CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

PUBLIC HOSPITAL DISTRICT NO. 1 - CHELAN COUNTY, WASHINGTON
BOARD OF COMMISSIONERS MEETING AGENDA
May 24, 2023 5:30 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**	5:30	ACTION
II.	**Pledge of Allegiance**	5:30	ACTION
III.	**Consent Agenda** Note: any of the following individual Consent Agenda items may be pulled for discussion at the request of a commissioner. Consent Agenda items pulled will be discussed and acted upon individually, immediately following Board approval of the remaining Consent Agenda items. All consent agenda items (not pulled for discussion) will be approved by the Board with a single motion). • Agenda Approval • April 26, 2023 Board Meeting Minutes • Change Order Authority Policy • Financial Assistance Policy • **Previous Month's Warrants Issued** #10119054 – 10119343 04/11/2023--05/17/2023 **$ 1,185,960.61** • **Accounts Payable EFT Transactions** #20220227 – 20220244 04/11/2023--05/17/2023 **$ 508,681.36** • **Payroll EFT Transactions** #13697—14235 04/21/2023--05/19/2023 **$ 1,169,095.65** • April Bad Debt	5:30	ACTION
IV.	**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.	5:35	REPORT
V.	**CM Values**	5:40	DISCUSSION
VI.	**Foundation Report**	5:45	REPORT
VII.	**Public Relations Report**	5:50	REPORT
VIII.	**Discussion/Report: Old Business** a. IT Update	5:55	DISCUSSION
IX.	**Discussion/Report: New Business** a. Kitchen Update and Repair	6:05	DISCUSSION
X.	**Committee Reports** a. Quality Oversight Committee b. Part Time Resident Advisory Council c. WSHA Board Meeting	6:15	REPORT
XI.	**Action Items: New Business** a. Credentialing b. Appoint Part Time Resident Advisory Council Members c. CHNA Work Plan (Discussion questions: What gaps or areas of need remain unaddressed in the current plan, that we need to prepare for? What should we be thinking about in the next 2-3 years? What else would we like to know about our community?) d. Resolution 2023-04: Surplus Work Truck e. Resolution 2023-05: Surplus Snowman Drag Plow f. Resolution 2023-06: Surplus Snowmobile Trailer g. Approve Chiller Purchase h. Medical Staff Rules and Regulations	6:35	ACTION
XII.	**April Finance Report**	7:05	REPORT
XIII.	**Administrator Report**	7:15	REPORT
XIV.	**Board Action Items**	7:25	DISCUSSION
XV.	**Strategic Question/Meeting Evaluation/Commissioner Comments** Roundtable discussion where each Commissioner shares thoughts, impressions, and questions on the meeting/meeting topics, including sharing best practice ideas based on other board experience. Also a time to identify what worked well and where there are opportunities for improvement.	7:30	DISCUSSION
XVI.	**Adjournment**	7:35	ACTION

BOARD CALENDAR REMINDERS

June 6, 2023	Benevolent Night	Munchen Haus	4:00 PM
June 14, 2023	CMF Board Meeting	Arleen Blackburn Conference Room	9:00 AM
June 19, 2023	CMF Golf Tournament	Kahler Mountain Club	All Day
June 28, 2023	Board Meeting	Arleen Blackburn Conference Room	5:30 PM
July 2, 2023	Benevolent Night	Plain Cellars	4:00 PM
July 11, 2023	Benevolent Night	Squirrel Tree Resort	All Day

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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 May 24, 2023

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

- **Consent Agenda** – Please feel free to connect with Marianne or Diane with any questions in advance of Wednesday's meeting and / or pull individual warrants or other items from the consent agenda at the meeting, should you wish to discuss. The policies in the consent agenda have been reviewed by the Finance Committee, and that committee recommends them for approval.
- **Discussion/Report: Old Business**
    - IT Update – No documents are included in your packet for this topic. Chad Schmitt, VFCIO, will provide an update on recent work and Molly Bloss, Director of Informatics, will be on hand as well.
- **Discussion/Report: New Business**
    - Kitchen Update and Repair – Included in your packet is a summary sheet describing planned work in our Dietary department. A good portion of this work includes an unbudgeted repair on the kitchen drain. The remainder of the work is a budgeted upgrade. Per standard process, management is presenting this request to you in May for discussion and to allow for any follow up requests from you, and then we will plan to bring the item back in June for approval. Pat Songer will be in attendance to answer questions and provide additional information.
- **Committee Reports**
    - Quality Oversight Committee – Included in your packet is an agenda from the most recent committee meeting, to inform Mall's report.
    - Part Time Resident Advisory Council – Included in your packet is an agenda from the most recent meeting, to inform Mall's report.
    - WSHA Board Meeting – No documents are included in your packet for this item. Bruce will provide a verbal report from the most recent WSHA board meeting.
- **Action Items: New Business**
    - Credentialing – Included in your packet is a list of providers ready to be considered for approval.
    - Appoint PTRAC Members – Included in your packet is a list of appointments to consider for approval for the Part Time Resident Advisory Council (PTRAC). The PTRAC members have voted to forward these names to you for appointment consideration.
    - CHNA Work Plan – Included in your packet is work plan which is required to be reviewed and approved by the Board this month. This will be appended to our published Community Health Needs Assessment as required by regulation. This work plan has been developed both through the strategic planning process and via further collaboration between management and providers. Additionally, we have included some discussion questions as a strategy to drive strategic thinking on this topic. Please feel free to bring your own questions and additional thoughts as well.

- Resolution 2023-04 – Included in your packet is a resolution to surplus a work truck which no longer runs and, for us, is not worth the investment to repair. As a reminder, in order for CM to dispose of certain assets, we must first gain approval from the Board of Commissioners via surplus resolution.
- Resolution 2023-05 – Included in your packet is a resolution to surplus a drag snowplow which we no longer use.
- Resolution 2023-06 – Included in your packet is a resolution to surplus an old snowmobile trailer, which in the long past was utilized by the Ambulance department as part of the winter rescue program. This particular trailer has not been in use for years.
- Chiller Purchase – Included in your packet is a summary document outlining management's thinking regarding the need to act on replacing the chiller this year. Because of the lead time on this unit, we are proposing this for approval without review at a prior meeting. Pat will be on hand to answer additional questions.
- Medical Staff Rules and Regulations – Included in your packet, in draft changes format, are the updates to the Medical Staff Rules and Regulations forwarded by Medical Staff. These updates have been reviewed and made by management and the Medical Executive Committee. The full Medical Staff has reviewed the updated Rules and Regulations and voted at their May meeting to advance them to the Board of Commissioners for approval. The bulk of the updates relate to the coming changes which will occur with the addition of the hospitalists.

- **April Finance Report** – Included in your packet are the April financials, to support Marianne's report.

Further Notes

- Included in your packet is a calendar of Foundation board meetings through the remainder of 2023. Please consider whether you can attend any of the meetings. We will, additionally, have the sign up sheet available at the May meeting as well.
- We will be bringing an agenda topic back in June regarding clinic changes (team-based care/practice share) so the board may hear from Deb Williams and team members about how the change implementation is proceeding.
- As you review your packet, please be thinking about strategic questions and ways to engage in strategic discussion as we move through the meeting.
- Dr. Kendall joined the CM Diversity, Equity, and Inclusion Committee and will begin reporting out on that committee at Med Staff as well. This work touches the interest expressed earlier by the board to hear more about gender affirming care. We will plan to bring this topic to the board for an update in the coming months.

CASCADE MEDICAL
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Minutes of the Board of Commissioners Meeting
Chelan County Public Hospital District No. 1
Arleen Blackburn Conference Room & Video Conference Connection
April 26, 2023

Present: Tom Baranouskas, President; Bruce Williams, Vice President; Gustavo Montoya, Commissioner; Diane Blake, Chief Executive Officer; Pat Songer, Chief Operating Officer; Marianne Vincent, Chief Financial Officer; Melissa Grimm, Chief Human Resources Officer; Clint Strand, Director of Public Relations**;** Megan Baker, Executive Assistant
Via Zoom: Jessica Kendall, Commissioner
Excused: Mall Boyd, Secretary; Chad Schmitt, Virtual Fractional Chief Information Officer

Guests: Deborah Williams, DW Consulting; Natasha Piestrup, Director of Nursing**;** Bob Keller, CM Foundation**;** Karl Kranz, Upper Valley Mend
Via Zoom: Whitney Lak, Clinic Director

Topics	Actions/Discussions
Call to Order	• President Tom Baranouskas called the meeting to order at 5:30 pm. He then led the pledge of allegiance.
Consent Agenda	• Tom moved to approve consent the agenda. • Gustavo seconded the motion and the commissioners unanimously approved
Community Input	• None

CM Values	• Diane Blake provided the CM Values report.
	• Listening session recap
	  ○ The consistent message heard by leadership was that folks love CM and their team, and they have significant job satisfaction in their roles.
	• CM EMS
	  ○ The crew was dispatched by District 3 to help rescue a dog from a creek. The crew went above and beyond call of duty and safely rescued the dog, and it's a reminder of the wide breadth of work team across the organization do to take care of the community.

Foundation Report	• Bob Keller provided the Foundation Report.
	• Established in 1992, the CM Foundation has raised more than $1.7 million for Cascade Medical. There is currently $450,000 in their endowment account.
	  ○ The Cardiac Rehabilitation Program is the Foundation's priority 2023 project. The CMF Golf Tournament funds are ahead of projection and will support the new addition to Rehab services.
	  ○ Golf Tournament: Kahler Mountain Club on June 19, 2023
	  ○ Benevolent Night @ Yodelin, May 18, 4:00 PM
	  ○ Jive Time in the Cascades: September 16, 6:30-9:30 PM

Public Relations Report	• Clint Strand provided the Public Relations Report.

	• Leavenworth Community Engagement Night, May 2nd ○ Promotional items include connecting with Commissioners, openings on the Part Time Resident Advisory Council and Dr. Wefel's arrival. • Kudos to Jade Wolfe for her diligence and commitment to publicize the Patient Family Advisory Council. • Kudos to Melissa for her preliminary work to make Hospital Appreciation Week (May 7-12) a success. • Cascade Medical Health and Safety Fair: Saturday, June 24 @ Alpine Lakes Elementary • The Annual Report to our Community is on track to be published in June.

Discussion/Report: Old Business	• IT Update
	  ○ None
	• Nursing Update
	  ○ Natasha Piestrup provided the Nursing Update.
	  ○ Kudos to Rachel Avery, Continuous Quality Improvement Director for her work on revamping nursing education with Natasha.
	  ○ Education
	  ▪ Nursing staff have participated in a variety of training and education efforts including Safe Patient Handling, AVADE Workplace Violence, Lippincott modules, and mock codes.
	  ▪ The team has upcoming mandatory trainings including restraint and moderate sedation, which will be completed by both practitioners and nurses. Other optional education offerings include tissue donation, hospice education, and poison control.
	  ○ Onboarding
	  ▪ Nurses have received training binders with instructions to provide feedback to Natasha who will then work to revise and update the material as requested.
	  ▪ Melissa and Rachel are working together to standardize the onboarding process which will include two full days of HR-related content.

Discussion/Report: New Business	• Clinic Practice Share Update
	  ○ Deb Williams provided the Practice Share Update
	  ○ CM providers, staff, and leadership have been incredibly collaborative and engaged in the work.
	  ○ After performing the assessment, Deb identified the following areas of focus:
	  ▪ Best practice sharing
	  ▪ Operational workflows
	  ▪ Optimizing staff skillsets
	  ▪ Developing efficiencies
	  ▪ Creating access for the community
	  ○ Team Based Care Model
	  ▪ Deb shared a one touch philosophy that a patient will receive the care and attention at the time of service. A traditional model is more typically a "back and forth" communication style between the patient, PSR, MA, and practitioner.

	▪ Patient care is the responsibility of all team members which will be guided through team agreements. ▪ The work includes development, implementation and evaluation, and sustainability phases. CM is currently in the operational foundation phase of team development. Within this phase, Deb is working to rally the team around a shared vision of care. Whitney and Clint are working together to develop the communication that will be provided to patients. • Q1 Organizational Dashboard o Diane Blake provided the Q1 Organizational Dashboard o CM updated the format of the dashboard and discussed the format of the new version. o Q1 : Below Target ▪ The Patient & Family Engagement Council experienced recruitment challenges but anticipates moving forward with new interest from applicants. ▪ Exploring and developing service in expansion strategies - most items are on track or ahead of schedule, and one project is lagging slightly, which puts the goal behind schedule. o Q1: Potential Regression ▪ Exploring off-campus care delivery strategies requires a creative approach to continue moving the work forward. ▪ The Living Well Program is a heavy lift yet currently on track. • Board Goals Check-in o Tom provided the Board Goals Check-in o WSHA's governance education program has been published. Completion of these modules will help commissioners reach their WSHA Health Care Governance Certification. o The Community Engagement Night is a great opportunity for the board o Gustavo and Jessica are participating in an ongoing mentorship process to ensure full board integration. • Listening Sessions Loop Closure o Diane provided the Listening Sessions Loop Closure o 50-60 attendees throughout all four sessions. o WSHA initiated a state-wide effort to encourage hospitals to participate in listening sessions, which CM hosted in November. o In March, CM leadership circled back with staff and shared feedback from the listening sessions, including that the majority of suggestions became work items and shared the status of those items, including which were also incorporated into the organization's strategic plan. o Leadership received great feedback during the listening sessions that included safety improvement opportunities, request for communication and loop closure, and additional tools to support efficiency.
Committee Reports	• Governance Committee

	○ Tom provided the Governance Committee Report ○ The group recommended approval of the Public Records Request Policy which creates structure and a formal process around managing incoming requests. ○ The Board retreat is anticipated to be held in late fall, 2023. Retreat priorities include a review of the CHNA and succession planning. ○ Commissioners were asked to consider how they could think strategically about what topics they want to explore. • Finance Committee ○ Bruce provided the Finance Committee Report ○ The committee engaged in a robust discussion of the financial assistance policy. The state requirement is to apply charitable care efforts to hospital care, but CM includes EMS and clinic services. ○ Gustavo commended leadership's effort to ensure control systems are in place and transparent. • Quality Oversight Committee ○ Diane provided the Quality Oversight Committee Report via Mall's summary. ○ CM may elect to display data differently by using a control chart to more easily identify outliers that skew results. ○ Quality-related policies were approved internally, and the quality structure was updated. This reflects board involvement in CMs quality direction and initiatives. ○ Committee members described their appreciation for the presentation of committee reports and the overall content of documented discussions.
Action Items: New Business	• Resolution 2023-03 Authorizing Advance Voucher Payments ○ Bruce moved to approve the motion and Gustavo seconded. ○ The board unanimously approved the motion.
March Finance Report	• Marianne provided the finance report. ○ Year-to-date professional fees are over budget by $151,000 due to Meditech consulting fees. ○ Purchased Services shows a negative variance of ($60,000) for the month of March resulting from Business Office support, Centricity Hosting fees, and Pharmacy Expense. ○ Strong cash collections on patient accounts of $2,130,000 in March were above budgeted account collections of $1,706,000 by $424,000. We received a Medicare lump sum from Medicare in January which has us above budgeted cash receipts. ○ Days in Net Accounts Receivable decreased to 58.4 days in March, dropping from 60.5 days in February. ○ Our 2022 financial audit is still underway with just a few remaining schedules to be completed related to the Medicare cost report. We anticipate moving Chargemaster recommendations forward within the next few weeks.
Administrator Report	• Diane provided the administrator report. • Notice of capital budget overage ○ We budgeted to replace flooring and cabinets in the kitchen. The repair to the kitchen drain added around $40,000 to the anticipated request of $60,000 bringing the total to around $100,000.

