation payable to Tekmate, in the original amount of $98,700, due in monthly payments of $3,174, including interest at 9.75% through February 2019. The capital lease obligation is collateralized by a backup storage system. The lease obligation is reflected in the Center's assets and liabilities. The equipment acquired under a capital lease had a capitalized cost of $98,700, and accumulated amortization of $21,385, for the year ended December 31, 2016.

Scheduled principal and interest repayments on the capital lease obligations are as follows:

Years Ending December 31,	Principal	Interest	Total
2017	$ 32,287	$ 5,804	$ 38,091
2018	35,580	2,512	38,092
2019	6,270	76	6,346
	$ 74,137	**$ 8,392**	**$ 82,529**

7. Notes Payable:

The Center has notes payable due to the City of Cordova in the amount of $3,093,127 at December 31, 2016. The notes payable had no interest due and no payback terms as of December 31, 2016. The City of Cordova classifies it as notes receivable. The notes payable are deemed on-demand and are classified as current liabilities on the statement of net position.

8. Net Patient Service Revenue:

The Center recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients who do not qualify for charity care, the Center recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Center's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Center records a significant provision for bad debts related to uninsured patients in the period the services are provided. The Center's provisions for bad debts and writeoffs have increased from the prior year due to an increase in self-pay patients during fiscal year 2016. Patient service revenue, net of contractual adjustments and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

		2016
Patient service revenue (net of contractual adjustments and discounts):		
Medicare	$	**1,985,890**
Medicaid		**3,614,460**
Other third-party payors		**1,791,064**
Patients		**420,393**
		7,811,807
Less:		
Charity care		**136,510**
Provision for bad debts		**387,759**
Net patient service revenue	$	**7,287,538**

The Center has agreements with third-party payors that provide for payments to the Center at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

- *Medicare* – The Center has been designated a critical access hospital. The Center is paid on a cost reimbursement method for substantially all services provided to Medicare beneficiaries. The Center is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Center and audits thereof by the Medicare administrative contractor. The Center is reimbursed for skilled nursing facility services under prospective payment systems.
- *Medicaid* – Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed based upon a prospective reimbursement methodology. The Center is reimbursed at a prospective rate based on its cost from four years prior, plus a four-year inflation add-on rate.

8. Net Patient Service Revenue (continued):

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient service revenue increased by approximately $180,000 for the year ended December 31, 2016, due to differences between original estimates and final settlements or revised estimates.

The Center provides charity care to patients who are financially unable to pay for the healthcare services they receive. The Center's policy is not to pursue collection of amounts determined to qualify as charity care. Accordingly, the Center does not report these amounts in net operating revenues or in the allowance for uncollectible accounts. The Center determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including salaries and wages, benefits, supplies, and other operating expenses, based on data from its costing system. The costs of caring for charity care patients for the year ended December 31, 2016, were approximately $183,000. The Center did not receive any gifts or grants to subsidize charity services during 2016.

9. Rural Health Care Program:

The Center participates in the Rural Heath Care Program (RHC) of the Universal Service Fund (USF), which is administered by the Universal Service Administrative Company. RHC is a support program authorized by Congress and designed by the Federal Communications Commission (FCC) to provide reduced rates to rural health care providers for telecommunications services and internet access charges related to the use of telemedicine and telehealth. RHC is intended to ensure that rural health care providers pay no more for telecommunications in the provision of health care services than their urban counterparts.

Payments under RHC are made directly by USF to the Center's telecommunications provider upon submission by the Center of the required FCC forms. The Center's contribution benefit under the program, which meets the definition of contributed services under generally accepted accounting principles was $962,530 for the year ended December 31, 2016, and is included in operating revenues in the accompanying statement of revenues, expenses, and changes in net position. In the event that the Center does not file all required FCC forms and payment in not made by USF, the telecommunications provider may seek payment from the Center for amounts unpaid.

10. Contingencies:

Risk management – The Center is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries; and natural disasters. The Center manages the risk of liability claims through commercial insurance coverage for all risks of loss. Settled claims resulting from these risks have not exceeded commercial insurance coverage in any of the past three fiscal periods.

Medical malpractice claims – The Center obtains medical malpractice insurance through NORCAL Mutual Insurance Company. NORCAL offers the Center a professional and general liability policy on a "claims made" basis with primary limits of $2,000,000 per claim and an annual aggregate limit of $4,000,000. The policy has a $-0- deductible per claim. The renewal date of the policy is October 15, 2017.

10. Contingencies (continued):

Medical malpractice claims (continued) – No liability has been accrued for future coverage for acts occurring in this or prior years. Also, it is possible that claims may exceed coverage obtained in any given year.

Industry regulations – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of various statutes and regulations by healthcare providers. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. Management believes that the Center is in compliance with fraud and abuse statutes as well as other applicable government laws and regulations. If the Center is found in violation of these laws, the Center could be subject to substantial monetary fines, civil and criminal penalties, and exclusion from participation in the Medicare and Medicaid programs.

11. Defined Benefit Pension Plan:

The Center reports a liability, deferred outflows of resources, deferred inflows of resources, and expense as a result of its requirement to contribute to the State of Alaska Public Employees' Retirement System (PERS).

Plan description – The Center contributes to the PERS, which is a cost-sharing multiple-employer defined benefit pension plan (DB Plan), which includes defined benefit health plan and occupational death and disability plan (OPEB). PERS is governed by the Alaska Retirement Management Board, which consists of nine trustees as follows: two members, consisting of the commissioner of administration and the commissioner of revenue; two trustees who are members of the general public; one trustee who is employed as a finance officer for a political subdivision participating in either the PERS or Teachers' Retirement System (TRS); two trustees who are members of PERS; and two trustees who are members of TRS. PERS issues a publicly available financial report that includes financial statements and the required supplementary information. That report may be obtained at: http://doa.alaska.gov/drb/pers/employee/resources/index.html.

Benefit and contribution provisions are established by state law and may be amended only by the State Legislature. With the passage of Senate Bill (SB) 141, the DB Plan is closed to all new members, effective July 1, 2006.

The DB Plan's membership consisted of the following at June 30, 2016:

	2016
Inactive plan members or beneficiaries currently receiving benefits	33,263
Inactive plan members entitled to but not yet receiving benefits	5,948
Active plan members	16,237
Total DB Plan membership	55,448

11. Defined Benefit Pension Plan (continued):

Benefits provided – PERS provides retirement, health insurance premium supplement, long-term disability, occupational death and disability, and survivor benefits. Retirement benefits are calculated on the basis of age, average monthly compensation and service credit as follows:

	"Tier 1"	"Tier 2"	"Tier 3"
Hire Date	1/1/1961 - 6/30/1986	Entered after 6/30/1986	Entered after 6/30/1996
Employee contribution rate	6.75%	6.75%	6.75%
Employer contribution rate	22.00%	22.00%	22.00%
Vesting	Five Years	Five Years	Pension Plan - Five Years Medical Plan - Ten Years
Qualifications for retirement after vesting	55, or early retirement at 50, or any age with 30 or more service years	60, or early retirement at 55, or any age with 30 or more service years	60, or early retirement at 55, or any age with 30 or more service years
Pension benefit:			
Basis	Average of the high three consecutive years' salary	Average of the high three consecutive years' salary	Average of the high five consecutive years' salary
Amount per year of service	2% to 2.5%, depending on hire date and length of service	2% to 2.5%, depending on hire date and length of service	2% to 2.5%, depending on hire date and length of service
Death benefit:			
Occupational causes	40% of member's salary	40% of member's salary	40% of member's salary
Non-occupational causes	Spouse receives 50% of member's benefit, or lump-sum to other beneficiaries	Spouse receives 50% of member's benefit, or lump-sum to other beneficiaries	Spouse receives 50% of member's benefit, or lump-sum to other beneficiaries
Disability benefit:			
Occupational causes	40% of member's salary	40% of member's salary	40% of member's salary
Non-occupational causes	Based on member's service and salary at the time of disability	Based on member's service and salary at the time of disability	Based on member's service and salary at the time of disability
OPEB benefits	No premium cost	Under 60 - full monthly premium, over 60 - no premium cost	Full monthly premium

11. Defined Benefit Pension Plan (continued):

Member and employer contributions – Contribution requirements of the active plan members and the participating employers are actuarially determined and approved by the Board as an amount that, when combined, is expected to finance the costs of benefits earned by plan members during the year, with an additional amount to finance any unfunded accrued liability. The DB Plan members' contribution rates are 7.5 percent for peace officers and firefighters, 9.76 percent for some school district employees, and 6.75 percent for general DB Plan members, as required by statute. Employer effective contribution rates are 22.00 percent of annual payroll. Alaska Statute 39.35.280 provides that the State, as a nonemployer contributing entity, contributes each July 1, or as soon after July 1 as possible for the ensuing fiscal year, an amount that, when combined with the total employer contributions, is sufficient to pay the System's past service liability at the actuarially determined contribution rate adopted by the Board for that fiscal year.

Additionally, there is a Defined Benefit Unfunded Liability (DBUL) amount levied against the Defined Contribution Retirement Pension Plan payroll. The DBUL amount is computed as the difference between:

1. The amount calculated for the statutory employer contribution rate of 22.00 percent on eligible salary less
2. The total of the employer contributions for:
   a) The defined contribution employer matching amount
   b) Major medical
   c) Occupational death and disability
   d) Health reimbursement arrangement

The difference is deposited based on an actuarial allocation into the DB Plan's pension and healthcare funds.

Refunds – DB Plan member contributions may be voluntarily or, under certain circumstances, involuntarily refunded to the member or a garnishing agency 60 days after termination of employment. Voluntary refund rights are forfeited on July 1 following the member's 75th birthday, or within 50 years of the member's last termination date. Members who have had contributions refunded forfeit all retirement benefits, including postemployment healthcare benefits. Members are allowed to reinstate refunded service due to involuntary refunds by repaying the total involuntarily refunded balance and accrued interest. Members are allowed to reinstate voluntarily refunded service by repaying the voluntarily refunded balance and accrued interest, as long as they reestablished an employee relationship with a participating DB Plan employer before July 1, 2010. Members who did not reestablish an employee relationship with a participating DB Plan employer by June 30, 2010, are not eligible to reinstate voluntarily refunded service and have forfeited any claim to DB Plan membership rights. Balances previously refunded to members accrue interest at the rate of 7.0 percent per annum, compounded semiannually.

11. Defined Benefit Pension Plan (continued):

Pension liabilities, pension expense, and deferred outflows of resources and deferred inflows of resources related to pensions – The Center reports a liability for its proportionate share of the net pension liability that reflects a reduction for State pension support provided to the Center. The amounts recognized by the Center as its proportionate share of the net pension liability, the related State support, and the total proportion of the net pension liability that was associated with the Center were as follows:

		2016
Center's proportionate share of the net pension liability	**$**	**6,907,864**
State's proportionate share of the net pension liability associated with the Center		**871,786**
Total net pension liability	**$**	**7,779,650**

The net pension liability was measured as of June 30, 2016, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The Center's proportion of the net pension liability was based on the projection of the Center's long-term share of contributions to the pension plan relative to the projected contributions of all participating PERS employers. At June 30, 2016, the Center's proportion was 0.12358%.

