CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Public Hospital District No.1: Board of Commissioners Meeting Agenda

Wednesday December 17, 2025 | 4:30 PM

Arleen Blackburn Conference Room and Zoom Connection

All times listed are approximates and not a true indication of the amount of time to be spent on any area.

I.	**Call to Order**	4:30	Shari Campbell
II.	**Pledge of Allegiance**	4:30	Shari Campbell
	• **Consent Agenda**	4:30	Shari Campbell

All consent agenda items will be approved by the Board with a single motion. Any of the following individual items may be pulled for discussion at the request of a commissioner.

- Meeting Agenda
- November 19, 2025 Board Meeting Minutes
- 2026 Proposed Board Meeting Dates
- **Charters**: Governance Committee, Community Outreach and Awareness Committee, Quality Oversight Committee, Finance Committee
- **Policies**: Commissioner Compensation, Identify Theft Red Flag, Financial Assistance, Organizational Integrity Compliance Committee Structure and Purpose, Reporting Improper Government Action, , Quality Assessment and Performance Improvement Plan
- Role of a Hospital Commissioner
- 2025 Dingus, Zarecor, & Associates Engagement Letter

Previous Month's Warrants Issued:	10127788 – 10127902	11/13/2025 – 12/08/2025	$ 1,212,890.34
Accounts Payable EFT Transactions:	20250162 – 20250175	11/13/2025 – 12/08/2025	$ 543,259.84
Payroll EFT Transactions:	29059 – 29482	11/13/2025 – 12/08/2025	$ 1,006,669.74

- Bad Debt: November 2025

III.	**Community Input** Public comments concerning employee performance, personnel issues, or service delivery issues related to specific patients will not be permitted during this public comment portion of the meeting. Public comments should be limited to three minutes per person.	4:30	Commissioners
IV.	**Foundation Report**	4:35	Wade Nash
V.	**CM Values**	4:40	Diane Blake
VI.	**Discussion: 2026 Board Committee Assignments**	4:45	Shari Campbell
VII.	**Committee Reports**	4:50	
	a. Community Outreach & Awareness Committee		Shari Campbell
	b. Finance Committee		Tom Baranouskas
	c. Quality Oversight Committee		Jessica Kendall
VIII.	**Master Facility Plan Presentation & Discussion**	5:05	Wipfli
	BREAK	6:05	
IX.	**Master Facility Plan Presentation & Discussion (Continued)**	6:15	Wipfli
X.	**Review Proposed 2026-2028 Organizational Objectives and 2026 Annual Objectives**	7:15	Diane Blake
XI.	**Action Items**	7:45	Commissioners
	a. **MOTION**: Approve Credentialing		
	b. **MOTION**: Approve Cardiac Monitor Purchase		
	c. **MOTION**: 2026 Board Officer Election		
XII.	**Oath of Office**	7:55	Commissioners
	○ Shari Campbell, Jessica Kendall, Cary Ecker, & Dr. Jesse Knight		
XIII.	**Administrator Report**	8:00	Diane Blake
XIV.	**Board Follow Up Items / Meeting Evaluation / Commissioner Comments** Roundtable discussion to evaluate meeting topics and identify opportunities for improvement.	8:10	Commissioners
XV.	**Adjournment**	8:15	Shari Campbell

BOARD CALENDAR REMINDERS

Date	Event	Commissioners (Max 2 for non Open Public Meetings)	Location	Time
January 6, 2026	Special Board Meeting		Administration Conf. Room	3:00 PM – 5:00 PM
January 7, 2026	Medical Staff		ABC Room	7:00 AM – 8:30 AM
January 21, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
February 4, 2026	Medical Staff		ABC Room	7:00 AM – 8:30 AM
February 9, 2026	Quality Oversight Committee	Jessica & Dr. Knight	Clinic Conference Room	10:00 AM – 12:00 PM
February 11, 2026	Community Outreach & Awareness Committee	Shari & Jessica	Administration Conf. Room	1:00 PM – 3:00 PM
February 18, 2026	Governance Committee	Shari	Administration Conf. Room	2:00 PM – 4:30 PM
February 25, 2026	CMF Board Meeting		ABC Room	10:00 AM-12:00 PM
March 16, 2026	Finance Committee	Tom & Cary	Administration Conf. Room	9:00 AM -11:00 AM
March 18, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
April 15, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
April 25, 2026	Part-time Resident Advisory Council		ABC Room	9:30 AM-12:00 PM
May 6, 2026	Medical Staff		ABC Room	7:00 AM – 8:30 AM
May 11, 2026	Quality Oversight Committee	Jessica & Dr. Knight	Clinic Conference Room	10:00 AM – 12:00 PM
May 20, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
June 17, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
June 22, 2026	CMF Annual Golf Tournament		Kahler Mountain Club	All Day
July 15, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
August 5, 2026	Medical Staff		ABC Room	7:00 AM – 8:30 AM
August 10, 2026	Quality Oversight Committee	Jessica & Dr. Knight	Clinic Conference Room	10:00 AM – 12:00 PM
August 19, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
September 16, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
October 7, 2026	Medical Staff		ABC Room	7:00 AM – 8:30 AM
October 21, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
October 24, 2026	Part-time Resident Advisory Council		ABC Room	9:30 AM-12:00 PM
November 11, 2026	CMF Board Meeting		ABC Room	9:00 AM-11:00 AM
November 16, 2026	Quality Oversight Committee	Jessica & Dr. Knight	Clinic Conference Room	10:00 AM – 12:00 PM
December 9, 2026	CMF Board Meeting		TBD	TBD

Values

Commitment – We demonstrate our pursuit of individual and organizational development by always going above and beyond to find the answer, discover the cause, and advocate the most appropriate course of action.

Community – We demonstrate our effectiveness and quality in complete transparency with each other and in line with the values of our medical center.

Empowerment – We prove our promise to patients and our dedication to both organization and community through the manner in which we empower each other and carry out each action.

Integrity – We set a strong example of behavioral and ethical standards by demonstrating our accountability to patient needs and our devotion to performing alongside one another as we exhibit our high standards each and every day.

Quality – We demonstrate an exceptional and enduring commitment to excellence. We are devoted to processes and systems that align our actions to excellence, compassion and effectiveness on a daily basis.

Respect – We embrace equality on a daily basis through positive, personal interactions and recognize the unique value within each of our colleagues, patients, and ourselves.

Transparency – We demonstrate complete openness by providing clear, timely and trusted information that shapes the health, safety, well-being and stability of each other and our community.

AGENDA / PACKET EXPLANATION
For Meeting on December 17, 2025

REMINDER: Board meeting will commence at 4:30 PM

Below is an explanation of agenda items for the upcoming Board meeting for which you may find pre-explanation helpful.

- **Consent Agenda** – The charters and policies in the consent agenda have been reviewed by their respective Board committees, who recommend them to the full Board for approval. The Role of a Hospital Commissioner was shared and discussed at the November board meeting. Additionally, the Finance Committee has reviewed and recommends engaging Dingus, Zarecor & Associates again for this year's audit. Please feel free to connect with Marianne or Diane with any questions in advance of Wednesday's meeting and / or pull individual items from the consent agenda at the meeting, should you wish to discuss.
- **Discussion: 2026 Board Committee Assignments** – Included in your packet is a list of current Board officers and committee members, to facilitate the discussion.
- **Committee Reports**
    - Community Outreach & Awareness Committee – Included in your packet is the agenda from the most recent committee meeting as well as the completed workplan for 2025, to facilitate Shari's report.
    - Finance Committee – Included in your packet is the agenda from the most recent committee meeting and the completed workplan for 2025, to facilitate Tom's report.
    - Quality Oversight Committee – Included in your packet is the agenda from the most recent committee meeting, the completed 2025 workplan and a list of accomplishments, to facilitate Jessica's report.
- **Master Facility Plan Presentation & Discussion** – No documents are included in your packet for this item. Wipfli will attend virtually and present the culmination of our collective work to date, with options explored, the financial and other implications of each option, and recommendations on what is next. There will be no decision at the December meeting, but we will be looking for your questions and feedback on potential future pathways, with plan finalization intended for early 2026.
- **Review Proposed 2026-2028 Organizational Objectives & 2026 Annual Objectives** – Included in your packet is a document with proposed 2026 – 2028 organizational objectives and objective themes for 2026. This document was also sent to you on December 7, to facilitate early review and provide time to consider. We intend to discuss and seek feedback and then present a final version to you in January for approval.
- **Action Items**
    - Credentialing – Included in your packet is a document with a list of providers for your consideration for credentialing approval.

- Approve Cardiac Monitor Purchase – Included in your packet is justification and recommendation of the purchase of a monitor to support the Mobile Integrated Health work. The Foundation has raised the funds to purchase this item, and it is included in our 2025 budget. Due to its cost, it meets the threshold of our policy to seek board approval prior to purchase.
- 2026 Board Officer Election – Officer elections traditionally occur in January, but given we have a planned absence for the January meeting, we are planning to conduct elections this December, for the coming year. The officer and committee document included earlier in the packet to support the 2026 committee discussion supports this item as well.

- **Oath of Office** – No documents are included in your packet for this item. Megan will lead the four commissioners elected in November through the Oath of Office process.

Further Notes

- As you review your packet, please be thinking about strategic questions and ways to engage in strategic discussion as we move through the meeting.
- November financials are not included in this month's packet, due to both the earlier timing of the December Board meeting and a desire to give the Accounting department additional time to prepare, given some recent staffing changes. Diane will provide a brief November financial update in her administrator report.
- The completed 2025 workplan for the Governance Committee is included in your packet as informational item. Governance met prior to the November meeting and so reported out in November rather than at the December meeting.
- Below are proposed dates and times from which to choose for the next Board Quality Rounding. The intent is that attendees and a final date and time will be decided during the Board Action Items section of this meeting. This list of proposed dates is included to simplify the work of scheduling; please come prepared to know which dates may work for you. Board Quality Rounding requires scheduling two hours in total.
  - Thursday, January 8th, 9:30am-11:30am
  - Thursday, January 8th, 2:00pm-4:00pm
  - Thursday, January 29th, 2:30pm-4:30pm
  - Thursday, February 5th, 12:30pm-4:00pm (any 2-hour window during this timeframe will work for our teams.)

Minutes of the Board of Commissioners Meeting
Chelan County Public Hospital District No. 1
Arleen Blackburn Conference Room & Video Conference Connection
November 19, 2025

Present: Shari Campbell, President; Tom Baranouskas, Vice President; Jessica Kendall, Commissioner; Cary Ecker, Commissioner; Dr. Jesse Knight, Commissioner; Diane Blake, Chief Executive Officer; Pat Songer; Chief Operating Officer/Chief of EMS; Marianne Vincent, Chief Financial Officer; Melissa Grimm, Chief Human Resources Officer; Natasha Piestrup, Senior Director of Nursing; Whitney Lak, Senior Director of Rural Health Clinic; Megan Baker, Executive Assistant

Guests: Rachel Avery, Director of Continuous Quality Improvement

Zoom: John Sambrook

Topics	Actions/Discussions
Call to Order	• President Shari Campbell called the meeting to order at 4:59 PM. Dr. Knight then led the Pledge of Allegiance.
Consent Agenda	• Cary moved to approve the consent agenda. Dr. Knight seconded the motion; motion unanimously approved.
Community Input	• None
CM Values	Diane Blake provided the report. • Diane shared a letter from a community member that reflected our values of community—listening and responding to local needs—and quality—ensuring everything we do supports high-quality patient care. The community member praised Dr. Butruille, the physician assistant program, and the mobile clinic, noting the exceptional care he received.
Governance Committee Report	Shari Campbell provided the Governance Committee report. • The Committee reviewed the Commissioner Compensation policy, discussed the draft "Role of a Hospital Commissioner" document, and welcomed feedback. They also recommended that other Board Committees shift from individual self-evaluations to group discussion formats. The Committee reviewed the 2025 work plan, began outlining the 2026 work plan, and initiated planning for 2026 Board Education, noting that education in 2025 exceeded the quarterly expectation. Lastly, the group discussed the CEO annual evaluation process, which will be addressed further in the next agenda section.
Discussions & Reports	**A. CEO Annual Evaluation Process and Materials** Shari Campbell led the discussion. • A few updates were made to the CEO evaluation timeline. The latest version was emailed and provided in print to Commissioners. The Board will hold a Special Meeting on January 6 to review and Collaborate on the CEO evaluation together. **B. Department of Health (DOH) Survey** Rachel Avery gave the presentation. • Rachel presented Cascade Medical's recent Department of Health Survey, including the Fire & Life Safety review. Both areas identified opportunities for improvement, and the Department approved extensions to support development of the required plans of correction. Kudos to Rachel and her team for their swift, thorough work in developing these plans.

Action Items	**MOTION: Approve Organizational Succession Plan** • The group requested that the term "grooming" be replaced with alternative language. Jessica moved to approve the document with that revision; Tom seconded. Motion unanimously approved. **MOTION: Approve 2026-2028 Community Health Needs Assessment** • Tom moved to approve; Cary seconded. Motion unanimously approved. **MOTION: Approve Credentialing** • Cary moved to approve; Dr. Knight seconded. Motion unanimously approved**.**
BREAK	The Commission took a 20-minute break at 5:50 PM and resumed the meeting at 6:10 PM.
October Financial Report	**Marianne Vincent provided the report.** • Our October margin of ($623,000) compared to a budgeted margin of $272,000 for a variance of ($894,000). • Gross revenues are still tracking close to budget. Operating expenses exceeded budgeted expenses by ($283,000). • Professional fees continued to run over budget ($143,000) in October as we moved forward with Meditech optimization work, utilized outside staffing for Rehab services, and incurred provider recruiting expenses. • The budget reflects a positive $928K. • Cash receipts exceeded budget by $460,000, and year-to-date cash balances are $2,137,000 above projections. October capital expenditures totaled $294,000. Cash receipts show a $3.7 million favorable variance. • Days in Net Accounts Receivable are at 41.6 days; the increase from September is due to the contractual allowance adjustment for the interim Medicare Cost Report. • Recent staffing changes resulted in some process gaps; however, ambulance charges are being reestablished. The GEMT cost report for Medicaid ambulance transports is complete, and we anticipate reimbursement from the state. • E-signature pads are nearly ready for rollout.
Administrator Report	**Diane Blake provided the report**. • **Reminders:** The Food Drive runs through Monday, November 24. The Holiday Party will be held on December 3 at 6:00 PM at LOGE. • **Staffing and Recruitment:** Physician recruitment is ongoing, with residents unavailable until fall 2026. CM continues efforts to hire a full-time physician with leadership capacity for the Medical Director role and plans to extend an offer to a resident. On Monday, November 17, CM welcomed its new Marketing and Public Relations Director, Katie Grove. • **Master Facilities Plan:** The only option within CM's $30 million borrowing capacity is the "do nothing" scenario. The executive team is determining next steps. • **Community Engagement Night:** Kudos to the team for coordinating the 11/18 event. Whitney, Janeth, and Blossom prepared materials and engaged with community members, and Megan secured a table by coordinating with the City. This is a great reminder of what we accomplish when we work together. • **Radiology Update:** October mammograms increased by 30%, totaling 88. Kudos to the radiology team for their strong Breast Cancer Awareness campaign. • **Shari added:** Commissioners' attendance at the December 3 Holiday

	Party is to express appreciation to staff—not for business or meeting purposes so it meets the legal requirements allowing attendance by more than two.
Board Follow Up Items	• If you plan to attend any of the outreach events listed on your agenda, please let Megan know. • Please consider supporting the Food Drive. Checks can be made out to Upper Valley MEND, and Megan can help route donations.
Meeting Evaluation/Commissioner Comments	• None
Executive Session: Performance of a Public Employee (RCW 42.30.110(1)(g)	• Shari called the executive session to order at 6:45 PM for 30 minutes. • At 7:15 PM, the group extended the meeting for one hour. • The group exited the executive session at 8:15 PM
Adjournment	• Shari moved to adjourn the meeting at 8:15 PM; Dr. Knight seconded, and the group unanimously agreed.

_____ Shari Campbell, President

_____ Jessica Kendall, Secretary

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Proposed 2026 Board Meeting Dates

January 6, 2026	3:00 PM	Special Board Meeting, Administration Conf. Room
January 21, 2026	5:00 PM	Special Board Meeting (third Wednesday)
February 25, 2026	5:00 PM	
March 25, 2026	5:00 PM	
April 22, 2026	5:00 PM	
May 27, 2026	5:00 PM	
June 24, 2026	5:00 PM	
July 22, 2026	5:00 PM	
August: No Meeting		
September 23, 2026	5:00 PM	
October 28, 2026	5:00 PM	
November 18, 2026	5:00 PM	(third Wednesday)
December 16, 2026	5:00 PM	(third Wednesday)

Meetings are held in the Arleen Blackburn Conference Room unless otherwise noted.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Governance Committee Charter
Cascade Medical Board of Commissioners

Purpose

To provide for the Board's effectiveness and continuing development as well as to continuously enhance the effectiveness of communication between the Board and Administration.

Responsibilities

- At least annually, review Committee Charter.
- Review policies related to Governance work on an at least annual basis.
    a. Conflict of Interest
    b. New Commissioner Orientation
    c. Procedure for receiving legal documents from a process server
    d. Open Public Meetings
    e. Policy Creation, Review, and Approval
    f. Request for Public Records
    g. Commissioner Compensation
- Define Committee work plan and goals annually at first meeting of the year.
- Perform an annual committee self-assessment by November 30.
- Define how new committee members will be efficiently oriented to the committee.
- Recommend an ad hoc committee for review of Bylaws as needed
- Develop and refine process for CEO review
- Work with Administration to plan annual Board retreat
- Recommend to the Board processes designed to provide for effective and efficient governance, including:
    - Developing and monitoring an annual education plan for the Board
    - Reviewing and recommending position descriptions detailing responsibilities of and expectations for Board members and Board President
    - Leading commissioner succession planning and Board recruitment efforts
    - Leading Board's self-assessment work on an at least biennial basis
- Oversee and ensure a robust board mentorship program
- Recommend to the full Board annual Board Objectives and monitor for success
- Oversee strategic-level dashboarding

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Membership

The Governance Committee will be made up of two Commissioners, one of whom will be designated Chair of the committee; Cascade Medical's CEO; Cascade Medical's CHRO; and the Executive Assistant. Ideally, the President of the Board will chair the

Governance Committee and the second Commissioner comprising the committee will be the Vice President of the Board. Other non-Commissioners will be invited on an ad hoc basis. The CEO shall be considered the staff liaison to the Governance Committee.

Annually at the January Board meeting, Board will select a chairperson and one other Board member to serve on each committee. The full Board will ratify these appointments via vote.