	○ The chiller may need to be replaced sooner than next year and is anticipated to cost around $340,000. • Advocacy Update ○ A legislature agreement was reached to increase Medicaid payments to approximately 80% of cost coverage for PPS hospitals via the Safety Net Assessment Program, a large improvement from current status. ○ The Difficult to Discharge bill yielded payment incentives and payment rate increases to support long-term care providers and appropriate patient placement efforts. ○ The 2023 legislative budget funds operation of 23-hour behavioral health crisis facilities and several programs to support individuals living with behavioral health conditions who have long-term care needs. The budget focuses heavily on behavioral health services for children and youth, including funding for the children's partial hospitalization/intensive outpatient treatment program (PHP/IOP) Medicaid benefit that WSHA successfully advocated for last year. ○ The Nurse Licensure Compact (NLC) was passed in April 2023. The compact allows registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) to have one multistate license, with the ability to practice in person or via telehealth, in both their home territory/state and other NLC states. ○ CM operates under a nurse staffing committee which provides a nurse staffing plan. Agreement was reached in the legislature to strengthen nurse staffing committees and require additional data reporting from larger hospitals as an alternative to set staffing ratios. ○ The Cost Transparency Board, an effort to cap costs at 3%, despite much higher increased in labor and supply costs, did not pass, but we will continue to keep close eye on the efforts of the Cost Transparency Board. • UW Clerkship Program ○ CM's participation is on pause and will resume in late 2023. • Workforce Development ○ CM has regenerated their work with the high school job shadow program. We are currently hosting two students. ○ Melissa is participating in an advisory council with AHEC. ○ Rachel Avery received a scholarship to attend a project management course. ○ Aisha recently completed an Eye Movement Desensitization and Reprocessing (EMDR) training which is going to be a great tool for our patients at CM. She is also facilitating trauma workshops for first-responder families.
Board Action Items	• Commissioner filing dates are May 15-19. • Tom will attend the CM foundation meeting on May 17. • Please check your email.
Strategic Question/Meeting Evaluation/ Commissioner Comments	• The commissioners would like a practice share update from Deb Williams in the near future. • There was a request to hear from Molly and Chad on EMR and IT matters. • Interest was expressed in hearing more about gender affirming care in the future.

Executive Session	• Tom called the executive session at 8:15 PM. • The group extended the meeting at 8:35 PM for an additional 10 minutes. • The group exited the executive session at 8:45 PM.
Adjournment	• Tom made a motion to adjourn the meeting at 8:45. Bruce seconded the motion and the commissioners unanimously agreed.

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Tom Baranouskas, President Mall Boyd, Secretary

CASCADE MEDICAL
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Title:	**Change Order Authority**	Effective Date:	**11/01/2007**
Categories:	**Board of Commissioners**	Approved Date:	**06/01**/2021
Prepared By:	**Marianne Vincent (Chief Financial Officer)**		
Reviewed By:	**Diane Blake (Chief Executive Officer); Board Finance Committee**		
Approved By:	**Diane Blake (Chief Executive Officer), Board of Commissioners**		

POLICY:

1. In order to facilitate and expedite construction projects, the Board of Commissioners delegate authority for approving change orders according to the following guidelines: whereas (X) designates the individual with authority to sign change orders

2. Project Manager will keep a change order log and present this on a regular basis to the Facility Committee and to the Board.

3. The change order log shall identify the nature, cost and time impacts of all change orders.

PROCEDURE:

Change Order Level	Project Manager and/or Facility Consultant	Administrator	Board
No cost, no time impact	X		
Up to $15,000 and within project budget and time delay less than working 10 days		X	
Greater than $15,000, or exceeds project budget or time delay greater than working 10 days (may require special board meeting)			X

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Title:	**Financial Assistance**	Effective Date:	**05/01/2005**
Categories:	**Business Office**	Approved Date:	**Not Approved** Yet
Prepared By:	**Marianne Vincent**		
Reviewed By:	**Diane Blake, Board Finance Committee**		
Approved By:	**Board of Commissioners; No Users**		

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 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 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.

C. 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.

D. 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.

E. In accordance with RCW 70.170.060(8)(a) All ~~hospital~~ billing statements and other written communications concerning billing or collection of a ~~hospital~~ 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.

Title:	**Financial Assistance**	Effective Date:	**05/01/2005**
Categories:	**Business Office**	Approved Date:	**Not Approved** Yet
Prepared By:	**Marianne Vincent**		
Reviewed By:	**Diane Blake, Board Finance Committee**		
Approved By:	**Board of Commissioners; No Users**		

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. ~~Upon request,~~ Aapplications 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.

FINANCIAL ACCOUNTING
WARRANTS / EFTS ISSUED

Commissioner Meeting: May 24, 2023

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

Accounts Payable Warrant Numbers	10119054 - 10119343	$1,185,960.61	04/11/2023 – 05/17/2023
Accounts Payable EFT Transactions	20220227 - 20220244	$508,681.36	04/11/2023 – 05/17/2023
Payroll EFT Transactions	13697 – 14235	$1,169,095.65	04/21/2023-05/19/2023
	Grand Total	$2,863,737.62	

Prepared by:

Kathy Jo Evans
Director of Accounting

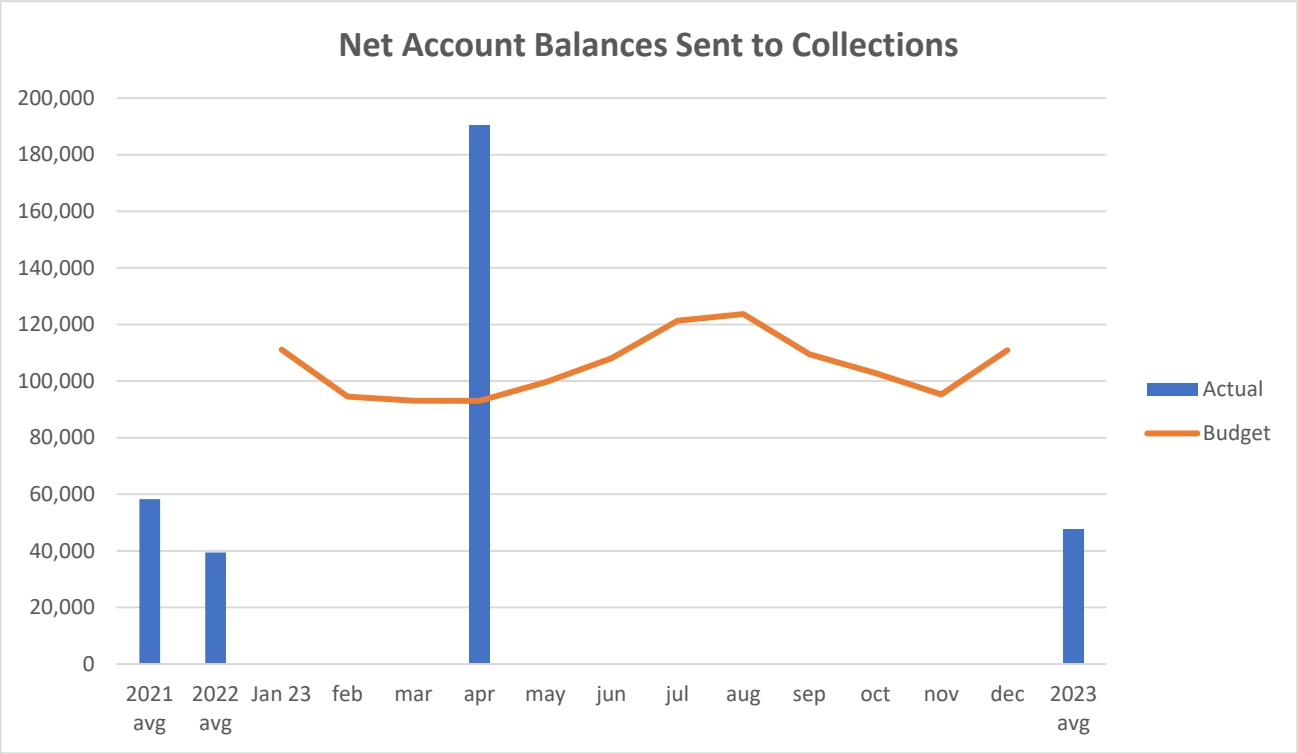
Cascade Medical

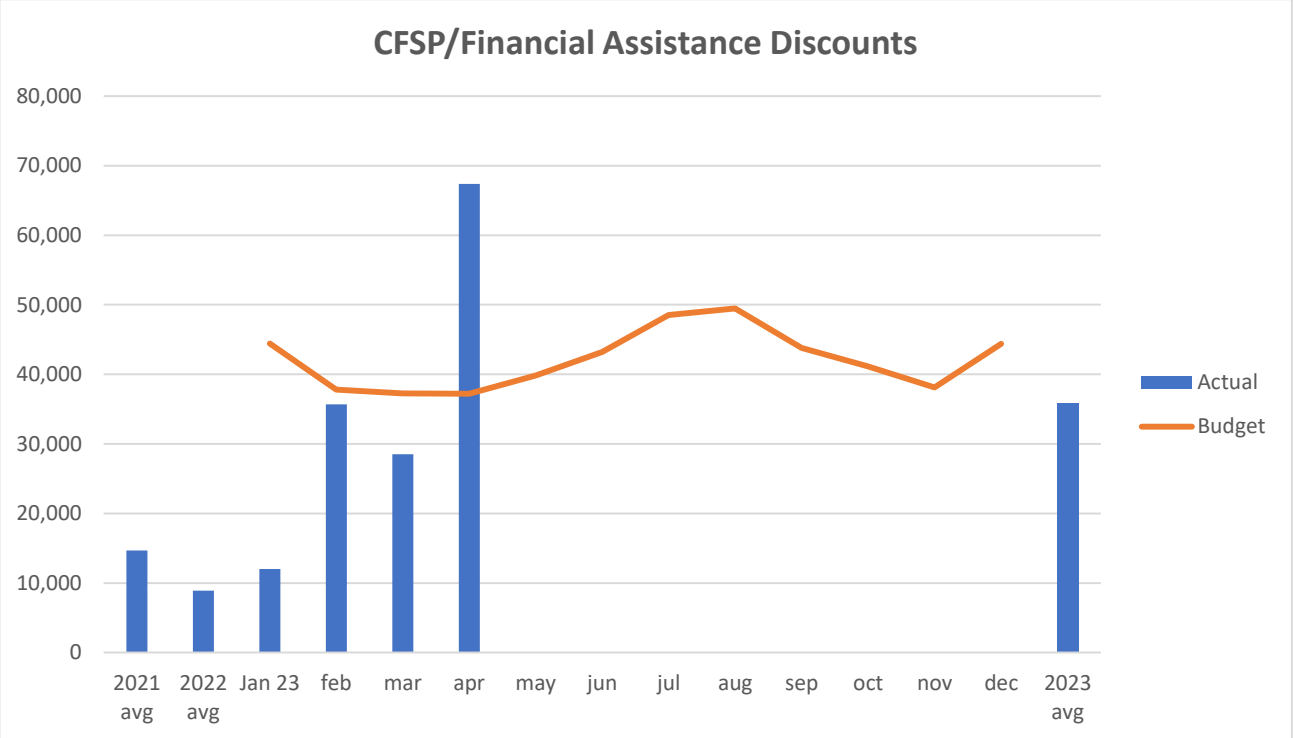
Bad Debt Write Offs
Financial Assistance Program Discounts

Month of April, 2023

Net Bad Debt Write-Offs for Board Approval	**$**	**190,347.81**
CFSP/Financial Assistance Program Discounts for Board Approval	**$**	**67,391.57**

Bad Debt/ Financial Assistance Supplemental Information		
Bad Debt Write-Offs	Sent to Collection Agency	190,347.81
	less: pullback from Agency due to receipt of payments	-
	Net Bad Debt Write-Offs	190,347.81
CFSP/Financial Assistance Applications - Discounts Approved		67,391.57
	Total	257,739.38


Net Account Balances Sent to Collections
200,000
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
2021 avg
2022 avg
Jan 23
feb
mar
apr
may
jun
jul
aug
sep
oct
nov
dec
2023 avg
Actual
Budget


CFSP/Financial Assistance Discounts
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
2021 avg
2022 avg
Jan 23
feb
mar
apr
may
jun
jul
aug
sep
oct
nov
dec
2023 avg
Actual
Budget

SUMMARY OF PLANNED KITCHEN UPGRADES

We budgeted to replace the kitchen flooring this year, due to its age.