For the year ended December 31, 2016, the Center recognized pension expense of $1,592,167, including revenue of $131,217, for support provided by the State. In addition, at December 31, 2016, the Center reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Difference between expected and actual experience	$ 635	$ 77,000
Changes in assumptions	31,861	-
Difference between projected and actual investment earnings	679,010	-
Changes in proportion and differences between Center contributions	440,053	-
Center contributions subsequent to measurement date	67,229	-
Total	**$ 1,218,788**	**$ 77,000**

The $67,229 reported as deferred outflows of resources related to pensions resulting from Center's contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ending December 31, 2017.

11. Defined Benefit Pension Plan (continued):

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

Years Ending December 31:		
2017	$	477,231
2018		140,503
2019		277,581
2020		179,244
Total	**$**	**1,074,559**

Actuarial assumptions – The total pension liability was determined by an actuarial valuation as of June 30, 2015, using the following actuarial assumptions, applied to all periods included in the measurement and rolled forward to the measurement date of June 30, 2016:

Inflation	3.12%
Salary increases	Graded by service, from 9.66% to 4.92% for Peace Officers/Firefighters Graded by age and service, from 8.55% to 4.34% for All Others
Investment rate of return	8.00%, net of pension plan investment expenses. This is based on an average inflation rate of 3.12% and a real rate of return of 4.88%.

11. Defined Benefit Pension Plan (continued):

Pre-termination mortality rates were based upon the 2010-2013 actual mortality experience, 60 percent of male and 65 percent of female post-termination rates. Deaths are assumed to be occupational 70 percent of the time for peace officers/firefighters, 50 percent of the time for others. Post-termination mortality rates were based on 96 percent of all rates of the RP-2000 table, 2000 Base Year projected to 2018 with Projection Scale BB.

The actuarial assumptions used in the June 30, 2015, actuarial valuation were based on the results of an actuarial experience study for the period July 1, 2009 to June 30, 2013, resulting in changes in actuarial assumptions effective for the June 30, 2014, actuarial valuation adopted by the Board to better reflect expected future experience. The assumptions used in the June 30, 2015, actuarial valuation are the same as those used in the June 30, 2014, actuarial valuation.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These real rates of return are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. Best estimates of arithmetic real rates of return for each major asset class included in the pension plan's target asset allocation as of June 30, 2015, are summarized in the following table:

Asset class	Long-Term Expected Real Rate of Return
Domestic equity	5.35%
Global equity (non-U.S.)	5.55%
Private equity	6.25%
Fixed income composite	0.80%
Real estate	3.65%
Alternative equity	4.70%
Cash equivalents	-

Discount rate – The discount rate used to measure the total pension liability was 8.00 percent. The projection of cash flows used to determine the discount rate assumed that employer and nonemployer State contributions would continue to follow the current funding policy, which meets State statutes. Based on these assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

11. Defined Benefit Pension Plan (continued):

Sensitivity of the Center's proportionate share of the net pension liability to changes in the discount rate – The following presents the net pension liability of the Center calculated using the discount rate of eight percent, as well as what the Center's net pension liability would be if it were calculated using a discount rate that is one-percentage point lower (seven percent) or one-percentage point higher (nine percent) than the current rate:

	1% Decrease (7%)	Current discount rate (8%)	1% Increase (9%)
Center's proportionate share of the net pension liability	$ 8,896,979	$ 6,907,864	$ 5,230,137

Pension plan fiduciary net position – Detailed information about the pension plan's fiduciary net position is available in the separately issued PERS financial report.

Payable to the pension plan – At December 31, 2016, the Center reported payables to the PERS of $82,454.

12. Defined Contribution Retirement Pension Plan:

Plan description – The Center participates in the State of Alaska Defined Contribution Plan (DC Plan), Tier 4, administered by the State of Alaska, which provides retirement benefits for eligible employees hired after July 1, 2006. Additionally, certain active members of the DB Plan were eligible to transfer to the DC Plan if that member had not vested in the DB Plan. Benefit and contribution provisions are established by the State law and may be amended only by the State Legislature. Included in the DC Plan are individual pension accounts, retiree medical insurance plan and a separate Health Reimbursement Arrangement account that will help retired members pay medical premiums and other eligible medical expenses not covered by the medical plan. The DC Plan is included in the comprehensive annual financial report for PERS, and at the following website: http://doa.alaska.gov/drb/pers.

Pension benefits – A participating member is immediately and fully vested in that member's contribution and related earnings (losses). A member shall be fully vested in the employer contributions made on that member's behalf, and related earnings (losses), after five years of service. A member is partially vested in the employer contributions made on that member's behalf, and the related earnings, in the ratio of (a) 25 percent with two years of service; (b) 50 percent with three years of service; (c) 75 percent with four years of service; and (d) 100 percent with five years of service.

Contributions – Alaska statutes require an 8.0 percent contribution rate for DC Plan members. Employers are required to contribute 5.0 percent of the member's compensation. For the year ended December 31, 2016, employee contributions totaled $173,516 and employer contributions were $453,277.

Refunds – A member is eligible to request a refund of contributions from their account 60 days after termination of employment.

12. Defined Contribution Retirement Pension Plan (continued):

Participant accounts – Participant accounts under the DC Plan are self-directed with respect to investment options. Each participant designates how contributions are to be allocated among the investment options. Each participant's account is credited with the participant's contribution and the appreciation or depreciation in unit value for the investment funds.

Record-keeping/administrative fees consisting of a fixed amount, applied in a lump sum each calendar year, and a variable amount, applied monthly, are deducted from each participant's account, and applied pro rata to all the funds in which the employee participates. This fee is for all costs incurred by the record keeper and by the State. The investment management fees are netted out of the funds' performance.

13. Other Postemployment Benefit Plans (OPEB):

Defined Benefit OPEB (DB OPEB)

As part of its participation in the PERS DB Plan (Tiers I, II, III), the Center participates in the Alaska Retiree Healthcare Trust (ARHCT). The ARHCT is self-funded and provides major medical coverage to retirees of the Center. Benefits vary per Tier level. The Plan is administered by the State of Alaska, Department of Administration. Employer contribution rates are established in concert with the DB Plan described earlier in these notes. From January 1, 2016 to June 30, 2016, the Center was required to contribute 8.75 percent of covered payroll into the DB OPEB plan. From July 1, 2016 to December 31, 2016, the rate was 7.04 percent.

The Center's annual DB OPEB costs and actual contributions for the years ending December 31, 2016, 2015, and 2014, and the amounts actually contributed are listed below. The amounts reported here include only the employer required contributions and do not include any amounts attributed to the on-behalf contributions by the State.

December 31,	Annual OPEB Cost	Center Contributions	Percentage of required contribution
2016	$ 161,036	$ 161,036	100%
2015	$ 185,604	$ 185,604	100%
2014	$ 235,970	$ 235,970	100%

13. Other Postemployment Benefit Plans (OPEB)(continued):

Defined Contribution OPEB (DC OPEB)

DC Plan participants participate in the Occupational Death and Disability Plan (ODD) and the Retiree Medical Plan. Information on these plans is included in the comprehensive annual financial report for PERS as noted in Note 11 and Note 12. These plans provide for death, disability, and postemployment healthcare benefits.

Employees do not contribute to the DC OPEB plans. The Center's contribution rate for the Retiree Medical and ODD plans for year ended December 31, 2016, were 1.18 percent and .17 percent, respectively. In addition, DC Plan members also participate in the Health Reimbursement Arrangement. Alaska Statute 39.30.370 establishes this contribution amount as "three percent of the average annual employee compensation of all employees of all employers in the plan." For actual remittance, this amount is calculated as a flat rate for each full-time or part-time employee per pay period. For the year ended December 31, 2016, the rate was approximately $2,049 per year for each full-time employee and $1.31 per hour for part-time employees. For year ended December 31, 2016, the Center contributed $118,935 in DC OPEB costs and this was recognized as an expense.

14. Healthcare Self-insurance:

The Center participates in a self-insured health insurance plan administered by Professional Benefit Services, Inc. (PBS). The Center self-insures the first $45,000 in claims per eligible participant. The Center also purchases annual stop-loss insurance coverage for all claims in excess of $45,000 per participant. The calculation of loss coverage is based upon a set dollar amount per covered employee. The Center accrues an incurred but not reported liability for plan claims that had been incurred but that have not yet been reported to PBS. This liability is included in accrued compensation and related liabilities in the accompanying statement of net position. Activity in the Center's accrued employee health claims liability is as follows:

		2016
Claim liability, beginning of year	$	-
Current year claims and changes in estimates		947,821
Claims payments		(925,821)
Claim liability, end of year	**$**	**22,000**

15. Concentration of Risk:

Patient accounts receivable – The Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party agreements.

The mix of patient receivables was as follows:

	2016	
Medicare	**16**	**%**
Medicaid	**28**	
Other third-party payors	**33**	
Patients	**23**	
	100	**%**

Physicians – The Center is dependent on local physicians practicing in its service area to provide admissions and utilize hospital services on an outpatient basis. A decrease in the number of physicians providing these services or changes in their utilization patterns may have an adverse effect on the Center's operations.

REQUIRED SUPPLEMENTARY INFORMATION

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Schedule of Proportionate Share of Net Pension Liability
State of Alaska Public Employees' Retirement System –
Defined Benefit Pension Plan
Last 10 Years *

June 30,	Center's portion of the net pension liability	Center's proportionate share of the net pension liability	Center's covered-employee payroll	Center's proportionate share of the net pension liability as a percentage of its covered-employee payroll	Plan fiduciary net position as a percentage of the total pension liability
2016	0.12358000%	$ 6,907,864	$ 787,599	877.08%	59.55%

*GASB Statement No. 68 requires ten years of information to be presented in this table. However, until a full 10-year trend is compiled, the Center will present information for those years for which information is available. Information for 2014 and 2015 is not available for the first two years GASB Statement No. 68 was effective.

Data reported is measured as of June 30, 2016 (measurement date).

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Schedule of the Center's Contributions
State of Alaska Public Employees' Retirement System –
Defined Benefit Pension Plan
Last 10 Years *

December 31,	Contractually required contribution	Contributions in relation to the contractually required contributions	Contribution (deficiency) excess	Center's covered-employee payroll	Contributions as a percentage of covered-employee payroll
2016	$ 227,258	$ 227,258	$ -	$ 682,883	33.28%

*GASB Statement No. 68 requires ten years of information to be presented in this table. However, until a full 10-year trend is compiled, the Center will present information for those years for which information is available. Information for 2014 and 2015 is not available for the first two years GASB Statement No. 68 was effective.

Data reported is measured as of December 31, 2016.

