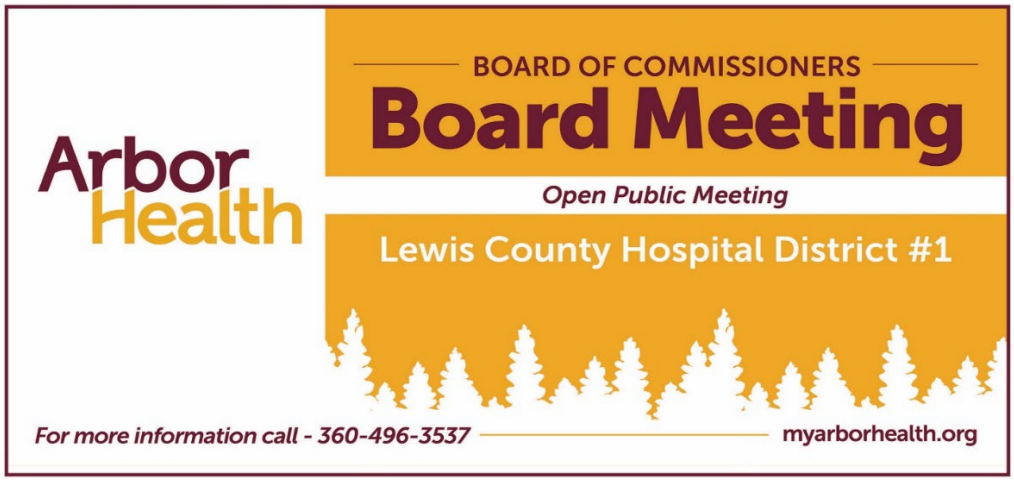
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

Board Chair –, Secretary – Tom Herrin,
Commissioner – Craig Coppock, Commissioner-Laura Richardson,
Commissioner – Wes McMahan & Commissioner-Kim Olive

January 26, 2022 @ 3:30 PM
Join Zoom Meeting: https://myarborhealth.zoom.us/j/82773022576
Meeting ID: 827 7302 2576
One tap mobile: +12532158782,,82773022576#
Dial: +1 253 215 8782

Arbor Health

Specialty Clinic
521 ADAMS AVENUE
360-496-3641

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

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LEWIS COUNTY HOSPITAL DISTRICT NO. 1
FINANCE COMMITTEE MEETING
January 19, 2022 at 12 p.m.
Join Zoom Meeting
https://myarborhealth.zoom.us/j/81732924295
Meeting ID: 817 3292 4295
One tap mobile: +12532158782,,81732924295#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	PAGE	TIME
Call to Order **Approval or Amendment of Agenda** **Conflicts of Interest**		12:00 p.m.
Consent Agenda • Minutes of December 22, 2021 Finance Committee Meeting o *To be approved at the Regular Board Meeting on 01.27.22.*	5	12:02 p.m.
• Revenue Cycle Update o *To review the December highlights in the Revenue Cycle Department-Business Office and Patient Access.*	9	
• Board Oversight Activities o *To review YTD department performance.* o *To review Superintendent's monthly credit card-11.20.21-12.21.21.*	12 13	
• Cost Report Update o *To review the position of open cost reports.*	17	
• Financial Statements o *To review the December 2021 Financials.*	18	
Old Business • Financial Department Spotlight o *340B Program*	30	12:05 p.m.
• Disaster Funding Update o *To provide an update on PPP Funds, Cares Act Lost Revenue and Rural Distribution ARP.*	32	12:10 p.m.
New Business • 2021 Health Insurance Review o *To discuss the performance of the 2021 self-insurance health plan.*	35	12:15 p.m.
• Debt Capacity & Long-Term Debt Schedule o *To review the debt structure of the District.*	48	12:25 p.m.
• Changes in Medicare Payment Structure o *To discuss the 2021 December Interim Rate Review.*	52	12:35 p.m.

• NW Momentum Accountable Care Organization o *To provide an update on 2021 performance and discuss the direct contracting requirements for 2022.*	55	12:45 p.m.
• Surplus or Dispose of Certain Property o *To declare as surplus or to dispose of items beyond their useful life.*	61	12:55 p.m.
Appendix • Appendix A-Acronym List o *To identify commonly used acronym's in the healthcare industry.*	63	
• Appendix B-Financial Statements o *Income Statement by Line-Item Reports.*	65	
Meeting Summary & Evaluation		
Next Meeting Date and Time- February 16, 2022 @ 12 p.m.		
Adjournment		1:00 p.m.

Arbor Health

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MEMORANDUM

To: Board of Commissioners

From: Richard Boggess, CFO

Date: January 11, 2022

Re: Department Spotlight-340B Program

This month, we reviewed the last 12 months performance of the 340B program. The revenue generated by this program supports the cost of the contracted ambulance transport service at Arbor Health. This program goes a long way to support the mission of Arbor Health. To provide an understanding of the foundations of the program we will present a video at the meeting to share the beginning of the program and the intent from a governmental perspective, along with a document outlining the current legal environment.

The video is call 340B simplified and is produced by Association of American Medical Colleges and presents an unbiased view of the program. https://m.youtube.com/watch?v=SpeqIW7ALr8

As drug manufacturers remove drugs from the 340B program formulary, Arbor Health's slice of the revenue will decline. This will reduce the monetary support of the cost of the ambulance transport program. In the short term there a no actions that Arbor Health can take. Long term we can only respond as the legal battles get resolved. Paraphrasing one commissioner in a previous meeting on this topic – we ride this horse to get the benefit of the program until we get to the next phase.

More Court Battles Ahead for 340B in 2022

by Admin | January 12, 2022 3:00 pm

Jan. 12, 2022– The dispute between safety-net hospitals and a growing group of drug companies over community-based pharmacies in the 340B drug pricing program is heading into a new phase of legal wrangling that ensures this fight will remain a dominant issue in the 340B world for months to come.

As 2021 ended, two industry giants – Amgen and AbbVie – joined the group of drugmakers restricting 340B discounted pricing for outpatient drugs purchased by hospitals and dispensed at local pharmacies. AbbVie's move alone has the potential to be a major one for safety-net hospitals. The company manufactures the immunosuppressive drug *Humira*, which brought in nearly $20 billion in net revenues in 2020 as the world's top-selling drug. The development brings the total number of drugmakers imposing 340B community pharmacy restrictions to 11, and safety-net hospitals fear more companies could choose to join the fray and adopt similar policies in 2022. The companies that are restricting 340B pricing (or have announced a plan to do so) are Eli Lilly, Sanofi, AstraZeneca, Novartis, Novo Nordisk, United Therapeutics, Boehringer Ingelheim, UCB, Merck, Amgen, and AbbVie.

In its oversight and enforcement roles, the federal government has sent written warnings to most of these companies telling them their pricing policies violate the 340B statute and ordering them to restore the discounts. In the case of six companies, the Health Resources & Services Administration (HRSA) has referred the matter to the Department of Health and Human Services (HHS) Office of Inspector General (OIG) to investigate whether the government should impose steep civil fines for the noncompliant drugmakers.

The government's efforts have been held up by lawsuits that many of the drug companies filed challenging whether the 340B statute prohibits them from limiting or conditioning 340B pricing. The litigation also challenges whether HRSA has the authority to take enforcement actions in these matters.

Where the Court Cases Stand

To date, three federal district courts have weighed in on whether the law permits drug companies to impose unilateral restrictions or conditions on 340B discounts when safety-net providers contract with community pharmacies to dispense drugs to their patients. Courts in Indiana and New Jersey largely sided with the federal government, stating the law does not allow such restrictions. However, they found some faults with HRSA's letters initiating enforcement actions that were challenged in those cases, setting aside all or part of the violation letters. A third court based in Washington, D.C., decided in favor of two drug companies that are challenging the government's authority to prohibit them from limiting the discounts. A fourth district court in Delaware has yet to issue a final decision in the case it is considering.

The government has made it clear it is not backing down in this fight. Just before the new year, government attorneys representing HHS appealed the decision of the D.C. district court. HHS is asking an appeals court to reverse that ruling and back enforcement actions against companies that have restricted 340B pricing through community pharmacies.

But the drug companies show no signs of backing down, either. Three companies that were told by the Indiana and New Jersey courts that their actions were unlawful filed appeals of their own. The federal government also filed appeals in those cases that will challenge the elements of the decisions that found fault with the HRSA violation letters initiating enforcement actions.

Where the Dispute Is Headed

With all three main stakeholders – hospitals, drug companies, and the federal government – vowing to continue the fight, the dispute now is moving to the next crucial phase. Federal appeals courts in each of these jurisdictions are responding to the notices of appeal. They likely will set schedules soon for submissions of briefs by the parties, followed by hearings for oral argument, to determine who will prevail.

The 340B community is steeling itself for a lengthy court process. Appellate courts typically take months or more than a year to consider cases and issue final rulings. With appeals being heard in at least three separate districts, courts could end up being split on the merits of the cases.

The fact that at least five drugmakers adopted restrictive pricing policies after the government warned the first six they were breaking the law – and that three drugmakers have done so after the recent court decisions – indicates some in the industry are willing to take the risk of possible big fines to pull back on 340B discounts. Safety-net hospitals are concerned that the D.C. district court decision emboldened some drug companies and could encourage others to follow suit.

What Remains at Stake

As the community pharmacy dispute drags out, 340B providers and government officials continue to point to the mounting harm that they say the drug company restrictions are causing the health care safety net. In various court filings, letters, and other communications, they demonstrate how the financial hit to 340B providers is translating into reduced access to care for patients in need. It is for these patients and their families that safety-net providers say they are arguing for a resolution to the problem.

Drug companies have a significant stake in the outcome of this dispute as well. Some of the companies involved have publicly stated their policies are saving billions of dollars that are going directly to their bottom lines. As a result, there could be little incentive for drugmakers to change course until there are final appeals court decisions supporting HRSA's position. The companies are telling judges they should not be subject to fines, at least while the court cases are pending, because they are not "knowingly and intentionally" overcharging 340B providers in violation of the law.

With so much riding on the line, all eyes will be on the appeals courts in the coming weeks and months.

Source URL: https://340binformed.org/2022/01/more-court-battles-ahead-for-340b-in-2022/

COMMITTEE REPORTS

Arbor Health | FOUNDATION

521 Adams Avenue, Morton, WA 98356 | 360-496-3749
Mailing Address: P.O. Box 1132, Morton, WA 98356

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Arbor Health Foundation Meeting
November 9, 2021
ZOOM

Mission Statement

To raise funds and provide services that will support the viability and long-term goals of the Lewis County Hospital District No. 1. This includes, but is not limited to, taking a leadership role in maintaining and improving community pride and confidence in all aspects of the hospital's health care system.

Attendance: Ali Draper, Jessica Scogin, Caro Johnson, Linda Herrin, Christine Brower, Ann Marie Forsman, Martha Wright, Jeannine Walker, Wes McMahan, Betty Jurey, Gerri Maize, Marc Fisher, Julie Taylor, Gwen Turner

Excused: Lynn Bishop

Call to Order by President Ali Draper at 12:07pm

October 2021 Treasurers report was approved. Gwen Turner/Jeannine Walker

October 2021 minutes were approved. Gwen Turner/Jeannine Walker

Administrators Report- Julie Taylor
The number of Covid cases has plateaued and the hospital only has one covid patient now. A booster clinic was held last week in Packwood and Morton and good feedback was received.

Directors Report:
Jessica reported on the storyteller's conference that she recently attended in San Diego. It was helpful in teaching non-profits be successful in their fund-raising efforts.

Old Business:

Arbor Health | FOUNDATION
521 Adams Avenue, Morton, WA 98356 | 360-496-3749
Mailing Address: P.O. Box 1132, Morton, WA 98356

New Business:

Bank Housekeeping

The following motion was made:

Arbor Health Foundation requests the following changes to the bank accounts at Key Bank and Security State Bank. Add Jessica Scogin to all Arbor Health accounts.

Arbor Health Foundation Officers and signers on the bank accounts are to be assigned as follows:
Jessica Scogin, Executive Director
Virginia Ali Draper, President
Marc Fisher, Vice President - ***Remove Martha Wright, per vote on 11/9/21***
Caro Johnson, Secretary
Gerri Maize, Treasurer

Online banking rights are to be granted to Jessica Scogin, Virginia Ali Draper and Gerri Maize.

Motion approved Gwen Turner/Wes McMahan

A committee is being formed to work on the 2022 Foundation Budget and volunteers are welcome.

Election for 2022 officer will be addressed at the December meeting.

The foundation will have a Christmas sale in the board room Nov 30 & Dec 1, 2021 10-6pm. The sale is open to employees and patience's with procedures.

The foundation will have a booth at the Friends of Morton Park Bazar scheduled Nov 19, 20, 21 at the Lyle Building. The table fee is $30 and the vendor permit is $5.

Jessica Scogin showed a video that she made that featured the 15 Minute Philanthropist Program which allows employees and others to donate to the scholarship fund.

Meeting adjourned 12:54

Arbor Health | FOUNDATION

521 Adams Avenue, Morton, WA 98356 | 360-496-3749
Mailing Address: P.O. Box 1132, Morton, WA 98356

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Arbor Health Foundation Meeting
December 13, 2021
ZOOM

Mission Statement

To raise funds and provide services that will support the viability and long-term goals of the Lewis County Hospital District No. 1. This includes, but is not limited to, taking a leadership role in maintaining and improving community pride and confidence in all aspects of the hospital's health care system.

Attendance: Ali Draper, Caro Johnson, Linda Herrin, Christine Brower, Jeannine Walker, Wes McMahan, Julie Taylor

Excused: Betty Jurey, Jessica Scogin

Call to Order by President Ali Draper at 12:07pm

November 2021 Treasurers report was approved. Christine Brower/Wes McMahan

November minutes were tabled

Administrators Report- Julie Taylor
Julie said that we are moving forward with a Rapid Care Unit which they hope to have opened in January. The hospital is still working to located a site for a facility in Packwood. The hospital is looking into a charging station for electric cars. An accreditation has been received for the sleep clinic and the stroke readiness in the ER. An update for the Pyxis software for meds is underway.

Directors Report:

Arbor Health | FOUNDATION
521 Adams Avenue, Morton, WA 98356 | 360-496-3749
Mailing Address: P.O. Box 1132, Morton, WA 98356

Old Business:
A budget meeting has been held to draft the 2022 budget

New Business:
Employee Appreciation cards were distributed the first week of December.

The artwork project has been tabled.

Volunteers are needed to take down the lights in the park the first week of January.

A motion was made to approve the 2022 Arbor Health Foundation Budget. Wes McMahan/Christine Brower

Meeting adjourned 12:25

Arbor Health | FOUNDATION

521 Adams Avenue, Morton, WA 98356 | 360-496-3749
Mailing Address: P.O. Box 1132, Morton, WA 98356

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Arbor Health Foundation Meeting
January 11, 2022
ZOOM

Mission Statement

To raise funds and provide services that will support the viability and long-term goals of the Lewis County Hospital District No. 1. This includes, but is not limited to, taking a leadership role in maintaining and improving community pride and confidence in all aspects of the hospital's health care system.

Attendance: Ali Draper, Caro Johnson, Linda Herrin, Christine Brower, Jeannine Walker, Wes McMahan, Marc Fisher, Ann Marie Forsman, Jessica Scogin, Martha Wright

Excused: Betty Jurey, Lynn Bishop

Call to Order by President Ali Draper at 12:12pm

The president read the mission statement

Nov 2021 and December 2021 minutes were approved. Martha Wright/Jeannine Walker

December 2021 Treasurers report was approved. Caro Johnson/Christine Brower

No Administrators Report

Directors Report: Jessica reported that the gift shop made over $2500 in the course of the week following the sale. Diane Markham made the annual buying trip for the gift shop. Jessica was able to complete the inventory. The gift shop remains open to staff and people with procedures.

Arbor Health | FOUNDATION
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Old Business:

Jessica will email a link to show engraved cobblestones which could be used for memorials.

New Business:

It was discussed and agreed to make the February meeting a hybrid meeting with members meeting at Rivers, if available, and also invite members to attend on Zoom.

A new event coordinator is needed as Lynn Bishop has resigned. Planning needs to start for the October Dinner meeting.

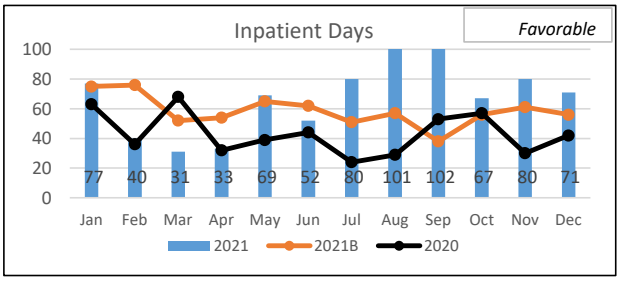
A motion was made to re-elect the current officers for 2022. Marc Fisher/Martha Wright.

Marc Fisher stated that Cowlitz Valley Historical Society calendars are on sale for $11.