Additionally, while we have periodically had issues with the kitchen drain, it is only recently that the problem has been fully identified and a plan for mitigation established. This repair needs to be performed, and management wishes to make the repair in conjunction with replacing the flooring, for both efficiency and total cost savings reasons. Additionally, management recommends the replacement of the aging kitchen cabinetry, for similar reasons.

The drain in the sink in the NW corner of the kitchen is rotted and leaking under the slab, resulting in plumbing issues. The original grease interceptor drain is too low in its current location to drain the sink in its current location, adding to the problems created by the leak.

The rotten drain is forcing water to leak under the building, eroding the soil and undermining the stability of the concrete slab the kitchen is on. The low drain for the grease interceptor is causing water to sit in the drainpipe from the sink and allowing the grease to flow through the grease interceptor. The original 60-plus-year-old flooring contains asbestos, requiring abatement before repairs to the plumbing.

After consulting with contractors, it was determined that the only way to repair this is to remove the flooring and cut a 3-foot by 6-foot hole in the concrete slab to access plumbing in both locations. The slab on grade construction does not allow a way under the building to access the plumbing. As stated, the old flooring contains asbestos which requires professional remediation and disposal. The original wood cabinets will also need to be removed for abatement of flooring; they are original handmade cabinets but not foodservice grade.

We recommend making the necessary repairs to the plumbing for the sink drain and the grease interceptor. At the same time, we recommend replacing the asbestos-containing floor with low maintenance, high quality, food service grade flooring. The current flooring in the kitchen is budgeted to be replaced due to its deteriorated state and concerns that the Department of Health would consider it a deficiency due to the potential for infection control issues. We also recommend replacing the wood cabinets with stainless steel, food-grade certified versions.

During the construction, we have a plan to rent the Leavenworth Senior Center kitchen to prepare meals for patients and staff.

Below is a table summarizing costs of the total project. The 2023 capital budget allocates $59,675 for the flooring replacement. Total project exceeds budget by $50,000 because it includes the substantial plumbing repair, asbestos remediation, and the replacement of cabinets. It is essential to perform the repair, and management will be working on a plan to adjust remaining capital purchase plans for the year to remain as close to planned budget as possible.

Anticipated Project Costs:

Concrete Floor Cutting	$ 5,000.00
Plumbing Repair	$ 13,500.00
Concrete Pouring	$ 4,000.00
Flooring Replacement	$ 55,650.00
Asbestos Remediation	$ 15,576.00
Senior Center Kitchen Rental	$ 7,000.00
Stainless (Food Grade) Cabinets	$ 8,800.00
Total Approximate Expense:	$ 109,526.00

**Flooring Deposit (50%): $ 27,825*

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

A G E N D A

Board Quality Oversight Committee
May 16, 2023
8:00 – 10:00 AM
Administration Building Meeting 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	8:00 AM
2.	Consent Agenda Approval • May 16, 2023, Agenda • March 28, 2023, Minutes	8:00 AM
Committee Work		
1.	Review Action Items • New data display- Sarah • Acronym removal in committee reports- Sarah	8:00 AM
2.	Patient Story	8:10 AM
3.	Q1 Quality Committee Reports	8:20 AM
4.	Review Q1 Data • Patient Safety and Quality Data • Incident Reporting Data • Patient Satisfaction Report • Notable Achievements	8:30 AM
5.	Quality Dashboard Discussion	9:00 AM
6.	Quality Structure Updates	9:10 AM
7.	Mock DOH Survey Updates	9:15 AM
8.	CAH Program Evaluation Updates	9:30 AM
9.	Board Quality Rounding Updates	9:35 AM
10.	Confirm Q3 Meeting Date • Tuesday, August 15th	9:50 AM
11.	Provider Credentialing	9:55 AM
Adjournment		
1.	Adjournment	10:00 AM

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. March 28, 2023, Minutes
2. Quality Data (Old View)
3. Quality Data (New View)
4. Incident and Satisfaction Data
5. Mock Survey- Updates
6. Rounding- Sample Message to Staff
7. Board Quality Rounding Form
8. Rounding Follow-up Tool: Stoplight Report
9. Rounding- Sample Stoplight Report
10. Board Quality Rounding Calendar

Committee Reports:

- Safety Committee
- Infection Control Committee
- Pharmacy & Therapeutics Committee
- Emergency Care Committee
- Utilization Management Committee
- PFAC Steering Committee
- Safe Patient Handling Committee

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Part-time Resident Advisory Council

Meeting Agenda
Saturday, April 22, 2023
Optional Social Time 9:30 – 10:00
Meeting Begins at 10:00 AM
In-Person at CM (Arleen Blackburn Conference Room) with Zoom Hybrid Option
Lunch Immediately Following

I.	Call to Order	Ken Hamm	10:00
II.	Introductions	Ken Hamm	
III.	Approval of October 22, 2022 Minutes		
	<u>Discussion</u>		
IV.	Cascade Medical • Value Story • CM & Industry Updates	Diane Blake, CEO	10:05
V.	Foundation Update	Foundation Member	10:35
VI.	Leavenworth Update	Clint Strand, PR Director	10:45
VII.	Council Input • Broad Strategic Plan Thoughts • Communicating Capacity	Diane B & Clint Strand	10:55
VIII.	<u>Council Business</u> • Council Leadership Appointments ○ President ○ Vice President • Council member appointments ○ Tracy Owen, Marni Moore, Juli Bowen	Ken Hamm	11:40
IX.	General Q&A / Council Thoughts		11:50
X.	Adjournment		12:00

<u>Tentative Upcoming Meeting Schedule:</u>

Saturday, October 28, 2023	10:00 AM
Saturday, April 20, 2024	10:00 AM

Credentialing Approvals

Adjunct Privileges: (1-year appointment)

- Megan Guffey, MD

Initial Appointment, Provisional Privileges: (6-month appointment)

- Mark Wefel, MD
- Lauren Liebling, PA-C
- Reese Bradburn, PA-C
- Dr. Andrew Ciccarelli (Teleradiologist)
- Dr. Nidal Dabassi (Teleradiologist)
- Dr. Colin Thompson (Teleradiologist)

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

Appointments to the Part Time Resident Advisory Council
Cascade Medical
2023

Name	Position No.	Term Expiration	Notes
Tracy Owen	Position 7	4/30/2026	Returning member
Juli Bowen	Position 9	4/30/2026	New, committee recruitment
Jane Mounsey	Position 10	4/30/2026	New, committee recruitment
Marni Moore	Position 11	4/30/2026	New, City Engagement Night recruitment

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Community Health Needs Assessment
Implementation Plan
2023 – 2025

The Board of Commissioners of Chelan County Public Hospital District No 1, dba Cascade Medical, adopted its 2023-2025 Community Health Needs Assessment (CHNA) in December of 2022. This Implementation Plan is in support of the CHNA and was informed by community stakeholders, partners, the Board of Commissioners, and employees, including medical staff. It has also been integrated into Cascade Medical's three-year organizational strategic plan.

The data presented in the CHNA identified a relatively heathy community with pockets of disparities, including those living in poverty and other traditionally underserved groups. The data suggest behavioral health needs persist and recently, what has emerged for many community residents, is lack of timely access to primary care. The community convening confirmed these results, and importantly identified that the community served by Cascade has slightly differing perceptions of needs and gaps based on age and race or ethnicity.

Between the adoption of the CHNA and the development of the Implementation Plan, Cascade Medical continued outreach with a specific focus on those traditionally underserved residents of our communities. By the end of January 2023, we had more robust engagement with those who report their primary language to be Spanish. Cascade Medical used this additional information as it developed the below strategies.

The adopted CHNA priorities and focus areas include:

1. **Child and Family Wellness, with Particular Focus on Primary Care Access and Youth Behavioral Health:**
    a) *Innovations to increase access to primary care, including mitigating lack of providers, language, trust, and service locations; and by focusing on recruiting and retaining staff.*
    b) *Continuing growth in behavioral health programming, including substance abuse and opioid prescribing.*
    c) *Continuing outreach and partnership with the schools.*

2. **Aging in Place:**
    a) *Innovations to increase access to care.*
    b) *Increasing use of mobile clinic and mobile integrated care.*
    c) *Focus on management of chronic diseases.*
    d) *Advocating for more community-based services for elderly needing additional support.*

3. **Equity, and Building Trust in Traditionally Underserved Communities:**
    a) *Primary care that is accessible and available.*
    b) *Building trust and recognition that all are welcome at Cascade.*
    c) *Continuing existing and growing new partnerships to support our traditionally underserved.*
    d) *Development of a Patient and Family Engagement Council that actively seeks the voice of these communities.*

The table below delineates Cascade Medical's planned implementation tactics to address these three priorities and focus areas during the 2023–2025 period. Progress and completion will be tracked through a combination of standard quarterly strategic plan dashboarding as well as other methods of regular monitoring.

Tactic / Initiative	Timeline	Focus Area
Implement Team-based Care	By end of 2023	1a, 2a, 3a
Implement Hospitalist Program	By end of 2023	1a, 2a, 3a
Develop and Implement a Living Well Program	Fully implemented by end of 2025	1a
Continue MA Apprenticeship Program	Continue through 2025	1a, 2a, 3a
Implement CNA Apprenticeship Program	By end of 2023	1a
Continue Robust Student Preceptorship Programs	Continue through 2025	1a, 1c, 3a
Build and Implement Robust Education Program Across the Organization	Fully implemented by end of 2025	1a
Utilize Consulting Pharmacy Resources for Prescription Refills	Implemented by end of 2023	1a, 3a
Expand Telepsychiatry Referral Options	Continue through 2025	1b
Explore Restarting School-Based Clinic	By end of 2024	1a, 1c, 3a, 3c
Explore Certification for Swing Bed Program	By end of 2023	2a

Tactic / Initiative	Timeline	Focus Area
Certify Telestroke Program	By end of 2023	2a
Implement Cardiac Rehab program	By end of 2023	2a
Optimize Utilization of Mobile Clinic	By end of 2023 & continuing	1a, 2a, 2b, 3a, 3b, 3c
Finalize Mobile Integrated Health Needs Assessment and Implement Program	By end of 2023 & continuing	1a, 2a, 2b, 2c, 3a
Restart Chronic Care Management Program	By end of 2023	2c
Continue to Conduct and Grow Chronic Disease Group Classes	Continue through 2025	2c
Develop and Implement Gender-Affirming Care Program	By end of 2024	3a, 3b
Continue Focused DEI Work and Participation in WSHA DEI Collaborative	Continue through 2025	3a, 3b, 3c
Continue Partnership with UV MEND for Free Clinic	Continue through 2025	3a, 3b, 3c
Expand Opportunities for Employment for Disabled Adults	By end of 2023 & continuing	3b, 3c
Implement Patient & Family Advisory Council	By end of 2023 & continuing	3d
Explore Options to Replace Translation Services Provider	By end of 2023	3a, 3b, 3c
Initiate Full External Communication Plan	By end of 2023	3a, 3b, 3c, 3d
Continued Focus on Dual Language Recruitment	Continue through 2025	1a, 3a, 3b
Continue Free Sports Physicals Night with Vaccination Support	Continue through 2025	1a, 1c
Continue to Offer Drive Through Flu Shot Clinics	Continue through 2025	1a, 2a
Explore IHI's Concept of an Age Friendly Health System	By end of 2024	2a, 2b, 2c, 2d
Develop Expanded Hours for Clinic/Urgent Care Services	By end of 2024	1a, 3a, 3b
Explore Additional Service Line Expansion including for Wound Care, Infusion Services, and Outpatient Ultrasound	By end of 2023 & continuing	2a, 2c, 3a
Implement OTAGO (Community Fall Prevention Program)	By end of 2023	2a, 2d, 1a
Continue working with North Central Region Fall Prevention Coalition and host fall prevention education event	By end of 2023 & continuing	2a, 2d, 1a

Tactic / Initiative	Timeline	Focus Area
Explore transportation options, including whether DART expansion is possible and understand possibilities about being able to bill for wheelchair van service	By end of 2025	1a, 2a, 2d, 3a, 3c
Continue peer support work	Continue through 2025	1b
Provide behavioral health education to partner organizations' teams, to support their staff working through behavioral health emergencies	By end of 2023 & continuing	1a, 1b, 3c
Provide Cognitive Pyramid training to Mountain Meadows	By end of 2023	2a, 2d
Broaden community events offerings	By end of 2025	3b, 3c
Explore offering behavioral health services in conjunction with the Mobile Clinic	By end of 2025	1a, 1b, 2a, 2b, 3b

CHELAN COUNTY PUBLIC HOSPITAL DISTRICT NO. 1
CHELAN COUNTY, WASHINGTON

RESOLUTION 2023-04

A RESOLUTION of the Board of Commissioners of Public Hospital District No. 1 of Chelan County, Washington (the "District"), relating to the finances of the District; authorizing the surplus of equipment identified by the following descriptions:

Description	Serial Number	CM Asset Tag #	Market Value	Recommendation
2006 F350 Plow Truck	1FDWF37PX6EA85918	None	$1,000.00	Sealed Bid Auction

WHEREAS, the members of the commission approved a motion for the surplus of equipment at a regular meeting of the board on May 24, 2023.

WHEREAS, the members of the commission of the district, after due consideration, declare that the above equipment is surplus to the needs of the District, agree to dispose of the equipment listed above.

BE IT RESOLVED BY THE COMMISSION OF PUBLIC HOSPITAL DISTRICT NO 1, CHELAN COUNTY, WASHINGTON, AS FOLLOWS:

It is hereby found and declared that the equipment be disposed of.

ADOPTED and APPROVED by the Commission of Chelan County Public Hospital District No. 1, Chelan County, Washington, at an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 24th day of May 2023, the following commissioners being present and voting in favor of this resolution.

_____
President and Commissioner

_____
Secretary and Commissioner

_____
Commissioner

_____
Commissioner

_____
Commissioner

CHELAN COUNTY PUBLIC HOSPITAL DISTRICT NO. 1
CHELAN COUNTY, WASHINGTON

RESOLUTION 2023-05

A RESOLUTION of the Board of Commissioners of Public Hospital District No. 1 of Chelan County, Washington (the "District"), relating to the finances of the District; authorizing the surplus of equipment identified by the following descriptions:

Description	Serial Number	CM Asset Tag #	Market Value	Recommendation
Snowman Drag Plow	PO #196788	None	$1,000.00	Sealed Bid Auction

WHEREAS, the members of the commission approved a motion for the surplus of equipment at a regular meeting of the board on May 24, 2023.