It is preferred that Commissioners serving on the Governance Committee have experience serving on other boards as well as the CM Board of Commissioners.

Meetings

The Governance Committee meets at least five times per year.

Before each meeting, the CEO will send a draft agenda to the committee chair for review and amendment. The CEO and committee chair will work together in this fashion to develop the final agenda, in advance, for each committee meeting. Preferably, all meeting materials will be sent to committee members five calendar days in advance.

- Every agenda will include an estimated time frame for each agenda item.

Ideally every committee meeting should be attended by two commissioners. If a commissioner who is a regular member of the committee is unavailable to attend a meeting, the committee chair and CEO will decide together whether to reschedule the meeting or invite another commissioner to attend.

- Cascade Medical is a public entity. As such, the Board of Commissioners must follow the Open Public Meetings Act. This act requires that all ordinances, resolutions, rules, regulations, orders and directives, in order to be valid, be adopted at open public meetings. The committee meetings are not open public meetings and, as such, committees are not able to take official action on behalf of the Board of Commissioners. As a result, there is no quorum requirement at the committee level.

Minutes will be taken by the Executive Assistant. In his or her absence, the ~~CEO~~ CHRO will take minutes.

Reporting

The committee chair will provide a verbal report at the full board meeting subsequent to each committee meeting.

- The committee meeting agenda will go out in the full board packet for the meeting at which the committee chair reports.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Community Outreach & Awareness Committee Charter
Cascade Medical Board of Commissioners

Purpose

The purpose of the Community Outreach & Awareness Committee (COAC) is to provide strategic oversight and direction to maximize Commissioner connection to the community and to ensure CM's communication to and engagement with the community consistently furthers the strategic direction of the organization and continues to position it as trusted care that puts patients first.

Responsibilities

- At least annually, review the committee charter.
- Define committee work plan and goals annually by February 28.
- Perform an annual committee self-assessment by November 30
- When possible, use input and/or data from community engagement work, patient surveys, social media and other data sources to better understand what's important, what may be lacking awareness, and/or where opportunities exist to increase market share and services, to help guide future work.
- Define how new committee members will be efficiently oriented to the committee.
- Evaluate and oversee communication regarding CM's key services; recommend strategic initiatives and direction to enhance community awareness of these services and how to access them, including what tools/communication vehicles work best for various segments of the community served by CM.
- ~~Provide strategic direction regarding communication around being a public hospital district.~~
- Provide strategic direction around the collection of community feedback, to learn what's important to the community and why, and be a conduit for community input on how understanding of needs, services and challenges, if any, can be improved.
- Recommend strategic communication and marketing work, such as around timing of rebranding and defining mission/vision/values, for consideration in the strategic planning process.
- Consider and recommend opportunities for community outreach opportunities for commissioners.
- Consider and recommend opportunities for strategic outreach broadly for Cascade Medical.

Membership

The Community Outreach & Awareness Committee will be made up of two Commissioners, one of whom will be designated Chair of the committee; Cascade Medical's CEO; Cascade Medical's COO; Cascade Medical's Director of Marketing and Public Relations; and the Executive Assistant. The Clinic Medical Director and/or other

provider representation will be included on an ad hoc basis, based on planned agenda topics. The board may choose to add one or more community members to the committee. The CEO shall be considered the staff liaison to the Community Outreach & Awareness Committee.

Ideally, Commissioners serving on the COAC will possess experience in communications and/or marketing.

Annually at the January Board meeting, the Board will appoint a chairperson and one other Board member to serve on each committee. ~~At that time t~~ The Board may also appoint one or more community members to serve on the committee.

Meetings

The Community Outreach & Awareness Committee meets at minimum four times per year, on an at least quarterly basis.

Before each meeting, the CEO and the Chair will work together to draft an agenda prior to each meeting. Preferably, all meeting materials will be sent to committee members five calendar days in advance.

- Every agenda will include an estimated time frame for each agenda item.

Ideally every committee meeting should be attended by two commissioners. If a commissioner who is a regular member of the committee is unavailable to attend a meeting, the committee chair and CEO will decide together whether to reschedule the meeting or invite another commissioner to attend.

- Cascade Medical is a public entity. As such, the Board of Commissioners must follow the Open Public Meetings Act. This act requires that all ordinances, resolutions, rules, regulations, orders and directives, in order to be valid, be adopted at open public meetings. The committee meetings are not open public meetings and, as such, committees are not able to take official action on behalf of the Board of Commissioners. As a result, there is no quorum requirement at the committee level.

Minutes will be taken by the Executive Assistant. In his or her absence, the CEO will take minutes.

Reporting

The committee chair will provide a verbal report at the full board meeting subsequent to each committee meeting.

- The committee meeting agenda will go out in the full board packet for the meeting at which the committee chair reports.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Quality Oversight Committee Charter
Cascade Medical Board of Commissioners

Purpose

To provide a mechanism to assist the Board in fulfilling its oversight responsibilities related to patient safety, operational and clinical quality, patient satisfaction, risk management and medical staff credentialing. The Committee shall provide oversight to Cascade Medical's efforts in measuring quality and patient safety, disseminating information, improving clinical practices and supporting a culture of high-quality care and safety throughout the organization.

Responsibilities

- At least annually, review Committee Charter.
- Define Committee work plan goals annually.
- Define how new committee members will be efficiently oriented to the committee.
- Review policies related to Quality and Risk Management work on an at least annual basis.
  a. Quality Assessment and Performance Improvement ~~Program~~ Plan
  ~~b. Yearly Quality Reporting and Improvement Plan~~
  ~~c.~~b. Risk Management Program ~~Plan~~
  ~~d.~~ Governance Policy regarding Washington's Death with Dignity Act
  ~~e.~~c. Medical Staff Credentialing Policy
  ~~f.~~d. Medical Staff Professional Practice Evaluation Policy
  ~~g.~~e. ~~Notice~~ Disclosure of Unanticipated Outcomes
- Review reports from at least the following committees on a quarterly basis:
  a. Safety Committee
  b. Utilization Management Committee
  c. Infection Control Committee
  d. Emergency Care Committee
- Review the following quarterly:
  a. Quality Assurance data from Cascade Medical departments
  b. Cascade Medical Quality Improvement projects and progress
  c. Patient Satisfaction Survey data
- Review ~~publically~~publicly reported data annually.
- Ensure Board Quality Rounds are conducted.
- Ensure the review of medical staff credentialing documents as required, following medical staff input as per medical staff bylaws, and present to the Board for approval.
- Make recommendations to the full board on safety & quality education.
- ~~Challenge~~ Collaborate with a~~A~~dministration and s~~S~~taff when Quality measures are below expectations or Quality Improvement projects are not achieving desired outcomes.
- Summarize and report information shared at Quality Oversight Committee meetings with the entire Board.

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Membership

The Quality Oversight Committee will be made up of two Commissioners, one of whom will be designated Chair of the committee; and at least Cascade Medical's CEO; Chief Operating Officer; Chief Human Resources Officer; Director of Continuous Quality Improvement; Quality Manager; ~~Operational Safety Manager~~; ~~Quality Data Specialist~~; Senior Director of Nursing; Senior Clinic Director; Executive Assistant; and other ad-hoc representation as required. The COO shall be considered the staff liaison to the Quality Oversight Committee.

Annually at the January Board meeting, the Governance Committee recommends a chairperson and one other Board member to serve on each committee. The full Board will ratify these appointments via vote.

Meetings

The Quality Oversight Committee meets at least four times per year, ideally on a quarterly basis.

Before each meeting the COO sends a draft agenda to the committee chair for review and amendment. The COO and committee chair work together in this fashion to develop the final agenda, in advance, for each committee meeting. The agendas will include an estimated time frame for each agenda item. In addition, the COO will ensure preparation of a Quality Assurance dashboard with current data for each department prior to the scheduled meeting. The agenda and supporting documents will be distributed to the Board Quality Oversite Committee members five days in advance of the meeting. The COO will also be responsible for ensuring Board Quality Rounds are scheduled.

Ideally every committee meeting should be attended by two commissioners. If a commissioner who is a regular member of the committee is unavailable to attend a meeting, the committee chair and COO will decide together whether to reschedule the meeting or invite another commissioner to attend.

- Cascade Medical is a public entity. As such, the Board of Commissioners must follow the Open Public Meetings Act. This act requires that all ordinances, resolutions, rules, regulations, orders and directives, in order to be valid, be adopted at open public meetings. The committee meetings are not open public meetings and, as such, committees are not able to take official action on behalf of the Board of Commissioners. As a result, there is no quorum requirement at the committee level.
- The Quality Oversight Committee reviews information that pertains to performance/quality improvement and peer review programs to improve the quality of medical care of patients and to prevent medical malpractice (RCW 70.41.200 (1) (a)). As such, information contained in meeting packets and reviewed at meetings may be confidential and subject to protection under RCW 4.24.250, RCW 70.41.200, and Senate Bill 5666.

Minutes will be taken by the Executive Assistant. In his or her absence, the COO will take minutes or designate a minute-taker.

Reporting

The committee chair will provide a verbal report at the full board meeting subsequent to each committee meeting.

- The committee meeting agenda will go out in the full board packet for the meeting at which the committee chair reports.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Finance Committee Charter
Cascade Medical Board of Commissioners

Purpose

The Finance Committee is responsible for recommending financial policies, goals and budgets that support the mission, values and strategic objectives of Cascade Medical. This committee also reviews CM's financial performance against its goals and is responsible for financial oversight of the organization.

Responsibilities

- At least annually, review Committee Charter.
- Review policies related to Finance work on an at least annual basis.
  - Spending Approval Matrix
  - Change Order Authority
  - Financial Assistance / Charity Care Policy
  - Warrant Approval Policy
  - Financial Management Policy
  - Identity Theft Red Flag Policy
  - Reporting Improper Government Actions
  - Organizational Integrity Compliance Committee Structure and Purpose
- Define Committee work plan and strategic goals annually by February 28.
- Perform an annual committee self-assessment by November 30.
- Define how new committee members will be efficiently oriented to the committee.
- Review and recommend annual operating budget to full board
- Review insurance coverage for adequacy on an annual basis
- Annually, ensure compliance with bond covenants and ratings firms
- Participate in meetings conducted by auditors
- Regularly review financial indicators and work with administration to recommend which indicators to monitor and to set threshold goals
- Review quarterly financials
- Review OICC quarterly reports
- Make recommendations to administration regarding effective financial reporting to the full board
- Recommend auditor selection to the Board annually
- Oversee process for long term financial planning of critical future events
- Make recommendations for financial education for the full Board
- The Committee should be made aware of liabilities that are extraordinary, unusual, and that may have material financial impacts to the organization.
- Committee focuses and frames work on strategies, not daily operations.

Membership

The Finance Committee will be made up of two Commissioners, one of whom will be designated Chair of the committee; Cascade Medical's CEO; Cascade Medical's CFO; and the Executive Assistant. The board may choose to add one or more community members to the committee.

Other non-Commissioners will be invited on an ad hoc basis. The CFO shall be considered the staff liaison to the Finance Committee.

Ideally, Commissioners serving on the Finance Committee will possess experience in finance.

Annually at the January Board meeting, the Board will appoint a chairperson and one other Board member to serve on each committee. At that time the Board may also appoint one or more community members to serve on the committee.

Meetings

The Finance Committee meets at minimum four times per year, on an at least quarterly basis.

Before each meeting, the CFO will send a draft agenda to the committee chair for review and amendment. The CFO and committee chair will work together in this fashion to develop the final agenda, in advance, for each committee meeting. Preferably, all meeting materials will be sent to committee members at least three calendar days in advance. This advance disbursement may need to be adjusted depending on the timing of the completion of current financial statements.

- Every agenda will include an estimated time frame for each agenda item.

Ideally every committee meeting should be attended by two commissioners. If a commissioner who is a regular member of the committee is unavailable to attend a meeting, the committee chair and CFO will decide together whether to reschedule the meeting or invite another commissioner to attend.

- Cascade Medical is a public entity. As such, the Board of Commissioners must follow the Open Public Meetings Act. This act requires that all ordinances, resolutions, rules, regulations, orders and directives, in order to be valid, be adopted at open public meetings. The committee meetings are not open public meetings and, as such, committees are not able to take official action on behalf of the Board of Commissioners. As a result, there is no quorum requirement at the committee level.

Minutes will be taken by the Executive Assistant. In his or her absence, the CFO will take minutes.

Reporting

The committee chair will provide a verbal report at the full board meeting subsequent to each committee meeting.

- The committee meeting agenda will go out in the full board packet for the meeting at which the committee chair reports.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Department: Board of Commissioners

Commissioner Compensation Policy

PURPOSE:

1. To establish uniform standards on compensable commissioner activities
2. To ensure compliance with RCW 70.44.050
3. To use public resources in appropriate ways
4. To provide an appropriate way to manage the unavoidable conflict of interest when commissioners determine the circumstances of their compensation.

POLICY:

Per RCW 70.44.050, a Commissioner shall receive $161 as compensation for each day in which services are performed as a member of the governing body. Such compensation shall not be deemed lucrative and shall not exceed more than $15,456 per year.

A Chelan County Public Hospital District No. 1 Commissioner will be compensated for the following meeting attendance and services participation:

1. All regular and special meetings of the Board
2. All meetings of committees set forth by the hospital district bylaws or committees established for temporary purpose by majority vote of the Board of Commissioners
3. All administration meetings appropriate for commissioner participation, for example audits or consultant meetings
4. The following regularly scheduled meetings which the board has determined are beneficial for one commissioner to attend:
    a. Medical Staff meetings
    b. Cascade Medical Foundation meetings
    c. Open Forums
    d. Part Time Resident Advisory Committee meetings
    e. Board Quality Rounding (Up to 2 Commissioners per event)
5. A maximum of two community outreach events per month for which Board President seeks commissioner participation, such as City of Leavenworth Community Engagement Nights, community education events, etc.
6. Attendance at WSHA educational conferences or advocacy events with daily compensation for each day or partial day that includes education, a related event, and/or travel to and from the event

Commissioner Compensation Policy

7. Participation in education which can be logged toward achieving Health Care Governance certification
8. One meeting per month either in person or remotely to set either Special or Regular board meeting agenda(s) with the CEO
9. One meeting in advance of each committee meeting to prepare committee meeting agenda with the committee liaison
10. A maximum of two meetings per month either in person or remotely between the Board President and the CEO to conduct hospital business
11. Other days of service not included in this policy may be compensated with approval of the Board President

When more than one meeting or service occurs on the same day, Commissioner will receive the daily rate of pay of $161.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Department: Board of Commissioners

Identity Theft Red Flag Policy

POLICY:

Cascade Medical's (CM) Identity Theft Prevention Program was developed to comply with the Federal Trade Commission's Identity Theft Prevention Red Flags Rule (16 CFR § 681.1). The Program has been created in consultation with the Business Office, Medical Records, Admitting, Information Technology and Administration after conducting an assessment of risk of Identity Theft associated with covered patient accounts. Nothing in this policy is intended to prevent a patient from receiving emergency medical care.

PROCEDURE:

I. Definitions

For purposes of the Program, a covered patient account is defined as any patient account CM offers for its patients that may involve multiple payments or transactions, including one or more deferred payments, that has a reasonably foreseeable risk to patients of Identity Theft.

Identity Theft means fraud committed using the identifying information of another person, and Red Flag means a pattern, practice, or specific activity that indicates the possible existence of Identity Theft.

II. Program Purposes

The purposes of the Program are to identify the relevant Red Flags based on the risk factors associated with CM's covered accounts, institute policies and procedures for detecting Red Flags, identify steps the institution will take to prevent and mitigate Identity Theft, and create a system for regular updates and administrative oversight to the Program.

III. Identification of Red Flags

The Identity Theft Red Flags Mitigation and Resolution Procedures (Attachment A) identify the Red Flags that would be most relevant to CM. The Red Flags generally fall within one of the following four general types of Red Flags:

A. Suspicious Documents;
B. Suspicious Personal Identifying Information;
C. Suspicious or Unusual Use of Covered Account; and
D. Alerts from Others (e.g., patient, Identity Theft victim, or law enforcement)

IV. Detection of Red Flags

In order to facilitate detection of the Red Flags identified in Attachment A, appropriate CM staff will take steps to obtain and verify the identity of new and existing patients arriving at CM for care. These steps will include the verification of government-issued identification, membership cards from Medicare, Medicaid, or Commercial Insurance plans and, where applicable, orders or referral documents from outside providers or healthcare institutions. Where practical, CM staff will utilize an electronic eligibility verification system to verify the patient's coverage.

V. Program Administration

The Chief Financial Officer and his/her delegate is responsible for developing, implementing, administering, and updating the Program and for developing a training program for staff identified as responsible for or having a role in implementing the Program. The Organizational Integrity Compliance Committee will establish, as an agenda item for their regular meetings, review of any actual or suspected Red Flag events.

Identity Theft Red Flag Policy

Attachment A

Relevant Identity Theft Red Flags Mitigation and Resolution Procedures

IDENTITY THEFT RED FLAG	PREVENTION/MITIGATION PROCEDURE	RESOLUTION OF RED FLAG
Documents provided for identification appear to have been altered or forged.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.
The SSN provided is the same as that submitted by other persons opening an account or other patients.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.
Patient has an insurance number but never produces an insurance card or other physical documentation of insurance.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process. Contact insurance company as necessary. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient (*e.g.*, inconsistent blood type).	Investigate complaint, interview individuals as appropriate, review previous files for potential inaccurate records. Items to consider include blood type, age, race, and other physical descriptions may be evidence of medical identity theft.	Depending on the inconsistency and review of previous file, either delay/ do not open a new covered account or terminate services. If the results of the investigation do not indicate fraud, all contact and

		identifying information is re-verified with patient.
Complaint/inquiry from an individual based on receipt of: • a bill for another individual • a bill for a product or service that the patient denies receiving • a bill from a health care provider that the patient never patronized • a notice of insurance benefits (or Explanation of Benefits) for health services never received.	Investigate complaint, interview individuals as appropriate	Terminate treatment/credit until identity has been accurately resolved; refuse to continue attempting to collect on the account until identity has been resolved. Notify law enforcement as appropriate. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Complaint/inquiry from a patient about information added to a credit report by a health care provider or insurer	Investigate complaint, interview individuals as appropriate	Terminate treatment/credit until identity has been accurately resolved; refuse to continue attempting to collect on the account until identity has been resolved. Notify law enforcement as appropriate.

