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BOARD OF COMMISSIONERS – WORK SESSION
TUESDAY, MAY 26, 2020
6:00 PM - WHITEHEAD CONFERENCE ROOM
AGENDA

COMMISSIONERS:
Stephen Kenny, Ph.D.
Sharon Dietrich, M.D.
Glenn Bestebreur
Kit Watson
Susan Reams
Keith Sattler
Brandon Bowden

STAFF:
Craig Marks, CEO
Merry Fuller, CNO/COO
David Rollins, CFO
Shannon Hitchcock, CCO
Kevin Hardiek, CIO
Kristi Mellema, CQO
Ro Kmetz, CHRO
Dr. Brian Sollers, CMO
Dr. Jacobo Rivero
Christi Doornink-Osborn, ED Director/ Provider Recruitment

GUESTS:
Luke Zarecor/DZA
Joe Lodge; DZA
Gary Hicks/G.L. Hick Financial, LLC

CALL TO ORDER

A. Pledge of Allegiance

1. Public Comment

2. Medical Staff Development

a. Review PMH Medical Staff Engagement Plan **(Attachment AA)** — **Dr. Rivero/Christi Doornink-Osborn**

3. Executive Session

a. RCW 42.30.110 (b) – Real Estate – To consider the selection of a site or the acquisition of real estate by lease or purchase when public knowledge regarding such consideration would cause a likelihood of increased price.
b. RCW 42.30.110 i(iii) – Legal Counsel - Litigation or legal risks of a proposed action or current practice that the agency has identified when public discussion of the litigation or legal risks is likely to result in an adverse legal or financial consequence to the agency.
c. RCW 42.30.110 (g) – Personnel – To evaluate the qualifications of an applicant for public employment or to review the performance of a public employee.

4. Services (6:45 p.m.)

a. Review Replacement Hospital Feasibility Study **(Attachment BB)** — **Luke Zarecor**, **Joe Lodge**, **Gary Hicks**

5. Adjourn

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BOARD OF COMMISSIONERS
THURSDAY, May 28, 2020 - *REVISED
6:00 PM, WHITEHEAD CONFERENCE ROOM
AGENDA

DRAFT

COMMISSIONERS:
Stephen Kenny, Ph.D.
Sharon Dietrich, M.D.
Glenn Bestebreur
Kit Watson
Susan Reams
Keith Sattler
Brandon Bowden

STAFF:
Craig Marks, CEO
Merry Fuller, CNO/COO
David Rollins, CFO
Ro Kmetz, CHRO
Kevin Hardiek, CIO
Kristi Mellema, CQO
Shannon Hitchcock, CCO
Dr. Wali Martin, MD

I. CALL TO ORDER
A. Pledge of Allegiance

II. PUBLIC COMMENT

III. APPROVE AGENDA
Action Requested – Agenda

IV. CONSENT AGENDA
A. Board of Commissioners Meeting Minutes for April 30, 2020.
B. Payroll and AP Vouchers #151306 through #151771 in the amount of $4,921,713.77.
Action Requested – Consent Agenda

V. MEDICAL STAFF DEVELOPMENT
A. Medical Staff Report and Credentialing **Dr. Wali Martin**
1. New Appointment
Action Requested – New Appointment
Pratik Bhattacharya, MD – Provisional/Telemedicine staff with requested privileges in Neurology effective May 28, 2020 through November 27, 2020.

2. Advancement from Provisional Status
Action Requested – Advancement from Provisional Status
Becca Warnick, ARNP – Allied Health Professional staff with privileges in Family Medicine effective May 28, 2020 through September 26, 2021.

Syed Abbas, MD – Telemedicine staff with privileges in Neurology effective May 28, 2020 through December 19, 2021.

Abdelrahman Beltagy, MD – Telemedicine staff with privileges in Neurology effective May 28, 2020 through December 19, 2021.

Sheila Smith, MD – Telemedicine staff with privileges in Neurology effective May 28, 2020 through December 19, 2021.

3. **Reappointment**
Action Requested – Reappointment and Requested Clinical Privileges
Susan Whitaker, DO – Reappointment to Active staff with requested clinical privileges in Emergency Medicine from May 28, 2020 through May 27, 2022.

Danielle Whitley, MD – Reappointment to Locum Tenens staff with requested clinical privileges in Emergency Medicine from May 26, 2020 through May 27, 2022.

VI. FINANCIAL STEWARDSHIP

A. Review Financial Reports for April 2020 **(Attachment DD)** — **David**
Action Requested – Financial Reports

B. COVID-19 Financial Plan **(Attachment M)** — **David/Craig**

C. PMH Foundation Update — **Shannon Hitchcock**

VII. EMPLOYEE DEVELOPMENT

A. Review PMH Uniform Program **(Attachment Y)** — **Ro/Merry**

VIII. QUALITY

A. COVID-19 Update — **Merry**

B. Practice Transformation Grant Update **(Attachment O)** — **Merry**

C. Legislative and Political Updates — **Commissioner Bestebreur**

D. CEO/Operations Report — **Craig**

IX. EXECUTIVE SESSION

***A.** RCW 42.30.110 i(iii) – Contract - Litigation or legal risks of a proposed action or current practice that the agency has identified when public discussion of the litigation or legal risks is likely to result in an adverse legal or financial consequence to the agency. — **Craig**

***B.** RCW 42.30.110 (g) – Personnel – To evaluate the qualifications or an applicant for public employment or to review the performance of a public employee. — **Craig**

X. ADJOURN

DRAFT

PMH
Board of Commissioners
Work Plan – FY2020

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Month	Goals & Objectives	Education
January	QUALITY: • Review/Approve 2020 Strategic Plan and 2020 Patient Care Scorecards • Sign Financial Disclosure and Conflict of Interest Statements • Approve 2020 Risk Management and Quality Assurance Plans • Select and Approve Board Officers	EMPLOYEE DEVELOPMENT: • Review 2019 Employee Engagement Survey Results • Review 2019 Medical Staff Engagement Survey Results QUALITY: • Review Board Self-Evaluation FINANCIAL STEWARDSHIP: • Review semi-annual financial performance report for PMH Clinics SERVICES: • Wellness Center • Sunnyside • Astria Health • Update Architectural Services

Month	Goals & Objectives	Education
February	PATIENT LOYALTY: • Approve Studer Contract QUALITY: • Approve 2020 Corporate Compliance Plan • Approve 2020 Infection Prevention Control Plan • Approve 2020 Board Action Plan EMPLOYEE DEVELOPMENT: • Approve Hospital-wide Patient Monitoring System • Review and Approve 2020 Leadership Incentive Compensation Program	PATIENT LOYALTY: • Review Customer Service Program EMPLOYEE DEVELOPMENT: • Attend AHA Governance Conference QUALITY: • Review 2019 Corporate Compliance Report • Review 2019 Infection Prevention Summary
March	QUALITY: • Review/Approve Board Polices MEDICAL STAFF DEVELOPMENT: • Support Providers' Day Celebration EMPLOYEE DEVELOPMENT: • Approve IAFF Contract (EMS) FINANCIAL STEWARDSHIP: • Accept 2019 Audit Report	PATIENT LOYALITY: • Review Patient Engagement Plan • Review 2019 Utilization Review Performance • Approve 2020 Utilization Review Plan EMPLOYEE DEVELOPMENT: • Review Employee Performance Report • Regulatory Compliance FINANCIAL STEWARDSHIP: • Presentation of the 2018 Audit Report by Auditors
April	QUALITY: • Approve 2020 Community Benefits Report	QUALITY: • Strategic & Patient Care Score Cards • Review 2019 Community Benefits Report

Month	Goals & Objectives	Education
	EMPLOYEE DEVELOPMENT • Conduct CEO Evaluation	EMPLOYEE DEVELOPMENT: • Review Employee Engagement Plan • Review 2019 Leadership Performance (LEM) MEDICAL STAFF DEVELOPMENT: • Review 2019 FPPE/OPPE Summary
May	EMPLOYEE DEVELOPMENT: • Support Hospital Week	EMPLOYEE DEVELOPMENT: • Review PMH Uniform Program FINANCIAL STEWARDSHP: • PMH Foundation Update SERVICES: • Review Replacement Facility Feasibility Study MEDICAL STAFF • Medical Staff Engagement Plan
June	QUALITY: • Review/Approve Board Polices • Approve 2019 CAH Annual Review SERVICES: • Approve Nuclear Medicine Renovation	QUALITY: • Report 2020 Q1 Utilization Review • Contract Review Process EMPLOYEE DEVELOPMENT: • Review New Employee Orientation Process • Review Employee Benefit Changes FINANCIAL STEWARDSHIP: • Review PMH Work Optimization Plan SERVICES: • Marketing Update • Review PMH IT Security Plan

Month	Goals & Objectives	Education
July	EMPLOYEE DEVELOPMENT: • Attend midsummer BOC, Medical Staff, and Leadership Engagement Activity FINANCIAL STEWARDSHIP: • Approve Audit Firm SERVICES: • Approve Nuclear Medicine Renovation	PATIENT LOYALTY: • Review Cultural Transformation Program SERVICES: • EMS Review • Review Nuclear Medicine Services QUALITY: • Quality Committee Report • Strategic & Patient Care Score Cards EMPLOYEE DEVELOPMENT: • Employee Health Update FINANCIAL STEWARDSHIP: • Review Semi-annual Financial Performance Report for PMH Clinics • Auditor Selection Review • Compare PMH Financial Metrics to National Standards (Cleverly) • Review HR/Accounting Software (IT)
August	EMPLOYEE DEVELOPMENT: • Attend end of summer Engagement Activity for BOC, Medical Staff, and all staff	No Board Work Session QUALITY: • iVantage Update FINANCIAL STEWARDSHIP: • Centralized Scheduling/POS Collections Update

Month	Goals & Objectives	Education
September	QUALITY: • Review/Approve Board Polices FINANCIAL STEWARDSHIP: • Select PMH Banking Institution	FINANCIAL STEWARDSHIP: • Review Banking Services
October		QUALITY: • Conduct 2021 Strategic Planning Retreat • Strategic & Patient Care Score Cards • Review iVantage Update
November	EMPLOYEE DEVELOPMENT: • Approve AFSCME Contract FINANCIAL STEWARDSHIP: • Approve Budget and Property Tax Request for County Commissioners	QUALITY: • iVantage Update EMPLOYEE DEVELOPMENT: • Review LDIs and status update on key Studer initiatives SERVICES: • Review draft 2021 Strategic Plan; 2021 Marketing and IT Plans; and Medical Staff Model/2021 Provider Recruitment Plan FINANCIAL STEWARDSHIP: • Review draft 2020 Budget
December	QUALITY: • Complete Board Self-Evaluations • Review/Approve Board Polices • Approve the 2021 Environment of Care Plan SERVICES:	QUALITY: • Review the 2020 Environment of Care Plan

Month	Goals & Objectives	Education
	• Approve 2021 Strategic Plan; 2021 Marketing and IT Plans; and Medical Staff Model/2021 Provider Recruitment Plan FINANCIAL STEWARDSHIP: • Approve 2021 Operating and Capital Budgets EMPLOYEE DEVELOPMENT: • Attend holiday celebration	