WHEREAS, the members of the commission of the district, after due consideration, declare that the above equipment is surplus to the needs of the District, agree to dispose of the equipment listed above.

BE IT RESOLVED BY THE COMMISSION OF PUBLIC HOSPITAL DISTRICT NO 1, CHELAN COUNTY, WASHINGTON, AS FOLLOWS:

It is hereby found and declared that the equipment be disposed of.

ADOPTED and APPROVED by the Commission of Chelan County Public Hospital District No. 1, Chelan County, Washington, at an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 24th day of May 2023, the following commissioners being present and voting in favor of this resolution.

_____
President and Commissioner

_____
Secretary and Commissioner

_____
Commissioner

_____
Commissioner

_____
Commissioner

CHELAN COUNTY PUBLIC HOSPITAL DISTRICT NO. 1
CHELAN COUNTY, WASHINGTON

RESOLUTION 2023-06

A RESOLUTION of the Board of Commissioners of Public Hospital District No. 1 of Chelan County, Washington (the "District"), relating to the finances of the District; authorizing the surplus of equipment identified by the following descriptions:

Description	Serial Number	CM Asset Tag #	Market Value	Recommendation
Snowmobile Trailer	4RACS17275N032469	None	$0	Dispose

WHEREAS, the members of the commission approved a motion for the surplus of equipment at a regular meeting of the board on May 24, 2023.

WHEREAS, the members of the commission of the district, after due consideration, declare that the above equipment is surplus to the needs of the district, agree to surplus and sell or dispose the equipment listed above.

BE IT RESOLVED BY THE COMMISSION OF PUBLIC HOSPITAL DISTRICT NO 1, CHELAN COUNTY, WASHINGTON, AS FOLLOWS:

It is hereby found and declared that the equipment be surplused.

ADOPTED and APPROVED by the Commission of Chelan County Public Hospital District No. 1, Chelan County, Washington, at an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 24th day of May 2023, the following commissioners being present and voting in favor of this resolution.

_____
President and Commissioner

_____
Secretary and Commissioner

_____
Commissioner

_____
Commissioner

_____
Commissioner

REQUEST TO REPLACE CHILLER

Our chiller, the unit that primarily regulates temperature spring through fall but also supports the heat function during colder months, has been failing. We are budgeted to replace the chiller next year, however, we have been analyzing whether we need to move that timeframe forward, as we continue to experience system malfunctions. You may recall this topic coming up periodically in the Administrator Report during board meetings.

After a full analysis, and learning the lead time for a replacement chiller is nearly a year, management is asking the board to consider approving moving forward with replacement. The 2024 budgeted amount for this work is $542,500. The quote for replacement is $339,365 plus tax. More details follow below.

Our chiller continues to be problematic with both heating and cooling issues. We continue to have high expenses with repairs that are not expected to be resolved anytime soon due to the age of the chiller. Over the past 6-7 years, we have been using Sno Valley Process Solutions to service and repair our chillers and HVAC equipment. During this time, we have suffered many breakdowns, large repair expenses and at one point had to evacuate the hospital due to chiller failure during a heat wave. We have experienced multiple compressor and condenser failures on this 13-14 year old unit along with multiple cooling line failures.

After consulting multiple contractors, we determined that Salcido Connection has provided us with the best service and most affordable, long term solution. They informed us that we will continue to throw good money after bad into our current chiller.

The recommendation from Malachi Salcido is to replace the chiller before we have catastrophic failure potentially causing another hospital evacuation. The cost of replacing the chiller should save money in the long run. According to Salcido Connection the cost of the chillers have been going up 5-10% every 6-10 months. Ordering a replacement chiller now will lock in current pricing and secure a slot to replace it early spring of 2024 prior to the heat of next summer. Currently there is a 42-44 week lead time on new chillers, so any delay would force us to go through 2 summers trying to keep our current chiller operating, and potentially costing $71,000 more due to increasing prices.

We recommend securing a new chiller immediately and have it installed early next spring. That chiller package will likely go up 5-10% between now and early next year alone, based on how major manufacturers are enacting cost increases every 6-8 months according to multiple contractors.

Chiller Cost: $339,365.00
Deposit to Order/Lock Pricing: $237,555.50 (70%)

MEDICAL STAFF RULES AND REGULATIONS

Cascade Medical

Revised Month 2023
Revised August 2017
Revised April 2017
Revised February 2015

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MEDICAL STAFF RULES AND REGULATIONS

Patient Stays

Definitions:

Medical Staff: Practitioners who are credentialed by Cascade Medical (CM)
Physician: Those holding the MD or DO degree
~~Mid Level~~PA or NP: Those holding the ARNP degree or PA-C
Practitioner: Any Physician (MD or DO), ARNP, PA-C, Dentist, Podiatrist or Psychologist licensed to practice in the State of Washington.

Inpatient – Acute Care

1. Who is privileged:
   a. Admission privileges to Acute Care are extended to Active, Adjunct, Provisional and Temporary/Locum Tenens Staff Members. Temporary/Locum Tenens staff members are not required to have an Active Staff Member agree to the Acute Care admission. Only a member of the medical staff with admitting privileges may admit a patient to the medical center. All practitioners shall be governed by the official admitting policies of the medical center.
   b. A member of the medical staff shall be responsible for the medical care and treatment of each patient admitted to the medical center.
   ~~b.~~c. Inpatient care shall typically be provided by PA or NP hospitalists seven days per week. Weekdays when the clinic is open during which no PA or NP hospitalist is on shift, Clinic Practitioners with inpatient privileges will be responsible for the medical care and treatment of inpatients.
   ~~c.~~d. After clinic hours or~~,~~ over weekends and on holidays when a hospitalist is not on shift~~the clinic is closed~~, inpatient care will be automatically assumed by the ~~physician~~ practitioner on call for the emergency department unless otherwise specified by the attending physician.
   ~~d. A patient to be admitted on an emergency basis, who does not have a Primary Care Provider, may select a Practitioner from the current medical staff to attend to him/her.~~

2. Admission Criteria:
   a. Except in an emergency, no patient shall be admitted to the medical center until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.
   b. Before a patient is admitted, the Practitioner shall first contact the acute care unit to ascertain whether there is an available bed.

3. Patient Management:
   a. The attending practitioner shall be responsible for the prompt completeness and accuracy of the medical records, for necessary special instructions, and for transmitting reports of the condition of the patient to the relatives of the patient.

b. Each member of the staff shall name a member of the Active or Adjunct staff that may be called to attend his/her patient in an emergency. In case of failure to name such alternate, the Administrator of the medical center, Chief of Staff, or Chairperson of the Department concerned shall have authority to call any Member of the Active Staff to attend the patient who shall be required to attend the patient. Each practitioner must assure timely, adequate professional care for his/her patients in the medical center by being available or having available through his/her office an eligible alternate practitioner with whom prior arrangements have been made.

c. Patients must be seen by a medical staff member each day that they are admitted under acute care or observations status.

~~c.~~d. Code Blue and Rapid Response Team event responses are delineated separately via policy.

4. Special Rules:
   a. PAs or NP~~Mid level~~s that have admitting privileges will discuss admission orders with the supervising physician ~~at the time of admission~~ and have them countersigned within 72~~24~~ hours.
   b. The attending practitioner shall comply with the Utilization Review Plan and the Quality Improvement Plan.

5. Patient Transfer:
   a. A patient is transferred from one level of care to another upon approval by the responsible practitioner.
   b. A patient may be transferred to another hospital for hospitalization and further care if the patient requests such transfer and if the practitioner who will receive the patient and assume responsibility is determined to be available and concurs in the judgment to transfer the patient. Patients who qualify for a different level of care, for example, Swing Bed care, may not be transferred to that level until authorized by the responsible practitioner.
   c. A patient may be transferred to another hospital if its facilities are more appropriate for the care of the patient and if the attending practitioner concurs and feels that the transfer does not involve an unwarranted risk.
   d. The admitting practitioner shall be responsible for providing such information as may be necessary to protect a patient from self-harm, and to protect others when a patient may be dangerous for any reason. Restraint orders must be episode-specific and time-limited with specific starting and end times as outlined in the restraints policy and procedure.

6. Patient Discharge:
   a. A patient shall be discharged only on a written order of the attending practitioner. Should a patient leave the medical center against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record by the attending practitioner.
   b. When a patient dies in the medical center, the deceased shall be pronounced dead by the attending Practitioner or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the

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deceased by the attending practitioner or his/her designee of the staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to the release of decedent's remains shall conform to local law.

c. It shall be the duty of all members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent signed in accordance with state law. All autopsies shall be performed by a pathologist or by the Coroner. Provisional anatomic diagnoses shall be recorded on the medical record within 24 hours and should be made a part of the record within sixty (60) days.
d. Patients who are emotionally ill or are suffering from alcohol or drug abuse shall be offered appropriate referral.

Inpatient – Swing Bed

1. Who is privileged:
   a. Admission privileges to the Swing bed Unit are extended to Active, Adjunct, Provisional, and Temporary/Locum Tenens Staff Members. Temporary/Locum Tenens staff members are not required to have an Active Staff member agree to the Swing Bed Unit admission. Additionally, Adjunct staff members are not required to have an Active staff member who is responsible for the care of the patient in the absence of the Adjunct staff member. The call coverage for the Adjunct staff member will assume responsibility for the patient.

2. Admission Criteria:
   a. A three midnight inpatient stay within 30 days is required before admission to Swing Bed for Medicare patients. The Swing Bed admission must be related to the same diagnosis as the Acute Stay.
   b. Patients admitted to the Swing Bed unit from an acute care facility must have been seen by the physician within 48 hours prior to discharge from the acute facility or within 48 hours of the admission to the sub acute unit.

3. Patient Management:
   ~~a. It is the responsibility of the admitting practitioner or his/her alternate to be available at all times. In the event that the responsible physician or his/her alternate cannot be reached, the physician on call for the Emergency Department will be notified and may initiate care of the patient.~~
   ~~b.~~a. Swing Bed Patients must be seen by the practitioner at least every 7 days or more often if the patient's medical condition warrants more frequent ongoing visitation and monitoring by the physician.
   ~~c.~~b. A progress note will be entered in the Medical Record for each Practitioner visit.
   ~~d.~~c. Whenever possible, admission orders to the Swing Bed unit will be written when a patient is discharged from the acute care facility, per recommendations of the discharging physician.

4. Special Rules:

a. The admitting practitioner shall comply with the Utilization Review and the Quality Improvement Plan of the Swing Bed unit.
b. ~~Mid levels that have admitting privileges will have admission orders countersigned at the time of admission by the on-call physician. Other o~~PAs and NPs with admitting privileges will have their orders and notes ~~will be~~ countersigned by the on-call physician within 72~~2~~4 hours.

Outpatient – Emergency Department

1. Who is privileged:
   a. Emergency Department privileges are extended to Active, Adjunct, Provisional, and Temporary/Locum Tenens staff members who have applied for and been granted Emergency Department privileges through the CM Credentialing process.
   b. Practitioners with CM Emergency Department privileges or Registered Nurses with current ACLS certification shall perform medical screening exams in accordance with the CM EMTALA policy.
   c. Evaluation, treatment, stabilization and admission, discharge or transfer decisions shall only be made by CM practitioners who have been granted Emergency Department privileges.

2. Admission Criteria:
   a. Such services shall be in accordance with all EMTALA regulations and other policies and procedures of Cascade Medical.

3. Patient Management:
   a. A medical screening exam must be performed in accordance with EMTALA regulations and shall be a part of the medical record.
   b. A medical record shall be kept for every patient and shall become part of the CM record. Past records and CM Family Practice clinic records shall be made available upon request of the Emergency Department. Emergency Department records shall be retained per Washington State retention guidelines for Public Hospital Districts.

4. Special Rules:
   a. PA or NP~~Mid-level~~ providers in the Emergency Department are required to obtain consultations from physicians according to established policy.
   b. PA or NP~~Mid-level~~ Emergency Department charts will be countersigned by supervising physician within 72 hours.

Outpatient – Observation

1. Who is privileged:
   a. Admission privileges to Observation are extended to Active, Adjunct, Provisional, and Temporary/Locum Tenens Staff Members. Temporary/Locum Tenens staff members are not required to have an Active staff member agree to the Observation admission.~~.~~

2. Admission Criteria:
   a. Patients admitted to this category must be expected to be discharged within 48 hours.

3. Patient Management:
   a. Written orders and an admission note and diagnosis must accompany the patient's admission, and the patient must meet observation criteria per utilization management and the ~~physician's~~ practitioner's recommendation.
   b. History and physical must be recorded within 24 hours.
   c. Practitioner~~hysician~~ must see the patient at least once per 24 hours.
   d. A progress note is required at discharge or transfer.

4. Special Rules:
   a. Deaths should be handled according to inpatient policies.

Outpatient – Ambulatory Outpatient Medication Services

1. Who is privileged:
   a. Admission privileges to Ambulatory Outpatient Medication Services are extended to Active, Adjunct, Provisional and Temporary/Locum Tenens Staff Members. Temporary/Locum Tenens staff members are not required to have an Active staff member agree to the Ambulatory Outpatient Medication Services admission.

2. Admission Criteria:
   a. Patients admitted to this category must be expected to be discharged within 4 hours. Consider observation/short stay/acute status for unstable patients or those patients requiring longer stay.

3. Patient Management:
   a. Admissions to Ambulatory Outpatient Medications Services shall comply with established policies.
   b. If a patient is referred from the Cascade Medical clinic, a clinic nurse should contact the hospital clinical resource~~harge~~ nurse to determine bed availability and explain reason for admission.
   c. Post-injection discharge vital signs are necessary for patients receiving parenteral medications. Parenteral antibiotics require a 15 minute post-injection waiting period before vital signs are obtained.
   d. The nurse may request a patient evaluation from practitioner~~hysician~~ at any time.