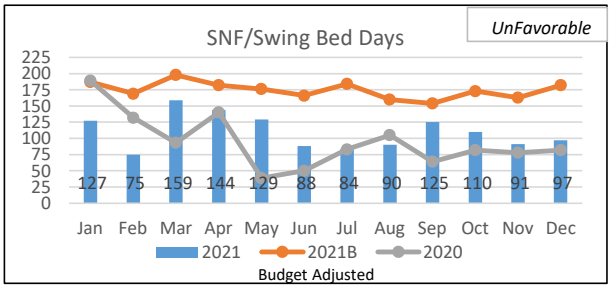
Meeting adjourned 12:50

Lewis County Hospital District No. 1
Board Financial Summary
December 31, 2021

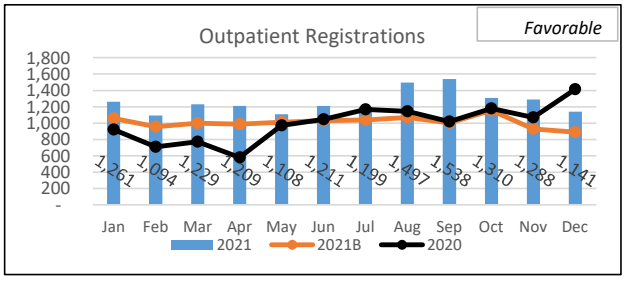
Growth



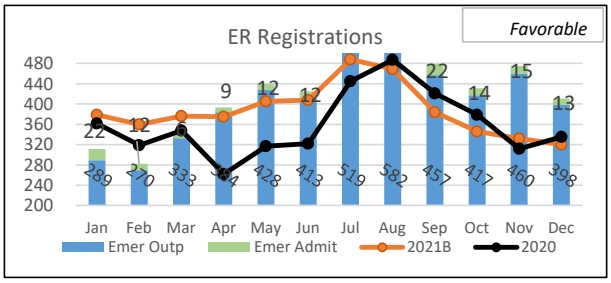
YTD: 803 Budget: 703 Pr Yr: 517



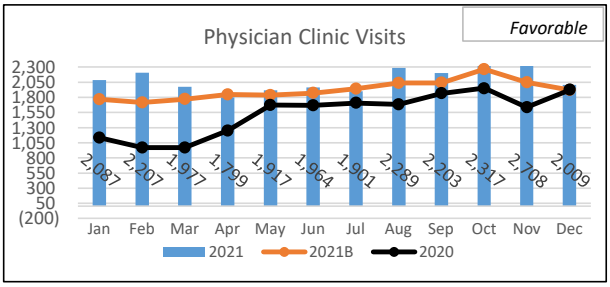
YTD: 1,319 Budget: 2,094 Pr Yr: 1,137



YTD: 15,085 Bud: 12,121 Pr Yr: 11,991

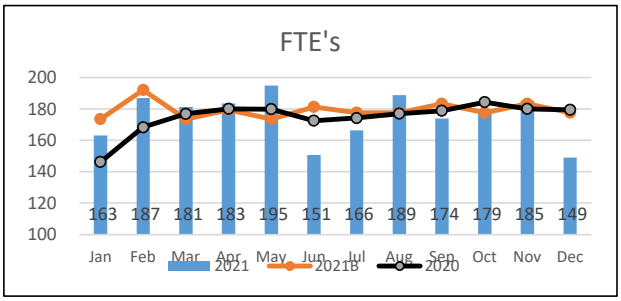


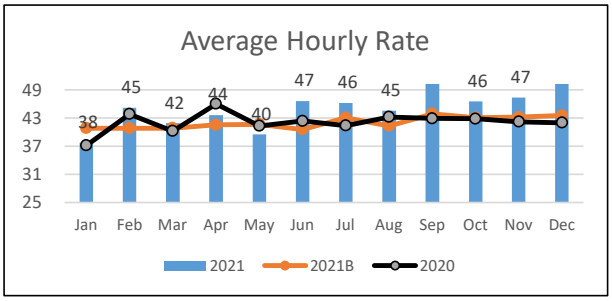
YTD: 4950 Bud: 4642 Pr Yr: 4309

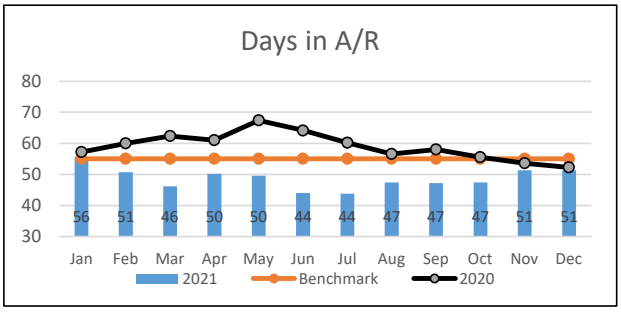


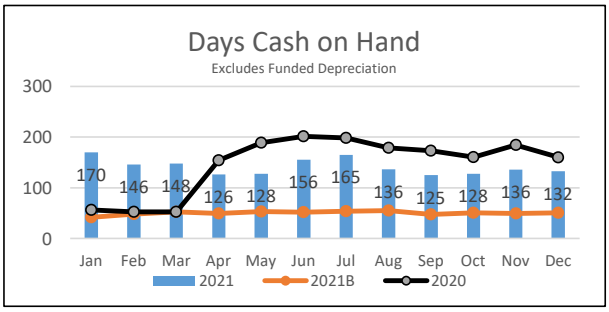
YTD: 25,378 Bud: 23,073 Pr Yr: 18,434

People and Operational Aspects









All Morton General Hospital
Income Statement
December, 2021

Pr Yr MTD	% Var	MTD $ Var	MTD Budget	MTD Actual		YTD Actual	YTD Budget	YTD $ Var	YTD % Var	PY YR YTD
652,439	-2%	(12,517)	805,346	792,829	Total Hospital IP Revenues	8,572,277	9,893,672	(1,321,396)	-13.4	7,430,722
2,573,358	-4%	(114,711)	3,039,068	2,924,357	Outpatient Revenues	33,562,562	37,875,507	(4,312,946)	-11.4	29,957,845
384,355	-6%	(21,524)	388,117	366,593	Clinic Revenues	4,486,601	4,638,349	(151,749)	-3.3	3,597,372
3,610,152	-4%	(148,752)	4,232,531	4,083,779	**Total Gross Patient Revenues**	46,621,439	52,407,529	(5,786,090)	-11.0	40,985,939
(313,504)	4%	(62,284)	(1,442,018)	(1,504,302)	Contractual Allowances	(15,979,525)	(19,074,360)	3,094,834	-16.2	(13,995,287)
(187,698)	131%	(74,745)	(56,963)	(131,708)	Bad Debt & Bankruptcy	(653,074)	(699,830)	46,756	-6.7	(521,296)
(45,460)	75%	(23,358)	(31,198)	(54,556)	Charity Care	(417,768)	(404,556)	(13,213)	3.3	(413,112)
19,242	47%	(21,760)	(45,896)	(67,656)	Other Adjustments	(598,810)	(650,000)	51,190	-7.9	(626,030)
(527,420)	12%	(182,147)	(1,576,075)	(1,758,221)	**Total Deductions From Revenue**	(17,649,177)	(20,828,745)	3,179,568	-15.3	(15,555,724)
3,082,732	-12%	(330,899)	2,656,456	2,325,557	**Net Patient Revenues**	28,972,262	31,578,784	(2,606,521)	-8.3	25,430,215
2,455,982	40%	29,511	73,805	103,317	Other Operating Revenue	1,494,438	885,666	608,772	68.7	5,534,221
5,538,714	-11%	(301,388)	2,730,262	2,428,874	**Total Operating Revenue**	30,466,700	32,464,450	(1,997,749)	-6.2	30,964,436
					Operating Expenses					
1,552,610	-10%	(163,027)	1,571,455	1,734,482	Salaries	18,707,786	18,076,139	(631,646)	-3.5	17,202,430
275,871	0%	(8)	373,010	373,018	Total Benefits	4,143,763	4,359,002	215,240	4.9	3,929,506
1,828,481	-8%	(163,035)	1,944,465	2,107,500	Salaries And Benefits	22,851,548	22,435,142	(416,407)	-1.9	21,131,936
86,297	35%	55,599	158,159	102,560	Professional Fees	1,380,397	1,977,510	597,113	30.2	1,703,174
249,401	-37%	(68,842)	187,972	256,814	Supplies	2,408,179	2,271,276	(136,903)	-6.0	2,072,897
437,721	-5%	(15,445)	333,404	348,849	Total Purchased Services	4,199,687	4,357,730	158,043	3.6	3,595,544
48,205	15%	7,525	50,252	42,726	Utilities	481,941	540,829	58,888	10.9	517,969
14,542	-20%	(3,830)	19,632	23,462	Insurance Expense	246,947	221,618	(25,328)	-11.4	214,206
152,520	24%	27,681	115,900	88,219	Depreciation and Amortization	1,256,255	1,328,652	72,397	5.4	1,720,483
41,848	11%	4,474	39,802	35,328	Interest Expense	426,765	458,643	31,878	7.0	441,484
46,585	-9%	(3,628)	40,438	44,066	Other Expense	558,598	505,562	(53,036)	-10.5	556,797
2,905,600	-6%	(159,500)	2,890,024	3,049,525	**Total Operating Expenses**	33,810,316	34,096,963	286,647	0.8	31,954,489
2,633,114	288%	(460,888)	(159,763)	(620,651)	**Income (Loss) From Operations**	(3,343,616)	(1,632,513)	(1,711,102)	104.8	(990,053)
(183,940)	-168%	222,925	(132,774)	(355,698)	Non-Operating Revenue/Expense	(4,765,222)	(1,593,284)	3,171,938	-199.1	(1,843,600)
2,817,053	882%	(237,964)	(26,989)	(264,953)	**Net Gain (Loss)**	1,421,606	(39,230)	1,460,836	-3723.8	853,547

Lewis County Public Hospital District No. 1
Balance Sheet
December, 2021

	Current Month	Prior-Month	Month Variance	Prior-Year end	Incr/(Decr) From PrYr
Assets					
Current Assets:					
Cash	$ 12,656,195	12,570,612	85,583	13,907,559	(1,251,364)
Total Accounts Receivable	6,780,509	6,980,629	(200,120)	6,254,724	525,785
Reserve Allowances	(2,675,536)	(2,581,110)	(94,426)	(2,586,216)	(89,319)
Net Patient Accounts Receivable	4,104,973	4,399,520	(294,546)	3,668,507	436,466
Taxes Receivable	55,207	(75,098)	130,304	50,622	4,585
Estimated 3rd Party Receivables	56,300	54,132	2,168	1,087,432	(1,031,132)
Prepaid Expenses	299,720	324,270	(24,550)	262,018	37,702
Inventory	283,994	327,208	(43,214)	312,749	(28,755)
Funds in Trust	1,400,538	2,374,021	(973,483)	3,205,817	(1,805,279)
Other Current Assets	192,811	189,793	3,018	66,706	126,105
Total Current Assets	19,049,738	20,164,457	(1,114,719)	22,561,411	(3,511,673)
Property, Buildings and Equipment	34,687,777	34,575,236	112,541	31,221,772	3,466,005
Less Accumulated Depreciation	(23,182,426)	(23,092,902)	(89,524)	(22,305,474)	(876,952)
Net Property, Plant, & Equipment	11,505,351	11,482,335	23,016	8,916,298	2,589,053
Total Assets	$ 30,555,089	31,646,792	(1,091,703)	31,477,709	(922,620)
Liabilities					
Current Liabilities:					
Accounts Payable	1,637,156	1,638,946	(1,790)	583,624	1,053,532
Accrued Payroll and Related Liabilities	925,898	711,879	214,020	903,749	22,149
Accrued Vacation	784,018	885,639	(101,621)	894,536	(110,518)
Third Party Cost Settlement	5,671,570	5,661,286	10,284	6,149,286	(477,716)
Interest Payable	23,999	161,529	(137,529)	0	23,999
Current Maturities - Debt	1,544,174	1,316,175	227,999	1,316,175	227,999
Unearned Revenue	1,787,417	1,706,783	80,634	773,947	1,013,470
Other Payables	(0)	(8)	8	(8)	8
Current Liabilities	12,374,232	12,082,229	292,004	10,621,309	1,752,923
Total Notes Payable	1,389,173	1,596,452	(207,279)	4,560,487	(3,171,314)
Capital Lease	(0)	(0)	0	(0)	0
Net Bond Payable	5,214,448	6,125,924	(911,475)	6,140,283	(925,835)
Total Long Term Liabilities	6,603,621	7,722,376	(1,118,754)	10,700,771	(4,097,150)
Total Liabilities	18,977,854	19,804,604	(826,751)	21,322,080	(2,344,227)
General Fund Balance	10,155,629	10,155,629	0	10,155,629	0
Net Gain (Loss)	1,421,606	1,686,559	(264,953)	(0)	1,421,606
Fund Balance	11,577,235	11,842,188	(264,953)	10,155,629	1,421,606
Total Liabilities And Fund Balance	$ 30,555,088	31,646,792	(1,091,704)	31,477,709	(922,621)

Arbor Health
Cash Flow Statement
For the Month Ending December 2021

	MTD	YTD
Cash Flows from Operating Activites		
Net Income	(264,953)	1,421,606
Adjustments to reconcile net income to net cash provided by operating activities		
Decrease/(Increase) in Net Patient Accounts receivable	294,547	(436,465)
Decrease/(Increase) in Taxes receivable	(130,305)	(4,585)
Decrease/(Increase) in Est 3rd Party Receivable	(2,168)	1,031,132
Decrease/(Increase) in Prepaid expenses	24,550	(37,702)
Decrease/(Increase) in Inventories	43,214	28,755
Decrease in Other Current Assets	(3,018)	(126,104)
Increase/(Decrease) in Accrued payroll liabilities	112,398	(88,369)
Increase/(Decrease) in 3rd Party cost stlmt liabilities	10,284	(477,716)
Increase/(Decrease) in Accounts payable	78,852	2,067,010
Increase/(Decrease) in Interest payable	(137,530)	23,999
Depreciation expense	89,524	876,952
Net Cash Flow from Operations	115,395	4,278,513
Cash Flows from Investing Activities		
Cash paid for		
Purchases of Fixed assets	(112,540)	(3,466,005)
Net Cash Flow from (used) in Investing Activities	(112,540)	(3,466,005)
Cash Flows from Financing Activities		
Cash paid for		
Additions to long-term debt	0	0
Principal payments of long-term liabilities	(890,755)	(3,869,151)
Net Cash Flow from (used) in Financing Activities	(890,755)	(3,869,151)
Net Increase (Decrease) in Cash	(887,900)	(3,056,643)
Cash at Beginning of Period	$ 14,944,633	$ 17,113,376
Cash at End of Period	$ 14,056,733	$ 14,056,733

CONSENT AGENDA

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
December 15, 2021 at 3:30 p.m.
ZOOM
https://myarborhealth.zoom.us/j/94428106689
Meeting ID: 944 2810 6689
One tap mobile: +12532158782,,94428106689#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Reading the Mission & Vision Statements	Board Chair Frady called the meeting to order via Zoom at 3:30 p.m. **Commissioners present:** ☒ Trish Frady, Board Chair ☒ Tom Herrin, Secretary ☒ Craig Coppock ☒ Wes McMahan ☒ Chris Schumaker **Others present:** ☒ Leianne Everett, Superintendent ☒ Shana Garcia, Executive Assistant ☒ Sara Williamson, CNO/CQO ☒ Kathleen Arnold, Interim Pharmacist ☒ Robert Hirst, Interim Quality Manager ☒ Janice Cramer, Medical Staff Coordinator ☒ Richard Boggess, CFO ☒ Van Anderson, Packwood Community Member ☒ Larry Sinkula, Surgical Services Director			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	☒ Diane Markham, Marketing & Communications Manager ☒ Kim Olive, Human Resource Assistant ☒ Laura Richardson, Morton Community Member ☒ Buddy Rose, Reporter ☒ Spencer Hargett, Compliance Officer ☒ Shannon Kelly, CHRO ☒ Julie Allen, Quality Data Analyst ☒ Julie Taylor, Ancillary Services Director ☒ Michelle Matchett, Clinical Administrative Assistant/Notary			
Approval or Amendment of Agenda		Commissioner Coppock made a motion to approve the agenda. Commissioner Schumaker seconded and the motion passed unanimously.		
Conflicts of Interest	Board Chair Frady asked the Board to state any conflicts of interest with today's agenda.	Superintendent Everett noted all employees present at today's meeting have a conflict of interest with Resolution 21-44.		
Oath of Office	Craig Coppock, Kim Olive and Laura Richardson were sworn in by Michelle Matchett, Notary Public, for their Board of Commissioner terms beginning January 1, 2022.			
Comments and Remarks	Commissioners: Board Chair Frady thanked everyone and is confident the District is headed in the right direction. Commissioner Coppock thanked Board Chair Frady and Commissioner Schumaker for their services, welcomed Laura and Kim to the Board in 2022, as well as is excited for the ISO 9001 journey. Secretary Herrin thanks Board Chair Frady for her six years of service to the Hospital District, along with Commissioner			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	Schumacher's service since being appointed. Commissioner Schumaker welcomed Laura and Kim and thanked the staff for their services, along with his peers on the board for their support during his term. He reiterated the importance of affordable healthcare and to keep asking "why" as the Board moves forward on their strategic journey. Commissioner McMahan thanked Board Chair Frady and Commissioner Schumaker, along with welcoming Laura and Kim. He recognizes there are more challenges to come in 2022. Audience: Superintendent Everett thanked Board Chair Frady for her services, expertise in the field and leadership of the Board in the last six years and even before that for the District.			
Executive Session- RCW 70.41.205	Executive Session began at 3:45 p.m. for 15 minutes to discuss RCW 70.41.205, RCW 42.30.110 (i) and RCW 70.41.200. At 4:00 p.m. Board Chair Frady extended by 15 minutes. At 4:15 p.m. Board Chair Frady extended by 10 minutes. The Board returned to open session at 4:25 p.m. No decisions were made in Executive Session. Initial Appointments- Radia 1. Lauren Fetty, MD (Consulting Radiology Privileges) 2. Alice Josafat, MD (Consulting Radiology Privileges) 3. Kambrie Kato, MD (Consulting Radiology Privileges)	Secretary Herrin made a motion to approve the Medical Privileging as presented and Commissioner Schumaker seconded. The motion passed unanimously.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	4. John McGown, MD (Consulting Radiology Privileges) 5. Ross Ondersma, MD (Consulting Radiology Privileges) Reappointments- Arbor Health 1. Kevin McCurry, MD (Emergency/Family Medicine Privileges) 2. Amy Nielsen, CRNA (Anesthesia Privileges) PeaceHealth Pathology 1. Helen Kim, MD (Consulting Pathology Privileges) Radia 1. Matthew Stein, MD (Consulting Radiology Privileges) Telestroke/Neurology Consulting Privileges 1. Mimi Lee, MD (Consulting Telestroke/Neurology Privileges) 2. James Wang, MD (Consulting Telestroke/Neurology Privileges)			
Department Spotlight	To resume in January 2022.			
Board Committee Reports • Hospital Foundation Report	Commissioner McMahan identified the most recent minutes were not included in the packet and proposed bringing the January meeting.			
• Finance Committee Report	Commissioner Coppock highlighted the committees work which included discussions related to the budget and levies, as well as			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	support to approve Resolutions 21-40 & 21-41.			
• Quality Improvement Oversight Report	CNO/CQO Williamson proposed a new schedule for the QIO Committee in 2022 to align with DNV recommendations and build on the ISO 9001 journey. There may be fees along the way associated to the accreditation, but no different than there was with DNV. ISO 9001 stresses the importance that operational activities are in alignment with strategic initiatives.			
Consent Agenda	Board Chair Frady announced the consent agenda items for consideration of approval: 1. Approval of Minutes a. November 10, 2021, Regular Board Meeting b. November 10, 2021, Special Board Meeting c. November 17, 2021, Finance Committee Meeting d. November 29, 2021, Special Board Meeting e. December 1, 2021, Quality Improvement Oversight Committee Meeting 2. Warrants & EFT's in the amount of $3,881,175.96 dated November 2021 3. Approve Documents Pending Board Ratification 12.15.21	Commissioner Coppock made a motion to approve the Consent Agenda and Secretary Herrin seconded. The motion passed unanimously.		
Old Business • Incident Command Update	CNO/CQO Williamson highlighted the following: 1. Washington state's vaccination rate is 74.9% as of December 14, 2021. 2. The Lewis County 7 day rolling average is 28.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	3. Still waiting for Moderna and J & J to be approved for ages 5+, so we can offer it to the District. 4. The newest variant is Omicron and we continue to monitor the transmissibility, virulence and immune escape.			
• Board Self-Evaluation	Board Chair Frady reviewed and commented where the Board received a lower percentage, as well as recommended these are things to work on improving in 2022. Superintendent Everett reminded the Board that in 2022 we have engaged Kurt O'Brien for board development which will be a 12-month plan and there will be designated time during the Board Meeting for it.			
• Commissioner Compensation for Meetings and Other Services	Commissioner McMahan expressed a desire for more education. With more educational options online and bringing on new commissioners, he proposed increasing the number of hours a commissioner can be paid per month. The Board recognizes education is important and through the pandemic most conferences are online but want to be mindful that it does not become abused. Board Chair Frady recommended the Board reviews the budget and sets clear expectations.	Review budget at Finance Committee and propose expectations for Board members to report on the education/conference.	Commissioners Coppock and McMahan and Secretary Herrin	01.19.22 Finance Committee Meeting
New Business • Resolution 21-43- Approving the Purchase of the Network Redesign	The Board fully supported approving the resolution.	Secretary Herrin made a motion to approve Resolution 21-43 and Commissioner Schumaker seconded. The motion passed unanimously.		
• Resolution 21-44-	Superintendent Everett presented that the Hospital continues to	Secretary Herrin made a motion to		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Approving the Second 2021 Retention Bonus Methodology	experience difficultly in recruiting staff, as well as retaining with the contracted rates in the market. While a retention bonus is a short-term fix, the Hospital wants to recognize staff who continue to serve Arbor Health. The Board noted employees are our number one asset, we will know when bonuses are no longer needed; however, in order to continue providing services we need to value our staff. Superintendent Everett explained that funding will be out of operations but given our model some will be absorbed through the cost report and/or we can use PPP funds.	approve Resolution 21-44 and Commissioner Coppock seconded. The motion passed unanimously.		
• New Third Party Administrator for Flexible Spending Account & Health Reimbursement Arrangement Plans	Superintendent Everett noted this is part of our benefit package and there are no changes other than changing administrators. These documents will be effective 01.01.22. Administration will present via resolution in January 2022.	HRA & FSA Resolutions will be coming for approval in January.	Executive Assistant Garcia and CHRO Kelly	01.26.22 Regular Board Meeting
• 2022 Organization of the Board & New Commissioner Orientation	Board Chair Frady noted the Board will elect new officers and appoint committee assignments in January. Secretary Herrin will assume as chair in January until a new chair is elected. Superintendent Everett will schedule orientation for Laura and Kim, as well as technology will be assigned.	Add 2022 Organization of the Board to the January board meeting agenda. Schedule new commissioner orientation in January.	Executive Assistant Garcia Executive Assistant Garcia	01.26.22 Regular Board Meeting 01.26.22 Regular Board Meeting
Superintendent Report	Superintendent Everett noted the District may have a lead for a clinic in Packwood. Administration will close out the 2021 measures and present at the February board meeting.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	Superintendent Everett presented the draft 2022 measures and will continue to refine as we will use baselines from historical information on some of the upcoming measures. This is linked to at risk compensation.			
Meeting Summary & Evaluation	Superintendent Everett highlighted the decisions made and action items.			
Adjournment	Secretary Herrin moved and Commissioner Coppock seconded to adjourn the meeting at 5:52 p.m. The motion passed unanimously.			

Respectfully submitted,

Tom Herrin, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
December 22, 2021, at 12:00 p.m.
Via Zoom

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Reading the Mission & Vision Statements	Commissioner Coppock called the meeting to order via Zoom at 12:01 p.m. Commissioner(s) Present in Person or via Zoom: ☒ Tom Herrin, Secretary ☒ Craig Coppock, Commissioner Committee Member(s) Present in Person or via Zoom: ☐ Shana Garcia, Executive Assistant ☒ Richard Boggess, CFO ☒ Leianne Everett, Superintendent ☐ Marc Fisher, Community Member ☐ Clint Scogin, Controller ☒ Sherry Sofich, Revenue Cycle Director ☒ Sara Williamson, CNO/CQO			
Approval or Amendment of Agenda	No amendments noted.	Secretary Herrin made a motion to approve the agenda and CFO Boggess seconded. The motion passed unanimously.		
Conflicts of Interest	Commissioner Coppock asked the Committee to state any conflicts of interest with today's agenda.	None noted.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Consent Agenda	Commissioner Coppock announced the following in consent agenda up for approval: 1. Review of Finance Minutes – November 17, 2021 2. Revenue Cycle Update 3. Board Oversight Activities 4. Financial Statements- November	Secretary Herrin made a motion to approve the consent agenda and CFO Boggess seconded. The motion passed unanimously.		
Old Business • Financial Department Spotlight	Commissioner Coppock reminded the committee that the department spotlights will resume in January 2022.			
• Small Business Administration (SBA) Paycheck Protection Program (PPP) Loan Forgiveness	North Cascade Bank, part of Glacier Bank, notified Arbor Health that the SBA forgave $2,697,915.00 of the $2,850,600.00 loan. CFO Boggess has already challenged the $152,685.00 that was not forgiven. CFO Boggess suspects that the unforgiven portion is due to the loan issuance being higher than allowed. The repayment schedule has been delayed to March 2022 due to appealing the outstanding balance.	CFO Boggess will provide an update on the appeal of the unforgiven amount of the loan ($152,685.00)	CFO Boggess	01.19.22 Finance Committee Meeting
New Business • CPA Firm Audit in Lieu of the State Auditor's Office Audit	Arbor Health was officially notified that the Office of the Washington State Auditor has accepted DZA's audit report.			
• Petty Cash Drawer – Morton Clinic	A new cash drawer is needed due to the opening of the Rapid Clinic. CNO Williamson questioned account #10145, Petty Cash – Resident Trust. With the closing of the Custodial Program, this is no longer needed.	The Finance Committee supported requesting the Board's approval of a resolution at the Regular Board Meeting. CFO Boggess will investigate deactivating account #10145, Petty Cash – Resident Trust.	Executive Assistant Garcia CFO Boggess	01.26.22 Regular Board Meeting 01.26.22 Regular Board Meeting

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
• Amerigroup Quality Contract	Arbor Health partners with two other facilities in a value-based reimbursement program with Amerigroup. We will be receiving funds from the shared savings of $18,281.00 This will be evenly split by the 3 hospitals in the program The new Amerigroup program will drop the quality metrics and only have a per member per month payment.			
• Medicaid Rate Adjustment for Rural Health Clinics (RHCs)	Arbor Health filed for a rate review due to the addition of behavioral health services within our RHCs. This review resulted in substantial increases in the reimbursement rates of all three RHCs. This should result in an increase of approximately $300,000 of 2021 revenue to be paid in 2022. This rate will not change unless we have a future change in scope of services. Current claims are being held to process under the new rates, and Days in AR will move up by 2-3 days at year end.	CFO Boggess to report at a future Finance Committee meeting the progress of claims paid under the new rates.	CFO Boggess	01.19.22 Finance Committee Meeting
• No Surprises Act	The act is a new federal standard to protect the patient from balance billing, effective 01/01/2022. This focuses on out-of-network services we provide and for which the patient would be billed. Out-of-network services tend to result in more out-of-pocket costs for patients. Arbor Health is compliant.			
• Hospital 501r Discounts	The District completed the annual process of determining the 501r discount for 2022. This term is sometimes referred to as "amounts generally billed" There was no change to the method as it is prescribed by regulation. This resulted in a 2022 501r discount of 35%, down from 2021's rate of 37%.			
• Surplus or Dispose of Certain Property	The list of assets was presented.	The Finance Committee supported requesting the Board's approval of a resolution at the	Executive Assistant Garcia	01.26.22 Regular Board Meeting

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
		Regular Board Meeting.		
Meeting Summary & Evaluation	CFO Boggess highlighted the decisions made and the action items that need to be taken to the entire board for approval.			
Adjournment	Commissioner Coppock adjourned the meeting at 12:38 pm.			

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
January 19, 2022, at 12:00 p.m.
Via Zoom

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Call to Order Roll Call Reading the Mission & Vision Statements	Commissioner Coppock called the meeting to order via Zoom at 12:00 p.m. Commissioner(s) Present in Person or via Zoom: ☒ Tom Herrin, Secretary ☒ Craig Coppock, Commissioner Committee Member(s) Present in Person or via Zoom: ☒ Shana Garcia, Executive Assistant ☒ Richard Boggess, CFO ☒ Leianne Everett, Superintendent ☐ Marc Fisher, Community Member ☒ Clint Scogin, Controller ☒ Sherry Sofich, Revenue Cycle Director ☒ Sara Williamson, CNO/CQO			
Approval or Amendment of Agenda	Superintendent Everett requested to add ED Physician Salary Analysis to New Business.	Secretary Herrin made a motion to approve the amended agenda and Superintendent Everett seconded. The motion passed unanimously.		
Conflicts of Interest	Commissioner Coppock asked the Committee to state any conflicts of interest with today's amended agenda.	None noted.		