2020 - Strategic Plan Scorecard

Major Goal Areas & Indicators	2020 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2020 YTD	2019 Avg	2018 Avg
Patient Loyalty																
IP - "Would Recommend"	> 85.1%	84.4%	85.7%	97.2%	95.7%									90.4%	85.1%	83.8%
ED - "Would Recommend"	> 80.7%	73.8%	80.0%	85.0%	77.4%									79.4%	80.3%	80.7%
Acute Care - "Would Recommend"	> 79.7%	80.9%	50.0%	94.4%	90.0%									86.9%	78.6%	79.7%
OB - "Would Recommend"	> 92.2%	93.3%	92.3%	100.0%	100.0%									9520.0%	92.2%	88.6%
Outpatient Surgery - "Would Recommend"	> 91%	86.4%	83.3%	94.3%	85.0%									87.6%	91.0%	84.9%
Swing Bed - "Would Recommend"	> 94.1%	100.0%	50.0%	100.0%	0.0%									62.5%	85.3%	94.1%
Clinic - "Would Recommend"	> 87.1%	92.9%	91.1%	87.9%	85.2%									89.2%	87.1%	85.2%
Outpatient - "Would Recommend"	> 88.4%	88.5%	88.5%	85.0%	85.0%									87.6%	88.4%	84.7%
Medical Staff Development																
Medical Staff Turnover	< 0.2%	0.0%	0.0%	0.0%	0.0%									0.0%	0.2%	0.6%
Specialty Clinic Visits	> 1063	1,197	1,101	1,021	588									977	950	872
Benton City Clinic Visits	> 1005	1,118	950	984	643									924	958	857
Prosser RHC Clinic Visits	> 1052	1,030	1,011	988	842									968	960	821
Grandview Clinic Visits	> 618	702	724	650	474									638	568	N/A
Women's Health Center	> 709	673	605	633	455									592	469	N/A
Comprehensive Pain Clinic	> 91	86	83	81	28									70	80	55
*# of Active Medical Staff	> 51	43	43	43	43									43	41	40
Employee Development																
Average Recruitment Time (days)	< 28	19	28	50	41									35	28	N/A
# of Open Positions (Vacancies)	< 23	35.0	27.0	27.0	24.0									28.3	23	8.8
Hours of Overtime - Overtime/Total Hours Worked	< 4.5%	7.9%	5.4%	6.0%	4.0%									5.8%	5.7%	4.5%
Agency - Cost/Total Labor	< 8.7%	7.7%	9.0%	10.3%	8.1%									8.8%	14.5%	10.5%
Turnover Rate	< 0.7%	0.4%	0.4%	0.7%	1.1%									0.7%	0.7%	0.7%
Timely Evaluations	> 79.6%	89.0%	54.0%	91.0%	81.0%									78.8%	79.6%	60.5%
Education Hours/FTE	> 2.15	1.57	0.01	1.93	0.98									1.12	1.55	2.15
New Hire (Tenure) < 1 year	< 10%	3%	0%	0%	0%									1%	0%	N/A
* Lost Workdays due to On-the-Job Injuries	< 167	8.00	8.00	8.00	16.00									10.00	167	163
Quality																
ED Encounters - Left Without Being Seen	< 1.0%	1.2%	0.9%	1.03%	0.2%									0.8%	1%	1.0%
*Falls with Injury	< 3	0	1	0	0									0.25	3	3
Healthcare Associated Infection Rate per 100 Inpatient Days	< 0.1%	0.0%	0.0%	0.0%	0.0%									0.0%	0.1%	0.1%
All-Cause Unplanned Readmissions within 30 Days	< 2.7%	2.2%	6.9%	10.5%	8.8%									7.1%	5.4%	2.7%
Diabetes Management - Outpatient A1C>9 or missing result	< 30.3%	37%	30%	33%	39%									35%	30.3%	34.50%
Services																
ED Visits	> 1,023	1,131	1,000	874	526									883	1,016	930
Inpatient Admissions	> 86	83	77	72	70									76	83	75
OB Deliveries	> 38	38	26	38	36									35	37	31
Surgeries and Endoscopies	> 126	109	100	90	32									83	118	117
Diagnostic Imaging Procedures	> 2,116	2,466	2,308	2,078	1,358									2,053	1,957	1,649
Lab Procedures	> 12,262	12,098	11,587	9,776	7,900									10,340	11,051	9,671
Adjusted Patient Days	>1,769	1,603	1,490	1,355	871									1,330	1,624	1,373
Therapy Visits	> 1,706	1,692	1,792	1,374	324									1,296	1,145	1,084
Outpatient Special Procedures Visits	> 225	268	226	319	222									259	224	225
Financial Performance																
Net Days In Accounts Receivable	< 48.62	59.97	64.28	61.84	48.35									48.35	63.79	50.96
*Total Margin	> 7.06%	4.50%	1.20%	-0.20%	16.40%									4.50%	5.30%	1.8%
Net Operating Revenue/FTE	> $16,753	$ 16,075	$ 14,867	$ 15,320	$ 19,583									$ 16,461	$15,794	$16,094
Labor as % of net Revenue	< 60.2%	60.3%	65.0%	63.8%	53.8%									60.7%	59.6%	62.6%
Operating Expense/FTE	< $15,760	$ 15,534	$ 15,443	$ 15,969	$ 16,562									$ 15,877	$15,190	$16,190
*Days Cash on Hand	> 120.39	96.39	93.02	97.86	152.33									152.33	120.39	108.23
Commercial %	> 28.7%	27.1%	27.4%	28.8%	28.9%									28.1%	28.7%	28.2%
Total Labor Expense/Total Expense	< 62%	62.4%	62.6%	61.2%	63.7%									62.4%	62%	63%

Green at or above Goal
Yellow within 10% of Goal
Red More than 10% below Goal
*Cumulative Total - goal is year end number

Prosser
Memorial Health

2020 - Patient Care Scorecard

Major Goal Areas & Indicators	2019 Goal	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	2020 YTD	2019	2018
Quality																
Left Without Being Seen (ED & iVantage)	<1.0%	1.24%	0.90%	1.03%	0.19%									0.93%	1.11%	1.00%
All-Cause Unplanned 30 Day Inpatient Readmissions (AC & iVantage)	<2.7%	2.22%	6.98%	10.53%	8.82%									6.88%	5.4%	2.7%
Sepsis - Early Management Bundle (AC)	>84.6%	33.33%	50.00%	N/A	33.33%									37.50%	80.0%	84.6%
Head CT Interpretation within 45 minutes - Stroke (DI)	>90%	100.00%	100.00%	66.67%	100.00%									80.00%	62.16%	N/A
Healthcare Associated Infection Rate per 100 Inpatient Days	<0.07%	0.00%	0.00%	0.00%	0.00%									0.00%	0.07%	0.10%
Diabetes Management - Outpatient A1C>9 or missing result (PT)	<30.25%	37.43%	30.27%	32.62%	38.79%									34.42%	30.25%	34.50%
Medication Reconciliation Completed	>90%	89.26%	99.38%	44.72%	89.90%									71.27%	90.00%	2019 value is 85.16%
Turnaround time of 30 minutes or less for STAT testing (LAB)	<30 Minutes	34	31	34	38									34.25	30	30
Median Time to ECG (CP & iVantage)	< 7 Minutes	6	7	6	3.5									6	7	NA
Surgical Site Infection (OR)	<2.0%	0.00%	0.00%	0.00%	0.00%									0.00%	0.3%	0.3%
Colonoscopy Follow-up (OR/Clinic & iVantage)	>90%	100.00%	100.00%	100.00%	100.00%									100.00%	90.0%	NA
Safe Medication Scanning	>90%	88.80%	91.30%	93.82%	90.55%									91.12%	90.0%	NA
*Overall Quality Performance Benchmark (iVantage)	>48	48	48	58	58									48	48	0
*Inductions <39 Weeks without Clinical Indications (OB & iVantage)	<1	0	0	0	0									0	1	3
*Falls with Injury	<3	0	1	0	0									1	3	3

Green at or above Goal (4)
Yellow within 10% of Goal (2)
Red More than 10% below Goal (0)

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BOARD MEETING	APRIL 30, 2020		WHITEHEAD CONFERENCE ROOM
COMMISSIONERS	**STAFF**	**MEDICAL STAFF**	**GUESTS**
• Dr. Steve Kenny • Glenn Bestebreur • Susan Reams • Brandon Bowden • Sharon Dietrich, M.D. • Kit Watson • Keith Sattler	• Craig Marks, CEO • Merry Fuller, CNO/COO • David Rollins, CFO • Ro Kmetz, CHRO • Kevin Hardiek, CIO • Kristi Mellema, CQO • Shannon Hitchcock, CCO	• Dr. Brian Sollers, CMO	• Tom Dingus, CPA, DZA

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
I. Call to Order	Meeting was called to order by Commissioner Sattler at 6:00 p.m.	None	None
II. Public Comment	None	None	None
III. APPROVE AGENDA	None	Commissioner Reams made a motion to approve the Agenda. The Motion was seconded by Commissioner Sattler and passed with 7 in favor, 0 opposed, and 0 abstained.	
IV. APPROVE CONSENT AGENDA	None	Commissioner Sattler made a motion to approve the Consent Agenda. The Motion was seconded by Commissioner Reams and passed with 7 in favor, 0 opposed, and 0 abstained.	None

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
V. MEDICAL STAFF DEVELOPMENT			
B. Medical Staff Credentialing	Dr. Sollers presented the following **New Appointments**: **Tyler M. Neitlich, MD** – Provisional/Telemedicine staff with requested privileges in Diagnostic Radiology effective April 30, 2020 through October 29, 2020. **Veronica Ruvo, DO** – Provisional/Telemedicine staff with requested privileges in Diagnostic Radiology effective April 30, 2020 through October 29, 2020. **Jennifer Plymale, MD** – Provisional/Courtesy staff with requested privileges in Pediatric Cardiology effective April 30, 2020 through October 29, 2020. **Jeremy Nicolarsen, MD** – Provisional/Courtesy staff with requested privileges in Pediatric Cardiology effective April 30, 2020 through October 29, 2020. **Jenny Siv, MD** – Provisional/Telemedicine staff with requested privileges in Neurology effective April 30, 2020 through October 29, 2020. **Bailey Padilla, CNM** – Provisional/Allied Health Professional staff with requested privileges in	A motion to approve the initial appointment and requested clinical privileges that have been reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the new appointment(s) of the following providers was made by Commissioner Sattler and seconded by Commissioner Bowden. The Motion passed with 7 in favor, 0 opposed, and 0 abstained. • Tyler M. Neitlich, MD • Veronica Ruvo, DO • Jennifer Plymale, MD • Jeremy Nicolarsen, MD • Jenny Siv, MD • Bailey Padilla, CNM	None

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
	Midwifery effective April 30, 2020 through October 29, 2020.		
	Dr. Sollers presented the following **Advancement from Provisional Status:** **Heidi S. Weaver, MD –** Active staff with privileges in OB/GYN effective April 30, 2020 through October 30, 2021. **Theresa Longo, MD –** Locum Tenens staff with privileges in Pediatrics effective April 30, 2020 through October 30, 2021. **Angus Ng, MD –** Locum Tenens staff with privileges in Emergency Medicine effective April 30, 2020 through October 30, 2021.	A motion to approve the Advancements from Provisional Status and request for Clinical Privileges that have been reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the advancement from Provisional status for following providers was made by Commissioner Reams and seconded by Commissioner Dietrich. The Motion passed with 7 in favor, 0 opposed, and 0 abstained. • Heidi S. Weaver, MD • Theresa Longo, MD • Angus Ng, MD	None
	Dr. Sollers presented the following **Reappointments:** **Thomas Halvorson, MD –** Reappointment to Active staff with requested clinical privileges in Orthopedics from March 26, 2020 through March 25, 2022. **Walburga Martin, MD –** Reappointment to Active staff with requested clinical privileges in Family Medicine/OB/Emergency Medicine from March 26, 2020 through March 25, 2022.	A motion to approve the requested clinical privileges that have been reviewed and recommended by the Department Chair, the Credentialing Committee and Medical Executive Committee for the Reappointment of the following providers was made by Commissioner Reams and seconded by Commissioner Sattler. The Motion passed with 7 in favor, 0 opposed, and 0 abstained. • Thomas Halvorson, MD • Walburga Martin, MD • Sarabjit Atwal, MD • Benjamin Atkinson, MD • Archit Bhatt, MD	None

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
	Sarabjit Atwal, MD – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Benjamin Atkinson, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Archit Bhatt, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Todd Czartoski, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Amit Kansara, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Theodore Lowenkopf, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Bethany McClenathan, MD** – Reappointment to Telemedicine staff	• Todd Czartoski, MD • Amit Kansara, MD • Theodore Lowenkopf, MD • Bethany McClenathan, MD • Margarita Oveian, MD • Andrew Rontal, MD • Tomoko Sampson, MD • Ruth Thomson, DO • Lisa Yanase, MD • John Zurasky, MD • Syed F. Hashmi, MD • Patrick Moran, DO • Teresa Charvet, PA-C • Tomas King, MD	

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
	with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Margarita Oveian, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Andrew Rontal, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Tomoko Sampson, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Ruth Thomson, DO** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **Lisa Yanase, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from March 26, 2020 through March 25, 2022. **John Zurasky, MD** – Reappointment to Telemedicine staff with requested clinical privileges in Neurology from		

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
	March 26, 2020 through March 25, 2022. **Syed F. Hashmi, MD** – Reappointment to Active staff with requested clinical privileges in IM/Hospitalist from April 30, 2020 through April 29, 2022. **Patrick Moran, DO** – Reappointment to Active staff with requested clinical privileges in Family Medicine/OB from April 30, 2020 through April 29, 2022. **Teresa Charvet, PA-C** – Reappointment to Allied Health Professional staff with requested clinical privileges in Family Medicine/OB from April 30, 2020 through April 29, 2022. **Tomas King, MD** – Reappointment to Consulting staff with requested clinical privileges in Pathology from April 30, 2020 through April 29, 2022.		
VI. FINANCIAL STEWARDSHIP			
A. 2019 Financial Audit Report (Attachment AA)	Tom Dingus presented an overview of the 2019 Financial Audit Report.	Commissioner Sattler made a motion to approve the 2019 Financial Audit Report which was seconded by Commissioner Reams. The Motion passed with 7 in favor, 0 opposed and 0 abstained.	None
B. Review Financial Reports for March 2020 (Attachment Y and PMH Clinics (Attachment Z)	David Rollins presented the March 2020 Financial Reports.	Commissioner Bowden made a motion to approve the Financial Reports for March 2020 and the PMH Clinics which was seconded by Commissioner Bestebreur. The Motion passed with 7 in favor, 0 opposed and 0 abstained.	None

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
C. COVID-19 Financial Plan (Attachment E)	David Rollins presented the COVID-19 Financial Operations Forecast through September 2020.		None
D. PMH Foundation Update (Attachment DD)	Shannon Hitchcock provided the status of upcoming Foundation events and those recently cancelled due to COVID-19. She reported that the State Auditor's Office is requiring the Foundation to reimburse PMH for monies loaned earlier for the re-startup of the Gift Shop.	None	None
VII. EMPLOYEE DEVELOPMENT			
A. IAFF Contract (Attachment R)	Ro Kmetz presented the IAFF Contract.	Commissioner Reams made a motion to approve the International Association of Firefighters, Local I-24 Agreement (effective 1.1.20 until 12.31.22) which was seconded by Commissioner Sattler. The Motion passed with 7 in favor, 0 opposed and 0 abstained.	None
B. PMH Retirement Plan (403(b)) (Attachment U)	Ro Kmetz presented an overview of the current PMH Retirement Plan (403(b)) and options for consideration by the Board to replace the flat 3% with a matching program to increase staff participation.	The Commissioners agreed that the options presented seemed reasonable to further evaluate.	Craig and Ro will assess the current PMH Retirement Plan (403(b)) and present a draft for further review and discussion with the Board in a few months.
VIII. QUALITY			
A. COVID-19 Update	Merry Fuller presented an update on the current status of COVID-19 supplies available, testing and its impact on PMH. Dr. Sollers summarized a tentative game-plan for PMH based	None	None

AGENDA	DISCUSSION	ACTION	FOLLOW-UP
	upon the latest information available from our state and local entities.		
B. 2019 Utilization Review Performance (Attachment K) and 2020 Utilization Review Plan (Attachment L)	Merry Fuller presented the 2019 Utilization Review Performance Plan and 2020 Utilization Review Plan.	Commissioner Dietrich made a motion to approve the 2019 Utilization Review Performance Plan and 2020 Utilization Review Plan which was seconded by Commissioner Reams. The Motion passed with 7 in favor, 0 opposed and 0 abstained.	None
C. Community Benefits Report (Attachment F)	Kristi Mellema presented the 2020 Community Benefits Report.	Commissioner Reams made a motion to approve the 2020 Community Benefits Report which was seconded by Commissioner Bowden. The Motion passed with 7 in favor, 0 opposed and 0 abstained.	None
D. Legislative and Political Updates	Glenn Bestebreur gave updates on the Legislative and Political fronts and issues surrounding the COVID-19 pandemic.	None	None
E. CEO/Operations Report	Craig reported that we will be celebrating Hospital Week next week and praised the staff on the great job they are doing with the COVID-19 pandemic.	None	None

There being no further regular business to attend to, Commissioner Kenny adjourned the regular business meeting to 8:28 p.m. The Board entered into Executive Session at 8:33 p.m. which was expected to last approximately 1 hour.