4. Special Rules:
   a. If IV fluids over 100 cc are administered, vital signs at discharge and a practitioner~~hysician~~ evaluation of the patient prior to discharge are required.
   b. A clinic note needs to be included with the final hospital medical record.
   c. Standing orders (e.g., Neupogen q week) must be renewed each month.
   d. If a patient evaluation is done during the ambulatory services stay, a written or dictated encounter note will be provided.

Outpatient – Tests:

1. Who is privileged:
   a. Tests ordered by outside parties that are processed by our in house lab or radiology department fall into a separate category. (See Medical Staff policy titled, “Ordering Outpatient Tests”.)
   b. Active member of the hospital medical staff: this includes any member who holds Active, Adjunct, Provisional, or Temporary/Locum Tenens status.
      i. Management of test results:
         Outpatient test results are reported to the ordering practitioner. In addition, critical lab values or radiology findings, as defined by CM lab and/or radiology policy, will be

brought to the attention of the ordering provider or covering on call provider immediately.

It is the responsibility of the ordering provider or on call provider to evaluate and determine next management action for critical lab or radiologic abnormalities.

2. Admission Criteria:
   a. A diagnosis must accompany any order for outpatient tests.

3. Patient Management:
   a. A written order or prescription is required for outpatient tests.
   b. The patient must be notified of abnormal values within 24 hours of the time results are obtained.
   c. The ordering provider (or on-call provider) will be notified of results as they become available. It is the responsibility of the ordering provider (or on-call provider) to notify the patient of test results.

4. Special Rules:
   a. Test results will not be left in a voicemail unless patient has documented this is appropriate. Such documentation must be in the patient's medical record.

Outpatient – Special Procedures

1. Who is privileged:
   a. Special procedures may only be done by medical staff members who are privileged to do them through regular medical staff credentialing processes.

2. Admission Criteria:
   a. Patients must have a written diagnosis.

3. Patient Management:
   a. Patients must have a medical record established.
   b. A history and physical must be completed and written prior to the procedure.
   c. A post procedure note must be dictated or written within 72 hours.

4. Special Rules:
   a. Tissue specimens must be preserved and sent to pathology for review and diagnosis as determined by the practitioner.
   b. Patients must be scheduled in advance with the appropriate clinical department.

RULES AND REGULATIONS

SPECIAL RULES

1. PROCEDURAL SEDATION AND ANALGESIA

If performing Procedural Sedation & Analgesia (PSA) the practitioner must demonstrate competency by at least one of the three methods:

a. Training and demonstrated competence as part of a residency program within the past five years, documented in the procedure list or by verification from a residency program chair.
b. Documentation and attestation that the applicant has performed IV conscious sedation/moderate analgesia for at least ten patients in the last year.
c. Evidence of participation in Category 1 continuing medical education in conscious sedation/moderate analgesia within the past two years.

2. **Washington State Trauma Registry (WSTR) rules**:
   All practitioners who care for trauma patients must abide by WA State Trauma Service standard WAC 246-976-700.

Medical Records

1. The attending practitioner shall be responsible for insuring the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current. This record shall include patient identification data, and admission note in the EMR at the time of admission, code status**,** personal history, history of present illness, physical examination, nursing and ancillary notes, medication records, patient added notes, physician orders, special reports such as consultations, clinical laboratory and radiology services, and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, clinical resume and autopsy report when performed.

2. A complete admission history and physical examination shall be recorded within 24 hours following admission. This report shall include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed prior to the patient's admission to the medical center, a reasonably durable, legible copy of these reports may be used in the patient's medical record in lieu of the admission history and report of the physical examination, provided these reports are recorded by a member of the staff and are no older than 30 days. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded. If a patient is readmitted for treatment of the same or related problem within 30 days following discharge from the hospital, an interval history and physical examination report reflecting any subsequent changes may be used in the medical record provided the original information is readily available.

3. When the history and physical examination are not recorded before an operation (or any potentially hazardous diagnostic procedure) the procedure shall be cancelled unless the attending practitioner states in writing that such delay would be detrimental to the patient.

4. Pertinent progress notes shall be written at least every day on all acute care and observation patients. When possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. All LIPs visits must be recorded in the Electronic Medical Record (EMR).

5. Special procedure reports shall include a detailed account of the findings as well as the details of the technique. Reports shall be dictated immediately following the procedure for outpatients and inpatients and promptly signed by the ~~physician~~ practitioner and made a part of the patient's current medical record. ~~A brief handwritten note should be placed in the progress record at the time of procedure to bridge the time gap until the report is typed.~~

6. Consultation shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of the consultation. When operative or special procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the procedure.

7. Symbols and abbreviations may be used only when they have been approved by the Staff. An official record of approved abbreviations is kept on file in Medical Records.

8. Final diagnosis shall be recorded in terms of standard nomenclature in full, without the use of symbols or abbreviations, and dated and signed by the responsible Practitioner at the time of discharge of any patient. This is as important as the actual discharge order and shall be a condition of discharge.

9. A formal discharge summary shall be ~~written or dictated~~completed on all medical records of patients who die and for all patients who are hospitalized over 48 hours. This summary shall be ~~dictated~~ completed within 24 hours of discharge. For patients with problems of a minor nature and hospitalized less than 48 hours, a final summation progress note shall be sufficient.

~~10. Records may be removed from the medical center only in accordance with a court order, subpoena, statute, or the patient's written consent. All records are the property of the medical center and shall not otherwise be taken away without permission of the Administrator. In case of readmission of a patient, all previous medical records shall be available for use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the medical center is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee.~~

~~11.~~10. Medical records of all patients shall be available to members of the staff for genuine study and research consistent with preserving the confidentiality of personal and medical information concerning the patient.

~~12.~~11. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.

~~13.~~12. Incomplete Medical Record Procedure

a. Chart counts are made to determine when a medical record is delinquent. Practitioners will be notified when the chart count dates are by: Emailing the chart count(s) dates to the Clinic Director and each provider.
b. Chart count is performed each Friday for charts that fall into the delinquency definition by these Medical Staff Rules and Regulations. A tabulation will be made for each practitioner.
c. Medical Records Letter #1: A practitioner with delinquent records (greater than 14 days) will be notified via email with a copy to the Chief of Staff and Administration. To assist the office staff in identifying the urgency of this e-mail, the words "DELINQUENT RECORDS NOTIFICATION" will appear in block letters on the subject line of the email as well as the "High Importance" flag on the email. In the text of the email will be a statement informing the practitioner that if he/she is unable to complete his/her records, he/she must contact the Medical Records Department for a one week extension. Also in the text of the delinquent records notification will be a statement that the practitioner is being granted a three (3) working day "grace" period in which he/she may complete the delinquent records.
d. On the Thursday following the Friday of the count discovering the delinquency, a final determination will be made of the practitioners with delinquent records remaining. The practitioners responsible for these delinquent records will be put on a conjoined "Medical Records" list.
e. Those practitioners~~hysician~~s going on the "Medical Records" list will be docked ½ hour of PTO per chart per day outstanding. Medical Records will notify the CEO, CFO, COO, and the Clinic Director when a practitioner remains on the "Medical Records" list until his/her charts are completed.
f. The Medical Records Department will complete a PTO deduction form for each provider for each payroll cycle and turn it into the Payroll Clerk.
g. The Medical Records Department will notify the CEO, CFO, COO, and the Clinic Director as soon as the provider's delinquent medical records are brought current.
h. An incomplete chart of a patient whose practitioner has permanently moved away or is unable to complete the chart because of incapacitating illness or death shall be the responsibility of the Medical Executive Committee.
i. The above rule shall not be applied capriciously, and shall not be followed if there are legitimate reasons why the charts cannot be completed on time. These reasons shall include personal and family hardships. The Chief of Staff and administrator shall jointly make this determination. Delinquent charts that accumulate during vacation time shall not be counted until the practitioner returns to work.

General Conduct of Care

1. A general consent form, signed by or on behalf of each patient admitted to the medical center, must be obtained at the time of admission. It shall be, except in emergency situations, the Practitioner's obligation to obtain proper consent before a patient is treated in the medical center. A specific consent form that informs the patient of the risks inherent in any special treatment or surgical procedure shall be obtained. Written, signed, informed, consent forms shall be obtained prior to the procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor, incompetent or unconscious

patient in whom consent cannot be immediately obtained from parents, guardian, or next of kin, these circumstances shall be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency procedure is undertaken if time permits. Should a second procedure be required during the patient's stay in the medical center, a second consent form should be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they shall all be described and consented to on the same form.

2. All orders for treatment shall be a signed electronic format or writing. A verbal order shall be considered to be in writing if recorded by appropriate medical center personnel and signed by the responsible practitioner. All orders dictated over the telephone shall be signed by the appropriately authorized person who dictated with the name of the practitioner per his or her own name. The responsible practitioner shall authenticate such orders within 48 hours, and failure to do so shall be brought to the attention of the MEC for appropriate action. Only "Licensed" personnel, e.g. physicians, PAs and NP~~mid level~~s, licensed nurses, and pharmacists, may be authorized to give verbal orders.

3. A practitioner's orders must be written clearly, legibly and completely or documented in the EMR. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "renew," "repeat," or "continue orders," is not acceptable.

4. All previous orders are cancelled when a patient is taken to Surgery.

5. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations. Drugs for bona-fide clinical investigations may be exceptions.

6. Practitioners~~,~~ who care for patients in ambulatory care areas, emergency care areas, and medical center-sponsored home care areas, must follow the same Medical Staff Bylaws, Rules and Regulations and Policies**.** Emergency Care coverage will be provided in these areas in the same manner as prescribed by the Staff Bylaws and Rules and Regulations. Medical Center policies that have been approved by the Staff will be followed by each eligible practitioner when providing patient care in these areas.

Consultations

1. The right to added professional opinion is not only that of the attending practitioner, but is the patient's privilege. It is the duty of the staff, through its departmental chairperson and MEC to insure that a Practitioner seeks consultation when indicated. The consultant must be qualified to give an opinion in the service in which it is sought. This should require evidence of special training and experience in this service. The consultant's findings and opinion shall be recorded, signed and become a part of the medical record.

2. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He/she shall contact the Consultant and brief him/her on the problem involved and shall provide written authorization to permit

another attending practitioner to attend or examine his/her patient, except in an emergency.

3. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor who in turn may refer the matter to the Chief Operating Officer. If warranted, the Chief Operating Officer may bring the matter to the attention of the department Chairperson, or Chief of Staff or Medical Director of the department wherein the Practitioner has clinical privileges. Where circumstances are such as to justify such action the Chairperson of the department may request a consultation.

4. Any qualified practitioner with clinical privileges in the medical center may be called for consultation within his or her areas of expertise.

5. Consultation is recommended at least as follows:
   a. When a patient is not a good risk for surgery or treatment.
   b. For all patients, where the diagnosis is obscure or where there is doubt as to the best therapeutic measures to be utilized.
   c. For all cases where there is use of an investigational drug in research.
   d. Where known or suspected pregnancy may be interrupted.
   e. In unusually complicated situations, where specific skills or other practitioners may be needed.
   f. In instances in which the patient exhibits severe psychiatric symptoms.
   g. When requested by the patient or his/her family.
   h. PA and NP~~Mid-level~~ providers may have additional consultation requirements.

6. Informal Proceedings.
   Nothing in this policy or the Medical Staff Bylaws shall preclude collegial or informal efforts to address questions or concerns relating to an individual's practice and conduct at the medical center. This policy specifically encourages voluntary structuring of clinical privileges to achieve a clinical practice mutually acceptable to the individual, the Medical Executive Committee, and the Board.

Confidentiality and Reporting

1. Confidentiality and Reporting:
   a. Actions taken and recommendations made pursuant to this policy shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as may be adopted by the Board. In addition, actions and reports of actions taken pursuant to this policy shall be sent to the Administrator who shall notify such governmental agencies as may be required by laws.
   b. All records and other information generated in connection with and/or as a result of professional review activities shall be confidential, and each individual or committee member participating in such review activities shall agree to make no disclosures of any such information except as authorized, in writing, by the Administrator or by legal counsel to the medical center. Any breach of confidentiality by an individual or committee member may result in a professional review action, and/or may result in

appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

2. All practitioners shall follow all HIPAA guidelines and professional standards regarding patient confidentiality.

Peer Review

1. All minutes, reports, recommendation, communication, and actions made or taken pursuant to this policy are deemed to be covered by the provisions of RCW 4.24.240, RCW 4.24.250 and RCW Chapter 70.41 or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the medical center and its Board, including the medical center's Quality Improvement Committee, when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 and shall be deemed to be a regularly constituted Quality Improvement Committee for purposes of RCW Chapter 70.41.

2. All Active staff members shall participate in peer review activities as required by the medical staff or administration.