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Consent Agenda	Commissioner Coppock announced the following in consent agenda up for approval: 1. Review of Finance Minutes – December 22, 2021 2. Revenue Cycle Update 3. Board Oversight Activities 4. Financial Statements-December	Secretary Herrin made a motion to approve the consent agenda and CFO Boggess seconded. The motion passed unanimously.		
Old Business • Financial Department Spotlight-340B Program	CFO Boggess noted: 1. Started the 340B journey in 2019 with the intent of excess funds to support to ambulance transfer program. 2. Kirks Pharmacy has withdrawn leaving Walgreen's and CVS partnerships in place. 3. Program is experiencing revenue decline due to drug manufacturer withdrawal and cost issues with Kirks Pharmacy. 4. Drug manufactures continue to withdraw product(s) from program due to hospital refusing to provide PHI to manufacturers. 5. American Hospital Association has asked Congress to intervene. Current activity consists of judicial wrangling by HHS, CMS and drug manufacturers. 6. Reported a net income of $160,018 for 2021.			
• Disaster Funding	CFO Boggess noted: 1. A summary of funding received, reported by various entities and the next step with each entity. 2. Received two new rounds of funding in fourth quarter. Both on the Balance sheet; American Rescue Plan-$625,525 and HHS Provider Relief Fund Phase 4-$80,634. Based on future guidance these funds will be recognized.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
New Business • ED Physician Salary Analysis	Superintendent Everett noted: 1. ED Providers are dissatisfied. 2. Conditions of Participation (COP) require Critical Access Hospitals (CAH) to have 24/7 ED's. 3. Arbor Health utilizes a mix of employed and contracted physicians with complex pay structures. 4. Market salary data from MGMA was reviewed and a proposal presented to the physicians. The proposal was rejected. 5. A salary survey of our Rural Collaborative partners showed rates considerably above the MGMA rates. This information was reviewed by the committee. 6. Management is proposing a 43% rate increase effective 02.01.22. The Finance Committee recognizes this is an essential service. Expanded discussion at the upcoming Board Meeting with the whole board.	Present the Budget Amendment-Physician Salaries & Wages Increase and request approving a resolution for the increase.	Executive Assistant Garcia	01.26.22 Regular Board Meeting
• 2021 Healthcare Insurance Review	CFO Boggess noted: 1. Presented the plan's experience through quarter 4 of 2021 with a comparison to the last three years. 2. Claim costs declined by 9.6%. 3. Four claims exceed Individual Stop Loss and the plan was under the Aggregate Stop Loss amount. 4. Higher utilization this year and employees continue to use the AH Hospital and Clinics. 5. Brokerage and Administration fees have remained consistent. 6. AH is the second preferred provider by claim payment at 17% only behind Providence Centralia in first with 23% of plan payments.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
• Debt Capacity & Long-Term Debt Schedule	CFO Boggess noted: 1. The District's current debt structure, taxing limits, amounts outstanding and future payments. 2. Operating leases are not listed on the Balance Sheet, but new accounting standard will require the inclusion of leases, with related assets onto the Balance Sheet effective after the Public Health Emergency. 3. Management will identify opportunities to use the Tax and Bond structure to improve the Districts capabilities in the future.			
• Changes in Medicare Payment Structure	CFO Boggess noted: 1. In Quarter 4, the District completed and filed the Interim Rate Review (IRR) and filed it with Noridian. The interim rate review results as completed by Noridian indicates Medicare overpaid the District by $989,000. We have been expecting this outcome and already have $1,200,000 reserved on the Balance Sheet. This reduces cash but does not affect the Income Statement. Timely payment was made, as it has been expected and communicated throughout 2021. 2. Due to the overpayment condition, Noridian will adjusts the payment rates down by 20%. Superintendent Everett acknowledged the payment was above her spending authority, but it is normal business activity, as well as the right thing to do for the District.	The Finance Committee supported requesting the Board's approval of a resolution at the Regular Board Meeting.	Executive Assistant Garcia	01.26.22 Regular Board Meeting
• NW Momentum Accountable Care Organization	CFO Boggess noted: 1. AH continues to participate in the NW Momentum ACO – Next Generation ACO. That program stopped the end of December 2021.			

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
	2. Current projections from NW Momentum indicates a positive outcome for the participants. 3. The program will reconcile costs in 2022 and produce a final result with an expected positive outcome in Q42022 or Q12023. There has been no revenue or loss recognized with this program to date. 4. The next ACO program is called Direct Contracting. AH is proposing to join this program with the same partners from the Rural Collaborative. 5. This program requires an escrow payment of $517,496 to participate. Our partner NW Momentum will cover 50% of the amount. AH will need to provide $258,748. The Board approved RES 20-31; however, the District was never required to make a payment in the previous program. Further discussion at the Board about this will be necessary. 6. The goal of an ACO is to increase quality and value of care at a while reducing cost of delivering care. Superintendent Everett noted Elya Prystowsky with the Rural Collaborative will present this topic at the Regular Board Meeting.			
• Surplus or Dispose of Certain Property	CFO Boggess presented the list of assets.	The Finance Committee supported requesting the Board's approval of a resolution at the Regular Board Meeting.	Executive Assistant Garcia	01.26.22 Regular Board Meeting
Meeting Summary & Evaluation	CFO Boggess highlighted the decisions made and the action items that need to be taken to the entire board for approval.	Add HIM to Acronym list	Executive Assistant Garcia	02.16.22 Finance Committee Meeting

AGENDA	DISCUSSION	ACTION	OWNER	DUE DATE
Adjournment	Commissioner Coppock adjourned the meeting at 1:11 pm.			

WARRANT & EFT LISTING NO. 2021-12

RECORD OF CLAIMS ALLOWED BY THE BOARD OF LEWIS COUNTY COMMISSIONERS

The following vouchers have been audited, charged to the proper account, and are within the budget appropriation.

CERTIFICATION

I, the undersigned, do hereby certify, under penalty of perjury, that the materials have been furnished, as described herein, and that the claim is a just, due and unpaid obligation against LEWIS COUNTY HOSPITAL DISTRICT NO. 1 and that I am authorized to authenticate and certify said claim.

Signed:

Richard Boggess, CFO

We, the undersigned Lewis County Hospital District No. 1 Commissioners, do hereby certify that the merchandise or services hereinafter specified has been received and that total Warrants and EFT's are approved for payment in the amount of

$4,348,013.30 this 26th day

of January 2022

Secretary, Tom Herrin

Commissioner, Craig Coppock

Commissioner, Wes McMahan

Commissioner, Kim Olive

Commissioner, Laura Richardson

SEE WARRANT & EFT REGISTER in the amount of $4,348,013.30 dated December 1, 2021 – December 31, 2021.

Routine A/P Runs

Warrant No.	Date	Amount	Description
123734 - 123738	6-Dec-2021	663,608.07	CHECK RUN
123739 - 123792	3-Dec-2021	271,454.37	CHECK RUN
123793 - 123812	13-Dec-2021	124,280.22	CHECK RUN
123813 - 123852	10-Dec-2021	61,049.88	CHECK RUN
123853 - 123881	20-Dec-2021	1,128,918.24	CHECK RUN
123882 - 123973	17-Dec-2021	215,351.35	CHECK RUN
123974	1-Dec-2021	16,084.51	CHECK RUN
123975	1-Dec-2021	10,486.53	CHECK RUN
123976	1-Dec-2021	9.98	CHECK RUN
123977	7-Dec-2021	110.10	CHECK RUN
123978	14-Dec-2021	5.48	CHECK RUN
123979	21-Dec-2021	19.52	CHECK RUN
123980 - 124038	23-Dec-2021	199,130.98	CHECK RUN
124039 - 124047	24-Dec-2021	183,179.61	CHECK RUN
124048	1-Dec-2021	123.36	CHECK RUN
124049	15-Dec-2021	9,566.65	CHECK RUN
124050	27-Dec-2021	30,342.59	CHECK RUN
124059	17-Dec-2021	3,953.58	CHECK RUN
124060	28-Dec-2021	3.16	CHECK RUN
124061	31-Dec-2021	981.00	CHECK RUN
Total - Check Runs		$ 2,918,659.18	

Error Corrections - in Check Register Order

Warrant No.	DATE VOIDED	Amount	Description
1158	17-Dec-2021	(176,210.16)	VOID CHECK
123908	17-Dec-2021	(2,848.95)	VOID CHECK
123973	17-Dec-2021	(150.00)	VOID CHECK
TOTAL - VOIDED CHECKS		$ (179,209.11)	

COLUMBIA BANK CHECKS, EFT'S & VOIDS	$ 2,739,450.07

Eft	Date	Amount	Description
1158	10-Oct-2021	176,210.16	IRS
1159	10-Oct-2021	176,210.16	IRS
PAYROLL	20-Dec-2021	485,783.86	PAYROLL
1160	24-Dec-2021	190,472.32	IRS
PAYROLL	24-Dec-2021	579,886.73	PAYROLL
TOTAL EFTS AT SECURITY STATE BANK		$ 1,608,563.23	

TOTAL CHECKS, EFT'S, &TRANSFERS	$ 4,348,013.30

Documents Awaiting Board Ratification 1.26.22		
	LCHD No. 1's Policies, Procedures & Plans:	**Departments:**
1	C13: Guidelines for Distribution of P	Nutrition Services
2	C1: Diet Orders	Nutrition Services
3	No Surprise Billing	Business Office

In order to access the above documents you will need to log into Lucidoc. Once you have logged into Lucidoc, on the top toolbar click "My Meetings" and select the upcoming QIO meeting date that's highlighted in green to see the agenda with documents needing to be approved. You are able to view the documents once in the agenda. If the date is highlighted in yellow that means the agenda has not been released yet.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION DECLARING TO
SURPLUS OR DISPOSE OF CERTAIN
PROPERTY

RESOLUTION NO. 22-01

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

That the equipment and supplies listed on Exhibit A, attached hereto and by this reference incorporated herein, are hereby determined to be no longer required for hospital purposes. The Administrator is hereby authorized to surplus, dispose and/or trade in of said property upon such terms and conditions as are in the best interest of the District.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of January 2022, the following commissioners being present and voting in favor of this resolution.

_____
Craig Coppock, Commissioner

_____
Tom Herrin, Secretary

_____
Kim Olive, Commissioner

_____
Wes McMahan, Commissioner

_____
Laura Richardson, Commissioner

DISPOSAL/SURPLUS PERSONAL PROPERTY

EXHIBIT A

DATE	DESCRIPTION	DEPARTMENT	PROPERTY #	DISPOSITION	REASON
12/2021	Xerox Scanner	IT	6113	DISPOSAL/SURPLUS	OBSOLETE
12/2021	TV	IT	5439	DISPOSAL/SURPLUS	OBSOLETE
12/2021	LAPTOP SURFACE	IT	6127	DISPOSAL/SURPLUS	OBSOLETE
12/2021	LAPTOP HP	IT	6232	DISPOSAL/SURPLUS	OBSOLETE
12/2021	LAPTOP SURFACE	IT	6114	DISPOSAL/SURPLUS	OBSOLETE
12/2021	LAPTOP SURFACE	IT	6137	DISPOSAL/SURPLUS	OBSOLETE
12/2021	LAPTOP HP	IT	6229	DISPOSAL/SURPLUS	OBSOLETE
12/2021	DESKTOP HP	IT	5871	DISPOSAL/SURPLUS	OBSOLETE
12/2021	DESKTOP HP	IT	5942	DISPOSAL/SURPLUS	OBSOLETE
12/2021	DESKTOP HP	IT	5838	DISPOSAL/SURPLUS	OBSOLETE
12/2021	DESKTOP HP	IT	5692	DISPOSAL/SURPLUS	OBSOLETE
12/2021	DESKTOP HP	IT	5705	DISPOSAL/SURPLUS	OBSOLETE
12/2021	DESKTOP HP	IT	5701	DISPOSAL/SURPLUS	OBSOLETE
12/2021	LAPTOP SURFACE	IT	6221	DISPOSAL/SURPLUS	OBSOLETE
12/2021	DESKTOP HP	IT	5944	DISPOSAL/SURPLUS	OBSOLETE
12/2021	SONICWALL	IT	1919	DISPOSAL/SURPLUS	OBSOLETE
12/2021	SWITCH	IT	1903	DISPOSAL/SURPLUS	OBSOLETE
12/2021	SWITCH	IT	6193	DISPOSAL/SURPLUS	OBSOLETE
12/2021	NETGEAR SWITCH	IT	6124	DISPOSAL/SURPLUS	OBSOLETE
12/2021	NETGEAR SWITCH	IT	6146	DISPOSAL/SURPLUS	OBSOLETE
12/2021	SWITCH	IT	5638	DISPOSAL/SURPLUS	OBSOLETE
12/2021	LAPTOP LENOVA	IT	5912	DISPOSAL/SURPLUS	OBSOLETE
12/2021	DISHERWASHER	DIETARY	5329	DISPOSAL/SURPLUS	OBSOLETE
12/2021	COMPACT BOOSTER WATER HEATHER	DIETARY	6263	DISPOSAL/SURPLUS	OBSOLETE

DISPOSAL/SURPLUS PERSONAL PROPERTY

EXHIBIT A

DATE	DESCRIPTION	DEPARTMENT	PROPERTY #	DISPOSITION	REASON
11/18/2021	Auto Stereo System	PT	5850	DISPOSAL/SURPLUS	OBSOLETE

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
MEDICARE CMS PAYMENT RESOLUTION NO. 22-02

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

Approving the settlement payment of $989,000 to Medicare for the fiscal year 2021 from operating cash.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of January 2022, the following commissioners being present and voting in favor of this resolution.

_____
Craig Coppock, Commissioner

_____
Tom Herrin, Secretary

_____
Kim Olive, Commissioner

_____
Wes McMahan, Commissioner

_____
Laura Richardson, Commissioner

noridian
Healthcare Solutions

PO Box 6722
Fargo, ND 58108-6722

December 29, 2021

FIRST REQUEST
CERTIFIED MAIL

RICHARD BOGGESS CFO
ARBOR HEALTH MORTON HOSPITAL
PO BOX 1138
MORTON WA 98356-0019

RE: Lump Sum Adjustment and Initial Demand Letter
Provider Number: 50-1319
Fiscal Year End: December 31, 2021

Dear Mr. Boggess:

The following lump sum adjustments were calculated using data from the Provider Statistical & Reimbursement Reports (PS&Rs) that include claims paid through December 22, 2021, and the interim cost report for the period January 1, 2021 through July 31, 2021, submitted by the provider. For cost reporting purposes, these lump sum adjustments must be reported separately for each provider number listed below.

	50-1319	50-Z319
Part A	$ (253,000)	$ (507,000)
Part B	$ (229,000)	
	$ (482,000)	$ (507,000)

Total Lump Sum $ (989,000)

The total of $(989,000) should be immediately refunded in full. If you would prefer to send a check for the amount due, please contact the Provider Contact Center at (877) 908-8431.

Identify on the check what settlement the payment is to be applied to, the facility's provider number and make payable to Noridian Healthcare Solutions, Medicare A. Please mail your check to :

Part A Provider Audit - JF
Noridian Healthcare Solutions
PO Box 6722
Fargo, ND 58108-6722

If payment in full is not received by January 12, 2022, we will recoup (reduce or withhold) 100% of your Medicare payments until the overpayment amount is received or an acceptable extended repayment request is received. If you have reason to believe this withhold should not occur on January 13, 2022, you must notify Noridian Healthcare Solutions (Noridian) before January 12, 2022. We will review your documentation

but will not delay recoupment. This is not an appeal of the overpayment determination. The appeal process is detailed in the Notice of Program Reimbursement (NPR). In addition, in accordance with 42 CFR 447.30, if payment in full or an extended repayment request is not received by January 12, 2022, Noridian may request that your Federal Share of Title XIX (Medicaid) be withheld, if applicable. If this withholding is initiated it will not be removed until payment in full is received or an acceptable extended repayment request is received

We request that you refund this amount in full. If you wish to make arrangements for an Extended Repayment Schedule, according to the procedure described in the Medicare Reimbursement Bulletin, General Series No. 234, please contact us at JF-ERS@noridian.com immediately to determine if you are eligible for a repayment schedule. (See Medicare Financial Management Manual, Chapter 4 Debt Collection, Section 50). Any repayment schedule (if approved) would begin from the date of this letter and is subject to interest charges of 9.375%. If you do not contact us, your interim payments will be withheld beginning January 13, 2022, and applied towards the outstanding overpayment balance. Any amount that is withheld will not be refunded.

To avoid delay due to mailing, you may email your statement to JF-ERS@noridian.com. Please use a subject of ERS Request - 50-1319 FYE 12/31/2021.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request you notify us immediately of a bankruptcy so we may coordinate with both the Centers for Medicare and Medicaid Services and the Department of Justice to ensure we handle your situation properly. If possible, when notifying us of a bankruptcy, please include the name under which the bankruptcy is filed and the district in which the bankruptcy is filed.

We expect to hear from you shortly.

Sincerely,

/s/

Provider Audit and Reimbursement Department
Noridian Healthcare Solutions

JW

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE PETTY CASH DRAWERS & CUSTODIANS OF THE DISTRICT

RESOLUTION NO. 22-03

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

To approve the District's petty cash drawers, along with the custodians responsible for the drawers.

Account & Location Base	Amount	Custodian
101421 Cash drawer - ER	$ 200.00	Revenue Cycle Director
101434 Cash drawer - Admitting 2	$ 200.00	Revenue Cycle Director
101435 Cash drawer - Admitting	$ 200.00	Revenue Cycle Director
101436 Petty Cash - Materials Mgmt	$ 100.00	Controller
101440 Cash drawer - Randle Clinic	$ 300.00	Randle Clinic Manager
101441 Cash drawer – Mossyrock Clinic	$ 100.00	Mossyrock Clinic Manager
101442 Petty Cash – Mossyrock Clinic	$ 200.00	Mossyrock Clinic Manager
101465 Cash drawer – Dietary	$ 200.00	Dietary Manager
101470 Petty Cash – Kitchen	$ 200.00	Dietary Manager
101471 Cash Drawer - Gift Shop	$ 260.00	Gift Shop Manger
101472 Cash Drawer - Morton Clinic	$ 100.00	Morton Clinic Manager
101473 Cash Drawer-Rehabilitation Svs	$ 100.00	Rehabilitation Services Manager
101474 Cash Drawer – Rapid Care Clinic	$ 200.00	Morton Clinic Manager

This resolution supersedes RES 21-33.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of January 2022, the following commissioners being present and voting in favor of this resolution.

_____
Craig Coppock, Commissioner

_____
Tom Herrin, Secretary

_____
Kim Olive, Commissioner

_____
Wes McMahan, Commissioner

_____
Laura Richardson, Commissioner

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Richard Boggess
Date: January 12, 2022
Subject: Resolution 22-03-Approving the Petty Cash Drawers & Custodians of the District

Each year Arbor Health (AH) provides a listing of all petty cash drawers used in the organization. Following is the list:

Account & Location Base	Amount	Custodian
101421 Cash drawer - ER	$ 200.00	Revenue Cycle Director
101434 Cash drawer - Admitting 2	$ 200.00	Revenue Cycle Director
101435 Cash drawer - Admitting	$ 200.00	Revenue Cycle Director
101436 Petty Cash - Materials Mgmt	$ 100.00	Controller
101440 Cash drawer - Randle Clinic	$ 300.00	Randle Clinic Manager
101441 Cash drawer – Mossyrock Clinic	$ 100.00	Mossyrock Clinic Manager
101442 Petty Cash – Mossyrock Clinic	$ 200.00	Mossyrock Clinic Manager
~~101455 Petty Cash - Resident Trust~~	~~$ 300.00~~	~~LTC supervisor~~
101465 Cash drawer – Dietary	$ 200.00	Dietary Manager
101470 Petty Cash – Kitchen	$ 200.00	Dietary Manager
101471 Cash Drawer - Gift Shop	$ 260.00	Gift Shop Manger
101472 Cash Drawer - Morton Clinic	$ 100.00	Morton Clinic Manager
101473 Cash Drawer-Rehabilitation Svs	$ 100.00	Rehabilitation Services Manager

Actions requested of the Commissioners.
Authorize:

101474 – Cash Drawer – Rapid Care Clinic	$ 200.00	Morton Clinic Manager

Deauthorize:

101455 Petty Cash - Resident Trust	$ 300.00	LTC supervisor

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION ADOPTING THE
FLEXIBLE SPENDING ACCOUNT PLAN (FSA) RESOLUTION NO. 22-04

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

On this date, the Commissioners of Lewis County Hospital District No. 1 (Employer and Plan Administrator) did meet to discuss the implementation of the Lewis County Hospital District No. 1 Flexible Spending Account, to be effective 01/01/22. Let it be known that the following resolution was adopted by the Commissioners of Lewis County Hospital District No. 1 and that this resolution has not been modified or rescinded as of the date hereof;

RESOLVED, that the form of amended Flexible Spending Plan including a Dependent Care Flexible Spending Account and Health Flexible Spending Account effective January 1, 2022, presented to this meeting is hereby approved and adopted and that the duly authorized agents of the Employer are hereby authorized and directed to execute and deliver to the Plan Administrator one or more counterparts of the Plan.

RESOLVED, that the Plan Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

RESOLVED, that the duly authorized agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Cafeteria Plan by delivering to each employee a copy of the summary description of the Plan in the form of the Summary Plan Description presented to this meeting, which form is hereby approved.

The undersigned certifies that attached hereto are true copies of the Plan Document for Lewis County Hospital District No. 1 Flexible Spending Account approved and adopted in the foregoing resolution. The undersigned further certifies and attests that the above resolution was made with the consent of the Board of Commissioners:

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of January 2022, the following commissioners being present and voting in favor of this resolution.

_____ _____
Craig Coppock, Commissioner Tom Herrin, Secretary

_____ _____
Kim Olive, Commissioner Wes McMahan, Commissioner

_____
Laura Richardson, Commissioner

LEWIS COUNTY HOSPITAL DISTRICT #1 DBA ARBOR HEALTH

FLEXIBLE SPENDING ACCOUNT

SUMMARY PLAN DESCRIPTION

01/01/2022

LEWIS COUNTY HOSPITAL DISTRICT #1 DBA ARBOR HEALTH
FLEXIBLE SPENDING ACCOUNT
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

INTRODUCTION

Lewis County Hospital District #1 dba Arbor Health (the "Company") established the Lewis County Hospital District #1 dba Arbor Health Flexible Spending Account (the "Plan") effective 01/01/2007. This summary describes the Plan as amended and restated effective 01/01/2022. The Plan is a cafeteria plan that provides an eligible employee with the opportunity to choose among benefits offered under the Plan.

This summary supersedes all previous summaries of the Plan. Although the purpose of this document is to summarize the more significant provisions of the Plan, it is only a summary - the terms of the Plan document ultimately govern the operation and administration of the Plan. The Company and any employer who has adopted the Plan is referred to in this document as the "Company".

ELIGIBILITY

You are an "Eligible Employee" if you are an employee of the Company or any affiliate who has adopted the Plan. The age and service requirements for the Plan are further modified by the following: Employees eligible for the Medical Insurance benefit offered by Lewis County Hospital District #1 dba Arbor Health, are eligible for the Health FSA.