IX. EXECUTIVE SESSION

1. RCW 42.30.110 (g) – Personnel – To evaluate the qualifications of an applicant for public employment or to review the performance of a public employee.

Executive Session ended at 9:14 p.m. and Open Session Resumed.

X. ADJOURN

There being no further regular business to attend to, Commissioner Kenny adjourned the meeting at 9:20 p.m.

Vision

Patients
Employees
Medical Staff
Quality
Services
Financial

Mission: To improve the health of our community.

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

FINANCE COMMITTEE MEETING
WEDNESDAY, May 26, 2020
TUESDAY, 5:00 p.m. - VINEYARD CONFERENCE ROOM
AGENDA

MEMBERS:
Keith Sattler
Glenn Bestebreur
Brandon Bowden

STAFF:
Craig Marks
David Rollins
Stephanie Titus

CALL TO ORDER

I. **APPROVE MINUTES**
Action Requested – April 29, 2020 Minutes

II. **FINANCIAL STEWARDSHIP**

a. Review Financials April **(Attachment DD)** — **David**
Action Requested – April 2020 Financial Statements

b. Review Accounts Receivable and Cash Goal — **David**

c. Voucher Lists — **David**
Action Requested - Voucher List (#151306 - #151771 for $4,921,713.77)

d. Financial Projections / COVID-19 Funds **(Attachment M)** — **David**

e. Work Plan in Response to Audit Management Letter **(Attachment HH and II)** — **Stephanie/David**

III. **ADJOURN**

Vision

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FINANCE COMMITTEE MEETING MINUTES
WEDNESDAY, April 29, 2020
NOON - VINEYARD CONFERENCE ROOM

MEMBERS:
Keith Sattler
Glenn Bestebreur
Brandon Bowden

STAFF:
Craig Marks
David Rollins
Stephanie Titus

CALL TO ORDER
Keith Sattler called the meeting to order at 12:12 p.m.

I. APPROVE MINUTES

ACTION ITEM
A motion to approve the Finance Committee Meeting minutes for February 2020 and April 8, 2020 as presented was made by Glenn Bestebreur. The Motion was seconded by Brandon Bowden and approved.

II. FINANCIAL STEWARDSHIP

a. David Rollins reviewed the Financial Statements (Including PMH Clinics) for March (Attachment Y and Attachment Z)

ACTION ITEM
A motion to recommend approval of the March Financial Statements (Including PMH Clinics) as presented to the PMH Board of Commissioners was made by Glenn Bestebreur. The Motion was seconded by Brandon Bowden and approved.

b. Review Accounts Receivable and Cash Goal
David reviewed and discussed the Accounts Receivable and Cash Goal.

c. Voucher List

ACTION ITEM
A motion to recommend approval of the Voucher List (#150779 - #151305 for $5,152,257.34) as presented to the PMH Board of Commissioners was made by Glenn Besterbreur and seconded by Keith Sattler and approved.

ACTION ITEM

A motion to recommend approval of the Voucher List (#150278 - #150778 for $4,404,743.30) as presented to the PMH Board of Commissioners was made by Glenn Besterbreur and seconded by Keith Sattler and approved.

d. Surplus Item Resolution # 1005; #1016; #12020

ACTION ITEM

A motion to recommend approval of the surplus Item Resolutions # 1005, #1016, and #12020 as presented to the PMH Board of Commissioners was made by Glenn Besterbreur and seconded by Keith Sattler and approved.

e. DZA Management Letter

David reviewed and discussed the DZA Management Letter (Attachment V-1).

f. COVID-19 Projections (Attachment E)

David presented the COVID-19 Financial Model/Projection (Statement of Operations) scenario.

II. ADJOURN

Having declared no further business, the meeting was adjourned at 12:50 p.m.

DRAFT

MEMORANDUM

TO: BOARD OF COMMISSIONERS
PROSSER MEMORIAL HEALTH

FROM: CRAIG J. MARKS, CEO

DATE: MAY 2020

RE: CEO REPORT

QUALITY

1. COVID-19 Update

It has now been almost two months since the worldwide COVID-19 pandemic was declared and our world changed forever. We have learned a lot over the past eight weeks yet know there is still a lot to learn as new information pours in every day regarding the virus and how best to fight it. The one thing that has been constant at Prosser Memorial Health has been the commitment and dedication of our staff to our patients, each other, and PMH. Collectively we are doing well and will come out of this stronger than ever. To date, we have conducted 459 COVID-19 tests, with 89 (18%) of them being positive. Of those, 13 have been treated at PMH as inpatients, and the remainder have recovered at home. We have had six of our staff members test positive (unknown sources). Five of the six have recovered and one is still at home. Our priority remains to care for the needs of our community while keeping our staff safe. As we have now dealt with COVID-19 every day for the past two months (e.g. mask wearing, PPE donning and doffing, frequent hand washing, social distancing, virtual meetings, etc.) we are now preparing to safely transition to providing all the services we provided before the pandemic was declared.

Prosser Memorial Health along with hospitals all across the country have realized that many patients have waited, and postponed elective and non-emergent care, understanding that fighting COVID-19 was our priority, but non-COVID-19 health issues also need to be addressed in a timely manner. It is important to recognize that so-called elective care or scheduled care often involves providing treatments and procedures that are critical to caring for those patients with chronic illnesses such as cancer, diabetes and heart disease, and delays in care can result in worsening conditions for these vulnerable patients. To this end, the American and Washington State Hospital Associations recently began marketing campaigns to encourage individuals that need care to go to their local providers and hospitals to receive that care because we are ready **(Attachment A)**.

That is certainly true at PMH where we have adequate supplies and other resources for any increased COVID-19 activity and we have providers and staff ready to welcome back our patients, with the proper safety precautions in place. The COVID-19 Task Force has been discussing this for several weeks and is following the lead of our State and Federal Governments **(Attachment B).** On May 18th, Governor Inslee signed a proclamation outlining the process for hospitals and healthcare providers to begin increasing the services they provide to their communities **(Attachment C).** In addition, the PMH surgeons and the COVID-19 Task Force developed a form to help surgeons and patients decide if they should undergo surgery now or continue to wait **(Attachment E).** Utilizing these criteria, on May 18th we performed ten surgeries and are prepared to continue meeting the surgical and other healthcare needs of our community. Finally, I want to once again thank the members of the PMH COVID-19 Task Force for all their hard work and dedication and to share a letter Merry Fuller wrote to the Task Force **(Attachment F).** The performance of everyone at PMH throughout this pandemic demonstrates our strength, ability to change, and commitment, all characteristics of successful organizations that are well prepared to take on the challenges of a changing world!

2. COVID-19 Financial Plan

You do not have to look very far to hear or read about the financial stress that the COVID-19 pandemic is placing on our economy, especially as it relates to smaller businesses. This is certainly true in healthcare as hospitals in the State of Washington struggle financially **(Attachment G)** and hospitals across the country are projected to be losing $50 billion a month **(Attachment H)** as a result of the COVID-19 crisis. Fortunately, PMH was financially strong before the crisis and remains financially strong. Like hospitals across the country we have seen a dramatic drop in outpatient volumes, especially surgical procedures and adjusted patient days, which is a proxy for total patient volumes **(Attachment I and J).** As a result, we have also seen a significant decline in net revenue, that we project will continue through the remainder of 2020 **(Attachment K).** With the declining volumes and revenue, we would be projecting a significant loss, however, because of the financial assistance we have received, we are projecting that we can finish 2020 near our budget goal **(Attachment L and M).** Attachment M also indicates how we are planning to utilize the federal assistance dollars over the remainder of the year. These projections may change, however, as we transition to seeing more patients and we actually see how quickly our community returns for care.

A key to our optimism is the financial assistance we have received. To date, we have received $18.1 million to assist us during this challenging time **(Attachment N).** This $18.1 million includes $5.2 million from Health and Human Services (HHS), $6.35 million from the Small Business Administration (SBA) and $6.6 million from CMS for Advanced Medicare Payments. Of the $18.1 million of assistance, only the Medicare Advanced Payments are in the form of a loan that must be paid back. At this point in time, we are not using any of the Medicare dollars in our projections. It should be noted, however, the AHA is pushing Congress to make the Medicare Advanced Payments forgivable in any future COVID-19 relief measures.

At the present time, the funds we have received exceed our projected need and will be paid back if they are not needed. While it has been suggested that we should us the funds to build our new hospital or pay our staff more, this is not allowed nor is it the right thing to do. However, it is impossible to predict how quickly our business will return, which may necessitate utilization of more or all of the funds in the future. We are very blessed to be in this position as hospitals all across the country are laying off staff, cutting salaries and benefits, etc. Our plan is to keep our staff whole, with the exception of encouraging staff to take vacation, and to the best of our ability not negatively impact the take-home pay of any of our team members. We still have a long way to go, but at this time our financial picture is very positive and there is speculation that there may be more relief funds on the way. It is my hope that Prosser Memorial Health will not need any further assistance.

3. Practice Transformation Grant

The Practice Transformation Project work has continued the last several months, despite resources being diverted towards our COVID-19 response. The Practice Transformation Dashboard **(Attachment O)** provides a detailed accounting of milestone expectations for the hospital and our progress towards achieving them. A similar accounting for both the Benton City Clinic and Prosser Family Medicine will be provided in the future. Follow up of high-risk patients has improved in Q1 over the prior year. This progress is due to changes in the process by which follow- up occurs after discharge, management of patients who frequent the ED, and how referrals to the Community Paramedic Program are captured.

Communicating with patients and families in an effective and meaningful way is the primary focus for the remainder of 2020. This will be accomplished with staff training on using teach-back methodology when providing patient education. Teach-back is a process for validating the patient's understanding of the education or instructions they were provided. We will also implement patient decision tools, which help identify the patient's willingness and ability to participate in the care goals. The efforts of the Practice Transformation Grant project facilitate the patient and their families to participate as an essential member of the care team. Merry Fuller will discuss this project at the May Board Meeting.

4. May Board Meetings

While we are trying to minimize group meetings, we are going to have both a Board Work Session and a regular Board Meeting in May. The main reason for this is to hear a presentation from our auditors, DZA (Luke Zarecor – Partner) and Gary Hicks, our financial consultant, on our Feasibility Study for a replacement hospital. Unfortunately, Luke and Gary will not be physically present at the meeting but will present virtually. Board members are welcome to attend in person or virtually and we will minimize the number of staff physically present. The public will not be allowed to attend per Governor Inslee's Proclamation, but the meeting will be available via conference call for the public. The Board will not be asked to take any action regarding the Study in May, but it will be discussed again in June and possibly acted upon. At the May Work Session, we will also hear a presentation from Dr. Rivero and Christi Doornink-Osborn regarding our Medical Staff Engagement Plan. The Board will go into Executive Session at the end of the

Work Session to discuss contracts, real estate and personnel issues. The Board will hear presentations regarding a proposed PMH Uniform Policy to be implemented in 2020, a Practice Transformation Grant and a COVID-19 update. These items will not require any action by the Board.

PATIENT LOYALTY

1. Community Support

While the past two months have been very challenging for everyone at PMH, the support of our great community has been palpable and greatly appreciated. On May 8th, Fairchild Air Force Base conducted a flyover of all the hospitals in the Yakima Valley as a sign of support and thanks for everything healthcare workers are doing during this crisis. The United States Air Force did this across the country and raised the spirits of many healthcare workers. Our local community got into the action when they conducted a second parade around the hospital and our Prosser Clinics on May 11th as a way to thank everyone at PMH and kick-off Hospital Week. What a way to start this special week, especially this year! We have also been overwhelmed by the generosity of our community through their donations of personal protective equipment (PPE) and meals. Included with my report is a list, to date, of all the organizations and individuals that have supported us **(Attachment P).** Thank you! I have also included several letters of thanks that we have received **(Attachment Q).** We truly live and work in a great community!

2. Patient Satisfaction

While most of our focus the past two months has been on COVID-19, we continue to care for patients with non-COVID-19 issues. To our staff's credit, despite all of the distractions, we have been able to maintain our overall patient satisfaction level at 86.3%, which is just slightly below our goal of 86.6% **(Attachment R).** In particular, inpatient (acute care and OB) and our clinics, have experienced a significant improvement in patient satisfaction. It is also important to note that for those departments not meeting their goal, several are very close. We are also seeing that most of the responses are on the favorable side of the graphs. In the coming months, we will focus on moving even more of our patients to the "definitely yes" category which will enable us to exceed our patient satisfaction goal.