		If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Complaint or question from a patient about the receipt of a collection notice from a bill collector.	Investigate complaint, interview individuals as appropriate	Terminate treatment/credit until identity has been accurately resolved; refuse to continue attempting to collect on the account until identity has been resolved. Notify law enforcement as appropriate. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Patient or insurance company report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.	Investigate complaint, interview individuals as appropriate	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process. Contact insurance company as necessary. Notify law enforcement as appropriate. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified

		with patient.
Mail sent to the patient is returned repeatedly as undeliverable although transactions continue to be conducted in connection with the patient's covered account.	Skip-tracing procedures are used to find the patient's current mailing address.	Patient is found and contact information is updated.

CM is notified by a patient, a victim of identity theft, a law enforcement authority, or any other person that it has opened a fraudulent account for a person engaged in identity theft.	Investigation to determine if billing was made fraudulently.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process. Contact insurance company as necessary. Notify law enforcement as appropriate. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Personal identifying information provided by the patient is associated with known fraudulent activity as indicated by internal or third-party sources used by CM. For example: • The address on an application is the same as the address provided on a fraudulent application; or • The phone number on an application is the same as the number provided on a fraudulent application.	Investigate complaint, interview individuals as appropriate	Terminate treatment/credit until identity has been accurately resolved; refuse to continue attempting to collect on the account until identity has been resolved. Notify law enforcement as appropriate. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.

CASCADE MEDICAL PARTNERS IN YOUR HEALTH	**Department:** Board of Commissioners

Identity Theft Red Flag Policy

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Department: Business Office

Financial Assistance

POLICY

Cascade Medical is committed to the provision of health care services to all persons in need of medically necessary care regardless of ability to pay. In order to protect the integrity of operations and fulfill this commitment, the following Financial Assistance Program is established, which is designed to be consistent with the requirements of the Washington Administrative Code (WAC), Chapter 246-453, the 2016 WSHA/DOH voluntary Financial Assistance Program application guidelines and the Internal Revenue Service 501(r) regulations. The program criteria will assist staff in making consistent, objective decisions regarding eligibility for financial assistance while maintaining Cascade Medical's financial integrity.

PROCEDURE:

COMMUNICATIONS TO THE PUBLIC

Information about Cascade Medical's Financial Assistance Program will be made publicly available as follows:

A. A notice advising patients that Cascade Medical provides financial assistance will be posted in key public areas of the facility, including Admissions, the Emergency Department and the Family Practice Clinic. Information about the Program will also be featured prominently on CM's website. This notice will conform to IRS 501(r) regulations and the WSHA/DOH standardized application process.

B. In order to meet Notice Language requirements, both written information about the Financial Assistance Program and verbal explanations shall be available in any language spoken by more than five~~ten~~ percent of the population in Cascade Medical's service area. As of the effective date of this policy, written and verbal information will be made available in English and Spanish. At any point in the future, should Cascade Medical determine that another language is spoken by five~~ten~~ percent or more of the service area population, written and verbal information will be provided in that language as well. Where possible, interpretation for other non-English speaking or limited-English speaking patients and for other patients who cannot understand the writing and/or explanation will be provided. Cascade Medical will, on at least an annual basis, provide training to receptionists, registration and other front-line staff. This training will help staff answer financial assistance and charity care questions correctly, provide staff with the appropriate Financial Assistance Program application and informational materials, and direct further inquiries to the Patient Financial Counselor in a timely manner.

C. Written notice about Cascade Medical's Financial Assistance Program, including a plain-language summary of its provisions, financial assistance application form, and information on the current federal poverty levels by family size will be made available to any person who requests the information, by mail, by email, by telephone or in person. Information about Cascade Medical's current discount schedule, schedule of charges and estimates of charges for planned procedures will also be made available upon request.

D. In accordance with RCW 70.170.060(8)(a) All billing statements and other written communications concerning billing or collection of a bill will include a statement displayed prominently on the first page of the statement in both English and the second most spoken language in the hospital's service area that the patient may qualify for free care or a discount on their hospital bill, whether or not they

have insurance, and will direct the patient to contact our Financial Assistance Counselor at cascademedical.org or at 509-548-3436. Patients with self-pay balances who are receiving periodic statements from CM's Billing department will, at the time of or prior to receiving a final notice, be provided with a plain language summary of the Financial Assistance Program, including necessary contact information and other key information about the Program. Patient accounts will not be turned to collections and no other extraordinary collection efforts will be undertaken until such notice has been provided and the patient has been provided 30 days to respond.

ELIGIBILITY CRITERIA AND DESCRIPTION OF BENEFITS

1. Discounts made under Cascade Medical's Financial Assistance Program will be considered secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, other state, federal or military programs, third party liability (e.g. auto accidents or personal injuries covered under a liability insurance policy), or any other situation in which another person or entity has a legal responsibility to pay for the costs of medical services. Cascade Medical will work to identify patients and guarantors eligible for medical assistance programs under Medicaid or the Washington State health benefit exchange and assist patients in applying for available coverage. If a patient or guarantor is eligible for retroactive Medicaid coverage, Cascade Medical may choose to not provide financial assistance to any patient or guarantor who does not make reasonable efforts to cooperate with Cascade Medical in the Medicaid application process.
2. Patients will be eligible to receive financial assistance without discrimination due to age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, association, veteran or military status, the presence of any sensory, mental, or physical disability or the related need for a trained dog guide or service animal, or any other basis prohibited by federal, state, or local law.
3. Hospital, Clinic and Ambulance services eligible for discount under the Financial Assistance Program will be limited to appropriate, medically necessary hospital, outpatient, and professional services that Cascade Medical provides. With the exception of Clinical Pathology services, which are provided and billed through an outside medical group, all professional services provided at Cascade Medical will be from physicians, mid-levels and other providers employed or contracted by CM and will be eligible for program discounts.
4. Discounts made under the Financial Assistance Program will be based on the patient's family income, Federal Poverty Level (FPL) published by the US Department of Health and Human Services and Cascade Medical's Amounts Generally Billed (AGB), as defined by the Internal Revenue Service 501(r) regulations. The AGB is calculated annually by Cascade Medical financial staff and represents the average percent of billed charges paid by the Medicare and Medicaid programs and commercial insurance plans. To calculate discounts under the Program, the AGB discount percentage will be applied to billed charges as follows:
    1. Patients with family incomes at or below 200% of the Federal Poverty Levels: 100% discount.
    2. Patients with family incomes between 201% and 250% of FPLs: 75% discount from the Amounts Generally Billed (AGB) percentage.

3. Patients with family incomes between 251% and 300% of FPLs: 50% discount from the AGB percentage.

4. Patients with family incomes over 300% of FPL: at the discretion of the Cascade Medical CFO, patients suffering severe financial hardship, personal loss or other catastrophic circumstances may qualify for a discount under the program.

5. A Financial Assistance Program Schedule of Discounts will be prepared and updated annually by CM financial staff, showing the current Federal Poverty Levels applicable to the state of Washington, the current AGB discount percentages and the income levels by family size used for eligibility determination. Federal Poverty Levels are determined annually by the US Department of Health and Human Services and are shown at https://aspe.hhs.gov/poverty-guidelines. The description of the Financial Assistance Program shown on Cascade Medical's website will include the Program's current Schedule of Discounts and will also include this hyperlink.
6. For the purposes of determining family income, CM will normally require inclusion of the incomes of those persons defined in WAC 246-453-010 as family members.
7. The responsible party's financial obligation which remains after the application of any Financial Assistance Program discounts will be payable as negotiated between Cascade Medical and the responsible party. If three or more installment payments are missed and there is no satisfactory contact with the patient or responsible party, Cascade Medical reserves the right to initiate its standard collection efforts to recover any remaining balances.
8. Cascade Medical will not require a disclosure of the existence and availability of family assets from Financial Assistance Program applicants whose income is at or below 200% of the current Federal Poverty Level. Patients with family income above 200% of the current FPL will be required to disclose the existence and availability of family assets, and the CFO may require that available liquid assets, with the exception of the specific monetary assets exempt from consideration listed below be used to meet all or part of the patient's financial obligation prior to approving eligibility for the Program. Monetary Assets exempt from consideration: 1) The first $5,000 in monetary assets for an individual, $8,000 for a family of two, and $1,500 of monetary assets for each additional family member. 2) Equity in a primary residence. 3) Retirement plans other than 401(k) plans. 4) One motor vehicle (and a second motor vehicle if it is necessary for employment or medical purposes). 5) Prepaid burial contracts or burial plots. 6) Life insurance policies with a face value of $10,000 or less.

INITIAL DETERMINATION OF ELIGIBILITY

A. Cascade Medical's Financial Assistance Program will use an application process to determine eligibility. CM will utilize the standard application form developed by the Washington State Hospital Association and Department of Health.

B. Requests to provide financial assistance will be accepted from patients, family members or those parties responsible for the patient's financial obligations. Requests will also be accepted from sources such as physicians, community or religious groups, social services or CM financial services

personnel who are aware of factors that might qualify the patient for assistance under the Program. Patients are encouraged to apply prior to receiving services at CM, but applications will be accepted at any point from preadmission through settlement of the final bill.

C. Patients, family members or other parties may apply for program benefits by completing an application and submitting it, along with supporting documentation, to CM's Patient Financial Counselor. Applications may be submitted prior to receiving services or at any time after receiving services up to the final adjudication of the patient's account. Patients and other parties may obtain applications, receive assistance in completing applications and ask questions about the Financial Assistance program by speaking with the Patient Financial Counselor, between the hours of 8 am and 5 pm, Monday through Friday. Applications and information may also be requested from Registration or Business Office staff, by telephone at 509-548-3436 or on the hospital's website at www.cascademedical.org. Applications will be provided at no charge.

D. An initial determination of eligibility for financial assistance will, to the extent feasible, be completed by the Patient Financial Counselor or other CM financial services personnel at the time an application is made or as soon as possible thereafter. The patient, family member or responsible party will be duly informed of this determination.

E. During the application review process CM financial services staff will work with the patient and/or responsible party to pursue other sources of payment, such as Medicare, Medicaid and other assistance programs, and will attempt to verify application information as feasible. CM financial services staff will not impose application procedures or verification requirements that place an unreasonable burden upon the responsible party, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the responsible party's capability of complying with the application process. Where verification would impose such a burden or is otherwise not possible, CM may rely on written or verbal attestations made by the patient or responsible party. CM will not require a patient to apply for any state or federal aid program for which they are clearly ineligible, or for which they have been found ineligible in the past 12 months.

F. In accordance with WAC 246-453-030(3), if a patient or responsible party is unable to complete the Financial Assistance Program application process, but CM staff are able to determine through other means that there is a high likelihood the patient would qualify for Program benefits, CM's CFO may approve Program eligibility based solely on this determination. In these cases, CM staff will not be required to complete full verification of documentation.

G. Pending final eligibility determination, CM will initiate no collection efforts, will not require deposits for current services or payments on previous account balances and will not require patients to apply for bank loans or other credit as a condition for receiving benefits under the Program.

FINAL DETERMINATION OF ELIGIBILITY

A. Cascade Medical will notify the patient, family member or responsible party of its final determination of eligibility within 14 days of receipt of a complete application and required documentation. This determination will be made by the Business Office Manager or, in his/her absence, a designee. For discounts under the program that exceed $1,000, the approval of the Chief Financial Officer will also be required.

B. If a patient is determined to be eligible for Program benefits, that eligibility will extend for one year from the time of the application. If the application has been made more than three months prior to a new request, CM financial staff will request verification from the patient or responsible party that a patient's family income and Medicare, Medicaid or insurance coverage availability are unchanged and, if necessary, will request updates to the information provided in the application.

C. If, after due consideration, the patient is determined to be ineligible for benefits under the Program, the patient or responsible party will be provided written notice of the application denial, a description of the reasons for the denial and instructions for appeal or reconsideration. If eligibility was denied due to a lack of needed information, CM will so inform the patient or responsible party of the needed information.

D. The patient or responsible party will have 30 days from the date of the final determination of eligibility to appeal the decision.

E. In the event a patient or responsible party has made partial or full payment for hospital services and is subsequently found to have been eligible for Program benefits at the time of those services, the patient or responsible party will be reimbursed the amounts paid.

F. In the event that the hospital's final decision upon appeal affirms the previous denial of financial assistance designation under the criteria described in WAC 246-453-040 (1) or (2), the responsible party and the Department of Health shall be provided with copies of the documentation upon which the decision was based.

DOCUMENTATION AND RECORDS

A. All information relating to applications made for Financial Assistance Program benefits, including supporting documentation provided and copies of any related correspondence, will be kept confidential and not disclosed to any outside parties, except as required by law.

B. In accordance with the State of Washington's Record Retention requirements for Public Hospital Districts, documents pertaining to the Financial Assistance Program will be retained for six years following final account activity.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Department: Compliance

Organizational Integrity Compliance Committee Structure and Purpose

POLICY:

The Organizational Integrity Compliance Committee (OICC or Compliance Committee) exists to guide Cascade Medical (CM) in its mission to comply with and deter violations of Federal and State law. Compliance efforts are designed to create and support a culture which promotes ethical conduct and adherence to CM's Values, and establishes procedures to prevent, detect and resolve violations of statutes, regulations and contract provisions with which CM must comply.

PROCEDURE:

Compliance Committee Members

- Compliance Officer
- Chief Financial Officer
- Risk Manager
- HIPAA / Privacy Officer
- Business Services Director
- Director of Health Information Management and Revenue Integrity
- Virtual Fractional Chief Information Officer
- Clinic Director
- Director of Nursing (as needed)
- Utilization Manager (as needed)
- Chief Human Resources Officer (as needed)

Compliance Committee Organization

1. Compliance Committee shall meet once per month, with ad hoc committee meetings held as needed.
2. Compliance Committee meetings shall be organized and chaired by the Compliance Officer.
3. The Compliance Committee reports directly to the Chief Executive Officer and the Board of Commissioners on an at least quarterly basis, in conjunction with the quarterly Finance Committee meetings.

Elements of a Compliance Program

Organizational Integrity Compliance Committee Structure and Purpose

1. Develop and distribute written standards of conduct, as well as policies and procedures that promote Cascade Medical's commitment to compliance.
2. Develop and / or assist with ongoing regular training and effective education for members of CM's Board of Commissioners as well as all CM staff.
3. Develop and carry out a regular program of audits, chart reviews or other evaluation techniques to monitor compliance and assist with reduction of compliance risks.
4. Develop and maintain a mechanism to receive compliance complaints, protect the anonymity of the complainants and reduce concerns of retaliation.

Specific Areas of Risk

This list is not all-inclusive, but rather provides a framework or focus to the areas which require greatest attention:

1. Billing for items or services not actually rendered or that are not medically ~~un~~necessary.
2. Coding, or selecting a billing code that provides a higher payment than the billing code that most correctly represents the services rendered to the patient.
3. Unbundling (billing separately for tests or services in order to increase reimbursement) where the guidelines require billing the tests or services together.
4. Failure to refund credit balances.
5. Violations of Health Insurance Portability and Accountability Act (HIPAA) and/or Health Information Technology for Economic and Clinical Health Act (HITECH)
6. A lack of current knowledge of Centers for Medicare and Medicaid Services (CMS) regulations, Office of Inspector General (OIG) regulations and/or other compliance requirements.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Department: Compliance

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4. Failure to refund credit balances.
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6. A lack of current knowledge of Centers for Medicare and Medicaid Services (CMS) regulations, Office of Inspector General (OIG) regulations and/or other compliance requirements.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Department: Compliance

Reporting Improper Government Action

POLICY: In compliance with the Local Government Employee Whistleblower Protection Act, RCW 42.41, Cascade Medical (CM) encourages employees to disclose any improper governmental action taken by CM officials or employees, as defined in this law, without fear of retaliation. Such reporting will be done in good faith, will not include personnel actions such as employee grievances or performance evaluation issues, and will not include patient care issues unless that process has failed to remedy the condition, or an unsafe environment persists. This policy encourages complaints to be made first to CM so that they can be processed for speedy dispute resolution and legitimate business and operational interests of CM can be safeguarded. As outlined in RCW 42.41.030, paragraph 5, violations of the Policy may negate any protections under the Act.

PROCEDURE: CM employees, who become aware of improper governmental action as defined in the law, should:

1. Bring the matter to the attention of his/her supervisor, in writing, stating in detail the basis for the employee's belief that an improper action has occurred. If possible, this should be done within 24 hours, or by the end of the following business day, of the observation of the improper action. The supervisor will report the incident to the CEO within 24 hours or by the end of the following business day following receipt.

2. The CEO or his/her designee shall promptly investigate the report of improper government action. After the investigation is completed (usually within thirty working days of the employee's report), the employee shall be advised of the results of the investigation, except that personnel actions taken as a result of the investigation may be kept confidential.

3. In case of an emergency when action is not taken immediately, and where the employee reasonably believes damage to persons or property may result if action is not taken immediately, the employee may bypass the above procedure and report the improper action directly to the appropriate government agency responsible for investigating the improper action.

Reporting Improper Government Action

4. Employees may report improper governmental action to an outside agency if the employee reasonably believes that an adequate investigation was not undertaken by CM, or that the improper action is likely to recur.

5. Outside agencies may include the Chelan County prosecuting attorney, State licensing agencies, Department of Health, local law enforcement agencies or appropriate federal agencies.

6. Employees who report improper action according to this policy will not be retaliated against as a result of their action and may seek relief as described in RCW 42.41.040 if such action occurs.

7. Employees are protected from retaliation but cannot use this protection to mask or cover up personal performance issues. These issues will be handled according to established policy and procedure in the same manner as any other employee.

Quality Assurance and Performance Improvement (QAPI) Plan

Definition of Terms

For the purposes of this document, the Quality Assurance and Performance Improvement (QAPI) *Plan* refers to this written document. The QAPI *Program* refers to the functioning, ongoing, organization-wide system that is implemented as outlined in this plan.

Purpose

The purpose of Cascade Medical's Quality Assessment and Performance Improvement (QAPI) Plan is to establish a hospital-wide framework for the ongoing, comprehensive, and objective evaluation of care delivery and organizational performance. By outlining systematic processes for measurement, assessment, and design, this written plan will create an active QAPI program which identifies opportunities to enhance safety, effectiveness, efficiency, and the patient experience, supporting a culture of continuous improvement.

This plan and resulting program are designed to reflect Cascade Medical's mission to be an exceptional rural healthcare facility with a team of compassionate and dedicated professionals who provide quality care, services, and resources to our patients and their families. Rooted in our values of community, commitment, empowerment, integrity, quality, respect, and transparency, it reaffirms our dedication to continuous learning and performance excellence.