However, you are not an "Eligible Employee" if you are any of the following:

- A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.

If you are eligible to participate in the Company-sponsored group health plan, then you are eligible to participate in the Health Flexible Spending Account, even if you do not elect to participate in the Company-sponsored group health plan.

ELECTION PROCEDURES

You may elect to participate in the Benefits under the Plan within 30 days after your eligibility date (or a shorter period if established by the Plan Administrator).

If you do not enroll in the Plan upon your initial eligibility, you may enroll during the enrollment period established by the Plan Administrator. Your election will be effective as of the first day of the Plan Year following the enrollment period.

You may also enroll in the Plan upon a change in status event as described below.

To enroll in the Plan, you may need to submit a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. If, as of the start of a Plan Year, you have not submitted a completed election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

If you fail to submit an election form, prior year elections will automatically apply to the following benefits: Premium Conversion Account. An election to participate in the Plan is generally irrevocable for the Plan Year.

You may not change your election during a Plan Year unless you experience a change in status. Your change in election must be on account of and correspond with a change in status that affects your eligibility for coverage under the Plan.

Depending on the Benefit, a "change in status" includes:

- Change in your marital status.
- Change in the number of your dependents.
- Change in your employment status or the employment status of your spouse or dependents.
- Your dependent satisfies or ceases to satisfy eligibility requirements.
- Change in your place of residence.
- Commencement or termination of an adoption proceeding.
- Court judgment, decree, or order.
- Entitlement to Medicare or Medicaid by you, your spouse, or your dependent.
- Significant cost or other coverage changes.
- You change coverage under another cafeteria plan.
- You take leave under the FMLA.
- You lose coverage under the group health plan due to a reduction in hours.
- You are eligible to enroll in a qualified health plan through the Marketplace.

BENEFITS

Contributions pertaining to a Benefit will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes. Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

If you are a highly paid employee or an owner of your Company, federal law may impose limits on your behalf to participate in the Plan and/or the benefits you may receive from the Plan. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify your election in order to assure compliance with such requirements or limitations.

Premium Conversion Account

The Plan will automatically establish a Premium Conversion Account in your name when you become an Employee for the payment of premiums under the Company-sponsored benefits/contracts listed below unless you affirmatively elect to not establish or contribute to such account. Your Premium Conversion Account will be credited with amounts withheld from your compensation. The amount of the contribution to your Premium Conversion Account is equal to the amount of your portion of the premium due for the following benefits/contracts:

- Company Health
- Company Dental
- Company Vision

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts sponsored by the Company as permitted by applicable law.

If you affirmatively elect not to participate in the Premium Conversion Account for a Plan Year, you will not be enrolled unless and until you elect to participate in the Premium Conversion Account as described in the "Election Procedures" above. Contributions to the Premium Conversion Account are not subject to federal income tax or social security taxes.

In the event of a conflict between the terms of this Plan and the terms of the applicable contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Flexible Spending Account (Health FSA)

The following Health Flexible Spending Account is available under the Plan:

- General Purpose Health FSA

General Purpose Health FSAs may only be used to reimburse for qualifying medical expenses during the Plan Year.

If you are eligible, you may elect to contribute to a Health FSA in accordance with the "Election Procedures" described above.

Health FSA Eligibility

Please be aware that there are some limitations on your eligibility to participate in Health FSAs. If you are an Eligible Employee, you are eligible to contribute to a Health FSA. However, if you are not eligible to participate in the Company-sponsored group health plan, then you are not eligible to participate in a Health FSA.

Health FSA Contributions

Your Health FSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your General Purpose Health FSA and/or HSA-Compatible Health FSA is the maximum amount permitted under the tax code ($2,850 for 2022). The Company will not make additional contributions to your General Purpose Health FSA on your behalf.

Health FSA Eligible Expenses/Reimbursement

You will be entitled to receive reimbursement from your General Purpose Health FSA for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone you may claim as a dependent on your federal tax return and also include a child until the last day of the calendar year in which they turn 26. The entire annual amount you elect to contribute for the Plan Year to your Health FSA, less any reimbursements already distributed from your Health FSA, will be available for reimbursement throughout the Plan Year.

You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your Health FSA. Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return. Health insurance premiums are not an eligible expense for the Health FSA.

You will not be reimbursed for any expenses that were (1) incurred before you are eligible to participate in the Health FSA; (2) incurred after you have become ineligible to participate in the Health FSA and are attributable

to a tax deduction you took in a prior taxable year; or (3) covered, paid, or reimbursed from another source. Your claim for reimbursement must include substantiation that the Plan Administrator or Claims Administrator considers sufficient for determining that the claim constitutes an expense eligible for reimbursement under the Plan.

You must submit claims for reimbursement from your General Purpose Health FSA no later than 03/31. Any amounts remaining in your Health FSA after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the Company for any reason during the Plan Year, your contributions to your FSA will end as of your date of termination. You may submit claims for reimbursement from your FSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your Health FSA no later than 90 days after the date your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted prior to this date have been processed.

Dependent Care Assistance Plan Account (DCAP)

A Dependent Care Assistance Plan Account may be used to reimburse expenses incurred for the care of a qualifying dependent. If you are eligible, you may elect to contribute to a DCAP Account in accordance with the "Election Procedures" described above.

DCAP Contributions

Your DCAP Account will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount that you may contribute each year to your DCAP Account is the maximum amount permitted under the tax code ($5,000 for 2022, $2,500 if you are married and filing separately.)

The Company will not make additional contributions to your DCAP Account on your behalf.

DCAP Eligible Expenses/Reimbursement

The amount available for reimbursement is the balance in your DCAP Account at the time the reimbursement request is received by the Plan Administrator or Claims Administrator. You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your DCAP Account. Eligible expenses generally include those that you incur in order to be gainfully employed and for the care of (i) your dependent who is under age 13, or (ii) your spouse or dependent who lives with you and who is physically or mentally incapable of caring for themselves. Expenses incurred for overnight camp are not eligible for reimbursement. A dependent is generally someone who you may claim as a dependent on your federal tax return.

You must submit claims for reimbursement from your DCAP Account no later than 03/31 following the Plan Year. Any amounts remaining in your DCAP Account after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the Company for any reason during the Plan Year, your contributions to your DCAP Account will end as of your date of termination. You may submit claims for reimbursement from your

DCAP Account for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your DCAP Account no later than 90 days after the date your employment terminates. Any balance remaining in your DCAP Account will be forfeited after claims submitted prior to this date have been processed.

CLAIMS PROCEDURES

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to TPSC Benefits at:

Address: PO Box 1894 Tacoma WA 98401
Phone number: 800-426-9786

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Claims for Plan Benefits (except for Health FSAs)

You must file a claim for benefits under this Plan in accordance with the Plan Administrator's guidelines. If your claim does not include enough information to process the claim, you will be given an opportunity to provide the missing information. You may designate an authorized representative by providing written notice of the designation to the Plan Administrator.

You may apply for benefits under the Plan by completing and filing a claim with the Plan Administrator. Your claim must include all information and evidence that the Plan Administrator deems necessary to evaluate the merit of your claim and to make any necessary determinations on your claim. The Plan Administrator may request any additional information from you as necessary to evaluate the claim.

Claims for Health FSA Benefits

If you file a claim for benefits from your Health FSA and that claim is denied, the Plan Administrator will notify you within a reasonable period of time, but no later than 30 days after the Plan Administrator received the claim. The Plan Administrator may notify you, prior to the expiration of this 30-day period, of the need to extend the period by up to 15 days due to matters beyond its control. In such case the Plan Administrator will notify you of the circumstances requiring the extension of time and the date by which the Plan Administrator will notify you of its decision. If the extension is necessary because you did not submit information necessary to decide the claim, the notice of extension will describe the required information, and you will have at least 45 days from the day you receive the notice to provide the specified information.

If your claim is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for the denial, (B) the Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA after following the Plan's claims procedures. The notice will also include (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or (2) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If you wish to appeal the denial of a claim, you must file an appeal with the Plan Administrator on or before the 180th day after you receive the Plan Administrator's notice that the claim has been denied. You will lose the right to appeal if the appeal is not made within this 180-day period. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will be provided, upon request and free of charge, documents and other information relevant to your claim. Your appeal may also include any comments, statements or documents that you desire to provide. The Plan Administrator will consider the merits of your presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator will:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any denial that is based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the denial; and

(D) Provide that the health care professional engaged for purposes of a consultation under (B) above will be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify you of the Plan's benefit determination on review within 60 days after receipt by the Plan of your request for review of the denial.

Denial of Appeal. If your appeal is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for such denial, (B) the Plan provisions on which the denial is based, (C) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (D) a statement describing your right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

Exhaustion of Remedies; Limitations Period for Filing Suit. Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Benefits Provided under Contracts. Please see the underlying contracts for any additional claims and reimbursement rules under those contracts.

Debit/Credit Cards
Lewis County Hospital District #1 dba Arbor Health will provide you with a debit/credit and/or other stored-value card for purposes of making purchases that are eligible for reimbursement from your Health Flexible Spending Account and/or Dependent Care Assistance Plan Account. The Plan Administrator will provide you with more information about these cards as well as any limitations at the time you enroll in the Plan. You do not have to use the cards and may request reimbursements as listed above.

COBRA CONTINUATION COVERAGE

If you are participating in the Health FSA and your Company is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs fewer than 20 employees, but you should contact the Plan Administrator who can inform you if the Company is a small employer not subject to COBRA and is not required to comply with these rules. Depending on your Health FSA balance at the time of the Qualifying Event (described below), you may not be eligible for COBRA continuation coverage.

Qualifying Events

You have the right to continue your coverage under the Health FSA if any of the following events results in your loss of coverage under the Health FSA:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Health FSA if any of the following events results in their loss of coverage under the Health FSA:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."
If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Health FSA for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice which explains your rights regarding COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if they are not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of their COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Health FSA;
- The date that you first become entitled to Medicare; or
- The date the Company no longer provides a Health FSA to any of its employees.

YOUR RIGHTS UNDER ERISA

As a participant in the Health FSA under this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in a plan governed by ERISA shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance

contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants in plans governed by ERISA, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Company, your union, if applicable, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining an ERISA welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for an ERISA welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of ERISA plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court if you have exhausted the Plan's claims procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court if you have exhausted the Plan's claims procedures. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue

N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MISCELLANEOUS

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits. Contact the Plan Administrator for more information under the Plan.

Unclaimed Reimbursements

Payments from the Account that are not claimed on a timely basis (for example, checks issued from the Plan that are not timely cashed) will be forfeited and returned to the Plan. Please contact your Plan Administrator about what constitutes "timely" claims of payment from the Plan.

Excess Payments/Reimbursements

If you receive an excess benefit or payment under the Plan, you must immediately repay any such excess payments/reimbursements. You must also reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable to you under this Plan.

Beneficiaries

If you die, your beneficiaries or your estate may submit claims for eligible expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents, or a representative of your estate.

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Loss of Benefit

You may lose all or part of your Account(s) under the Plan if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

Non-Alienation of Benefits

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a

beneficiary to receive benefits under the Plan in the event of your death.

Amendment and Termination of the Plan

The Company may amend or terminate the Plan at any time.

Plan Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding on all persons and parties.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Governing Law

The Plan is governed by the laws of Washington to the extent not pre-empted by Federal law.

PLAN INFORMATION

1. The Plan Sponsor and Plan Administrator is Lewis County Hospital District #1 dba Arbor Health.

2. The Plan Sponsor's and Plan Administrator's Address is PO Box 1138, Morton, Washington 98356

3. The Plan sponsor's EIN is 91-1033860

4. The Plan Sponsor and Plan Administrator's phone number is 360-496-3531

5. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code. The Health FSA Benefit under the Plan is a welfare benefit plan.

6. The Plan number is 501.

7. The Plan's designated agent for service of legal process is the Plan Sponsor. Any legal papers should be delivered to the Plan Sponsor at the address listed above. However, service may also be made upon the Plan Administrator.

8. The Plan Year is the 12-consecutive month period ending on 12/31.

9. Amount contributed by Plan Participants and the Company to the Plan are general assets of the Company. All payments of benefits under the Plan are made solely out of the general assets of the Company. The Company has no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. The Company may, in its sole discretion, set

aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION ADOPTING THE
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) RESOLUTION NO. 22-05

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

On this date, the Commissioners of Lewis County Hospital District No. 1 (Employer and Plan Administrator) did meet to discuss the implementation of the Lewis County Hospital District No. 1 Health Reimbursement Arrangement, to be effective 01/01/2022. Let it be known that the following resolution was adopted by the Commissioners of Lewis County Hospital District No. 1 and that this resolution has not been modified or rescinded as of the date hereof;

RESOLVED, that the form of Health Reimbursement Arrangement, as authorized under Section 105 of the Internal Revenue Code, presented to this meeting is hereby adopted and approved and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Plan Administrator one or more copies of the Plan.
RESOLVED, that the Plan Year shall be for a 12-month period, beginning on 01/01/2022.

RESOLVED, that the Employer shall contribute to the Plan amounts sufficient to meet its obligation under the Health Reimbursement Plan, in accordance with the terms of the Plan Document and shall notify the Plan Administrator to which periods said contributions shall be applied.

RESOLVED, that the proper officers of the Employer shall act as soon as possible to notify employees of the adoption of the Health Reimbursement arrangement by delivering to each Employee a copy of the Summary Plan Description presented to this meeting, which form is hereby approved.

The undersigned certifies that attached hereto are true copies of the Plan Document for Lewis County Hospital District No. 1 Health Reimbursement Arrangement approved and adopted in the foregoing resolution. The undersigned further certifies and attests that the above resolution was made with the consent of the Board of Commissioners:

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of January 2022, the following commissioners being present and voting in favor of this resolution.

_____ _____
Craig Coppock, Commissioner Tom Herrin, Secretary

_____ _____
Kim Olive, Commissioner Wes McMahan, Commissioner

_____
Laura Richardson, Commissioner

LEWIS COUNTY HOSPITAL DISTRICT #1 DBA ARBOR HEALTH

HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

2022-01-10

LEWIS COUNTY HOSPITAL DISTRICT #1 DBA ARBOR HEALTH
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Lewis County Hospital District #1 dba Arbor Health (the "Employer") established the Lewis County Hospital District #1 dba Arbor Health Health Reimbursement Arrangement (the "Plan") effective 01/01/2006. The Plan is a health reimbursement arrangement that is integrated with the Lewis County Hospital District #1 Health Care Benefits Plan and that provides benefits that are excludable from gross income.The Plan has been amended effective 01/01/2022.

This document is intended to summarize and explain the Plan's principal provisions. The material contained in this summary is taken from the actual legal plan document that governs the principals and provisions under which the plan operates. Therefore, if any conflict exists between this Summary Plan Description and the actual plan provisions, the terms of the legal plan document will govern.

If you have any questions regarding the information in this Summary Plan Description, contact the Plan Administrator whose name and address are included on the last page of this summary.

ELIGIBILITY FOR PARTICIPATION

Who is an Eligible Employee?

You are an "Eligible Employee" if you are eligible to receive benefits from the Lewis County Hospital District #1 Health Care Benefits Plan.

BENEFITS

What expenses are eligible for reimbursement?

You will be entitled to receive reimbursement for the following Eligible Expenses:

- Health plan deductible amounts otherwise payable by you under the group health plan.

For whom can I receive reimbursement of eligible expenses?

You will be entitled to receive reimbursement for Eligible Expenses incurred by the following Covered Persons:

- You.
- Your spouse.
- Your Dependent(s) which is someone who you may claim as a dependent on your federal tax return and also includes a child who is under the age of 27.

Reimbursement for adult children may be paid for claims incurred until the date the child attains age 26.

Your benefits will be automatically adjusted to reflect mid-year changes to the number of Covered Persons.

How will the Plan be administered?

The Period of Coverage will end on 12/31.

You may receive reimbursement, up to the following coverage-based limits, for Eligible Expenses incurred at a time when you are actively participating in the Plan.

- Participant Only: $3,150.
- Participant plus dependents: $6,300.

Eligible Expenses will be reimbursed after exceeding the following coverage-based deductible(s):

- Participant Only: $500.
- Participant plus dependents: $1,000.

After satisfying the deductible threshold, 70% of Eligible Expenses will be reimbursed.

Will I be able to carryover any unused benefits?

No, you cannot carryover any unused benefits at the end of the Period of Coverage.

REIMBURSEMENT

When must I submit claims for reimbursement?

You Participant must submit claims for reimbursement of expenses by March 31 after the Period of Coverage ends.

If you terminate participation in the HRA during the Period of Coverage, you must submit claims for reimbursement of expenses no later than 90 days after termination of participation.

Where do I submit claims?

All claims must be submitted to the Employer at PO Box 1138, Morton, Washington 98356. The Employer's telephone number is 360-496-3531.

How are claims paid?

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

The Employer intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

You must immediately repay any excess payments/reimbursements. You must reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess

amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

What information should I include with the claim?

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

When does my coverage end?

If an individual ceases to be a Covered Person under the Plan, the Plan shall reimburse Eligible Expenses incurred through the date the person ceases to be a Covered Person.

Can my beneficiaries make claims after my death?

If you die, your beneficiaries may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose provided that such beneficiary is your spouse or one or more of your dependents. If no beneficiary is specified, the Plan Administrator may pay any amount due to your spouse or, if there is no spouse, to your dependents in equal shares.

MISCELLANEOUS

Administrative Information

1. Lewis County Hospital District #1 dba Arbor Health is the Plan Sponsor and Plan Administrator.
   Address: PO Box 1138, Morton, Washington 98356
   Phone number: 360-496-3531
   Fax number: 206-623-6714
   Email: skelly@myarborhealth.org
   Employer Identification Number: 91-1033860

2. The Employer's fiscal year and the plan year end on 12/31.

3. The Plan is a welfare benefit plan which has been designated by the sponsor as its plan number is 505.

4. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation, or application of the Plan by the Plan Administrator is final, conclusive, and binding.

Amendment and Termination

The Employer may amend, terminate or merge the Plan at any time.

Loss of Benefit

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you. You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

The Employer sponsored health plan has a deductible of $!@!CoordSPDDeduct - NOT VALID (contact the health plan for information about deductibles for two or more persons).

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

LEGAL PROVISIONS

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice. You may obtain a copy of the medical child support procedures from the Plan Administrator, free of charge.

Claim Procedures for Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial, and (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator will:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that, if possible, is conducted by an appropriate representative of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate Plan representative will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant will lose the right to appeal if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, and (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. The determination rendered by the Plan Administrator shall be binding upon all parties.

YOUR RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections. You have the right to:

Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including insurance contracts.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

In addition, the people who operate the Plan have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under the Plan.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done.

If you disagree with the Plan's decision or lack thereof concerning the status of a qualified medical child support order or national medical support notice, you may file suit in Federal and/or state court.

If you have any questions about the Plan, you should contact the Plan Administrator.

OLD BUSINESS

2022 Organization & Officers of the Board of Commissioners
Effective Date: January 1, 2022

Board Leadership	Board Representation
Board Chair	
Board Secretary	

Committee	Administration Representation	Committee Chair	Board Representation
Finance	Superintendent & CFO		
QI Oversight	Superintendent & CNO/CQO		
Governance	Superintendent		
Plant Planning	Superintendent & CFO		
Strategic Planning	Superintendent	Board of Commissioners	
Compliance Committee	Superintendent & Compliance Officer		

Other Board Representation	Board Representation
Foundation	
State Representation	

2021 Organization & Officers of the Board of Commissioners (Reference)

Board Leadership	Board Representation
Board Chair	Trish Frady
Board Secretary	Tom Herrin

Committee	Administration Representation	Committee Chair	Board Representation
Finance	Superintendent & CFO	Craig Coppock	Tom Herrin
QI Oversight	Superintendent & CNO/CQO	Chris Schumaker	Wes McMahan
Governance	Superintendent	Trish Frady	Tom Herrin
Plant Planning	Superintendent & CFO	Tom Herrin	Chris Schumaker
Strategic Planning	Superintendent	Board of Commissioners	
Compliance Committee	Superintendent & Compliance Officer	Wes McMahan	Craig Coppock

Other Board Representation	Board Representation
Foundation	Wes McMahan
State Representation	Wes McMahan

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 1/19/2022
Subject: Board Development

At the August 25, 2021 Regular Board Meeting, I received support for a 12-month board education plan for 2022. This was done because 40% of the 2022 Board are brand new. Additionally, 100% of the Commissioners' governance experience in healthcare has and will be served during a pandemic, which has not allowed for face-to-face meetings nor live commissioner educational events. Because of these barriers, Kurt O'Brien has been engaged to facilitate the development of a highly functioning governance presence for our hospital district.

Kurt is an associate teaching professor with the University of Washington's Master in Healthcare Administration program. He has over twenty years of organizational development experience and over eighteen years of direct leadership experience. Also, Kurt works as an independent consultant within the state of Washington.

Arbor Health has worked with Kurt in different capacities. Several of our managers attended leadership development training with Kurt through the Rural Collaborative. Additionally, we engaged Kurt in 2020 to coach our management team through several development exercises. In 2022, we will have Kurt working on leadership development with more of our management team to develop our future executive team.

In August, the directive was to do the first five education sessions as special board meeting so as to not make the regular board meetings excessively long. However, sessions six through twelve are designed to be incorporated into our regular board meetings. Please see the proposed 2022 schedule for the first five sessions below. Please provide feedback at our January 26, 2022 meeting.

- February 21, 2022: 3:30 – 5:30 pm
- March 21, 2022: 3:30 – 5:00 pm
- April 18, 2022: 3:30 – 5:00 pm
- May 16, 2022: 3:30 – 5:00 pm
- June 20, 2022: 3:30 – 5:00 pm

Arbor Health

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 1/19/2022
Subject: NW Momentum ACO – Year 2

In 2020, the then Board approved Arbor Health entering into an accountable community of health (ACO) with other Rural Collaborative partners. This ACO is the NW Momentum ACO. At that time, we discussed that participating hospitals fund an escrow account. The escrow protects the ACO from catastrophic losses. At that time, the escrow for year one was expected not to exceed $100,000.

As we entered the ACO, we were able to waive the Year 1 escrow. The ACO's performance was successful, and Arbor Health will receive funds in 2023 for 2021's performance. Arbor Health is one of seven Rural Collaborative hospitals comprising a group within the ACO called "Rurals." The Rurals group is expected to share a 2023 payout from the ACO of $800,000 to $1.1 million.

Performance was primarily evaluated based on four metrics: Annual Wellness Visits (AWV), Inpatient Readmissions, ER Visits and IP Admissions. The Rurals met two goals, exceeding the ACO averages. On one metric, they met the goal but lagged behind the ACO average. The Rurals, along with all other groups within the ACO, failed to meet the fourth metric.

Now that we are entering Year 2, the escrow payment is expected to be funded by March 31, 2022. Arbor Health has been assessed an escrow payment of $517,496. NW Momentum will fund 50% of the escrow payment, leaving Arbor Health responsible for $258,748. Please see Richard Boggess' January 11, 2022 memo to the Finance Committee regarding the Year 2 escrow.

Additionally, Elya Prystowsky, Executive Director of the Rural Collaborative, will join us at the January 26, 2022 meeting. We will answer as many questions as possible. This topic will be brought to the February 23, 2022 Board meeting with a resolution to make the escrow payment prior to the March 31, 2022 deadline.

