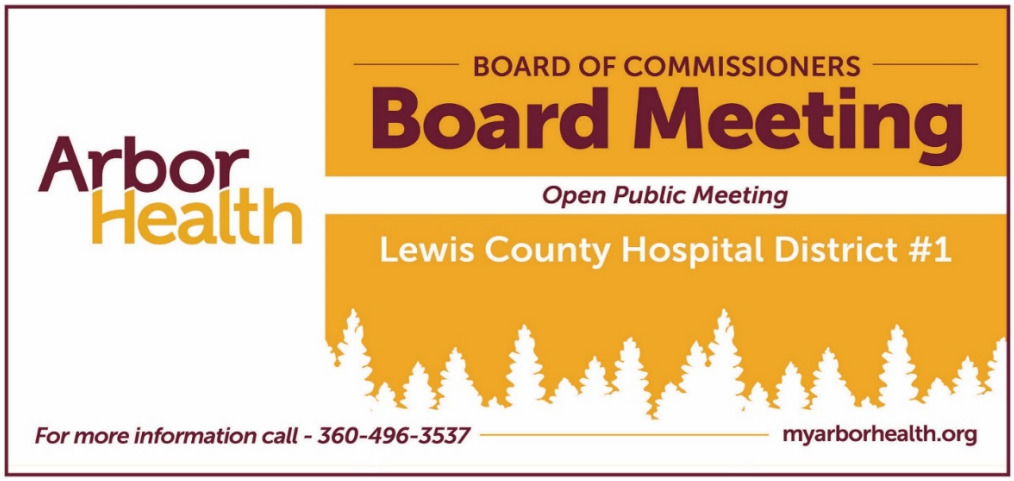
REGULAR BOARD MEETING PACKET



BOARD OF COMMISSIONERS

Board Chair – Trish Frady, Secretary – Tom Herrin,
Commissioner – Craig Coppock,
Commissioner – Wes McMahan & Commissioner-Chris Schumaker

December 16, 2020 @ 3:30 PM
Join Zoom Meeting: https://myarborhealth.zoom.us/j/91442234008
Meeting ID: 914 4223 4008
One tap mobile: +12532158782,,91442234008#
Dial: +1 253 215 8782

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LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
December 16, 2020 at 3:30 p.m.
ZOOM
https://myarborhealth.zoom.us/j/91442234008
Meeting ID: 914 4223 4008
One tap mobile: +12532158782,,91442234008#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

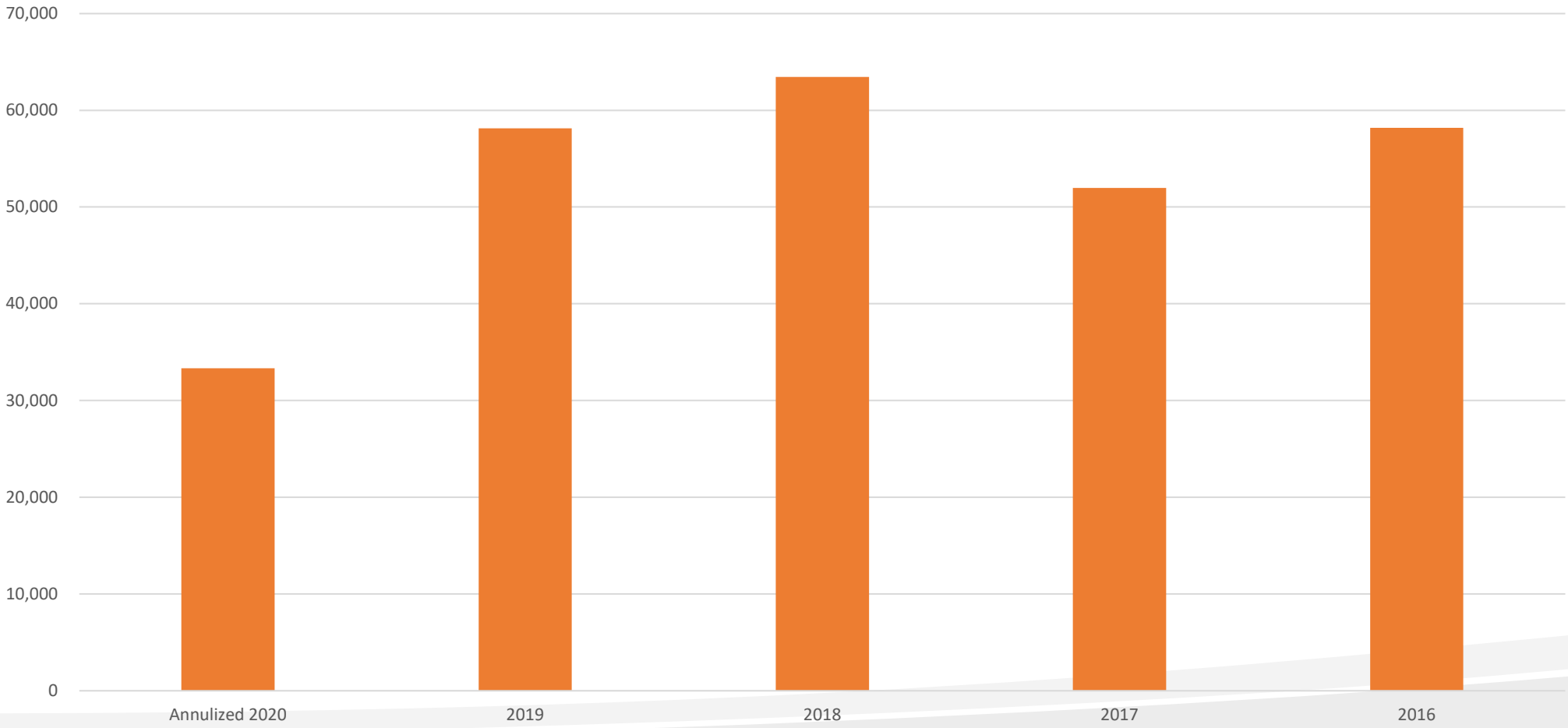
Vision Statement
To provide accessible, quality healthcare.

AGENDA	PAGE	TIME
Call to Order **Approval or Amendment of Agenda** **Conflict of Interest**		3:30 pm
Comments and Remarks • Commissioners • Audience		3:35 pm
Executive Session-*RCW 70.41.205 & RCW 70.41.200* • Medical Privileging-Janice Holmes • Quality Improvement Oversight Report-Commissioner McMahan & Dexter Degoma		3:45 pm
Guest Speaker • Deferring to the January meeting.		4:30 pm
Department Spotlight • Dietary Department o *To strategically discuss the department's current and future state.*	5	4:30 pm
Board Committee Reports • Hospital Foundation Report-Committee Chair-Commissioner McMahan	12	4:40 pm
• Finance Committee Report-Committee Chair-Commissioner Herrin	14	4:45 pm
Consent Agenda *(Action)* • Approval of Minutes: o *Minutes of the November 11, 2020 Regular Board Meeting* o *Minutes of the November 18, 2020 Finance Committee Meeting* o *Minutes of the November 30, 2020 Special Board Meeting* o *Minutes of the December 2, 2020 Quality Improvement Oversight Committee Meeting*	16 23 26 28	4:55 pm
• Warrants & EFT's in the amount of $4,278,483.73 dated October 2020	34	
• Warrants & EFT's in the amount of $4,278,483.73 dated November 2020	36	
• Resolution 20-49-Approving the Clinical/Non-Clinical Contracted Services Evaluation Matrix o *To approve the contracted services that have been evaluated to date. This*	38	

matrix will be presented at the meeting.		
• Resolution 20-50-Adopt Flexible Spending Account Plan o *To approve the flexible spending account portion of the employee benefit package; 3rd party administrator requires board resolution of plan.*	41	
• Resolution 20-51-Adopt the Health Reimbursement Arrangement o *To approve the health reimbursement portion of the employee benefit package; 3rd party administrator requires board resolution of plan.*	62	
• Approve Documents Pending Board Ratification 12.16.20 o *To provide board oversight for document management in Lucidoc.*	81	
Old Business • Resolution 20-47-Approving the Fire District No. 4 Agreement *(Action)* o *To approve new operating expense.*	85	5:00 pm
• Board Meeting Teleconference o *To review the revised policy and procedure.*	88	5:15 pm
Break		5:25 pm
• Board Self-Evaluation o *To discuss as a Board the evaluations completed for 2020.*	90	5:35 pm
New Business • Board Education-iProtean o Recruitment and Orientation o Two Imperative for Boards	 94 102	6:00 pm
• Pricing Transparency o *CFO Boggess to demonstrate District's pricing transparency compliance.*		6:10 pm
• Resolution 20-52-Approving the DZA Financial Audit, Single Audit for Cares Act Funding and Cost Report Annual Engagement *(Action)* o *To approve the engagement with DZA.*	113	6:20 pm
• Resolution 20-53-Approving the Capital Purchase of Cerner Modules *(Action)* o *To approve the purchase of the Cerner Modules for Case Management.*	123	6:30 pm
• DNV Accreditation Appointments o *To appoint positions as required for accreditation by DNV.*	126	6:35 pm
• Incident Command Update o *CNO/CQO Williamson to discuss the DRAFT Expansion & Contraction of Care Plan.*	129	6:45 pm
• 2021 Organization of the Board *(Action)* o *To review and assign committee assignments and to vote on a 2020 Board Chair and Secretary.*	136	6:55 pm
Superintendent Report • Superintendent Everett will provide a verbal report.	137	7:15 pm
Next Board Meeting Dates and Times • Regular Board Meeting-January 27, 2021 @ 3:30 PM (ZOOM) **Next Committee Meeting Dates and Times** • Compliance Committee Meeting-December 30, 2020 @ 12:00 PM (ZOOM) • Arbor Health Foundation Meeting-January 12, 2021 • QIO Committee Meeting-January 13, 2021 @ 7:00 AM (ZOOM) • Finance Committee Meeting-January 20, 2021 @ 12:00 PM (ZOOM)		
Meeting Summary & Evaluation		7:25 pm
Adjournment		7:30 pm

Dietary

Meals Served



The COVID Experience

- 2020 decrease in meals served
- Reduction in patients
- Closure of the dining area to outside patrons

Repairs and Maintenance Increase

- Built-in freezer and cooler required significant repair.
- Most of the equipment in the dietary department is 26 years old and will need to be replaced in the coming years.

A Day in the Dietary Department!

Dietary's 2021 Strategic Measures

- Strategy 1: Provide To-Go meals to seniors in food scarce homes. Measure is # of meals served with a baseline of zero.
- Strategy 2: Conduct healthy cooking demonstrations for public. Measure is one demonstration per quarter with a baseline of zero.
- Strategy 3: Increase rebates from GPO food supplier. Measure will be an increase of 20% or more of the CY 2020 rebates (baseline).

BOARD COMMITTEE REPORTS

Arbor Health Foundation Meeting Minutes

Tuesday November 10, 2020

Online Zoom Meeting

Attendance: Ali Draper, Diane Markum, Caro Johnson, Jeannine Walker, Jenn Katz, Betty Jurey, Marc Fisher, Gwen Turner

Guest: Christine Brower

Call to Order by President Ali Draper at 12:05pm

President Ali Draper read the mission statement

September and October minutes and treasurers' reports were reviewed and approved. Gwen Turner/Marc Fisher

CEO Report: Leiane Everett was absent but Diane reported that progress continues to be made on the accreditation process.

Directors Report: Diane said that Foundation is preparing the annual Employee Gift Cards which will go out in December in the amount of $15 and $30. There will be no Gift Sale this year because of the Covid restrictions. Volunteers are still needed for the gift shop.

Old Business: none

New Business: Chris Preheim will not be able to continue as the merchandiser for the gift shop and Ali Draper will take on that job. Diane questioned if anyone saw this as a conflict of interest as Ali serves as the President and the position pays a monthly stipend of $100. None of the Board members had any concerns.

Slate of Officers for 2021 was presented as follows:

President: Ali Draper

Vice President: Marc Fisher

Secretary: Caro Johnson

Treasurer: Gerri Maize

Lynn Bishop will continue as the Event Chair

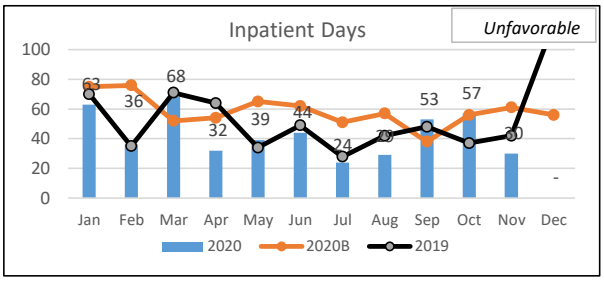
Voting will take place at the December meeting.

Diane reported that because of her husband's illness and her own surgery, the work on the projected budget did not take place. The first draft of the 2021 Budget will be presented in December rather than November.

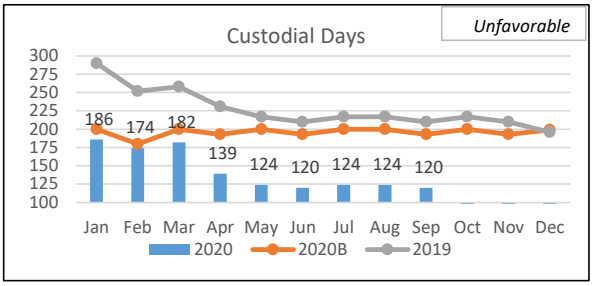
Meeting adjourned 12:27

Lewis County Hospital District No. 1
Board Financial Summary
November 30, 2020

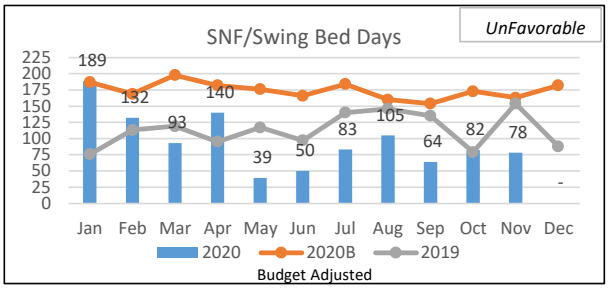
Growth



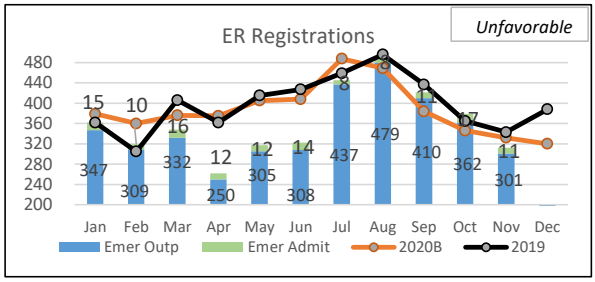
YTD: 475.00 Budget: 647.00 Pr Yr: 520.00



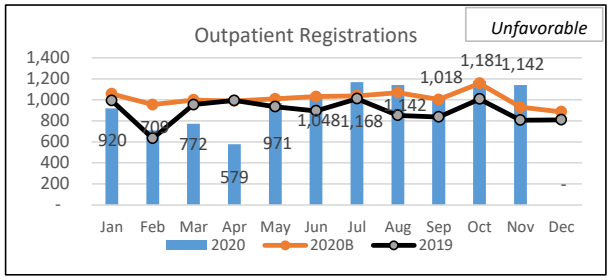
YTD: 1,332 Budget: 2,152 Pr Yr: 2,529



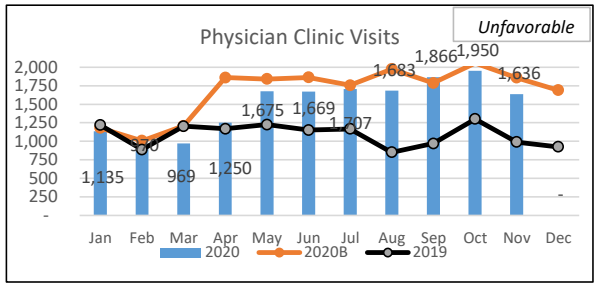
YTD: 1,055 Budget: 1,912 Pr Yr: 1,271



YTD: 3840 Bud: 4322 Pr Yr: 4377

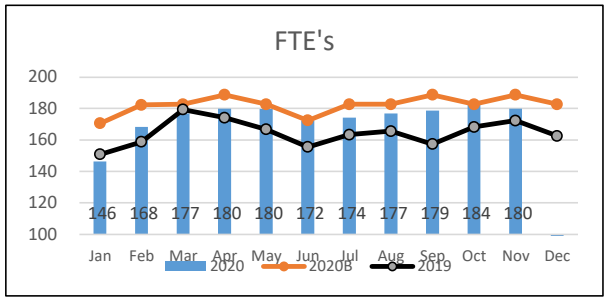


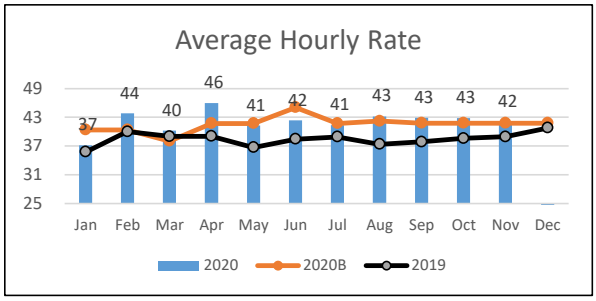
YTD: 10,650 Bud: 11,233 Pr Yr: 9,920

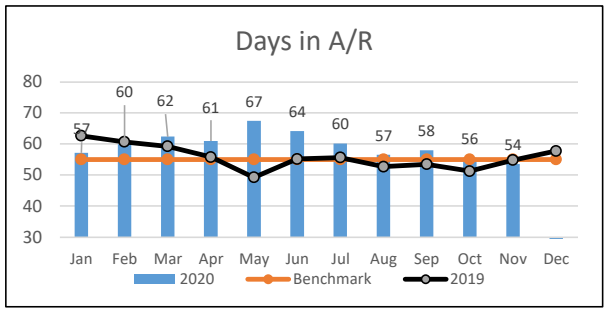


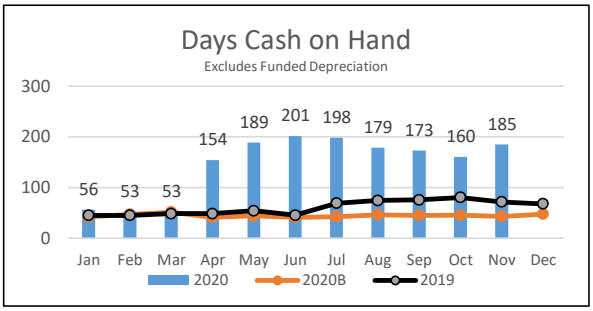
YTD: 16,510 Bud: 18,393 Pr Yr: 12,130

People and Operational Aspects









CONSENT AGENDA

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
REGULAR BOARD OF COMMISSIONERS' MEETING
November 11, 2020 at 3:30 p.m.
ZOOM
https://myarborhealth.zoom.us/j/97594596868
Meeting ID: 975 9459 6868
One tap mobile: +12532158782,,97594596868#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA TOPIC	CONCLUSION	ACTION ITEMS
Call to Order	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 ☒ Roy Anderson, Compliance Officer ☒ Janice Holmes, Medical Staff Coordinator ☒ Diane Markham, Marketing/Communication Manager & Foundation Executive Director ☒ Richard Boggess, CFO ☒ Buddy Rose, Reporter ☒ Elee Fairhart, Morton Resident ☒ Brandy Childress, Clinic Manager ☒ Larry Sinkula, Surgical Services Director ☒ Shannon Kelly, CHRO ☒ Julie Taylor, Ancillary Services Director ☒ Todd Gorham, 2767 Union Representative ☒ Van Anderson, Packwood Resident	

	☒ Dexter Degoma, Interim Quality Manager ☒ Julie Allen, Quality Data Analyst ☒ Travis Nelson, WSNA Union Representative ☒ Cassie Sauer, WSHA's President & CEO ☒ Zosia Stanley, WSHA's Associate General Counsel	
Approval or Amendment of Agenda	Superintendent Everett requested to remove Resolution 20-45-Approving the 2021 Proposed Tax Levies due to the lack of information from Dianne Dorey, Lewis County Assessor. The District will need to schedule a Special Board Meeting by November 15, 2020. Superintendent Everett requested to edit Exhibit A in Resolution 20-44- from RUNG DOCTOR to RUG DOCTOR. Superintendent Everett noted Executive Assistant Garcia emailed the matrix for Resolution 20-43 and an updated list of documents needing board ratification. Both documents were approved by the Medical Staff Meeting this morning in preparation for the upcoming DNV Survey.	Secretary Herrin made a motion to approve the amended agenda. Commissioner McMahan seconded and the motion passed unanimously. Action Item-Executive Assistant Garcia will schedule a Special Board Meeting for Friday, November 13, 2020.
Conflicts of Interest	Board Chair Frady asked the board to state any conflicts of interest with today's agenda.	None noted.
Comments and Remarks	Commissioners: Board Chair Frady extended condolences to the Kenton Smith family on his passing. Commissioner Schumaker extended condolences to Kenton Smith family from not only the Hospital District, but the White Pass School District too. Also, he thanked the Veterans and Arbor Health for the computers that were donated to the School District for students. Commissioner Coppock noted it was a pleasure to know Kenton Smith and a thank you to our veterans. Commissioner McMahan extended a thank to our veterans, as well as noted his condolences to the Kenton Smith family, he will be greatly missed. Audience: Van Anderson, Packwood Resident shared that Kenton Smith passed away peacefully on his birthday with his family. Elee Fairhart, Morton Resident questioned the proposed increase in taxes and requested the Board take into consideration the impact to the District. He requested more information on how the District utilizes the monies.	