Scope

The scope of this plan encompasses all departments, clinical and non-clinical services, medical staff, and contracted services, ensuring a unified approach to performance improvement across the organization. The plan will serve as the blueprint for evaluating organizational processes, functions, and services using objective measures to identify trends, assess performance, and design improvements that strengthen patient care and operational effectiveness. This coordinated effort fulfills applicable regulatory requirements, including those outlined in 42 CFR §485.641 (Critical Access Hospital Conditions of Participation), RCW 70.41.200, and WAC 246-320-171. All information, data, and analyses produced through QAPI activities are confidential and protected as quality assurance materials under state and federal law.

Governance & Oversight

The Governing Board maintains ultimate accountability for the quality and safety of care delivered by the organization and ensures that this plan outlines adequate structures, resources, and oversight mechanisms to support an effective QAPI Program. The Board fosters a culture in which quality, safety, respect, and patient-centered care are organizational priorities, and it sets expectations that encourage open communication, staff accountability, and a non-punitive approach to identifying and reporting quality concerns. The Board designates the Quality

Oversight Committee (QOC) to provide operational leadership for QAPI activities and to ensure that program efforts remain consistent, sustainable, and aligned with regulatory requirements, even during periods of staffing or leadership transition.

The Quality Oversight Committee is a multidisciplinary group that includes two members of the Governing Board, the senior leader who serves as the Board's liaison for quality, and representatives from quality management, clinical services, and other relevant departments. The QOC meets quarterly to review program performance, evaluate improvement initiatives, analyze quality indicators, and assess resource needs such as staff time, training, and technical support necessary to advance QAPI activities. The Committee Chair reports quarterly to the full Governing Board, ensuring transparent communication, alignment with organizational priorities, and informed governance.

Quality subcommittees report to the QOC through a standardized quarterly reporting process that includes updates on current work, identified barriers, planned activities, accomplishments, and related performance indicators. This reporting structure ensures that improvement of work across the organization is coordinated, visible, and supported. Through this governance model, the organization promotes an environment where staff feel safe to report events, share concerns, participate in improvement efforts, and contribute to a culture of continuous learning and high reliability.

Data Systems, Monitoring, and Feedback

The hospital maintains an integrated, organization-wide system for gathering and evaluating data related to patient care, services, and organizational performance. Information is drawn from multiple sources—including caregiver and patient input, adverse event reports, performance indicators, survey findings, and complaints—and is obtained through established processes such as the incident reporting system, patient experience activities, EHR data extraction, chart audits, and routine quality monitoring. This system emphasizes indicators that reflect health outcomes and support the prevention and reduction of medical errors. The hospital will collect, monitor, and assess data including, but not limited to:

- Operative, invasive, or high-risk procedures
- Infection rates and antimicrobial resistance patterns
- Mortality
- Medication use
- Medication-related incidents, errors, and near misses
- Patient injuries, falls, restraint use, and/or other negative health outcomes and incidents injurious to patients in the hospital
- Adverse events
- Diagnostic discrepancies (pre-/post-procedure)
- Adverse drug reactions
- Confirmed transfusion reactions

- Patient grievances, needs, satisfaction
- Hospital-acquired conditions (e.g., pressure injuries)
- Transitions of care (e.g., readmission rates)
- Quality control and risk management activities
- Clinical outcome measures (e.g., length of stay)
- Peer review findings

All information is aggregated and analyzed to identify trends, evaluate performance against internal and external benchmarks, and assess compliance with regulatory requirements and evidence-based practices. Findings are communicated through standardized and ad-hoc reports, scorecards, and dashboards that support both routine monitoring and performance improvement projects. Quality data are shared with frontline staff, department leaders, executive leadership, and the Governing Board at frequencies appropriate to each audience to ensure transparency, accountability, and timely feedback. These insights inform the prioritization of improvement opportunities, initiation of performance improvement projects (PIPs), policy revisions, and strategic planning.

Performance Improvement Processes

Identification and Prioritization

Opportunities for improvement are identified through the hospital's data systems, monitoring activities, and feedback mechanisms, including input from patients, staff, and external reviewers. Prioritization is done annually following a structured approach outlined in the *Prioritization Worksheet*. Leadership conducts an initial assessment of organizational needs and prepares a draft prioritized list of improvement projects. This list is presented to the Quality Oversight Committee for review, input, and approval, ensuring governing body oversight of QAPI priorities. Selected Performance Improvement Projects (PIPs) are structured using a standardized methodology outlined in the *Performance Improvement Project Worksheet*. All worksheets are approved annually by the QOC to ensure alignment with organizational goals and regulatory requirements.

Root Cause Analysis (RCA)

A Root Cause Analysis is initiated when an event indicates a significant actual or potential risk of harm, involves a serious safety event, reveals a pattern of recurring issues, or is otherwise required by policy or regulation. RCA activities are conducted using a standardized process to identify underlying system contributors rather than individual blame. Findings, corrective actions, and follow-up steps are documented in the organization's designated quality and patient safety systems and reviewed by the QOC to validate completeness and appropriateness.

Evaluating and Sustaining Improvements

Following implementation, interventions are monitored to evaluate their impact and to ensure improvements are effective, reliable, and free from unintended consequences. Measures may include audits, data trend analysis, observation, or feedback from staff and patients. Sustainability plans—such as policy revision, workflow redesign, staff education, competency validation, and integration into ongoing monitoring systems—are incorporated into each project. The QOC reviews progress at regular intervals to determine whether the improvement has been sustained, requires adjustment, or warrants broader adoption across the organization.

Outcomes, lessons learned, and recommendations from PIPs and RCAs are communicated to relevant departments, frontline staff, and leadership to support transparency, organizational learning, and accountability. Successful strategies are disseminated and reinforced to maintain long-term performance gains and continuous improvement.

Communication and Education

Effective communication and structured education are foundational to maintaining a transparent, learning-focused culture that supports quality, safety, and continuous improvement. Staff receive clear and consistent information about organizational expectations beginning at onboarding and continuing throughout employment. New employees are introduced to foundational quality concepts during orientation using the *Quality 101 (*link here*)* educational handout. To ensure continued awareness and emphasize the organization's commitment to quality, Quality will be a standing agenda item during all quarterly all-staff Open Forums. Leadership reinforces these priorities through consistent top-down communication that emphasizes the importance of quality, safety, and active participation in improvement efforts.

Ongoing communication ensures that all team members remain engaged in QAPI activities and aligned with organizational goals. Quality disseminates key data and updates to department directors, who then share the information with their teams. Staff may receive updates through performance dashboards, meeting summaries, safety alerts, policy changes, or lessons learned from incident reviews, with the specific communication method tailored to the needs and responsibilities of each department. Reporting pathways—including event reporting systems, department leadership channels, committee reporting structures, and safety huddles—support timely exchange of quality information across the organization. These mechanisms help maintain awareness, reinforce expectations, encourage staff participation, and ensure transparency in the hospital's continuous improvement efforts.

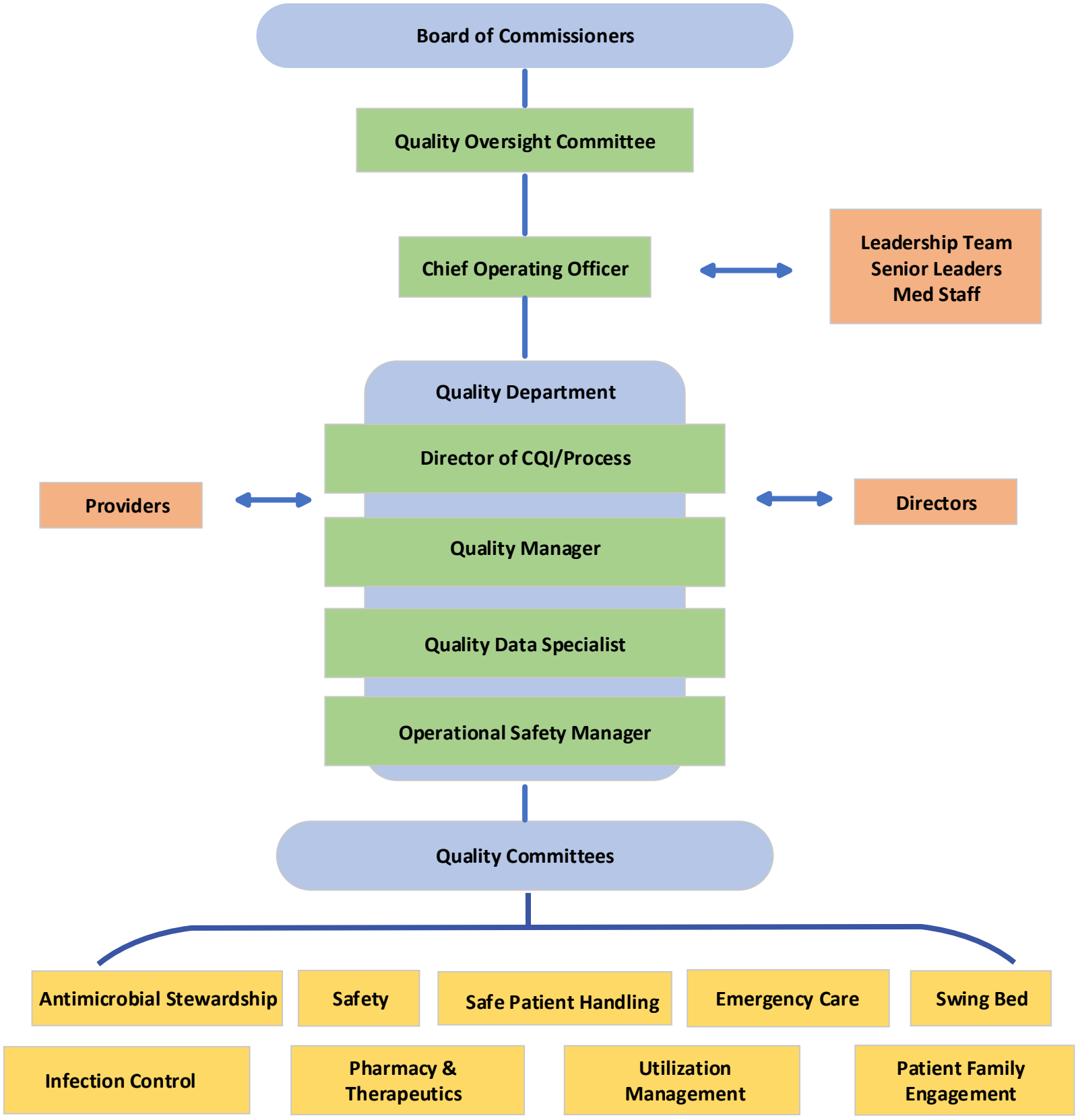
Program Evaluation

The Quality Oversight Committee shall evaluate the effectiveness of the Quality Assurance and Performance Improvement (QAPI) Program at least annually, aligned with the calendar year. The annual evaluation will be included as a standing item on the committee's workplan and documented in the meeting minutes upon completion. Findings from the evaluation will be used to update this written QAPI Plan, refine priorities, and strengthen the hospital's continuous improvement efforts.

Approval and Review

This Quality Assessment and Performance Improvement (QAPI) Plan will be reviewed annually by the Quality Oversight Committee and approved by the Governing Board. Revisions will be made as necessary to reflect regulatory changes, organizational priorities, emerging risks, and evidence-based best practices.

Quality Assurance and Process Improvement
Quality Structure



Prioritization Worksheet

Directions : This tool will assist in identifying which potential areas for improvement are the highest priority based on the needs of patients, the community, staff, and the organization. Follow this systematic assessment process below to identify potential areas for Process Improvement Projects (PIPs). This tool is intended to be completed and used by the Quality Oversight Committee on an annual basis to select PIPs. Rating is subjective and meant to be a guide to stimulate discussion.

Begin by listing potential areas for improvement in the left-hand column. Then score each area in the following columns based on a rating scale of 0 to 5 as defined below. The total score will automatically populate in the final column. Potential improvement areas with a higher score indicate a higher priority.

(This worksheet has been adapted from CMS's Prioritization Worksheet for Performance Improvement Projects)

	0 = Not applicable	**1 = Very low**	**2 = Low**	**3 = Medium**	**4 = High**	**5 = Very high**	
POTENTIAL AREAS FOR IMPROVEMENT	**PREVALENCE**	**RISK**	**RESPONSIVENESS**	**FEASIBILITY**	**CONTINUITY**	**COMPLIANCE**	**TOTAL SCORE**
Consider areas identified through: Dashboard(s), routine quality monitoring, patient satisfaction, feedback from staff, incidents, survey deficiences, etc.	The frequency at which this issue arises in our organization	The level to which this issue poses a risk to the well-being of our patients and/or staff	The likelihood an initiative on this issue would address a need expressed by patients, the community, and/or staff.	The ability of our organization to implement a PIP on this issue given current resources (staffing, cost, equipment, time, etc.)	The level to which an initiaive on this issue would support our organizational goals and priorities	The level to which an initiative on this issue would support regulatory requirements.	
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CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Performance Improvement Project Worksheet

Directions: This worksheet is intended for use when developing and implementing a PIP to address an identified quality improvement opportunity. Following the SMART formula outlined below, teams should fill out the portions in white to assist in developing a PIP that best meets the needs of the organization.

Project Title:	

Describe the problem to be solved:

Use the SMART formula to develop a goal:

S	**SPECIFIC**	Describe the goal in terms of 3 'W' questions:	*What* do we want to accomplish?	
			Who will be involved/affected?	
			Where will it take place? (Scope)	
M	**MEASURABLE**	Describe how you will know the goal is reached:	What is the measure you will use?	
			What is the current data?	
			What do you want to increase/decrease the number to?	
A	**ACHIEVABLE**	Defend the rationale for setting the goal measure above:	Is the goal measure based on a particular best practice/benchmark?	
			Is the goal measure set too low that it is not challenging	
			Do we have the resources in place to work towards this measure? (time, skills, staffing, support, etc.)	
R	**RELEVANT**	Briefly describe how the goal is relevent for Cascade Medical:	How will the goal address the problem statement?	
T	**TIME-BOUND**	Define the timeline for achieving the goal:	What is the target date?	

Write a goal statement based on the SMART elements above. The goal should be descriptive yet concise enough that it is easily communicated and remembered.

Goal Statement

QUALITY 101

KEY CONCEPTS

Quality is everyone's responsibility!

- Quality is meeting standards consistently.
- Continuous Improvement focuses on small, ongoing changes.
- Safety and reliability are core to quality in healthcare.
- Everyone plays a role in quality and patient safety.

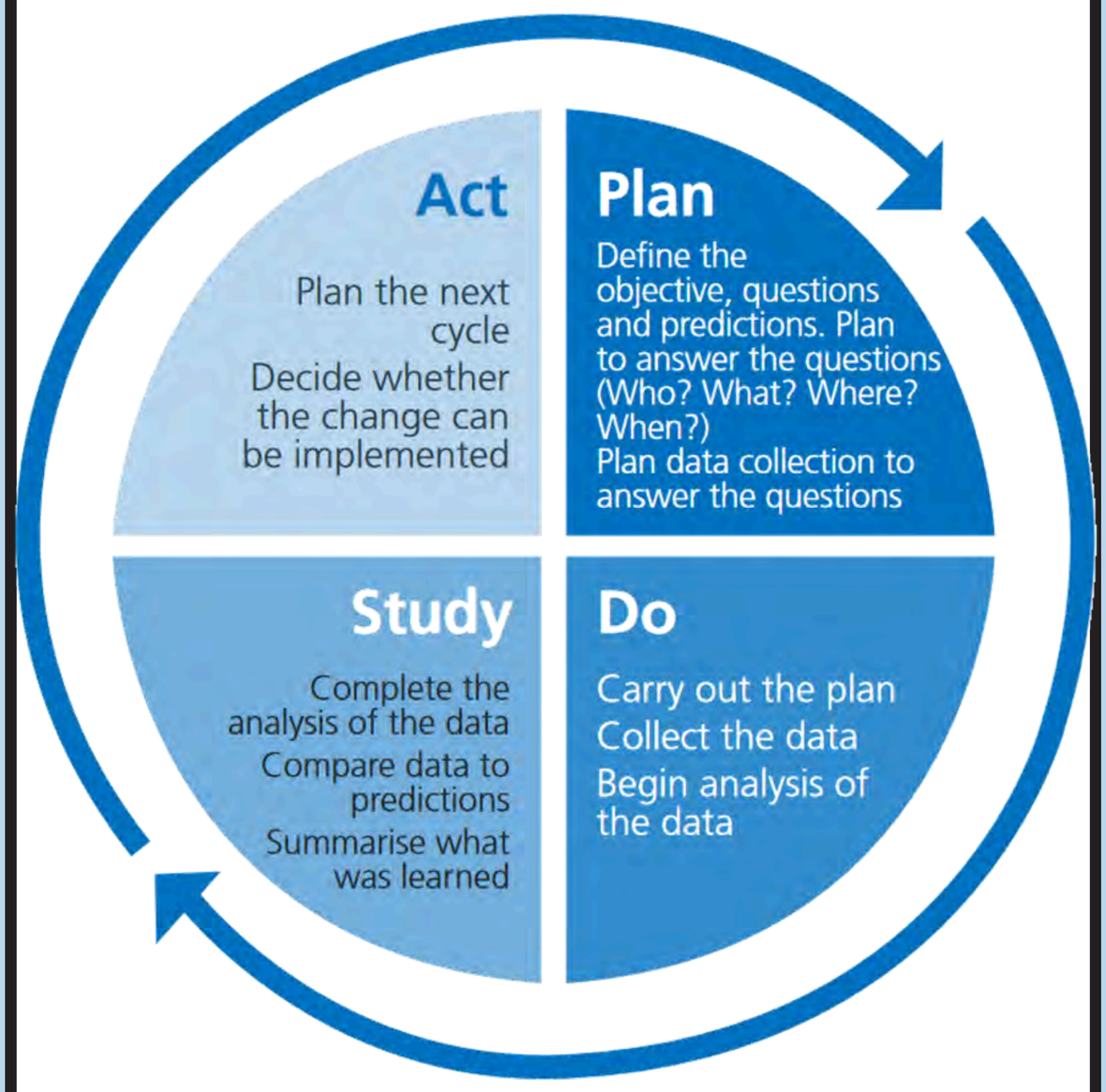
SMART

SMART goals help teams and individuals create clear actionable improvement targets

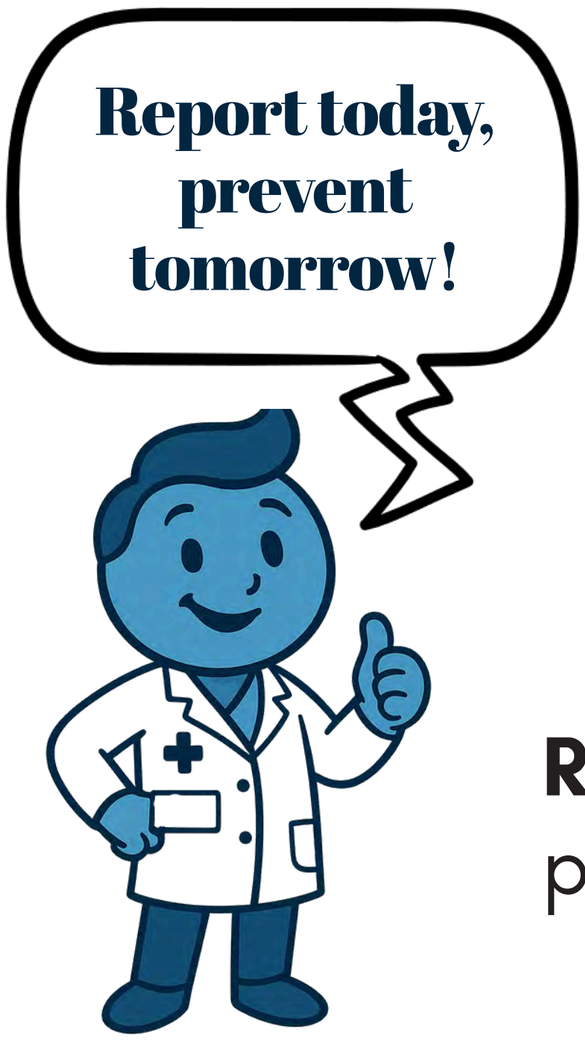


Specific
Measurable
Achievable
Relevant
Time-Bound

PDSA



INCIDENT REPORTING & PATHWAYS



- Incident reporting helps us learn, prevent harm, and improve systems.
- Report all safety events, near misses, and incidents promptly.
- Details matter!