Adopted by the Medical Staff on:

_____ _____
Chief of Staff Date

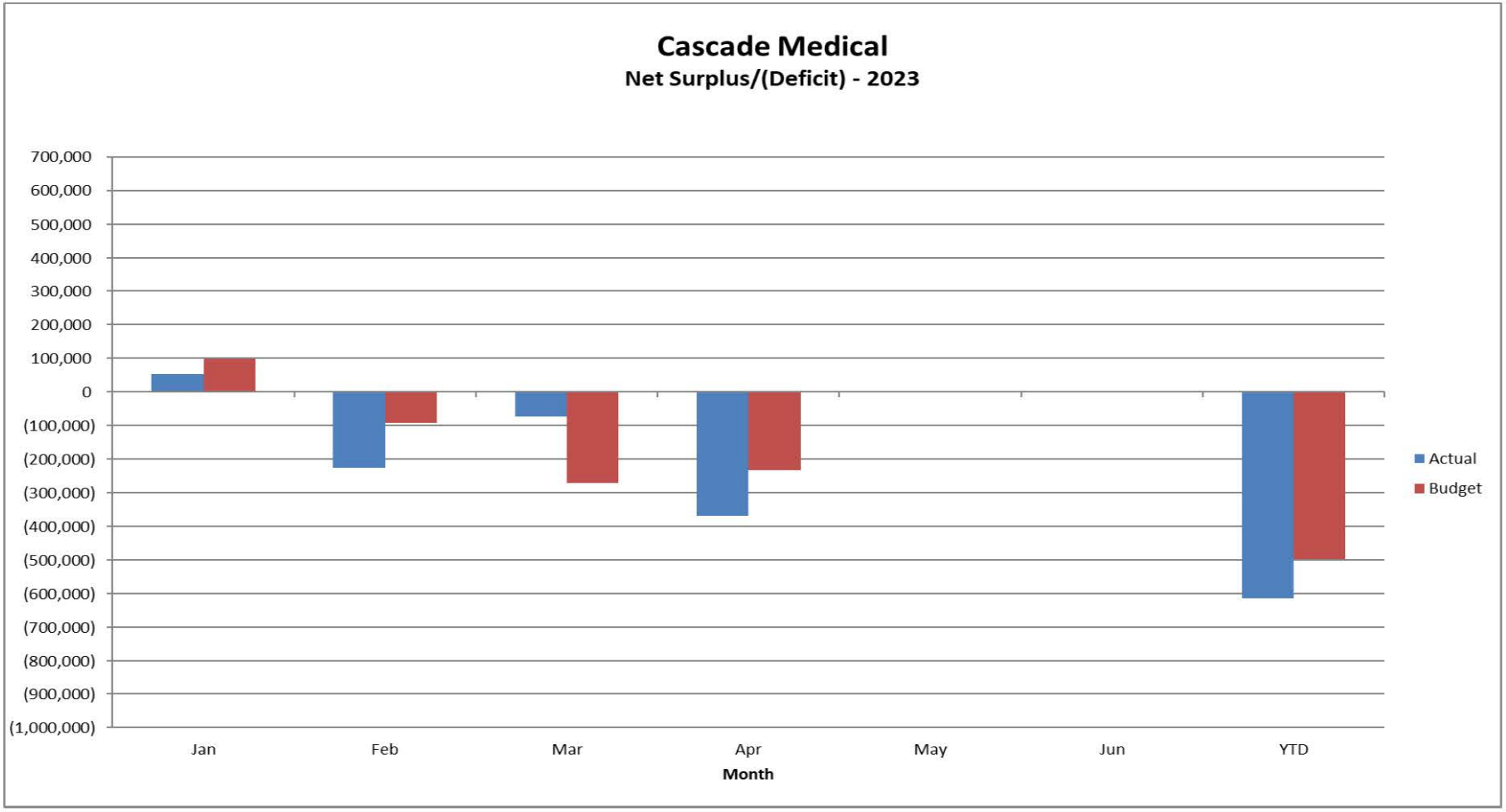
Approved by the Board on:

_____ _____
Chairperson Date

Approved by the Administration on:

_____ _____

Administrator Date


Cascade Medical
Net Surplus/(Deficit) - 2023
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
(100,000)
(200,000)
(300,000)
(400,000)
(500,000)
(600,000)
(700,000)
(800,000)
(900,000)
(1,000,000)
Jan
Feb
Mar
Apr
May
Jun
YTD
Month
Actual
Budget

Cascade Medical Center
Financial Performance Summary
Year-to-Date - April, 2023

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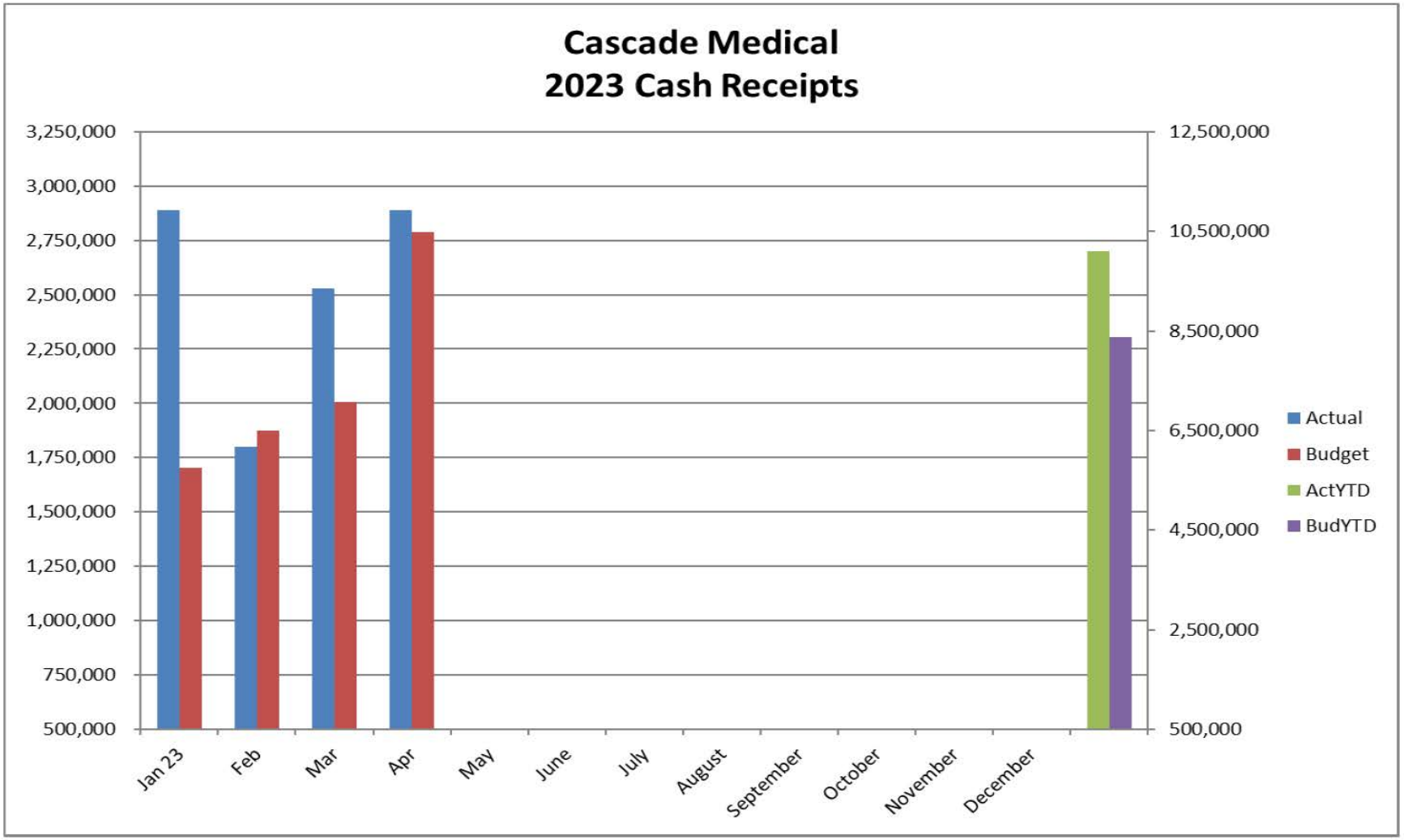
	YTD April
Net Margin	
Actual	(614)
Budget	(497)
Better (Worse) than Budget	(117)
Variance Analysis - favorable vs (unfavorable)	
Gross Revenue - SBed ($278); Amb ($228); Lab ($180); Clin ($118)	(786)
Contractual Allowances	912
Net Patient Revenue	126
Other Operating Revenue	129
Total Operating Revenue	255
Expenses	
Salaries & Benefits	30
Prof. Fees - Informatics ($130); Admin ($71); Pharm ($38); ED Prov ($20)	(262)
Supplies	7
Purchased Services/Repairs - IT ($63); Rad ($52); BusOff ($37);Plant ($30); Lab $36	(161)
Other Operating Expenses	13
Total Operating Expenses	(374)
Non-Operating Revenues & Expenses	2
Actuals Better/(worse) than Budget	(117)

Cascade Medical Center
Statement of Revenues, Expenses and Net Income
For the Month Ending April 30, 2023

	Current Period			Year-to-Date				
	Actual	Budget	Variance	Actual	Budget	Variance		Prior YTD
Operating revenues								
Net Patient Revenue	1,630,949	1,628,739	2,210	7,072,321	6,946,342	125,979		5,747,467
Grants, Contribs, Other Op Revenue	61,384	71,665	(10,281)	402,593	273,660	128,933		198,623
Tax Levies, unrestricted	149,665	149,665	-	598,660	598,660	-		579,152
Total Operating Revenue	1,841,998	1,850,069	(8,071)	8,073,574	7,818,662	254,912		6,525,242
Operating expenses								
Salaries & Benefits	1,410,317	1,467,228	56,911	5,764,822	5,794,955	30,133		5,816,210
Professional fees	197,693	86,137	(111,556)	673,841	411,427	(262,414)		331,564
Supplies	163,807	148,261	(15,546)	609,376	616,565	7,189		599,059
Purchased services	140,932	104,998	(35,934)	611,908	450,613	(161,295)		716,061
Depreciation	166,550	169,956	3,406	666,211	679,824	13,613		598,623
Other Operating Expenses	210,630	185,280	(25,350)	680,434	679,562	(872)		538,103
Total operating expenses	2,289,929	2,161,860	(128,069)	9,006,591	8,632,946	(373,645)		8,599,620
Operating gain / (loss)	(447,931)	(311,791)	(136,140)	(933,017)	(814,284)	(118,733)		(2,074,378)
Nonoperating revenues (expenses)								
Tax Levies, restricted	108,294	108,294	-	433,176	433,176	-		404,064
Interest expense on bonds	(27,214)	(27,214)	-	(108,856)	(108,856)	-		(115,833)
Other Non-Operating rev (exp)	(639)	(1,673)	1,034	(5,121)	(6,692)	1,571	*	(7,009)
Total nonoperating rev (exp), net	80,441	79,407	1,034	319,199	317,628	1,571		281,222
Net Income	(367,490)	(232,384)	(135,106)	(613,818)	(496,656)	(117,162)		(1,793,156)

Cascade Medical Center
Statement of Revenues, Expenses and Net Income
For the Month Ending April 30, 2023

	Current Period			Year-to-Date			
	Actual	Budget	Variance	Actual	Budget	Variance	Prior YTD
Operating revenues							
Gross Patient Revenue	2,684,706	2,657,671	27,035	10,406,967	11,192,483	(785,516)	9,054,184
less:							
Contractual Allowances	902,677	898,706	(3,971)	2,856,518	3,697,708	841,190	2,913,470
Reserve for Bad Debts	107,499	93,019	(14,480)	340,185	391,738	51,553	315,387
Reserve for Financial Assistance	43,581	37,207	(6,374)	137,943	156,695	18,752	77,859
Total Deductions from Revenue	1,053,757	1,028,932	(24,825)	3,334,646	4,246,141	911,495	3,306,717
Net Patient Revenue	1,630,949	1,628,739	2,210	7,072,321	6,946,342	125,979	5,747,467
Grants, Contributions	554	12,100	(11,546)	36,547	86,400	(49,853)	69,118
Other Operating Revenue	60,830	59,565	1,265	366,046	187,260	178,786	129,505
Tax Levies, unrestricted	149,665	149,665	-	598,660	598,660	-	579,152
Total Operating Revenue	1,841,998	1,850,069	(8,071)	8,073,574	7,818,662	254,912	6,525,242
Operating expenses							
Salaries and wages	1,135,050	1,189,837	54,787	4,694,115	4,691,365	(2,750)	4,773,193
Employee benefits	275,268	277,391	2,123	1,070,708	1,103,590	32,882	1,043,017
Professional fees	197,693	86,137	(111,556)	673,841	411,427	(262,414)	331,564
Supplies	163,807	148,261	(15,546)	609,376	616,565	7,189	599,059
Utilities	30,480	23,496	(6,984)	96,654	98,067	1,413	92,565
Repairs and maintenance	21,676	17,473	(4,203)	117,380	94,042	(23,338)	89,491
Purchased services	119,256	87,525	(31,731)	494,528	356,571	(137,957)	626,570
Continuing medical education	875	1,417	542	3,095	5,664	2,569	-
Other expenses	13,657	32,271	18,614	43,220	47,659	4,439	38,575
Dues and subscriptions	197,588	61,781	(135,807)	256,023	266,508	10,485	75,395
Travel / training / meetings	22,054	12,393	(9,661)	67,351	41,644	(25,707)	35,956
Leases and rentals	17,382	13,354	(4,028)	74,495	55,945	(18,550)	59,271
Depreciation	166,550	169,956	3,406	666,211	679,824	13,613	598,623
Licenses and taxes	(102,999)	20,127	123,126	58,122	82,311	24,189	160,326
Insurance	30,267	19,074	(11,193)	76,170	76,296	126	68,724
Interest	1,326	1,367	41	5,304	5,468	164	7,291
Total operating expenses	2,289,929	2,161,860	(128,069)	9,006,591	8,632,946	(373,645)	8,599,620
Operating gain / (loss)	(447,931)	(311,791)	(136,140)	(933,017)	(814,284)	(118,733)	(2,074,378)
Nonoperating revenues (expenses)							
Tax Levies, restricted	108,294	108,294	-	433,176	433,176	-	404,064
Interest expense on bond financing	(27,214)	(27,214)	-	(108,856)	(108,856)	-	(115,833)
Gain (loss) on disposal of equipment	500	-	500	500	-	500	-
Investment income	630	96	534	1,456	384	1,072	68
Net of bond premium/amortization	(1,769)	(1,769)	(0)	(7,077)	(7,076)	(1)	(7,077)
CARES Funds	-	-	-	-	-	-	-
PPP Loan Proceeds	-	-	-	-	-	-	-
Total nonoperating revenues (expenses), net	80,441	79,407	1,034	319,199	317,628	1,571	281,222
Net Income	(367,490)	(232,384)	(135,106)	(613,818)	(496,656)	(117,162)	(1,793,156)


Cascade Medical
2023 Cash Receipts
3,250,000
3,000,000
2,750,000
2,500,000
2,250,000
2,000,000
1,750,000
1,500,000
1,250,000
1,000,000
750,000
500,000
12,500,000
10,500,000
8,500,000
6,500,000
4,500,000
2,500,000
500,000
Actual
Budget
ActYTD
BudYTD
Jan 23
Feb
Mar
Apr
May
June
July
August
September
October
November
December