	Travis Nelson, WSNA Union Representative appreciated the invite to the Board Meeting and looks forward to working with the management team.	
Executive Session- RCW 70.41.205 & RCW 70.41.200	Executive Session began at 3:55 p.m. for 35 minutes to discuss Medical Privileging and Quality Improvement Oversight Report. The Board returned to open session at 4:30 p.m. No decisions were made in Executive Session. New Appointments 1. James Jordan, MD (Providence – Telestroke Privileges) 2. Brendan McCullough, MD (Radia – Radiology Privileges) 3. Kyle Ogami, MD (Providence – Telestroke Privileges) 4. Daniel Susanto, MD (Radia – Radiology Privileges) 5. Milton Van Hise, MD (Radia – Radiology Privileges) Reappointments 1. Tariq Balawi, MD (Radia – Radiology Privileges) 2. Andrew Bauer, MD (Radia – Radiology Privileges) 3. James Bell, MD (Radia – Radiology Privileges) 4. Lawrence Bennett, MD (Radia – Radiology Privileges) 5. Minal Bhanushali, MD (Providence – Telestroke Privileges) 6. Archit Bhatt, MD (Providence – Telestroke Privileges) 7. Neha Mirchandani, MD (Providence – Telestroke Privileges) 8. Pawani Sachar, MD (Providence – Telestroke Privileges)	Commissioner Coppock made a motion to approve the Medical Privileging as presented and Secretary Herrin seconded. The motion passed unanimously.
Guest Speaker-WSHA-Cassie Sauer & Zosia Stanley	Cassie Sauer with the Washington State Hospital Association (WSHA) provided an overview of how WSHA advocates for the District and the resources available to the District. Zosia Stanley added that there will likely not be a Special Legislative Session in 2020 and the Regular Session will be in January 2021. She encouraged the District to stay	

	engaged when possible even if it is remotely. She noted WSHA is still accepting PAC Monies. She encouraged connecting with legislators on how COVID has changed how we do business. Cassie encouraged the Board to the Governance Education Programs at www.wsha.org/governance.	
Break	Board Chair Frady called for a 5-minute break at 5:20 p.m. The Board returned to open session at 5:25 p.m.	
Department Spotlight •	Deferring to the December meeting.	
Board Committee Reports • Hospital Foundation Report	Commissioner McMahan announced the Foundation Auction raised $29,053 of a $30,000 goal. This is impressive as this is the Foundation's first online auction.	
• Finance Committee Report	Commissioner Herrin shared while the swing bed program is trending below budget, ER and Outpatient Registrations, as well as Clinic Visits are on target a Q3 2020. While Days Cash on Hand continues to be strong, net income for the month was unfavorable to budget.	
Consent Agenda	Board Chair Frady announced the following in consent agenda up for approval: 1. Minutes of the September 30, 2020 Regular Board Meeting *(Action)* 2. Minutes of the October 7, 2020 Special Board Meeting *(Action)* 3. Minutes of the October 13, 2020 Special Board Meeting *(Action)* 4. Minutes of the October 14, 2020 Quality Improvement Oversight Committee Meeting *(Action)* 5. Minutes of the October 21, 2020 Finance Committee Meeting *(Action)* 6. Minutes of the October 28, 2020 Special Board Meeting *(Action)* 7. Warrants & EFT's in the amount of $3,980,538.39 dated September 2020 *(Action)* 8. Resolution 20-43-Approving the Clinical/Non-Clinical Contracted Services Evaluation Matrix *(Action)* 9. Resolution 20-44-Declaring to Surplus or Dispose of Certain Property *(Action)* 10. Approve Documents Pending Board Ratification 11.11.20 *(Action)*	Commissioner Coppock made a motion to approve the Consent Agenda and Commissioner Schumaker seconded. The motion passed unanimously.
Old Business	Superintendent Everett noted the agenda was amended and this topic was removed from the agenda.	

• Resolution 20-45- Approving the 2021 Proposed Tax Levies RCW 84.55.120		
• Resolution 20-46- Adopting the Lewis County Hospital District No. 1 2021 Budget	Superintendent Everett noted the budget presented today was supported by the Finance Committee for approval and no changes were made since the October 28, 2020 when it was originally presented.	Secretary Herrin made a motion to approve Resolution 20-46, Commissioner Coppock seconded. The motion passed unanimously.
• Department Specific Measures	Superintendent Everett presented the management team's department specific measures that align with the three strategic initiatives. There are some measures that may not be substantial; however, will demonstrate measurable movement in the right direction when achieved. The Board supported the measures. Superintendent Everett will present the metrics in the third month of each quarter: in March, June, September and December.	
New Business • Board Education o Board Mindsets to Drive Value o Driving a Sustained Culture of Quality	Board Chair Frady noted both iProtean articles were informative and reiterated the importance of employee stability. Also, she shared the importance of continuity of care, as well as providing quality care even if we are a small hospital. Superintendent Everett was encouraged by the articles as they reinforced one of the reasons we are moving towards accreditation -- to build a framework around processes versus people.	
• 2021 Board Meeting Schedule	Board Chair Frady presented a proposed 2021 schedule. She highlighted that we have added four additional Quality Improvement Oversight Meetings as another change towards shifting our culture to a quality and safety centric organization. The Board supported moving forward with this schedule. Board Chair Frady shared that the Board needs to be thinking about the 2021 elections of officers and committee assignments for 2021 as this will be an agenda item at the December meeting.	
• Resolution 20-47- Approving the Fire District No. 4 Agreement	Superintendent Everett noted Fire District No. 4 has approached the District with an agreement for compensation due to lost revenue on parcels owned by the District, given the District is tax exempt.	Action Item- Superintendent Everett will seek legal opinion on if this agreement opens the

	Bill Reynolds, Fire Chief noted the monies received pay for fire fighters to have training and equipment. He would rather have an agreement than bill per call to the District. Superintendent Everett presented three versions but would recommend version two as the minimal option. Version 2 compensates Fire District No. 4 for lost tax revenues on residential parcels owned by the District. Version 3 was proposed as an alternative to Version 2 as it provides the District the opportunity to compensate the Fire District more in recognition of their services and the District's desire to be good citizens. The Board agreed they want to support Fire District No. 4, but there is not enough information to decide tonight. The Board requested Superintendent Everett get legal advice if this agreement will open the District to additional asks from the other municipalities where the District owns property.	District to additional asks due to our tax-exempt status. Plan to bring the Resolution back to the Regular Board Meeting on December 16, 2020. Action Item-Superintendent Everett will email Bill Reynold's the spreadsheet with the three options.
• Board Policies & Procedures	The Board supported marking the following three policies and procedures as reviewed. 1. Board Mobile Device Management 2. Board Self-Evaluation 3. Board Spending Authority The Board agreed to revise the following policy and bring back to the December 16th Regular Board Meeting for review: 1. Board Meeting Teleconference	Secretary Herrin made a motion to approve P & P's 2, 3 & 4 and Commissioner Schumaker seconded. The motion passed unanimously. Action Item-Executive Assistant Garcia will mark the three policies and procedures as reviewed. Action Item-Board Chair Frady and Executive Assistant Garcia will revise Board Meeting Teleconference policy and procedure and present at the Regular Board Meeting on December 16, 2020 for approval.

		Action Item-Commissioners need to complete the self-evaluation for the Regular Board Meeting on December 16, 2020.
Superintendent Report	Superintendent Everett updated the Board on the following: 1. Took possession of the Morton duplexes. 2. Focused on DNV Survey Preparedness.	
Meeting Summary & Evaluation	Superintendent Everett highlighted the decisions made and action items. Secretary Herrin noted he will be on vacation next week. Commissioner Coppock will chair the Finance Committee and Commissioner Schumaker will attend in his absence. Board Chair Frady requested to send a sympathy card to the Kenton Smith family and Executive Assistant Garcia will sign for the Board.	Action Item-Executive Assistant Garcia will send Commissioner Schumaker's mail to the Randle Clinic for pick up. Action Item-Executive Assistant Garcia will send a sympathy card to the Kenton Smith family on the Board's behalf.
Adjournment	Commissioner Schumaker moved and Commissioner Coppock seconded to adjourn the meeting at 7:02 p.m. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Finance Committee Meeting
November 18, 2020 at 12:00 p.m.
Conference Room 1 & Via Zoom

AGENDA	DISCUSSION	ACTION
Call to Order	Craig 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 ☒ Chris Schumaker, Commissioner **Committee Member(s) Present in Person or via Zoom:** ☐ Shana Garcia, Executive Assistant ☒ Richard Boggess, CFO via Zoom ☒ Leianne Everett, Superintendent ☒ Marc Fisher, Community Member ☐ Clint Scogin, Controller ☒ Sara Williamson, CNO/CQO	
Approval or Amendment of Agenda	CFO Boggess requested to amend the agenda by adding Bond Levies and Impact on Organization and Community Discussion in New Business.	Commissioner Schumaker made a motion to approve the amended agenda. Community Member Fisher seconded, and the motion passed unanimously.
Conflicts of Interest	Commissioner Coppock shared his son works for the Assessor's Office.	
Consent Agenda • **Review of Finance Minutes –October 21, 2020** • **Revenue Cycle Update** • **Board Oversight Activities**		Commissioner Schumaker made a motion to approve the consent agenda and Community Member Fisher seconded. The

• **Cost Report Update** • **Financial Statements**		motion passed unanimously.
Old Business • **Financial Department Spotlight-Dietary-Nutritional Services**	Dietary Manager Conger noted she joined the organization in 2018 with Morrison Healthcare. We have since transition away from this model to our own staff and dietician. The Management Staffing costs were in Purchased Services and now are reflected in Salaries in 2020 following the exit of Morrison in Q2. There are numerous impacts of COVID-19 such as: the closure of the cafeteria to the community, closing the salad bar and converting to single use meals, single use tableware and staff separation.	
• **Disaster Funding Update**	CFO Boggess highlighted HHS third methodology of lost revenues calculation for Care Act monies. The measurement element is now Net Patient Services Revenue compared to 2019. The District recalculated the amount based on Quarters 1, 2 and October 2020. CFO Boggess discussed the differences between the three methodologies. CFO Boggess shared the PPP monies extended from an 8-week program to a 24-week program and we are anticipating a 100% forgiveness. CFO Boggess noted the District will be subject to a Single Audit and we do not anticipate any issues; however, we should expect an increase in engagement fees.	
New Business • **Bond Levies & Impact on Organization & Community Discussion**	CFO Boggess highlighted the following on the levies: 1. The District is authorized to several types of levies. 2. The Regular Levy is at $610,027.19. The standard 1% increase is allowed. The District has a 6.93% of "Banked Capacity," which would allow a max levy amount of $652,286. 3. The Bond Levy is $803,604.91. The District sets the amount to collect and can change annually with notice to the Assessor's Office. 4. The District has no control over the Timber Tax but does receive benefits from this tax. CFO Boggess identified scenarios and future impacts to the District if population exceeds 10,000 and the use of the banked capacity. Recommendation to Board to accept the Highest Lawful Levy using all banked points.	

• **Cost Report Education**	CFO Boggess requested to defer this topic to the December Finance Committee Meeting due to time.	
• **Purchase of New Cerner Modules**	CFO Boggess noted the new Cerner modules will allow Case Management and Revenue Cycle personnel to work better together. This upgrade will allow for better, more timely documentation. The Finance Committee supported moving to the Board for approval via resolution.	Action Item-Executive Assistant Garcia will include a resolution in the Board Packet in December for the approval of the Capital Purchase for the Cerner Modules.
• **Capital Update**	CFO Boggess noted we have a verbal agreement and McKinstry is on contract.	
Adjournment	Commissioner Schumaker moved and Community Member Fisher seconded to adjourn the meeting at 1:05 pm. The motion passed unanimously.	

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
SPECIAL BOARD OF COMMISSIONERS' MEETING
November 30, 2020 at 3:30 p.m.
Zoom
https://myarborhealth.zoom.us/j/91224019372
Meeting ID: 912 2401 9372
One tap mobile: +12532158782,,91224019372#
Dial: +1 253 215 8782

Mission Statement
To foster trust and nurture a healthy community.

Vision Statement
To provide accessible, quality healthcare.

AGENDA TOPIC	CONCLUSION	ACTION ITEMS
Call to Order	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 ☒ Michelle Matchett, Nursing Administrative Assistant ☒ Richard Boggess, CFO	
Reading of the Notice of the Special Meeting	Commissioner Frady read the meeting notice aloud to the audience.	
Public Comment	There were no members of the public present at the meeting.	
New Business Resolution 20-45-Approving the 2021 Proposed Tax Levies *RCW 84.55.120 (Action)* *To discuss the consideration of possible increases in property tax revenues.*	CFO Boggess provided education to the Commissioners about the excess levy and the maintenance and operations levy. The excess levy is a predetermined amount, whereas the District can ratify an increase up to 6.93% over the 2019 levy for the maintenance and operations levy. Secretary Herrin made a motion to approve the proposed 2021 tax levies at 6.93% above the 2019 levy rate. There were no seconds. (The motion fell to the floor.)	

	Commissioner McMahan felt that public input would be needed to consider an increase. Commissioner Schumaker concurred. Superintendent Everett reminded the group that the maintenance and operations levy monies are put into a general fund supporting the maintenance and overall operations of the Hospital District. Commissioner McMahan made a motion to approve the proposed 2021 tax levies at 1% above the 2019 rate. There were no seconds. (The motion fell to the floor.) Commissioner Coppock made a motion to approve the proposed 2021 tax levies at 3.464% over the 2019 rate.	Commissioner Coppock made a motion to approve Resolution 20-45, the 2021 proposed tax levies, at 3.464%. Secretary Herrin seconded. The resolution passed with Commissioner Coppock and Secretary Herrin voting yea; Commissioner McMahan nay; and Commissioner Schumaker abstained from voting.
Resolution-20-48-Reapproving the 2021 Budget *(Action)* *To discuss reapproving the Budget as impacted by the Levies.*	CFO Boggess presented a revised 2021 operating budget that reflects Resolution 20-45's financial impact.	Commissioner McMahan made a motion to reapprove the 2021 budget impacted by the levy rate. Secretary Herrin seconded. The motion passed unanimously.
Adjournment	Commissioner Schumaker moved to adjourn the meeting at 4:57 p.m. and Secretary Herrin seconded. The motion passed unanimously.	

Respectfully submitted,

Tom Herrin, Secretary Date

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
Quality Improvement Oversight Committee Meeting
December 2, 2020 at 7:00 a.m.
Conference Room 1 & 2 & Zoom

AGENDA	DISCUSSION	ACTION
Call to Order	Commissioner McMahan called the meeting to order at 7:01 a.m. **Commissioner(s) Present in Person or via Zoom:** ☒ Wes McMahan ☒ Chris Schumaker **Committee Member(s) Present in Person or via Zoom:** ☒ Leianne Everett, Superintendent ☒ Dexter Degoma, Interim Quality Manager ☒ Roy Anderson, Compliance Officer ☒ Sara Williamson, CNO/CQO ☒ Dr. Kevin McCurry, CMO ☒ Julie Taylor, Ancillary Services Director ☒ Katelin Forrest, HR ☒ Michelle Matchett, Administrative Assistant ☒ Dr. Tom Anderson, Chief of Staff ☒ Julie Allen, Quality Analyst ☒ Maudie Jordan, LifeCenter Northwest ☒ Amanda Seals, Employee Health **Committee Member(s) Absent:** ☒ Shana Garcia, Executive Assistant ☒ Edwin Meelhuysen, Rehabilitation Services Director	
Approval or Amendment of the Agenda	Interim Quality Manager Degoma requested to add a guest presentation from The LifeCenter Northwest to share the 2019 tissue donation dashboard and the 2020 tissue dashboard.	Commissioner McMahan made a motion to amend the agenda and Superintendent Everett seconded. The motion passed unanimously.
Conflicts of Interest	The Committee noted no conflicts of interest.	None noted.
Consent Agenda	1. Approval of the following meeting minutes: a. Quality Improvement Oversight (QIO) Committee Meeting 10/14/20 b. Environment of Care (EOC) Committee Meeting 11/16/20	Dr. Anderson made a motion to approve the consent agenda and Dr. McCurry seconded. The motion passed unanimously.

	c. Infection Prevention and Control (IPC) Committee Meeting 10/26/20 2. Approval of the following Policies and Procedures. a. Contracts Management b. Patient Grievance and Complaint Form 3. Clinical and Non-Clinical Contracted Services Performance Review.	
Guest Presentation • LifeCenter Northwest – Organ Procurement Annual Report (M. Jordan)	Ms. Jordan presented the process for physicians and nursing to contact her organization to begin the process organ and tissue procurement. Arbor Health has had only one patient in the past two years eligible for organ and tissue procurement and three potential patient donators. Timely referral rate for 2020 is down. There have been five potential donators. Only one patient was a viable donation, however, the family declined donation. The other four were ruled out. Ms. Jordan asked to present training to our organization. Interim Quality Manager Degoma assured her that we would reach out to her for training once it is scheduled.	Action Item-Interim Quality Manager will send an invitation for learning once it is time to schedule annual training for staff.
Old Business PI Projects • Employee Injury Management (Forrest & Seals) • COVID-19 Update (S. Williamson & J. Taylor) • 2021 QIO Meeting schedule and frequency (L. Everett)	Human Resources Generalist Forrest and Employee Health & Wellness Coordinator Seals highlighted the following on Employee Injury Management: 1. The Workplace Injury Policy and Procedure was revised and a staff injury packet was created and placed into Lucidoc for employees for easier access. 2. Lift training is now a part of the orientation process. 3. In 2019 the workplace injuries trended downward. Claims have been reduced by 36%. 4. In 2020 there have been a total of 40 injuries and 16 claims. 70% of claims are being reported within 24 hours. Not really in change in types of injuries. 5. The reason for statistics of delayed reporting was because it was not tracked in 2020. This will begin in 2021. Root cause analyses will be conducted on each injury beginning in 2021. CNO/CQO Williamson highlighted the following on COVID-19: 1. Gov. Inslee has again updated the COVID proclamation to limit non-urgent procedures. The Leadership Team will be meeting today to review and develop a plan to respond to the proclamation	

	and to ensure safety to the community and employees. 2. COVID is trending upward in our community. Some staff have been exposed to COVID and have had to quarantine. 3. The CDC has issued new guidelines for quarantining and this will be reviewed at the Leadership Meeting today. 4. COVID testing is available at all three of our clinics. 5. There have been COVID-positive patients treated in the hospital recently. 6. Arbor Health is collaborating with the Washington Coordination Center to facilitate transfer activity for bed access as needed across the state. They will assist when we are challenged in transferring to a higher level of care and we will assist by accepting patients lower acuity COVID positive patients if overflowed from larger facilities. 7. Currently, we are planning for COVID immunization distribution once available. 8. We now have monoclonal antibodies available. It is designed for high-risk people in the community that are COVID positive and not inpatient at the hospital. It is a one-hour infusion followed by one-hour monitoring and then the patient is discharged. Ancillary Services Director Taylor highlighted the following on COVID-19: 1. 1,073 tests have been conducted so far. Positive rate is currently at 4.2%. 2. Rapid testing is now being used more frequently instead of having to send out all tests. 3. Looking for in-house testing equipment but is running into hurdles and having no success. Superintendent Everett highlighted the following on the 2021 QIO Schedule: 1. Proposed moving away from quarterly meetings to meeting twice per quarter to allow for the regular work of the committee to be done in the first month of the quarter. The proposed QIO meeting dates are: a. January 13, 2021 b. March 3, 2021 c. April 7, 2021	

	d. June 2, 2021 e. July 7, 2021 f. September 8, 2021 g. October 6, 2021 h. December 1, 2021 2. All meetings will continue to be held at 7:00am to allow for physician participation.	
New Business Quality and Patient Safety QAPI Dashboard – 3Q2020 (D. Degoma) • Improve Patient Safety, Quality, and Service • Hospital Acquired Infections (HAI) • Unassisted Falls • Hospital Acquired Pressure Injuries • Patient Experience • Event Reporting Improve Resource Utilization • Readmissions Monitor External Regulatory, Accreditation, and Collaborative Indicators • The Quality healthcare Indicator (QHi) Project • WSHA Quality Benchmarking Department Specific Performance Improvement (D. Degoma)	Interim Quality Manger Degoma highlighted the following from the QAPI Dashboard: 1. ZERO Hospital Acquired Infections in all 5 categories 2. Subsequent to re-education, 4th Quarter to date is showing improvement 3. Only one fall with minor injury related to a Rehab outpatient that slipped and fell in the hallway. a. Restraint/Seclusion Policy and Procedure under review to align with DNV Standards. b. Director of Surgical Services in concert with Wound Care to facilitate surveillance and consistent reporting mechanisms for hospital acquired pressure injuries c. Specific to Patient Experience Reporting, return rate challenges continue. In coordination with the Rural Collaborative, Arbor Health will participate in a new vendor trial. Additional improvement opportunities will be addressed in the next Annual Skills Fair specific to: d. Communication About Medication 4. Purpose and Side Effects 5. Care Transitions Interim Quality Manger Degoma highlighted the following from the Improve Resource Utilization Dashboard: 1. While the 3rd Quarter readmission rate remains high, improvement is noted with downward trending. Interim Quality Manger Degoma highlighted the following from the Monitor External Regulatory, Accreditation, and Collaborative Dashboard: 1. Only one outlier related to ED transfer medications 2. Poor performance of 3 Hour Sepsis Bundle in 3rd quarter. Pharmacy and ED leadership to develop consistent processes for 3 Hour Sepsis Bundle program. 3. 3rd quarter Antimicrobial Stewardship review noted adverse trending of Clindamycin and Cephalosporins. Ancillary Services Director Julie Taylor related that it was reviewed as appropriate secondary to two specific patients requiring this drug regimen under the supervision of an	Action Item: Interim Quality Manger Degoma to facilitate trial with new Patient Experience vendor. Action Item-Pharmacy (Don Roberts), Medicine and ED leadership (Dr. Ford, Joyce Bailey & Daneen Lindh) to develop consistent processes for 3 Hour Sepsis Bundle program.