Remember: Reporting is confidential and not punitive—it's about learning and improving.

WHEN?

- Near misses
- Safety events or injuries
- Equipment issues
- Process failures or deviations
- Any event that could impact quality, safety, or compliance

HOW?

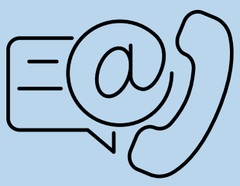
- Identify an incident that needs to be reported
- Access the incident report and gather all necesary information.
- Complete the incident Report

QUALITY 101

Questions ?

Reach out to our Quality Department

- Rachel Avery
- Sarah Portin
- MJ Meza



Role of a Hospital Commissioner: DRAFT

October 17, 2025

Short, simple: Preserve, guide and advise.

Medium form:

1. Hospital commissioners help **preserve** and protect local healthcare so it's accessible when and where you need it.
2. We work hand in hand with hospital leaders to **guide** our strategic direction, policies and focus on serving our community.
3. Hospital commissioners come to their role with deep and diverse expertise that, in turn, helps **advise** leaders on areas from finance and community advocacy to communications and quality standards.

Long form, with proof points:

1. Hospital commissioners help **preserve** and protect local healthcare so it's accessible when and where you need it.
    a. Commissioners help develop and approve the organization's three-year strategic plan; this helps ensure services meet today's need, while also evaluating and planning for future growth.
    b. Commissioners review and approve Cascade's annual budget, adding financial oversight to maintain the organization's stability.
    c. Commissioners also approve the organization's capital budget and consent to actions such as levy or bond financing. This provides additional oversight into the expenditure of taxpayer dollars.
    d. Foundational to our work as Commissioners, we support and uphold Cascade Medical's mission, vision and values.

2. We work hand in hand with hospital leaders to **guide** our strategic direction, policies and focus on serving our community's healthcare needs.
    a. Cascade's leadership is a strong, experienced team of operational leaders, so we help **guide** their work by providing strategic direction, working on

policies that support operational effectiveness and adding an additional voice and lens from a community perspective.

3. Hospital commissioners come to their role with deep and diverse expertise that, in turn, helps us **advise** leaders on areas from finance and advocacy to community awareness and quality standards.
    a. In addition to serving as a hospital Commissioner, each of us also serves on a committee such as Finance, Quality, Community Outreach and Awareness or Governance. This is where our business and professional expertise can help **advise** and complement the skills of organizational leaders.
    b. With our expertise and connections to the larger community we serve, Commissioners provide valuable perspectives to help ensure Cascade offers high quality, accessible services.

ACCOUNTANTS | ADVISORS

November 19, 2025

Board of Commissioners
Chelan County Public Hospital District No. 1
doing business as Cascade Medical Center
817 Commercial Street
Leavenworth, Washington 98826

We are pleased to confirm our understanding of the services we are to provide Chelan County Public Hospital District No. 1 doing business as Cascade Medical Center (the District) for the year ending December 31, 2025.

Audit Scope and Objectives

We will audit the financial statements of the District, which comprise the statement of net position as of December 31, 2025, the related statements of revenues, expenses, and changes in net position, and cash flows for the year then ending, and the disclosures.

Accounting standards generally accepted in the United States of America (GAAS) provide for certain required supplementary information (RSI), such as management's discussion and analysis (MD&A), to supplement the District's 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. As part of our engagement, we will apply certain limited procedures to the District's RSI in accordance with GAAS. These limited procedures will consist 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 will 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. The following RSI is required by generally accepted accounting principles and will be subjected to certain limited procedures, but will not be audited:

- Management's Discussion and Analysis
- Schedule of changes in the District's total Other Post Employment Benefits (OPEB) liability and related ratios
- Schedule of proportionate share of the net pension asset Law Enforcement Officers' and Fire Fighters' retirement system plan

The objectives of our audit are to obtain reasonable assurance as to whether the financial statements as a whole are free from material misstatement, whether due to fraud or error; issue an auditors' report that includes our opinion about whether your financial statements are fairly presented, in all material respects, in conformity with generally accepted accounting principles (GAAP).

Reasonable assurance is a high level of assurance but is not absolute assurance and therefor is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. Misstatements, including omissions, can arise from fraud or error and are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgement of a reasonable user made based on the financial statements.

The objectives also include reporting on internal control over financial reporting and compliance with provisions of laws, regulations, contracts, and award agreements, noncompliance with which could have a material effect on the financial statements in accordance with *Government Auditing Standards*.

Auditors' Responsibilities for the Audit of the Financial Statements

We will conduct our audit in accordance with GAAS and the standards for financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and will include tests of your accounting records and other procedures we consider necessary to enable us to express such an opinion. As part of an audit in accordance with GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

We will evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management. We will also evaluate the overall presentation of the financial statements, including the disclosures, and determine whether the financial statements represent the underlying transactions and events in a manner that achieves a fair presentation. We will plan and perform the audit to obtain reasonable rather than absolute assurance about whether the financial statements are free of material misstatement, whether from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity. Because the determination of abuse is subjective, *Government Auditing Standards* do not expect auditors to provide reasonable assurance of detecting waste or abuse.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, and because we will not perform a detailed examination of all transactions, there is an unavoidable risk that some material misstatements may not be detected by us, even though the audit is properly planned and performed in accordance with U.S. generally accepted auditing standards and *Government Auditing Standards*. In addition, an audit is not designed to detect immaterial misstatements or violations of laws or governmental regulations that do not have a direct and material effect on the financial statements. However, we will inform the appropriate level of management of any material errors, any fraudulent financial reporting, or misappropriation of assets that come to our attention. Our responsibility as auditors is limited to the period covered by our audit and does not extend to later periods for which we are not engaged as auditors.

In connection with this engagement, we may communicate with you or others via email transmission. As emails can be intercepted and read, disclosed, or otherwise used or communicated by an unintended third party, or may not be delivered to each of the parties to whom they are directed and only to such parties, we cannot guarantee or warrant that emails from us will be properly delivered and read only by the addressee. Therefore, we specifically disclaim and waive any liability or responsibility whatsoever for interception or unintentional disclosure of emails transmitted by us in connection with the performance of this engagement. In that regard, you agree that we shall have no liability for any loss or damage to any person or entity resulting from the use of email transmissions, including any consequential, incidental, direct, indirect, or special damages, such as loss of revenues or anticipated profits, or disclosure or communication of confidential or proprietary information.

With respect to cost reports that may be filed with a third party (such as federal and state regulatory agencies), the auditors have not been engaged to test in any way, or render any form of assurance on, the propriety or allowability of the specific costs to be claimed on, or charges to be in reported in, a cost report. Management is responsible for the accuracy and propriety of all cost reports filed with Medicare, Medicaid, or other third parties.

We will also conclude, based on the audit evidence obtained, whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the entity's ability to continue as a going concern for a reasonable amount of time.

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts and may include direct confirmation of certain assets and liabilities by correspondence with selected individuals, funding sources, creditors, and financial institutions. We may request written representations from your attorneys as part of the engagement.

We may, from time to time and depending on the circumstances, use third-party service providers in serving your account. We may share confidential information about you with these service providers but remain committed to maintaining the confidentiality and security of your information. Accordingly, we maintain internal policies, procedures, and safeguards to protect the confidentiality of your personal information. In addition, we will secure confidentiality agreements with all service providers to maintain the confidentiality of your information and we will take reasonable precautions to determine that they have appropriate procedures in place to prevent the unauthorized release of your confidential information to others. In the event that we are unable to secure and appropriate confidentiality agreement, you will be asked to provide your consent prior to the sharing of your confidential information with the third-party service provider. Furthermore, we will remain responsible for the work provided by any such third-party service providers.

Our audit of the financial statements does not relieve you of your responsibilities.

Audit Procedures — Internal Control

We will obtain an understanding of the entity and its environment, including the system of internal control, sufficient to identify and assess the risks of material misstatement of the financial statements, whether due to error or fraud, and to design and perform audit procedures responsive to those risks and obtain evidence that is sufficient and appropriate to provide a basis for our opinions. Tests of controls may be performed to test the effectiveness of certain controls that we consider relevant to preventing and detecting errors and fraud that are material to the financial statements and to preventing and detecting misstatements resulting from illegal acts and other noncompliance matters that have a direct and material effect on the financial statements. Our tests, if performed, will be less in scope than would be necessary to render an opinion on internal control and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to *Government Auditing Standards*. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentation, or the override of internal control.

An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weaknesses. Accordingly, we will express no such opinion. However, during the audit, we will communicate to management and those charged with governance internal control related matters that are required to be communicated under AICPA professional standards and *Government Auditing Standards*.

Audit Procedures — Compliance

As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we will perform tests of the District's compliance with the provisions of applicable laws, regulations, contracts, agreements, and grants. However, the objective of our audit will not be to provide an opinion on overall compliance, and we will not express such an opinion in our report on compliance issued pursuant to *Government Auditing Standards*.

The auditors' procedures do not include testing compliance with laws and regulations in any jurisdiction related to Medicare and Medicaid antifraud and abuse. It is the responsibility of management of the entity, with the oversight of those charged with governance, to ensure that the entity's operations are conducted in accordance with the provisions of laws and regulations, including compliance with the provisions of laws and regulations that determine the reported amounts and disclosures on the entity's financial statements. Therefore, management's responsibilities for compliance with laws and regulations applicable to its operations, including, but are not limited to, those related to Medicare and Medicaid antifraud and abuse statutes.

Responsibilities of Management for the Financial Statements

Our audit will be conducted on the basis that you acknowledge and understand your responsibility for designing, implementing, and maintaining internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error, and for evaluating and monitoring ongoing activities to help ensure that appropriate goals and objectives are met; following laws and regulations; and ensuring that management and financial information is reliable and properly reported. Management is also responsible for implementing systems designed to achieve compliance with applicable laws, regulations, contracts, and grant agreements. You are also responsible for the selection and application of accounting principles; and for the preparation and fair presentation of the financial statements and all accompanying information in conformity with accounting principles generally accepted in the United States of America, and for compliance with applicable laws and regulations and the provisions of contracts and grant agreements.

Management is responsible for making all financial records and related information available to us and for the accuracy and completeness of that information, including information from outside of general and subsidiary ledgers) and for the evaluation of whether there are any conditions or events, considered in the aggregate, that raise substantial doubt about the entity's ability to continue as a going concern for the 12 months after the financial statement date or shortly thereafter (for example, within an additional three months if currently known). You are also responsible for providing us with (1) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, such as: records, documentation, identification of all related parties and all related-party relationships and transactions, and other matters; (2) additional information that we may request for the purpose of the audit, and (3) unrestricted access to persons within the entity from whom we determine it necessary to obtain audit evidence. At the conclusion of our audit, we will require certain written representations from you about the financial statements, compliance with laws, regulations, contracts, and grant agreements; and other responsibilities required by GAAS and *Government Auditing Standards.*

Your responsibilities include adjusting the financial statements to correct material misstatements and for confirming to us in the written representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

You are responsible for the design and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the entity involving (1) management, (2) employees who have significant roles in internal control, and (3) others where the fraud could have a material effect on the financial statements.

Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the entity received in communications from employees, former employees, grantors, regulators, or others. In addition, you are responsible for identifying and ensuring that the entity complies with applicable laws, regulations, contracts, agreements, and grants and for taking timely and appropriate steps to remedy fraud and noncompliance with provisions of laws, regulations, contracts or grant agreements, or abuse that we report.

Management is responsible for establishing and maintaining a process for tracking the status of audit findings and recommendations. Management is also responsible for identifying and providing report copies for us of previous financial audits, attestation engagements, performance audits or other studies related to the objectives discussed in the Audit Scope and Objectives section of this letter. This responsibility includes relaying to us corrective actions taken to address significant findings and recommendations resulting from those audits, attestation engagements, performance audits, or other studies. You are also responsible for providing management's views on our current findings, conclusions, and recommendations, as well as your planned corrective actions, for the report, and for the timing and format for providing that information.

Other Services

We will also assist in preparing the financial statements and related notes of the District in conformity with U.S. generally accepted accounting principles based on information provided by you. These nonaudit services do not constitute an audit under *Government Auditing Standards* and such services will not be conducted in accordance with *Government Auditing Standards.* We will perform the services in accordance with applicable professional standards. The other services are limited to the financial statement services previously defined. We, in our sole professional judgment, reserve the right to refuse to perform any procedure or take any action that could be construed as assuming management responsibilities.

You agree to assume all management responsibilities relating to the financial statements and related notes, financial preparation services, cost report, and any other nonaudit services we provide. You will be required to acknowledge in the management representation letter our assistance with preparation of the financial statements and related notes and that you have reviewed and approved the financial statements and related notes prior to their issuance and have accepted responsibility for them. Further, you agree to oversee the nonaudit services by designating an individual, preferably from senior management, with suitable skill, knowledge, or experience; evaluate the adequacy and results of those services; and accept responsibility for them.

Preparation of Cost Reports and Consulting

We will prepare the District's Medicare cost report, the Ground Emergency Medical Transport report, and the Department of Health report for the year ending December 31, 2025.

We remind you that you have the final responsibility for all reports and, therefore, you should review them carefully before you sign and file them. We make no representation that our services will identify any or all opportunities to maximize reimbursement.

All of the information included in the cost report is the representation of management. We direct your attention to the fact that management has the responsibility for the proper recording of the transactions in the books of account, for the safeguarding of assets, for the substantial accuracy of the cost report, and for identifying and ensuring the District complies with the laws and regulations applicable to its activities.

We will also provide Medicare and other reimbursement consulting services as requested throughout the year, including but not limited to review of Medicare rate settings and desk-review and audit adjustments. These services will be provided at our standard rates.

You are also responsible for management decisions and functions; for designating a senior management-level individual with suitable skill, knowledge, or experience to oversee the cost report preparation services we provide; and for evaluating the adequacy and results of those services and accepting responsibility for them.

Conformance with Section 952 of Public Law 96-499

Section 952 of P.L. 96-499 requires access by the Secretary of Health and Human Services and the U.S. Comptroller General to the books and records of subcontractors of Medicare providers. Absent the allowability of such access, the provider's cost for such services would not be allowable for Medicare reimbursement purposes if the contract value over 12 months is $10,000 or more. We would grant such access if this law is applicable to our services.

HIPAA Business Associate Agreement

You agree that you are solely responsible for the accuracy, completeness, and reliability of all data and information you provide us for our engagement. You agree to provide any requested information on or before the date we commence performance of the services. To protect the privacy and provide for the security of any protected health information, as such is defined by the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the regulations and policy guidances thereunder ("HIPAA"), we shall enter into a HIPAA Business Associate Agreement ("BAA").

Engagement Administration, Fees, and Other

We understand that your employees will prepare all cash, accounts receivable, or other confirmations we request and will locate any documents selected by us for testing.

We will provide copies of our reports to the District; however, management is responsible for distribution of the reports and the financial statements. Unless restricted by law or regulation, or containing privileged and confidential information, copies of our reports are to be made available for public inspection.

The audit documentation for this engagement is the property of DZA PLLC and constitutes confidential information. However, subject to applicable laws and regulations, audit documentation and appropriate individuals will be made available upon request and in a timely manner to the Washington State Auditor's Office, cognizant or oversight agency for the audit or its designee, a federal agency providing direct or indirect funding, or the U.S. Government Accountability Office for purposes of a quality review of the audit, to resolve audit findings, or to carry out oversight responsibilities. We will notify you of any such request. If requested, access to such audit documentation will be provided under the supervision of DZA PLLC personnel. Furthermore, upon request, we may provide copies of selected audit documentation to the aforementioned parties. These parties may intend, or decide, to distribute the copies or information contained therein to others, including other governmental agencies.

Suralink is used solely as a method of exchanging information and is not intended to store your information. At the end of the engagement, DZA PLLC will provide you with a copy (in an agreed-upon format) of deliverables and data related to the engagement from Suralink. For multi-year engagements, this exchange will occur annually.

Upon completion of the engagement, data and other content will either be removed from Suralink or become unavailable to DZA PLLC within a reasonable time frame. For multi-year engagements, completion of the engagement occurs when the deliverables are completed for that year.

The audit documentation for this engagement will be retained for a minimum of seven years after the report release date or for any additional period requested by a regulatory agency.

We expect to begin our audit in approximately February 2026 and to issue our reports no later than May 31, 2025. Kami Matzek is the engagement partner and is responsible for supervising the engagement and signing the reports or authorizing another individual to sign them.

Our fee for these services will be as follows:

Audit	$35,000
Preparation of Medicare cost report	$12,500
Department of Health report	$6,500
Ground Emergency Medical Transport report	$4,250

Out-of-pocket travel and shipping costs will be billed at our cost in addition to the above fees.

Travel time will be billed in addition to the above fees at hourly rates ranging from $80 to $180 per hour.

Our invoices for these fees will be rendered each month as work progresses and are payable on presentation.