Cascade Medical
Statistics Summary - 2023

	YTD 2022 avg/mo	Jan 23	feb	mar	apr	2023 Act mo	2023 Bud mo	Act/Bud % var	2023 Act YTD Tot	2023 Act avg/mo	2023 Bud YTD Tot	2023 Bud avg/mo	Act/Bud % var
Acute Care	11	32	6	15	24	24	15	55.3%	77	19	83	21	-7.2%
Swing Bed	101	75	98	49	66	66	85	-22.3%	288	72	374	94	-23.1%
Laboratory tests	2,645	2,875	2,395	2,285	3,001	3,001	2,912	3.1%	10,556	2,639	11,648	2,912	-9.4%
Radiology exams	256	305	280	301	306	306	284	7.7%	1,192	298	1,137	284	4.8%
CT scans	88	112	82	115	89	89	100	-11.0%	398	100	416	104	-4.3%
ED visits	252	324	253	244	283	283	251	12.5%	1,104	276	1,114	279	-0.9%
Ambulance runs	61	88	61	57	54	54	72	-25.0%	260	65	293	73	-11.3%
Clinic visits	951	1,059	984	1,197	1,091	1,091	1,073	1.7%	4,331	1,083	4,522	1,131	-4.2%
Rehab procedures	2,077	2,363	2,157	2,169	2,227	2,227	2,151	3.5%	8,916	2,229	8,554	2,139	4.2%

Patient Statistics

	2022	2023												2023
Admits	**YTD Mo Avg**	**Jan**	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**YTD Mo Avg**
Acute Care	2.8	5	2	5	7									4.8
Short Stay	1.5	-	4	5	3									3.0
Swing Bed	5.8	5	4	5	5									4.8
Respite Care	0.3	2	-	-	1									0.8
Total Admits	10.3	12	10	15	16									13.3
Patient Days														
Acute Care	9.5	19	6	15	24									16.0
Short Stay	1.7	1.2	5.1	4.5	4.5									3.8
Swing Bed	91.8	75	98	49	66									72.0
Respite Care	12.8	13	20	-	5									9.5
Total Patient Days	115.7	108.2	129.1	68.5	99.5									101.3
Average Length of Stay	11.3	9.0	12.9	4.6	6.2									8.2
Average Patients per Day	3.9	3.5	4.5	2.2	3.3									3.4
Worked FTEs	-													#DIV/0!
FTEs (W/ Non-Working Pay*)	-													#DIV/0!
Laboratory (tests)	2,645	2,875	2,395	2,285	3,001									2,639
Radiology (tests)	222	253	245	231	254									246
Mammography (tests)	27	35	28	42	32									34
Cardiac Diagnostics	66	84	74	79	102									85
CT (Scans)	88	112	82	115	89									100
DXA (Scans)	8	17	7	28	20									18
PT (services billed)	1,620	1,778	1,645	1,764	1,686									1,718
ER (visits/procedures)	256	324	253	244	283									276
Ambulance (runs)	61	88	61	57	54									65
Clinic (visits)	932	1,051	976	1,197	1,091									1,079
Occupational Therapy	428	516	446	364	469									449
Speech Therapy	29	69	66	41	72									62
Endoscopy Procedures	4	7	22	20	13									16

REVENUE COMPARISON	2022	2023												2023
	YTD Mo Avg	**Jan**	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**YTD Mo Avg**
Acute Care	$ 44,331	$ 122,267	$ (28,105)	$ 44,978	$ 104,755									$ 60,974
Short Stay	5,783	3,846	15,659	14,765	13,764									12,009
Respite Care	525	5,785	14,960	-	445									5,298
Swing Bed	222,083	144,900	272,895	118,335	113,505									162,409
Central Supply	34,588	18,694	13,789	15,385	20,622									17,123
Laboratory	306,299	323,582	273,385	356,070	356,554									327,398
Cardiac Diagnostics	16,865	24,824	23,326	25,498	33,963									26,903
CT	280,813	382,550	289,072	376,137	340,517									347,069
Radiology	105,157	126,184	121,002	126,516	141,478									128,795
Mammography	14,850	17,620	18,493	25,513	20,365									20,498
Pharmacy	123,404	132,753	87,704	193,768	150,174									141,100
Respiratory Therapy	103	-	-	-	-									-
Physical Therapy	157,284	179,529	180,871	178,606	186,602									181,402
Emergency Room	487,847	595,285	566,371	592,177	573,591									581,856
Ambulance	195,970	164,881	244,598	225,217	178,209									203,226
Clinic	196,986	206,005	249,653	282,355	310,787									262,200
Occupational Therapy	46,143	52,920	59,886	44,284	52,754									52,461
Outpatient Diagnostic Svcs	14,496	14,952	44,461	62,002	60,911									45,582
Speech/Contracted Svcs	9,109	20,019	25,402	13,392	20,241									19,764
Dietary/Contracted Svcs	911	5,366	3,407	8,471	5,469									5,678
Total Patient Revenue	**$ 2,263,546**	**$ 2,541,962**	**$ 2,476,829**	**$ 2,703,469**	**$ 2,684,706**									$ 2,601,742

Increase (Decrease) in Cash and Cash Equivalents

Cascade Medical Center

For the Month Ending April 30, 2023

	Apr-23	2023 YTD	2022 YTD
Cash flows from operating activities			
Receipts from and on behalf of patients	$ 1,662,750	$ 8,258,682	$ 5,773,300
Other receipts	$ 14,212	$ 183,103	$ 218,977
Payments to & on behalf of employees	$ (1,163,788)	$ (4,605,946)	$ (4,615,126)
Payments to suppliers and contractors	$ (1,194,647)	$ (3,608,211)	$ (2,978,850)
Net cash gained / (used) in operating activities	$ (681,473)	$ 227,627	$ (1,601,699)
Cash flows from noncapital financing activities			
Taxation for maintenance and operations, EMS	$ 916,168	$ 1,146,398	$ 1,163,548
Noncapital grants and contributions	$ 554	$ 36,547	$ 252,684
Net cash provided by noncapital financing activities	$ 916,722	$ 1,182,946	$ 1,416,232
Cash flows from capital and related financing activities			
Taxation for bond principal and interest	$ 247,731	$ 308,981	$ 303,811
Purchase of capital assets	$ -	$ (12,222)	$ (86,286)
Payments toward construction in progress	$ (21,646)	$ (21,646)	$ (142,415)
Proceeds from disposal of capital assets	$ 500	$ 500	$ -
Proceeds from long-term debt	$ -	$ -	$ -
Principle & Interest paid on long-term debt	$ -	$ -	$ -
Bond maintenance & issuance costs	$ -	$ -	$ -
Capital grants and contributions	$ -	$ -	$ 24,118
Net cash provided by capital and related financing activities	$ 226,585	$ 275,613	$ 99,228
Cash flows from investing activities			
Investment Income	$ 47,443	$ 173,622	$ 6,790
Net increase (decrease) in cash and cash equivalents	$ 509,278	$ 1,859,808	$ (79,450)
Cash and Cash equivalents, beginning of period	$ 14,269,736	$ 12,919,205	$ 12,895,031
Cash and cash equivalents, end of period	$ 14,779,014	$ 14,779,014	$ 12,815,581

Forecasted Statement of Cash Flows
Cascade Medical Center
For the year ending April 30, 2023

	Actual 1st Qtr	Actual April	Forecast May	Forecast June	Forecast 2nd Qtr	Forecast 3rd Qtr	Forecast 4th Qtr	Actual/Forecast Year End 2023	Budget 2023
Cash balance, beginning of period	$ 12,919,205	$ 14,269,736	$ 14,779,014	$ 14,657,445	$ 14,269,736	$ 13,718,984	$ 13,725,496	$ 12,919,205	$ 12,919,205
Cash available for operating needs	$ 12,707,225	$ 13,935,775	$ 13,956,012	$ 13,734,232	$ 13,935,775	$ 12,962,634	$ 12,925,997	$ 12,707,225	12,707,225
Cash restricted to debt service, other restricted funds	$ 211,980	$ 333,961	$ 823,002	$ 923,213	$ 333,961	$ 756,350	$ 799,499	$ 211,980	211,980
Cash flows from operating activities									
Receipts from and on behalf of patients	$ 6,595,932	$ 1,662,750	$ 1,428,968	$ 1,489,735	$ 4,581,453	$ 5,317,289	$ 6,872,431	$ 23,367,105	$ 21,346,379
Grant receipts	$ 35,993	$ 554	$ 13,377	$ 23,985	$ 37,916	$ 52,642	$ 2,090	$ 128,641	$ 133,798
Other receipts	$ 168,890	$ 14,712	$ 14,509	$ 61,347	$ 90,568	$ 58,378	$ 89,939	$ 407,775	$ 403,985
Payments to or on behalf of employees	$ (3,442,158)	$ (1,163,788)	$ (1,034,155)	$ (1,567,413)	$ (3,765,356)	$ (3,373,645)	$ (3,948,637)	$ (14,529,796)	$ (16,977,604)
Payments to suppliers and contractors	$ (2,413,564)	$ (1,194,647)	$ (742,774)	$ (787,422)	$ (2,724,843)	$ (2,153,381)	$ (2,308,131)	$ (9,599,920)	$ (6,239,189)
Net cash provided by operating activities	$ 945,094	$ (680,419)	$ (320,075)	$ (779,768)	$ (1,780,262)	$ (98,718)	$ 707,691	$ (226,195)	$ (1,332,631)
Cash flows from noncapital financing activities									
Unencumbered M & O taxation	$ -	$ -	$ -	$ -	$ -	$ -	$ 246,325	$ 246,325	$ 243,957
Taxation for Emergency Medical Services	$ 169,499	$ 674,859	$ 140,219	$ 9,163	$ 824,241	$ 58,685	$ 722,608	$ 1,775,033	$ 1,795,981
Investment Income	$ 126,178	$ 47,443	$ 5,725	$ 7,961	$ 61,129	$ 48,778	$ 90,954	$ 327,039	$ 44,952
Donations	$ -	$ -		$ -	$ -	$ -	$ 67,269	$ 67,269	$ 90,000
Net cash provided by noncapital financing activities	$ 295,678	$ 722,302	$ 145,944	$ 17,124	$ 885,370	$ 107,463	$ 1,127,155	$ 2,415,666	$ 2,174,890
Proceeds from Long Term Debt	$ -				$ -	$ -	$ -	$ -	$ -
Less Funds Expended for Capital Purchases	$ (12,222)	$ (21,646)	$ (47,649)	$ (8,954)	$ (78,249)	$ (45,381)	$ (93,804)	$ (229,656)	$ (554,448)
Increase/(decrease) in cash available for operations	$ 1,228,550	$ 20,237	$ (221,780)	$ (771,599)	$ (973,141)	$ (36,637)	$ 1,741,042	$ 1,959,814	$ 287,811
Cash available for operating needs	**$ 13,935,775**	**$ 13,956,012**	**$ 13,734,232**	**$ 12,962,634**	**$ 12,962,634**	**$ 12,925,997**	**$ 14,667,039**	**$ 14,667,039**	**$ 12,995,036**
Taxation for bond prin & int (incl encumbd M&O)	$ 121,981	$ 489,040	100,211	$ 6,887	$ 596,138	$ 43,149	$ 270,318	$ 1,031,587	$ 1,055,568
Principle & Interest paid on long-term debt				$ (173,749)	$ (173,749)	$ -	$ (854,219)	$ (1,027,969)	$ (1,065,568)
Restricted grants and contributions	$ -				$ -	$ -	$ -	$ -	
Increase/(decrease) in restricted cash	$ 121,981	$ 489,040	$ 100,211	$ (166,862)	$ 422,389	$ 43,149	$ (583,901)	$ 3,618	$ (10,000)
Cash restricted to debt service, other restricted funds	**$ 333,961**	**$ 823,002**	**$ 923,213**	**$ 756,350**	**$ 756,350**	**$ 799,499**	**$ 215,598**	**$ 215,598**	**$ 201,980**
Cash balance, end of period	**$ 14,269,736**	**$ 14,779,014**	**$ 14,657,445**	**$ 13,718,984**	**$ 13,718,984**	**$ 13,725,496**	**$ 14,882,637**	**$ 14,882,637**	**$ 13,197,016**

CASCADE MEDICAL CENTER

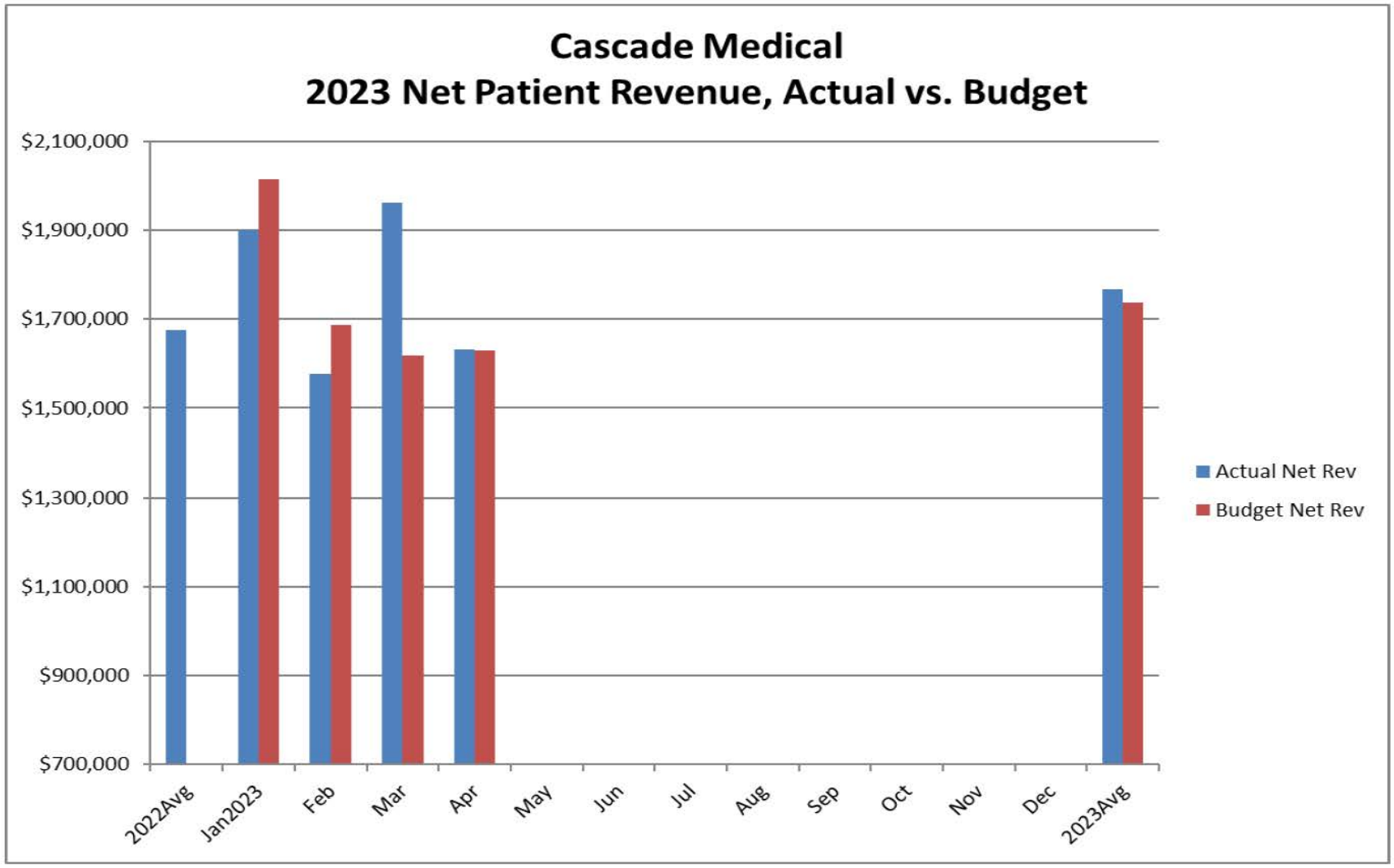
EMERGENCY MEDICAL SERVICES - APRIL, 2023