	Infectious Disease provider. 4. No data was submitted specific to outpatient Clinical Depression & FU Plans from the clinics. With new leaders in place, education is being provided to ensure timely data submission.	Action Item-Clinic Managers Hancock and Childress to ensure appropriate data submission for Depression metrics. Action Item-Interim Quality Manager Degoma to present the Department Specific Performance Improvements at the next meeting due to lack of time.
Regulatory and Accreditation • DNV Stroke Certification Update (D. Degoma) • DNV Hospital Survey Readiness Update (D. Degoma)	Interim Quality Manager Degoma highlighted the following on the Corrective Action Plan submitted: 1. Re-Enforce Code STROKE protocols to include but not limited to Door-to-Needle Time target of ≤60 minutes with EMS and Code STROKE Team to include but not limited to ED Physicians, ED RNs, and Imaging Technicians. 2. Re-Enforce documentation of post-alteplase flush order and administration in the EMR with ED RNs. 3. Installation of new 80 slice CT scanner 4. Improved neurological assessments documentation 5. Updated BP parameters on all related stroke order sets 6. Updated alteplase order set to address angioedema treatment and monitoring 7. Annual Physician stroke education by documenting education hours through 8. Continuing Medical Education (CME) 9. Internal selected online courses through Relias 10. Quarterly M&M stroke review with community partners	Action Item-Interim Quality Manager Degoma will submit ongoing stroke corrective action data to DNV at three, six and nine month intervals.

	11. Peer Review and Medical Staff Meetings 12. Strengthened individualized stroke patient education documentation by nursing and medicine 13. Add “alternatives” to alteplase informed consent Interim Quality Manger Degoma also provided a progress report of DNV Hospital Survey preparations.	
Meeting Summary & Evaluation	Commissioner McMahan appreciates all the hard work everyone is doing, especially dealing with COVID.	
Adjournment	Dr. Anderson made a motion to adjourn at 8:13 a.m. and Dr. McCurry seconded. The motion passed unanimously.	

WARRANT & EFT LISTING NO. 2020-10

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

$4,278,483.73 this 16th day

of December 2020

Board Chair, Trish Frady

Commissioner, Craig Coppock

Secretary, Tom Herrin

Commissioner, Wes McMahan

Commissioner, Chris Schumaker

SEE WARRANT & EFT REGISTER in the amount of ***$4,278,483.73*** dated ***October 1, 2020 –October 31, 2020.***

Routine A/P Runs

Warrant No.	Date	Amount	Description
118722 - 118726	5-Oct-2020	22,251.83	CHECK RUN
118727 - 118745	2-Oct-2020	86,918.75	CHECK RUN
118748	5-Oct-2020	3,303.94	CHECK RUN
118749	7-Oct-2020	3,533.33	CHECK RUN
118750	8-Oct-2020	966.97	CHECK RUN
118751 - 118762	12-Oct-2020	809,003.27	CHECK RUN
118763 - 118840	9-Oct-2020	183,186.92	CHECK RUN
118841	8-Oct-2020	2,597.48	CHECK RUN
118842 - 118847	16-Oct-2020	379,706.53	CHECK RUN
118848 - 118899	16-Oct-2020	130,378.21	CHECK RUN
118900 - 118906	26-Oct-2020	625,674.20	CHECK RUN
118907 - 118984	23-Oct-2020	194,387.48	CHECK RUN
118991	8-Oct-2020	4,486.52	CHECK RUN
118992	27-Oct-2020	16,382.28	CHECK RUN
118993	28-Oct-2020	691.93	CHECK RUN
118994	30-Oct-2020	1,872.64	CHECK RUN
118995 - 119057	30-Oct-2020	166,061.55	CHECK RUN
119058 - 119108	30-Oct-2020	14,498.38	CHECK RUN
119109	27-Oct-2020	69,143.52	CHECK RUN
119110	28-Oct-2020	12,742.94	CHECK RUN
Total - Check Runs		$ 2,727,788.67	

Error Corrections - in Check Register Order

Warrant No.	DATE VOIDED	Amount	Description
VARIOUS	31-Oct-20	(2,976.13)	VOIDS/UNCLAIMED PROPERTY CASHED -SEE ATTACHED
TOTAL - VOIDED CHECKS		(2,976.13)	

COLUMBIA BANK CHECKS, EFT'S & VOIDS	$ 2,724,812.54

Eft	Date	Amount	Description
1126	2-Oct-2020	151,003.45	IRS
	2-Oct-2020	417,699.42	PAYROLL
1069	6-Oct-2020	1,988.44	MCKESSON
1127	16-Oct-2020	143,647.97	IRS
	16-Oct-2020	409,680.41	PAYROLL
1070	20-Oct-2020	594.04	MCKESSON
	30-Oct-2020	429,057.46	PAYROLL
TOTAL EFTS AT SECURITY STATE BANK		$ 1,553,671.19	

TOTAL CHECKS, EFT'S, &TRANSFERS	$ 4,278,483.73

WARRANT & EFT LISTING NO. 2020-11

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

$3,681,703.27 this 16th day

of December 2020

Board Chair, Trish Frady

Commissioner, Craig Coppock

Secretary, Tom Herrin

Commissioner, Wes McMahan

Commissioner, Chris Schumaker

SEE WARRANT & EFT REGISTER in the amount of ***$3,681,703.27*** dated ***November 1, 2020 –November 30, 2020.***

Routine A/P Runs

Warrant No.	Date	Amount	Description
118985 - 118990	2-Nov-2020	87,201.37	CHECK RUN
119111 - 119112	2-Nov-2020	2,021.02	CHECK RUN
119113	4-Nov-2020	3,303.94	CHECK RUN
119114	5-Nov-2020	2,015.00	CHECK RUN
119115	6-Nov-2020	2,597.48	CHECK RUN
119116 - 119173	6-Nov-2020	509,021.58	CHECK RUN
119174 - 119184	9-Nov-2020	857,249.43	CHECK RUN
119186 - 119190	16-Nov-2020	12,078.51	CHECK RUN
119191 - 119291	13-Nov-2020	107,664.43	CHECK RUN
119292 - 119363	20-Nov-2020	134,201.67	CHECK RUN
119364 - 119369	23-Nov-2020	641,654.21	CHECK RUN
119370 - 119374	27-Nov-2020	10,345.41	CHECK RUN
119376 - 119378	27-Nov-2020	20,584.49	CHECK RUN
119379	27-Nov-2020	18,523.41	CHECK RUN
119380	30-Nov-2020	1,672.91	CHECK RUN
119381 - 119382	30-Nov-2020	1,672.91	CHECK RUN
119394	23-Nov-2020	117.00	CHECK RUN
Total - Check Runs		$ 2,411,924.77	

Error Corrections - in Check Register Order

Warrant No.	DATE VOIDED	Amount	Description
119380	30-Nov-2020	(1,672.91)	VOID CHECK
TOTAL - VOIDED CHECKS		$ (1,672.91)	

COLUMBIA BANK CHECKS, EFT'S & VOIDS	$ 2,410,251.86

Eft	Date	Amount	Description
1128	2-Nov-2020	152,857.20	IRS
1071	4-Nov-2020	106.17	MCKESSON
1072	10-Nov-2020	1,056.90	MCKESSON
1073	17-Nov-2020	1,347.58	MCKESSON
1129	13-Nov-2020	149,807.54	IRS
PAYROLL	13-Nov-2020	424,991.12	PAYROLL
1074	1-Nov-2020	835.77	MCKESSON
1075	24-Nov-2020	2,470.98	MCKESSON
1077	1-Nov-2020	2,217.81	MCKESSON
1130	27-Nov-2020	137,388.27	IRS
PAYROLL	27-Nov-2020	398,372.07	PAYROLL
TOTAL EFTS AT SECURITY STATE BANK		$ 1,271,451.41	

TOTAL CHECKS, EFT'S, &TRANSFERS	$ 3,681,703.27

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE
CLINICAL/NON-CLINICAL CONTRACTED
SERVICES EVALUATION MATRIX

RESOLUTION NO. 20-49

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 Clinical/Non-Clinical Contracted Services Performance Review Matrix.

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 16th day of December 2020, the following commissioners being present and voting in favor of this resolution.

_____
Trish Frady, Board Chair

_____
Tom Herrin, Secretary

_____
Craig Coppock, Commissioner

_____
Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

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

MEMORANDUM

To: Board of Commissioners

From: Dexter A. Degoma, Interim Manager, Quality

Cc: Sara Williamson, RN, Chief Nursing Officer & Chief Quality Officer

Leianne Everett, Chief Executive Officer

Date: December 16, 2020

Re: **Clinical and Non-Clinical Contracted Services Performance Review**

The following contracts have been reviewed and recommended for continuation of the contract services. Contract evaluation criteria includes:

- Compliance with applicable laws, regulations, organizational policies, and certifying agencies
- Adherence to comparable standard of Arbor Health
- Participation in quality improvement programs
- Assurance of timely, safe, and efficient care

CONTRACT	TYPE OF SERVICE	EXECUTIVE	EVALUATION DATE
1. TRIAD ISOTOPES (JUBILNT RADIOPHARMACIES)	PROVIDES INJECTABLE ISOTOPES FOR THE NUCLEAR MEDICINE SERVICE PROVIDER	Leianne Everett Chief Executive Officer	10/29/2020
2. RADIA	RADIOLOGISTS (IMAGE INTERPRETATION, CONSULTATION, OVERSIGHT, AND REPORTING)	Leianne Everett Chief Executive Officer	10/29/2020
3. FAIRWAY COLLECTIONS	BAD DEBT COLLECTIONS	Richard Boggess Chief Financial Officer	10/15/2020
4. ASPIRION	FOLLOW UP AND BILLING FOR ALL MOTOR VEHICKE, WORKERS COMP AND VETERANS SERVICE	Richard Boggess Chief Financial Officer	10/15/2020
5. REVENUE ENTERPRISES	SELF PAY EARLY OUT COLLECTIONS	Richard Boggess Chief Financial Officer	10/15/2020
6. LIFECENTER NORTHWEST ORGAN	ORGAN RECOVERY	Sara Williamson, RN Chief Nursing Officer/ Chief Quality Officer	11/16/2020
7. JEREMY LAUSCH	SLEEP STUDY SCORER	Richard Boggess Chief Financial Officer	1/16/2020
8. MISSION SEARCH	TEMPORARY OR RN LEADERSHIP	Leianne Everett Chief Executive Officer	12/02/2020

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

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 12/09/2020
Subject: Resolutions 20-50 and 20-51

Resolutions 20-50 and 20-51 are being presented for ratification by this Board of Commissioners. The plan documents for the Flexible Spending Account and the Health Reimbursement Arrangements have not changed since they were ratified by the previous Board of Commissioners for the Plan Year 2020.

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION ADOPTING THE
FLEXIBLE SPENDING ACCOUNT PLAN (FSA) RESOLUTION NO. 20-50

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 01/01/21. 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, 2021, 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 16th day of December 2020, the following commissioners being present and voting in favor of this resolution.

_____
Trish Frady, Board Chair

_____
Tom Herrin, Secretary

_____
Craig Coppock, Commissioner

_____
Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

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

SUMMARY PLAN DESCRIPTION

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ADDITIONAL PLAN INFORMATION

X
CONTINUATION COVERAGE RIGHTS UNDER COBRA

XI
SUMMARY

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

INTRODUCTION

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

You can join the Plan on the same day you can enter our group medical plan.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan,

you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

4. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

-- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

-- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan.

There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your coverage under our Employer sponsored group health plan if you are eligible to obtain coverage through the health exchanges.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will assume you want your elections for insured benefits only to remain the same and you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

IV
BENEFITS

1. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan or privately held insurance policies and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed.

You may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

For 2020, the most you can contribute is $2,750. After 2020, the dollar limit may increase for cost of living adjustments.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

2. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

3. Premium Expense Account

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

-- Health care premiums under our insured group medical plan.

-- Certain health benefit premiums under privately held insurance policies.

-- Dental insurance premiums.

-- Vision insurance premiums.

-- Other insurance coverage that we may provide.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

"Privately held insurance policies" do not include coverage obtained through a spouse's employment. Cost of these policies will only be reimbursed on adequate proof of coverage. Please see your Administrator as to which policies qualify.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are

generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for qualifying dependent care expenses incurred prior to your date of termination from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after termination.

(c) For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Lewis County Hospital District #1 dba Arbor Health Flexible Spending Account Plan Document is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on January 1st, 2021. Your Plan was originally effective on January 1st, 2002.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1st and ends on December 31st.

2. Employer Information

Your Employer's name, address, and identification number are:

Lewis County Hospital District #1 dba Arbor Health
521 Adams Street
Morton, Washington 98356
91-1033860

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Lewis County Hospital District #1 dba Arbor Health
521 Adams Street
Morton, Washington 98356
360-496-3531

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Lewis County Hospital District #1 dba Arbor Health
521 Adams Street
Morton, Washington 98356

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Northwest Marketing Resources, Inc.
P.O. Box 447
Olympia, WA 98507

IX
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. For those benefits subject to ERISA, these laws provide that Participants, eligible employees and all other employees are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, 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;

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;

(c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and

(d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

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 a benefit or exercising your rights under ERISA.

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, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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 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 it should happen that Plan fiduciaries misuse the Plan's money, or 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.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Health Flexible Spending Account claims within 90 days after your termination of employment. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Dependent Care Flexible Spending Account claims within 90 days after your termination of employment. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;

(e) 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 claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

X
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

There may be other options available when you lose group health coverage**.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure

to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(d) A covered Employee's enrollment in any part of the Medicare program.

(e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

4. What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan**.**

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment or reduction of hours of employment,

(b) death of the employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Lewis County Hospital District #1
dba Arbor Health
521 Adams Street
Morton, Washington 98356

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

9. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

13. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

14. Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of

COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

16. What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

17. Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

18. How is my participation in the Health Flexible Spending Account affected?

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

XI
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

ADOPTING RESOLUTION

The undersigned authorized representative of Lewis County Hospital District #1 dba Arbor Health (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer on _____, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of amended Cafeteria Plan including a Health Flexible Spending Account and Dependent Care Flexible Spending Account effective January 1st, 2021, presented to this meeting is hereby approved and adopted and that an authorized representative of the Employer is hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

The undersigned further certifies that attached hereto as Exhibits A and B, respectively, are true copies of Lewis County Hospital District #1 dba Arbor Health Flexible Spending Account Plan Document as amended and restated, and the Summary Plan Description approved and adopted in the foregoing resolutions.

Date: _____

Signed: _____

_____
[print name/title]

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

PLAN SPONSOR CERTIFICATION

The Lewis County Hospital District #1 dba Arbor Health ("Employer") sponsors a Health Flexible Spending Account (the "Plan") as part of the Lewis County Hospital District #1 dba Arbor Health Flexible Spending Account Plan Document. Certain members of Employer's workforce perform service in connection with administration of the Plan. Employer acknowledges and agrees that the Standards for Privacy of Individually Identified Health Information (45 CFR Part 164, the "Privacy Standards"), prohibit the Plan or its business associates from disclosing Protected Health Information (as defined in Section 164.501 of the Privacy Standards) to members of the Employer's workforce unless the Employer agrees to the conditions and restrictions set out below. To induce the Plan to disclose Protected Health Information to members of Employer's workforce as necessary for them to perform administrative functions for the Plan, the Employer hereby accepts these conditions and restrictions and certifies that the Plan documents have been amended to reflect these conditions and restrictions. The Employer agrees to:

(a) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by the Plan or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such Information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and Section COMPLIANCE WITH HIPAA PRIVACY STANDARDS of the Lewis County Hospital District #1 dba Arbor Health Flexible Spending Account Plan Document.

Adopted this _____ day of _____, 20_____

_____
Plan Sponsor

IN WITNESS WHEREOF, this Plan document is hereby executed this _____ day of _____.

Lewis County Hospital District #1 dba Arbor Health

By _____
EMPLOYER

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION ADOPTING THE
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) RESOLUTION NO. 20-51

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 01/01/2021. 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 01/01/2021.

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 16th day of December 2020, the following commissioners being present and voting in favor of this resolution.

_____
Trish Frady, Board Chair

_____
Tom Herrin, Secretary

_____
Craig Coppock, Commissioner

_____
Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

SUMMARY PLAN DESCRIPTION FOR
Lewis County Hospital District #1 dba Arbor Health
HEALTH REIMBURSEMENT ARRANGEMENT
1/1/2021 –12/31/2021

Lewis County Hospital District #1 dba Arbor Health
HEALTH REIMBURSEMENT ARRANGEMENT

Summary Plan Description

We are pleased to announce that we have established a medical expenses reimbursement program for you and other eligible employees. Under this program, you will be able to receive reimbursement for the cost of eligible medical expenses or other similar expenses or deductibles, without taxation to you individually. The purpose of this Summary Plan Description is to briefly describe the conditions for reimbursement, as well as provide an outline of other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

However, one of the most important features of our Plan is that the cost of all benefits being offered to you within this Plan are entirely paid for by us, the Employer, at no additional cost to you or your family.

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a participant. You should direct any questions you have to the Plan Administrator. There is a Plan document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan document, the Plan document will control. Also, to the extent there are any type of insurance contracts that exist to provide any portion of benefits under this Plan, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract would control.

TABLE OF CONTENTS

Lewis County Hospital District #1 dba Arbor Health
HEALTH REIMBURSEMENT ARRANGEMENT

ARTICLE I

INTRODUCTION

1.1 Creation and Title. The Employer hereby creates a welfare benefit plan under the terms and conditions set forth in this document. The Plan is to be known as **Lewis County Hospital District #1 dba Arbor Health Healthcare Reimbursement Arrangement**.

1.2 Effective Date. The provisions of the Plan shall be effective as of **1/1/2021**.

1.3 Purpose. The purpose of the Plan is to provide reimbursement for certain medical expenses of Participants not otherwise covered by insurance or by the Employer. The Employer intends that the Plan qualifies as an accident and health plan under Section 105(e) of the Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participants' income under Section 105(b) of the Code.

ARTICLE II

DEFINITIONS

As used in this Plan document, the following terms shall have the following meanings:

2.1 "Agreement to Participate" means the agreement evidencing an Eligible Employee's election to participate in the Plan and setting forth the amount of Health Reimbursement Benefits to be made available to the Participant for a Plan Year or portion of a Plan Year as reimbursement for Qualified Expenses. (Most employees are automatically enrolled, no form for election, but they must sign an opt out form if they choose to enroll in the Exchange)

2.2 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.3 "Compensation" means wages, salaries, or bonuses paid to the employee for work performed.

2.4 "Dependent" means an individual who is a dependent within the expanded definition of the Code105 of a dependent;

any son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the employee who is under age 27.

2.5 "Effective Date" shall be 1/1/2021.

2.6 "Eligible Employee" means an Employee, as defined in section 2.7 below, who has met the Eligibility requirements of the Plan set out in Section 3.1.

2.7 "Employee" means an individual employed by the Employer who regularly works at least 24 hours per week.

2.8 "Employer" means **Lewis County Hospital District #1 dba Arbor Health** or any of its affiliates, successors or assignors which adopt the Plan.

2.9 "Entry Date" means the first day of the month coinciding with or next following the date on which an Employee meets the eligibility requirements of Sections 2.7 and 3.1.

2.10 "Health Reimbursement Benefits, for any Plan Year, the amount available to a Participant as benefits in the form of reimbursements of Qualified Expenses.

2.11 "Health Reimbursement Benefits Arrangement" means the account established by the Plan Administrator under the Plan for each Participant from which benefits in the form of reimbursements of Qualified Expenses shall be paid.

2.12 "Participant" means any Employee who has met the eligibility requirements of Section 3.1 of the Plan.

2.13 "Plan" means **Lewis County Hospital District #1 dba Arbor Health Healthcare Reimbursement Arrangement**, as described herein. Your Employer has assigned the number 505 to this Plan.

2.14 "Plan Administrator" means the Employer or such other person or committee as may be appointed by the Employer to administer the Plan. The Plan Administrator is agent for service of legal process. The name, address, identification number and business telephone number are:

Lewis County Hospital District #1 dba Arbor Health
521 Adams,
PO Box 1138
Morton, WA 98356
360-496-5112
Tax ID: 91-1033860

2.15 "Plan Year" means the 12-consecutive month period beginning on 1/1/2021 and ending 12/31/2021. Future Plan Years will be the 12 months beginning on January 1st and ending on December 31st.

2.16 "Qualified Expenses" mean medical expenses incurred during a Plan Year by a Participant, while the Participant is a Participant and is otherwise allowed as a deduction for medical expenses under Section 213(d) of the Code. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

2.17 "Spouse" means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

2.18 "Status Change" With regard to the election to participate in the Plan and elections for benefits Status Change shall mean the marriage or divorce of the Participant; the adoption, birth or death of a child or other dependent of the Participant or the Participant's Spouse; the emancipation or coming of age of a child of the Participant so that the child is no longer eligible as a Dependent under the Plan; and the employment of the Participant's Spouse, or any such other event as may qualify as a change in family status in the opinion of the Plan Administrator.
An employee may also elect to opt out of the plan to allow enrollment in the State or Federal Exchange program.

ARTICLE III

PARTICIPATION

3.1 Eligibility. Each Employee, as defined in section 2.7 above, shall be eligible to participate in the Plan if the Employee participates in the insurance option offered by Lewis County Hospital District #1 dba Arbor Health, so long as the Participant is employed by the Employer as of his or her Entry Date.

3.2 Commencement of Participation. An Eligible Employee shall become a Participant in the Plan after enrolling in the company health plan for the immediately following Plan Year or remaining portion of the Plan Year.

3.3 Term of Participation. Each Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

(a) date the Participant dies, resigns or terminates employment with the Employer, subject to the provisions of Section 3.4;
(b) date the employee opts-out or waives the plan;
(c) date the Participant ceases to be an Employee; or

(d) date the Plan terminates.