In accordance with our firm policies, work may be suspended if your account becomes 60 days or more overdue and may not be resumed until your account is paid in full. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our report(s). You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket costs through the date of termination.

The above fee is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the audit. If significant additional time is necessary, we will discuss it with you and arrive at a new fee estimate before we incur the additional costs.

You have requested that we provide you with a copy of our most recent external peer review report and any subsequent reports received during the contract period. Accordingly, our 2022 peer review report accompanies this letter.

Reporting

We will issue a written report upon completion of our audit of the District's financial statements. Our report will be addressed to management and those charged with governance of the District. Circumstances may arise in which our report may differ from its expected form and content based on the results of our audit. Depending on the nature of these circumstances, it may be necessary for us to modify our opinions, add a separate section, or add an emphasis-of-matter or other-matter paragraph to our auditors' report, or if necessary, withdraw from this engagement. If our opinion is other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed opinions, we may decline to express an opinion or withdraw from this engagement.

We will also provide a report (that does not include an opinion) on internal control related to the financial statements and compliance with the provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a material effect on the financial statements as required by *Government Auditing Standards*. The report on internal control and on compliance and other matters will include a paragraph that states (1) that the purpose of the report is solely to describe the scope of 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 on compliance, and (2) that the report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. The report will also state that the report is not suitable for any other purpose. If during our audit we become aware that the District is subject to an audit requirement that is not encompassed in the terms of this engagement, we will communicate to management and those charged with governance that an audit in accordance with U.S. generally accepted auditing standards and the standards for financial audits contained in *Government Auditing Standards* may not satisfy the relevant legal, regulatory, or contractual requirements.

We appreciate the opportunity to be of service to Chelan County Public Hospital District No. 1 doing business as Cascade Medical Center and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this letter, please print and sign a copy or e-sign and return it to us.

DZA PLLC



Kami Matzek, CPA
Owner

RESPONSE:

This letter correctly sets forth the understanding of Chelan County Public Hospital District No. 1 doing business as Cascade Medical Center.

Management signature: _____

Title: _____

Date: _____

Governance signature: _____

Title: _____

Date: _____

KraftCPAs PLLC

Report on the Firm's System of Quality Control

To the Members of
Dingus, Zarecor & Associates PLLC
and the Peer Review Committee of
the Colorado Society of CPAs

We have reviewed the system of quality control for the accounting and auditing practice of Dingus, Zarecor & Associates PLLC (the firm) in effect for the year ended November 30, 2022. Our peer review was conducted in accordance with the Standards for Performing and Reporting on Peer Reviews established by the Peer Review Board of the American Institute of Certified Public Accountants (Standards).

A summary of the nature, objectives, scope, limitations of, and the procedures performed in a system review as described in the Standards may be found at www.aicpa.org/prsummary. The summary also includes an explanation of how engagements identified as not performed or reported on in conformity with applicable professional standards, if any, are evaluated by a peer reviewer to determine a peer review rating.

Firm's Responsibility

The firm is responsible for designing and complying with a system of quality control to provide the firm with reasonable assurance of performing and reporting in conformity with the requirements of applicable professional standards in all material respects. The firm is also responsible for evaluating actions to promptly remediate engagements deemed as not performed or reported on in conformity with the requirements of the applicable professional standards, when appropriate, and for remediating weaknesses in its system of quality control, if any.

Peer Reviewer's Responsibility

Our responsibility is to express an opinion on the design of and compliance with the firm's system of quality control based on our review.

Required Selections and Considerations

Engagements selected for review included engagements performed under *Government Auditing Standards*, including a compliance audit under the Single Audit Act; and audits of employee benefit plans.

As a part of our peer review, we considered reviews by regulatory entities as communicated by the firm, if applicable, in determining the nature and extent of our procedures.

Opinion

In our opinion, the system of quality control for the accounting and auditing practice of Dingus, Zarecor & Associates PLLC in effect for the year ended November 30, 2022, has been suitably designed and complied with to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Firms can receive a rating of *pass*, *pass with deficiency(ies), or fail*. Dingus, Zarecor & Associates PLLC has received a peer review rating of *pass*.



KraftCPAs PLLC
May 30, 2023

FINANCIAL ACCOUNTING
WARRANTS / EFTS ISSUED

Commissioner Meeting: December 17, 2025

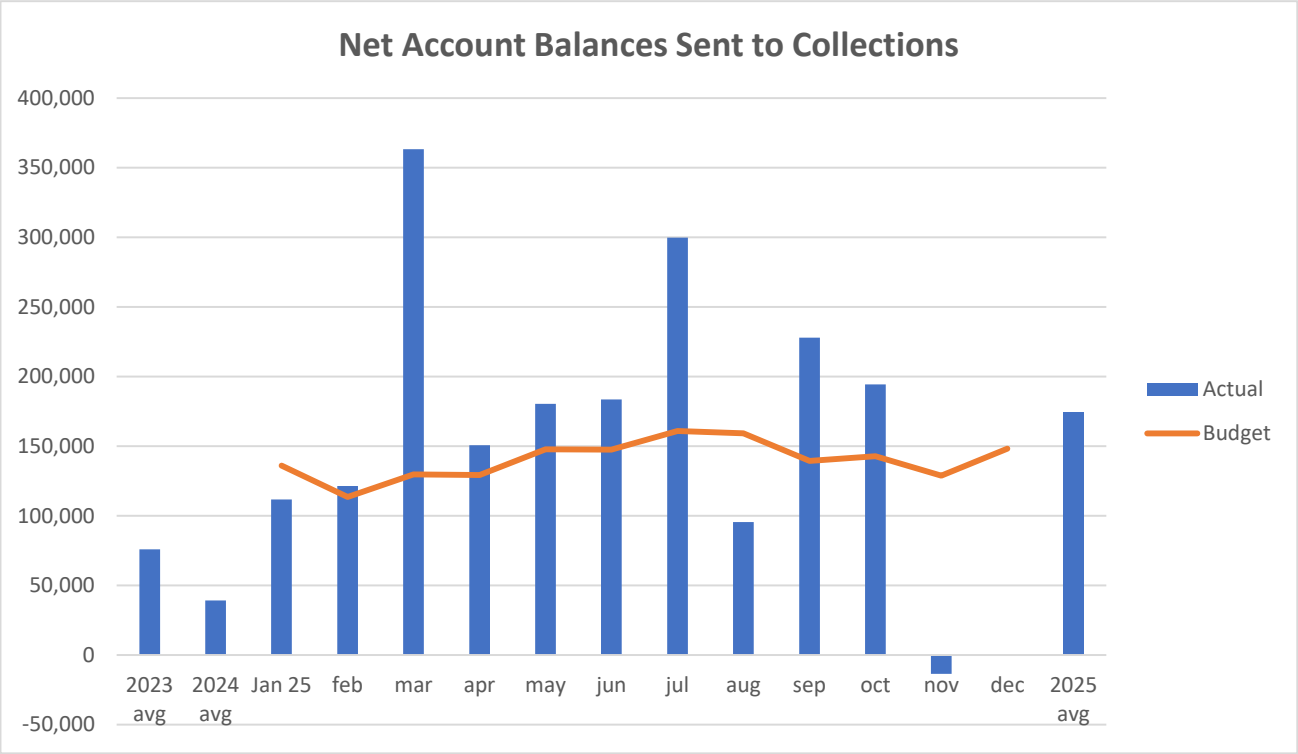
Below is a listing of the Accounts Payable warrants and EFT/ACH transactions issued since the last Board of Commissioners meeting along with the payroll EFT transactions since the last Board of Commissioners meeting.

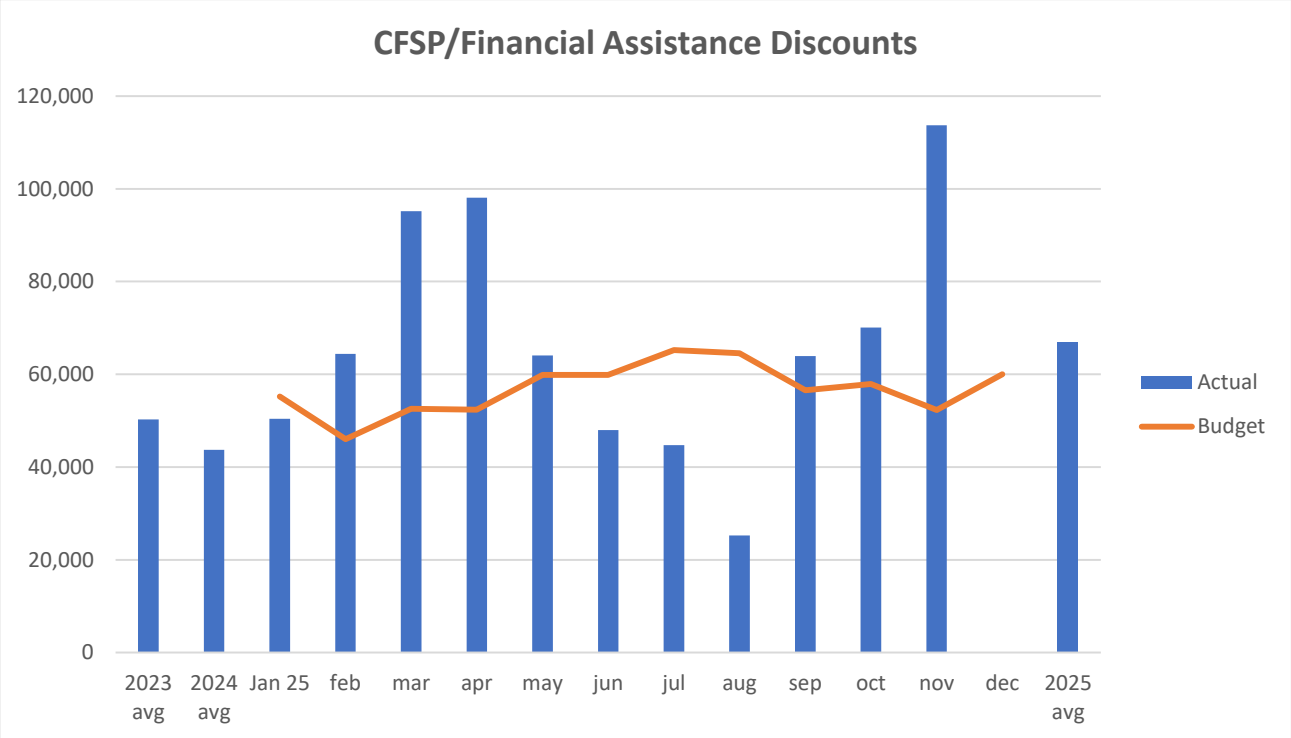
Accounts Payable Warrant Numbers	10127788 – 10127902	$1,212,890.34	11/13/2025 – 12/08/2025
Accounts Payable EFT Transactions	20250162 – 20250175	$543,259.84	11/13/2025 – 12/08/2025
Accounts Payable ACH Transactions	EP13538 – EP13608 EP13614 – EP13652 EP13692 – EP13721 EP13747 – EP13785	$786,528.83	11/13/2025 – 12/08/2025
Payroll EFT Transactions	29059 – 29482	$1,006,669.74	11/13/2025 – 12/08/2025
	Grand Total	$3,549,348.75	

Note: The ACH transaction numbers are not reported sequentially; there is a gap between batch runs.

Prepared by:

Kathy Jo Evans
Director of Accounting


Net Account Balances Sent to Collections
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
-50,000
2023 avg
2024 avg
Jan 25
feb
mar
apr
may
jun
jul
aug
sep
oct
nov
dec
2025 avg
Actual
Budget


CFSP/Financial Assistance Discounts
120,000
100,000
80,000
60,000
40,000
20,000
0
2023 avg
2024 avg
Jan 25
feb
mar
apr
may
jun
jul
aug
sep
oct
nov
dec
2025 avg
Actual
Budget

Cascade Medical

Bad Debt Write Offs
Financial Assistance Program Discounts

Month November, 2025

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Net Bad Debt Write-Offs for Board Approval	**$**	**(13,592.26)**
CFSP/Financial Assistance Program Discounts for Board Approval	**$**	**113,689.78**

Bad Debt/ Financial Assistance Supplemental Information			
Bad Debt Write-Offs	Sent to Collection Agency		21,626.73
	less: pullback from Agency due to receipt of payments		(35,218.99)
	Net Bad Debt Write-Offs		(13,592.26)
CFSP/Financial Assistance Applications - Discounts Approved		$	113,689.78
	Total		100,097.52

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

2025 Board of Commissioners Committee & Liaison Assignments

Commissioners

Name	Email	Term Expiration	Status of Term
Jessica Kendall **Secretary**	jessica.kendall@cascademedical.org	Position 1 12/2031	Elected to 6-year term in 2025.
Cary Ecker	cary.ecker@cascademedical.org	Position 2 12/2029	Appointed in 2025 and elected to serve remainder of term.
Tom Baranouskas **Vice President**	tomb@cascademedical.org	Position 3 12/2027	Re-elected in 2021.
Jesse Knight	jesse.knight@cascademedical.org	Position 4 12/2031	Elected to 6-year term in 2025.
Shari Day-Campbell **President**	shari.daycampbell@cascademedical.org	Position 5 12/2027	Appointed in 2024 and elected to serve remainder of term.

Committee Assignments

Finance	Governance	Quality Oversight	COAC
Tom Baranouskas - Chair	Shari Day-Campbell - Chair	Jessica Kendall - Chair	Shari Day-Campbell-- Chair
Cary Ecker	Tom Baranouskas	Jesse Knight	Jessica Kendall

Ad Hoc Liaison Appointments

Medical Staff	Foundation	Part Time Resident Advisory Council
Open to All Board Members	Open to All Board Members	Open to All Board Members

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

AGENDA

Community Outreach and Awareness
November 24, 2025
1:00 PM-3:00 PM
Administration Conference Room

Agenda Item		Time
1.	Call to Order	1:00 PM
2.	Consent Agenda Approval • November 24, 2025 Agenda • July 7, 2025 Minutes	1:00 PM
Committee Work		
1.	Welcome and Introduce Luke Knutson, Community Member and new Committee Member, and Katie Grove, new Marketing & Public Relations Director	1:05 PM
2.	Review COAC Charter and Purpose • Discuss and answer questions about COAC's work	1:10 PM
3.	Committee Discussion • What worked well in 2025? • What items from 2025 still need more work? (Google Analytics insights, social media metrics, use of data to drive decisions, defined marketing plan, etc.) • What might we do differently in 2026 to provide additional strategic direction and focus for COAC? • Review 2025 workplan completion notes for accuracy • Begin to draft 2026 committee workplan	1:20 PM
4.	Community conversations and questions to help inform Communication Plan • What are you hearing in the community about healthcare overall? • What concerns or questions are you hearing from your friends and neighbors? • What is one thing you think CM should do to improve any negative or neutral perceptions about the organization? • What do you think CM does well and should do more of? • Are there any organizations (Rotary, Lion's, School District, etc.) you think CM should regularly communicate with in a more formal, structured way, including potentially for Board outreach? • What should we be communicating to the community relative to our CHNA?	2:15 PM
5.	Discuss Quarterly Talking Points • Brainstorm potential proactive focus areas • Suggest questions/concerns leaders, commissioners should be prepared to talk about in Q1	2:45 PM
6.	Set next meeting date	2:55 PM
Adjournment		
1.	Adjournment	3:00 PM

Materials provided in advance of meeting along with agenda:

- Minutes from July 7, 2025, meeting
- Committee charter
- Committee work plan with completion notes
- Draft 2026 work plan
- Draft 2026 – 2028 Community Health Needs Assessment (CHNA)

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

COMMUNITY OUTREACH & AWARENESS COMMITTEE WORK PLAN
For 2025

Month	Goal / Responsibility	Notes	Completion Status
	1.	1.	1.
	2.	2.	2.
	3.	3.	3.
	4.	4.	4.
	5.	5.	5.
	6.	6.	6.
	7.	7.	7.
	8.	8.	8.
	9.	9.	9.
May	1. EMS Levy communication recap: what worked well and what can be improved for future education pushes	1.	1. Done, thoughts memorialized
	2. Check-in on CHNA, define next steps for board involvement	2.	2. Complete, set plan for board education / report in June
	3. Check-in on outreach plan for board and organization, ensure strategic priorities are met	3.	3. Complete, reviewed existing and brainstormed additional outreach opportunities
	4. Strategic lens on marketing – does it appropriately support organizational strategy	4.	4. Complete, reviewed marketing firm's work from early 2025 and realigned areas of focus
	5. Finalize draft work plan	5.	5. Done
	6. Define skills/attributes for potential community member committee appointment	6.	6. Discussed
	7. Plan for additional commissioner participation in COAC	7.	7. Discussed
July	1. Check-in on outreach plan for board and organization, ensure strategic priorities are met	1.	1. Discussed, including opportunities at August Community Block Party
	2. Strategic lens on marketing – does it appropriately support organizational strategy and have we maximized effectiveness	2.	2. Discussed, with focused discussion on how to leverage meaningful data to drive decision-making

Month	Goal / Responsibility	Notes	Completion Status
	3. Review data to inform committee on effectiveness of current communication work and discuss strategic adjustments, if necessary	3.	3. Minimal data available, discussed need for more meaningful data
	4. Discuss timing and opportunity for strategic communication work related to mission / vision / values as it relates to the strategic planning process	4.	4. Did not discuss; M/V/V strategy moved to purview of Governance Committee
	5. Review what worked well from EMS levy (Google analytics, newsletters, mailer, social, etc.) from a data perspective	5.	5. Reviewed metrics / data that were available and discussed increasing access to and usage of meaningful data in future
	6. Discuss collection of community feedback and what further strategic opportunities exist	6.	6. Discussed in relation to August Block Party and recommended collection of feedback related to expansion of clinic hours
	7. Touch base on committee membership planning	7.	7. Discussed, reviewed community member resume and recommended to Governance for review
Sept	1. Check-in on outreach plan for board and organization, ensure strategic priorities are met	1.	1. NA – Sept topics bundled with November meeting
	2. Strategic lens on marketing – does it appropriately support organizational strategy and have we maximized effectiveness	2.	2. NA – Sept topics bundled with November meeting
	3. Review data to inform committee on effectiveness of current communication work and discuss strategic adjustments, if necessary	3.	3. NA – Sept topics bundled with November meeting
	4. Discuss collection of community feedback and what further strategic opportunities exist	4.	4. NA – Sept topics bundled with November meeting
	5. Determine / check in on use of CHNA as communication tool with community	5.	5. NA – Sept topics bundled with November meeting
	6. Finalize Committee self-evaluation survey	6.	6. Given committee changes, will plan to skip self-evaluation survey in 2025
	7. Touch base on committee membership planning	7.	7. NA – Sept topics bundled with November meeting
	8. Discuss topics for Part Time Resident Advisory Council meeting	8.	8. NA – Sept topics bundled with November meeting