EMPLOYEE DEVELOPMENT

1. Employee Engagement

This past week we celebrated National Hospital Week (May 11 – 15) which provided us a wonderful opportunity to thank our staff for everything they do for our patients and PMH **(Attachment S).** This year was a little challenging with COVID-19, but we did our best to make the week special. Led by our Employee Engagement Team, Kayla Campbell, Gaylyn Concienne, Merry Fuller, Kevin Hardiek, Shannon Hitchcock, Anna Kellogg, Randy McCombs, Kristi Mellema, Kristal Oswalt, Bryan Scheer, Kaylee Swan, Annie Tiemersma, Rochelle Kmetz and Crystal Blanco, the week included lots of food (breakfast, lunch, donuts, ice cream and Italian sodas),

competition (cornhole, graduation pictures, puzzles) and a lot of safe fun **(Attachment T)**. Congratulations to the winners of each of these activities and a big thank you to everyone that participated **(Attachment U)**. In addition to Hospital Week, we celebrated National Superhero Day on April 28th by having Merry Fuller, David Rollins and I bring ice cream to all the Superheroes at PMH. Looking forward, we will celebrate National Donut Day on June 5th by having the Blissful Bites donut truck serve donuts to all our staff at the hospital and clinics **(Attachment V)**. I have also included the May Employee Newsletter which captures some of the activities at PMH in April **(Attachment W)**.

2. Aspire Awards

For several years now we have been awarding PMH team members with ASPIRE Awards (gold, silver, bronze) for being caught living our Values. This program has been very successful, as we have recognized many PMH staff for the wonderful things they do every day. The past two months, however, we thought that we might be missing something with our current program. What was missing was a way to recognize teams that are living our Values. For this reason, we developed a new award, The Platinum Award, for PMH teams that go above and beyond to serve our patients. This program was introduced in May as we recognized our first team winners – The COVID-19 Clinic Team. Each member of the team (Dr. O'Connor, Daisy Magana, Claudia Blackburn, Steve Zirker, PA, Gloria Zuniga, Jaqueline Rodriguez, Mireya Aguilar, Monique Saenz, Isabel De La Cruz, Daniel Solis, Pam Morris, ARNP, Dr. Johansing and Laura Sosa) received a $100 gift card and our sincere appreciation and thanks for how well they have served our community. They truly are on the frontlines of this pandemic **(Attachment X)**. Congratulations and thank you!

3. Uniform Program

For the past year, a PMH Uniform Committee lead by Rusti Wilson, Director of Cardiopulmonary Services, has been meeting to determine the feasibility of having an expanded uniform program throughout PMH. The committee has determined which department will participate; a draft uniform policy was developed; colors and types of uniforms for each department have been selected; a vendor for the uniforms has been selected; and a cost estimate was developed and included in the 2020 Budget **(Attachment Y)**. We were prepared to implement this program in 2020 as outlined in our 2020 Strategic Plan, but with all of the uncertainty surrounding the financial future for healthcare in general, we have decided to postpone this project until 2021. We will share the program with the Board in May and encourage all staff to review the program and provide feedback to their department leader. We have plenty of time to make adjustments, so we look forward to your thoughts.

MEDICAL STAFF DEVELOPMENT

1. Medical Staff Recruitment

Despite the COVID-19 pandemic, provider recruitment activity has remained very robust. We are currently in very active discussions with a pediatrician from the Yakima Valley that is interested in joining our Grandview Clinic. The pediatrician has met many members of our team and is very impressed. The individual is currently reviewing a contract and hopes to make a decision by the end of the month. While we paused having any Certified Nurse Midwives visit us over the past two months, we currently have three scheduled to visit in late May through early June. We hope to be successful in recruiting our second CNM to join our team and add additional capacity on our Women's Health Program. Finally, we have been recruiting Advanced Practice Clinicians (APC) to join our clinics in Prosser and Grandview and I am pleased to report that Afton Dunham – Certified Nurse Practitioner (CNP) has agreed to join us **(Attachment Z)**. Afton has worked part time at PMH for several years as a registered nurse. Please join me in welcoming Afton to her new role at PMH! In addition to Afton, we continue to recruit for an additional APC to help cover evening and weekend hours in Grandview and Prosser. We are not quite halfway through the year and we have almost completed our recruitment needs for 2020 in our Medical Staff Model. A big thank you to Christi Doornink-Osborn for all her hard work in this area, in addition to all of her other duties! Also, a thank you to everyone in our organization that has assisted in our recruitment efforts because it truly takes a team to be successful.

2. Medical Staff Engagement

Dr. Rivero, Christi Doornink-Osborn and the Medical Staff engagement Team have been working on refining their Team Charter, the Medical Staff Engagement and Retention Plan, and a plan to reduce burnout amongst healthcare providers **(Attachment AA)**. Dr. Rivero and Christi will review their plans with the board at the May Board Work Session. It is interesting to note that over the past two years the PMH Medical Staff satisfaction rates were 90.6% and 89.0% respectively. These are excellent scores and Dr. Rivero and the Engagement Team deserve a lot of credit for this success. While these scores are good, we will continue to try to improve and achieve 100% satisfaction. One of the activities that has been very well received in the past is the Medical Staff /Board/Leadership dinner cruise on the Columbia River. We have once again tentatively scheduled this event for July 10, 2020. Unfortunately, due to the COVID-19 restrictions placed on the State of Washington, we may not be able to hold the event on that date. If we cannot hold it on July 10th, we will work with Water2Wine to reschedule our event in August or early fall. Stay tuned as we work on this and other Medical Staff Engagement activities.

SERVICES

1. PMH Replacement Hospital Feasibility Study

Last year the Board approved engaging Dingus, Zarecor and Associates (DZA) to complete a Feasibility Study of Prosser Memorial Health building a replacement hospital. Luke Zarecor, CPA, DZA Partner, led the work along with Joe Lodge, CPA, DZA Associate **(Attachment BB)**.

They also contracted with Jody Carona, Health Facilities Planning & Development, to complete a Market Overview and Assessment **(Attachment CC)**, which was used in making financial projections. Gary Hicks, PMH Financial Advisor, also participated in the project as a representative for PMH. The project would have been completed last year but we decided it would be better to have 2019 audited financial statements included in the study. I do not want to steal the thunder from the experts, but the study looks very favorable. We plan to have Luke, Joe and Gary present the study to the Board at the May Board Work Session. Because this is so important to the future of PMH, we are not in a rush for the Board to take action. Our intent is to share the information with the Board in May, and let the Board direct us as to when they want to consider acting on the study (e.g. immediately move forward with pursuing USDA funding; continue building up cash reserves for a decision at a later date; or abandon the concept of a replacement facility). We look forward to discussing this very important study with the Board.

2. Sewer Lines

One of the challenges in working in a facility the age of PMH (in some areas over 70 years old) is that eventually the infrastructure (e.g. water/sewer pipes, roof, etc.) wears out and needs to be repaired or replaced. This past month was not a positive one for the PMH facility as two sewer lines were inoperable and needed to be repaired/replaced. One line affected the Business Office Building (Whitehead Conference Room, PFS, IT, Accounting and the COVID-19 Clinic) and the other was in the lower level hallway inside the hospital between Nutrition Services and Surgical Services. The first line could not be repaired because of the large volume of tree roots in the line and the large trees all along the line. The second line was the result of settling, which allowed water to stand in the pipe and rust it out. Fortunately, both lines are in the process of being fixed/replaced and should be ready for use by the end of this week. Unfortunately, these are not anticipated expenditures and they will continue when you have an older facility. They are also very disruptive to patient care and expensive to fix because they are emergency repairs (e.g. weekends, nights, overtime). I wonder if the hospital gods were sending us a message about our need for a new facility?

3. Nuclear Medicine Project

Since our last update, the nuclear medicine project has gained significant momentum. The Department of Health Construction Review Services approved the renovation of the existing therapy gym for the nuclear medicine project. The next phase is to work with KDA to review the project documents to comply with applicable WA State regulation. Once completed, the revised plan will be sent to the Department of Health Construction Review Services for approval. In tandem, we will put the project out for bid to determine the total cost of construction. We will request board approval for construction by the end of June. Our project is on track with a completion date by the end of December 2020.

FINANCIAL STEWARDSHIP

1. Financial Performance – April

April is projected to be the worst financial month on record in the healthcare industry across the country. Prosser Memorial Health would have been right there with the rest of the industry, however, with the financial assistance we received (e.g. HHS, SBA) we are now at our budgeted financial performance targets **(Attachment DD)**. In April our gross revenue was 44% ($5.8 million) under budget and 38% ($4.5 million) less than last April. Fortunately, our deductions from revenue were less than budget and we accounted for approximately $2.2 million of financial assistance, which brought our net revenue to 12% ($669,394) better than our budget. Our expenses were slightly over budget ($30,343), resulting in an income from operations of $929,805. After adding in non-operating income, our net income was $986,436 compared to our budgeted net income of $349,831. It is important to remember that without the financial assistance, we would have lost approximately $1.2 million in April.

COVID-19 is also significantly impacting our year-to-date financial performance. All of our metrics (e.g. gross revenue, expenses, patient volumes, net patient services revenue) have been negatively impacted, but with the financial assistance we have received, we were able to bring our financial performance back to budget. Our current projections indicate that we will be able to maintain our budgeted financial performance if our business returns gradually over the next six months as shown in our projections **(Attachment M).** At the end of April, our net income (bottom line) is $957,101, exactly at our budgeted level. As stated previously, if our projections are accurate, we will return some of the financial assistance we received at the end of the year.

In addition to our strong income statement, our balance sheet has also improved dramatically due to the financial assistance we received in April. In April, we experienced a positive cash flow of $7.7 million, bringing our year-to-date cash flow to $7.3 million. The positive cash flow is reflected on our income statement where our cash position has improved significantly (152.33 days cash on hand). In addition, our days in net accounts receivable have declined to 48.35 days. In conclusion, PMH is in a very strong financial position as we continue our battle against COVID-19 and slowly transition back to being a full-service community hospital.

2. PMH Foundation Update

This past week, the Foundation Board met and reviewed/discussed several issues raised by the Washington State Auditor **(Attachment EE).** When the State Auditor audited PMH, they indicated that the PMH Foundation should pay back the Hospital the $21,500 that the Hospital gave to the Foundation in 2018 to restart the Gift Shop. The Foundation Board had no issue with this request and agreed to reimburse the Hospital $21,500. The Foundation Board also reviewed a revised contract between the Hospital and the Foundation **(Attachment FF**). The State Auditor wanted the agreement to be more specific, especially as it relates to the services provided by each party. The Foundation and Hospital Boards will be asked to approve this agreement in June. A subcommittee of the Foundation Board has been reviewing the Foundation Bylaws and recommended several changes **(Attachment GG**). The Foundation and

Hospital Boards will be asked to approve the revised Bylaws in June. Finally, the Foundation Board is still hoping to hold a PMH Foundation Golf Tournament on September 19, 2020. However, due to the COVID-19 restrictions, it is still too early to determine if this will be feasible. Stay tuned....

3. Audit Management Letter - Update

The Director of Finance has formed a team, the Audit Compliance Task Force, to collaborate and address all items as identified in the DZA Management Letter **(Attachment HH)** resulting from the 2019 Audit. The first Audit Compliance Taskforce meeting occurred May 19 and will be recurring mid-month throughout the remainder of the year. All DZA recommendations have been assigned a group to work through them specifically with deadlines of deliverables due back to the committee for review. Additionally, it has been identified in order to complete many of the policy recommendations, Standards of Procedures (SOPs) are needing completion and/or revisions. These SOPs have been identified and split into their own individual projects amongst the team accordingly. Each Task Force meeting will review, provide feedback as needed, approve to proceed with next steps, and ultimately formally publish the Policies as recommended with the SOPs that align with each. The Director of Finance will also provide to the Board Finance Committee project updates each month to review and assess progress. Included as **(Attachment II)** is the presentation provided at the Leadership Quality Meeting in May to provide more specifics to the taskforce, its purpose, process, and ultimate goals. This presentation will also be discussed with the Finance Committee in May. The Audit Compliance Task Force will continue each year and adapt as required for any additional items identified resulting from our annual audits to organize, address, and to ensure future compliance as required by the following audit or deadlines as indicated.

If you have any questions regarding this report, or other Hospital activities, please contact me at (269) 214-8185 (cell), (509) 786-6695 (office), or stop by and see me at the Hospital.

Need Care? Get Care. We're Here.

Arbor Health

Staff Contact

(/staff/beth-zborowski)

Beth Zborowski (/staff/beth-zborowski)

(206) 577-1807 (/staff/beth-zborowski)

Español (https://www.wsha.org/for-patients/obtenercuidado/)

Washington's response to the COVID-19 crisis has been nothing short of amazing. By staying home, you've saved lives. Lately though, we're seeing the consequences of people staying away from health care, including:

- Waiting too long to seek care for injuries like broken bones or deep cuts and ending up with serious infections that could have been prevented.
- Not seeking care for new or worsening health conditions, such as warning symptoms for heart attacks or strokes.

Related News

Washington hospitals

- Making themselves more vulnerable to severe COVID-19 symptoms by not managing chronic conditions.