3.4 Participation by Rehired Employees. Each Participant in the Plan who separates from service with the Employer shall suspend participation under this Plan for the period from the date of termination to the last day of the Plan Year in which the termination occurred. Participation in the Plan shall terminate on the first day of the next Plan Year, provided the terminated Employee has not been rehired by the Employer on such date. If a terminated Employee should later be rehired by the Employer in the same Plan Year as the Plan Year in which he or she separated from service, such Employee may elect to resume participation in the Plan under the terms of the Benefits Enrollment Form in force on the date of termination of employment, (if applicable). Most plans are an automatic enrollment.

3.5 HIPAA Portability. Notwithstanding any other provisions in this Article III, any Employee who becomes eligible under the Health Portability and Accountability Act of 1996("HIPAA") for coverage by an Accident or Health benefit under the Plan shall be allowed to participate in the Plan, so long as such Employee complies with the provisions set out in HIPAA.

3.6 COBRA Continuation Coverage. Subject to any provision in the Code, Regulations or Contract governing COBRA Continuation Coverage to the contrary, COBRA type continuation shall be available to all participants. Notwithstanding any other provisions in this Article III, any Participant, Spouse or Dependent eligible for continuation coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, shall be allowed to continue to participate in the Plan, so long as such Participant, Spouse or Dependent complies with the provisions set out in COBRA.

The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

3.7 Family Medical Leave Act. Subject to any provision in the Code, Regulation or Contract governing FMLA leave coverage to the contrary, FMLA type continuation coverage shall be available to all participants.

Payment Options for coverage while on unpaid Family Medical Leave Act leave for group plans:

(a) Pre-pay before commencement of leave through pre-tax or after-tax Salary Reduction Agreement from any taxable compensation, including cashing out of unused sick or vacation days, provided all other plan requirements are met.

(b) Pay-as-you-go. Employees may pay their share of premium payments on the same schedule as payments would be made if the employee were not on leave, or under another schedule permitted under Department of Labor regulations.

The Employer shall not be required to continue the health coverage of an Employee who fails to make required premium payments while on FMLA leave. However, if the Employer chooses to continue the health coverage of an Employee who fails to make required premium payment while on FMLA leave, the Employer is entitled to recoup those payments after the Employee returns from FMLA leave.

(c) Catch-up-option. Under this payment option the Employer shall advance the Employee's share of group health premiums while the Employee is on FMLA leave and thereafter shall be entitled to recover such advanced amounts when the Employee Returns from FMLA leave.

ARTICLE IV

BENEFITS

4.1 Provision of Benefits. Benefits under the Plan shall take the form of reimbursement of Qualified Expenses incurred by a Participant during the Plan Year. A Participant, or former Participant, shall be entitled to benefits under the Plan for Qualified Expenses incurred only while a Participant.

4.2 Amount of Reimbursement. A Participant shall be entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's Healthcare Reimbursement Benefits. The amount of a Participant's Healthcare Reimbursement Benefits shall be uniformly available during the Plan Year. There is a $5000 per participant in-network annual deductible, to a family maximum in-network deductible of $10,000 for employees participating in the hospital sponsored medical plan.

For single employees, the employee will be responsible for the first $500.00 in deductible expenses. For deductible expenses from $501.00 to $5000.00, the HRA will reimburse these deductible expenses at 70%. The maximum annual benefit for single employees is $3150.00.

For employees with dependents, each participant will be responsible for the first $500.00 in deductible expenses, to a family maximum responsibility of $1000.00. For deductible expenses from $501.00 to $5000.00 for each participant, the HRA will reimburse these deductible expenses at 70%. The maximum annual benefit for employees with dependents is $6300.00.

The HRA is for in-network deductible expenses only. However, in the event that an Anesthesiologist or Emergency Room Physician is billed as out-of-network, the HRA will reimburse at the in-network level if: 1) you appeal the claim through Healthcare Management Administrators and 2) the appeal is denied.

Claims are payable on a calendar year basis. Claims for 2021 deductible expenses must be received no later than 90 days after the end of the calendar year (3/31/2022) for previous calendar year deductible expenses (ending 12/31/2021). For deductible expenses, the Health Reimbursement Arrangement pays first, the Flexible Spending Account pays second.

4.3 Nondiscriminatory Benefits. The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated employees from participation in the Plan if, in the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

4.4 Maximum Benefits. Notwithstanding any other provisions of this Plan, no Participant shall receive Health Reimbursement Benefits in excess of $3,150 for individuals and $6,300 for employees with dependents per calendar year per Plan Year.

ARTICLE V

FUNDING AND PAYMENT OF BENEFITS

5.1 Funding. The Employer shall contribute amounts necessary to fund the Plan, as determined primarily by the amount of the Healthcare Reimbursement Arrangement to be made available for the Plan Year. Contributions to the Plan shall be made to, and all Plan assets shall be held in, such accounts or funds as the Employer deems appropriate.

5.2 Payment of Benefits. Reimbursement shall only be made under the Plan on the basis of Qualified Expenses incurred by the Participant, as presented to the Plan Administrator on a written form specified by the Plan Administrator and as evidenced by a written statement from a third party. It shall be the duty of the Plan Administrator to construe what are and what are not Qualified Expenses subject to reimbursement from a Participant's Healthcare Reimbursement Arrangement. If the Plan Administrator determines that an expense is a Qualified Expense subject to reimbursement, the Plan Administrator shall reimburse the Participant for the Qualified Expense within a reasonable time. To make the determination that a Qualified Expense subject to reimbursement has been incurred, the Plan Administrator may require proper evidence of any or all of the following:

(a) name of the person or persons for whom the expenses have been incurred;

(b) nature of the expenses incurred;

(c) date the expenses were incurred;

(d) amount of the requested reimbursement; or

(e) that the expenses have not been otherwise paid through an insurance program offered by the Employer or any other employer, or reimbursed from any other source.

The Plan Administrator shall be the sole arbiter of what constitutes a Qualified Expense subject to reimbursement under the Plan.

In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority:

(a) Executor of the Estate of the deceased Participant,

(b) Spouse,

(c) Family member held responsible for payment of deceased's medical bills,

(d) Spouse of dependent with COBRA continuation rights.

5.3 Forfeiture of Benefits. A Participant forfeits any amount of Health Reimbursement Benefits under the Plan for a Plan Year if a claim for reimbursement is not provided to the Plan Administrator within 90 days after the last day of the Plan Year or the last day of participation in the Plan, if earlier. Upon such forfeiture, the Participant's Health Reimbursement Benefits Account shall be reduced to zero. At the discretion of the Employer, forfeitures of benefits under the Plan may be reallocated to Participants in any reasonable manner. Forfeitures of benefits may also be applied towards the cost of administering the Plan. Forfeitures of benefits shall become the sole property of the Employer.

ARTICLE VI

PLAN ADMINISTRATION

6.1 Plan Administrator. The Plan Administrator shall be responsible for the administration of the Plan.

6.2 Plan Administrator's Duties. In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator shall have the following rights, duties and powers to: (e.g., will be performed by NMR as appointed by the Employer)

(a) interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;

(b) adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;

(c) determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;

(d) develop appellate and review procedures for any Participant, Spouse, Dependent or beneficiary denied benefits under the Plan;

(e) to provide the Employer with such tax or other information it may require in connection with the Plan;

(f) employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) report to the Employer, or any party designated by the Employer, after the end of each Plan year regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

However, nothing in this section 6.2 is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written

approval of the Employer regarding any amendment or change in administrative procedure, or Benefit Provider. Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he sees fit to assure that the Plan complies with the nondiscrimination requirements of Section 105 of the Code.

6.3 Information to be Provided to Northwest Marketing Resources (NMR). The Employer, or any of its agents, shall provide to NMR any employment records of any employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information NMR may need for the proper administration of the Plan. Any Participant or Dependent or any other person entitled to benefits under the Plan shall furnish to NMR his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data NMR might reasonably request to insure the proper and efficient administration of the Plan.

6.4 Decision of Plan Administrator Final. Subject to applicable State or Federal law, and the provisions of Section 6.5, below, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he considers equitable and practicable.

6.5 Review Procedures. In cases where the Plan Administrator denies a benefit under this Plan for any Participant, the Plan Administrator shall furnish in writing to said party the reasons for the denial of benefits. The written denial shall be provided to the party within 30 days of the date the benefit was denied by the Plan Administrator. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within 30 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 30 days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of the final decision on the reviewed claim. The claimant has 60 days from the date of the claim denial to provide the requested information for the claim to be reevaluated. The Plan Administrator has absolute final say on the approval or declination of a claim within the guidelines of the Federal Laws pertaining to Health Reimbursement Arrangements.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

6.6 Extensions of Time. In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any Participant, Spouse, Dependent or designated beneficiary may need to appeal a claim, upon proper application to the Plan Administrator.

6.7 Rules to Apply Uniformly. The Plan Administrator shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

6.8 Indemnity. The Employer does hereby agree to indemnify and hold harmless, to the extent allowed by law and over and above any liability coverage contracts or directors and officers insurance, any officer or director of the Employer, designated by the Employer or the Plan Administrator who has been employed, hired or contracted to assist in the fulfillment of the administration of this Plan. In addition, the Employer agrees to pay any costs of defense or other legal fees incurred by any of the above parties over and above those paid by any liability or insurance contract.

ARTICLE VII

GENERAL PROVISIONS

7.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant, Spouse, Dependent or beneficiary was entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendments that apply retroactively to the extent necessary so that the Plan remains in compliance with Section 105 of the Code or any other provision of the Code applicable to

the Plan.

7.2 Non-assignability. Any benefits to any Participants under this Plan shall be non-assignable and for the exclusive benefit of Participants, Spouses, Dependents and beneficiaries. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

7.3 Medical Child Support Orders. The Plan Administrator shall adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which

(i) relates to the provision of child support related to health benefits for a child of a Participant of a group health plan;
(ii) is made pursuant to a state domestic relations law; and
(iii) which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.

The Plan administrator shall promptly notify the Participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Any such Qualified Medical Child Support Order (QMCSO) must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Any such QMCSO shall not require the Plan to provide any type or form of benefit, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Reconciliation Act of 1993 (OBRA '93).

Upon determination of a Qualified Medical Child Support Order, the Plan must recognize the QMCSO by providing benefits for the Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

7.4 Not an Employment Contract. By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

7.5 Participant Litigation. In any action or proceeding against the Plan, or the administration thereof, employees or former employees of the Employer or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The Employer, the Plan Administrator, or their registered representatives shall be the sole source for service of process against the Plan. Any final judgment, which is not appealed, or appeal able shall be binding on the Employer and any interested party to the Plan.

7.6 Addresses, Notice and Waiver of Notice. Each Participant shall furnish the Employer with his correct post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

7.7 Required Information. Each Participant, Spouse or Dependent shall furnish to the Employer such documents, evidence or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

7.8 Severability. In any case where any provision of this Plan is held to be illegal or invalid, such illegality or

invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

7.9 Applicable Law. The Plan shall be construed under the laws of the State of Washington, to the extent not preempted by any Federal law.

ARTICLE VIII

STATEMENT OF ERISA RIGHTS

8.1 Statement of ERISA Rights. As a participant in Lewis County Hospital District #1 dba Arbor Health Health Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants 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 plan documents, including insurance contracts, copies of the latest annual report (Form 5500 series if applicable), updated Summary Plan Description, collective bargaining agreements and copies of all documents filed by the plan with the Department of Labor, such as detailed annual reports and plan descriptions.

In addition to creating rights for plan participants, 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 participants and beneficiaries. No one, including your employer, union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, 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 frivolous. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Privacy Policy Notice

PURPOSE OF THIS NOTICE

The privacy of personal information is important to our organization. Title V of the GrammLeach-Bliley Act (GLBA) is a United States law that generally prohibits any financial institution, directly or through its affiliates, from sharing nonpublic personal information about consumers or customers with a nonaffiliated third party unless the institution provides the appropriate consumer or customer with a notice of its privacy policies and practices, such as the type of information that it collects from consumers or customers and the categories of persons or entities to whom the information may be disclosed. In compliance with the GLBA and state laws relating to privacy in the insurance industry, and in order to notify our clients of our privacy practices, we are providing you with this document, to inform you of our privacy policies and practices.

OUR PRIVACY POLICIES AND PRACTICES

We provide insurance brokerage, risk management, and related services to our individual, corporate, and association clients ("Clients").

1. Information we collect:

We collect nonpublic personal information about the employees and members of our corporate and association Clients, in certain cases their family members, and from our individual Clients (collectively "Participants") from the following sources:

- Information we receive from Clients and Participants on applications or other forms in connection with providing services to Clients and Participants.
- Information we receive as a result of processing and verifying the information provided to us about Clients and Participants.
- Information we receive from affiliates, insurers, other intermediaries, third party providers and others regarding our Clients and Participants.
- Information available from external sources (such as publicly available records).

2. Information we may disclose to third parties:

We do not disclose any nonpublic personal information about our Clients, former Clients, Participants or former Participants to any third parties except as stated in this policy and as otherwise permitted by law. We may share this information outside the company in order to process or complete the transaction for which the information was provided or as otherwise authorized by our Clients or Participants. The law permits us to share this information with our affiliates.

The GLBA and this notice does not effect any rights an individual Client or Participant may have under the Fair Credit Reporting Act.

3. Our practices regarding information confidentiality and security:

We restrict access to nonpublic personal information about Clients and Participants to those who need to know that information in order to provide products or services to our Clients and Participants. We have in place physical, electronic, and procedural safeguards in order to guard any nonpublic personal information we maintain regarding Clients and Participants.

You do not need to call or do anything as a result of this notice. It is meant to inform you of how we treat your nonpublic personal financial information.

1/1/2021 to 12/31/2021

Health Reimbursement Arrangement
Claim Form

To expedite your claim:
- Provide *all* appropriate information.
- Include most recent medical insurance EOB.

☐ **Check if this is change of address**

Employer: **Lewis County Hospital District #1 dba Arbor Health**

Employee Name: Last Four Digits of SSN:

Employee Address: City, State, Zip:

Phone: E-mail:

Healthcare Expense Claims		
(Attach a copy of your EOB (explanation of benefits) from your medical carrier.	**Total Medical Care Expense Claim**	**$**

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Your Health Reimbursement Arrangement (HRA) Plan may be limited to the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan, for a list of eligible expenses.

Employee's Signature _____ Date _____

Lewis County Hospital District #1 dba Arbor Health

Health Reimbursement Arrangement

1/1/2021 to 12/31/2021
Claim Form & Filing Instructions

On the reverse side of this page is a claim form. Please feel free to copy this form.

When filing your claim, you must attach copies the EOB (Explanation of Benefits) from the carrier. Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable.

Benefits under your plan are: There is a $5000 per participant in-network annual deductible, to a family maximum in-network deductible of $10,000 for employees participating in the hospital sponsored medical plan.

For single employees, the employee will be responsible for the first $500.00 in deductible expenses. For deductible expenses from $501.00 to $5000.00, the HRA will reimburse these deductible expenses at 70%. The maximum annual benefit for single employees is $3150.00.

For employees with dependents, each participant will be responsible for the first $500.00 in deductible expenses, to a family maximum responsibility of $1000.00. For deductible expenses from $501.00 to $5000.00 for each participant, the HRA will reimburse these deductible expenses at 70%. The maximum annual benefit for employees with dependents is $6300.00.

The HRA is for in-network deductible expenses only. However, in the event that an Anesthesiologist or Emergency Room Physician is billed as out-of-network, the HRA will reimburse at the in-network level if: 1) you appeal the claim through Healthcare Management Administrators and 2) the appeal is denied.

Claims are payable on a calendar year basis. Claims for 2021 deductible expenses must be received no later than 90 days after the end of the calendar year (3/31/2022) for previous calendar year deductible expenses (ending 12/31/2021). For deductible expenses, the Health Reimbursement Arrangement pays first, the Flexible Spending Account pays second.

RESOLUTIONS OF THE BOARD OF DIRECTORS FOR THE ADOPTION OF

Lewis County Hospital District #1 dba Arbor Health

HEALTH REIMBURSEMENT ARRANGEMENT

On this date, the Board of Directors of Lewis County Hospital District #1 dba Arbor Health did meet to discuss the implementation of the Lewis County Hospital District #1 dba Arbor Health Health Reimbursement Arrangement, to be effective 1/1/2021. Let it be known that the following resolutions were duly adopted by the Board of Directors of Lewis County Hospital District #1 dba Arbor Health and that such resolutions have 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 of more copies of the Plan.

RESOLVED, that the Plan Year shall be for a 12-month period, beginning on 1/1/2021.

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 #1 dba Arbor Health Health Reimbursement Arrangement approved and adopted in the foregoing resolutions.

The undersigned further certifies and attests that the above resolutions were made with the consent of the Board of Directors of the Corporation:

_____ _____

Signature and Title Date

LITIGATION OF LEGAL LIABILITY

Lewis County Hospital District #1 dba Arbor Health

HEALTH REIMBURSEMENT ARRANGEMENT

The adopting Employer of this Plan understands and agrees that Northwest Marketing Resources, Inc. is in no way liable for the legal and tax aspects of this Plan. Full legal and tax responsibility is assumed by the undersigned Employer establishing this Plan, which acknowledges that it has reviewed the terms and conditions of the plan with its legal and tax advisors with respect to the adoption of this Plan and the various options available under the Plan

Lewis County Hospital District #1 dba Arbor Health

_____ _____

Signature and Title Date

7.9 Applicable Law. The Plan shall be construed under the laws of the State of Washington, to the extent not preempted by any Federal law.

Executed this _____ day of _____, _____.

Employer: Lewis County Hospital District #1 dba Arbor Health

_____
Signature and Title

Documents Awaiting Board Ratification 12.16.20		
	LCHD No. 1's Policies, Procedures & Contracts:	Departments:
1	B1: Purchasing and Inventory	Dietary Services
2	B2: Receiving	Dietary Services
3	B3: Food and Supply Storage	Dietary Services
4	B4: Cold Storage Temperatures	Dietary Services
5	B5: Menu Substitutions	Dietary Services
6	B6: Food Handling Guidelines (HACCP)	Dietary Services
7	B7: Handling of Enteral Feedings and Nutritional Supplements	Dietary Services
8	BAA - (FSA) Northwest Marketing Resources, Inc.	Business Associate Agreements
9	Bamlanivimab Antibody Playbook	Pharmacy
10	Bamlanivimab EUA FAQ's	Pharmacy
11	Bamlanivimab EUA Healthcare Provider Fact Sheet	Pharmacy
12	Bamlanivimab EUA Letter of Authorization 11.10.20	Pharmacy
13	Bamlanivimab EUA Patient-Caregiver Fact sheet Spanish	Pharmacy
14	Bamlanivimab EUA Patient-Caregiver fact sheet English	Pharmacy
15	Bamlanivimab Informed Consent	Pharmacy
16	Bamlanivimab Protocol	Outpatient Services
17	Billing Modification	Business Office
18	Concern Grievance Complaint Form	Patient Rights
19	D1 A:Nutrition Care Manual Review	Nutrition Services
20	Documentation Requirements	Health Information Management
21	Emergency Medications	Pharmacy
22	Employee Refusal of Patient Movement	Safe Patient Handling
23	F10: Sanitizing Food Contact Surfaces/Logs	Dietary Services
24	F11: Dishmachine Temperatures/Logs	Dietary Services
25	F12: Vomiting and Diarrheal Incident Response	Dietary Services
26	F13: Disposable Glove Use	Dietary Services
27	F14: Use of Corrugated Cardboard	Dietary Services

28	F15: Associate Guidelines: Infection Prevention and Control Practices	Dietary Services
29	F1: Hand Hygiene	Dietary Services
30	F2: Cutting Boards	Dietary Services
31	F3: Pest Control	Dietary Services
32	F4: Solid Waste Disposal	Dietary Services
33	F5: Damaged China and Glassware Surveillance	Dietary Services
34	F6: Cleaning of Food and Non-Food Contact Surfaces	Dietary Services
35	F7: Area and Equipment Cleaning	Dietary Services
36	F8: Ice Handling	Dietary Services
37	F9: Storage of Pots, Dishes, Flatware, Utensils	Dietary Services
38	G1: Dietary Technician Safety Guidelines	Dietary Services
39	G2: Chemical Accident	Dietary Services
40	G3: Repairs	Dietary Services
41	G4: Equipment Manual	Dietary Services
42	G5: Mold Prevention	Dietary Services
43	Green River College Affiliation Agreement	Affiliation Agreements
44	H10: Disaster Menus	Dietary Services
45	H2: Department Preparedness	Dietary Services
46	H3: Activation of Department Disaster Plan	Dietary Services
47	H4: Failure of Gas Supply	Dietary Services
48	H5: Failure of Electrical Supply	Dietary Services
49	H6: Failure of Refrigeration/Freezers	Dietary Services
50	H7: Sewage Back-Up or Flood Emergency	Dietary Services
51	H8: Patient Meal Times	Dietary Services
52	H9: Tray Identification-Non-Selective Menu	Dietary Services
53	High Alert Medication Policy	Pharmacy
54	Johnson Search Group Staffing Agreement	Professional Services Agreement
55	Look Alike Sound Alike Drugs	Pharmacy
56	Medefis Vendor Management Agreement	Professional Services Agreement
57	Medicare Outpatient Observation Notice	Patient Access
58	Medication Management	Pharmacy
59	Orientation of Dietary Employees	Dietary Services
60	Outside Employment	Human Resources

61	PTO, EIL & PSL Donation	Human Resources
62	Patient Grievance or Complaint Management	Quality
63	Patient Type Change	Patient Access
64	Payment Posting	Business Office
65	Peri-operative Prophylactic Antibiotics	Surgery
66	Physical Inventory	Materials Management
67	Prepaid Expense	Finance, Bonds, Lines of Credit
68	Printing Medical Records	Health Information Management
69	Prompt Pay Discount	Business Office
70	Registering Unidentified Emergency Room Patients	Patient Access
71	Snow and Ice Removal	Maintenance
72	Solicitation	Human Resources
73	Standardized Recipes	Dietary Services
74	Therapy Pool Maintenance	Maintenance
75	Treatment of Minors	Emergency Services
76	Work Request	Maintenance

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.