NEW BUSINESS

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
BUDGET AMENDMENT-PHYSICIANS
SALARIES & WAGES INCREASE

RESOLUTION NO. 22-06

WHEREAS, the Lewis County Hospital District No. 1 owns and operates Arbor Health, a 25-bed Critical Access Hospital located in Morton, Washington, and;

WHEREAS, the Lewis County Hospital District No. 1 feel that this is worthy,

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Lewis County Hospital District No. 1 as follows:

Approving the budget amendment to increase physician salaries and wages effective 02.01.22 which is not included in the District 2022 Budget by RES 21-39 on November 29, 2021.

ADOPTED and APPROVED by the Commissioners of Lewis County Hospital District No. 1 in an open public meeting thereof held in compliance with the requirements of the Open Public Meetings Act this 26th day of January 2022, the following commissioners being present and voting in favor of this resolution.

_____
Craig Coppock, Commissioner

_____
Tom Herrin, Secretary

_____
Kim Olive, Commissioner

_____
Wes McMahan, Commissioner

_____
Laura Richardson, Commissioner

Arbor Health

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 1/19/2022
Subject: Physician Salaries & Wages Increase

Due to the inflationary market and the increasing acuity in our emergency room, our emergency room physicians have expressed an expectation to increase their wages to $220/hour. Accompanying this memo is the analysis that I constructed to attempt to understand where ER Physician compensation is in today's market. The following are points of interest from the spreadsheet:

- Arbor is currently paying anywhere from $136.59 to $177.50, depending on physician status.
- Traditional compensation analyses (MGMA) indicated an increase to $146.73 to $197.49. This is well below the $220 demand.
- Two Collaborative facilities are paying less that Arbor Health.
- One Collaborative facility engaged an organization to staff their ER Physicians. They are paying $228.56 and the organization is requesting an increase to $253.
- Two other Collaborative facilities are paying at or over the $200 mark with expected or recent increases implemented.

Staffing the ER twenty-four hours a day, 365 days per year is imperative. We cannot maintain a critical access license without a staffed ER. We will lose, at a minimum, a couple of ER physicians if we do not meet this demand. Replacing them in this market will require us to increase our rate at or near that level.

I am proposing a budget amendment of $625,000 to fund the 43% increase to ER Physician wages, at $200.00 for ER Physicians that are not ER board certified and $220/hours for ER board certified physicians. Those physicians that are not on payroll receive a 15% gross up of their wages in lieu of receiving benefits. Their wages would increase to $230 and $253/hour. This rate increase would be effective February 1, 2022.

Richard has provided a 2022 Income Statement demonstrating the impact this budget amendment will have on the approved 2022 operating budget.

Lewis County Hospital District #1
Income Statement
CY 2022 Budget as Amended

	CY 2022 As approved Dec 2021	BUDGET AMENDMENT ED Physician Compensation Change	CY 2022 Budget As Amended
	Approved	Proposed	
Inpatient Revenenue	9,210,076		9,210,076
Outpatient Revenues	37,250,067		37,250,067
Clinic Revenues	6,367,089		6,367,089
Total Gross Patient Revenues	52,827,232		52,827,232
Contractual Allowanc	16,667,773		16,667,773
Bad Debt	657,415		657,415
Indigent Care	23,822		23,822
Other Adjustments	0		-
Total Deductions From Reven	17,349,010		17,349,010
Net Patient Revenues	**35,478,222**		**35,478,222**
NPSR %	67%		67%
Other Operating Revenue	982,805		982,805
Total Operating Revenue	36,461,027		36,461,027
Operating Expenses			
Salaries & Compensa	21,491,914	277,000	21,768,914
Benefits	5,185,314	46,000	5,231,314
Professional Fees	1,496,047	302,000	1,798,047
Supplies	2,413,129		2,413,129
Purchases Services	4,687,248		4,687,248
Utilities	546,621		546,621
Insurance Expense	267,252		267,252
Depreciation and Am	1,276,519		1,276,519
Interest Expense	422,436		422,436
Other Expense	696,525		696,525
Total Operating Expenses	38,483,006	625,000	39,108,006
Income (Loss) From Operatior	(2,021,979)	(625,000)	(2,646,979)
Non-Operating Revenue/Expe	1,650,795		1,650,795
Net Gain (Loss)	(371,184)	(625,000)	(996,184)
Net Income Margin %	-1.0%		-2.7%

Purpose:

To increase the Emergency Room physician rates to current market - 43% increase on current amounts

Shana Garcia

From: Ask MRSC <it@mrsc.org>
Sent: Friday, December 10, 2021 10:50 AM
To: Shana Garcia
Subject: Ask MRSC: December 2021

Follow Up Flag: Follow up
Flag Status: Flagged

Ask MRSC

December 2021

In This Issue

I am a newly elected councilmember. May I set up my own website (at my own expense) to provide a forum to communicate with my constituents?

Have a question?

Officials and employees from eligible government agencies can use our free

What is the proper timing for the swearing in of new councilmembers?

Once the first phase of a phased subdivision is approved, are subsequent phases subject to the timelines to file a final plat at RCW 58.17.140? What about extension requirements?

What are the training requirements for newly elected officials?

Our city initially banned cannabis sales when it was legalized in WA State. My understanding is that means we cannot receive any tax revenue from cannabis sales. If our city lifted the ban, would we be eligible to receive revenue from state sales, even if we did NOT have a cannabis business in our city?

Scroll down to read the answers

one-on-one inquiry service, Ask MRSC.

Ask MRSC

I am a newly elected councilmember. May I set up my own website (at my own expense) to provide a forum to communicate with my constituents?

The first thing we would suggest is to look at your city code and council rules as they relate to social media usage. Second is to look at MRSC's Social Media Policies topic page and our blog post on Elected Officials Guide — What's Personal and What's Public?

There are three main concerns with maintaining your own website for city-related communications. First, depending on your city's policies, anything you write could be considered a public record. This would require you to archive your website for the time required by state law and to produce responsive records if the city gets a public records request. Second, if a quorum of your fellow councilmembers comments on your website (assuming you intend to allow two-way communications) it raises the possibility of there being an illegal serial meeting. See our FAQ "What is a serial meeting?" for more details on serial meetings. Third, *if* this website is considered to be an officially city-sanctioned communication tool you may be limited in whether you can block subscribers or delete comments. As we note in the "Elected Officials Guide" blog, if you blog about public business, make sure your blog is public, not private, or you could run afoul of the First Amendment.

Many of these issues are more easily managed if all communications are part of the official city communication plan. While a plan could allow an individual councilmember to control their own content, it could make it easier to comply with record retention and public records requirements.

Finally, you'll want to talk to your city attorney about this (and we recommend new councilmembers sit down with their city attorney and get to know them). They can take this general guidance and help focus it to comply with your city's code and council rules.

What is the proper timing for the swearing in of new councilmembers?

There are various options for when to take the oath (both before and after January 1), and the timing will also depend on whether the new councilmember is filling a vacancy or starting a new full term. The official oath need not occur at an open public meeting, however it is not uncommon for there to be a ceremonial oath (which is separate from the official oath) at the first meeting in January. Here is a link to our Oath of Office blog article that includes a section on when the oath can be taken.

Once the first phase of a phased subdivision is approved, are subsequent phases subject to the timelines to file a final plat at RCW 58.17.140? What about extension requirements?

Authorizing a subdivision to be developed in phases does not relieve the developer of the statutory deadlines in RCW 58.17.140 or from the requirement to obtain extensions pursuant to local code. RCW 58.17.140(3) establishes deadlines for submittal of a final plat after preliminary plat approval. RCW 58.17.140(4) gives local governments discretion to provide for extensions of that time, through procedures adopted by ordinance. Chapter 58.17 RCW does not actually address phasing of

subdivisions. Nevertheless, it is a common practice. Some codes provide specific extensions for phasing, but most do not, other than extensions that might be available for any subdivision. Again, how and whether to grant extensions is a matter of local policy (implemented through an adopted ordinance).

What are the training requirements for newly elected officials?

There are mandatory trainings associated with both the Open Public Meetings Act (OPMA) and the Public Records Act (PRA) that apply to both state and local officials. These are at RCW 42.30.205, RCW 42.56.150, and RCW 42.56.152**.** The OPMA training is required for members of a governing body (e.g., city councilmembers or county commissioners), and the PRA training is required for all elected officials (and officials appointed to elected office), and public records officers.

PRA and OPMA training for all members of governing bodies must be completed **within 90 days** of taking the oath of office or assuming duties. **A refresher PRA and OPMA training is also required every four years** (RCW 42.56.150 and 42.56.152). For more information, see the Washington State Attorney General's webpage on Open Government Training. Here are the RCW citations for these requirements:

1. RCW 42.30.205 Open Public Meetings for elected officials
2. RCW 42.56.150 Public Records Act and records retention for elected officials

MRSC and AWC have an online e-training for both the OPMA and PRA that meets the above requirements. The trainings can be found at this link: https://mrsc.org/Home/Training/PRA-OPMA-E-Learning.aspx - select “Open Public Meetings Act eLearning” and “Public Records Act eLearning.”

Our city initially banned cannabis sales when it was legalized in WA State. My understanding is that means we cannot receive any tax revenue from cannabis sales. If our city lifted the ban, would we be eligible to receive revenue from state sales, even if we did NOT have a cannabis business in our city?

The marijuana excise tax has two components- the per capita share and the retail share. The per capita share is a portion that is distributed to all cities and counties that do not prohibit marijuana businesses. The retail share is distributed to all cities and counties where marijuana retailers are located. If the city were to allow marijuana businesses, it would qualify for the per capita share. If it had any marijuana retailers, it would also qualify for the retail share. For more information on the marijuana excise tax, we would recommend reviewing our Revenue Guide for Washington Cities and Towns, page 133.

DocID:	19383
Revision:	0
Status:	Official
Department:	Governing Body
Manual(s):	

Policy & Procedure : Electronic Signatures

Policy:

It is the policy of Lewis County Hospital District No. 1 to utilize electronic signatures for board commissioners to officially authorize board business, such as board of commissioner minutes, resolutions and warrants listings.

Procedure:

1. Board action is taken, such as approving minutes, resolutions, and warrants listing.
2. Within two business days, the Executive Assistant will generate and email documents to be signed by commissioners in Adobe Pro. Only commissioner district email addresses will be used in this process.
3. The order of signers will be as follows:
    a. Secretary Herrin
    b. Commissioner McMahan
    c. Commissioner Coppock
    d. Commissioner Schumaker
    e. Board Chair Frady
    f. Superintendent, as required
    g. CFO, as required
4. Once the documents have been distributed via email, the Executive Assistant will send an email to signers alerting them of a document needing signed.
5. Commissioners are expected to sign the document within 48 hours of receipt.
6. Signed documents will be stored in the Board of Commissioners designated sections of Lucidoc.

Document Owner:	Frady, Trish
Collaborators:	
Approvals	
- Committees:	(10/28/2020) Board of Commissioners,
- Signers:	
Original Effective Date:	10/29/2020
Revision Date:	[10/29/2020 Rev. 0]

Superintendent's Evaluation

Superintendent _____

Commissioners Board Chair _____

Secretary _____

Commissioner _____

Commissioner _____

Commissioner _____

Date _____

Overall Performance _____

Dimensions

Using the following definitions of levels of performance, please indicate your preceptions and evaluations of your CEO's work performance.

Excellent	**Continually exceeds expectations**
Good	**Generally meets or exceeds expectations**
Satisfactory	**Meets expectations**
Needs Improvement	**Fails to meet one or a few expectations**
Unacceptable	**Fails to meet most expectations**
N/A	**Have not observed this skill/activity**

Leadership & Managerial Qualities

	Excellent	Good	Satisfactory	Needs Improvement	Unacceptable	N/A	Average
Self-starter; high level of drive and energy	☐	☐	☐	☐	☐	☐	
Effective member of a work group; gains respect and cooperation of others	☐	☐	☐	☐	☐	☐	
Provides leadership and direction to staff	☐	☐	☐	☐	☐	☐	
Functions within scope of responsibility	☐	☐	☐	☐	☐	☐	
Open to constructive communication	☐	☐	☐	☐	☐	☐	
Demonstrates willingness to try new approaches	☐	☐	☐	☐	☐	☐	
Develops realistic solutions	☐	☐	☐	☐	☐	☐	
Establishes vision and direction	☐	☐	☐	☐	☐	☐	
Communicates appropriately to staff	☐	☐	☐	☐	☐	☐	

Personal Qualities and Judgement/Sensitivity

	Excellent	Good	Satisfactory	Needs Improvement	Unacceptable	N/A	Average
Person of Integrity	☐	☐	☐	☐	☐	☐	
Professionally presents self to the public	☐	☐	☐	☐	☐	☐	
Values people, shows concern	☐	☐	☐	☐	☐	☐	
Makes sound, timely decisions	☐	☐	☐	☐	☐	☐	
Handles problems professionally	☐	☐	☐	☐	☐	☐	

Knowledge and Skill

Demonstrates knowledge of hospital management/operations	☐	☐	☐	☐	☐	☐	
Assures facilities/equipment meet immediate and long-term needs	☐	☐	☐	☐	☐	☐	
Assures hospital is compliance with applicable standards, codes, laws and regulations	☐	☐	☐	☐	☐	☐	

Board Relations

	Excellent	Good	Satisfactory	Needs Improvement	Unacceptable	N/A	Average
Works closely with Board to develop short and long range strategies	☐	☐	☐	☐	☐	☐	
Communicates appropriate information to Board at and between meetings	☐	☐	☐	☐	☐	☐	
Readily available to Board members	☐	☐	☐	☐	☐	☐	
Works with Board to create a governance environment	☐	☐	☐	☐	☐	☐	
Provides education opportunities for Board	☐	☐	☐	☐	☐	☐	
Supports policies, procedures and philosophy of Board	☐	☐	☐	☐	☐	☐	
Creates a sense of trustworthiness in Board/CEO relations	☐	☐	☐	☐	☐	☐	

Medical Staff Relations

	Excellent	Good	Satisfactory	Needs Improvement	Unacceptable	N/A	Average
Has good rapport with Medical Staff	☐	☐	☐	☐	☐	☐	
Communicates with and works closely with medical staff on matters of mutual concern	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
Ensures Board involvement and approval in an effective credentialling process	☐	☐	☐	☐	☐	☐	
Assists in determining community health care needs	☐	☐	☐	☐	☐	☐	
Assumes a leadership role in provider recruitment	☐	☐	☐	☐	☐	☐	
Is an effective liason between the Board and medical staff.	☐	☐	☐	☐	☐	☐	

Community Relations/Political Effectiveness

	Excellent	Good	Satisfactory	Needs Improvement	Unacceptable	N/A	Average
Promotes a positive image of the Hospital	☐	☐	☐	☐	☐	☐	
Represents the Hospital in the community	☐	☐	☐	☐	☐	☐	
Works closely with community in determining local health care needs	☐	☐	☐	☐	☐	☐	
Listens to diverse ideas	☐	☐	☐	☐	☐	☐	
Maintains an advocacy role in promoting needs of the institution	☐	☐	☐	☐	☐	☐	

Strengths and Development Needs

What are the CEO's major strengths?

1 _____

2 _____

3 _____

What are areas that need further development?

1 _____

2 _____

3 _____

What are the resources needed to address further development?

1 _____

2 _____

3 _____

Current Goals for CEO

Personal Goals	Status

Organizational Goals	Status
Strategic Initiative 1	
Strategic Initiative 2	
Strategic Initiative 3	
Operational Goals	

DocID:	15804
Revision:	4
Status:	Official
Department:	Governing Body
Manual(s):	

Policy : Code of Ethics

Policy:

It is the policy of Lewis County Hospital District No. 1 that the Board of Commissioners will adopt and comply with this Code of Ethics.

Procedure:

Introduction

This Board of Commissioners Code of Ethics (Code) has been adopted by the Board of Commissioners (Board) of Lewis County Public Hospital District No. 1, Arbor Health of Lewis County, Washington (District) to promote honest and ethical conduct and compliance with applicable laws, rules and regulations by the members of the Board (Commissioners).

Applicability

This Code applies to each Commissioner.

How to Use the Code

This Code is a general guide to the Board's standards of conduct and regulatory compliance. This Code is not intended to cover every issue or situation Commissioners may face in their official capacity. This Code does not replace other more detailed policies and procedures adopted by the District, including but not limited to the District's Bylaws, the Lewis County Hospital District No. 1 Code of Ethics (to the extent applicable to Commissioners), and specific directives adopted from time to time by the Board.

It is essential that Commissioners thoroughly review this Code and make a commitment to uphold its requirements. Failure to read and/or acknowledge this Code does not exempt a Commissioner from his or her responsibility to comply with this Code, applicable laws, rules and regulations, and District policies and procedures.

None of the principles and practices outlined in the Code is intended to restrict any Commissioner from exercising its constitutional rights of free speech and should not be so construed. Furthermore, the exercise of such rights shall not subject any Commissioner to any sanctions under this Code, even if such exercise is otherwise inconsistent with a stated principle or practice of appropriate ethical conduct.

The Board does not intend to adopt any rule in this Code that violates existing law. If, as a result of changes in the law or otherwise, any provision of the Code is subsequently determined to violate applicable law, such provision

shall be construed in such a way as to eliminate such violation and, if no such construction of the applicable provision is possible, the provision shall be void.

Fundamental Responsibilities of Commissioners

The fundamental responsibility of each Commissioner is to promote the best interests of the public by overseeing the management of the District's business and community operations. In doing so, each Commissioner shall act in accordance with this Code, the District's other policies and procedures, and applicable laws, rules and regulations, including, but not limited to, Washington state law and the District's Bylaws. The Commissioners acknowledge that the purpose of Chapter 70.44 RCW, pursuant to which the District was formed, is to authorize the establishment of public hospital districts to own and operate hospitals and other health care facilities and to provide hospital and other health care services for the residents of such districts and other persons. The discharge of this responsibility requires the District to operate its hospital and other health care facilities in a competitive manner. Were it not to do so, the District could not compete with other private and public health care providers for patients, medical staff, executives and other critical operational support and would cease to be an economically viable entity notwithstanding the public support provided through tax levies against real property located within the District's boundaries.

Principles and Practices

1. In the performance of their official duties, Commissioners shall act ethically, in good faith, with integrity, with care, and in a manner they reasonably believe to be in the best interests of the public that is served by the District.

2. Commissioners shall not allow outside activities or personal financial or other interests to influence or appear to influence their ability to make objective decisions with respect to the District.

3. Commissioners shall conduct their official and personal affairs in such a manner as to give the clear impression that they cannot be improperly influenced in the performance of their official duties.

4. Commissioners in discharging their duties to the District shall use their best efforts to comply with all applicable laws, rules and regulations of federal, state and local governments and other regulatory agencies.

5. Commissioners shall not be beneficially interested, directly or indirectly, in any contract or transaction which may be made by, through or under the supervision of such Commissioner, in whole or in part, or which may be made for the benefit of their office, or accept, directly or indirectly, any compensation, gratuity or reward in connection with such contract or transaction from any other person beneficially interested therein, except to the extent permitted under applicable law. Should a Commissioner have a beneficial interest in any contract or transaction proposed for the District, such beneficial interest shall be disclosed to the Board, before the Board authorizes the District to enter into such contract or transaction. The existence of such conflict of interest shall be reflected in the official minutes of the Board. Any Commissioner having such a conflict of interest shall not vote when the matter is presented to the Board for approval. Moreover, such Commissioner shall not influence or attempt to influence any other Commissioner to enter into a contract or transaction in which such Commissioner has a beneficial interest.

6. At the time of a Commissioner's election, a Commissioner shall disclose in writing to the Board all personal or professional relationships that create, or have the appearance of creating, a conflict of interest with the District. Should any such personal or professional relationships arise in the future, the Commissioner shall promptly disclose such relationships to the Board.

7. Commissioners shall not use their position to secure special privileges or exemptions for themselves or others.

8. Commissioners may not, directly or indirectly, give or receive or agree to give or receive any compensation, gift, reward, or gratuity from a third party for the Commissioners' services to the District or as to any contract or transaction between the District and any other party.

9. Commissioners shall not receive any compensation, remuneration, payments or distributions from the District for their services as Commissioners, except as and only to the extent permitted by applicable law.

10. Commissioners shall not accept employment or engage in any business or professional activity that could reasonably be expected to place them in a conflict of interest with the District or require or induce them, by reason of their new employment or engagement, to disclose confidential information acquired by the Commissioners by the reason of their office.

11. To the extent Commissioners obtain confidential information by reason of their office, they will not disclose such confidential information to others unless authorized to do so by the Board. For purposes of this paragraph "confidential information" means information that the Commissioners are required to treat as confidential under applicable law (whether such law is derived from statutes, regulations, case law, the District's charter documents, or otherwise). Information regarding the District not deemed confidential under applicable law may be shared by the Commissioners with others.

12. If Commissioners receive frequent inquiries from individuals or other persons requesting the disclosure of confidential information, Commissioners shall bring that information to the attention of the other Commissioners to allow the Board to determine if it wishes to adopt preventive measures to further protect the Board and District's legitimate interest in controlling access to its confidential information.

13. Commissioners shall not simultaneously hold any other incompatible office or position, including, but not limited to, another office or position whose functions are inconsistent with the functions of a Commissioner for the District, or where the occupation of such other office or position is detrimental to the public interest.

14. Commissioners shall comply with all of the District's policies and procedures, including those applicable to District employees and medical staff generally, to the extent applicable to their services as Commissioners.

15. The Superintendent is, by statute, the District's chief administrative officer and, in such capacity, is responsible for the administration of the District. Accordingly, if Commissioners receive questions or concerns from employees, from members of the medical staff, or from the public concerning District operations, they shall promptly notify the Superintendent and it shall be the responsibility of the Superintendent (or the Superintendent's designee) to respond on behalf of the District. Similarly, if third parties, such as third party payors, employee groups, real estate developers, or others, communicate with Commissioners regarding existing or proposed business or other relationships with the District, such matters shall promptly be referred to the Superintendent to take whatever action the Superintendent deems appropriate. The Superintendent shall be accountable to the full Board for follow-up on such items.

16. Commissioners shall fully cooperate with government investigators as required by applicable law. If a Commissioner encounters an investigator, or receives a subpoena, search warrant or other similar document, related to an investigation of the District, the Commissioner shall promptly give notice of such investigation to the Board.

17. Commissioners shall not destroy or alter any information or documents in anticipation of, or in response to, a request for documents by any applicable governmental agency or from a court of competent jurisdiction.

18. The Commissioners are expected to prepare for, participate in, and attend all Board meetings. They should commit the time necessary to review all Board materials. The same level of participation is expected with respect to all Board committees, if any, to which the Commissioners are assigned. For purposes of the foregoing, "attend" shall mean that the Commissioner arrives at the Board meeting (or, if applicable, the Board committee meeting) on time and stays until the conclusion of the meeting.

19. Commissioners are expected to engage in robust, active discussions of the issues submitted to the Board for consideration in order to arrive at the most carefully considered decisions for the District. With this in mind, Commissioners must study all relevant information (including materials in Board packages), articulate clearly their personal views, be prepared to argue for and support their positions, and, when appropriate, question and challenge the views of others. Such deliberations should be conducted in a respectful manner in line with customary standards of civility and decorum.