Washington's health care providers are united in ensuring the availability and safety of accessing care. We're available to care for you and your family, whether your concern is physical or emotional. **Don't delay.**

Find a location to get care (https://www.wsha.org/for-patients/find-a-hospital/)

Hospitals & Clinics are Safe

Care at clinics and hospitals looks different now. That's because health care teams are taking concrete steps to keep you safe when you seek care, including:

- **Screen** for symptoms and temperature when anyone arrives at a hospital or clinic, often before they even enter the building
- **Separate** people with COVID-like symptoms from others. All hospitalized COVID-19 patients are cared for in special units of the hospitals, away from other patients
- **Distance** people from one another with reminders of safe distances and protective barriers in some areas
- **Limit visitors** for appointments and patients
- **Increase the use of masks for staff and visitors**
- **Change the waiting room experience**, or eliminating the waiting room entirely
- **Increase cleaning** of common and high touch items like door handles, elevator buttons, tables, and chairs. Clinics and hospitals always have high standards when it comes to cleaning and keeping germs from spreading.

To find out which precautions a specific health care provider is taking to make care at their location COVID-safe, give them a call or visit their website.

launch campaign: Need Care? Get Care. (/articles/washingt hospitals-launch-campaign-need-care-get-care)

Follow up: WSHA Virtual Press Conference (/articles/follow-up-wsha-virtual-press-conference)

Media Advisory: Washington health care providers unite to address misconceptions, encourage appropriate use of health care (/articles/media-advisory-washington-health-care-providers-unite-to-address-misconceptions-encourage-appropriate-use-of-health-care)

What kind of care is available right now?

Under Gov. Inslee's current orders, patients have access to most, but not all, health care services. The order does allow for regular clinic visits so you can maintain care for any current or urgent conditions.

- **Urgent and emergency care is available and safe to access.** Patients with COVID-like symptoms are separated away from others.
- **Doctor and clinic visits** for routine care were never prohibited under the Governor's order. Contact your provider to find out what in-person and virtual options are available.
- **Telehealth visits** connect you with your health care provider through phone and video conference. This is a good option for routine care, mental health, managing chronic conditions, and having new conditions or symptoms evaluated to determine if you need an in-person visit.
- **Some surgical and diagnostic procedures are now available.** You and your health care provider will need to work together to determine if the procedure is needed urgently enough that a delay would have a detrimental impact on your health.

While we're not fully back to normal operations, you shouldn't delay care for new or worsening symptoms. Part of doing your part means staying healthy and connecting with your health care team if you experience troubling symptoms.

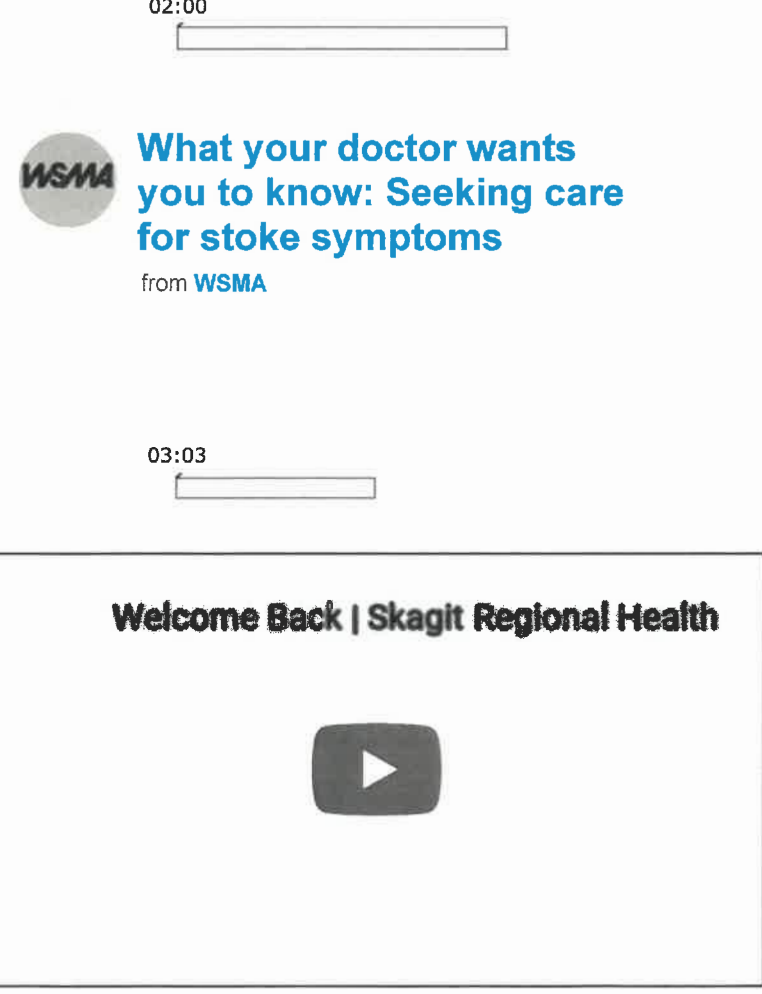
Please do not delay getting the health care you need. We strongly encourage you to call your health care provider to discuss your concerns. Many issues can be addressed with informed guidance, prescriptions or a tele-medicine appointment.

Find a location to get care ➔ (https://www.wsha.org/for-patients/find-a-hospital/)

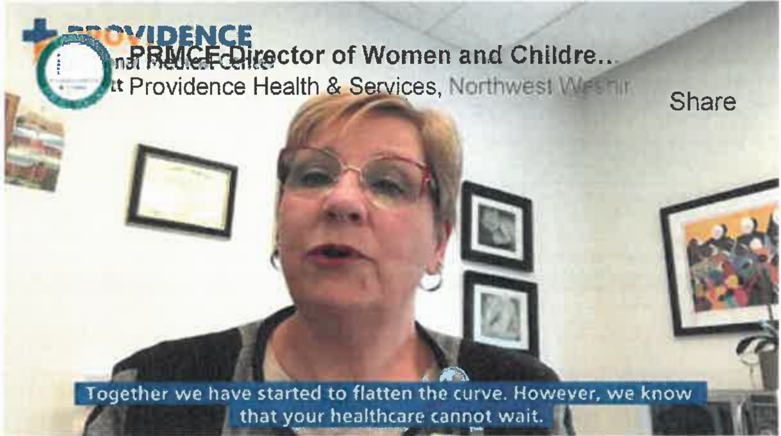
As always, if there is a medical or psychiatric emergency, call 911 immediately.

112 Hospitals. One Voice. Hospitals and health systems that serve every community across state are concerned about the health of Washingtonians. We've come together as one voice to ensure you that clinics and hospitals are still safe, you still have options for accessing medical care, and your physical and emotional health is still of utmost importance. Need care? Get care. We're here.

Videos



Legacy Health urges patients to not de...



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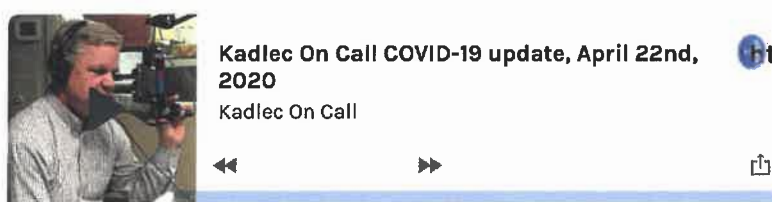
Podcasts



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Washington State Hospital Association
999 Third Avenue
Suite 1400
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Attachment B

Craig Marks

From:	Jim R. Chesemore <jrchesemore@psfinc.com>
Sent:	Tuesday, April 21, 2020 4:14 PM
To:	Jim R. Chesemore
Subject:	CMS Guidance for Reopening Health Care Systems in Areas with Low Incidence of COVID-19
Follow Up Flag:	Follow up
Flag Status:	Flagged

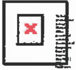
External Email: Please Proceed with Caution

You may have seen this already. But just in case.

Regards,

Jim

From: StayAlert! [mailto:stayalert@mcnhealthcare.com]
Sent: Tuesday, April 21, 2020 3:54 PM
To: Danielle M. Donovan
Subject: CMS Guidance for Reopening Health Care Systems in Areas with Low Incidence of COVID-19



Notice:
CMS Guidance for Reopening Health Care Systems in Areas with Low Incidence of COVID-19
Source:
Centers for Medicare and Medicaid Services
Relevant to:
All Healthcare Organizations
Date:
April 21, 2020

The Centers for Medicare and Medicaid Services (CMS) has issued recommendations for reopening health care systems in areas with low incidence of COVID-19. According to CMS Administrator Seema Verma, "Today, some areas of the country are experiencing fewer cases and lower incidence of the virus, necessitating a more tailored and flexible approach. Every state and local official will need to assess the situation on the ground to determine the best course forward, but these guidelines provide a gradual process for restarting non-COVID-19 essential care while keeping patients safe."

This new guidance, the first in what CMS states will be a series of recommendations, is based on the "Gating Criteria" issued by the White House. The Gating Criteria proposes that prior to reopening, the following is in place:

- **SYMPTOMS:** downward trajectory of influenza-like illnesses reported within a 14-day period and a downward trajectory of COVID-like syndromic cases within a 14-day period.
- **CASES:** downward trajectory of documented cases within a 14-day period, or, downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests) CASES

- **HOSPITALS:** Treat all patients without crisis care AND robust testing program in place for at-risk healthcare workers, including emerging antibody testing.

According to CMS, if states or regions have passed the Gating Criteria (symptoms, cases, and hospitals), then they may proceed to Phase I:

- Continue to maximize the use of all telehealth modalities.

- Non-COVID-19 care should be offered to patients as clinically appropriate and within a state, locality, or facility that has the resources to provide such care and the ability to quickly respond to a surge in COVID-19 cases, if necessary.

- Decisions should be consistent with public health information and in collaboration with state public health authorities.

- Careful planning is required to resume in-person care of patients requiring non-COVID-19 care, and all aspects of care must be considered, including but not limited to:

  - Adequate facilities, workforce, testing, and supplies

  - Adequate workforce across phases of care (such as availability of clinicians, nurses, anesthesia, pharmacy, imaging, pathology support, and post-acute care)

The following recommendations aim to give healthcare facilities some flexibility in providing essential non-COVID-19 care to patients without symptoms of COVID-19 in regions with low incidence of COVID-19.

- **General Considerations:**

- In coordination with State and local public health officials, evaluate the incidence and trends for COVID-19 in the area where re-starting in-person care is being considered.

- Evaluate the necessity of the care based on clinical needs. Providers should prioritize surgical/procedural care and high-complexity chronic disease management; however, select preventive services may also be highly necessary.

- Consider establishing Non-COVID Care (NCC) zones that would screen all patients for symptoms of COVID-19, including temperature checks. Staff would be routinely screened as would others who will work in the facility (physicians, nurses, housekeeping, delivery and all people who would enter the area).

- Sufficient resources should be available to the facility across phases of care, including PPE, healthy workforce, facilities, supplies, testing capacity, and post-acute care, without jeopardizing surge capacity.

- **Personal Protective Equipment:**

- Consistent with CDC's recommendations for universal source control, CMS recommends that healthcare providers and staff wear surgical facemasks at all times. Procedures on the mucous membranes including the respiratory tract, with a higher risk of aerosol transmission, should be done with great caution, and staff should utilize appropriate respiratory protection such as N95 masks and face shields.

- Patients should wear a cloth face covering that can be bought or made at home if they do not already possess surgical masks.

- Every effort should be made to conserve personal protective equipment.

- **Workforce Availability:**

- Staff should be routinely screened for symptoms of COVID -19 and if symptomatic, they should be tested and quarantined. Staff who will be working in these NCC zones should be limited to working in these areas and not

rotate into "COVID-19 Care zones" (e.g., they should not have rounds in the hospital and then come to an NCC facility).

- Staffing levels in the community must remain adequate to cover a potential surge in COVID-19 cases.

  - **Facility Considerations:**

- In a region with a current low incidence rate, when a facility makes the determination to provide in-person, non-emergent care, the facility should create areas of NCC which have in place steps to reduce risk of COVID-19 exposure and transmission; these areas should be separate from other facilities to the degrees possible (i.e., separate building, or designated rooms or floor with a separate entrance and minimal crossover with COVID-19 areas).

- Within the facility, administrative and engineering controls should be established to facilitate social distancing, such as minimizing time in waiting areas, spacing chairs at least 6 feet apart, and maintaining low patient volumes.

- Visitors should be prohibited but if they are necessary for an aspect of patient care, they should be pre-screened in the same way as patients.

  - **Sanitation Protocols:**

- Ensure that there is an established plan for thorough cleaning and disinfection prior to using spaces or facilities for patients with non-COVID-19 care needs.

- Ensure that equipment such as anesthesia machines used for COVID-19 (+) patients are thoroughly decontaminated, following CDC guidelines.

  - **Supplies:**

- Adequate supplies of equipment, medication and supplies must be ensured, and not detract for the community ability to respond to a potential surge.

  - **Testing Capacity:**

- All patients must be screened for potential symptoms of COVID-19 prior to entering the NCC facility, and staff must be routinely screened for potential symptoms as noted above.

- When adequate testing capability is established, patients should be screened by laboratory testing before care, and staff working in these facilities should be regularly screened by laboratory test as well.

All facilities should continually evaluate whether their region remains a low risk of incidence and should be prepared to cease non-essential procedures if there is a surge. According to CMS, by following the above recommendations, flexibility can allow for safely extending in-person non-emergent care in select communities and facilities.

Stay*Alert*! is closely following recommendations for re-opening our health care systems and will publish additional notices when more guidance is available.