OLD BUSINESS

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

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 12/09/2020
Subject: Approving Fire District No. 4 Agreement

Recently, Bill Reynolds approached me to discuss lost revenue Fire District #4 experiences given the number of parcels the District owns in Morton and our tax-exempt status. He presented a list of parcels, their assessed value (cumulatively $11,008,400), and the lost revenue ($5,961.80). This is an ask that I had never experienced in 20+ years of healthcare leadership experience.

To better understand Bill's request, I reached out to Washington State hospitals, as well as one of our attorneys. My research found that some, but not all, of the hospitals had been approached by their local fire district with a similar request. Some did enter into an agreement while others did not.

Our attorney was very familiar with these types of agreements, having drafted several for other clients. He explained that the law allows for fire districts to request financial support, but it does not require us to comply. However, several municipalities enter into agreements out of a sense of community and being good neighbors.

You are being presented with several options for discussion. The attached document was built upon Bill's information. His lost revenue calculation is represented in the column titled "Original Request."

- Version 1 removes all parcels that do not have structures but continues to include the hospital and MOB. This version is the most generous of the options I am proposing ($5,871.25).
- Version 2 builds upon V.1 and further removes the hospital and MOB. This version is the most aggressive proposal ($405.36).
- Version 3 is similar to V.2, however, it does add back 50% of the lost revenue associated with the hospital and MOB. This version was presented as a collegial option between V.1 and V.2 ($3,153.15).

I want to reiterate that we are under no regulatory obligation to agree to any version presented. However, the Fire District does provide services to our hospital district. They do an annual walkthrough, and they respond to all fire alarms, including false alarms due to aging technology. Bill is expected to attend the regular board meeting to answer and questions you may have.

This expense is well within the scope of my spending authority. However, I thought it prudent to discuss a new, on-going operating expense that is not as black and white as most operating expenses. There will be a resolution to ratify on this matter.

UPDATE:
RCW 52.30.020 allows fire districts that are supported by property taxes to enter into agreements with public agencies that are exempt from paying property taxes. These agreements allow fire districts to collect fees for their services. No other entities, such as school districts or cities, are afforded this opportunity. However, other fire districts that provide services where the District owns properties are governed by RCW 52.30.020.

Recommendation: I am recommending the Commissioners adopt Version 3, $3,153.15. In this scenario, we are compensating Fire District No. 4 for the property taxes on the assessed values of the residential parcels, 50% of the assessed value of the MOB Building and Lot, and 50% of the assessed value of the Main Hospital.

Address	Use/Description	Assessed Value $	Original Request	V.1	V.2	V.3
277 5th Street	Lot behind red house	$ 13,700.00	$ 7.42	$ 7.42	$ 7.42	$ 7.42
488 Adams Ave	Red House	$ 165,700.00	$ 89.74	$ 89.74	$ 89.74	$ 89.74
430 Temple Ave	ED House	$ 109,900.00	$ 59.52	$ 59.52	$ 59.52	$ 59.52
522 Temple Ave	MOB Building	$ 3,908,700.00	$ 2,116.83	$ 2,116.83	$ 2,116.83	$ 2,116.83
501 Cottlers Lane	Garden Lot	$ 27,500.00	$ 14.89	$ 14.89	$ 14.89	$ 14.89
451 Temple Ave	Trailer House	$ 61,400.00	$ 33.25	$ 33.25	$ 33.25	$ 33.25
439 Cottlers Ln	Robbins Nest	$ 118,600.00	$ 64.23	$ 64.23	$ 64.23	$ 64.23
588 Adams Ave	MOB Building Lot	$ 35,000.00	$ 18.95	$ 18.95	$ 18.95	$ 18.95
522 Adams Ave	Parking Lot	$ 20,000.00	$ 10.83	$ 10.83	$ 10.83	$ 10.83
497 Adams Ave	Parking Lot	$ 43,000.00	$ 23.29	$ 23.29	$ 23.29	$ 23.29
541 Adams Ave	Main Hospital	$ 6,149,000.00	$ 3,330.10	$ 3,330.10	$ 3,330.10	$ 3,330.10
554 Adams Ave	Parking Lot	$ 28,000.00	$ 15.16	$ 15.16	$ 15.16	$ 15.16
450 Temple Ave	ED Parking Lot	$ 35,000.00	$ 18.95	$ 18.95	$ 18.95	$ 18.95
121A Collar Ave	Duplex	$ 147,800.00	$ 80.04	$ 80.04	$ 80.04	$ 80.04
121B Collar Ave	Duplex	$ 145,100.00	$ 78.58	$ 78.58	$ 78.58	$ 78.58
		$ 11,008,400.00	$ 5,961.80	$ 5,961.80	$ 5,961.80	$ 5,961.80
			$ -	$ 90.55	$ 5,556.44	$ 2,808.65
			$ 5,961.80	$ 5,871.25	$ 405.36	$ 3,153.15

Removes the parcels that do not have structures; includes hospital & MOB
Removes the parcels that do not have structures; excludes hospital & MOB
Removes the parcels that do not have structures; 50% of hospital & MOB value removed

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE FIRE
DISTRICT NO. 4 AGREEMENT RESOLUTION NO. 20-47

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 a new operating expense of $XXX.

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 16th day of December 2020, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

DocID:	14518
Revision:	5
Status:	In preparation
Department:	Governing Body (Board of Commissioners)
Manual(s):	

Policy & Procedure : Board Meeting Teleconference

Policy:

It is the policy of Lewis County Hospital District No. 1 that the Board can participate virtually or by teleconference for board meetings.

Procedure:

The Board may attend Regular, Special and/or Committee Meetings via the following guidelines:

1. The Board will comply with the OPMA regulations.
2. Virtual and/or teleconference meetings will be permitted when at least one Board Member or the Superintendent are present at the established meeting place.
3. The Board is able to conduct board business i.e., motions and votes.
4. The Board Chair will conduct the meeting ensuring that each board member can hear and be heard.
5. The Board meeting access information will be distributed via any of the following:
    a. Board Notices
    b. Board Agendas
    c. Board Packets
    d. Arbor Health Website
    e. Arbor Health Facebook Page

In a state of emergency, the Board will adhere to the Governor's Proclamations.

Document Owner:	Frady, Trish
Collaborators:	
Approvals	
- Committees:	
- Signers:	
Original Effective Date:	06/18/2010
Revision Date:	[06/18/2010 Rev. 0], [08/28/2012 Rev. 1], [08/12/2014 Rev. 2], [07/24/2015 Rev. 3], [11/27/2018 Rev. 4]
Review Date:	[04/11/2011 Rev. 0], [05/31/2016 Rev. 3], [09/05/2019 Rev. 4]

Attachments:
(REFERENCED BY THIS DOCUMENT)
Other Documents:
(WHICH REFERENCE THIS DOCUMENT)

Sample #1 — Board of Directors Full Board Evaluation

Rankings go from 1 = Low/Disagree up to 5 = High/Agree

	Board Activity	LOW 1	2	3	4	HIGH 5
1.	The board operates under a set of policies, procedures, and guidelines with which all members are familiar.					
2.	The Executive Committee reports to the board on all actions taken.					
3.	There are standing committees of the board that meet regularly and report to the board.					
4.	Board meetings are well attended, with near full turnout at each meeting.					
5.	Each board member has at least one committee assignment.					
6.	Nomination and appointment of board members follow clearly established procedures using known criteria.					
7.	Newly elected board members receive adequate orientation to their role and what is expected of them.					
8.	Each board meeting includes an opportunity for learning about the organization's activities.					
9.	The board follows its policy that defines term limits for board members.					
10.	The board fully understands and is supportive of the strategic planning process of the ministry.					
11.	Board members receive meeting agendas and supporting materials in time for adequate advance review.					
12.	The board adequately oversees the financial performance and fiduciary accountability of the organization.					
13.	The board receives regular financial updates and takes necessary steps to ensure the operations of the organization are sound.					
14.	The board regularly reviews and evaluates the performance of the CEO.					
15.	The board actively engages in discussion around significant issues.					
16.	The board chair effectively and appropriately leads and facilitates the board meetings and the policy and governance work of the board.					

Sample #1 — Board of Directors Full Board Evaluation

		LOW				HIGH
	Mission and Purpose	1	2	3	4	5
1.	Statements of the organization's mission are well understood and supported by the board.					
2.	Board meeting presentations and discussions consistently reference the organization's mission statement.					
3.	The board reviews the organization's performance in carrying out the stated mission on a regular basis.					
	Governance / Partnership Alignment					
1.	The board exercises its governance role: 1) Ensuring that the organization supports and upholds the mission statement, core values, statement of faith, vision statement, and partnership policies.					
2.	The board periodically reviews, and is familiar with, the organization's partnership core documents. (Note: This item applies when a ministry has partnered with other ministries.)					
3.	The board reviews its own performance and measures its own effectiveness in governance work.					
4.	The board is actively engaged in the board development processes.					
	Board Organization					
1.	Information provided by staff is adequate to ensure effective board governance and decision-making.					
2.	The committee structure logically addresses the organization's areas of operation.					
3.	All committees have adequate agendas and minutes for each meeting.					
4.	All committees address issues of substance.					

Please make any other comments about the work and effectiveness of our boards:

NEW BUSINESS

COURSE TRANSCRIPT: RECRUITMENT & ORIENTATION

Expert Presenters:
Barry Bader
Anne McGeorge
Larry Prybil

OPEN

WELCOME TO THE GOVERNANCE COURSE: RECRUITMENT AND ORIENTATION.

IN THIS COURSE, OUR GOVERNANCE EXPERTS PROVIDE: AN OVERVIEW OF BOARD RECRUITMENT; BOARD SIZE AND COMPOSITION; CHARACTERISTICS OF GOOD DIRECTORS; BOARD LEADERSHIP; TERMS AND TERM LIMITS; AND BOARD ORIENTATION.

1. OVERVIEW OF BOARD RECRUITMENT

LAWRENCE PRYBIL, PROFESSOR AND ASSOCIATE DEAN AT THE COLLEGE OF PUBLIC HEALTH AT THE UNIVERSITY OF KENTUCKY, HAS EXPERIENCE AS A HOSPITAL AND HEALTH SYSTEM EXECUTIVE, A HEALTH SYSTEM BOARD MEMBER, AND HAS CONDUCTED RESEARCH IN HOSPITAL AND HEALTH SYSTEM GOVERNANCE.

Lawrence Prybil: When we think about a board and the current array of people serving on that board, one's mind moves to, "Well, how did they get there, and how will others get there in the future?" That leads to the notion that one facet of board development is board succession planning. And that means thinking about the talent we have, the talent we need, and how to recruit people who will provide those competencies to complement the competencies we have. How does all that happen? Well, it's not going to happen by itself.

In today's world there is growing awareness among most boards that the whole board nomination process needs to be thoughtful and intentional. In my work with boards and the boards where I serve as a board member, I have seen a ramping up of the visibility and recognition that doing that well—nomination, appointment, orientation—is one of the key determinants of effectiveness of the board.

BARRY BADER IS A CONSULTANT, SPEAKER AND FACILITATOR SPECIALIZING IN THE GOVERNANCE OF HOSPITALS AND HEALTH SYSTEMS INCLUDING BOARD RETREATS, GOVERNANCE ASSESSMENTS AND RESTRUCTURING AND REDESIGN INITIATIVES.

Barry Bader: Traditionally people used to come onto boards through what I've often called B-U-G-S-A-T—a bunch of guys sitting around a table. It was done very informally. It was literally a group—a bunch of the male board members, because most of them were male at that time—and when there would be a vacancy coming up on the board they would say, "Well, who do we know who could fill that vacancy?" Sometimes they would say, "Well, Jim's going off the board and he has been great. He works for the local bank. Who else from the bank could we have come on to the board? Who else do we know at the country club or in our social circles?" We had a lot of folks who looked alike, who thought alike and, frankly, who did some wonderful jobs as trustees for our hospitals and health systems over the years.

But the requirements for governance have become more stringent and the work of being a director has become more demanding. Clearly, boards need to be more informed about a whole variety of areas of finance, of quality, of human resources, of technology, of how they play together. Boards need a more sophisticated and diverse understanding of the communities they serve from all ages and genders and ethnic groups. Putting together this almost magical team of skills, talents and perspectives on a board becomes something that can't be left to the serendipity of a group of well-intentioned people sitting around a table saying, "Well, who's out there?"

This has led to what some folks call competency-based [selection], or one of my clients calls it attribute-based selection of board members. What does it mean to have an attribute-based process? First, it means that a board, usually through its governance and nominating committee, says, "What, in fact, are the areas of knowledge and skills, and what are the individual traits, the personal traits and behaviors that we are looking for from directors? Let's identify them. Let's share that with all the members of the board. We will make everybody on the board, as well as our physician leaders and our management, potential board recruiters to identify people who fill these skills and talents."

Governance committees can then develop a long list of potential individuals, can refine that into a short list of the most highly qualified, best prospects for the vacancies that are foreseen. Then, they can have those people come in for an interview, vet their backgrounds and make a more informed choice for ultimate election to the board.

ANNE MCGEORGE IS THE NATIONAL MANAGING PARTNER OF THE HEALTH CARE INDUSTRY PRACTICE AT GRANT THORNTON WHERE SHE PROVIDES FINANCIAL, COMPLIANCE AND GOVERNANCE CONSULTING TO HOSPITALS AND HEALTH SYSTEMS.

Anne McGeorge: The issue of recruiting board members has really evolved over the past couple of decades. Before, generally just community members made up most of the hospital boards. Now, the board selection process is a much more sophisticated exercise [sometimes] involving, believe it or not, recruiters who actually recruit board members to some of the larger hospital and health system boards.

With that in mind, the best practices include identifying a particular area of expertise among the existing board as one that the board would like to expand or fill. For example, a CPA might be needed or an auditor might be needed to fill a spot on the audit committee or as the chairperson of the audit committee; likewise with an investment person chairing an investment committee or an attorney for general expertise to the board.

In addition to the community members on the board, it is also important to have clinical involvement on a hospital board. It is become increasingly important that not only physicians, but also nurses become involved in the board. There have been numerous studies that have indicated that a higher level of clinical involvement on a board actually is attributable to higher performance for a hospital and its operations.

2. BOARD SIZE

RECRUITING BOARD MEMBERS TO FILL UPCOMING VACANCIES ON THE BOARD MAY ALSO STIMULATE A GENERAL REVEW OF OPTIMAL BOARD SIZE. DO WE NEED TO FILL THIS VACANT BOARD POSITION? IS OUR BOARD TOO LARGE TO FUNCTION EFFECTIVELY?

Bader: Most people who have looked at either effective working groups of any sort or at governing boards say board size needs to be a blend—small enough to be effective as an interactive working group to give everyone a chance to participate and listen to viewpoints of others, but large enough to include a range of the areas of skills and knowledge that are relevant to the board's work. In the hospital and healthcare setting, that effective working group usually has a floor of about nine, ten, eleven members, typically including the CEO, and stays effective as a working group up to around 15, 16, 17 members.

This is not to say that suddenly a board of 18, 19, 20 or more members is ineffective, but as a board grows in size, it becomes more difficult to be able to involve everyone, get everyone engaged in participating in discussion. Conversely, at the lower end as boards begin to get smaller—and I have worked with effective boards of 7 or 8 or 9 members—it begins to be more difficult to have all of the talents at the table.

Boards on either the higher end or the lower end have some practices they could use to ameliorate the potential downsides of their size—because there is no perfect answer. Even right in the middle, size still has to be managed. On a board, you will never have all the areas of skills and talents that you need. So, on a board's working committees, they can add non-board members who bring a particular skill, talent or connectedness or experience to enhance the work of that committee.

SUMMARY

BOARDS INCREASINGLY ARE RECRUITING BASED ON ORGANIZATIONAL NEEDS THAT ARE MET BY SPECIFIC, INDIVIDUAL ATTRIBUTES.

ATTRIBUTE-BASED RECRUITMENT FOCUSES ON AN INDIVIDUAL'S SKILLS, KNOWLEDGE, TRAITS AND BEHAVIORS.

OPTIMAL BOARD SIZE IS WHEN THE GROUP IS SMALL ENOUGH TO ENSURE ACTIVE ENGAGEMENT AND DISCUSSION, BUT LARGE ENOUGH TO INCLUDE THE NEEDED RANGE OF SKILLS, KNOWLEDGE AND EXPERIENCE.

3. CHARACTERISTICS OF GOOD DIRECTORS

Bader: The most important characteristic that a board member needs is what I've heard called "governance temperament." This is, for example, directors or trustees who just naturally by their personality or by their experience understand innately the difference between governance and management. They know how to stay at a high level; they know how to be visionary. They know how to inspire and motivate and constructively challenge management and physician leaders without becoming confrontational. They know how to disagree without being disagreeable. This is an example of governance temperament.

I think this can be supported through board education but, frankly, people either have it or they don't when they walk in the boardroom. The trick is to know it before you nominate an individual to be on a board and not to learn about it only after the fact.

One of the most important ways to determine if someone has director's temperament is to ask other people who have served on boards or who have been executives of organizations where this individual has been on their board how this director functions as a board member.

What are some of the other characteristics? I think a record of accomplishment is important—whether it is in business or the community or academia or in medical care. There should be a record that shows the person has achieved a great deal but also is able to and enjoys sharing his or her knowledge and perspective.

It is important that the board looks for directors who are willing to commit the time that will be necessary to serve on the board. There was a time when we could say, "Oh well, it's only one meeting, a couple of hours a month;" but that is just not being honest anymore. A board has to be economical and efficient in its time demands on prospective directors, but it also has to be honest and it has to ask individuals, "Can you put this time in?"

One hospital I know of has determined that the responsibilities of being on their board are so significant—and they are not unusual—that they are saying to prospective directors, "We know that you are on a number of volunteer boards in the community. We would like our hospital to be your number one or number two commitment. If you feel you can't do that, that you can't give that amount of time for our number of scheduled board and committee meetings and retreats a year, then we appreciate it very much, but perhaps this is not the right place for you."

It would be nice to say there are magic bullets for finding board members, but there aren't. Increasingly, it is hard work, especially as we want to be driven by attributes and not just on who knows who in the community.

In some ways there is no difference between looking for a new director and looking for a new chief executive. This is an executive search process. It just happens to be carried out by the governance committee rather than by a search firm. Having said that, there are an increasing number of health system boards, particularly larger regional and national organizations, that are engaging search firms. But whether the search is done by the governance committee or with the help of an outside search firm, it needs to be based on objective criteria. It needs to include extensive outreach to people who are key connectors. And it needs to include a careful review and vetting process to ensure that the folks you are inviting to come into your boardroom are going to be a good fit, both for the skills areas that you need, but also for the desired culture that you want to have on the board.

4. BOARD LEADERSHIP

Prybil: It does no one a service to put a person in a leadership role when they are not suited for that, when they maybe are very good members but just not comfortable in leading. We have to guard against that. That is not a recipe for success. We have to have people around the table who have the capacity and, hopefully, the interest in stepping into leadership roles and can be prepared for it. That really is part of board development. We should be thinking about how to prepare people for leadership roles, and having dialogue with them about their level of interest or willingness to consider a leadership role. You can't surprise people with that.

People may be willing to invest the amount of time required to be a good member of a board, but because of other commitments or their own style, they just may not want or feel capable of taking a leadership role. We have to sort that out early. Don't figure it out later.

The leadership of board committees and leadership of the board are part of board development and succession planning. I like the idea of very deliberate thinking about succession planning. That is a sign of a healthy board.

5. TERM LIMITS

BOARD MEMBERS TYPICALLY ARE APPOINTED TO SERVE FOR A SPECIFIC PERIOD OF TIME, OR TERM, GENERALLY RANGING FROM ONE TO THREE YEARS. MANY BOARDS LIMIT THE NUMBER OF CONSECUTIVE TERMS A MEMBER MAY SERVE. THIS IS REFERRED TO AS "TERM LIMITS."

Bader: If you have term limits, it means that the board is going to need to institute an ongoing process of reaching out to the community to look for individuals who have the skills and talents and connectedness it needs, and that is positive. That keeps the board in touch with its community. It gives the board a simple, non-punitive way of weeding out board members who perhaps aren't as productive, aren't working as hard as they once did on the board.

Candidly, being on a hospital or health system board today is incredibly demanding work and more and more people who come on to those boards are saying, “You know what, three three-year terms, four three-year terms, nine, ten, eleven, twelve years, that is enough. I'm tired. I'm ready to move on.” Term limits are a way to keep a board continually reinvigorated and connected with its community.

It also gives the board an opportunity, on an ongoing basis, to ask itself, “What are the skills and talents we need, because what we're looking for today may not necessarily be what we looked for years ago.”

Term limits have the impact of requiring an ongoing board succession planning process. Having said that, there are some boards, particularly in smaller communities who say, “We have functioned very effectively without term limits.” If a board has made the decision that it can achieve high performance without term limits, there is one thing it has to do, and it is not an easy thing to do. It has to rigorously have performance-based reappointment.

Now, all boards should look at the performance of their board members. A three three-year term limit is not a nine-year term. You should always as a board be looking at an individual’s attendance, participation and continuing provision of a skill that is needed on the board. You should always look at that before electing them to a new term. But it becomes even more important on a board that has no term limits. Performance-based reappointment is difficult, but it is essential if there are no term limits for a board.