20. Commissioners when discussing District business, whether at Board meetings or elsewhere, are urged to adhere to the following standards: Commissioners should be respectful of the views of other Commissioners and executives, even if such views are contrary to the Commissioners' personal opinions; not divulge confidential information regarding the District's affairs; not purport to represent the views of the Board, unless authorized to do so by the Board; and not intentionally misrepresent, demean or belittle positions taken by other Commissioners or District executives and, where appropriate, take all reasonable steps to ensure that a balanced presentation of competing points of view is given so as to promote common understanding of (rather than to foster a spirit of divisiveness with respect to) the issues before the Board and the various competing points of view taken by other Commissioners and District executives. Nothing in this Code is intended to limit any Commissioner’s constitutionally-protected rights of free speech, nor is this Code to be construed so as to impair the ability of Commissioners to participate in ceremonial, representational or informational functions in the pursuit of their official duties.

21. Commissioners are publicly-elected officials. As a consequence, if incumbent Commissioners choose to run for re-election, they will of necessity be involved in campaign-related activities during the tenure of their service on the Board. Nothing in this Code of Ethics is intended to deprive such individuals of, or to inhibit or limit the lawful exercise of, the right to engage in customary re-election activities, including but not limited to seeking and securing

endorsements, soliciting campaign contributions, distributing voter pamphlets and other campaign related materials, or making public appearances. They may solicit financial or other support for the community at large, hospital employees, medical staff members, nurses, and others, provided that the support comes from such persons when acting in their personal capacities, and not as representatives or employees of the District. All such support must be voluntary and may not be given or received with the expectation or understanding that the contributing individual will receive any consideration, privilege or benefit, directly or indirectly, from the District. Commissioners may not, claim, suggest or create the impression that their re-election is supported or endorsed by the District itself, nor may they use or gain access to the District financial resources to support their re-election campaign. They may however fully discharge their duties and responsibilities as Commissioners during the re-election campaign (as indeed they are obligated to do), and such activities are not wrongful.

22. Commissioners shall refrain from any illegal, unethical, or inappropriate conduct, whether or not specifically identified in this Code.

General Standards of Conduct

Commissioners' compliance with the principles and practices of this Code will be subject to the following guidelines:

1. Commissioners may not be considered in violation of the ethical guidelines of the Code as long as they have acted in good faith, and in a manner they believed to be consistent with their obligations under Code.

2. To the extent that Commissioners receive advice from the District's legal counsel (consisting of in-house counsel or legal counsel engaged by the District), Commissioners may rely upon such advice in discharging their duties to the District. If Commissioners have in good faith relied upon such advice in conducting the District's business, such reliance will constitute a defense to charges that actions based upon such reliance violated the provisions of the Code.

3. Absent evidence of bad faith, inadvertent violations of the Code that do not adversely affect the District in a material way and that do not create private benefits in favor of the Commissioner or related parties will not constitute grounds for disciplining a Commissioner.

Enforcement of Code

The Board is the body vested with the exclusive authority to enforce the provisions of the Code and to take disciplinary action against Commissioners for violations. As provided in Article VIII, the Board may, under certain circumstances, enlist the support of others to assist with fact finding and to make recommendations.

While members of the public may give the Board notice of alleged violations of the Code, they may not, except as qualified below, bring legal actions against Commissioners for alleged violations, whether such actions seek specific performance, damages or other forms of judicial relief. The Commissioners are not liable to members of the public for damages resulting for Code violations.

Notwithstanding the foregoing, if a Commissioner's misconduct constitutes official misconduct as to which a legal action may be brought by a member of the public, separate and apart from its constituting a violation of the Code, members of the public may pursue such matters, at law or in equity, in the same manner as they might otherwise have pursued such matters under then-existing law. Hence, as relates to members of the public, the Code does not, and is not intended to create, a basis for making claims or pursuing remedies that would not otherwise be available under existing law.

Reporting Procedures and Process

1. Any individual may advise the Board of an alleged violation of the Code by a Commissioner. To the extent feasible, any such notice should be given in writing and specify in reasonable detail the alleged misconduct.

2. The District will not take retribution or disciplinary action against any District employee who raises concerns or reports potential violations of the Code by a Commissioner, whether or not it is subsequently determined that there is a legal or factual basis to support such allegations. On the other hand, should members of the public allege official misconduct by Commissioners, and should such allegations not be supported either for factual or legal reasons, Commissioners may pursue such remedies as are available, at law or in equity, including but not limited to claims for libel or slander, against the parties wrongfully accusing the Commissioners of misconduct.

3. The Board shall review promptly, and in a prudent manner, allegations of Commissioner misconduct to determine whether there have been violations of the Code and what disciplinary action, if any, is appropriate. The processing of such allegations shall be under the direction of the Board Chair, acting with the advice of counsel, and being subject to the other guidelines provided for in this Article VIII. If the Board Chair is the subject of alleged misconduct, the responsibilities vested in the Board Chairman under the Code will pass to the next ranking officer (or, if none, the senior most member) of the Board who is not accused of the alleged Code violations.

4. The Board may, from time to time, adopt procedures for investigating, handling, and resolving allegations of misconduct, subject to adopting reasonable procedures for:

    a. gathering information regarding the alleged misconduct, including but not limited to, accepting written submissions, hearing testimony, conducting hearings, undertaking fact finding, and soliciting information from experts;

    b. the right of the accused to respond to the allegations and to be represented by counsel;

    c. the screening out of frivolous complaints; and

    d. the right of the public to observe such proceedings under the Open Public Meeting Act ("OPMA").

5. If the Board determines that a Commissioner has violated one or more of the provisions of the Code, the Board may give written or oral warnings, issue formal reprimands, publicly censure the Commissioner and/or relieve the commissioner of board committee assignments. Such disciplinary action shall be recorded in the minutes of the Board's meetings and, as directed by the Board, be published in local newspapers, the District's communications with residents, or through other media. In those instances where the misconduct is of a serious nature, the Board may, after receiving legal advice from counsel, initiate legal action in a court of competent jurisdiction to remove such Commissioner from office.

6. Subject to the following guidelines, the Board may appoint the Values, Ethics & Conflict of Interest committee to assist in fact-finding and/or making recommendations to the Board regarding allegations of Commissioner misconduct:

    a. It will be left to the discretion of the Board to determine whether such a panel should be convened and to determine the scope of the responsibility given to such panel. The Board shall consider all facts and circumstances in making such determinations, including but not limited to the seriousness of the allegations, the history of the alleged misconduct – whether constituting an isolated incident or pattern of misconduct, the publicity surrounding the activities, the level of public interest, and whether and to what extent the public's interest might be advanced by enlisting the support of others outside of the Board. The Board's determinations regarding such matters will be final and binding. It is not expected that such panels would be convened to handle frivolous complaints or allegations regarding inadvertent or minor violations of the Code.

    b. If the Board elects to solicit outside support in processing allegations of Code violations, the Board Chair, acting with the advice of legal counsel, shall appoint, on such basis as the Board Chair deems appropriate, the individuals to serve on the advisory panel, which participants may be drawn from public officials or members of the local business community (such as members of the chambers of commerce) from those municipalities whose geographic boundaries fall primarily within the boundaries of the District. The size of the panel will be determined by the Board Chair.

    c. The Board or, absent specific direction from the Board, the Board Chair will establish the specific fact-finding and advisory responsibilities of the panel.

    d. If such a panel is constituted, the panel's activities will be subject to the public access requirements of the OPMA, to the extent required by OPMA.

    e. The Board will, however, in all instances, retain ultimate decision making regarding whether the alleged misconduct constitutes a violation of the Code and whether and to what extent to take disciplinary action against any Commissioner found to be in violation of the Code.

7. To the extent that alleged misconduct constitutes a violation of law, separate and apart from a violation of the Code, such misconduct may be referred to the county prosecuting attorney for action.

Waiver

If a Commissioner believes that it is inappropriate to apply any of the provisions of this Code to such Commissioner, such Commissioner may submit to the Board a written request for a waiver from such provision. Such written request must be accompanied by a statement setting forth the reasons why the waiver should be granted under the circumstances. Such waiver shall be effective if approved by a majority vote of the Commissioners (excluding the requesting Commissioner). Furthermore, such waiver may be granted only if supported by legal advice from the District's in-house or outside legal advisors.

Review

The Board shall review this Code to ensure compliance with all applicable laws, rules and regulations, and to ensure that the Commissioners are held to the highest standards of conduct and ethics. In connection with such review, the Board should discuss what, if any, amendments or revisions are necessary to improve the effectiveness of this Code.

Amendments

This Code may be amended from time to time by the Board, if approved by a majority vote of all Commissioners, and any amendment must be disclosed as required by and in accordance with applicable laws, rules and regulations.

Affirmation

Each Commissioner is responsible for reviewing, understanding, acknowledging and personally upholding this Code and other policies and procedures. Each of the Commissioners shall certify that he or she has read, understands, is in compliance with and is not aware of any violations of this Code upon the initial adoption of this Code; upon the adoption of any amendments to this Code; upon a Commissioner's appointment, election or re-election to office; and at the beginning of each fiscal year. Each such certification shall be made by the execution of the Receipt and Acknowledgement attached hereto as Exhibit A.

EXHIBIT A

LEWIS COUNTY HOSPITAL DISTRICT NO. 1

Board of Commissioners Code of Ethics

Receipt and Acknowledgement

I understand that each Commissioner is responsible for reviewing, understanding, acknowledging and personally upholding the Board of Commissioners Code of Ethics (Code), and for familiarizing him or herself with the applicable detailed elements of other policies and procedures.

By executing this Receipt and Acknowledgement, I hereby acknowledge that:

1. I have received and read a copy of the Code;
2. I understand the contents of the Code;
3. I have familiarized myself with the applicable detailed elements of the Code of Ethics and other policies and procedures;
4. I affirm my commitment to and compliance with the standards and procedures set forth in the Code; and
5. I am not aware of any violations of the Code involving myself that occurred since the later of the adoption of the Code, the last time I executed and delivered a Receipt and Acknowledgement or the beginning of the last fiscal year that have not otherwise been reported in accordance with the procedures set forth in the Code.
6. I acknowledge that my execution of this Receipt and Acknowledgement has been requested by the Board of Commissioners as a part of the District's ongoing program to ensure compliance with the terms of the Code and that the District and the Board intended to rely upon the representations made herein.

Printed name: _____

Signature: _____

Date: _____

Document Owner:	Frady, Trish
Collaborators:	
Approvals	
- Committees:	(09/25/2019) Board of Commissioners, (07/29/2020) Board of Commissioners,
- Signers:	
Original Effective Date:	07/17/2012
Revision Date:	[07/17/2012 Rev. 0], [07/17/2012 Rev. 1], [08/27/2015 Rev. 2], [08/27/2018 Rev. 3], [09/06/2019 Rev. 4]
Review Date:	[11/08/2013 Rev. 1], [12/23/2014 Rev. 1], [06/20/2016 Rev. 2], [08/24/2017 Rev. 2], [07/21/2020 Rev. 4]
Attachments: (REFERENCED BY THIS DOCUMENT)	
Other Documents: (WHICH REFERENCE THIS DOCUMENT)	

DocID:	17988
Revision:	0
Status:	Official
Department:	Compliance
Manual(s):	

Policy & Procedure : Conflict of Interest

Policy:

It is the policy of Lewis County Hospital District #1 that employees must avoid any actual or perceived Conflicts of Interest to ensure that the Conflict of Interest does not affect, or appear to affect patient safety, quality of care, research integrity or interfere with the District's responsibility to the community it serves. For example, any situation where a District employee may benefit financially, whether directly or indirectly (e.g., through a family member) as a result of that employee's position with District is a potential Conflict of Interest.

Purpose:

This Conflict of Interest Policy is intended to guide District employees in structuring appropriate relationships with care providers, payors, educational institutions, manufacturers and other vendors that affect or have the potential to affect or give the appearance of affecting patient safety or quality of care, treatment, research and payment for services.

A Conflict of Interest is not illegal per se. rather, most Conflicts of Interest can be managed or cured with disclosure, consent or modification. However, depending on the circumstances, it is prudent to simply avoid certain Conflicts of Interest. District employees must disclose all potential Conflicts of Interest pursuant to this Conflict of Interest Policy for review and appropriate action.

Procedure:

Individual Conflicts of Interest

All Employees are subject to this Conflict of Interest Policy and are required to be familiar with its content.

A. Regular Disclosures. All Employees must disclose potential Conflicts of Interest as follows:

1. All employees are required to disclose potential Conflicts of Interest by submitting a Conflict of Interest Disclosure Form ("Form") to Human Resources or the Compliance Officer upon hire or appointment and then annually.
2. Board Members and Agents must complete and submit Forms to Human Resources or Compliance Officer upon hire or appointment and then annually.
3. Employees who are below the manager level should complete the Conflict of Interest form and disclose potential Conflicts of Interest to their immediate supervisors with copies of the completed form to the Compliance Officer.
4. Volunteers must complete and submit Conflict of Interest forms to the Director of Volunteers when they begin providing services to the District and then annually.

B. Disclosing New Conflicts of Interest.

1. If during the year any new potential Conflicts of Interest arise, employees must report the potential Conflicts of Interest immediately (and prior to undertaking any activity that may raise a potential Conflict of Interest) as outlined

above.

C. Confidentiality.

1. Disclosure information will be confidentially maintained. It may be shared in a confidential manner with the person to whom the Employee directly reports, the Compliance Committee of the District, the Board of Commissioners and as required by law.

D. Review of Individual Disclosure forms and Resolution of Conflicts. Forms will be reviewed and conflicts resolved in the following manner:

1. For Board Members and the Chief Executive Officer, the Corporate Compliance Officer will review the completed form and make a recommendation to the Compliance Committee. The Committee will review the recommendation and forward a plan for curing or managing any disclosed conflict to the Board of Commissioners.

2. For Volunteers, the Director of Volunteers will review the completed Form and send the Form and his/her written recommendation to the Compliance Officer. The Compliance Officer will review the recommendation of the Director of Volunteers and the completed Form and will take appropriate action.

3. For all other Employees, the Corporate Compliance Officer will review the Forms along with department manager. The Corporate Compliance Officer will review the Forms for Conflicts of Interest and may discuss with the Compliance Committee any needed action to cure or manage the conflict

4. For Members of the Board of Commissioners and the Chief Executive Officer, any appeal will be made to the entire Board of Commissioners. For employees who sit on the Compliance Committee or who directly report to the Chief Executive Officer, appeals may be made to the Compliance Committee and/or the Board of Commissioners. Appeals for all other employees will be made to the Compliance Committee.

5. Review Factors. The Corporate Compliance Officer and the Compliance Committee shall consider the following factors when reviewing completed Form:

    i. Whether the employee or an Immediate Family Member is a party to, or may directly or indirectly benefit from, a proposed agreement or transaction involving the District;

    ii. Whether the employee's desire for, or expectation of, direct or indirect external economic advantage could distort a District decision or activity;

    iii. Whether the employee or an Immediate Family Member is engaging in an activity, business, or transaction in which the District is likely to engage;

    iv. Whether the employee's outside activities may conflict with rights of, or the employees's obligations to, the District or the District's patients;

    v. Whether the Conflict of Interest can be cured or managed by recusal or other appropriate action;

    vi. Whether the employee is supervising a family member or relative;

    vii. Whether there is an appearance of a Conflict of Interest.

6. Determination and Course of Action.

    i. If the Compliance Committee and the Compliance Officer determines that a Conflict of Interest exists,

    ii. The Compliance Officer shall notify the applicable employee in writing of the determination and the recommended course of action.

    iii. The Employee shall respond in writing indicating how he/she complied with the determination.

7. Discipline.

    i. Failure to comply with this Policy, as well as refusal to complete the Form, or follow recommended course of actions may result in disciplinary measures, up to and including removal from office or termination of employment.

8. Records.

i. Forms, in hard copy and electronic format, will be retained by all departments as required by District retention requirements.

ii. The Compliance Officer will retain memoranda of all Compliance Committee decisions as required by District retention requirements

Institutional Conflicts of Interest

A. Reporting. Institutional conflicts of interest are conflicts involving the District or an institutional component thereof, rather than an individual. Anyone who becomes aware of a potential institutional conflict of interest should refer the potential conflict to the Compliance Officer who with the Compliance Committee will review the potential conflict and either issue a recommendation or refer the matter to the CEO and the Board of Commissioners for a decision.

B. Regular Reviews. The District conducts regular conflicts of interest reviews of its relationships with other health care providers, educational institutions, payors, and pharmaceutical, device and equipment manufacturers to determine whether conflicts exist and whether these relationships comply with applicable laws.

Conflicts of Interest Related to Immediate Patient Care

1. Potential conflicts of interest that effect direct care of any particular patients may be referred to the Compliance Committee.
2. Contact: Compliance Officer

RESPONSIBLE PARTY:

1. All District Employees.

DEFINITIONS:

"Agents" means all persons and entities that have contracted with the District to provide health care related services, equipment or other goods or services. Agents do not include Volunteers.

“Board Members” means members of the Board of Commissioners of Lewis County Hospital District #1.

"Employee" means all District employees and temporary, per diem personnel, volunteers, students and others rendering paid or unpaid services to the District, including, but not limited to, Agents, Board Members, Medical Staff, and Officers.

“Conflict of Interest” means a situation in which financial, professional, or personal interests, including the interests of Immediate Family Members, may compromise one’s professional judgment or other obligations to the District. There is no minimum amount below which financial Conflicts of Interest do not need to be disclosed.

“Entity” means any for-profit or not-for-profit organization, including, but not limited to, any corporation, trust, foundation, association, company, sole proprietorship, partnership, firm, venture, vendor, or other form of organization.

“Equity” means any investment having a value greater than 1% of total worth or ($25) or having an unknown value (such as stock options).

“Immediate Family Member” means a spouse/domestic partner, parent, child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, aunts, uncles, nephews, nieces and spouse of a grandparent or grandchild.

“Significant Financial Interest” means anything of monetary value, including, but not limited to, salary or other payments for services (e.g., consulting fees or honoraria); equity interests (e.g., stocks, stock options or other ownership interests); and intellectual property rights (e.g., patents, copyrights and royalties from such rights). Significant Financial Interest does not include:

- Salary, royalties, or other remuneration from the District;

- Income from seminars, lectures, or teaching engagements sponsored by, or from service on advisory committees or review panels for, public or nonprofit entities;
- An equity interest that when aggregated for Employee and the Employee's spouse and dependent children, does not exceed $25 in value and does not represent more than a 1% ownership interest in any single entity; or
- Salary, royalties or other payments that when aggregated for the Employee and the Employee's spouse and dependent children are not expected to exceed $500 over the next twelve months.

References:

- Anti-kickback Statute, 42 U.S.C. §1320A ff.

Document Owner:	Hargett, Spencer
Collaborators:	
Approvals	
- Committees:	(11/08/2017) Non-Clinical Policy Review Committee, (11/27/2017) Policy Oversight Committee, (02/27/2019) Board of Commissioners,
- Signers:	
Original Effective Date:	01/25/2019
Revision Date:	[01/25/2019 Rev. 0]
Review Date:	
Attachments: (REFERENCED BY THIS DOCUMENT)	Annual Conflict of Interest Disclosure Form
Other Documents: (WHICH REFERENCE THIS DOCUMENT)	Outside Employment Annual Conflict of Interest Disclosure Form

Annual Conflict of Interest Disclosure Form

Administrators, Managers, and Commissioners complete this form annually to identify and resolve possible conflicts of interest. A conflict of interest may exist when an employee or Board member is involved in any activity, or has a personal, familial, or financial interest, that may interfere in their performance or objectivity in performing their duties. (Where appropriate please check boxes yes or no and please use the additionally provided lined paper if needed.)

Name_____ Position _____ Date: _____

1. Are you or do you
   - 1.1. Have a relationship with an entity that does business with Lewis County Hospital District No.1
   - 1.2. Have you referred business from LCHD to the organization(s): yes ☐ No ☐
   - 1.3. Have you referred business from the organization to LCDH: yes ☐ No ☐
   - 1.4. Provide products or services similar to Lewis County Hospital District No.1 products or services.
     - 1.4.1. If you check "**Yes**" state: yes ☐ No ☐
   - 1.5. The name and address or the organization(s):_____
     _____
   - 1.6. Your position(s): _____

2. Do you have a financial interest in any other entity that does business in any capacity with, or competes in any way with LCHD? If you check "**Yes**" state: yes ☐ No ☐
   - 2.1. The name and address of the organization(s)_____
   - 2.2. What is your financial interest in the organization(s):_____
   - 2.3. Do you own more than one-tenth of one percent of the organization(s): yes ☐ No ☐
   - 2.4. Have you referred business from LCHD to the organization(s): yes ☐ No ☐
   - 2.5. Has the organization referred business to LCHD through you: yes ☐ No ☐

3. Do you have any relative(s) that: (check boxes yes or no)
   - 3.1. Are employed by Lewis County Hospital District No.1 yes ☐ No ☐
   - 3.2. Provide contracted services to Lewis County Hospital District No.1 yes ☐ No ☐
   - 3.3. Serve as a board of commissioner for Lewis County Hospital District No.1 yes ☐ No ☐
   - 3.4. Has a financial interest in an entity doing business, in any capacity, with LCHD No. 1
   - 3.5. Has a financial interest in an entity that provides products and services that competes with Lewis County Hospital District No.1

3.6. If you check "**Yes**" state: yes ☐ No ☐

3.6.1. The name(s) of the relative(s) and your relationship to such person:

_____

3.6.2. The name and address of the organization(s) with which associated:

_____

3.6.3. The relative(s) position(s) with the organization(s):

_____

3.6.4. The relatives(s) financial interest in the organization(s):

_____

3.7. Have you referred business to the organization(s): yes ☐ No ☐

3.8. Has the relative or family member has referred business to LCHD: yes ☐ No ☐

4. Has any current or prospective vendor, supplier, or customer of LCHD No1, or any other entity that does or has sought to do business with LCHD No1 provided you or your family members with, or assumed on behalf of you or your family members behalf the cost of, goods or services of any kind whose value exceeds $25.00 as a gift or other perquisite? If you check "**Yes**" state: yes ☐ No ☐

4.1. The name of the person who provided you with, or assumed the cost of, such goods and/or services and the business entity with which such person is associated:

_____

4.2. The goods / services you received, their estimated value and when you received them:

_____

5. Are you or a family member involved in any public service or charitable organizations to which LCHD contributes or whose actives may conflict with those or LCHD? yes ☐ No ☐
If you check "**Yes**" state/describe the activity and/or relationship:

_____

6. In your capacity with Lewis County Hospital District No.1 No. 1, have you hired or retained, as an employee, an independent contractor or otherwise, or do you supervise, a family member or other relatives?
If you check "**Yes**" yes ☐ No ☐

6.1. The name of the family member(s) or other relative(s) and your relationship to such person(s):

_____

7. Medicare or other government programs exclusions are reviewed by HR or Finance departments.

Signature: _____

Date: _____

Please complete this form and return it to the Compliance Official or Administrative Office. If you need additional space, please use the labeled and lined paper that came with this form.