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Certified Public Accountants

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Cordova Community Health Services Board
Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Cordova, Alaska

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Cordova Community Medical Center, a component unit of the City of Cordova, Alaska (the Center) as of and for the year ended December 31, 2016, and the related notes to the financial statements, which collectively comprise the Center's basic financial statements as listed in the table of contents, and have issued our report thereon dated September 22, 2017.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Center's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Center's internal control. Accordingly, we do not express an opinion on the effectiveness of the Center's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We did identify certain deficiencies in internal control, described in the accompanying schedule of audit findings and responses that we consider to be material weaknesses: 2016-001 and 2016-002.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Center's financial statements are free from material misstatement, we performed tests of their compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

The Center's Response to Findings

The Center's response to the findings identified in our audit is described in the accompanying schedule of audit findings and responses. The Center's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
September 22, 2017

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Schedule of Audit Findings and Responses
Year Ended December 31, 2016

2016-001 Auditor-Detected Adjusting Journal Entries and Prior Period Adjustments

Condition	Material adjustments were necessary to accounts payable, accounts receivable, other receivables, electronic health records revenue, third-party settlements, capital assets, and beginning net position to properly present the financial statements in accordance with generally accepted accounting principles (GAAP).
Criteria	[ ] Compliance Finding [ ] Significant Deficiency [X] Material Weakness Financial statements are used by management and the Cordova Community Health Services Board to make decisions. Therefore, the financial statements should reflect correct balances throughout the year.
Context	This finding appears to be a *systemic* problem.
Cause	The systemic processes for reconciliation of statement of net position and statement of revenues, expenses, and changes in net position accounts were not in place.
Effect	The accounting records were materially misstated at year end.
Recommendation	We recommend all statement of net position accounts be properly reconciled to supporting documentation and accounts of the statement of revenues, expenses, and changes in net position be monitored and reconciled throughout the year to ensure correct reporting.
Management's Response	Management agrees that it is an accepted practice to reconcile all balance sheet accounts; however given the short amount of time the 4th CFO for 2016 had to get a lot of things accomplished prior to the audit, it was not possible for all accounts to be reconciled for the 2016 audit. It was apparent in the review of accounts and from the audit, not much reconciliation had been done for two years. Furthermore, history was lost when a computer system conversion was done in April 2015 increasing the difficulty in reconciling accounts for the 2016 audit. It is expected account reconciliations will be done for the accounting year 2017.

2016-002 Manual Journal Entries

Condition	There is no supervisory review of manual journal entries.
Criteria	[ ] Compliance Finding [ ] Significant Deficiency [X] Material Weakness Review of a system generated manual journal entries report would ensure the manual journal entry listing is complete. All manual journal entries should have documented supervisor approval and be supported by adequate supporting documentation.
Context	This finding appears to be a *systemic* problem.
Cause	Management turnover created limited personnel who could supervise such activity effectively.
Effect	There is a risk of error or fraud in which manual journal entries could be recorded without proper approval.
Recommendation	We recommend someone with sufficient accounting knowledge review all manual journal entries.
Management's Response	Given that the Medical Center operates at a loss, and will continue to operate at a loss for the foreseeable future, hiring additional accounting staff is a use of scarce resources not providing patient care. The CEO will get access to the Healthland general ledger system so that he or she can pull a list of journal entries made during the quarter, the CEO will then make a random selection of a third to a half of the paper journal entries made during the quarter. The CEO will receive the monthly journal entry files from the CFO and review the journal entries selected and sign the selected ones indicating that they have been reviewed.

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Summary Schedule of Prior Year Audit Findings
Year Ended December 31, 2016

2015-001 Internal Controls over Financial Reporting – Reconciliation of Significant Balance Sheet Accounts – Repeated – 2016-001

2015-002 Internal Controls over Financial Reporting – Internal Controls Over Disbursements – Resolved

2015-003 Internal Controls over Financial Reporting – Backup of Accounting Software – Resolved

Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska

Financial Indicators

December 31, 2016

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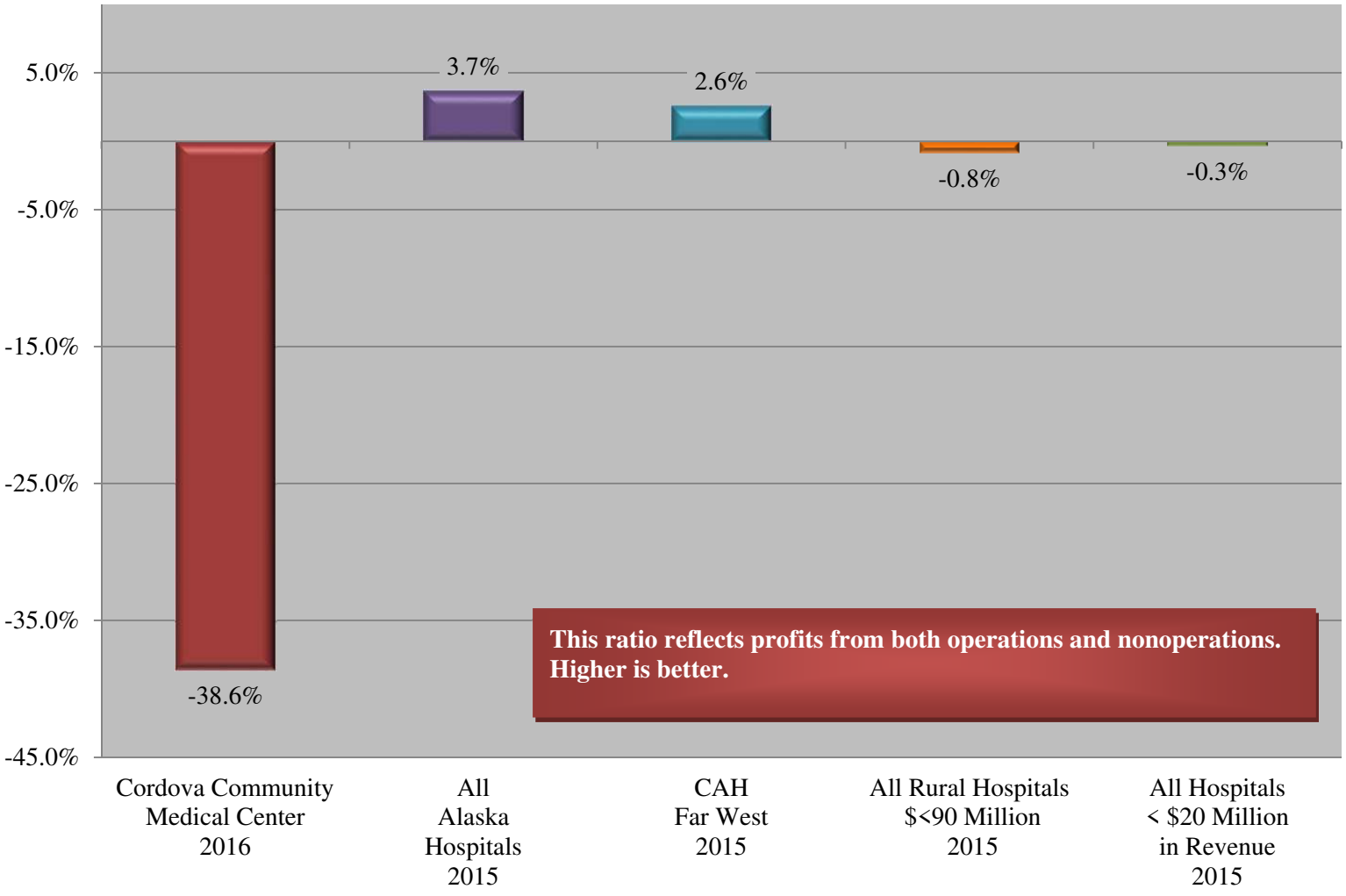
Certified Public Accountants