When a board has term limits, it means invariably there are times when the board loses a very valuable individual both in terms of the content as well as the energy and the connectedness that he or she provides. This is usually the reason boards give for not having term limits. So, what happens when you have that rare individual or those rare individuals who are still very valuable but are coming off the board? Well, number one, if they are truly outstanding, very rare, you use the opportunity for them to leave the board for a year, as most bylaws provide, and then be reelected. But that should be done very rarely.

More often, if they want to stay involved, it is better to find other roles for them: on a foundation board, for example; by serving on a board committee; or, if the organization is part of a health system, by moving to another board, perhaps from a subsidiary hospital to a health system board or moving on to a physician group practice board that is part of the organization.

There is some value, though, for an organization with term limits to have individuals come on the board, serve their time and then move into friends status. They are connected, they are outreach to the community, but they are not actively involved in governance. And just think about the number of individuals who, over time, are extending an organization's outreach and connectedness to its community.

Some boards have the category of *emeritus* trustee to honor either all board members who have completed full terms on the board, or all board members who have served with particularly high honor, or all board chairs and officers.

SUMMARY

GOOD DIRECTORS ARE VISIONARY, CAN INSPIRE AND CHALLENGE MANAGEMENT, AND CAN DISAGREE WITHOUT BEING DISAGREEABLE.

SOME HOSPITALS AND HEALTH SYSTEMS USE AN EXECUTIVE SEARCH FIRM TO IDENTIFY CANDIDATES FOR BOARD MEMBERSHIP.

ENCOURAGE AND SUPPORT THOSE WHO HAVE THE TIME AND TALENT TO BECOME BOARD LEADERS, BUT RECOGNIZE THAT NOT ALL BOARD MEMBERS CAN OR WANT TO MOVE TO A LEADERSHIP POSITION.

TERMS LIMITS REINVIGORATE THE BOARD AND REINFORCE THE ORGANIZATION'S CONNECTION TO THE COMMUNITY.

IF A VALUABLE BOARD MEMBER TERMS OUT, CONSIDER REAPPOINTMENT AFTER A PERIOD OF TIME, OR BETTER STILL, FIND OTHER ADVISORY ROLES FOR THAT PERSON.

6. BOARD ORIENTATION

McGeorge: The best organizations have a formal process of board orientation with very formal materials. It is a significant investment on the part of the board member, but an important investment to gain the knowledge and an understanding of the organization including the history of the organization; some of the legal documents associated with the organization; the regulatory requirements associated with complying with the regulatory environment; some of the audit, tax, and other financial kinds of issues associated with the organization; and an understanding the culture and the mission of the organization.

Bader: If I come onto the board as a new director, what do I need to know, what do I want to know? First, I want a clear understanding of what you expect from me. What is my role; what are my responsibilities on this board? Ideally, I've asked that question and it has been answered as part of my recruitment process, but that should be reinforced through orientation.

Second, I need to understand as a director, what is this organization all about? How is it organized? What does it do? Who's on the executive team? Who's on the clinical leadership team? Who is responsible for what? I want to have a good understanding of the organization's vision and strategy and major programs. I can read a lot of that on paper and I should get some sort of a board orientation packet or manual. I can get that in a formal orientation briefing from the CEO and executives and I can also get it by physically going out and seeing the organization in action.

Third, as a new director, I want to have some understanding of the healthcare industry. What are the major trends in the industry? What is quality all about? What is finance all about? What are my expectations and responsibilities in the context of the changes going on in healthcare?

Increasingly hospitals and health systems are viewing orientation as a year-long process that needs to be individualized for each board member. A board member who comes in with a finance background just needs a little bit of knowledge about healthcare finance but probably a lot of information about clinical care and quality. On the other hand, a physician who may have been through a number of medical staff positions probably has a pretty good understanding of quality and credentialing, but much less understanding of hospital finance. So orientation should be individualized.

What are some practices over this year that would make orientation more gradual, individualized and job related for the board member? One is mentoring—assigning an experienced board member to help answer questions and have periodic discussions with the board member to put today's work in the context of the policy, practices and history of the organization.

Second, shadowing—where a board member may follow a physician or a nurse or visit particular facilities.

Third, follow-up brief meetings with other members of the C-Suite; for example, a one-hour meeting with the chief financial officer, an hour with the chief medical officer, an hour with the chief nursing officer. These meetings are not done all at once when a board member has just come onto the board, but are spread out over the year so he or she can gradually assimilate, understand and relate to the material.

A significant part of orientation will be done within and by the organization, but one part of it also ought to come from outside the organization, where a new director participates in an educational conference or orientation provided by some national group, where they may read materials by governance and healthcare experts.

The job of being a director is extremely challenging, increasingly complex. Orientation therefore needs to be equally comprehensive and come from a variety of sources.

Well-rounded orientation is going to produce a more well-rounded and better-equipped board member.

For more information, please go to www.iprotean.com.

COURSE TRANSCRIPT: TWO IMPERATIVES FOR BOARDS

Expert Presenters:
Karma Bass, MPH, FACHE
Thomas Dolan, Ph.D.

Welcome to the advanced Governance course, Two Imperatives for Boards.

Building trust between the CEO and the board, and the board self-assessment, are two important aspects of hospital governance. In this course, our experts first discuss the concept of trust, and then examine some of the key components of the board self-assessment.

PART ONE

The Learning Objectives of Part One are: the importance of trust, what trust looks like and rebuilding trust.

1. THE IMPORTANCE OF TRUST

KARMA BASS IS A SPEAKER, FACILITATOR AND CONSULTANT WITH DEEP KNOWLEDGE AND EXPERIENCE IN GOVERNANCE, PHILANTHROPY, QUALITY OVERSIGHT, HEALTHCARE POLICY AND BOARD EFFECTIVENESS.

Karma Bass: When you are responsible for the leadership of an incredibly complex organization like most hospitals or health systems, it is imperative that there be really clear communication and really crisp understanding between the folks who are running the show.

When trust is present between the board and the CEO, which really creates that clear communication, there is an opportunity for a level of synergy between the parties that puts the organization in a very good position for the future. If you want to be planning the future during this time when nobody really knows what's going to happen, you need to have the leadership parties really clear, communicating strongly and understanding each other's point of view.

TOM DOLAN SERVED AS PRESIDENT AND CEO OF THE AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES FROM 1991 TO 2013. HE IS CURRENTLY AN EXECUTIVE COACH AND CONSULTANT DEDICATED TO ASSISTING HEALTHCARE LEADERS IN ADVANCING THEIR ORGANIZATION'S OBJECTIVES.

Tom Dolan: The relationship between any board and its CEO should be a partnership—they are working together to advance the organization. The foundation of any partnership is trust. If there is no trust, there is not going to be an effective partnership.

The trusting relationship between a board and chief executive officer goes beyond those two parties. When there is an effective, trusting relationship, everything falls into place. There's strategic alignment in the organization. The medical staff, the employees and the community typically know where they stand, and they know where the organization stands, which is extremely important.

When there is not a trusting relationship and it's obvious to stakeholders, all the naysayers pop up. All the dissidents within the employees, within the medical staff, within the community take advantage of that and create even greater problems for the organization.

2. WHAT TRUST LOOKS LIKE

Karma Bass: One of the ways to know there is really a strong, trusting relationship between the board and the CEO is that the level of transparency is crystal clear. The CEO doesn't have any compunction about telling the board when something has happened in the organization that is not ideal; say, for instance, if there has been a sentinel event. Usually when that trusting relationship is present, the CEO has that information out to the board before all of the information has even been processed. The board has gotten an immediate heads-up that this is happening and board members are not overreacting to what has happened.

Board members understand that because this is such a complex organization—healthcare is shifting so fast and when you run a hospital, you run a 24 hours a day, seven days a week operation—things are going to happen. And so the board members err on the side of, “We want to know; we want to understand,” rather than, “We want to find out who's responsible and make sure that they're held accountable.”

Tom Dolan: I've had the privilege of working with and being on many boards that had a trusting relationship with their chief executive officer. The best way I can describe it is the organization runs like a well-oiled machine. The board knows its job, which is governance, and it focuses on governance. And the CEO knows that while he participates in governance, his primary responsibility is in management.

Now, unfortunately, a few times I have seen dysfunctional relationships, where the board did not trust the CEO. The immediate reaction, typically, was to micromanage. They questioned everything. They questioned the financial statements. They questioned the quality reports. They questioned everything the chief executive officer did.

I've often seen sometimes where the CEO didn't trust his or her own board and then what happens is there are usually end runs. The CEO doesn't tell the board certain things, and this eventually catches up with the chief executive officer.

Karma Bass: When there's a trusting relationship, the CEO and his or her executive team are often more willing to take some chances that they wouldn't have been willing to take when they understand that the board “has their back.” To enable you to be able to do your best work as a CEO, you have to feel that the people to whom you report, your board of directors, has your back. And you have to feel that if something goes wrong, they will hold you accountable because, of course, that's your job, but they will seek to understand what happened and work with you to figure out what can be done about it and how they can support you in the solution rather than focusing on who's accountable and how could this possibly have happened.

3. REBUILDING TRUST

Karma Bass: For the purposes of transparency, effective CEOs will often try to find time to meet individually with board members. And what that does over time is, first of all, hopefully the board member understands that the CEO is going out of his or her way to try to meet the needs of the board member, to make sure that he or she has what is needed to be effective as a board member. And it's a chance for the exchange of ideas and building a personal relationship at some level.

Tom Dolan: The best way to either build a relationship of trust or repair one is through honesty and communication. First of all, honesty—one has to be completely honest. When I was a chief executive officer, one of my commitments to my board members was “no surprises.” As soon as I found out something, I told them, even if I didn't like telling them, even if it reflected poorly on me—better to hear it from me than from somebody else. So I was always transparent, always honest. That's how effective CEOs act.

And if board members are hearing things out in the community, they need to tell the chief executive officer. During board meetings there shouldn’t be side meetings that don’t involve the CEO. So, certainly, total honesty, total transparency and frequent communication. I've never heard a board or a CEO say that the other party over-communicated.

When a board or a number of board members does not trust the CEO, the first question that has to be answered is, can the relationship be saved? Sometimes it can't; it’s better to part as amicably as possible and select a new CEO. But many times it can.

What I have found to be most effective is bringing in one or maybe even two consultants. One, certainly, may be an executive coach for the chief executive officer, because obviously something ruptured the trust between the board and the CEO. Between the executive coach, the CEO and the board chair, there can be some counseling and some behavior modification that may reestablish that trust.

It may also be a problem with the board itself, and that's why I think you are seeing more and more boards engaging governance consultants who work with them because sometimes that lack of trust may result from unrealistic expectations on the part of the board. An example that

I ran into once was a board member who felt he should know every complaint that an employee made within the organization. Well, that's not the job of a board member and that has no reflection on how trustworthy the chief executive officer is. So I think in those cases where they really feel that they want to reestablish a bond of trust and it's been seriously ruptured, then the possibility of bringing in an executive coach and/or a governance coach for the board could be very, very helpful.

EXECUTIVE SESSIONS

Tom Dolan: In this era of transparency, it is extremely important that boards have an executive session at every meeting, typically in two parts. The first part, the chief executive officer remains in the room, and this gives the board an opportunity to talk about maybe staff issues they are not comfortable talking about when other staff are there. It also gives the CEO the opportunity to talk about things with only the board. Then the last half of the executive session should be without the chief executive officer so that the board can talk about any issues they may have.

There are two provisos. First, it is extremely important that the board chair inform the CEO what was discussed in that part of the executive session the CEO did not attend. And, two, the board has to be careful that it doesn't put too much in the executive session. Only those things that have to be talked about in strict confidence should be in an executive session.

SUMMARY

TRUST IS THE FOUNDATION OF ANY PARTNERSHIP. AND THE RELATIONSHIP BETWEEN THE BOARD AND THE CEO SHOULD BE A PARTNERSHIP.

TRUST BETWEEN THE BOARD AND THE CEO ENSURES:

- CLEAR COMMUNICATION
- SYNERGY
- STRATEGIC ALIGNMENT
- AND THAT THE ORGANIZATION IS WELL-POSITIONED FOR THE FUTURE

EVIDENCE OF A TRUSTING RELATIONSHIP BETWEEN THE BOARD AND THE CEO INCLUDES:

- TRANSPARENCY
- THE CEO SHARES INFORMATION WITH THE BOARD QUICKLY
- THE BOARD FOCUSES ON UNDERSTANDING THE ISSUE, NOT ASSIGNING BLAME
- THE BOARD UNDERSTANDS ITS JOB IS GOVERNANCE: IT DOESN'T MICROMANAGE
- THE CEO UNDERSTANDS HIS OR HER JOB IS MANAGEMENT

A TRUSTING RELATIONSHIP BETWEEN THE BOARD AND THE CEO ENCOURAGES THE EXECUTIVE TEAM TO TAKE RISKS. THE TEAM WILL KNOW THE BOARD HAS ITS "BACK."

REBUILDING TRUST REQUIRES EFFORT FROM BOTH THE BOARD AND THE CEO:

- THE CEO MEETS WITH INDIVIDUAL DIRECTORS TO ENSURE NEEDS ARE BEING MET, IDEAS ARE BEING EXCHANGED, AND TO HELP BUILD PERSONAL RELATIONSHIPS

- The Board and the CEO Should Work on Honesty, Transparency and Frequent Communication

Consultants Can be Effective When the Board/CEO Relationship Has Deteriorated:
- An Executive Coach Can Work with the CEO, with the Board Chair Participating if Appropriate
- A Governance Coach Can Work with the Board

Consider Having an Executive Session After Every Board Meeting.
There are Two Provisos:
- The Board Chair Briefs the CEO So the CEO Knows of the Ramifications for Him or Her
- And Executive Sessions Should be Used Only to Discuss What Must be Held in Strict Confidence

PART TWO

The board self-assessment is another key imperative for effective governance. The Learning Objectives of Part Two are: why do a self-assessment, surveys and interviews, instruments and benchmarking, when to use a consultant and optimal uses of a self-assessment.

4. WHY DO A BOARD SELF-ASSESSMENT?

Karma Bass: A board should do a regular self-assessment of its own performance as a matter of governance best practice, to “sharpen the saw” and also as an insurance policy. If you are not doing a regular self-assessment, you may not realize that some of your board members have a particular point of view about your performance that differs from your own point of view. And so this is an opportunity to bring the board together and have a conversation so there is a shared point of view, at the very least, about the board's performance and how it is doing at serving your organization.

Tom Dolan: A board self-assessment is one of the most important things any board can do. It lays out the major responsibilities of a board. The assessment itself asks each board member how he or she thinks the board is doing. And that provides a road map for future actions. I have yet to meet a board that was doing everything perfectly. They can always do what they're doing better. Effective self-assessment provides them with that road map.

Karma Bass: When you sit on a board you want to do the right thing; you want to serve your community; you want to give back. The last thing you often want to do is focus on yourself, because as board members and as a board you want to think, "It's not about us." But, in fact, many boards are deeply unaware of the impact their own, interpersonal dynamics plays in the effectiveness of the board. A self-assessment is an opportunity to bring to the surface some of those opportunities for improvement.

Tom Dolan: The major features of an effective board self-assessment process are to first of all, make sure you are using a reliable and valid instrument. This is no place to make up your own. Also, it is extremely important that the board members take it very, very seriously. This is an important part of being a board member. And finally, probably the most important thing is after you get the results to carefully go over those, think about what the implications are for the hospital or the healthcare system, and then take definitive action to address any deficiencies you might find.

5. SURVEYS AND INTERVIEWS

Karma Bass: When you do a board self-assessment, you need to identify up-front if you are going do written surveys which can be administered through the Internet, or one-on-one interviews with board members, usually by an outside facilitator or consultant, or you are going to do both.

When you do that written survey, that's fairly straightforward, fairly easy to do. You could have your CEO's executive assistant get those results, tabulate them, prepare the results and you could do that internally relatively easily.

The interviews you probably want to have done by someone from the outside, although sometimes the board chair, if he or she has the inclination and the relationship with the board members, can do some of those interviews.

So it's really a level of difficulty, and a level of how much information you need to engage in a productive conversation. One of the primary purposes of the board self-assessment process is to get to a meaningful conversation where we consider how we can be better than we are today.

Tom Dolan: There are two ways to do a board self-assessment. The most common is a written instrument. But it is also important, from time to time, to do interviews because interviews have more depth to them. The skilled interviewer can oftentimes get nuances from board members that a written questionnaire can't. So an annual board self-assessment is important and it should be done in writing every year. But it should be supplemented by interviews every third year.

The best person to conduct interviews with a board around its own assessment is an outside consultant. Once the board consultant has completed these interviews, I think it's important that he or she compiles a written report. More importantly, the consultant leads a discussion of the board on the findings of those interviews supplemented by the findings from the written questionnaire. I think that gives you the total picture of how the board believes it is performing.

6. INSTRUMENTS AND BENCHMARKING

Tom Dolan: If you are going to go to the time and expense of doing a board self-assessment, you want to make sure you get the kind of results you want. So you need a valid, reliable self-assessment instrument.

You will look at the survey results in four ways. Most self-assessment instruments I've worked with use a one to five scale where five is excellent and one is poor. So the first thing you will look at is the actual score. And, clearly, if you are getting a four, you are doing pretty well. But if you are getting a two, you obviously have a problem.

The second way involves dispersion of results among the board members. If half the board rates you five on something and the other half rates you three, the average might be four, but that is very different from having everybody on the board rank it as a four.

The third way I like to look at the results is over time. You need assessment results from previous years; it's best to do the assessment annually so you have year-over-year comparisons. I like to look at the last three years' results and see what's happening with the functioning of the board.

And then finally, if you use a questionnaire provided by an organization that does a lot of hospitals, then you can find a peer group that is comparable to your organization and compare yourself to that group. And, again, a four might be a great score unless the peer group is averaging four-point-eight. Three could be a great score if the peer group is only averaging two-point-five.

Karma Bass: Many boards will go to the lengths of seeking a benchmark comparison for themselves. These can be found through many different venues specific to hospital, health system and other healthcare organizations. They are useful because they give the board a level of comfort sometimes that everybody is sort of in the same boat. Oftentimes you'll see that the results are a little bit lower in certain areas across many boards. For instance, quality oversight is an area that most boards find challenging to do well and to get comfortable with their responsibilities. So that will be an area where boards often will rate themselves a little lower. This provides a level of comfort for board members; they feel that, "We're not so bad, we're doing okay; we're doing about the same as other boards."

The problem that can arise, however, with using a benchmark is that it often engenders a sense of complacency. So if a board is inclined to not really do the tough work of being introspective, the benchmark can often give them an excuse not to do that.

People sometimes forget that this is all subjective. There is nothing in board self-assessments that yields objective data. The results do not show how you actually are performing as a board. The results show how you *think* you are performing as a board.

Boards inclined to skip over the steps of talking about areas for improvement and developing an action plan to take on just two to three things to do better or differently would use the benchmark perhaps as a reason not to do those key things. So I view benchmarks as a double-edged sword. They give you some frame of reference, which is always nice. But if you're using them to justify the *status quo*, then that may not be a good thing.

7. WHEN TO USE A CONSULTANT

Tom Dolan: The first time a board does a self-assessment is an especially important time. I recommend that they bring in a consultant for a number of reasons. First of all, if they have never done it before, often times it's reassuring if there is an outside party, somebody who does not work for the organization. That individual can talk to them about the assessment and about how the results will be used. And then I would suggest that the board take the self-assessment and the results go to the consultant. The consultant then may interview all the board members and follow up on questions and responses from the self-assessment. The consultant would then facilitate a discussion at a board meeting or, more likely, at a board retreat because this is not a 30-minute discussion. This typically takes quite a bit of time.

Then you almost have to start a to-do list. For example, I served on a board where we found that the board really didn't understand the risk management procedures of the organization, so that was obviously put on a to-do list. First of all, there was a presentation for the whole board on risk management. Second, every new board member, as he or she was oriented, was taught the risk management procedures of the organization. And there was a briefer refresher every year.

Initially, I would use a consultant every three years because a lot of boards change considerably in three years. It is time to bring in a fresh set of eyes. It doesn't have to be the same consultant. However, I would suggest that you use the same instrument over time because that is the only way you can effectively compare year-to-year results and, perhaps, improvement. Now, in the other two years the board should take it just as seriously. Discussion will not be as long. But, again, it is important to have that to-do list. Are there things we found in this assessment that we want to address? This typically is coordinated either by the leadership committee of the board, or management or the two together.

Karma Bass: The board does not need to hire a consultant to do a board self-assessment. In fact, if you are going to follow a practice of doing them regularly, every one or two years, you probably don't want to hire a consultant every time to present the results of your self-assessment because there may be higher and better uses for those resources.

However, it is a good practice to have, from time-to-time, someone from the outside talk to your board about how it’s performing. It is very rare that you'll find a board where there isn't something that could be uncovered, in the process of a good questionnaire and good dialogue, that the board could improve.

Now, there's one thing I've seen organizations do and I think this can be helpful: if you are dealing with issues at the board level that are incredibly divisive and controversial and people are not getting along, or there's a real schism between your board and your executive management team, sometimes a self-assessment is a soft way into that. People may not necessarily be willing to come to the table to talk about the very difficult relationship they may be experiencing together because that feels too soft. So sometimes you can position it that doing a regular board self-assessment is part of good governance practice and it's time to do one. If that is one of the reasons you are thinking about doing a self-assessment, then I would suggest a consultant is probably going be helpful. You don't want to have those kinds of conversations without someone who is experienced at setting the stage effectively, creating a safe environment and facilitating those conversations so that at the end of the day the board can have a productive outcome.

8. OPTIMAL USES OF A BOARD SELF-ASSESSMENT

Tom Dolan: From time to time, chairs have come to me and said, "We have a really bad board member and we should get rid of this person so I think we should do a board self-assessment and that will come out." That is not the purpose of an assessment. An assessment is not punitive; it is a learning experience. So, clearly, you use a self-assessment so the board can learn together and improve the organization. If you have a very obvious problem such as a bad board member who is not functioning well, or a CEO who is not functioning well, that is not the purpose of a board self-assessment.