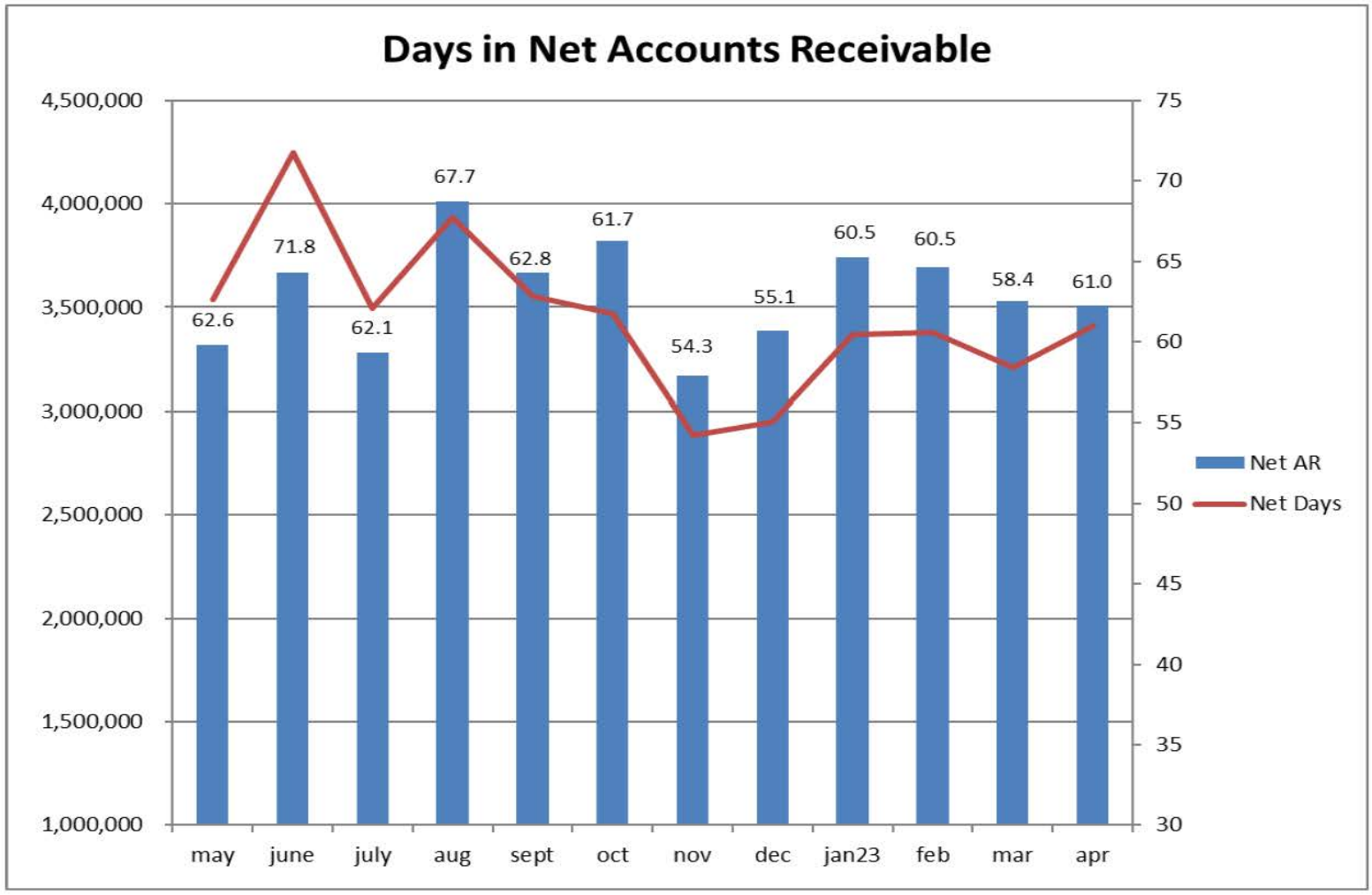
	EMERGENCY ROOM		AMBULANCE		COMBINED EMERGENCY MEDICAL SERVICES		
REVENUE	**4/30/23**	**4/30/23 YTD**	**4/30/23**	**4/30/23 YTD**	**4/30/23**	**4/30/23 YTD**	**4/30/2022 YTD**
PATIENT REVENUE	573,592	2,327,429	178,209	812,905	$751,801	$3,140,334	$0
DEDUCTIONS FROM REVENUE							
CONTRACTUAL ALLOWANCE, BAD DEBT &							
CHARITY CARE	$333,716	$1,354,098	$116,798	$532,778	$450,514	$1,886,876	$0
NET PATIENT REVENUE	**$239,876**	**$973,331**	**$61,411**	**$280,127**	**$301,287**	**$1,253,459**	**$0**
OTHER OPERATING REVENUE	$0	$0	-	-	$0	$0	$0
TOTAL OPERATING REVENUE	**$239,876**	**$973,331**	**$61,411**	**$280,127**	**$301,287**	**$1,253,459**	**$0**
OPERATING EXPENSES							
SALARIES AND WAGES	169,356	670,210	108,354	413,931	$277,710	$1,084,141	$0
EMPLOYEE BENEFITS	25,224	104,787	27,443	100,592	$52,667	$205,378	$0
PROFESSIONAL FEES	22,502	82,097	-	1,500	$22,502	$83,597	$0
SUPPLIES	8,065	24,087	11,183	33,596	$19,248	$57,681	$0
FUEL	-	-	1,305	7,669	$1,305	$7,669	$0
REPAIRS AND MAINT.	-	-	2,158	14,668	$2,158	$14,668	$0
PURCHASED SERVICES	3,255	10,900	19,102	61,150	$22,357	$72,050	$0
CONTINUING MEDICAL EDUCATION	875	875	2,243	6,849	$3,118	$7,724	$0
DUES	1,759	3,777	458	8,954	$2,217	$12,731	$0
OTHER EXPENSES	159	635	1,584	5,676	$1,743	$6,311	$0
LEASES / RENTALS	561	1,421	3,000	10,100	$3,561	$11,521	$0
DEPRECIATION	4,522	18,087	17,920	71,681	$22,442	$89,768	$0
TAXES AND LICENSES	-	1,338	-	-	$0	$1,338	$0
INSURANCE	1,113	4,454	4,238	16,953	$5,352	$21,406	$0
OVERHEAD COSTS	195,232	752,774	92,434	356,405	$287,666	$1,109,178	$0
TOTAL OPERATING EXPENSES	**$432,623**	**$1,675,441**	**$291,422**	**$1,109,723**	**$724,045**	**$2,785,163**	**$0**
MARGIN ON OPERATIONS	**($192,747)**	**($702,111)**	**($230,012)**	**($829,596)**	**($422,759)**	**($1,531,704)**	**$0**
TAX REVENUE					**$149,665**	**$598,660**	**$0**
NET MARGIN WITH TAX REVENUE					**($273,094)**	**($933,044)**	**$0**
STATISTICS (ER - visits/procedures, AMB - billed runs) - 2023	**283**	**1,104**	**54**	**260**			
Total Ambulance Runs (includes unbillable runs)			**83**	**383**			
STATISTICS (ER - visits/procedures, AMB - billed runs) - 2022	**267**	**1,025**	**61**	**242**			
Total Ambulance Runs (includes unbillable runs)			**87**	**368**			

Cascade Medical Center
Balance Sheet
As of April 30, 2023 and December 31, 2022

	Apr 2023	Dec 2022
ASSETS		
Current Assets		
Cash and Cash Equivalents	1,285,442	879,569
Savings Account	10,491,905	9,042,895
Patient Account Receivable	6,168,319	6,045,511
less: Reserves for Contractual Allowances	(2,662,557)	(2,592,952)
Inventories and Prepaid Expenses	334,846	330,878
Taxes Receivable - M&O Levy	(76,722)	11,777
- EMS Levy	(82,838)	159,405
Other Assets	(692,135)	458,839
Total Current Assets	14,766,260	14,335,921
Assets Limited as to Use		
Cash and Cash Equivalents		
Funded Depreciation	1,334,650	1,314,457
CVB Memorial Fund	1,274	1,273
UTGO Bond Payable Fund	379,448	70,467
LTGO Bond Payable Fund	265,317	265,317
Investment Memorial Fund	126,452	124,539
Settlement Account	165,614	163,108
Paycheck Protection Loan Proceeds	-	-
Cash - EMS	755,712	1,160,753
	3,028,467	3,099,915
Taxes Receivable - Construction Bond Levy	(74,816)	11,494
Total Assets Limited as to Use	2,953,651	3,111,409
Property, Plant and Equipment		
Land	522,015	522,015
Land Improvements	1,392,089	1,392,089
Buildings & Improvements	10,502,549	10,502,549
Fixed Equip - Hospital	8,759,776	8,747,554
Major Movable Equipment Hospital	8,036,544	8,036,544
Construction in Progress	38,718	17,072
Total Property, Plant and Equipment	29,251,691	29,217,823
Less: Accumulated Depreciation	(19,921,215)	(19,255,003)
	9,330,476	9,962,820
Other Assets		
Long Term Pension Assets	1,274,192	1,274,192
Deferred OPEB/Pension Costs	597,265	597,265
Deferred Bond Costs	315,387	322,464
TOTAL ASSETS	29,237,231	29,604,072

	Apr 2023	Dec 2022
LIABILITIES & FUND BALANCE		
Current Liabilities		
Accounts Payable	152,635	592,145
Accrued Payroll	814,700	423,350
Refunds Payable	(6,446)	8,112
Accrued PTO	838,807	763,093
Payroll Taxes & Benefits Payable	(6,709)	(91,262)
Accrued Interest Payable	136,070	27,214
Current Long Term Debt	743,638	746,195
Current OPEB Liability	906,196	861,196
Settlement Payable	741,000	741,000
Total Current Liabilities	4,319,891	4,071,042
Long Term Liabilities		
Notes Payable	207,493	207,493
Covid SHIP Funding	-	-
PPP Note Payable	-	-
CARES Act Funds Reserve	-	-
UTGO Bond Payable	5,021,000	5,021,000
LTGO Bond Payable	4,440,000	4,440,000
Deferred Revenue/Bond Premium	87,235	89,106
Long Term OPEB/Pension Liability	3,212,153	3,212,153
Total Long Term Liabilities	12,967,880	12,969,752
Total Liabilities	17,287,771	17,040,794
Fund Balance - Prior Years	12,563,278	12,563,278
Fund Balance - Current Year	(613,818)	-
Total Fund Balance	11,949,460	12,563,278
TOTAL LIABILITIES & FUND BALANCE	29,237,231	29,604,072


Cascade Medical
2023 Net Patient Revenue, Actual vs. Budget
$2,100,000
$1,900,000
$1,700,000
$1,500,000
$1,300,000
$1,100,000
$900,000
$700,000
2022Avg
Jan2023
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2023Avg
Actual Net Rev
Budget Net Rev


Days in Net Accounts Receivable
4,500,000
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
75
70
65
60
55
50
45
40
35
30
62.6
71.8
62.1
67.7
62.8
61.7
54.3
55.1
60.5
60.5
58.4
61.0
may
june
july
aug
sept
oct
nov
dec
jan23
feb
mar
apr
Net AR
Net Days

Cascade Medical
Accounts Receivable Trending Report - 2023

Total Facility	Dec 2020	Dec 2021	Dec 2022	Jan 2023	Feb	Mar	Apr	May	Jun
0 - 30 days	2,902,699	2,437,008	2,660,733						
31-60 days	546,254	863,160	545,432						
61-90 days	547,840	332,252	349,290						
91-180 days	570,339	991,256	1,129,065						
over 180 days	728,885	1,016,613	1,360,992						
Total Balance	5,296,017	5,640,289	6,045,511	6,345,113	6,369,204	6,302,232	6,178,319		
Credit bals as % of AR	5.5%	2.5%	6.8%						
% >90 w/o installs	22.0%	33.6%	41.2%						

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

CM Foundation Meeting Sign Up
Wednesdays | 9:00-10:30 AM | ABC Room

Date	Board Commissioner
06/14/2023	No Commissioner needed, Golf Tournament prep
07/19/2023	
08/16/2023	
09/20/2023	
10/18/2023	
11/15/2023	
12/13/2023	***Annual Board Meeting. Location TBD**