Total Margin

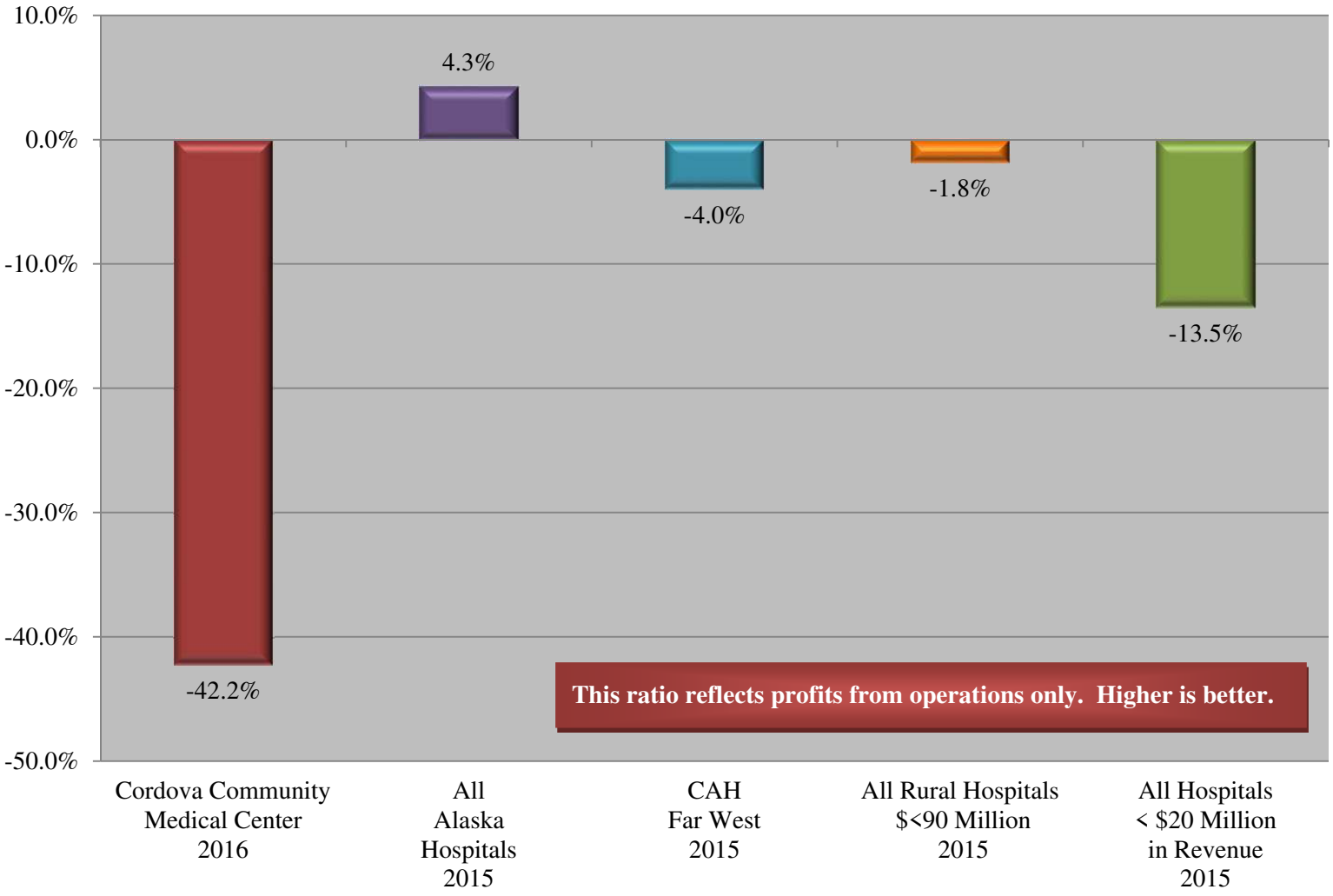
Change in Net Position
Total Revenues



Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska

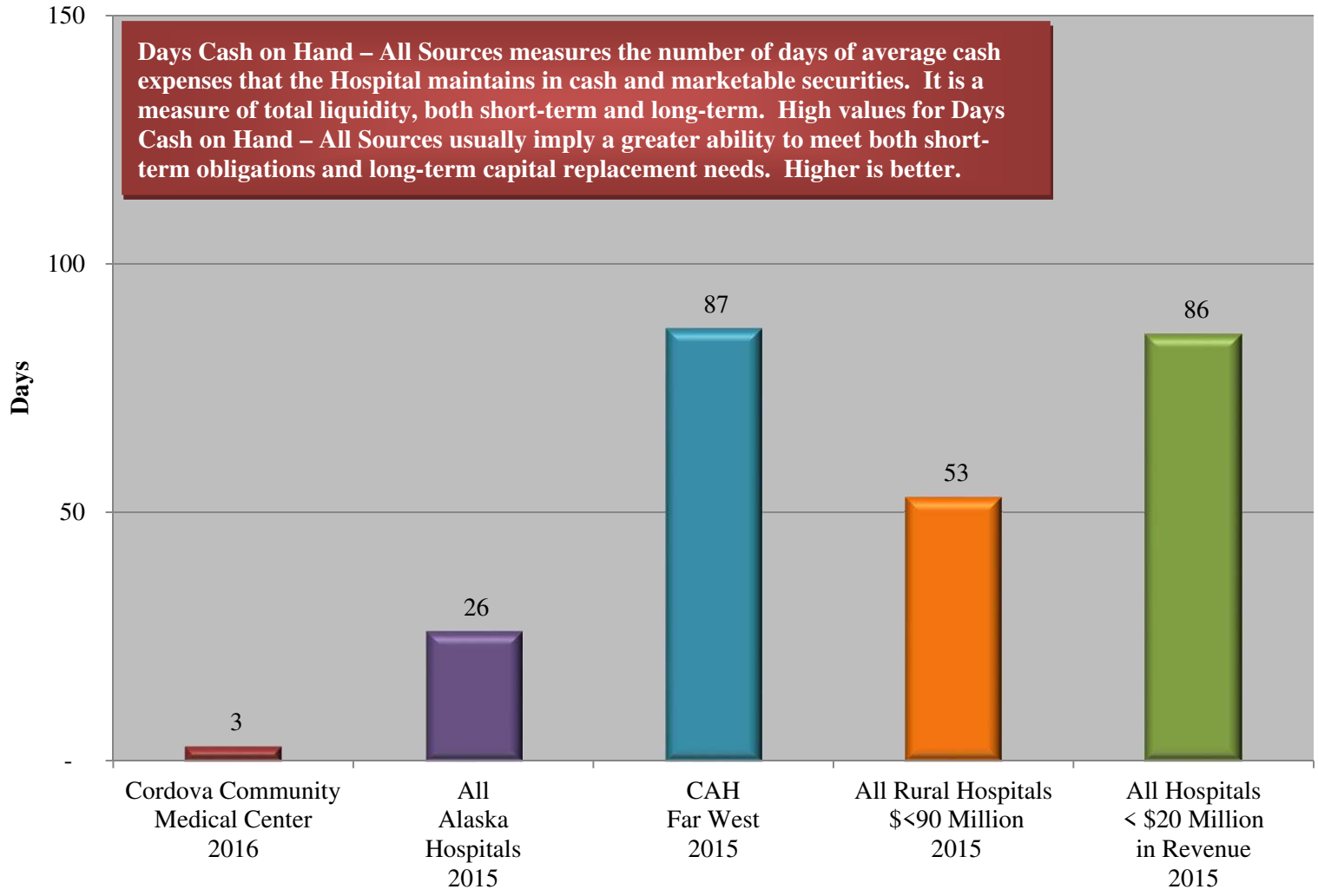
Operating Margin

Operating Income (Loss)
Total Operating Revenues



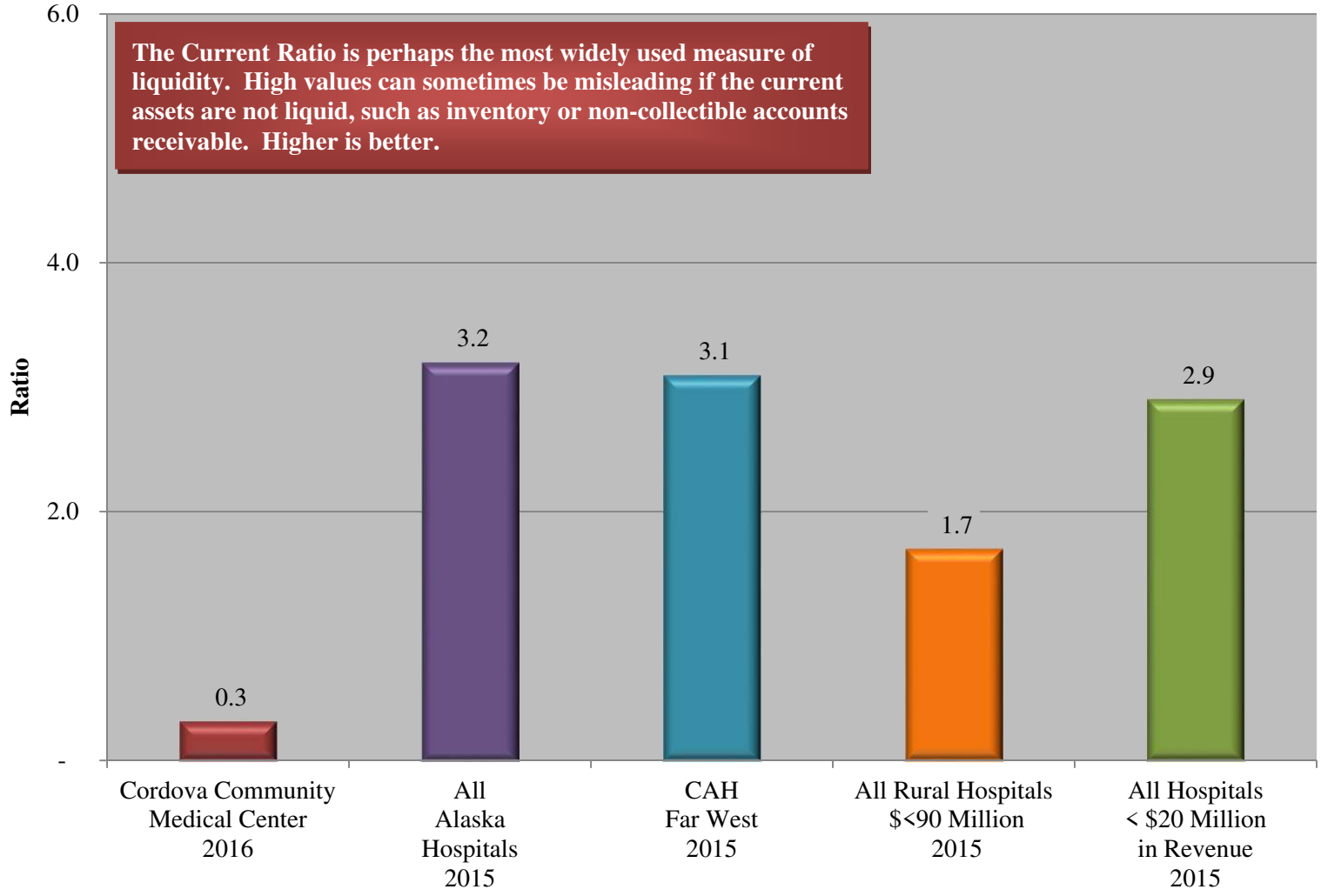
Days Cash on Hand – All Sources

$$\frac{\text{Cash + Short-term Investments + Noncurrent Cash and Short-term Investments}}{\text{(Total Expenses - Depreciation) / 365}}$$