Karma Bass: A board self-assessment is not useful for a board that wants to justify its behavior or its performance. A board self-assessment is completely subjective; it's what the board members think of themselves. If you have a deeply dysfunctional board, the self-assessment may be a good place to start, but it may not be where you want to end. A board self-assessment can be an entree into some of those very important conversations about what is not going well, but for a board that might be inclined to not want to deal with difficult issues about its own performance, the board self-assessment can be somewhat of a dead end.

I think the most important aspect of doing a self-assessment is to insure that you have time, at the end of the process, to go through the results in discussion. It should be the full board together, and it should be a dedicated period of time to talk about the results. It is important that some type of action plan come out of the discussion. Two or three things should be identified to work on in the coming year—areas where you aren't as strong as you would like to be.

Tom Dolan: Let me underscore the real value of a board self-assessment: doing something with the results. We don't do assessments just to do assessments. That would be a waste of time and money. The real value is in the discussion that takes place based on the results of the

assessment, and even more importantly what a board does with the results, how they change their behavior in the future to better serve their stakeholders.

SUMMARY

DOING A SELF-ASSESSMENT IS A GOVERNANCE BEST PRACTICE THAT BRINGS THE BOARD TOGETHER TO ENABLE A SHARED POINT OF VIEW ABOUT THE BOARD'S PERFORMANCE. IT'S A ROAD MAP FOR FUTURE ACTIONS TO IMPROVE THE BOARD'S PERFORMANCE, AND AN OPPORTUNITY FOR BOARD MEMBERS TO BECOME AWARE OF THE IMPORTANCE OF INTERPERSONAL DYNAMICS ON BOARD EFFECTIVENESS.

KEY ELEMENTS OF A SELF-ASSESSMENT:

- A RELIABLE AND VALID INSTRUMENT
- IT MUST BE TAKEN SERIOUSLY BY BOARD MEMBERS
- THERE NEEDS TO BE A REVIEW AND A DISCUSSION OF THE RESULTS
- THE BOARD MUST TAKE ACTION TO ADDRESS DEFICIENCIES

BOARDS CAN OPT FOR A WRITTEN SURVEY, ONE-ON-ONE INTERVIEWS, OR BOTH.

INTERVIEWS SHOULD BE DONE AT LEAST EVERY THREE YEARS. THEY YIELD MORE DEPTH AND NUANCE; AND MAY BE CONDUCTED BY AN OUTSIDE CONSULTANT.

WRITTEN SURVEY RESULTS SHOULD BE ASSESSED BY:

- THE ACTUAL SCORES
- DISPERSION OF SCORES AMONG BOARD MEMBERS
- SCORES OVER TIME (THAT IS, FROM YEAR TO YEAR)
- SCORES COMPARED TO A PEER GROUP

BENCHMARKING RESULTS AGAINST OTHER ORGANIZATIONS IS A DOUBLE-EDGED SWORD: IT MAY GIVE THE BOARD A LEVEL OF COMFORT AND A FRAME OF REFERENCE; BUT IT CAN ENGENDER A SENSE OF COMPLACENCY, JUSTIFY THE STATUS QUO, AND THE BOARD EVEN MAY SKIP IDENTIFYING AREAS FOR IMPROVEMENT.

CONSIDER USING A CONSULTANT FOR A SELF-ASSESSMENT IF IT'S THE FIRST TIME A BOARD HAS DONE A SELF-ASSESSMENT.

THE CONSULTANT WILL:

- DESCRIBE THE PROCESS TO THE BOARD
- REVIEW THE WRITTEN SURVEY RESULTS
- INTERVIEW INDIVIDUAL BOARD MEMBERS
- REPORT ON AND REVIEW RESULTS WITH THE BOARD
- FACILITATE BOARD DISCUSSION
- HELP FORMULATE AN ACTION PLAN

A BOARD THAT HAS BECOME DIVISIVE MAY WANT TO USE A CONSULTANT FOR ITS SELF-ASSESSMENT.

A Self-Assessment Should Not be Used Punitively, for example to Highlight One Particular Director's Behavior. It Should be a Learning Experience to Improve the Organization.

The Optimal Uses of the Self-Assessment Results are to:

- Discuss the Results and Come to a Shared Point of View About Moving Forward
- Develop an Action Plan to Address Deficiencies and Improve Performance

For additional information please go to www.iprotean.com

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE DZA
FINANCIAL AUDIT, SINGLE AUDIT
FOR CARES ACT FUNDING AND COST REPORT
ANNUAL ENGAGEMENT RESOLUTION NO. 20-52

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 engagement with Dingus, Zarecor & Associates, PLLC for the financial audit, single audit for Cares Act Funding and cost report preparation for year ended December 2020. The gross fee for these services is $42,000 plus out-of-pocket costs i.e., shipping & travel. Standard hourly rates apply for unexpected circumstances.

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 16th day of December 2020, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

December 1, 2020

Board of Commissioners
and Richard Boggess, CFO
Lewis County Public Health District No. 1
doing business as Arbor Health
521 Adams Street
Morton, Washington 98356

We are pleased to confirm our understanding of the services we are to provide Lewis County Public Health District doing business as Arbor Health (the District) for the year ending December 31, 2020. We will audit the financial statements of the District, which comprise the statement of net position as of December 31, 2020, the related statements of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the financial statements. Accounting standards generally accepted in the United States of America provide for certain required supplementary information (RSI), such as management's discussion and analysis (MD&A), to supplement the District's basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. As part of our engagement, we will apply certain limited procedures to the District's RSI in accordance with auditing standards generally accepted in the United States of America. These limited procedures will consist of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We will not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance. The following RSI is required by generally accepted accounting principles and will be subjected to certain limited procedures, but will not be audited:

1) Management's Discussion and Analysis.

We have also been engaged to report on supplementary information other than RSI that accompanies the District's financial statements. We will subject the following supplementary information to the auditing procedures applied in our audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America, and we will provide an opinion on it in relation to the financial statements as a whole, in a report combined with our auditors' report on the financial statements:

1) Schedule of expenditures of federal awards.

We will also prepare the District's Medicare cost report for the year ending December 31, 2020.

Audit Objectives

The objective of our audit is the expression of an opinion as to whether your financial statements are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles and to report on the fairness of the supplementary information referred to in the second paragraph when considered in relation to the financial statements as a whole. The objective also includes reporting on —

- Internal control over financial reporting and compliance with provisions of laws, regulations, contracts, and award agreements, noncompliance with which could have a material effect on the financial statements in accordance with *Government Auditing Standards*.
- Internal control over compliance related to major programs and an opinion (or disclaimer of opinion) on compliance with federal statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on each major program in accordance with the Single Audit Act Amendments of 1996 and Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance).

The *Government Auditing Standards* report on internal control over financial reporting and on compliance and other matters will include a paragraph that states (1) that the purpose of the report is solely to describe the scope of testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance, and (2) that the report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. The Uniform Guidance report on internal control over compliance will include a paragraph that states that the purpose of the report on internal control over compliance is solely to describe the scope of testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Both reports will state that the report is not suitable for any other purpose.

Our audit will be conducted in accordance with auditing standards generally accepted in the United States of America; the standards for financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; the Single Audit Act Amendments of 1996; and the provisions of Uniform Guidance, and will include tests of accounting records, a determination of major programs in accordance with Uniform Guidance, and other procedures we consider necessary to enable us to express such opinions. We will issue written reports upon completion of our single audit. Our reports will be addressed to the governing board of the District. We cannot provide assurance that unmodified opinions will be expressed. Circumstances may arise in which it is necessary for us to modify our opinions or add emphasis-of-matter or other-matter paragraphs. If our opinions are other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed opinions, we may decline to express opinions or issue reports, or may withdraw from this engagement.

Audit Procedures — General

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We will plan and perform the audit to obtain reasonable rather than absolute assurance about whether the financial statements are free of material misstatement, whether from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the government or to acts by management or employees acting on behalf of the government. Because the determination of abuse is subjective, *Government Auditing Standards* do not expect auditors to provide reasonable assurance of detecting abuse.

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

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts, and may include direct confirmation of certain assets and liabilities by correspondence with selected individuals, funding sources, creditors, and financial institutions. We may request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. At the conclusion of our audit, we will require certain written representations from you about your responsibilities for the financial statements; schedule of expenditures of federal awards; federal award programs; compliance with laws, regulations, contracts, and grant agreements; and other responsibilities required by generally accepted auditing standards.

Audit Procedures — Internal Control

Our audit will include obtaining an understanding of the government and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Tests of controls may be performed to test the effectiveness of certain controls that we consider relevant to preventing and detecting errors and fraud that are material to the financial statements and to preventing and detecting misstatements resulting from illegal acts and other noncompliance matters that have a direct and material effect on the financial statements. Our tests, if performed, will be less in scope than would be necessary to render an opinion on internal control and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to *Government Auditing Standards*.

As required by the Uniform Guidance, we will perform tests of controls over compliance to evaluate the effectiveness of the design and operation of controls that we consider relevant to preventing or detecting material noncompliance with compliance requirements applicable to each major federal award program. However, our tests will be less in scope than would be necessary to render an opinion on those controls and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to the Uniform Guidance.

An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weaknesses. However, during the audit, we will communicate to management and those charged with governance internal control related matters that are required to be communicated under AICPA professional standards, *Government Auditing Standards*, and the Uniform Guidance.

Audit Procedures — Compliance

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

The Uniform Guidance requires that we also plan and perform the audit to obtain reasonable assurance about whether the auditee has complied with applicable laws and regulations and the terms and conditions of federal awards applicable to major programs.

Our procedures will consist of tests of transactions and other applicable procedures described in the *OMB Compliance Supplement* for the types of compliance requirements that could have a direct and material effect on each of the District's major programs. The purpose of these procedures will be to express an opinion on the District's compliance with requirements applicable to each of its major programs in our report on compliance issued pursuant to the Uniform Guidance.

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

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

Other Services

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

Management Responsibilities

Management is responsible for (1) designing, implementing, establishing, and maintaining effective internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error, including internal controls over federal awards, and for evaluating and monitoring ongoing activities, to help ensure that appropriate goals and objectives are met; (2) following laws and regulations; (3) ensuring that there is reasonable assurance that government programs are administered in compliance with compliance requirements; and (4) ensuring that management and financial information is reliable and properly reported.

Management is also responsible for implementing systems designed to achieve compliance with applicable laws, regulations, contracts, and grant agreements. You are also responsible for the selection and application of accounting principles; for the preparation and fair presentation of the financial statements, schedule of expenditures of federal awards, and all accompanying information in conformity with U.S. generally accepted accounting principles; and for compliance with applicable laws and regulations (including federal statutes) and the provisions of contracts and grant agreements (including award agreements). Your responsibilities also include identifying significant contractor relationships in which the contractor has responsibility for program compliance and for the accuracy and completeness of that information.

Management is also responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. You are also responsible for providing us with (1) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, (2) access to personnel, accounts, books, records, supporting documentation, and other information as needed to perform an audit under the Uniform Guidance, (3) additional information that we may request for the purpose of the audit, and (4) unrestricted access to persons within the government from whom we determine it necessary to obtain audit evidence.

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

You are responsible for the design and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the government involving (1) management, (2) employees who have significant roles in internal control, and (3) others where the fraud could have a material effect on the financial statements. Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the government received in communications from employees, former employees, grantors, regulators, or others. In addition, you are responsible for identifying and ensuring that the government complies with applicable laws, regulations, contracts, agreements, and grants. Management is also responsible for taking timely and appropriate steps to remedy fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, or abuse that we report. Additionally, as required by the Uniform Guidance, it is management's responsibility to evaluate and monitor noncompliance with federal statutes, regulations, and the terms and conditions of federal awards; take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings; promptly follow up and take corrective action on reported audit findings; and prepare a summary schedule of prior audit findings and a separate corrective action plan. The summary schedule of prior audit findings should be available for our review at the beginning of audit fieldwork.

You are responsible for identifying all federal awards received and understanding and complying with the compliance requirements and for the preparation of the schedule of expenditures of federal awards (including notes and noncash assistance received) in conformity with the Uniform Guidance. You agree to include our report on the schedule of expenditures of federal awards in any document that contains and indicates that we have reported on the schedule of expenditures of federal awards. You also agree to include the audited financial statements with any presentation of the schedule of expenditures of federal awards that includes our report thereon OR make the audited financial statements readily available to intended users of the schedule of expenditures of federal awards no later than the date the schedule of expenditures of federal awards is issued with our report thereon.

Your responsibilities include acknowledging to us in the written representation letter that (1) you are responsible for presentation of the schedule of expenditures of federal awards in accordance with the Uniform Guidance; (2) you believe the schedule of expenditures of federal awards, including its form and content, is stated fairly in accordance with the Uniform Guidance; (3) the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (4) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the schedule of expenditures of federal awards.

You are also responsible for the preparation of the other supplementary information, which we have been engaged to report on, in conformity with U.S. generally accepted accounting principles. You agree to include our report on the supplementary information in any document that contains and indicates that we have reported on the supplementary information. You also agree to include the audited financial statements with any presentation of the supplementary information that includes our report thereon OR make the audited financial statements readily available to users of the supplementary information no later than the date the supplementary information is issued with our report thereon.

Your responsibilities include acknowledging to us in the written representation letter that (1) you are responsible for presentation of the supplementary information in accordance with GAAP; (2) you believe the supplementary information, including its form and content, is fairly presented in accordance with GAAP; (3) the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (4) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the supplementary information.

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

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

Preparation of Cost Reports and Consulting

We will prepare the District's Medicare cost report for the year ending December 31, 2020. We remind you that you have the final responsibility for the Medicare cost report and, therefore, you should review it carefully before you sign and file it . We make no representation that our services will identify any or all opportunities to maximize reimbursement.

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

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

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

Conformance with Section 952 of Public Law 96-499

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

HIPAA Business Associate Agreement

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

Engagement Administration, Fees, and Other

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

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

At the conclusion of the engagement, we will complete the appropriate sections of the Data Collection Form that summarizes our audit findings. It is management's responsibility to electronically submit the reporting package (including financial statements, schedule of expenditures of federal awards, summary schedule of prior audit findings, auditors' reports, and corrective action plan) along with the Data Collection Form to the federal audit clearinghouse. We will coordinate with you the electronic submission and certification. The Data Collection Form and the reporting package must be submitted within the earlier of 30 calendar days after receipt of the auditors' reports or nine months after the end of the audit period.

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

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

The audit documentation for this engagement will be retained for a minimum of seven years after the report release date or for any additional period requested by a regulatory agency. If we are aware that a federal awarding agency, pass-through entity, or auditee is contesting an audit finding, we will contact the party(ies) contesting the audit finding for guidance prior to destroying the audit documentation.

We expect to begin our audit in approximately February 2021 and to issue our reports no later than May 2021. Tom Dingus is the engagement partner and is responsible for supervising the engagement and signing the reports or authorizing another individual to sign them.

Our fee for these services will be at our standard hourly rates plus out-of-pocket costs (shipping and travel) except that we agree that our gross fee, excluding expenses, will be as follows:

Audit	$31,500
Preparation of Medicare cost report	$10,500

Our fee for the Uniform Guidance Single Audit includes one major program to be audited. Each additional major program will increase our fee by $2,500.

Our standard hourly rates vary according to the degree of responsibility involved and the experience level of the personnel assigned to your audit. Our invoices for these fees will be rendered each month as work progresses and are payable on presentation. In accordance with our firm policies, work may be suspended if your account becomes 60 days or more overdue and may not be resumed until your account is paid in full. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our report(s). You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket costs through the date of termination. The above fee is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the audit. If significant additional time is necessary, we will discuss it with you and arrive at a new fee estimate before we incur the additional costs.

You have requested that we provide you with a copy of our most recent external peer review report and any subsequent reports received during the contract period. Accordingly, our 2019 peer review report accompanies this letter.

We appreciate the opportunity to be of service to Lewis County Public Health District No. 1 doing business as Arbor Health and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this letter, please print and sign a copy and return to us.

DINGUS, ZARECOR & ASSOCIATES PLLC

Tom Dingus, CPA
Owner

RESPONSE:

This letter correctly sets forth the understanding of Lewis County Public Health District No. 1 doing business as Arbor Health.

Management signature: _____

Title: _____

Date: _____

Governance signature: _____

Title: _____

Date: _____

LEWIS COUNTY HOSPITAL DISTRICT NO. 1
MORTON, WASHINGTON

RESOLUTION APPROVING THE CAPITAL
PURCHASE OF CERNER MODULES RESOLUTION NO. 20-53

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 purchase of Cerner Software and Support.

The purchase price is $35,784.00.

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 16th day of December 2020, the following commissioners being present and voting in favor of this resolution.

_____ _____
Trish Frady, Board Chair Tom Herrin, Secretary

_____ _____
Craig Coppock, Commissioner Wes McMahan, Commissioner

_____
Chris Schumaker, Commissioner

BUDGETARY QUOTE

Prepared For:	Lewis County Hospital District No. 1 521 Adams Ave. Morton, WA 98356 United States			**Expiration Date:**	Jan 11, 2021
Cerner Sales Contact:	Laura Mann	**Phone #:**	(816) 201-8792	**E-mail Address:**	laura.mann@cerner.com

This Cerner Budgetary Quote ("Budgetary Quote") does not constitute or create any legally binding obligations on either party but, rather, is intended to facilitate discussions regarding the proposed solutions. In order for the transaction to be consummated, a formal legal document (typically a Cerner Sales Order) would need to be negotiated, executed, and delivered, and would be subject to the mutually agreed upon terms expressed therein. This document is nonbinding in all respects; without limitation, the expenditure of funds or the taking or not taking of any actions by either party shall not create a legally binding obligation, duty, commitment, or liability whatsoever.

FINANCIAL OVERVIEW

Description	One-Time Fees	Monthly Fees
SOLUTIONS		
Licensed Software	10,784.00	- -
Software Support	- -	723.00
PROFESSIONAL SERVICES		
Fixed Fee	25,000.00	- -
TOTALS:	**35,784.00**	**723.00**

All prices in this Cerner Budgetary Quote are shown in USD.

Not applicable is indicated by "- -".

SOLUTIONS

LICENSED SOFTWARE AND SOFTWARE SUPPORT

Mfg. Part No.	Solution Detail Description	Scope of Use Metric	Qty./ Scope of Use Limit	One-Time Fees	Monthly Fees	Solution Description Code	Third-Party Component(s)	Pass- Through Code
RC-20150	Cerner Acute Case Management	Full Time Equivalents (FTEs)	160	10,784	- -	SD100285_01	- -	- -
RC-20150	*SUP:Cerner Acute Case Management*	*Full Time Equivalents (FTEs)*		- -	*723*	- -	- -	- -
			TOTAL:	**10,784**	**723**	**- -**	**- -**	**- -**

PROFESSIONAL SERVICES

FIXED FEE				
Manufacturer Part No.	Service Project Detail	One-Time Fees	Third-Party Compo-nent(s)	Pass-Through Code
Custom Services				
- -	CommWks	25,000	- -	- -- -
	TOTALS:	25,000	- -	- -

FACILITIES

Permitted Facilities. For use and access by these facilities:

Name	Address	City	State/ Province	Zip/Postal Code	Country
Lewis County Hospital District No. 1	521 Adams Ave.	Morton	WA	98356	United States

SOLUTION DESCRIPTIONS

Each solution with a Solution Description has a code noted in the "Solutions" section of this Budgetary Quote, and that code can be entered at https://solutiondescriptions.cerner.com to view the Solution Description.

QUOTE SUMMARY (for internal use only)

COMBINED (Q-26365.1)
Solutions (Q-22906.1)
Professional Services (Q-25872.1)

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

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 12/09/2020
Subject: Approving Infection Preventionist and Medication Safety Officer and Antibiotic Steward Appointments

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In preparation for our DNV survey, I am asking you, via a motion of the Board of Commissioners, to approve the following appointments:

1. Don Roberts, RPh to serve as Arbor Health's Medication Safety Officer and Antibiotic Steward. This appointment is to fulfill DNV's NIAHO (National Integrated Accreditation for Healthcare Organizations) accreditation requirement IC.2,SR.1a *(an individual(s) who is qualified through education, training, or experience in infections diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program).*

2. Julie Taylor to serve as Arbor Health's Infection Preventionist. This appointment is to fulfill DNV's NIAHO accreditation requirement IC.1,SR.2a *(an individual(s) who is qualified through education, training, experience or certification in infection prevention, is appointed by the governing body as the infection control professional(s) responsible for the Infection Prevention and Control Program).*

MEDICATION SAFETY OFFICER AND ANTIBIOTIC STEWARD APPOINTMENT AND AUTHORITY STATEMENT

Having been duly qualified to be appointed as Medication Safety Officer and Antibiotic Steward, Arbor Health appoints Don Roberts, RPh to serve as Medication Safety Officer and Antibiotic Steward for the Hospital and Clinics, as described in the scope of the Medication Management Plan and Antibiotic Stewardship Program. Don Roberts, PharmD is hereby authorized to monitor the activities of the Medication Management Plan and Antibiotic Stewardship Program and develop appropriate corrective action plans when the Medication Management Plan and Antibiotic Stewardship Program of Arbor Health is compromised for non-compliance. This authority is designated by the Superintendent and Chief Executive Officer in concert with the Board of Commissioners with recommendations by the Medical Executive Committee of Arbor Health and is in effect until such time when the Superintendent and Chief Executive Officer rescinds the authority.