Thank you

Please place your name, position, and date on form. If you have no additional information write "nothing to report" on the first blank line and cross through the rest of the lines.

Name_____ Position _____ Date: _____

SUPERINTENDENT REPORT

SUPERINTENDENT'S REPORT January 2022

Mission: *To foster trust and nurture a healthy community*
Vision: *To provide accessible, quality healthcare*

	Opportunity	CY 2022 Progress	Status	Associated Documentation
Strategic	2022 Department Strategic Measures	Presenting the department strategic measures for 2022	on-going	*01192022 Department Strategic Measures Memo & Dashboard*
Strategic	Accessible Healthcare	A Packwood Clinic update is provided	on-going	*01192022 Packwood Clinic Update Memo*
Strategic	Accessibile, Affordable Healthcare	A Rapid Clinic update is provided	on-going	*01192022 Rapid Clinic Update Memo*
Regulatory	Redistricting	Providing Q1 update on progress to completion of Q1 Department Strategic Measures	Complete with quarterly updates	*01192022 Redistricting Memo & Redistricting for Public Hospital*

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 1/19/2022
Subject: 2022 Department Strategic Measures

Accompanying this memo are the one hundred 2022 strategic measures that myself and the management team will be tracking and reporting throughout 2022. Progress on these metrics will continue to be reported on a quarterly basis, with the calendar year to be wrapped up in February 2023.

We made some changes because of several learning opportunities from our 2021 experience. We have attempted to better define how to measure success. For example, some metrics are developed as quarterly measures, whereas others are developed as annual goals. Success on quarterly measures will be evaluated quarterly and will be independent of each other. In contrast, an annual goal may fluctuate quarter-to-quarter; however, success is determined based on the completion of the annual goal.

While we retired the volunteer hours as a department measure, we continue to have 24 volunteer hours within the district as an eligibility requirement for earning At-Risk Compensation. We exceeded our annual volunteer hour's goal but fell short of having 100% of the managers and directors performing community service. This will remain a criterion of eligibility for the foreseeable future.

Facilities and Anesthesia do not have goals included on the dashboard. We are experiencing turnover in both positions. Our new Anesthesia Director will not join us until March and the Facilities Director is not filled. Both will need to participate in establishing their own measures; however, eligibility in At-Risk Compensation will require being in the position for twelve months.

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2022				
			Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Open a primary care clinic in Packwood, WA by 12/31/2022		**Open by 12/31/2022**					
Clinical Informatics: Successful implementation of Cerner/WAIIS immunization interface that meets DOH minimum data transmission thresholds.		**Pass/Fail**					
Compliance: Provide responses to compliance questions from all departments within 2 business days of receipt.	**2**	**2**					
Communications: Partner with vendors and community groups to host an overall wellness week, including a health fair	**1**	**1 Event Annually**					
Environmental Services: 60% of staff members will become CHEST (Certified Health Care Environmental Services Technician) certified (16 EEs)	**0**	**10**					
Finance: Increase vendor invoice EFT utilization by 15%.	**79**	**91**					
Billing/HIM: Partner with Insurance Payor to address school needs/community youth programs	**1**	**1 coordinated event/year**					
Human Resources: Attend at least two local high school and college job fairs	**1**	**2**					
Foundation: Increase the number of Gift Shop Volunteers to 11	**7**	**11**					
Information Technology: Network uptime should be 99.85% or greater	**99.70%**	**≥ 99.85%**					
Employee Health: Develop a community weight loss challenge that culminates in a 5k/10k/Half Marathon	**1**	**1**					
Patient Access: Increase the number of patients referred to the Self Pay Biller to see if they qualify for Medicaid by 100%	**20**	**40**					
Quality and Risk: Improve grievance process compliance for *written acknowledgement letters* within 10 days of grievance by year end	**70%**	**95%**					
Supply Chain: Create Cycle Count process to improve inventory accuracy.	**75%**	**85%**					
CLINICAL							
Acute Care: Minimum of 1 community STEMI/Heart Attach event and 1 social media cardiac care message/newsletter article per quarter	**0**	**1/4**					
Case Management: Ensure *5 Wishes Advance Directives* are provided to 70% of patients with no current advance directive	**30%**	**70%**					
Dietary/Nutrition: Create one healthy cooking column with recipe in the quarterly Health & Life publications		**1/qtr**					

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2022				
			Q1	Q2	Q3	Q4	YTD
Emergency Department: Minimum of 1 community STROKE education event and 3 EMS STROKE education events	**0**	**1/3**					
Imaging: Develop & implement a Low Dose Lung Screening program by the end of 2022		**Pass/Fail**					
Infection Control: Participate in 3 external events promoting IC to the community		**3**					
Laboratory: Develop a process to notify providers of all hospital patient preliminary culture results		**85%**					
Respiratory Therapy: Develop & implement 1 social media message/quarter re: pulmonary disease	**0**	**1/qtr**					
Pharmacy: 50% of patients discharged during pharmacy hours on a new medication will be couseled by a pharmacist		**≥ 50%**					
Pulmonary Rehab: Extend two smoking cessation classes per year to public	**0**	**2 classes per year**					
Wellness: Create a community wide wellness plan that incorporates 2 additional partnerships with providers, employers, and community based entities focusing on overall health of our community by identifying target chronic illnesses and needs.	**2**	**4**					
Rehab Services: Increase focus on student athletic performance & injury management.	**0.75**	**2**					
Surgical Services: Facilitate awareness of and local access to outpatient Infusion Care by developing marketing literature and outreach to Lewis County clinics, home health, and Centralia, Longview and Tacoma hospitals' Case Management departments resulting in ≥ 20% increase in Same Day Surgery encounters	**400**	**480**					
Swing Beds: Acute patients transferred out of District with subsequent skilled needs are readmitted to Arbor Health for local care	21	**28 patients/year**					
Wound Care: Increase outpatient wound care visits by 10%	**550**	**605**					
CLINICS							
Morton: Develop 2 community engagement events at clinic per year.	3	**2/year**					
Mossyrock: Develop 2 community engagement events at clinic per year.	3	**2/year**					
Randle: Develop 2 community engagement events at clinic per year.	3	**2/year**					

EXECUTIVE DASHBOARD

TO BUILD RELATIONSHIPS AND PARTNERSHIPS THAT PRIORITIZE COMMUNITY HEALTH NEEDS

METRIC	BASELINE	TARGET	2022				
			Q1	Q2	Q3	Q4	YTD
Specialty: Develop 2 community engagement events at clinic per year.	3	**2/year**					

EXECUTIVE DASHBOARD

TO CREATE A CULTURE FOCUSED ON SAFETY, PATIENT SATISFACTION, EMPLOYEE ENGAGEMENT AND EXCELLENT OUTCOMES

METRIC	BASELINE	TARGET	2021				
			Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Conduct one physician satisfaction or engagement survey with comparative data by 12/31/2022.		**Pass/Fail**					
Clinical Informatics: Standardize drug protocols by increasing the number of Cerner order sets for P&T approved drug protocols and, as indicated, eliminate access to any other versions beyond P&T approved protocols	**1**	**6 new protocols**					
Compliance: Resolve compliance and HIPAA events within 15 business days	**25**	**15**					
Communications: Increase our Google Business Profile reviews by 25%	**93**	**116**					
Environmental Services: Decrease the percentage of overdue and incomplete work orders	**28%**	**≤ 15%**					
Finance: Financial information will be available for end-users by the 6th working day for 11 of 12 months	**9**	**11**					
Billing/HIM: Track the number of Financial Assistance applications provided, returned & approved. Increase the number of applications provided by 10%	**286**	**315**					
Human Resources: Conduct a minimum of 2 employee engagement surveys.	**1**	**2**					
Foundation: Increase the number of staff members participating in the 15-Minute Philanthropist program by 20%	**48**	**57.6**					
Information Technology: All Worxhub tickets, including weekend tickets, are acknowledged within an average of 2 days of input & calculated quarterly.	3 d 16 h 50 m	**≤ 2 days**					
Employee Health: Complete RCAs on 90% of all reportable workplace injuries	**0%**	**90%**					
Patient Access: Identify patients that qualify for charity care by using bill holds to flag encounters allowing biller to track and follow-up with patients.	**63**	**69**					
Quality and Risk: Initiate ISO 9001 as evidenced by development/implementation of Quality Management System, completion of organization pre-assessment/gap analysis, and initiation of an ISO implementation action plan/calendar		**Pass/Fail**					
Supply Chain: Implement & maintain a housewide monthly product out-date process	**85%**	**95%**					
CLINICAL							
Acute Care: Increase documented patient education related to admission diagnosis within 4 hours of admission to 80% by year end (#IP admissions/# of IP with education started w/in 4 hours)	**50%**	**≥ 80%**					
Case Management: Implement concurrent OPTUM admission review process for weekend admissions (# of OPTUM reviews sent/# weekend admissions) {WE = 1600 Fridays - 0600 Mondays}	**0%**	**≥ 60%**					
Dietary/Nutrition: Increase number of participants in healthy cooking demonstrations for public by 50%	**16**	**24**					

Emergency Department: Improve ED Moderate Sedation monitoring documentation to DNV standards (# of sedation patients/# of sedation documentation compliance with all elements of requirement)	**50%**	**≥ 95%**
Imaging: Decrease stroke/CT report turnaround to 15 minutes or less	**20 minutes**	**≤ 15 minutes**
Infection Control: Increase hand hygiene compliance	**87%**	**≥ 90%**
Laboratory: Decrease rate of reference lab rejected samples	**0.70%**	**≤ 0.5%**
Respiratory Therapy: Recruit RT to core level of 60 hours/week of coverage (without traveler staff) by year end	**24 hours/week**	**Pass/Fail**
Pharmacy: Intervene on new antibiotic starts to improve monitoring of antibiotic therapy and other narrow therapeutic index drugs to expedite the best drug therapy for our patients	**0**	**15/qtr**
Pulmonary Rehab: Reopen Pulmonary Rehab program by year end	**0**	**Pass/Fail**
Wellness: Create 2 additional programs that provide and improve overall patient outcomes.	**2**	**4**
Rehab Services: Overall patient outcomes will be at least 90% of expected outcomes based on FOTO risk adjusted predictions	**0%**	**≥ 90%**
Patient Satisfaction will be 90% net promotor score from FOTO	**0%**	**≥ 90%**
Surgical Services: Improve preoperative H&P compliance to DNV standards	**50%**	**≥ 90%**
Swing Beds: Improve rate of Skilled Swing Bed Comprehensive Assessments completed weekly (# of Skilled Swing Bed Comprehensive Assessments completed/# of Skilled Swing Bed patients on Wednesday)	**30%**	**≥ 90%**
Wound Care: 25% of all venous leg ulcer patients will achieve healed status or 50% reduction witin 90 calendar days of starting therapy	**18% (12/65)**	**25%**
CLINICS		
Morton: Increase annual wellness visits by 25%	**189**	**236**
Mossyrock: Increase annual wellness visits by 25%	**112**	**140**
Randle: Increase annual wellness visits by 25%	**75**	**94**
Specialty: Improve patient education and awareness by 50% of all patients seen their after visit summary (# of patients receiving after visit summary/total number of patients seen)	**0**	**≥ 50%**

EXECUTIVE DASHBOARD

TO CONTINUE AS STEWARDS OF PUBLIC FUNDS

METRIC	BASELINE	TARGET	2021 Q1	Q2	Q3	Q4	YTD
NON-CLINICAL							
Administration: Decrease Non-RN interim staffing costs by 10% or greater (excludes Medefis in Acute Care & ER).	$ 1,485,937	$ 1,337,343					
Clinical Informatics: Through training and workflow changes, reduce the number of encounters with missed charges secondary to admitting order errors by 20%	25	20					
Compliance: Audit work plan for implementation, follow-through, and outcomes reported to Compliance Committee		100%					
Communications: Increase number of annual wellness visits by 10% through the use of effective marketing messaging	375	413					
Environmental Services: Decrease overtime by 25% by optimizing staffing schedules.	$ 9,305	$ 6,979					
Finance: Pay external vendors timely and per schedule, reducing variation/errors	80%	85%					
Billing/HIM: Decrease timely filing write-offs by 25%	$ 91,691	$ 68,768					
Human Resources: All performance evaluations will be completed within 30 days of the due date	81%	100%					
Foundation: Establish a monthly donor program in the community to ease in the process of obtaining philanthropic donations to minimize the reliance on fund raising via events		Pass/Fail					
Information Technology: Implement an IT asset tracking system that meets compliance requirement & supports the District in tracking IT devices.		Pass/Fail					
Employee Health: Submit 100% of eligible claims to LNIs Stay-at-Work Program	80%	100%					
Patient Access: Increase point-of-service collections by 10% in ER and 10% in OP Services.	$ 20,261	$ 22,287					
	$ 156,376	$ 172,014					
Quality and Risk: Increase Medication Error reporting by 10% to minimize unknown/unreported litigation risk	68	75					
Supply Chain: All assets/capital purchases undergo asset purchase process/structure lead by Materials team.	50%	75%					
CLINICAL							
Acute Care: 30% reduction in lost revenue due to *Did Not Meet Inpatient Criteria* denials.	$ 113,984	$ 79,789					
Case Management: 15% reduction in Code 44s	50	43					
Dietary/Nutrition: Decrease department turnover by 40%	3	2					
Emergency Department: Implement review process to manage ED Diversions in 2022 to 4.75% or less. (Diversion Hours/Hours per quarter)	5%, 431 hrs annualized	≤4.7 5% or ≤416 hours					
Imaging: Redesign staffing model & recruit employees in order to offer all available services		Pass/Fail					
Infection Control: Update & distribute the hospital Antibiogram quarterly		Pass/Fail					
Laboratory: 10% reduction in lab test write-offs due to lack of medical necessity or ABN	$ 85,000	$ 76,500.00					
Respiratory Therapy: Reopen outpatient PFT, EKG & Stress Test Services by year end	0	Pass/Fail					

Pharmacy: Assess current inventory of medications for usage and number of different forms to reduce overall inventory by 5% and increase safety per ISMP guidelines.	**$ 146,874**	**$ 139,531**	
Pulmonary Rehab: Reopen Pulmonary Rehabilitation therapy (pending COVID guidelines) by year end	**0**	**Pass/Fail**	
Wellness: Promote a wellness program that is an efficient use of funds and demonstrates a commitment to reducing healthcare cost overall in the community. This may be done through outsourcing to share costs, etc..		**Pass/Fail**	
Rehab Services: Decrease our cancel/no show rate to reduce non-productive time and improve patient outcomes.	**13%**	**≤ 12%**	
Surgical Services: Increase surgical procedures by 30%	**320**	**416**	
Swing Beds: All Weekday Swing Bed referrals will have a next business day response re: admission eligibility	**40%**	**80%**	
Wound Care: Increase WOCN EPIFIX administration for chronic wounds by 30%	**60**	**78**	
CLINICS			
Morton: Increase telehealth visits by 25%	**187**	**234**	
Mossyrock: Increase telehealth visits by 25%	**166**	**208**	
Randle: Increase telehealth visits by 25%	**328**	**410**	
Specialty: Market and grow telehealth visits by 25%	**120**	**150**	

Mossyrock Clinic
745 WILLIAMS STREET
360-983-8990

Randle Clinic
108 KINDLE ROAD
360-497-3333

Morton Hospital
521 ADAMS AVENUE
360-496-5112

Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 1/19/2022
Subject: Packwood Clinic Update

I have been in contact with a developer in Packwood. They are negotiating on a property and would like for us to be their primary tenant. Due to the loss of our Facilities Director, the momentum of this project will be slowed until a replacement, interim or permanent, can be identified. The prospective buyer has been notified of this situation.

I am asking the Board of Commissioners to reaffirm their commitment to establishing a facility in Packwood. The minimum commitment would be to place one provider in practice with a longer-term goal of adding rehabilitation services.

Mossyrock Clinic
745 WILLIAMS STREET
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Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 1/19/2022
Subject: Rapid Clinic Update

Securing staffing, MAs and receptionists, has been more of a struggle than anticipated. We are adding to our MA/ER Tech staffing pool. Our intent is to rotate the ER Tech through both the ER and the Rapid Clinic. With a recent MA/ER Tech addition, we should have limited support in a couple of weeks.

Unfortunately, we have experienced no interest, internally or externally, in the Rapid Clinic receptionist position. To manage this, it is our intent to staff the Rapid Clinic with two MAs/ER Techs, on in front of clinic and one in back. This will allow us to open the clinic until the position can be filled.

The current plan is to open the Rapid Clinic on February 4, 2022. We may only be able to staff the clinic for two of the four days. The Morton Clinic staff will provide support the weekend of January 28, 2022, to allow for a soft open. This will allow the provider and staff to trial their workflows with a modest patient load to find efficiencies ahead of the official open.

Please take the time to thank Char Hancock, Dr. McCurry, LeeAnn Evans and the Morton Clinic team. They are finding creative ways to get the Rapid Clinic seeing patients.

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Morton Clinic
531 ADAMS AVENUE
360-496-5145

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 1/19/2022
Subject: Redistricting

Because 2020 census data has been released, public hospital districts (PHDs) with commissioner districts must redistrict. RCW 29A.76.010 states "it is the responsibility of each …special purpose district with a governing body comprised of …commissioner districts not based on statutorily required land ownership criteria to periodically redistrict its governmental unit, based on population information from the most recent federal decennial census." For this census, PHDs have a November 15, 2022, deadline as the redistricting will impact the 2023 general elections.

Matthew Ellsworth, Executive Director of the Association of Washington Public Hospital Districts (AWPHD), will be joining us as a guest for our February 2022 Regular Board Meeting. One of Matt's duties is to support and assist PHDs in their redistricting process. Matt will walk us through the pros and cons of commissioner districts, the regulatory requirements surrounding this task, as well as next steps. Arbor Health will need to engage a consultant to assist with this process.

Please find the PowerPoint presentation titled "Redistricting for Public Hospital Districts." This was provided at a governance education opportunity in December 2021. For those of you working towards governance certification, you may already have this information. Matt, and AWPHD, co-sponsored this event with WSHA.

Washington State Hospital Association | Association of Washington Public Hospital Districts

GOVERNANCE EDUCATION

WASHINGTON STATE HOSPITAL ASSOCIATION

ASSOCIATION OF WASHINGTON PUBLIC HOSPITAL DISTRICTS

Redistricting for Public Hospital Districts

12/13/2021

Facilitator

Matthew Ellsworth
Executive Director
Association of Washington Public Hospital Districts

Speakers

Daniel Pailthorp
Public Outreach Coordinator,
Washington State Redistricting Commission

Linda Gallagher
Legal Consultant,
Municipal Research Services Center

Oskar Rey
Legal Consultant,
Municipal Research Services Center

Washington State Redistricting Commission
MRSC Empowering local governments
Washington State Hospital Association
Association of Washington Public Hospital Districts

Washington State
Redistricting Commission

Washington State Redistricting Commission

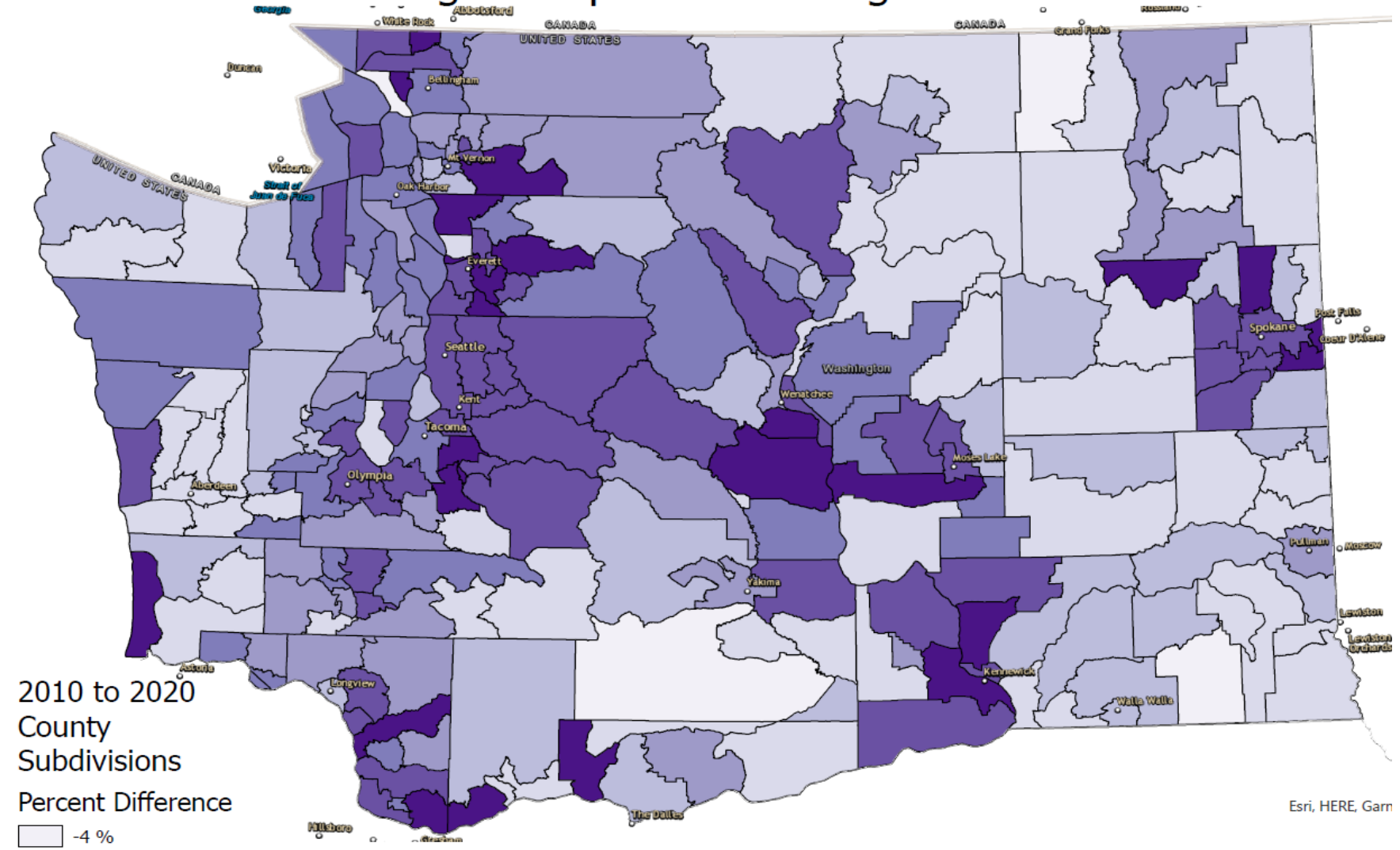
December 13, 2021

Washington State
Redistricting Commission

Census 2020

- 2020 Census: **7,705,281**
- Almost 1 million person growth over 10 years (980,000, 14.6% growth)
- Growth of metro areas outpaced rural ones 9.6%
- King County among five counties across country that grew by +300k (or 17.5%)
- Franklin Co. (23.8%), Clark (18.3%), Benton (18.1%), and Thurston Co. (16.9%)
- Kent – one of the 10 fastest growing cities in the nation @ 47.8% (137k)

Washington Population Change: 2010 to 2020



the Population change of county subdivisions from 2010 to 2020. Each Legend step is the average of a range.