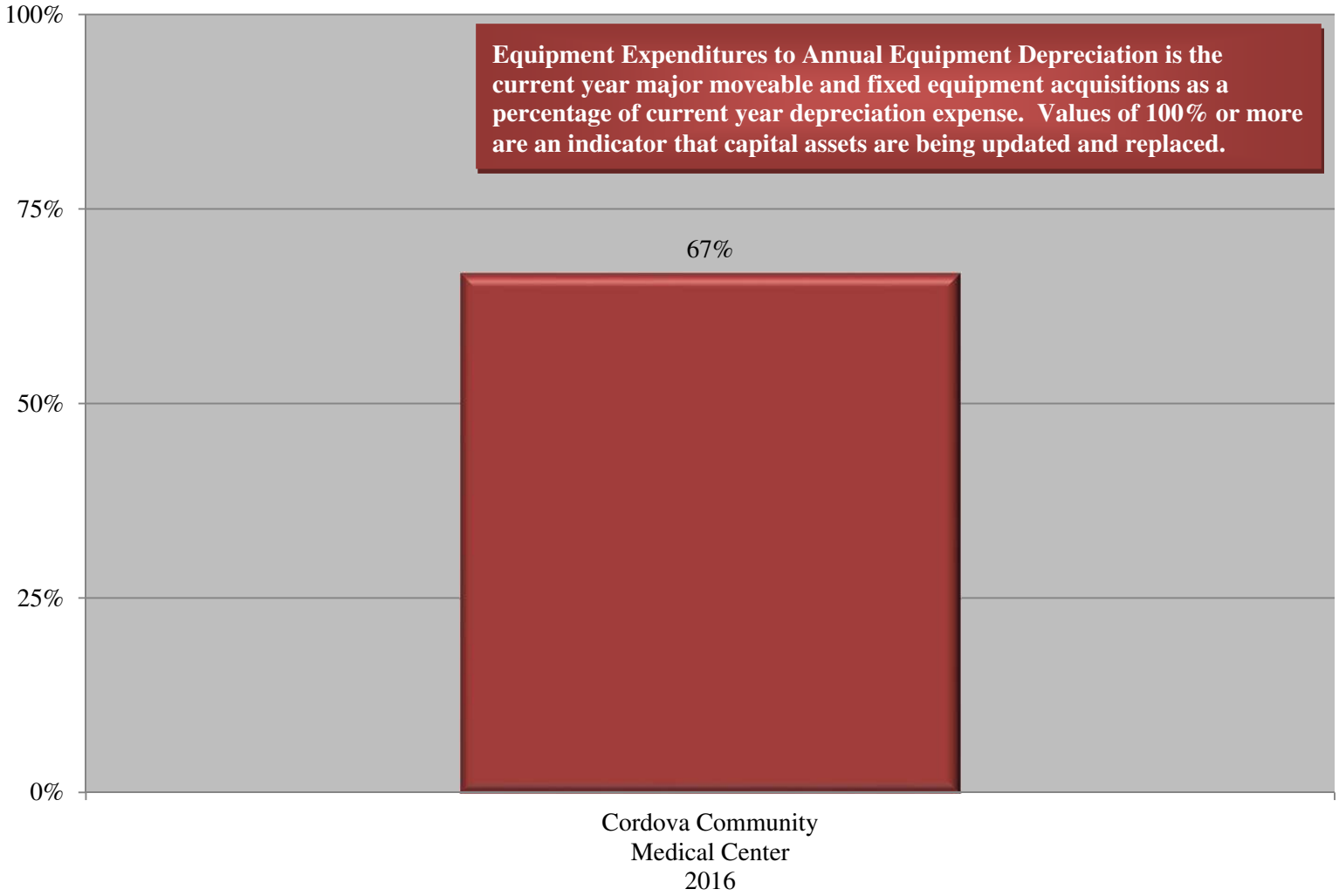
Current Ratio

$$\frac{\text{Current Assets}}{\text{Current Liabilities}}$$



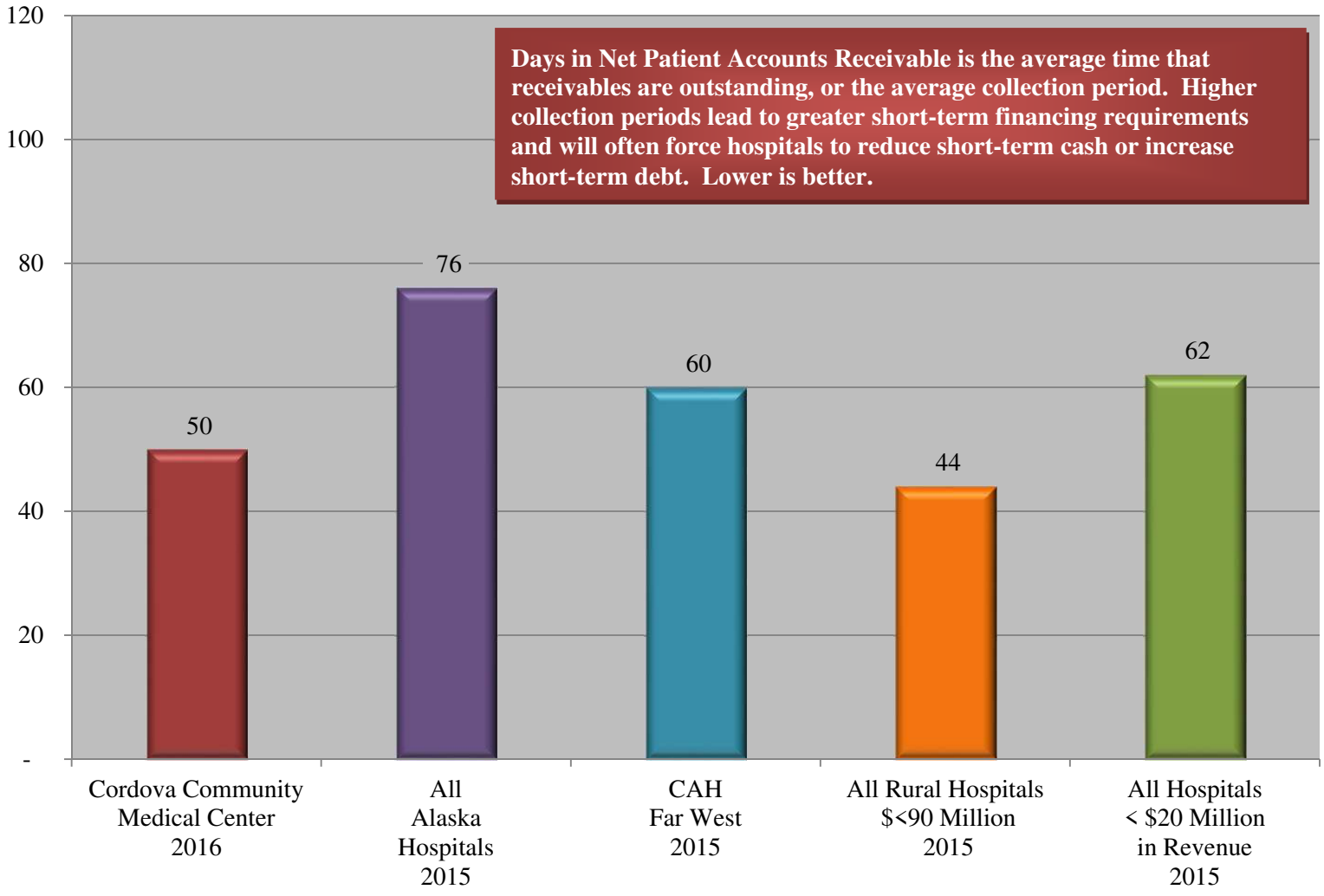
Capital Equipment Expenditures to Annual Equipment Depreciation

$$\frac{\text{Capital Equipment Additions}}{\text{Equipment Depreciation Expense}}$$



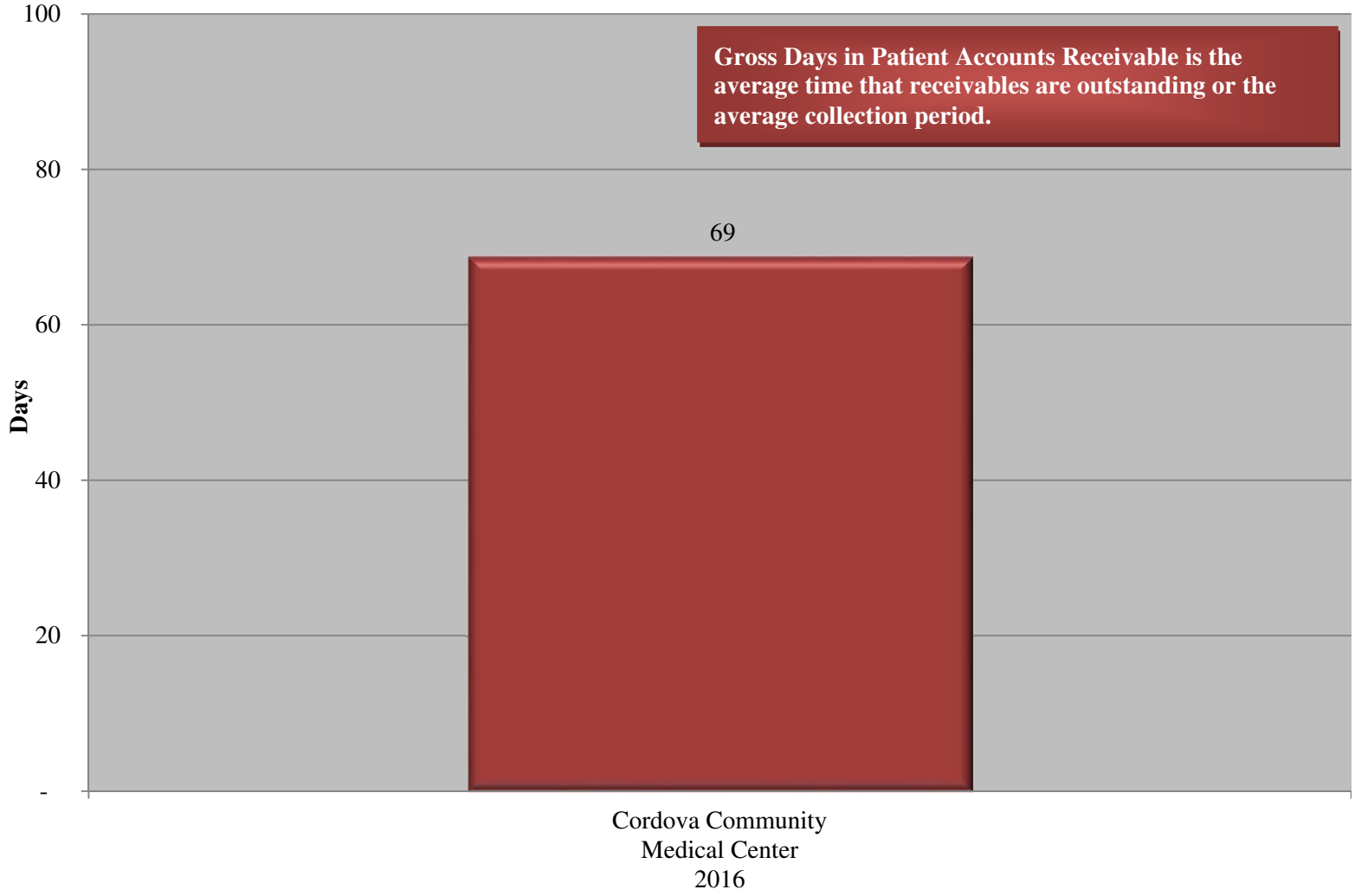
Days in Net Patient Accounts Receivable

$$\frac{\text{Net Patient Accounts Receivable}}{\text{Net Patient Service Revenues / 365}}$$



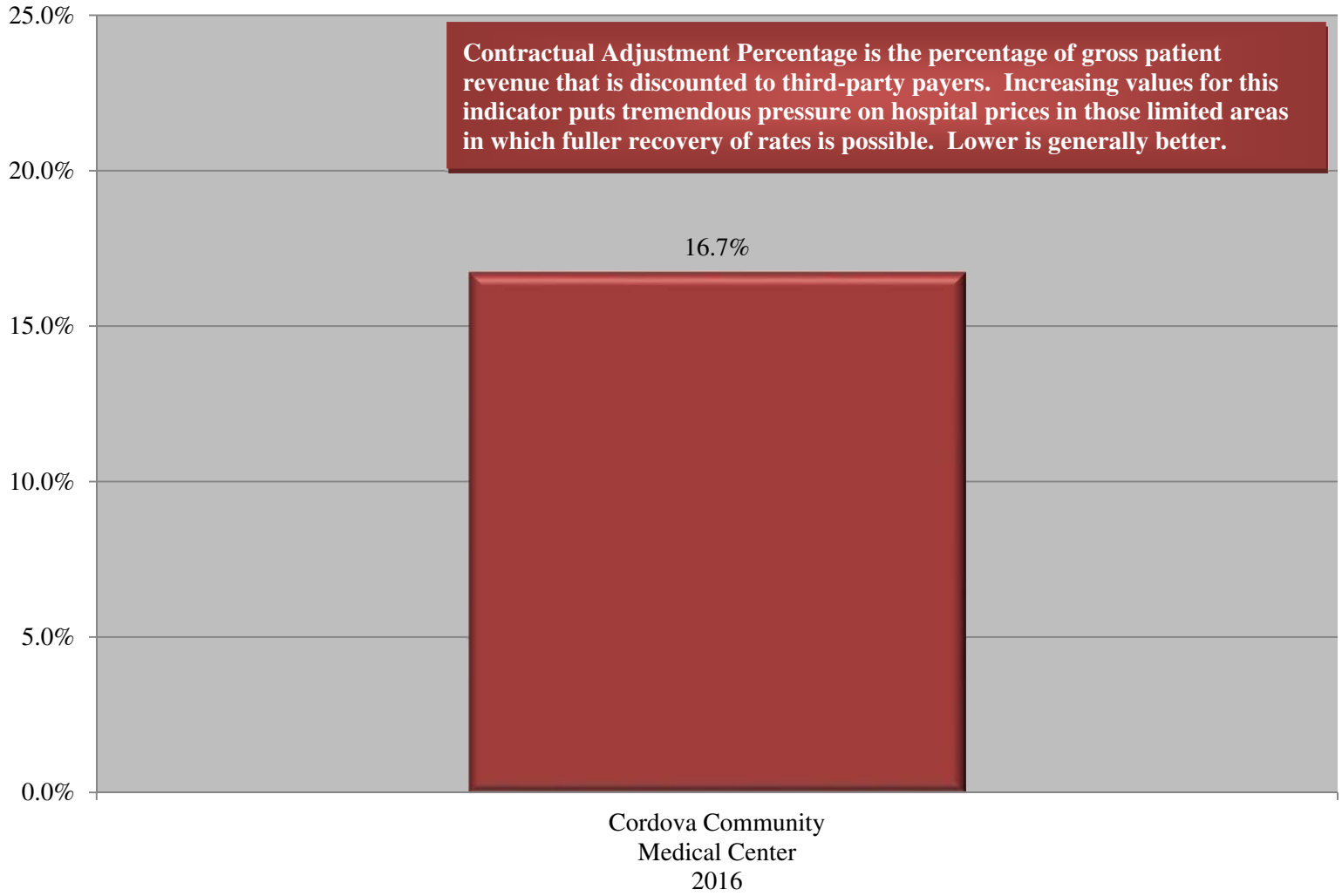
Gross Days in Patient Accounts Receivable