Resources:

External Links

- CMS Recommendations for Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare, Phase I

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Attachment C

Date: May 19, 2020
To: WSHA Members
From: Taya Briley, RN, MN, JD, Executive Vice President and General Counsel
Darcy Jaffe, MN, ARNP, FACHE Senior Vice President, Safety and Quality
Zosia Stanley, JD, MHA, Associate General Counsel
Re: **Overview of Governor Proclamation 20.24.1: Reducing Restrictions on, and Safe Expansion of, Non-Urgent Medical and Dental Procedures**

On May 18, 2020 Governor Inslee issued Proclamation 20.24.1[1], which provides updated direction on expansion of non-urgent medical and dental procedures. The Proclamation is the latest in a progression of Proclamations and Interpretive Statements that direct levels of clinical care that may be provided during the COVID-19 Declaration of Emergency. The Proclamation is intended to be in place for the duration of the emergency or until it is amended or rescinded, whichever occurs first.

WSHA is pleased with the direction provided in this proclamation, which recognizes and relies on the expertise of a wide range of health care community leaders in determining level of procedures that can be performed. WSHA chair-elect Bill Robertson, CEO of MultiCare Health System and Sally Watkins, Executive Director of Washington State Nurses Association, led this work and WSHA expresses its deep appreciation to them for their leadership.

The proclamation allows medical, dental and dental specialty facilities, practices and practitioners in Washington State to provide non-urgent health care and dental services, procedures and surgeries provided they act in good faith and with reasonable clinical judgment to meet and follow the procedures and criteria in the proclamation.

Here are key parts of the proclamation, summarized:

COVID-19 Assessment: Local Health Jurisdictions[2] are charged with assessing COVID-19 status in their communities and that assessment should be updated on a regular basis. A link is provided to the DOH dashboard relevant to the assessment.[3]

Expansion/Contraction of Care Plan: Each facility or practitioner is required to develop an expansion/contraction of care plan that is:

- Congruent with the COVID-19 assessment described above
- Consistent with clinical and operational capacity of the organization and

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[1] Proclamation: https://www.governor.wa.gov/sites/default/files/20-24.1%20-%20COVID-19%20Non-Urgent%20Medical%20Procedures%20Ext%20.pdf
Press release: https://medium.com/wagovernor/medical-services-resume-in-wa-4f7e578a820c
[2] Contact information for Local Health Jurisdictions:
https://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions
[3] DOH Data Dashboard:
https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/DataDashboard

- Responsive to standards of care in effect in the facility, practice or relevant geography as determined by the region's emergency health care coalition.

We believe most hospitals already have such a plan in place through their surge or emergency operations plans.

Care Phases – A Key Concept: The proclamation directs that the standards of care determined by the area emergency health care coalition[4] govern what level of care can be provided. Understanding that these care phases are a key driver of what levels of care can be provided is important. The phases are below:

- ***Conventional Care Phase.*** All appropriate clinical care can be provided.
- ***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%.
- ***Crisis Care Phase.*** All emergent and urgent care shall be provided; elective care, that the postponement of which for more than 90 days would, in the judgement 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.

Currently, the Department of Health has specified that the state, as a whole, is in the Contingency Care Phase, meaning 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%.

Definition of Harm[5]: Evaluation of patient harm has been an important consideration in what care may be provided under prior proclamations. In contrast, our understanding of the current proclamation is the consideration of harm (as defined in the prior proclamations) is only necessary when in the Crisis Care Phase.

Criteria for Resuming Non-Urgent Procedures: Recognizing the state has not yet normalized health care operations, the proclamation states hospitals and health jurisdictions will work together to maintain surge capacity and prudently use PPE to keep workers safe and provide needed care to the community. The proclamation also includes an extensive list of requirements that must be met by health care, dental and dental specialty facilities, practices, and practitioners. We will not provide the entire list here but

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[4] Regional Healthcare Coalitions by counties, with contact information: https://www.doh.wa.gov/AboutUs/ProgramsandServices/EmergencyPreparednessandResponse/EmergencyPreparednessRegions/RegionalHealthcareCoalitionLeads

[5] Per the proclamation (page 5): "...evaluation of 'harm' is the same as described in the May 7, 2020, Updated Interpretive Statement related to Proclamation 20-24, and is repeated here:
The decision to perform any surgery or procedure in hospitals, ambulatory surgical facilities, dental, orthodontic, and endodontic offices, including examples of those that could be delayed should be weighed against the following criteria when considering potential harm to a patient's health and well-being: • Expected advancement of disease process • Possibility that delay results in more complex future surgery or treatment • Increased loss of function • Continuing or worsening of significant or severe pain • Deterioration of the patient's condition or overall health • Delay would be expected to result in a less-positive ultimate medical or surgical outcome • Leaving a condition untreated could render the patient more vulnerable to COVID-19 contraction, or resultant disease morbidity and/or mortality • Non-surgical alternatives are not available or appropriate per current standards of care • Patient's co-morbidities or risk factors for morbidity or mortality, if inflicted with COVID-19 after procedure is performed. Furthermore, diagnostic imaging, diagnostic procedures or testing should continue in all settings based on clinical judgement that uses the same definition of harm and criteria as listed above."

will identify a few where we believe additional consideration or collaborative efforts by WSHA members to standardize practice may be necessary.

- Requirement: "Exercise clinical judgment to determine the need to deliver a health care service, in the context of the broader health care and dental needs of patients and communities and in the context of the pandemic, and within the parameters of operation provided by the health care, dental or dental specialty facility, practice or practitioner setting in which they are providing services."
    - WSHA comment: WSHA strongly encourages hospitals to support clinicians in standardizing documentation of their clinical decision-making that reflects not just the patient need for care but also the broader context in which they are providing the care, including their organizational setting. To this end, WSHA has developed informed consent language that can be incorporated into existing consent forms or as a standalone consent form.[6]

- Requirement: "Develop a formal employee feedback process to obtain direct input regarding care delivery processes, PPE, and technology availability related to expansion of care."
    - WSHA comment: Recognizing many hospitals may have existing employee feedback channels they wish to leverage for this process, WSHA will convene members to discuss avenues to ensure this requirement is met.

- Requirement: "Use on-site fever screening and self-reporting of COVID-19 symptom screening for all patients, visitors and staff prior to (the preferred approach), or immediately upon, entering a facility or practice."
    - WSHA comment: Some member hospitals have expressed confusion about whether this requirement allows a self-reported temperature by staff or visitors or if actual screening at the facility is the only way to meet the requirements. Members have also shared that the efficacy of on-site fever screening has not been established. The Governor's Office and DOH have indicated they are open to clarification on this element. WSHA will ask to convene the group that worked to develop the proclamation language to discuss interpretation of this element and how it is being met.

- Requirement: "For clinical procedures and surgeries, develop and implement setting-appropriate, pre-procedure COVID-19 testing protocols that are based on availability, DOH guidance, if any, and/or relevant and reputable professional clinical sources and research."
    - WSHA comment: WSHA intends to dialogue with hospitals, clinicians and the Department of Health on this requirement with the goal of providing further guidance. WSHA will also be working to acquire testing supplies for our members' use.

- Requirement: "Limit visitors to those essential for the patient's well-being and care. Visitors should be screened for symptoms prior to entering a health care facility and ideally telephonically prior to arriving. Visitors who are able, should wear a mask or other appropriate face covering at all times while in the health care facility as part of universal source control."

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[6] WSHA has created two model consent forms for use during the COVID-19 pandemic: The Model Short Form is drafted to be insert into a hospital admission form. The Model Long Form is drafted to respond to interest from some hospitals to have a separate COVID-19 consent form.

- WSHA comment: WSHA is working with clinicians and hospital legal staff to develop universal masking policy and updated visitor policy guidance.

Additional Considerations. Hospitals making capacity decisions are directed to take into consideration:

- Level and trending of COVID-19 infections in the relevant geography,
- Availability of appropriate PPE,
- Collaborative activities with relevant emergency preparedness organizations and/or LHJ,
- Surge capacity of the hospital/care setting, and
- Availability of appropriate post-discharge options addressing transitions of care.

The proclamation also acknowledges that given the geographic diversity of the state and variation in system capacity and varying levels of COVID-19 disease burden, it is impossible to have a uniform approach. It encourages participants to act with good judgment, within the context of patients' needs, their environment, their capabilities and capacity.

Penalties. The proclamation states violations of the order may be subject to penalties pursuant to RCW 43.06.220(5), which makes willful violation of the proclamation a gross misdemeanor. WSHA believes the prospect of these penalties, along with the highly restrictive approach of the prior proclamations led to a dramatic drop in the amount of care being provided to patients. While the penalties are a part of any proclamation from the Governor, it is our hope the additional clarifications made in this proclamation, along with the emphasis on clinical judgment will lead to less clinician concern.

For Further Information:

- **Taya Briley:** tayab@wsha.org, (206) 605-7437
- **Darcy Jaffe:** darcyj@wsha.org, (206) 216-2501
- **Zosia Stanley:** zosias@wsha.org, (206) 216-2511

JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
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**PROCLAMATION BY THE GOVERNOR
AMENDING AND EXTENDING PROCLAMATIONS 20-05 AND 20-24**

**20-24.1
Reducing Restrictions on, and Safe Expansion of,
Non-Urgent Medical and Dental Procedures**

WHEREAS, on February 29, 2020, I issued Proclamation 20-05, proclaiming a State of Emergency for all counties throughout Washington as a result of the coronavirus disease 2019 (COVID-19) outbreak in the United States and confirmed person-to-person spread of COVID-19 in Washington State; and

WHEREAS, as a result of the continued worldwide spread of COVID-19, its significant progression in Washington State, and the high risk it poses to our most vulnerable populations, I have subsequently issued amendatory Proclamations 20-06 through 20-53 and 20-55, exercising my emergency powers under RCW 43.06.220 by prohibiting certain activities and waiving and suspending specified laws and regulations; and

WHEREAS, the COVID-19 disease, caused by a virus that spreads easily from person to person which may result in serious illness or death and has been classified by the World Health Organization as a worldwide pandemic, has broadly spread throughout Washington State, and significantly increasing the threat of serious associated health risks statewide; and

WHEREAS, the health care personal protective equipment supply chain in Washington State has been severely disrupted by the significant increased use of such equipment worldwide, such that there are now critical shortages of this equipment for health care workers. To curtail the spread of the COVID-19 pandemic in Washington State and to protect our health care workers as they provide health care services, it is necessary to prohibit all medical, dental and dental specialty facilities, practices, and practitioners in Washington State from providing non-urgent health care and dental services, procedures and surgeries unless specific procedures and criteria are met; and

WHEREAS, the extensive public-private collaboration between our state and local governments, and the state's hospitals, health systems, and other providers of clinical services in addressing the health care issues created for people and communities by the COVID-19 pandemic is commendable; and

WHEREAS, Washington State's collaborative approach has been effective in addressing the significant public health issues associated with the disease, while greatly expanding the clinical and operational capacity of the health system to effectively care for COVID-19 patients and safely provide preventive, diagnostic, outpatient, ambulatory, acute, and post-acute care for all people in need of care

via both in-person and virtual means. The professionalism, expertise, and compassion of Washington's clinicians, nurses, and other health care professionals during the COVID-19 pandemic has been exemplary; and

WHEREAS in the early days of the pandemic, I, in collaboration with the Washington State Department of Health and health care system partners, established a data-driven approach to addressing the health and safely of Washington's citizens and communities. The actions taken pursuant to this approach reduced the impact of the disease in the State. As the State moves into its Safe Start of the economy, it is important that the healthcare system move rapidly towards a more normal operating position and expand access to care for patients in a manner that is safe and equitable; and

WHEREAS, I support extending Proclamation 20-29, which requires telemedicine payment parity through year-end 2020, when the new parity law in SB 5385 will formally take effect. However, the extension must be approved by the Legislature.

WHEREAS, recognizing that health status is impacted both by social determinants of health and untreated health conditions, it is vital that public and private sector participants in the health care system work to enhance public health capabilities and capacity, such as testing, contact tracing and follow-up, and that access to appropriate care be expanded as safely as possible; and

WHEREAS, the exercise of clinical judgement by healthcare and dental professionals related to the care of patients is essential, and it is essential for all of our health and dental partners to follow the same procedures as outlined in this proclamation and work together to protect the health of all of our residents; and

WHEREAS, the worldwide COVID-19 pandemic and its progression throughout Washington State continues to threaten the life and health of our people as well as the economy of Washington State, and remains a public disaster affecting life, health, property or the public peace; and

WHEREAS, the Washington State Department of Health continues to maintain a Public Health Incident Management Team in coordination with the State Emergency Operations Center and other supporting state agencies to manage the public health aspects of this ongoing incident; and

WHEREAS, the Washington State Military Department Emergency Management Division, through the State Emergency Operations Center, continues coordinating resources across state government to support the Department of Health and local health officials in alleviating the impacts to people, property, and infrastructure, and continues coordinating with the Department of Health in assessing the impacts and long-term effects of the incident on Washington State and its people.

NOW, THEREFORE, I, Jay Inslee, Governor of Washington, as a result of the above-noted situation, and under Chapters 38.08, 38.52 and 43.06 RCW, do hereby proclaim that a State of Emergency continues to exist in all Washington State counties, that Proclamation 20-05 and all amendments thereto remain in effect, and that Proclamations 20-05 and 20-24 are amended to immediately prohibit certain medical and dental procedures, with exceptions, and as provided herein.

I again direct that the plans and procedures of the *Washington State Comprehensive Emergency Management Plan* be implemented throughout state government. State agencies and departments are directed to continue utilizing state resources and doing everything reasonably possible to support implementation of the *Washington State Comprehensive Emergency Management Plan* and to assist affected political subdivisions in an effort to respond to and recover from the COVID-19 pandemic.