Month	Goal / Responsibility	Notes	Completion Status
Nov	1. Review Committee Charter	1.	1. Reviewed
	2. Review COAC self-assessment results	2.	2. NA – will survey in fall 2026
	3. Check-in on outreach plan for board and organization, ensure strategic priorities are met	3.	3. Discussed in relation to building future communication plan
	4. Strategic lens on marketing – does it appropriately support organizational strategy and have we maximized effectiveness	4.	4. Year in review discussion on this topic with foundational discussion in prep for 2026
	5. Determine / check in on use of CHNA as communication tool with community	5.	5. Discussed
	6. Begin draft Committee Work Plan for following year	6.	6. Began draft
	7. Review data to inform committee on effectiveness of current communication work and discuss strategic adjustments, if necessary	7.	7. NA – discussed opportunity for future board committee level data for regular committee review
	8. Touch base on committee membership planning	8.	8. NA – introduction of board-appointed community member as well as CM's new Marketing and Public Relations Director
	9. Discuss collection of community feedback and what further strategic opportunities exist	9.	9. Discussed in conjunction with community dialogue discussion
	10. Prepare for December report to full Board regarding progress / annual results of committee work	10.	10. Done
	11. Set at least first 2026 COAC meeting date	11.	11. Done

Other Completed Work:

- Finalization of messaging for EMS Levy education and more general marketing focus and messaging, including social media
- Guidance and determinations on EMS Levy outreach and materials
- Strategizing future of COAC, including updating charter and making recommendation to the board to continue as a permanent board committee
- Explored whether there is a role for advocacy for committee members

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

A G E N D A

Board Finance Committee
December 8, 2025
9:00 – 11:00 AM
Administration Conference Room

Agenda Item		Time
1.	Call to Order	9:00 AM
2.	Consent Agenda Approval • December 8, 2025 Agenda • October 20, 2025 Minutes	9:00 AM
Committee Work		
1.	Review follow-up items from minutes	9:05 AM
2.	Discuss viability of 2026 budget	9:10 AM
3.	Financial Assistance stats	9:20 AM
4.	Review Clinic stats/revenue	9:25 AM
5.	Policy Review • Financial Assistance • Identity Theft Red Flag • Reporting Improper Government Action • Organizational Integrity Compliance Committee Structure and Purpose	9:30 AM
6.	Review Finance Committee Charter	9:40 AM
7.	Committee self-evaluation discussion	9:50 AM
8.	Review completion status of 2025 work plan	10:05 AM
9.	Review DZA 2025 audit engagement letter	10:15 AM
10.	Discuss industry trends	10:20 AM
11.	Draft 2026 work plan	10:25 AM
12.	Discuss Board education	10:35 AM
13.	Discuss effectiveness of financial report to board and recommend improvements	10:40 AM
14.	Discuss long-term financial planning	10:45 AM
15.	Set following year committee meeting dates	10:55 AM
Adjournment		
1.	Adjournment	11:00 AM

Materials provided in advance of meeting along with agenda:

1. October 20, 2025 Minutes
2. Financial Assistance stats
3. Clinic stats
4. Financial Assistance Policy Draft
5. Identity Theft Red Flag Policy
6. Reporting Improper Government Action Policy
7. Organizational Integrity Compliance Committee Structure and Purpose Policy Draft
8. Finance Committee Charter

9. Committee self-evaluation questions
10. 2025 Work Plan
11. 2025 DZA audit engagement letter
12. Draft 2026 Work plan

2025 Meeting Schedule

- TBD

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Board Finance Committee Purpose

The Finance Committee is responsible for recommending financial policies, goals and budgets that support the mission, values and strategic objectives of Cascade Medical. This committee also reviews CM's financial performance against its goals and is responsible for financial oversight of the organization.

2025 BOARD FINANCE COMMITTEE WORK PLAN

Month	Goal / Responsibility	Notes	Completion Status
March	1. Review follow-up items from minutes	1.	1. Complete
	2. Review AI Governance Policy	2. No recommended changes	2. Complete
	3. Review December 2024 Financials, Contractual Allowance Summary, Bad Debt	3.	3. Complete
	4. Update on Financial Assistance	4. Updates approved	4. Complete
	5. Review Clinic stats	5. Update to include 2024 data if possible	5. Complete
	6. Discuss industry trends	6. Nothing new, continued uncertainty with change in Administration	6. Complete
	7. Approve Annual Committee Work Plan	7.	7. Complete
	8. Approve Finance Dashboard indicators and their targeted thresholds.	8.	8. Complete
	9. Review insurance limit/coverage recommendations	9. Focus USI on benchmarking only, connect with USI for attendance	9. Revisit in March if significant changes when policies are presented by USI
	10. Review Long-Term Planning Document	10. Current document still needing review and work on five-year projection needed or progress report in April	10. Tabled
	11. Discuss Board Education	11. Potential to use depreciation and bond payment education for future planning.	11. Complete
	12. Review OICC quarterly report	12.	12. Complete
	13. Set remaining meeting dates for the year	13. March 24, 2025	13. Complete

Month	Goal / Responsibility	Notes	Completion Status
April	1. Review follow-up items from minutes	1. Insurance follow-up, Tax refund, Long-term planning	1. Complete
	2. Review Policies • Change Order Authority • Financial Assistance Policy	2. Financial Assistance Policy review is delayed.	2. Financial Assistance Policy delayed
	3. Review OICC quarterly report	3. Complete	3. Complete
	4. Review Q1 financials, financial indicators, and dashboard	4.	4. Complete
	5. Update on Financial Assistance	5. What percentage of patients are self pay?	5. Complete
	6. Review Clinic stats	6.	6. Complete
	7. Discuss industry trends	7.	7. Complete
	8. Discuss Board Education	8.	8. Complete

Month	Goal / Responsibility	Notes	Completion Status
July	1. Review follow up items from minutes	1. Report on percentage of patients that are self-pay 5-7% Revenue	1. Complete
	2. Review Q2 financials, financial indicators, and dashboard	2.	2. Complete
	3. Update on Financial Assistance	3.	3. Complete
	4. Review Clinic stats	4.	4. Complete
	5. Discuss industry trends	5.	5. Complete
	6. Review Policies: • Non-Payroll / EFT Release Policy • Capital Spending Approval Matrix Policy • Financial Assistance Policy • Financial Management Policy	6. Financial Assistance Policy delayed, bring to October meeting. Update Capital Spending to reflect BOC approval at $20,000.	6. Three are complete, Financial Assistance Policy will need review in October. This was done at the December meeting.
	7. Review insurance limit/coverage recommendations	7. Request benchmarking from PS&F- no update on this at this time.	7. Complete

Month	Goal / Responsibility	Notes	Completion Status
	8. Review Long-Term Planning	8. Provide updated report with depreciation, will revisit after MFP completion.	8. Complete
	9. Review of market wage plans for the 2025 budget	9. Data not yet available	9. Revisit in October
	10. Discuss Board Education	10. Budget process or Long-term planning, opted for budget process planned for September meeting	10. Complete
	11. Review OICC quarterly report	11. Complete	11. Complete
Oct	1. Review follow up items from minutes	1. Insurance deductibles, Armada collection %	1. Reviewed
	2. Review Q3 financials, financial indicators, and dashboard	2.	2. Complete
	3. Update on Financial Assistance	3.	3. Complete
	4. Review Clinic stats	4.	4. Reviewed
	5. Discuss industry trends	5.	5. Discussed, Telehealth, RHTF
	6. Check-in to ensure compliance with bond reporting requirements.	6. Budget to Premier Bank after approval, upload Bond data and audited F/S to MSRB	6. Need to upload budget after approval. Data and F/S upload complete
	7. Review final proposed budget for next fiscal year	7.	7. Reviewed
	8. Review Long-Term Planning	8.	8. Reviewed
	9. Discuss and review draft of 5-year capital plan	9.	9. Completed
	10. Recommend audit firm selection / process.	10.	10. Completed
	11. Prepare committee self-assessment survey	11. New process for 2025?	11. Holding for Governance committee recommendation for questions
	12. Discuss Board Education	12.	12. Discussed
	13. Review OICC quarterly report	13. Complete	13. Reviewed

Month	Goal / Responsibility	Notes	Completion Status
Dec	1. Review follow up items from minutes	1.	1. Complete
	2. Review Policies: • Identity Theft Red Flag • Reporting Improper Government Action • Organizational Integrity Compliance Committee Structure and Purpose	2. OICC policy needs language update for medical necessity	2. Complete-also reviewed the Financial Assistance policy in December.
	3. Review Committee Charter	3.	3. Complete, with edits
	4. Check in on next year budget, if we still plan to be on track with approved budget	4.	4. Complete
	5. Update on Financial Assistance	5.	5. Complete
	6. Review Clinic stats	6.	6. Complete
	7. Discuss industry trends	7.	7. Complete
	8. Review Committee self-assessment results	8. Changing process, will likely use Governance committee recommended questions going forward	8. Complete
	9. Review Long-Term Planning	9.	9. Complete
	10. Review completion status of current year work plan	10.	10. Done
	11. Discuss effectiveness of financial reporting to the board and make recommendations for improvement	11.	11. Done
	12. Draft following year work plan	12.	12. Complete, with edits
	13. Set first committee meeting date for next year	13. Recommend March 23	13. March 16, tentative
	14. Discuss Board Education	14.	14. Complete

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

A G E N D A

Board Quality Oversight Committee
December 8, 2025
12:00 PM – 2:00 PM
Clinic Conference Room

The documents contained in this file are part of the performance/quality improvement and peer review programs to review the services rendered in the hospital/clinic areas, both retrospectively and prospectively, in order to improve the quality of medical care of patients and to prevent medical malpractice (RCW 70.41.200 (1) (a)).

Therefore, **all** information following the agenda is confidential and protected under: RCW 4.24.250; RCW 70.41.200; and Senate Bill 5666

Agenda Item		Time
1.	Call to Order	12:00 PM
2.	Consent Agenda Approval • December 8, 2025, Agenda • August 27, 2025, Minutes	12:00 PM
Committee Work		
1.	Review Action Items	12:00 PM
2.	Patient Story	12:05 PM
3.	Policy Review • Quality Assurance and Process Improvement Plan	12:15 PM
4.	Q3 Quality Committee Reports	12:55 PM
5.	Discuss Annual QOC Report for December Board Meeting	1:00 PM
6.	Discuss Annual Committee Self-Assessment	1:10 PM
7.	Review and Revise Committee Charter	1:30 PM
8.	Review and Draft 2026 Workplan	1:40 PM
9.	Schedule Initial 2026 Meeting Dates	1:50 PM
10.	Provider Credentialing	1:55 PM
Adjournment		
1.	Adjournment	2:00 PM

Quality – *We demonstrate an exceptional and enduring commitment to excellence. We are devoted to processes and systems that align our actions to excellence, compassion, and effectiveness on a daily basis.*

Materials provided in advance of meeting along with agenda:

1. August 27, 2025, Minutes
2. Policy
    a. Quality Assurance and Process Improvement Plan
        i. Quality Structure
        ii. Prioritization Worksheet
        iii. Performance Improvement Project Worksheet
        iv. Quality 101
3. Committee Reports
    a. Antibiotic Stewardship Committee
    b. Emergency Care Committee
    c. Infection Control Committee
    d. Patient and Family Advisory Council
    e. Safety Committee
    f. Utilization Management Committee
4. 2025 Workplan with notes
5. Annual Committee Self-Assessment Questions
6. Draft 2026 Charter

7. Draft 2026 Workplan

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Board Quality Oversight Committee Purpose

To provide a mechanism to assist the Board in fulfilling its oversight responsibilities related to patient safety, operational and clinical quality, patient satisfaction, risk management and medical staff credentialing. The Committee shall provide oversight to Cascade Medical's efforts in measuring quality and patient safety, disseminating information, improving clinical practices and supporting a culture of high-quality care and safety throughout the organization.

2025 BOARD QUALITY OVERSIGHT COMMITTEE WORK PLAN

Month	Goal / Responsibility	Notes	Completion Status
January	1. Board Quality Rounding	1. Endoscopy and Mobile Integrated Health (MIH) with Jessica and Gustavo	1. Complete
February	1. Review action items from prior meeting minutes	1.	1. Complete
	2. Patient Story	2.	2. Complete
	3. Finalize current year workplan	3.	3. Complete
	4. Review Policies • Death with Dignity	4. Recommended the policy to the board for full approval	4. Complete
	5. High level discussion regarding Q4 written reports	5. Request to add annual inpatient length of stay to utilization management report	5. Complete
	6. Board Quality Rounding Review	6. Reviewed MIH and endoscopy rounding takeaways and current data	6. Complete
	7. Review Q4 Quality Data • Event Reporting • Patient Safety and Quality Data • Patient Satisfaction Report	7.	7. Complete
	8. Quality Data & Dashboard Updates	8.	8. Complete
	9. Clinic Mock Survey Overview	9.	9. Complete

Month	Goal / Responsibility	Notes	Completion Status
	10. 2024 CAH Program Evaluation Discussion	10. Document standardized for future use	10. Complete
	11. Set Initial 2025 Meeting Dates	11.	11. Complete
	12. Provider Credentialing	12.	12. Complete
April	1. Board Quality Rounding	1. Business Services and Infection Control with Cary and Tom	1. Complete
May	1. Review action items from prior meeting minutes	1.	1. Complete
	2. Patient Story	2.	2. Complete
	3. Quality Data & Dashboard Updates	3. Discussion around proposed dashboard format moving forward	3. Complete
	4. Board Quality Rounding Review	4. Reviewed Business Services and Infection Control rounding takeaways and data	4. Complete
	5. Review Policies • Medical Staff Professional Practice Evaluation	5. Further updates required at this time, policy to go to MEC first	5. Postponed
	6. High level discussion regarding Q1 written reports	6.	6. Complete
	7. Schedule Q3 2025 Meeting	7.	7. Complete
	8. Provider Credentialing	8.	8. Complete
Aug	1. Board Quality Rounding	1. Operational Safety and Lab with Jessee and Cary	1. Complete
Sep	1. Review action items from prior meeting minutes	1.	1. Complete
	2. Patient Story	2.	2. Complete
	3. Board Quality Rounding Review	3. Reviewed Lab and Operational Safety rounding takeaways and data	3. Complete
	4. Quality Data & Dashboard Updates	4. Draft Dashboard Reviewed	4. Complete
	5. High level discussion regarding Q2 written reports	5.	5. Complete

Month	Goal / Responsibility	Notes	Completion Status
	6. Policy Review • Disclosure of Unanticipated Outcomes • Risk Management Program	6. Recommended the policies to the Board for full approval	6. Complete
	7. External Initiative Updates	7. New item recommended by Jessica to keep board members informed of Quality related external relationships/initiatives	7. Complete
	8. Plan for committee self-assessment survey	8. Plan for collaborative discussion vs written feedback	8. Complete
	9. Provider Credentialing	9.	9. Complete
October	1. Board Quality Rounding	1. Skipped due to priority DOH survey work	1.
Dec	1. Review action items from prior meeting minutes	1.	1. Complete
	2. Patient Story	2.	2. Complete
	3. Review Policies: • Quality Assessment and Performance Improvement Plan	3. Recommended the policy to the Board for full approval	3. Complete
	4. High level discussion regarding Q3 written reports	4.	4. Complete
	5. Board Quality Rounding Review	5. Board Rounding was skipped this quarter due to priority DOH work	5.
	6. Review Q3 Data • Event Reporting Data • Patient Safety and Quality Data • Patient Satisfaction Report	6. No data presented during this meeting as policy/program updates underway in response to DOH survey	6.
	7. Quality Data & Dashboard Updates • Review Final Dashboard	7. Dashboard discussion will continue as policy/program updates take effect	7.
	8. Discuss Annual QOC Report for December Board Meeting	8. Recommend Notable Achievements	8. Complete
	9. Review annual committee self-assessment	9.	9. Complete
	10. Review and revise Committee Charter	10. Recommend to full Board	7. Complete

Month	Goal / Responsibility	Notes	Completion Status
	11. Review and draft Work Plan for following year	8. Add in a quarterly dashboard update	11. Complete
	12. Set initial meeting dates for following year	12. All quarters scheduled	9. Complete
	13. Provider Credentialing	13.	10. Complete

Committee Reports to be presented quarterly:

a. Safety Committee
b. Infection Control Committee
c. Pharmaceutical & Treatment Committee
d. Utilization Management Committee
e. Emergency Care Committee
f. Safe Patient Handling Committee
g. PFAC Steering Committee
h. Swing Bed Committee
i. Antimicrobial Stewardship

Notable Achievements 2025

- Clinic construction complete, making staff workspaces and patient room workflows more efficient in support of Team Based Care
- Expanded service line offerings with the addition of weekly, onsite MRI.
- Expanded service line offerings with the addition of a second day/week for onsite Ultrasound.
- Hospital DOH Survey complete. Plan of correction approval received.
- Initiated focused quality projects and performed Board Quality Rounding with: Endoscopy, Mobile Integrated Health, Business Services, Infection Control, Lab, and Operational Safety.
- Clinic DOH Survey complete.
- Implementation of new policy software for all of Cascade Medical.
- Graduated 12 students through the CNA Apprenticeship Program, in collaboration with Mountain Meadows.
- Cascade Medical Board member and Quality Department member asked to speak at the WSHA Rural Hospital Leadership Conference.
- Welcomed a new member to the Quality team as the Quality Data Specialist.
- Welcomed a new board member to the Quality Oversight Committee.
- Received the WSHA CAH Achievement of Quality Excellence Silver Award.
- Enhanced data accessibility through optimization of Meditech reporting modules.
- Completion of annual Health and Safety Fair.
- Participation in North Central Regional Falls Prevention, offering education and resources to our community.
- Participation in the Arrive Alive Event for high school students.

DRAFT 2026 – 2028 Organizational Objectives
With VERY DRAFT 2026 Organizational Objectives Themes

Overview

This document comes to you ahead of the December board meeting to allow time to review, digest and consider the material in advance of our discussion, to set us up for a maximally productive conversation at the December board meeting. With that in mind, if your review generates specific questions, we encourage you to send those in advance to Diane, so we can be as prepared as possible to answer them in the board meeting. Of course, in the moment questions at the meeting are also completely welcome; it is the beauty of a good group discussion that often additional thoughts and considerations are sparked, and we look forward to those as well.