$$\frac{\text{Gross Patient Accounts Receivable}}{\text{Gross Patient Service Revenues / 365}}$$



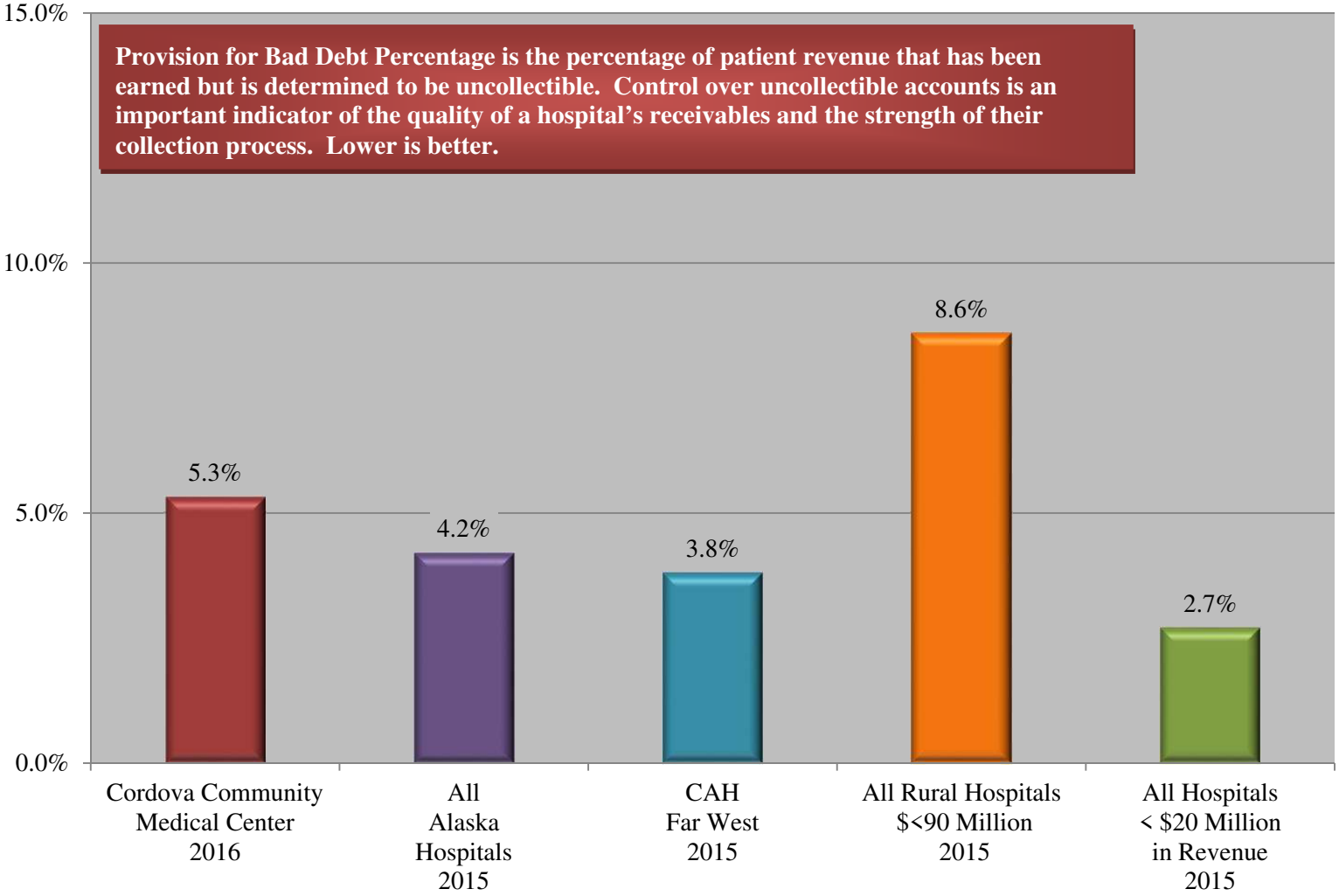
Contractual Adjustment Percentage

$$\frac{\text{Contractual Adjustments}}{\text{Gross Patient Revenues}}$$



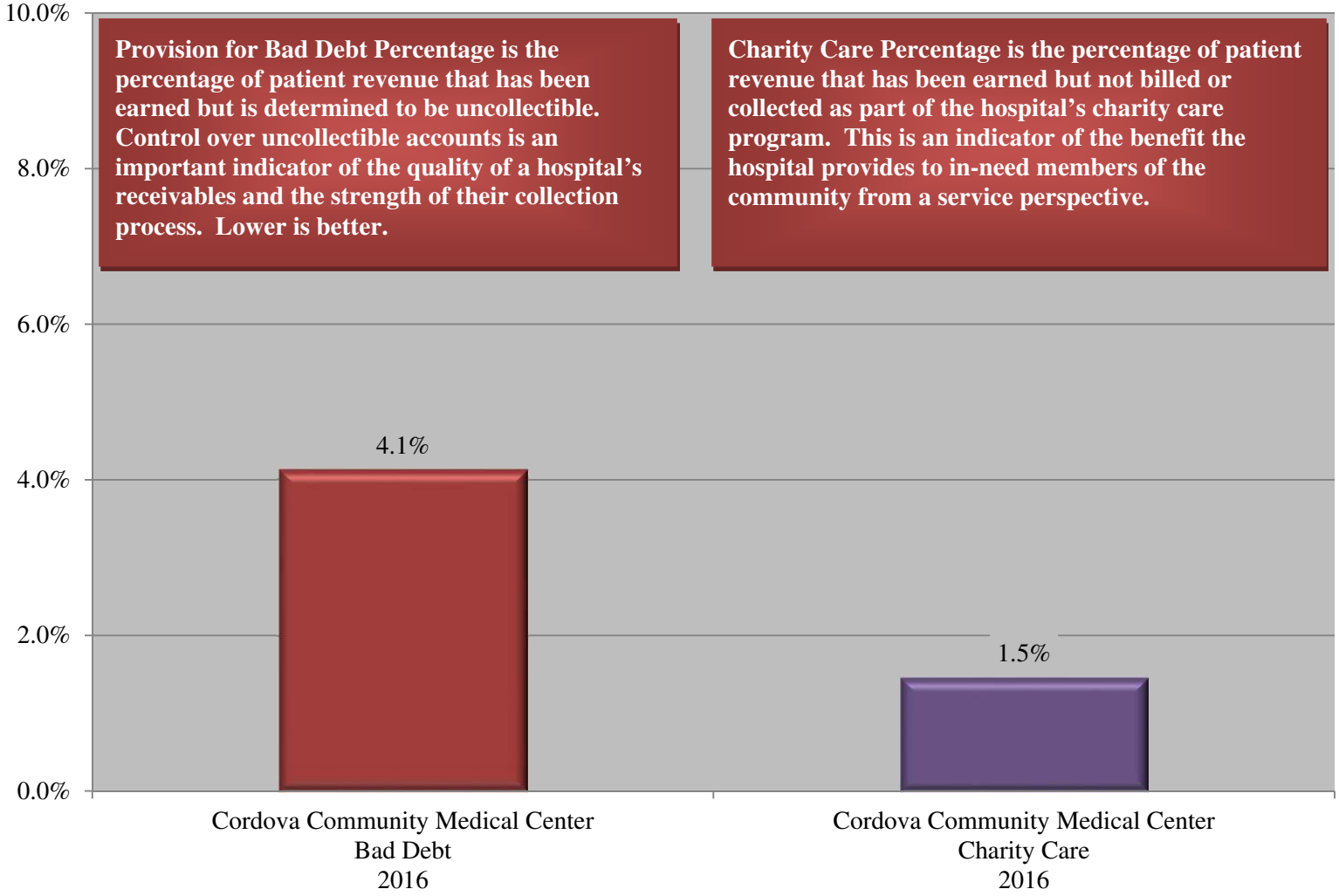
Bad Debt Percentage of Revenue

$$\frac{\text{Bad Debt Expense}}{\text{Net Patient Service Revenue}}$$

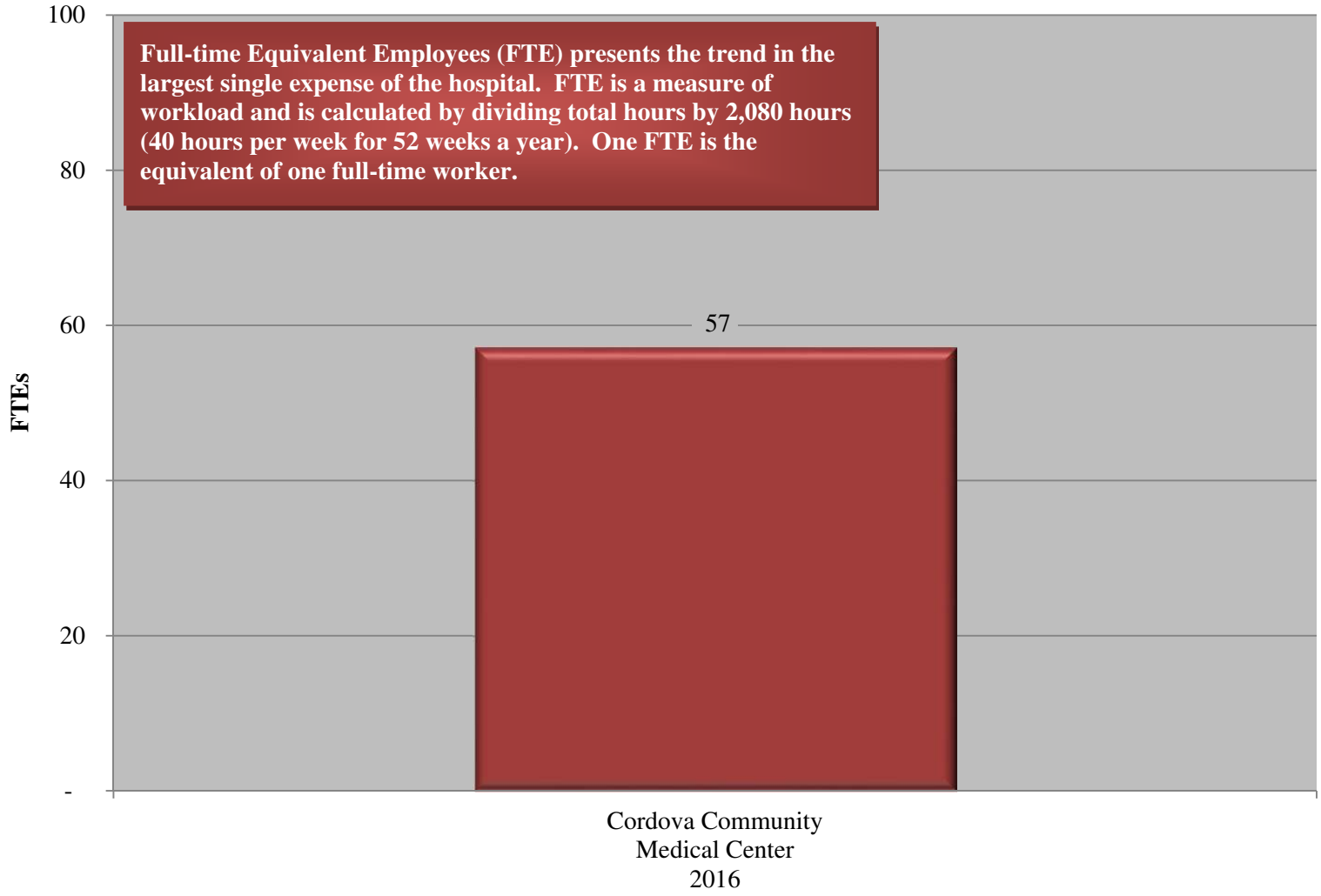


Bad Debt and Charity Percentage of Revenue

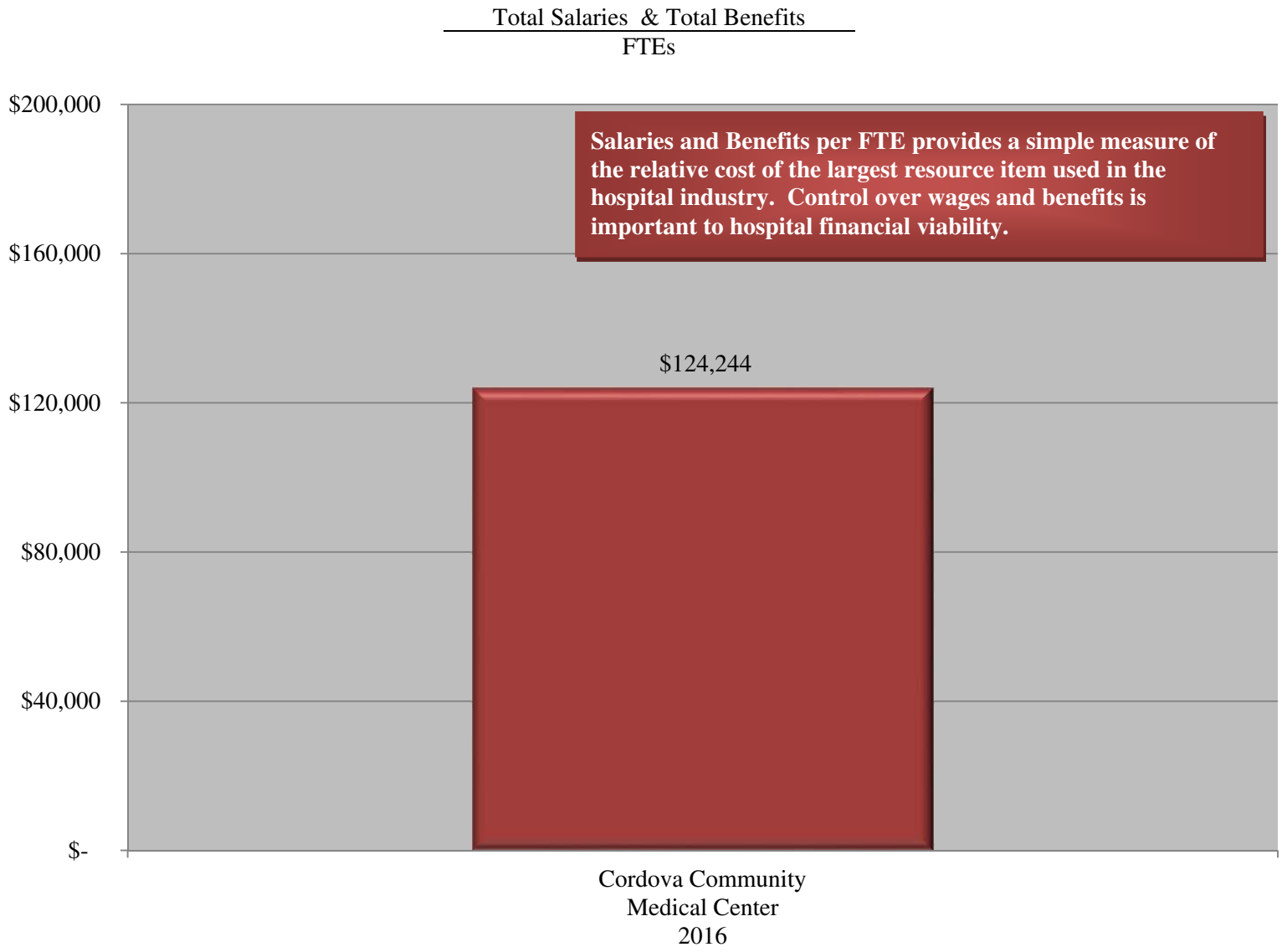
Provision for Bad Debt/ Charity Care
Gross Patient Revenue



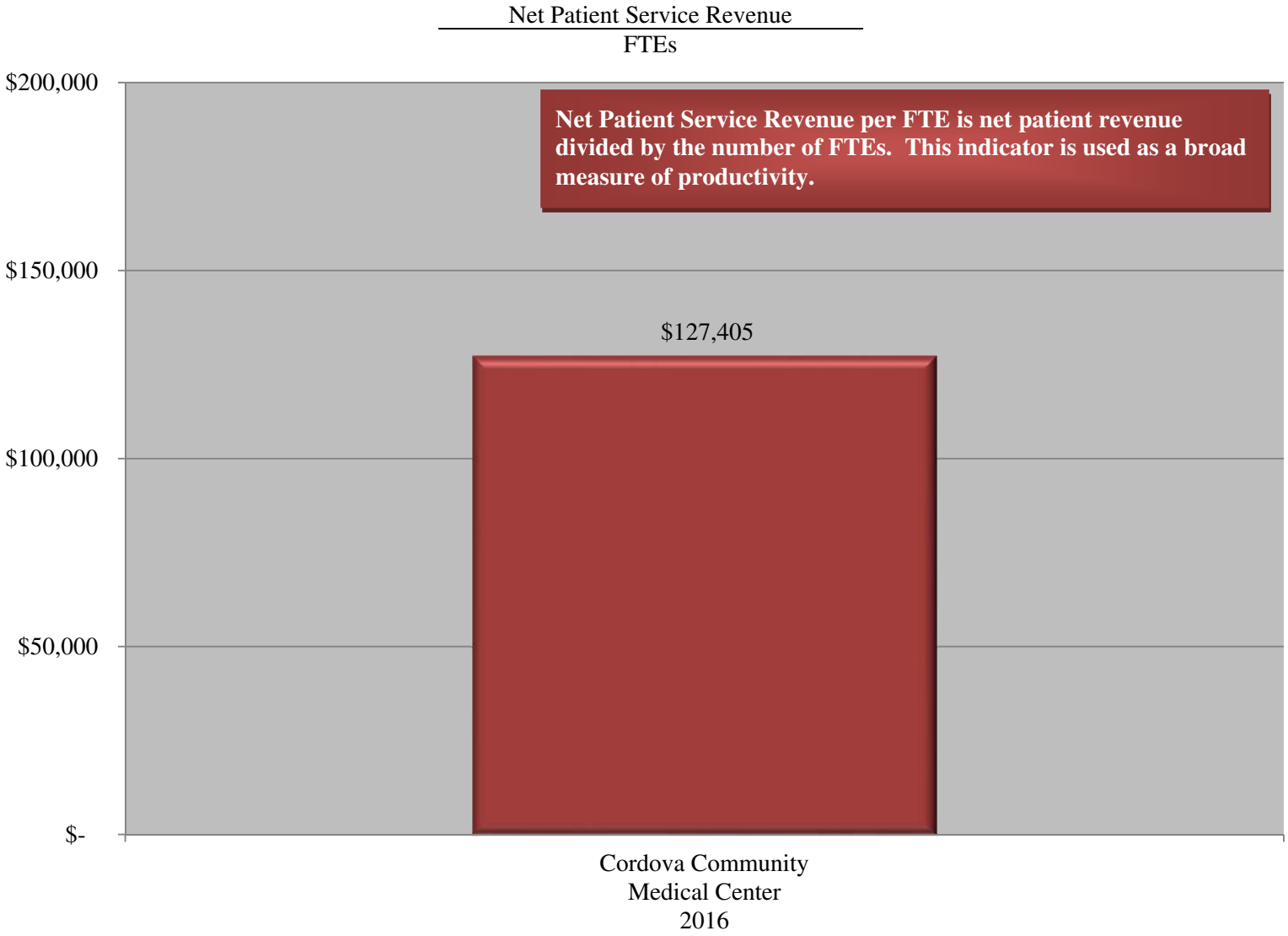
Full-time Equivalent Employees (FTE)



Salaries and Benefits per FTE



Net Patient Service Revenue per FTE



Cordova Community Health Services Board
Cordova Community Medical Center
a Component Unit of the City of Cordova, Alaska
Cordova, Alaska

We have audited the financial statements of Cordova Community Medical Center, a component unit of the City of Cordova (the Center) for the year ended December 31, 2016. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards and *Government Auditing Standards*, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated March 13, 2017. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Center are described in Note 1 to the financial statements.