I continue to order into active state service the organized militia of Washington State to include the National Guard and the State Guard, or such part thereof as may be necessary in the opinion of The Adjutant General to address the circumstances described above, to perform such duties as directed by competent authority of the Washington State Military Department in addressing the outbreak. Also, I continue to direct the Department of Health, the Washington State Military Department Emergency Management Division, and other agencies to identify and provide appropriate personnel for conducting necessary and ongoing incident related assessments.

FURTHERMORE: based on the above situation and under the provisions of RCW 43.06.220(1)(h), to help preserve and maintain life, health, property or the public peace, I hereby prohibit all medical, dental and dental specialty facilities, practices, and practitioners in Washington State from providing non-urgent health care and dental services, procedures, and surgeries unless they act in good faith and with reasonable clinical judgment to meet and follow the procedures and criteria provided below:

COVID Assessment:
Local health jurisdictions (LHJs) in collaboration with their health partners, should assess the COVID-19 status in the communities they serve. This assessment should be updated on a regular basis. Important COVID-19 disease information relevant to this assessment is available at https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/DataDashboard, and LHJs should have relevant information as well.

Expansion/Contraction of Care Plan
Each health care, dental or dental specialty facility, practice, or practitioner must develop an expansion/contraction of care plan that is both congruent with community COVID-19 assessment described above, consistent with the clinical and operational capabilities and capacities of the organization, and responsive to the criteria provided below.

Expansion/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 emergency health care coalition, as follows:

- Conventional Care Phase – All appropriate clinical care can be provided.
- 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%.
- Crisis Care Phase – All emergent and urgent care shall be provided; elective care, that the postponement of which for more than 90 days would, in the judgement 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.

Criteria for Resuming Non-Urgent Procedures

Until there is an effective vaccine, effective treatment, or herd immunity and until supply chains for PPE return to a more normal status, hospitals and LHJs will work together to maintain some level of surge capacity in our health care system and prudently 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:

- Exercise clinical judgment to determine the need to deliver a health care service, in the context of the broader health care and dental needs of patients and communities and in the context of the pandemic, and within the parameters of operation provided by the health care, dental or dental specialty facility, practice or practitioner setting in which they are providing services.
- Continuously monitor capacity in the system to ensure there are resources, including ventilators, beds, PPE, blood and blood products, pharmaceuticals, and trained staff available to combat any potential surges of COVID-19, participation, as required by Department of Health guidelines, with the WA HEALTH data reporting system to allow for a state-wide common operating perspective on resource availability.
- Follow Department of Health's current PPE conservation guidance, which will be regularly reviewed and updated by the Department of Health, as published on the Department of Health website at https://www.doh.wa.gov/Emergencies/Coronavirus. If the health care facility, practice or practitioner's PPE status deteriorates, adjustments to expansion of care will be required.
- Review infection prevention policies and procedures and update, as necessary, to reflect current best practice guidelines for universal precautions.
- Develop a formal employee feedback process to obtain direct input regarding care delivery processes, PPE, and technology availability related to expansion of care.
- Appropriately use telemedicine. Appropriate use of telemedicine will facilitate access to care while helping minimize the spread of the virus to other patients and/or health care workers.
- Use on-site fever screening and self-reporting of COVID-19 symptom screening for all patients, visitors and staff prior to (the preferred approach), or immediately upon, entering a facility or practice.
- For clinical procedures and surgeries, develop and implement setting-appropriate, pre-procedure COVID-19 testing protocols that are based on availability, Department of Health guidance, if any, and/or relevant and reputable professional clinical sources and research.
- Implement policies for non-punitive sick leave that adhere to U.S. Centers for Disease Control and Prevention (CDC) return-to-work guidance.
- Post signage that strongly encourages staff, visitors and patients to practice frequent hand hygiene with soap and water or hand sanitizer, avoid touching their face, and practice cough etiquette.
- Maintain strict social distancing in patient scheduling, check-in processes, positioning and movement within a facility. Set up waiting rooms and patient care areas to facilitate patients, visitors and staff to maintain ≥6 feet of distance between them whenever possible, consider rooming patients directly from cars or parking lots, space out appointments, and consider scheduling or spatially separating well visits from sick visits.

- Limit visitors to those essential for the patient's well-being and care. Visitors should be screened for symptoms prior to entering a health care facility and ideally telephonically prior to arriving. Visitors who are able should wear a mask or other appropriate face covering at all times while in the health care facility as part of universal source control.
- Ambulatory patients, who are able and when consistent with the care being received, should wear a mask or other appropriate face covering at all times while in the health care facility as part of universal source control.
- Frequently clean and disinfect high-touch surfaces regularly using an EPA-registered disinfectant.
- Identify and implement strategies for addressing employees who have had unprotected exposures to COVID-19 positive patients, are symptomatic, or ill, which should include requiring COVID-19 positive employees to stay at home while infectious, and potentially restricting employees who were directly exposed to the COVID-19 positive employee. Timely notification of employees with potential COVID-19 exposure and appropriate testing of employees who are symptomatic should be a component of these strategies. Follow CDC cleaning guidelines to deep clean after reports of an employee with suspected or confirmed COVID-19 illness. This may involve the closure of the business until the location can be properly disinfected.
- 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.
- Follow requirements in Governor Inslee's Proclamation 20-46 - *High-Risk Employees – Workers' Rights*.

ADDITIONALLY, for purposes of this Proclamation, evaluation of "harm" is the same as described in the May 7, 2020, Updated Interpretive Statement related to Proclamation 20-24, and is repeated here: The decision to perform any surgery or procedure in hospitals, ambulatory surgical facilities, dental, orthodontic, and endodontic offices, including examples of those that could be delayed should be weighed against the following criteria when considering potential harm to a patient's health and well-being:

- Expected advancement of disease process
- Possibility that delay results in more complex future surgery or treatment
- Increased loss of function
- Continuing or worsening of significant or severe pain
- Deterioration of the patient's condition or overall health
- Delay would be expected to result in a less-positive ultimate medical or surgical outcome
- Leaving a condition untreated could render the patient more vulnerable to COVID-19 contraction, or resultant disease morbidity and/or mortality
- Non-surgical alternatives are not available or appropriate per current standards of care
- Patient's co-morbidities or risk factors for morbidity or mortality, if inflicted with COVID-19 after procedure is performed

Furthermore, diagnostic imaging, diagnostic procedures or testing should continue in all settings based on clinical judgement that uses the same definition of harm and criteria as listed above.

ADDITIONALLY, when making health system care capacity decisions, health care, dental and dental specialty facilities, practices, and practitioners must, in addition to the above, 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 LHJ, 4) surge capacity of the hospital/care setting, and 5) the availability of appropriate post-discharge options addressing transitions of care.

ADDITIONALLY, given the geographic diversity of Washington, the variability in COVID-19 disease burden within the state, and health care system capabilities and capacity, no uniform approach to expanding access to care is possible nor would any such approach be effective or wise. It is essential that health care system participants act with good judgment within the context of their patients' needs, their environment, and their capabilities and capacity.

This Proclamation is retroactive to 11:59 PM on May 17, 2020, and shall remain in effect until the state of emergency, issued on February 29, 2020, pursuant to Proclamation 20-05, is rescinded, or until this order is amended or rescinded, whichever occurs first.

Violators of this order may be subject to penalties pursuant to RCW 43.06.220(5).

Signed and sealed with the official seal of the state of Washington on this 18th day of May, A.D., Two Thousand and Twenty at Olympia, Washington.

By:

/s/
Jay Inslee, Governor

BY THE GOVERNOR:

/s/
Secretary of State

Attachment E

Place patient sticker here

DECISION AID TO DETERMINE NEED FOR SURGERY OR PROCEDURE

It is the position of the State of Washington to allow performance of all services considered to be "emergent" or "urgent" for which delay would result in worsening a life-threatening or debilitating prognosis. Physicians should use clinical judgment to determine performance of surgeries or procedures considered to be non-urgent or "elective". To assist in that judgement, one or more of the following criteria must be met to consider moving forward with the surgery or procedure, check all that apply and include explanation for criteria selection:

- ☐ Expected advancement of disease process
- ☐ Possibility that delay results in more complex future surgery or treatment
- ☐ Increased loss of function
- ☐ Continuing or worsening of significant or severe pain
- ☐ Deterioration of the patient's condition or overall health
- ☐ Delay would be expected to result in a less-positive ultimate medical or surgical outcome
- ☐ Leaving a condition untreated could render the patient more vulnerable to COVID-19 contraction, or resultant disease morbidity and/or mortality
- ☐ Non-surgical alternatives are not available or appropriate per current standards of care
- ☐ Patient's co-morbidities or risk factors for morbidity or mortality, if inflicted with COVID-19 after procedure is performed

Explanation for criteria selection:

Physician Signature ______________________ Date ______________

Reference:
State of Washington/Office of the Governor, *Interpretive Statement Related to Proclamation by the Governor 20-24, Restrictions on Non-Urgent Medical Procedures,* April 29, 2020

Attachment F

Hospital Week 2020

Dear Covid-19 Task Force Members,

One of the experiences for which I will define 2020 has been participating in our Covid-19 Task Force. Every member of this team has stepped up and stepped in to make a heavy load and ambitious goals. I have been reflecting on why it has worked and how this team will inform my leadership going forward.

1. We had a clear goal despite the continually shifting variables. Our target never changed; it simply never stopped moving.
2. We invited the right people to the table. People with the ability to solve problems and implement change quickly. People with credibility throughout the organization so that we could move rapidly with the speed of trust.
3. We ensured all departments, locations, and disciplines across the organization were represented.
4. We created a safe place for honest discourse and disagreement. We understood that we could be unified in action without agreeing on every detail. We did not allow ego or frustration to sabotage our efforts. \
5. We delegated clear expectations to each team member, ensuring that all essential tasks were reliably accomplished. The load was equitably distributed, and redundancies created to allow team members periods of rest.
6. We honestly assessed progress and modified our approach until we found success.
7. We established a precise mechanism for communication and added elements as we identified additional needs.
8. We acknowledged and expressed gratitude for every member of the organization and community who partnered with us.
9. We laughed a lot and enjoyed being together.

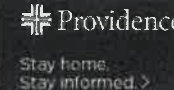
I am so grateful to each one of you. I am proud to be in the company of the committed.

With love and respect,

Merry

Merry B Fuller, MSN, RN CPHQ
Chief Nursing Officer/Chief Operating Officer/Risk Management
PROSSER MEMORIAL HEALTH
723 MEMORIAL ST | PROSSER, WA 99350
o: (509) 788 6038 | | c: (509) 388-4334 | f: (509) 788 6013
mfuller@prosserhealth.org | www.prosserhealth.org

This isn't going anywhere if you go everywhere.



http://www.chronline.com/community/washington-hospitals-community-health-centers-face-a-new-crisis-red-ink/article_34ced572-8e21-11ea-8234-47c854eb727e.html

Washington Hospitals, Community Health Centers Face a New Crisis: Red Ink

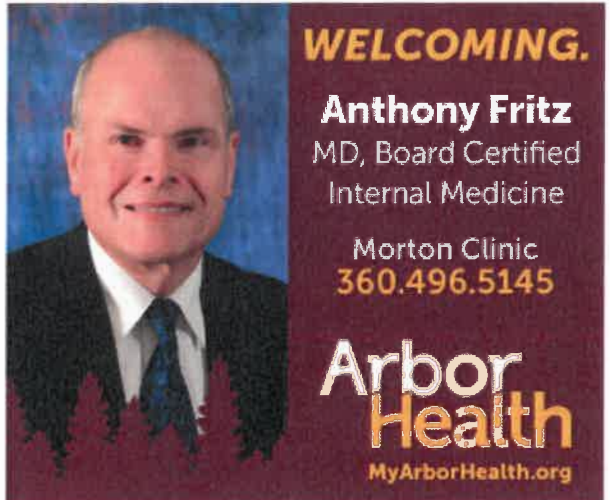
By Evan Bush / The Seattle Times
May 4, 2020

Grays Harbor Community Hospital has been among the hospitals to reduce staff amid the COVID-19 outbreak.
The Daily World

Jennifer Kreidler-Moss has no shortage of concerns to occupy her.

When schools hosting Peninsula Community Health Services sites shut down, her organization lost touch points to schoolchildren, including some struggling with mental health or at risk of suicide.

"I'm beside myself with worry," said Kreidler-Moss, the nonprofit's CEO.



And since COVID-19 began, 17% of the staff has been laid off or furloughed and March revenues fell $884,000 short of expectations.

At EvergreenHealth Medical Center, the first U.S. hospital system to identify a COVID-19 outbreak, March revenue was $20 million less than projected. The hospital system spent an unplanned $3 million on personal protective equipment, testing and screening, among other costs.

In the fight against COVID-19, health care systems have canceled surgeries, shuttered some primary care offices, created COVID-19 wards and left dental chairs empty to prevent the virus's spread. And as asked, many patients heeded officials' pleas and stayed home.

But now, as rates of new COVID-19 cases and deaths trend lower, some experts and health administrators say the measures that helped avoid the pandemic's deluge are barreling health systems toward a second crisis: a flood of red ink.

"We're bleeding money and people are cooped up in their homes, but it seems to be working," said Chelene Whiteaker, senior vice president of government affairs for the Washington State Hospital Association.

Altogether, hospitals' budget shortfalls could swell to $900 million for March and April in the state, Whiteaker said. Federal funds are supposed to put these institutions on more stable financial footing, but Whiteaker said it's not likely enough.

Myriad blows

The financial blows to health care systems are myriad, said Bob Malte, a clinical associate professor of health services at the University of Washington.

Patient volumes and revenues have fallen as patients stay home, Malte said. Costs are flat or have risen with COVID-19.