Washington State
Redistricting Commission

Diversity in WA

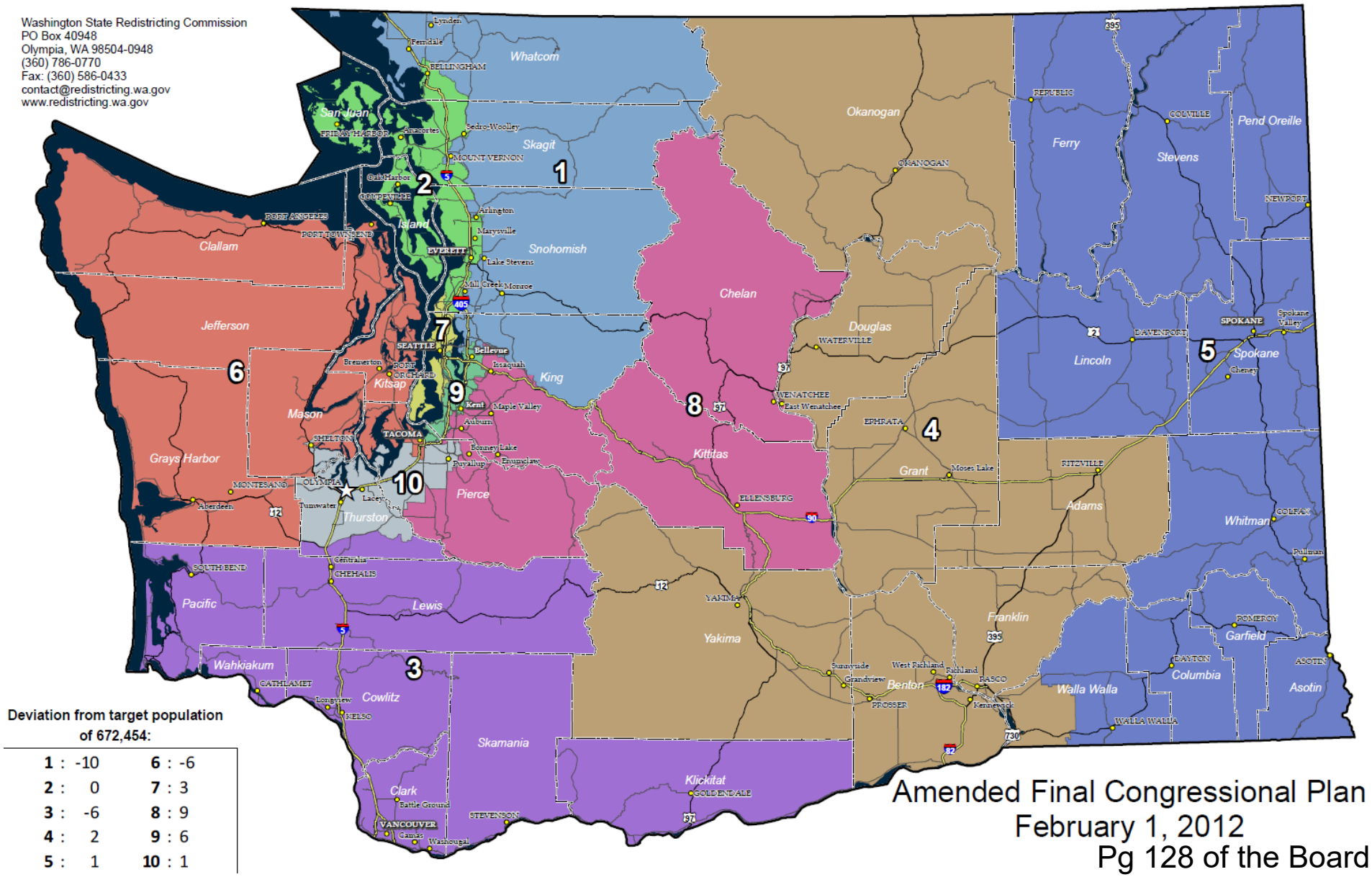
Demographic Breakdown by Race and Ethnicity				
ETHNICITY	2020 Census	Percent	2010 Census	Change (%)
Hispanic or Latino	1,059,213	13.7%	755,790	40.1%
Non-Hispanic or Latino	6,646,068	86.3%	5,968,750	11.3%
RACE				
White alone	5,130,920	66.6%	5,196,362	-1.3%
Asian alone	730,596	9.5%	481,067	52.0%
Black or African American alone	307,565	4.0%	240,042	28.1%
American Indian or Alaska Native alone	121,468	1.6%	103,869	1.5%
Native Hawaiian or Other Pacific Islander alone	64,933	0.8%	40,475	60.4%
Some Other Race alone	513,140	6.7%	349,799	46.7%
Two or More Races	836,659	10.9%	312,926	167.4%
TOTAL POPULATION				
Total Washington	7,705,281	100.0%	6,724,540	14.6%

Census 2020 Redistricting Data

Nation more diverse & multiracial due to more thorough & accurate depiction of how folks self-identify

- 276% increase in those self-identifying as multiracial
- 23% increase in Hispanic/LatinX population

Outreach Districts



Amended Final Congressional Plan
February 1, 2012
Pg 128 of the Board Packet

Washington State
Redistricting Commission

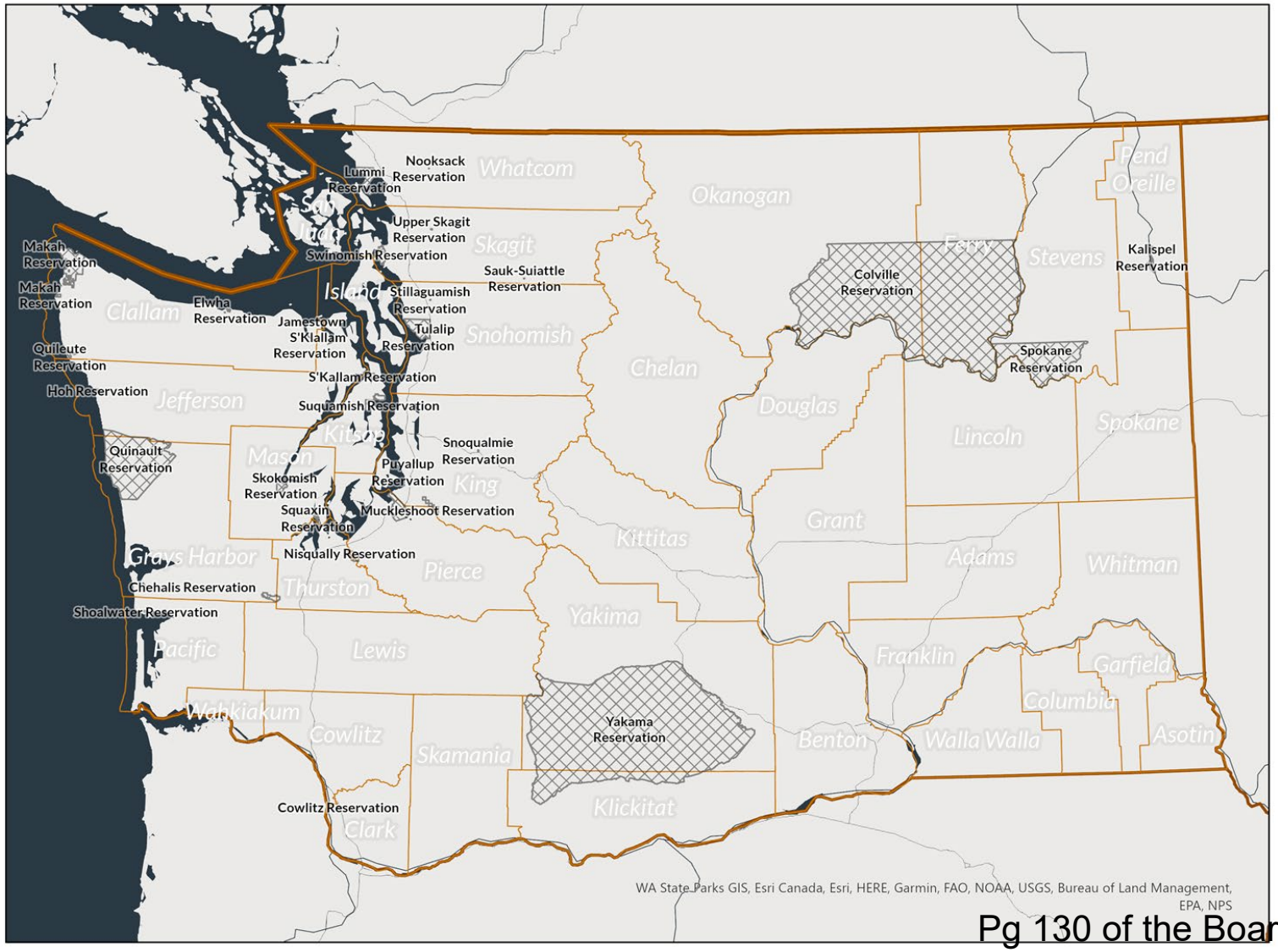
Public Engagement

- Engaging Branding and Slogans
- Interpretation: Offered Spanish & ASL for all public meetings, option for other languages
- Animated Videos (6): All translated into Spanish, one in 9 languages
- Outreach Meetings: 17 virtual public outreach meetings, plus commentary at 21 business meetings
- Multiple Avenues for Comment: Email, website forums, videos, mail, audio files, phone calls
- Paid Advertising on social media

Washington State
Redistricting Commission

Tribal Consultation

- A 1st for a Commission
- 8 Tribes



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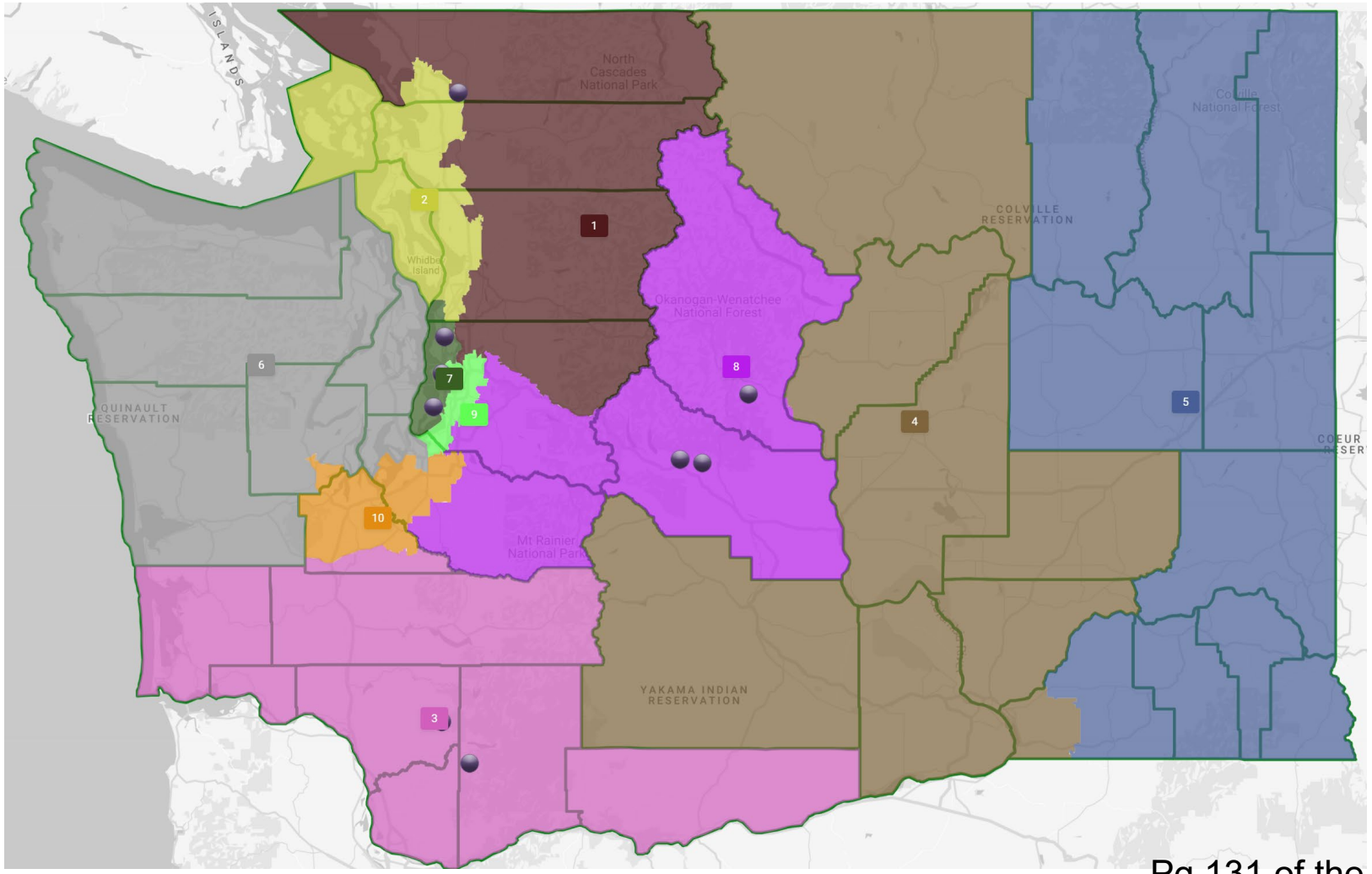
Washington State
Redistricting Commission

Comment Directly on Drafts



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Washington State
Redistricting Commission

Historic Engagement

- Reached over 2 million on Facebook and 350,000 on Instagram
- 750,000+ watched well over 16,000 hours of our YouTube content
- More than 400 individuals delivered commentary at live meetings
- 3,000 left comments on the draft maps
- 3,000 sent an email, commented on website form, wrote a letter, left a voice mail
- 1,300 drew a map of their own – 70 formally submitted maps

Questions?

Contact Information

- Lisa McLean, Executive Director – lisa.mclean@redistricting.wa.gov
- Daniel Pailthorp, Public Outreach Coordinator – daniel.pailthorp@redistricting.wa.gov

www.redistricting.wa.gov

Presenters

Oskar Rey

Legal Consultant
orey@mrsc.org
206-625-1300 ext. 102

Linda Gallagher

Legal Consultant
lgallagher@mrsc.org
206-625-1300 ext. 112

MRSC Services - Overview

Our Mission: Empowering local governments to better serve their communities.

MRSC contracts with special purpose district associations including AWPHD to provide members access to our services.

Pg 135 of the Board Packet

About MRSC

RESEARCH AND CONSULTING SERVICES FOR WASHINGTON LOCAL GOVERNMENTS AND STATE AGENCIES

Ask MRSC – Free, one-on-one legal and policy consultation

Webinars and in-person trainings

Timely news and information

Sample document library

Online research tools and publications

And more!

PHDs and Redistricting

Why do some PHDs have districts and others do not?

Who decides?

Under what circumstances might a PHD have districts but not be required to redistrict?

What latitude do PHDs have to abolish or re-establish commissioner districts?

Are PHDs subject to the Washington Voting Rights Act?

PHD Formation--Districts

PHDs do not make the original decision about commissioner districts.

RCW 70.44.040(1) provides that the county legislative authority decides how many commissioners (3, 5, or 7) and whether the positions are at-large, district-based, or some of each.

Many PHDs have not revisited the options for the number of commissioners and district versus at-large representation, but there are options.

PHDs that are not Required to Redistrict

A PHD need not redistrict if:

- It elects all of its commissioners on a district-wide basis (duh!);
- If it is county-wide and has three commissioner districts in a county with three county legislators (e.g., BOCC). The PHD commissioner districts simply follow the county legislative districts.

Statutory authority: RCW 70.44.040 (2): “If the proposed public hospital district initially will have three commissioner districts and the public hospital district is countywide, and if the county has three county legislative authority districts, the county legislative authority districts shall be used as public hospital district commissioner districts.”

Alternatives to Redistricting

A PHD has the option of abolishing commissioner districts by resolution.

Voter approval is not required. A public hearing is not required either (although it may be advisable).

The decision of whether to abolish commissioner districts is a policy question for the Board:

- Commissioner districts ensure that representation is spread out more evenly across the PHD territory
- At large representation may be administratively easier
- Remember, all of the voters of the PHD vote for all of the commissioner positions in both primaries and general election

Statutory authority: RCW 70.44.042: “Notwithstanding any provision in RCW 70.44.040 to the contrary, any board of public hospital district commissioners may, by resolution, abolish commissioner districts and permit candidates for any position on the board to reside anywhere in the public hospital district.”

Re-establishment of Districts

A PHD can decide to re-establish districts, but voter approval is required.

RCW 70.44.042 provides:

> At any general or special election which may be called for that purpose, the board of public hospital district commissioners may, or on petition of ten percent of the voters based on the total vote cast in the last district general election in the public hospital district shall, by resolution, submit to the voters of the district the proposition to reestablish commissioner districts.

Another Redistricting Scenario

Redistricting is most commonly associated with the ten-year census cycle. But it can come up if a PHD decides to increase its commissioners:

- A PHD may increase the number of commissioners to 5 or 7—RCW 70.44.053 and 054. Voter approval required.
- Default is that new commissioners are elected "at-large" unless Board opts for commissioner districts for the new positions.
- This might be a good option for a Board with 3 commissioners—that is an unwieldy number for OPMA purposes.

Redistricting—Commissioner Residency

What happens if redistricting results in a commissioner being moved into another commissioner district?

- Try to avoid that scenario;
- If it happens, RCW 70.44.047 provides the remedy:
  - If … more than the correct number of commissioners who are associated with commissioner districts reside in the same commissioner district, a commissioner or commissioners residing in that redrawn commissioner district equal in number to the number of commissioners in excess of the correct number shall be assigned to the drawn commissioner district or districts in which less than the correct number of commissioners associated with commissioner districts reside. The commissioner or commissioners who are so assigned shall be those with the shortest unexpired term or terms of office, but if the number of such commissioners with the same terms of office exceeds the number that are to be assigned, the board of commissioners shall select by lot from those commissioners which one or ones are assigned. A commissioner who is so assigned shall be deemed to be a resident of the commissioner district to which he or she is assigned for purposes of determining whether a position is vacant.

Washington Voting Rights Act

The WVRA applies to some special purpose districts, but not others. RCW 29A.92.010(4) defines "political subdivision" as:

> "any county, city, town, school district, fire protection district, port district, or public utility district, but does not include the state."

Why aren't PHDs included? Likely because voters elect commissioners on a district-wide basis—both primary and general.

Commissioner districts must still meet the requirements of RCW Chapter 29A.76.010(4)—more from Linda on that.

Additional resource: AWPHD Legal Manual—Commissioner Districts (pages 23-25)

Local Government Redistricting

The most common type of redistricting occurs every 10 years following the decennial census. Redistricting may also occur as a result of annexation or because of a federal or state voting rights act.

The U.S. Census Bureau supplies all census data to the states and each state provides the data to agencies responsible for redistricting.

Redistricting: Special Purpose Districts

RCW 29A.76.010 identifies local governments required to redistrict and outlines the process for local redistricting.

*"(1) It is the responsibility of **each** county, municipal corporation, and **special purpose district with a governing body comprised of internal director, council, or commissioner districts** not based on statutorily required land ownership criteria to periodically redistrict its governmental unit, based on population information from the most recent federal decennial census."*

Redistricting Process

RCW 29A.76.010(2):

"Within forty-five days after receipt of federal decennial census information applicable to a specific local area, the commission established in RCW 44.05.030 shall forward the census information to each municipal corporation, county, and district charged with redistricting under this section."

Redistricting Process – Due Dates

RCW 29A.76.010(3):

(3) Except as otherwise provided in chapter 301, Laws of 2018, the governing body of the municipal corporation, county, or district shall prepare a plan for redistricting its internal or director districts:

(a) By December 31, 2021, if the jurisdiction is scheduled to elect members to its governing body in 2022; or

(b) By November 15, 2022, if the jurisdiction is not scheduled to elect members to its governing body in 2022.

PHD Commissioners Elections: Timing

PHD board elections held at general elections in odd-numbered years. The next elections are in 2023.

For this census only: November 15, 2022 is the deadline for PHDs

Future deadlines starting with 2030 Decennial Census: "*no later than November 15th of each year ending in one, the governing body of the municipal corporation, county, or district shall prepare a plan for redistricting its internal or director districts*."

Criteria for Redistricting Plans

RCW 29A.76.010(4):

(4) The plan shall be consistent with the following criteria:

(a) Each internal director, council, or commissioner district shall be as nearly equal in population as possible to each and every other such district comprising the municipal corporation, county, or special purpose district.

(b) Each district shall be as compact as possible.

(c) Each district shall consist of geographically contiguous area.

(d) Population data may not be used for purposes of favoring or disfavoring any racial group or political party.

(e) To the extent feasible and if not inconsistent with the basic enabling legislation for the municipal corporation, county, or district, the district boundaries shall coincide with existing recognized natural boundaries and shall, to the extent possible, preserve existing communities of related and mutual interest.

Public Notice and Participation

RCW 29A.76.010(5):

(5) During the adoption of its plan, the municipal corporation, county, or district shall ensure that full and reasonable public notice of its actions is provided. Before adopting the plan, the municipal corporation, county, or district must:

(a) Publish the draft plan and hold a meeting, including notice and comment, within ten days of publishing the draft plan and at least one week before adopting the plan; and

(b) Amend the draft as necessary after receiving public comments and resubmit any amended draft plan for additional written public comment at least one week before adopting the plan.

Redistricting Plans: Potential Challenges

RCW 29A.76.010(6):

(6)(a) Any registered voter residing in an area affected by the redistricting plan may request review of the adopted local plan by the superior court of the county in which he or she resides, within fifteen days of the plan's adoption.

Provide Information to County Auditor

-

RCW 29A.76.020 requires the legislative authority of each county and each city, town, and special purpose district which lies within the county to provide the county auditor accurate information describing the district's geographical boundaries and the boundaries of its internal director, council, or commissioner districts and shall ensure that the information provided to the auditor is kept current.

Questions?

Contact your agency's attorneys!

Linda Gallagher
lgallagher@mrsc.org

Oskar Rey
orey@mrsc.org

206-625-1300

Thank you for attending!

A REMINDER FOR THOSE WHO ARE WORKING TOWARDS EARNING THEIR WSHA & AWPHD HEALTH CARE GOVERNANCE CERTIFICATION OR RECERTIFICATION, PARTICIPATION IN THIS COURSE QUALIFIES FOR (1) CREDIT HOUR.

YOU WILL BE SENT AN EMAIL TO THE ACCOUNT THAT YOU USED TO REGISTER FOR THIS COURSE.

THAT EMAIL WILL PROVIDE YOU WITH INSTRUCTIONS ON HOW TO LOG YOUR CREDIT HOURS.

IF THERE ARE MULTIPLE BOARD MEMBERS WHO HAVE REGISTERED UNDER ONE ACCOUNT, PLEASE HAVE EACH INDIVIDUAL FOLLOW THE LINK PROVIDED IN THE EMAIL TO ENSURE THAT EVERYONE WILL BE CREDITED FOR THEIR PARTICIPATION.

IF YOU HAVE ANY FURTHER QUESTIONS, OR WOULD LIKE TO PROVIDE FEEDBACK ON THE COURSE, PLEASE FEEL FREE TO EMAIL US: GOVEDU@WSHA.ORG