_____ _____

Leianne Everett — Date

Superintendent and Chief Executive Officer

_____ _____

Tom Anderson, MD — Date

Chief of Staff

_____ _____

Trish Frady — Date

Chair, Board of Commissioners

INFECTION PREVENTIONIST
APPOINTMENT AND AUTHORITY STATEMENT

Having been duly qualified to be appointed as the Infection Preventionist, Arbor Health appoints Julie Taylor to serve as Infection Preventionist for the Hospital and Clinics because of her qualifications through education, training, experience, certification and licensure to function in this role. Julie Taylor is responsible for all infection prevention and control issues as detailed in the job description and regulatory agency standards and is also hereby authorized to take necessary action needed relating to situations that pose immediate threat to the life, health and the property of Arbor Health's patients, employees, physicians and visitors. This authority is designated by the Superintendent and Chief Executive Officer in concert with the Board of Commissioners with recommendations by the Medical Executive Committee of Arbor Health and is in effect until such time when the Superintendent and Chief Executive Officer rescinds the authority.

_____ _____

Leianne Everett — Date

Superintendent and Chief Executive Officer

_____ _____

Tom Anderson, MD — Date

Chief of Staff

_____ _____

Trish Frady — Date

Chair, Board of Commissioners

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

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 12/09/2020
Subject: Incident Command Update

CNO/CQO Williamson and Ancillary Services Director Taylor have been leading a multi-disciplinary team to respond to the Expansion/Contraction of Care Plan required by Governor Inslee's Proclamation 20-24.2. A draft plan accompanies this memorandum for your review. CNO/CQO Williamson and Ancillary Services Director Taylor will provide a verbal update at the December 16, 2020 Regular Board of Commissioners meeting.

Arbor Health Expansion and Contraction of Care Plan
Responsive to Governor Inslee Proclamation 20-24.02 (12.01.2020)
December 10, 2020 DRAFT PLAN

BOTTOM LINE: when making capacity decisions, we must consider:

1. the level and *trending of COVID-19 infections* in the relevant geography,
2. the availability of appropriate *PPE*,
3. *collaborative activities* with relevant emergency preparedness organizations and/or local health jurisdictions,
4. *surge capacity* of the hospital/care setting, and
5. the *availability of appropriate post-discharge options* addressing transitions of care.

Arbor Health's Care Phase Descriptors/Triggers

1. Each health care, dental or dental specialty facility, practice, or practitioner must develop, and maintain, an expansion and contraction of care plan that is congruent with community COVID-19 assessment, consistent with the clinical and operational capabilities and capacities of the organization, and responsive to the criteria provided below.
2. Expansion and contraction of care plans should be operationalized based on the standards of care that are in effect in the health care facility, practice, or practitioner's relevant geography as determined by that region's regional healthcare coalition, as follows:
    a. ***Conventional Care Phase*** – All appropriate clinical care can be provided.
        i. Compliance with *Nurse Staffing Plan*
        ii. Scheduled and uninterrupted meals/breaks provided
        iii. Non-urgent clinical staff not compelled or required to work overtime
        iv. Ability to implement pre-procedure COVID testing protocols as appropriate
        v. PPE Burn rates > 45 days *and* ready ability to order PPE
        vi. Normal access to negative pressure rooms for both inpatient (3 – 4 available) and outpatients
        vii. No staff/patient outbreaks and flat/declining COVID trending in community
        viii. Open visitor or "escort", and cafeteria access
        ix. Timely access to lower level of care discharge dispositions

    b. ***Contingency Care Phase*** – All appropriate clinical care can be provided so long as there is sufficient access to PPE and, for hospitals, surge capacity is at least 20%.
        i. Utilizing PPE in contingent/crisis mode
            1. If in contingent/crisis mode: testing of all employees with COVID-19-like illness symptoms within 24 hours of the onset of those symptoms and implement randomized surveillance testing of employees in consultation with the local health jurisdiction.
            2. Extended PPE use – N95, simple masks and disposable gowns.
        ii. Limited/inconsistent access to inpatient negative pressure rooms
        iii. Difficult ability to access COVID testing/media
        iv. Surge Capacity = capacity and capability for 3 additional patients available ≤ 50%
        v. Increased COVID prevalence in community
        vi. Inpatient: Restricted visitors for COVID inpatients; limited hours for non-COVID patients
        vii. Outpatients: "escorts" allowed only for a medical purpose or minors
        viii. Some deviations from staffing plan and uninterrupted meal/breaks requirements
        ix. Staff reassignment from other departments and/or clinics as needed

    c. ***Crisis Care Phase*** – All emergent and urgent care shall be provided; non-urgent care, the postponement of which for more than 90 days would, in the judgment of the clinician, cause harm; the full suite of family planning services and procedures; newborn care; infant and pediatric vaccinations; and other preventive care, such as annual flu vaccinations, can continue.

i. Census at or above surge capacity ≥ 50%
ii. Inability to acquire adequate PPE
iii. Triaged access of negative pressure rooms for COVID patients w/aerosol generating procedures
iv. Inability to transfer patients to higher level of care
v. ≥ 2 patients holding in ED (> 12 hours)
vi. Inpatient ventilator use ≥ 2
vii. When staffing model cannot sustain inpatient care:
    1. Increased pool of ED Providers & Hospitalist Coverage
        a. In the absence of elective surgery, Dr. Anderson reassigned for ED coverage.
        b. Reassign all MD and DO providers to ED and/or Hospitalist coverage as appropriate
        c. Ensure one midlevel remaining at each clinic for family planning, vaccinations, and other preventive care which may cause harm if delayed > 90 days.
    2. Mandatory overtime utilized of clinical and non-clinical staff (housekeeping, materials, dietary, etc)
    3. Use of CRNA and RN backup for Respiratory Therapy
viii. Staff reassignment from other departments and/or clinics
ix. Increased Telemedicine use in clinics ??

Discussion of Urgent/Non-Urgent Services and Procedures

Procedures basically fall into four categories. . .

1. ***Urgent procedures***. No limit of procedures *considered to be urgent by clinicians*.
2. ***Non-urgent procedures where there is the possibility of harm***. There are restrictions on non-urgent services, procedures, and surgeries if certain compliance requirements are not met. . . but remember that the full definition of "non-urgent" means those procedures "that, if delayed, are not anticipated to cause harm to the patient within the next 90 days." In determining whether a service, procedure or surgery is non-urgent there *must be careful consideration of the meaning of harm, as assessed by the clinician*.
3. ***Non-urgent procedures where there is not a possibility of harm***. These are the procedures most subject to restriction. Non-urgent health services, procedures, and surgeries *must be restricted if certain compliance requirements are not met*.
4. ***"Not non-urgent" procedures***. The proclamation also creates a category of procedures considered "not non-urgent." Specifically included in this category is the full suite of family planning services and procedures and other services. While perhaps not rising to the level of an urgent procedure, these services are also not considered to be non-urgent and occupy a sort of middle ground of procedures that may be performed even if the operational criteria cannot be met. WSHA believes that, depending on the judgment of the clinician, other services and procedures, including potentially screening and preventive services, may fall into this category as well.

Non-urgent services, procedures, and surgeries are those that in the judgment of the clinician, if delayed, are not anticipated to cause harm to the patient within 90 days. The decision to perform any surgery or procedure in health care and offices should be weighed [and documented by the provider] against the *following criteria when considering potential harm* to a patient's health and well-being:

1. Expected advancement of disease process
2. Possibility that delay results in more complex future surgery or treatment
3. Increased loss of function
4. Continuing or worsening of significant or severe pain
5. Deterioration of the patient's condition or overall health
6. Delay would be expected to result in a less-positive ultimate medical or surgical outcome

7. Leaving a condition untreated could render the patient more vulnerable to COVID-19 contraction, or resultant disease morbidity and/or mortality
8. Non-surgical alternatives are not available or appropriate per current standards of care
9. Patient's co-morbidities or risk factors for morbidity or mortality, if inflicted with COVID-19 after procedure is performed

Diagnostic imaging, diagnostic procedures or testing should continue in all settings based on clinical judgment that uses the same definition of harm and criteria as listed above. The full suite of family planning services and procedures are not non-urgent.

Service Lines Expansion and Contraction Plans by Care Phase

Rehabilitation Services Expansion and Contraction Plan

I - Contingency Care Phase – Current Status Per New Guidelines

- No Non-essential community pool clients
- Further limited the pool capacity to 1 (2 under certain circumstances) – Pool Guidelines below
- No attendants in the waiting room unless medically indicated or Parent/CG of minor
- All patients assessed based on criteria for "harm and 'urgent'"
- Offer Appropriate visits via telehealth
- Patients that are ready for DC or do not meet essential criteria will be discharged

II - Contingency Care Phase – Significant Increase in Community Cases

- All community pool clients will be on-hold
- Encourage more visits via telehealth-
- Possibly adjust hours to allow for fewer patients in the gym.
- High risk patients that NEED to be seen will be done during a slow time or placed on hold
- Massage Therapy likely discontinued if not severely limited to prescribed patients only.

III - Crisis Care Phase – *Partial* – (may be in crisis effecting specific departments)

- Same as II but begin to assess patients for placing on hold with focus on preparation that we could move to Phase IV.
- Checking with Incident Command and CNO regarding resources and need to preserve and reallocate PPE and Staffing.
- No Massage Therapy Patients

IV - Crisis Care Phase – *Global*

- Only post-operative patients or high essential need patients
- Telehealth as appropriate
- All other patients will be either DC'd to home program or placed on hold pending return to "phase III or less as stated above.
- No Massage Therapy Patients
- Reassign staff as needed to meet immediate needs.

Surgery, Same Day Surgery, Infusion Expansion and Contraction Plan

1. **Contingency Care Phase**
   - Continued scheduling of elective, urgent, and emergent cases
   - COVID-19 testing of all elective patients 3 days prior to procedure
   - Extended use of N-95 masks
   - Monitor availability of PPE supplies
2. **Crisis Care Phase**
   - No elective procedures
   - Continue Bamlanivimab Infusions

- Only urgent/emergent procedures as outlined in Governor's proclamation
- Reassign staff as needed to meet immediate needs

Wound Care Expansion and Contraction Plan

1. **Contingency Care Phase**
   - All patients will be assessed, with specific documentation, based on "urgent or non-urgent" criteria when considering potential harm to patient's health and well-being if untreated for 90 days.
   - All urgent and non-urgent patients will be educated regarding contingency vs. crisis care phases and how it effects each persons' care.
   - Patients that are ready for discharge will be discharged.
   - Those patients assessed as non-urgent will receive information/education and begin transitioning to self-care at home and have fewer than usual scheduled visits.
   - Escorts for only medically necessary patients
   - The non-urgent patient will receive home delivered supplies to begin self-care at home.
   - Offer appropriate support via phone and email to those that are transitioning to self-care at home.
   - Adjust clinic hours to allow for fewer patients in the facility at any given time.
   - Consider entrance through door closest to wound clinic and start working with PT for a check in process via PT clerks with check.
   - Consider referral to home health services as available in this area
2. **Crisis Care Phase**
   - Continue Contingency Care Phase, assess and document to the urgent care needs.
   - Non-urgent patients will be placed on hold or discharged to their established self-care at home.
   - Only urgent care patients that cannot receive treatment at home related to specific equipment needs and/or lack of teachable caregiver will be scheduled clinic appointments.
   - Reduce clinic days and/or hours available for scheduling and continue appointments at low traffic hours.
   - Recruit/teach/train other department staff such as PT/OT, MA to absorb urgent wound care treatments to relieve wound RN to other acute/swing bed/surgical assignments.

Pulmonary Rehabilitation Expansion and Contraction Plan

1. **Contingency Care Phase**
   - Utilizing PPE in contingent/crisis mode
   - Use of a negative pressure room for medication delivery
   - Encounters will have pre-procedure COVID testing protocols as appropriate.
   - Pulmonary exercises and physical exercises to continue in Pulmonary Rehab Clinic.
   - Telemedicine – to establish to continue care with asymptomatic patients (with not or minimal V/Q mismatch)
2. **Crisis Care Phase**
   - Stage 4 patient therapy will continue only with provider documentation of harm.
   - No aerosolizing procedures will be used – patients to use inhalers as indicated.
   - Patients that are ready for discharge will be discharged.
   - Those patients assessed as non-urgent will receive information/education and begin transitioning to self-care at home and have fewer than usual scheduled visits.
   - Offer appropriate support via phone and email to those that are transitioning to self-care at home.
   - Adjust clinic hours to allow for fewer patients in the facility at any given time.
   - Consider entrance through door closest to department and start working with PT for a check in process via PT clerks with check.

Respiratory Therapy Outpatient Diagnostic Testing Expansion and Contraction Plan

1. **Contingency Care Phase**
   - Contact the ordering PCP to determine if delaying the PFT would cause harm and document response in patient medical record.

- Continue If the PCP determines that delay would cause harm.
- Coordinate with nursing access to negative pressure ante room equipment on day of testing. If unable to use equipment, delay testing until equipment is available.

2. **Crisis Care Phase**
   - Halt the performance of PFTs unless PCP determines the test is urgent.
   - If urgent, follow procedure outlined in Contingency Care Phase
   - Halt the performance of all Stress Tests

Imaging Expansion and Contraction Plan

1. **Contingency Care Phase**
   - XXX
2. **Crisis Care Phase**

- XXX

Clinics Expansion and Contraction Plan

1. **Contingency Care Phase**
   - XXX
2. **Crisis Care Phase**

- XXX

Additional Proclamation References:

Specific Criteria for Resuming, Continuing, or Discontinuing Non-Urgent Procedures

1. In addition to the general requirements in the section below, hospitals and ambulatory surgical facilities must also meet these criteria *in order to provide non-urgent services, procedures, and surgeries*. . . if a hospital cannot or does not comply with any of the requirements in the lists above or below, **non-urgent services, procedures, and surgeries must be reduced or stopped until compliance is achieved** and in accordance with the direction, order, requirements, or guidance issued by DOH or L&I, if any:
   a. To maintain capacity and staff readiness:
      i. Maintain WA Health database
      ii. Compliance with nurse staffing plan for all non-urgent services
      iii. Compliance with uninterrupted meal/rest breaks
      iv. No mandatory overtime
   b. For clinical procedures and surgeries, develop and implement setting-appropriate, pre-procedure COVID-19 testing protocols
   c. Specific to employees with known or suspected *high-risk workplace* exposures:
      i. Notification to the employee and, with the employee's authorization, to their union representative by the facility must occur within 24 hours of *confirmed* exposure.
      ii. Testing must be offered and made available within an appropriate timeframe in accordance with CDC guidelines for testing healthcare personnel. . . Test results should be available *within 24 hours of specimen collection*. If the health care facility is unable to provide testing results within this timeframe, the employee should be referred to another testing site.
   d. . . . During times when contingent/crisis PPE protocols are in use, healthcare organizations must implement active epidemiological monitoring protocols, including *testing of all employees with COVID-19-like illness symptoms within 24 hours of the onset of those symptoms, and implement randomized surveillance testing* of employees in consultation with the local health jurisdiction. *Note: WSHA is asking for DOH to develop state-wide guidance regarding this surveillance testing requirement*.

e. Maintain a *management/employee/union* group to review current PPE, projected PPE burn rates, and projected delivery of PPE supplies and understand how that impacts operations for PPE use *twice a month*.

Additional General **Criteria for Resuming, Continuing, or Discontinuing Non-Urgent Procedures**

1. Until there is a widely available effective vaccine or herd immunity, hospitals, emergency management agencies, regional healthcare coalitions, professional associations, unions and local health jurisdictions will work together to *maintain surge capacity* in our health care system and *use PPE* so that we can keep health care workers safe and provide the needed health care to our communities. To this end, the following must be met by health care, dental and dental specialty facilities, practices, and practitioners in order to provide non-urgent services, procedures, and surgeries. *If a health care facility, practice, or practitioner cannot or does not comply with any of these requirements, non-urgent services, procedures, and surgeries must be reduced or stopped* until compliance is achieved and in accordance with the direction, order, requirements, or guidance issued by the Department of Health (DOH) or Department of Labor & Industries (L&I), if any:
    a. Significant COVID prevalence in community
    b. Sufficient beds, drugs, staff, vents, blood, & PPE supply for a potential surge
    c. Ability to comply with nurse staffing plan, L&I, sufficient resources to provide uninterrupted meals/breaks, and safe work conditions
    d. Infection Control Policies reflect current best practice guidelines for universal precautions
    e. Use Multidisciplinary Team meeting for employee feedback re care delivery, PPE, and technology access.
    f. Utilize telemedicine as permitted by law for the type of care being provided in order to facilitate access to care while helping to minimize the spread of the virus to other patients and/or health care workers
    g. Non-punitive employee leave policies that adhere to CDC return to work guidelines
    h. Patient, visitor, staff, etc screening prior to, or immediately upon, entering a facility or practice
    i. Limit visitors and require visitors to wear face coverings
    j. Maintain strict physical distancing in staff rooms, patient scheduling, check-in processes, positioning, and movement within a facility, etc.
    k. Frequently clean and disinfect high-touch surfaces or closure of the facility or areas of the facility until the location can be properly disinfected
    l. Notify the local DOH within 24 hours of identification of a COVID-19 outbreak, among staff, patients, or visitors. . . create and maintain a list of staff, patients, contractors, volunteers, and visitors with confirmed or suspected cases or exposure.
    m. Exclude employees infected with or with known or suspected high-risk exposure to COVID-19 from the workplace in accordance with the CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 and Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection, including any subsequent amendments, subject to the direction of the local health jurisdiction.
    n. Promptly offer and make available, either on-site or by directing to an external local testing location, testing to employees who have signs or symptoms consistent with COVID-19.
    o. Educate patients about COVID-19 in a language they best understand. The education should include the signs, symptoms, and risk factors associated with COVID-19 and how to prevent its spread.

2020 Organization & Officers of the Board of Commissioners
Effective Date: June 10, 2020

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

Committee	Administration Representation	Committee Chair	Board Representation
Finance	Superintendent & CFO	Tom Herrin	Craig Coppock
QI Oversight	Superintendent & CCO	Wes McMahan	Chris Schumaker
Governance	Superintendent	Trish Frady	Wes McMahan
Plant Planning	Superintendent & Environmental Services Manager	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

2021 Organization & Officers of the Board of Commissioners
Effective Date: January 1, 2021

Board Leadership	Board Representation
Board Chair	
Board Secretary	

Committee	Administration Representation	Committee Chair	Board Representation
Finance	Superintendent & CFO		
QI Oversight	Superintendent & CCO		
Governance	Superintendent		
Plant Planning	Superintendent & Environmental Services Manager		
Strategic Planning	Superintendent	Board of Commissioners	
Compliance Committee	Superintendent & Compliance Officer		

Other Board Representation	Board Representation
Foundation	
State Representation	

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

To: Board of Commissioners
From: Leianne Everett, Superintendent
Date: 12/09/2020
Subject: Superintendent's Report

- CNO/CQO Sara Williamson will be providing an update on nurse staffing and some of the challenges currently facing healthcare facilities.
- CHRO Shannon Kelly will discuss our employee recognition policy. These programs are intended to increase employee morale, thus, improve employee retention. With the 2020 adoption of organizational core-values, we have added a recognition program to support employees that are emulating values that we determined as important to Arbor Health. The Employee Recognition Program policy is included for your review in preparation for this discussion.

DocID:	19319
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Status:	Official
Department:	Human Resources
Manual(s):	

Policy : Employee Recognition Program

Policy:

It is the policy of Lewis County Hospital District No. 1 to provide recognition programs as a benefit for all district employees. These recognition programs are designed to engage employees, maximize organizational performance, and aide the recruitment and retention of top talent.

Service Award Recognition Program

Lewis County Hospital District No. 1 recognizes and honors employees who have reached service milestones. Awards are presented to employees in recognition for years of service beginning at five years and continues every five-year milestone until retirement. A quarterly facility sponsored luncheon is held in their honor. In addition to the milestone recognition program, each employee will receive a small token of appreciation annually to recognize the completion of each service year.

Retirement Recognition Program

Lewis County Hospital District No. 1 recognizes and honors employees who retire from employment beginning after five years of service. With a facility-sponsored celebration that all employees are invited to attend. The celebration will include a minimum of a cake, beverage and an Arbor Health logo gift for the employee that is retiring.

Core Values-Based Recognition Program

The Core Values-Based Recognition Program gives employees, administrators, and managers the opportunity to thank employees who have gone out of their way in performing their jobs and serving others by exemplifying one of the facility's core values. Annually, managers and Leadership will host a celebratory facility sponsored recognition event that all employees and their guests are invited to attend. The event will offer food, drink, activities, prizes, entertainment and the opportunity to celebrate all of the Award recipients for the year. All employees in attendance and employees working during the time of the event are eligible to participate in the grand prize drawing. In addition, all award recipients are eligible to participate in a special prize drawing.

Annual Healthcare Week Recognition

This is an annual district-wide recognition event that offers food, drink and activities. Every employee will be recognized with a facility-sponsored Arbor Health Logo Item of their choice.

Departmental Recognition

In addition to district-wide recognition events, each department may choose to honor the contributions of its employees through celebrations, awards, and honors. Some departments offer achievement awards to recognize employees who have performed a special service or put forth unusually creative efforts that have resulted in improved departmental programs, services, or work environments.

Employees who have courageously handled an emergency or safety situation related to their job, or who have developed a special innovation or process resulting in significant economic or other extraordinary benefit to the department or the facility, may also receive departmental recognition. Departmental recognition may take many forms, ranging from celebrations, dinners, picnics, group awards and/or humorous surprise events.

If you think of an innovative way to recognize the achievements of your co-workers, speak with your manager or supervisor to further develop your recognition idea.

Employee & Community Connection Committee (ECC) Events

The ECC sponsors several social and fundraising events as well as community celebrations each year. The ECC partners with Leadership each year to plan a community heritage celebration for our employees known as Morton Logger's Jubilee.

Recognition programs are recognized in the approved annual operating budget.

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Collaborators:	Kim Olive Katelin Forrest
Approvals	
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- Signers:	
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Review Date:	
Attachments: (REFERENCED BY THIS DOCUMENT)	recognition for years of service
Other Documents: (WHICH REFERENCE THIS DOCUMENT)	Employee Benefits