Many of the proposed objectives in this packet, both long- and shorter-term, should not feel completely new to you as they were developed heavily from the work of the October board retreat. Additionally, we explored the resulting 2026 – 2028 themes together at the October board meeting and, while your feedback from that meeting was utilized to amend the themes into a bit more clearly stated objectives, they have not been substantially changed from your previous review, in line with the October board meeting discussion.

Normally by December we would have a version in front of you for approval, but we are asking for your review and feedback in December, with the goal of getting them in shape for approval in January. This timing is driven in part by the master facility plan work and our desire to not have objectives completed too far ahead of that substantial work as well as timing of meetings and internal leader input in Q4. We have worked to keep you abreast of process and timelines; hopefully our timing is not coming as a surprise to you.

We have followed our process for input on this work, including review and prioritization with medical staff and the broader leadership team, with fine-tuning by executive team and Dr. Kendall. This year we had the added benefit of hearing from many other team members at the May listening sessions, and that input helped inform the proposed plan as well.

Lastly, this document is organized to show our proposed 2026 – 2028 objectives first as stand alone items, with subsequent pages listing each 2026 – 2028 objective again with the proposed themes for 2026 annual objectives. The intent of this organization is to allow reviewers to maintain the highest level strategic focus and consideration on the long-term goals before narrowing focus on annual planning themes.

Proposed / DRAFT 2026 – 2028 Objectives

The next two pages list our proposed long-term organizational objectives. These are intended to support the evergreen pillar statements while providing big picture direction to us as an organization over the next three years. These objectives will direct the focus of our annual work and serve as our guide each year as we develop annual plans to move forward work that supports each long-term objective.

Evergreen statement for:
Patient & Family Centered Care: Patients and their families will experience exceptional, high-quality, safe, compassionate, whole-person care.

Proposed 2026-2028 Long Term Objectives:

Engage in a continuous process of expanding our community's access to healthcare, including through service expansion and exploration of visiting specialists, and with attention to clinician workforce, to meet community needs.

Continued focus on providing safe, high-quality care within a personalized, patient-centered environment, with emphasis on care integration, whole-person care and fostering an exceptional first-touch experience.

Evergreen statement for:
Financial Stewardship: Maintain a financially stable Public Hospital District that meets our communities' needs now and in the future.

Proposed 2026-2028 Long Term Objectives:

Implement master facility plan recommendations that allow for strategic service expansion through 2028 while positioning Cascade Medical for longer-term growth to meet community needs of the future.

Focused strengthening of organizational financial performance, including through innovation, to ensure CM's positioning to fully care for the community into the future.

Evergreen statement for:
Our People: Retain, attract, engage, develop, and support outstanding, community-focused team members who consistently demonstrate commitment to our Shared Values.

Proposed 2026-2028 Long Term Objectives:

Invest in and continue to grow a desirable working culture that retains, engages, develops and supports our outstanding community-focused team members.

Continued focus on sustainably enhancing pay and benefits coupled with a regular cadence of communication to educate team members on the value of their total compensation.

Actively promote Cascade Medical as the employer of choice to attract community-focused team members.

Evergreen statement for:
Community Connections: Deliver services, programs and outreach that increase access, meet community-defined needs and are developed in partnership with our communities.

Proposed 2026-2028 Long Term Objectives:

Increase options for and utilization of convenient access points for care and promote those and other services effectively across all segments of our community.

Strengthen and grow both service and access opportunities through mindful outreach with other potential partners or collaborators within our hospital district.

Proposed / DRAFT 2026 Objectives Themes

Below are the proposed / draft 2026 – 2028 organizational objectives with proposed 2026 areas of annual focus. A few things to keep in mind as you review:

- The executive team needs additional time to refine the themes into measurable and quantifiable objectives; we are scheduled to continue this work as a group on December 18, the day following the board meeting. We will also be looking at balance across the organization, to ensure we have appropriately spread the work across departments and areas, which is one way to build plan manageability.
- This list represents the top priority areas of focus as selected by our team, including Dr. Kendall, all of whom considered the strategic planning inputs (risk stratification, team input, market data, etc.) as part of the prioritization process. I have concerns that we still have too much on the list compared to available resources. We will be carefully working through those considerations in the coming weeks and potentially reducing scope in some areas.
- One of the Financial Stewardship 2026 goals is a placeholder for whatever actions come out of the master facility plan (MFP) process; that will be solidified in tandem with the MFP.
- Some of the initiatives discussed at the retreat and the October board meeting fit the categories of tactics rather than broad objectives. Many of those items will have focus at the departmental level, but you won't see them listed in the broad objectives below. This includes tactics like chronic disease management, Spanish language focus, further expansion of clinic hours, a marketing plan, etc.

Evergreen statement for:

Patient & Family Centered Care: Patients and their families will experience exceptional, high-quality, safe, compassionate, whole-person care.

Proposed 2026-2028 Long Term Objectives with 2026 Annual Themes:

> Engage in a continuous process of expanding our community's access to healthcare, including through service expansion and exploration of visiting specialists, and with attention to clinician workforce, to meet community needs.
>
> 2026 Annual Objectives to Consider/Narrow:
>
> 1. Increase family medicine market share by X amount / percentage the end of 2026.
> 2. Develop, implement and regularly update a long-term provider staffing plan, informed by community need, fiscal sustainability, and market/industry trends,

with regular data monitoring / measurement to ensure appropriate resources exist to meet community need short- and long-term.

3. TBD on tie with master facility plan outcome: Develop a comprehensive and fiscally sustainable behavioral health program, with implementation timelines, for the purpose of increasing community access to needed behavioral health services, including psychiatric access and ongoing counseling/therapy services for all ages.
4. Develop a blueprint for a best practice visiting specialist program within our Rural Health Clinic reimbursement model by the end of 2026, to position us to implement in subsequent year(s), depending on master facility plan direction.

Continued focus on providing safe, high-quality care within a personalized, patient-centered environment, with emphasis on care integration, whole-person care and fostering an exceptional first-touch experience.

2026 Annual Objectives to Consider/Narrow:

1. Meet the first year timelines of the three-year work plan to achieve hospital DNV accreditation by or before the end of 2028.
2. Continued focus on patient experience

Evergreen statement for:
Financial Stewardship: Maintain a financially stable Public Hospital District that meets our communities' needs now and in the future.

Proposed 2026-2028 Long Term Objectives with 2026 Annual Themes:

Implement master facility plan recommendations that allow for strategic service expansion through 2028 while positioning Cascade Medical for longer-term growth to meet community needs of the future.

2026 Annual Objectives to Consider/Narrow:

1. Recommend TBD based on outcome of master facility plan work, but this is the place we will memorialize next big steps for 2026 related to the master facility plan

Focused strengthening of organizational financial performance, including through innovation, to ensure CM's positioning to fully care for the community into the future.

2026 Annual Objectives to Consider/Narrow:

1. Meet budgeted total margin and cash projections for 2026
2. Perform charge master review by June with full implementation of recommendations by end of 2026
3. Continued emphasis on improving charge capture
4. Develop measurable goal structured around Rehab Services being margin neutral or better

Evergreen statement for:
Our People: Retain, attract, engage, develop, and support outstanding, community-focused team members who consistently demonstrate commitment to our Shared Values.

Proposed 2026-2028 Long Term Objectives with 2026 Annual Themes:

Invest in and continue to grow a desirable working culture that retains, engages, develops and supports our outstanding community-focused team members.

2026 Annual Objectives to Consider/Narrow:

1. Implement plan so all employees receive annual evaluations by the end of 2026 – discuss tracking / data / timeline
2. Implement designated trainer for Meditech (is this possible?) by end of 2026
3. Increase opportunities for intradepartmental connection
4. Grow effective communications methods for employees

Continued focus on sustainably enhancing pay and benefits coupled with a regular cadence of communication to educate team members on the value of their total compensation.

2026 Annual Objectives to Consider/Narrow:

1. Develop a three-year plan for this work RE pay and benefits (develop, implement and regularly update an organizational compensation philosophy / strategy to ensure CM's wage and benefit offerings can grow with market changes in a financially sustainable way while cultivating and retaining excellent employees) and meet 2026 plan timelines
2. Meet total compensation communication plan timelines

Actively promote Cascade Medical as the employer of choice to attract community-focused team members.

2026 Annual Objectives to Consider/Narrow:

1. Develop, implement and meet 85% of plan timelines per quarter to promote CM as an employer

Evergreen statement for:
Community Connections: Deliver services, programs and outreach that increase access, meet community-defined needs and are developed in partnership with our communities.

Proposed 2026-2028 Long Term Objectives with 2026 Annual Themes:

Increase options for and utilization of convenient access points for care and promote those and other services effectively across all segments of our community.

2026 Annual Objectives to Consider/Narrow:

1. Develop and implement an education plan to help community know what services are available at CM currently and to ensure a two-way communication loop with the community as we work to grow new services and implement a master facility plan
2. Achieve 80% of CHNA workplan tactics for 2026
3. Consider Mobile Integrated Health goal

Strengthen and grow both service and access opportunities through mindful outreach with other potential partners or collaborators within our hospital district.

2026 Annual Objectives to Consider/Narrow:

1. Increase utilization of mobile clinic by X
2. Explore viability of developing a formal outreach program

Credentialing Approvals

Locum Tenens Privileges: (90-days)

- Tai Moses, PA-C

Teleradiology Active Privileges: (2-years)

- Chad Barker, MD
- Sean Chang, MD
- Kyle Hirshman, DO
- Veronica Ruvo, DO

Cascade Medical's credentialing process has been followed for these providers.

SBAR: Replacement of LIFEPAK 15 Monitor/Defibrillator With ZOLL ZENIX for MSO Response Duties

Situation

Cascade Medical EMS's Medical Supervisor Officers (MSOs) are currently operating with a LIFEPAK 15 defibrillator/monitor that will reach end of life by the end of 2026, and it is experiencing increased maintenance issues. As we move toward full standardization of monitors across Cascade Medical, adopting the next-generation monitor/defibrillator platform is the logical progression, providing enhanced clinical capability and updated technology that has been reviewed and supported by both EMS and Nursing. Updating the MSO equipment now also supports continuity in care, training, and system integration as we prepare for the broader rollout of new monitors in 2026.

Funding has been made available through the Cascade Medical Foundation to purchase one ZOLL Zenix Monitor/Defibrillator at a price of $68,005.21. Additionally, this is a planned 2025 capital purchase, with a budgeted cost of $70,590. This single acquisition will initiate the transition to ZOLL as our standardized platform before full system replacement in 2026.

Background

- Our LIFEPAK 15 fleet is nearing the end of its service life and is increasingly costly to maintain.
- Cascade Medical has budgeted to replace all hospital and EMS monitors in 2026 with the ZOLL Zenix platform to ensure equipment uniformity across all clinical environments.
- The MSOs function as ALS first responders, provide advanced assessments, and support MIH and follow-up patient care. Access to the same monitor platform used across the system enhances clinical consistency and supports seamless patient care.
- Early procurement and deployment of a single ZOLL Zenix unit allows MSOs and field staff to become familiar with the device, easing transition during training, skills retention, and future integration across hospital departments and ambulance units.
- The Cascade Medical Foundation has raised funds specifically for this purchase.

Assessment

The current MSO LIFEPAK 15 unit is approaching its end-of-life cycle, with increasing maintenance needs and declining reliability in the field. These issues create operational risk during ALS responses and MIH visits, where dependable monitoring and defibrillation capabilities are essential. Replacing this end-of-life unit now ensures consistent performance, reduces maintenance burden, and supports safe, effective care delivery in all MSO response functions.

The ZOLL Zenix platform provides improved clinical functionality, including enhanced CPR feedback, advanced monitoring parameters, and improved durability. Aligning MSOs with the platform being adopted hospital-wide ensures:

- Consistent training, competencies, and skill retention
- Improved operational readiness for MIH and ALS response
- A controlled, phased transition for staff and educators before full deployment

Recommendation

Management recommends approval of the purchase of one ZOLL Zenix Monitor/Defibrillator for MSO response duties at the quoted price of $68,005.21, funded by the Cascade Medical Foundation.

This unit should serve as the first step in the planned transition of all Cascade Medical monitors to the ZOLL platform in 2026. Early acquisition supports training, implementation planning, and operational alignment while replacing an end-of-life unit essential for ALS and MIH field operations.

This approach ensures system continuity, prepares staff for broader implementation, and strengthens overall patient care across hospital and EMS operations.





CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Board Governance Committee Purpose

To provide for the Board's effectiveness and continuing development as well as to continuously enhance the effectiveness of communication between the Board and Administration.

2025 GOVERNANCE COMMITTEE WORK PLAN

Month	Goal / Responsibility	Notes	Completion Status
Feb	1. Develop / refine 2025 Board education plan	1. Will continually refine throughout the year	1. Done
	2. Develop/ finalize 2025 Work Plan	2.	2. Complete
	3. Discuss vision for annual Board retreat	3.	3. Discussed
	4. Review Policies: • Receiving legal documents from a process server • Policy Creation, Review & Approval	4. No revisions recommended	4. Reviewed, will recommend to full board for approval
	5. Review list of approved Commissioner outreach events	5.	5. Reviewed
	6. Discuss ways to continue to grow the Board's approach to thinking strategically	6.	6. Discussed, including regarding how to approach visioning 5 – 10 years out and how to encourage broad thinking and questions to help buffer against uncertainty in healthcare
	7. Finalize Board Objectives, plan work to meet them	7.	7. Done
	8. Annual review of Board skills matrix	8.	8. Reviewed
	9. Discuss topics for Part Time Resident Advisory Council	9.	9. Discussed
	10. Board future / succession planning	10.	10. Robust discussion and planning for new commissioner recruitment including setting strategy, reviewing applications, interview questions & process, etc.
Apr	1. Review Policies: • New Commissioner Orientation Policy • Public Records Request Policy	1. Minor update made to new commissioner orientation policy	1. Reviewed and recommended to full board for approval

Month	Goal / Responsibility	Notes	Completion Status
	2. Check-in on Board Retreat	2.	2. Discussed as well as more broadly strategic planning, with discussions on CHNA, master facility plan, and other strategic inputs. Recommended October for retreat.
	3. Review Board Education Plan	3.	3. Reviewed, discussed timing of quality education, concepts for Q3 education related to financial planning and budget, and AI
	4. Review list of approved Commissioner outreach events	4.	4. Reviewed, further discussed opportunities for commissioner involvement
	5. Check-in on progress of Board's 2025 objectives work	5.	5. Discussed, everything on track
	6. Board President report on how committee chairs are doing	6.	6. NA, many changes happening
	7. Discuss strategy and timing of full board self-assessment	7.	7. Discussed and recommend holding until 2026 due to timing of commissioner changes
	8. Board future / succession planning	8.	8. Significant work performed including recommending updates to committee and liaison assignments, mentorship planning, checking in on new commissioner orientation process, updating matrix
	9. Discuss ways to continue to grow the Board's approach to thinking strategically	9.	9. Did not separately discuss/plan for on the agenda, due to time required for other items
June	1. Check-in on progress of Board's objectives work	1.	1. Done, well on track
	2. Review Board education Plan	2.	2. Reviewed, refined Sept budget education plan
	3. Review list of approved Commissioner outreach events	3.	3. Reviewed
	4. Discuss ways to continue to grow the Board's approach to thinking strategically	4.	4. Discussed, focused on types of questions to provide to Board to encourage high-level thinking
	5. Check in on periodic review process for CEO	5.	5. NA, did not include on agenda due to robust discussion in April

Month	Goal / Responsibility	Notes	Completion Status
	6. Discuss plans for full board self-assessment	6.	6. NA, moved to 2026
	7. Board future / succession planning	7.	7. Done, discussion around new commissioner orientation plan progression
	8. Check in on Board Retreat Planning	8.	8. Discussed and refined plans. Additionally, made plans to approach Governance's future mission and vision work.
Aug	1. Policy Review: • Conflict of Interest Policy • Open Public Meetings Policy	1. No revisions recommended	1. Committee recommends for full board approval via consent agenda
	2. Preliminary discussion to refine/review process for CEO Annual Review	2.	2. Tabled to next meeting
	3. Check-in on Board objectives	3.	3. Reviewed, all on target
	4. Review list of approved Commissioner outreach events	4.	4. Reviewed. Committee determined no longer a need to include this item on future agendas, for now
	5. Finalize Committee self-evaluation survey	5.	5. Discussed and recommend updating questions and having a discussion on the questions at the next meeting, rather than performing a digital survey; will share with other committees
	6. Review Board Education Plan	6.	6. Discussed
	7. Finalize retreat	7.	7. Done, including recommending strategic planning packet be sent in advance of September board meeting
	8. Check in on full board self-assessment work	8.	8. NA, tabled to 2026
	9. Board future / succession planning	9.	9. NA, declined to include on this month's agenda, due to past bolus of work
	10. Brainstorm officer and committee rotations for 2026 planning	10.	10. Tabled to next meeting

Month	Goal / Responsibility	Notes	Completion Status
	11. Discuss topics for Part Time Resident Advisory Council meeting	11.	11. Discussed, topics recommended
	12. Discuss ways to continue to grow the Board's approach to thinking strategically	12.	12. Discussed
Nov	1. Review Committee Charter	1.	1. Reviewed
	2. Review Governance Committee self-assessment results	2.	2. Held robust committee self-evaluation discussion using updated questions/prompts
	3. Review Commissioner Compensation policy	3.	3. Reviewed
	4. Review list of approved Commissioner outreach events	4.	4. NA, committee removed from work list
	5. Begin draft Committee Work Plan for following year	5.	5. Draft begun/discussed
	6. Check in on 2026 Committee membership, officers	6.	6. Discussed, will recommend adjustments to full board in Dec
	7. Board President report on how committee chairs are doing	7.	7. Report given
	8. Finalize timeline and documents for CEO annual review	8.	8. Done
	9. Prepare for December report to full Board regarding progress / annual results of committee work	9.	9. Process change to include workplan as informational item only; workplan reviewed for accuracy
	10. Check-in on Board's progress toward meeting objectives	10.	10. Discussed, all on track
	11. Initiate discussion of board objectives for 2026	11.	11. Discussed
	12. Plan Board education for January & February 2026	12.	12. Discussed
	13. Board future / succession planning	13.	13. Discussed
	14. Discuss ways to continue to grow the Board's approach to thinking strategically	14.	14. Discussed
	15. Set at least first 2026 Governance meeting date	15.	15. Tentatively set

Additional work not included on the workplan:

- In April, performed retrospective / after action of CEO review process
- Developed draft Board decision-making matrix
- Developed process and structure for making community appointments to Board committees as well as reviewed a candidate for COAC consideration