We noted no transactions entered into by the Center during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the Center's financial statements were the allowances for uncollectible accounts and contractual adjustments, estimated third-party payors settlements, the net pension liability, and the liability for employee health insurance claims incurred but not reported:

- Management's estimate of the allowances for uncollectible accounts and contractual adjustments is based on experience, third-party collection history, and an analysis of the collectability of individual accounts.
- Management's estimate of third-party settlements is based on filed Medicare cost reports.
- Management's estimate of net pension liability is based on actuarially determined values and other calculations provided by the Alaska Public Employees' Retirement System (PERS).
- Management's estimate of the liability for employee health insurance claims incurred but not reported is based on historical data regarding the average cost and timing of employee health insurance claims.

We evaluated the key factors and assumptions used to develop the estimates in determining that they are reasonable in relation to the financial statements taken as a whole.

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The financial statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit

We experienced delays in the audit due to a significant number of adjusting journal entries, which was the result of turnover in the accounting department. A delay in receiving the required accounting information for Governmental Accounting Standards Board Statement No. 68 for the State of Alaska Public Employees' Retirement System also delayed the audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. Misstatements detected as a result of audit procedures which were material and were corrected by management consisted of misstatements to accounts receivable, grant receivables, accounts payable, accrued payroll, capital assets, and long-term debt. There were also adjustments made to beginning net position as a result of misstatements related to prior years.

Disagreements with Management

For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditors' report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated September 22 2017.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Hospital's financial statements or a determination of the type of auditors' opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Hospital's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters

We applied certain limited procedures to the Center's Schedule of Proportionate Share of Net Pension Liability and Schedule of Center's Contributions to the State of Alaska Defined Benefit Pension Plan (DB Plan), which are required supplementary information (RSI) that supplements the basic financial statements. Our procedures consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We did not audit the RSI and do not express an opinion or provide any assurance on the RSI.

Restriction on Use

This information is intended solely for the use of the Cordova Community Health Services Board and management of the Center and is not intended to be, and should not be, used by anyone other than these specified parties.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
September 22, 2017

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

DRAFT

EXECUTIVE PERFORMANCE APPRAISAL

Employee Name: **Position Title:** **Department:**	
Appraisal Type: **Introductory: Annual Reappraisal**	**Evaluation Period:** **From: To:**

PURPOSE OF PERFORMANCE APPRAISAL

The written performance appraisal is formal assessment of the employee's job performance over a specified period of time based on performance expectations identified by the supervisor and shared with the employee. Informal performance assessment is an ongoing aspect of effective supervision and communication and the written performance evaluation should not replace day to day supervisor and employee communication.

DRAFT

INSTRUCTIONS:

1. Have the employee complete the Self Appraisal Form
2. Review and complete Sections 1, 2 and 3.
3. Review your ratings and comments and make a determination of the staff member's overall performance using the Overall Rating Guidelines on page four.
4. Place the corresponding number (1, 2, 3, 4, or 5) that best describes your assessment of overall performance in the Evaluation Summary on page four.
5. Meet with CEO to review evaluation before discussing with the staff member.
6. Discuss the evaluation with the staff member, provide him/her with a copy and allow the staff member an opportunity to record any comments.
7. Return original form to HR to be included in the staff member's personnel file.

PERFORMANCE RATING GUIDELINES:

(5) This staff member has made significant contributions to advance the position of the department and/or Hospital toward excellence and prominence. Only a small percentage of staff members who exhibit uniform excellence and initiative will receive this rating.

(4) This staff member has been instrumental to the department's success and has performed in an exemplary manner. This rating is used for staff members who consistently excel in their job performance. It indicates that performance is well beyond that which can be expected from most staff members.

(3) This rating is used for staff members who perform their jobs well and are fully competent. This staff member is proficient in the job and may occasionally exceed expectations. Performance is what is expected of a fully qualified and experienced person.

(2) This staff member occasionally fails to exhibit proficiency in the job. Improvement is necessary to meet the expectations for acceptable performance.

(1) This staff member has serious deficiencies in key areas. Performance fails to meet expectations and is not acceptable. Significant improvement is necessary for the staff member to remain employed.

EXECUTIVE COMPETENCIES

DRAFT

RATING

ADMINISTRATIVE COMPETENCIES: + -

- ☐ Builds effective management teams and identifies optimal staffing levels necessary to effectively conduct the business of the department and facility. ☐ ☐
- ☐ Creates effective work plans; identifies the appropriate resources and processes; sets priorities; delegates authority and meets deadlines. ☐ ☐
- ☐ Incorporates control systems that monitor workflow and ensure task completion. ☐ ☐
- ☐ Creates an atmosphere in which information flows smoothly between self and others; encourages open expression of ideas and opinions. ☐ ☐
- ☐ Conveys information clearly and in a timely manner; prepares concise written reports; makes effective presentations. ☐ ☐
- ☐ Demonstrates the importance of sound financial performance and productivity; operates within budget; recommends methods to reduce costs. ☐ ☐
- ☐ Conducts all performance appraisals on time; evaluates performance based on results. ☐ ☐
- ☐ Empowers staff to take responsibility for their work processes; removes obstacles that hinder progress. ☐ ☐
- ☐ Understands and adheres to Hospital's compliance standards as they appear in Cordova Community Medical Center's Compliance Policy, Code of Conduct, and Conflict of Interest Policy; sponsors and implements initiatives to achieve the Hospital's compliance goals. ☐ ☐
- ☐ Enforces for all subordinates and personally complies with all CCMC disease prevention and control, policies, including tuberculosis, influenza and hepatitis B. ☐ ☐

CATEGORY SCORE: ☐

LEADERSHIP: + -

- ☐ Communicates the Hospital's and Department's vision and mission to staff members; shapes behavior in order to turn the vision and mission into reality. ☐ ☐
- ☐ Asserts own ideas and persuades others; gains support and commitment; mobilizes people to take action. ☐ ☐
- ☐ Coaches staff members and accurately assesses their developmental needs; provides specific and frequent feedback on performance; grooms employees for promotion. ☐ ☐
- ☐ Creates an environment conducive to cooperation and trust. ☐ ☐
- ☐ Acts professionally and responsibly within and outside of the Hospital; contributes to a positive image. ☐ ☐
- ☐ Adjusts to shifting priorities, ambiguity and rapid change; demonstrates flexibility. ☐ ☐
- ☐ Champions new initiatives; assumes risk and responsibility for the department; addresses difficult issues and stands firmly when necessary. ☐ ☐
- ☐ Models behavior consistent with Cordova Community Medical Center's Corporate Compliance Standards; ensures that all staff are trained and evaluated on their knowledge of and adherence to compliance policies and procedures specific to their jobs. ☐ ☐

CATEGORY SCORE: ☐

ORGANIZATIONAL and STRATEGIC COMPETENCIES: + -

- ☐ Thinks strategically; identifies critical, high pay-off strategies and prioritizes team efforts accordingly; effectively plans for future growth and/or direction. ☐ ☐
- ☐ Emphasizes the need to deliver quality services; defines standards for quality and evaluates processes against those standards in an effort to improve organizational performance. ☐ ☐
- ☐ Identifies customer needs and takes action to meet those needs; continually searches for ways to increase customer satisfaction. ☐ ☐
- ☐ Supports the employment, education and development of minorities and protected classes; makes decisions based on the principles of equal employment opportunity. ☐ ☐
- ☐ Recognizes the existence of, and necessity for, diversity in the workplace. ☐ ☐
- ☐ Possesses up-to-date knowledge in the profession and understands the issues relative to the broad organization and business. ☐ ☐
- ☐ Considers a broad range of internal and external factors when making decisions; uses information about the community, the market and competitors in making decisions; recognizes strategic opportunities for success. ☐ ☐

CATEGORY SCORE: ☐

PERFORMANCE GOALS

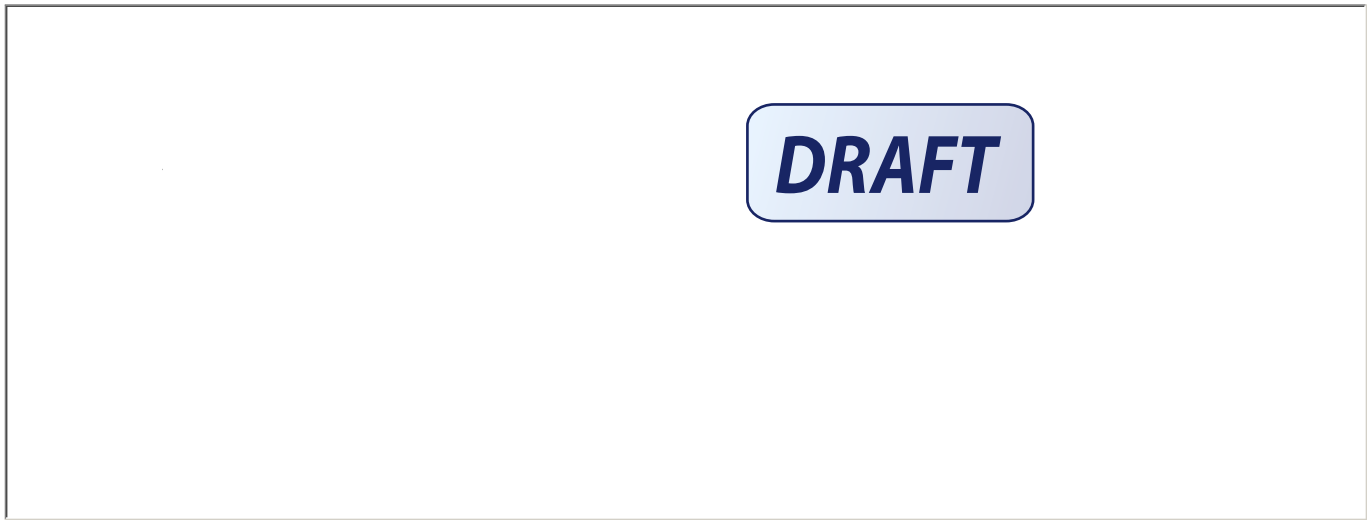
INSTRUCTIONS:

· List goals by order of importance.
· Review goals periodically and make changes to this section if goals or priorities change during the year.
· At the end of the evaluation period, rate each goal individually using the Performance Rating Guidelines listed on the cover of the form.
· Consider your individual rating for each goal relative to its priority. Assign a numeric category score for overall goal achievement.

PRIORITY RATING	GOAL DESCRIPTION	RESULTS and COMMENTS	RATING
1			
2			
3			
4			
5			

CATEGORY SCORE FOR PERFORMANCE GOALS:

EVALUATOR: Discuss your assessment of the Executive's developmental needs, suggest ways the Executive can meet those needs, and how you plan to help. Establish Performance Goals for the next review period.



EXECUTIVE: Discuss your thoughts on this evaluation and identify the specific ways CCMC can help you optimize your performance.

OVERALL RATING:

Staff Member's Name: **Signature:** **Date:**

Note: Staff member's signature indicates the appraisal was reviewed and discussed. It does not necessarily denote agreement.

Evaluator's Name: **Signature:** **Date:**

Manager's Name: **Signature:** **Date:**

CEO's Name: **Signature:** **Date**