The mixture of patients seeking services is changing, too, said Malte, a former hospital executive including at EvergreenHealth. For some hospitals, that could mean an increasing number of Medicaid or Medicare patients, who are less lucrative to the bottom line than commercial payers.

Medical centers' reserves also have taken a hit.

"Investment portfolios have been decimated," Malte said.

Malte said he worried most for hospitals in rural areas that often don't have hearty reserves, hospitals in areas experiencing inequality because of race or wealth, and hospitals with a higher proportion of patients on Medicare or Medicaid.

"COVID is underscoring we have a lot of inequities in our health care delivery system," Malte said.

Few institutions will remain unshaken, he said.

"I worry about them all."

"Very fluid"

March was bad for finances at EvergreenHealth Medical Center in Kirkland. April is expected to have been worse.

EvergreenHealth planned to take in about $780 million in total operating revenue this year, said Chief Financial Officer Tina Mycroft. April is expected to tally up to $20 million to $35 million short of monthly expectations.

"Things are very fluid," Mycroft said.

Emergency room visits have dropped by about 60% and procedures by 73%, said Chief Executive Officer Jeff Tomlin.

Meanwhile, costs rose about $3 million in March alone as EvergreenHealth invested in personal protective equipment, drive-thru testing, screening and extra staffing for COVID-19.

Mycroft said the hospital has cut planned capital expenditures in half for 2020, already instituted voluntary furloughs for some staffers, and sidelined others for lack of work.

EvergreeenHealth has about 100 days of reserves, Mycroft said. Hospital leaders are looking to dip into that money, seek more federal funds and try to establish a line of credit.

"We expect this recovery to be two years, maybe longer," Mycroft said.

Uncertainty further clouds planning.

How soon will patients feel comfortable returning for routine care? How many patients are now dealing with more emergent conditions because they went without that care? Will the virus that causes COVID-19 produce another wave of rapid growth?

Gov. Jay Inslee on Wednesday took steps to allow more medical procedures, which could help boost revenue.

But Tomlin said it won't be like turning on a spigot.

"It's going to be gradual," he said.

Most at risk

Community health centers, which serve vulnerable communities regardless of patients' ability to pay, could be among the institutions most at risk. These centers often rely on reimbursement from Washington state's Medicaid program, and also care for the uninsured or underinsured.

An economic analysis released last month of Washington's 27 community health centers by the accounting firm CliftonLarsonAllen estimated that together they could lose about 59% of revenues because of COVID-19 over six months' time, a combined loss of about $473 million dollars.

The analysis relied on financial information provided by most centers through February, and assumed that a plunge in patient volume would last through summer's end, but did not consider cost-cutting measures the centers could take, according to Kyla Delgado and Matthew Borchardt, the certified public accountants who performed the analysis.

In that scenario, the analysis found more than 8,000 full-time jobs could be lost across the state's community health centers, more than 600,000 patients could lose a provider and 167 clinical sites could be shuttered.

"People aren't coming in for care," said Bob Marsalli, CEO for the Washington Association for Community Health. "You're getting into those scarce reserves to keep the lights on."

At Columbia Valley Community Health, which serves Chelan and Douglas counties, visits for dental procedures have dropped by about 95%, said David Olson, the system's CEO. Routine dental services were halted to preserve protective equipment and avoid spreading the virus.

The community health center, which employs about 300 people and sees about 140,000 patient visits each year, also saw medical visits drop by about half.

Founded nearly 50 years ago to treat migrant farm workers, Olson said the health center is on the front lines of care to essential agricultural workers who often live in close quarters, could be susceptible to COVID-19 and don't have many options for health care. An outbreak was recently identified in agricultural housing near East Wenatchee.

Olson said North Central Washington hasn't seen the end of COVID-19.

"We're right at that time of year when people are coming in. They're getting ready to go out and plant fruit trees and farm," Olson said. "It's economics here, but we're talking about feeding a whole lot of people that don't live in Chelan and Douglas counties."

Olson said the health center, which was growing before the pandemic, might need to forgo planned construction of a new clinic to keep paying staff.

In the Seattle area, Neighborcare Health CEO Michael Erikson said the organization's monthly revenue had fallen by about 35%. Neighborcare offers 16 clinic locations.

"Primary care for us is medical, dental and behavioral health. Each of those areas was hit with a torpedo," Erikson said.

Erikson said Neighborcare has established a tent for COVID-19 testing, kept three dental sites open for emergency procedures and converted about 75% of behavioral health and medical visits to telehealth.

Still, the organization's shortfall totaled $1.3 million for March and an expected $2.5 million in April.

About 30% of Neighborcare's 700-person staff is furloughed or on standby status, Erikson said.

"We're looking for the bottom," he said. "If we can find that floor in the next six to eight weeks, we can begin to climb our way out."

Marsalli said the association for community health was appealing to federal and state officials for financial relief and also asking the state to immediately release some Medicaid funds usually contingent on quality measures.

Grim bottom lines

The statistics are grim for financial bottom lines.

Harvard researchers, in partnership with a health care data company, found that ambulatory visits dropped nearly 60% in March and held low into early April for Pacific Coast states. Telehealth only offset a small portion of visits.

About 20% of primary care physicians surveyed nationwide in mid-April by the Primary Care Collaborative predicted they would be forced to close in a month's time because they lacked staff, cash or patients.

Federal coronavirus relief programs have provided some relief, and Congress has approved more CARES Act funding than has been distributed. Still, what's available now is not expected to make up for health centers' lost revenue.

"This pales in comparison," said Leemore Dafny, a professor of business administration at Harvard University who studies health care.

So far, EvergreenHealth said it has received two payments of CARES Act funds, totaling $13.6 million, and well short of its March losses alone.

The first $30 billion of CARES Act funding was distributed based on health care centers' Medicare billings. Other awards are aimed at rural areas, places hard-hit by COVID-19 and for Indian health services.

How the money is allocated has been the subject of contention.

Using Medicare as a basis leaves children's hospitals out, said Jacqueline Barton True of the state hospital association. Washington state also is "more efficient" than states like Florida in Medicare spending, Barton True said, yielding a smaller proportion of federal funding.

Targeting areas hard-hit by COVID-19 makes sense, but Whiteaker noted that Washington "is not overwhelmed because we took early measures" that caused financial pain.

"We've been feeling the financial pain longer," she said.

No matter how the money is doled out, Dafny said there will be plenty to bicker about.

"The costs of this are going to be borne unevenly," she said, but the national conversation is not about fairness, but how to keep vulnerable institutions open.

Community Health Centers say they need more help.

Neighborcare in Seattle received nearly $2.1 million through the CARES Act, "about one month's worth of the loss we've been experiencing," Erikson said.

Columbia Valley Community Health got more than about $1.2 million -- the equivalent of about two weeks' payroll, Olson said. Peninsula Community Health Services received almost $1.1 million.

Kreidler-Moss said Peninsula also applied for a federal payroll protection program loan, received a loan Wednesday and will try to bring some staffers back.

More than 21% of Peninsula patients are experiencing homelessness. Without more support, "the safety net is going to collapse," Kreidler-Moss said, adding that clinicians were concerned about delayed care and reported seeing more signs of stroke and heart issues in recent weeks.

Jill Horwitz, a health policy expert and professor at the UCLA School of Law, said COVID-19's economic fallout will leave many without insurance and unable to pay for care. Hospitals and community health centers could absorb more costs.

"We had a decade of reducing health care benefits and shifting toward out-of-pocket costs, but if there's nothing in the pocket, the providers of last resort are going to have a tsunami of patients," Horwitz said.

Erikson said safety net providers will be more important during the expected downturn.

And after months of patients withdrawing from care,"What's building is a wave of health care needs that could crash the system," he said.

Attachment H

Craig Marks

From: American Hospital Association <circulation@aha.org>
Sent: Tuesday, May 05, 2020 7:29 AM
To: Craig Marks
Subject: New AHA Report on Financial Impact of COVID-19

External Email: Please Proceed with Caution

Click here to access a web or mobile friendly version of the newsletter.

May 5, 2020

New AHA Report Finds Financial Impact of COVID-19 on Hospitals and Health Systems to Be Over $200 Billion through June

A new report released today confirms the tremendous financial strain that hospitals and health systems on the front lines in the fight against COVID-19 are under. **The AHA report estimates a total financial impact of $202.6 billion in losses resulting from COVID-19 expenses and lost revenue for hospitals and health systems over the four-month period from March 1, 2020, to June 30, 2020 — or an average of over $50 billion in losses a month.**

"America's hospitals and health systems have stepped up in heroic and unprecedented ways to meet the challenges caused by COVID-19. However, the fight against this virus has created the greatest financial crisis in history for hospitals and health systems," said AHA President and CEO Rick Pollack. "While we appreciate the support and resources from Congress and the Administration, many hospitals are still on the brink. We need further support and resources to ensure that we can continue to deliver the critical care that our patients and communities are depending on while also ensuring that we are prepared for the continuing challenges we face from this pandemic as well as other potential emergencies."

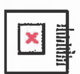
For this report, the total financial impact on hospitals and health systems includes the costs of COVID-19 hospitalizations, the impact of canceled and foregone services due to COVID-19 on hospital revenue, the additional costs associated with purchasing needed personal protective equipment, and the costs of additional support some hospitals are providing to their workers. For example, some hospitals are providing child care, housing and transportation for their front-line caregivers and other employees.

The financial impact estimates in this report do not include other important costs borne by hospitals, such as the increases in drug and labor costs that have resulted from the pandemic. The extent of these increases on hospitals will be better understood as more data becomes available. It is also

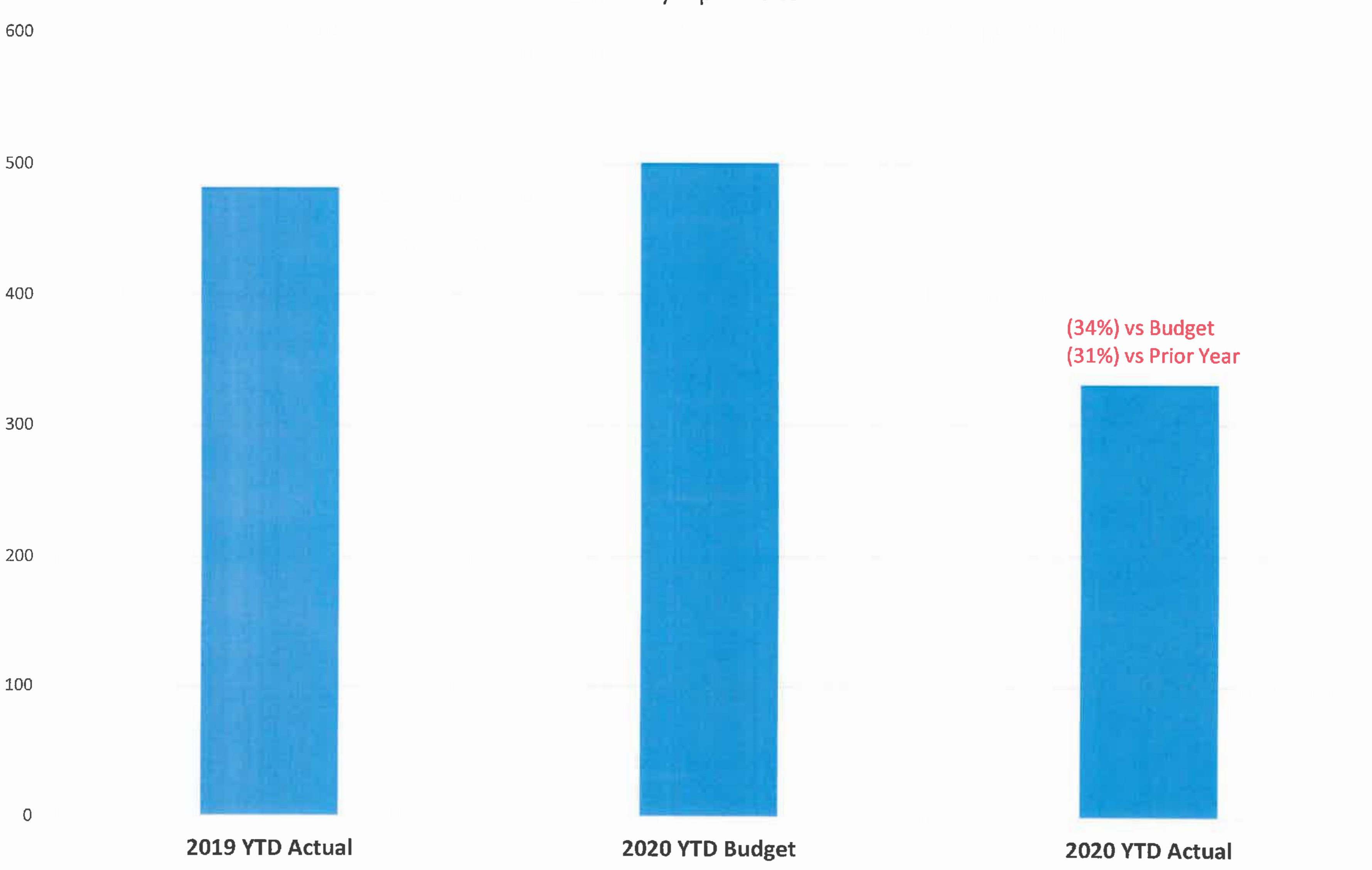
important to understand that the report estimates costs through June 30, 2020, and it remains to be seen how quickly life will return to normal across the country in the months to come. Hospitals will likely continue to see lower service use while treating COVID-19 patients beyond June 30, which would result in continued financial pressures.

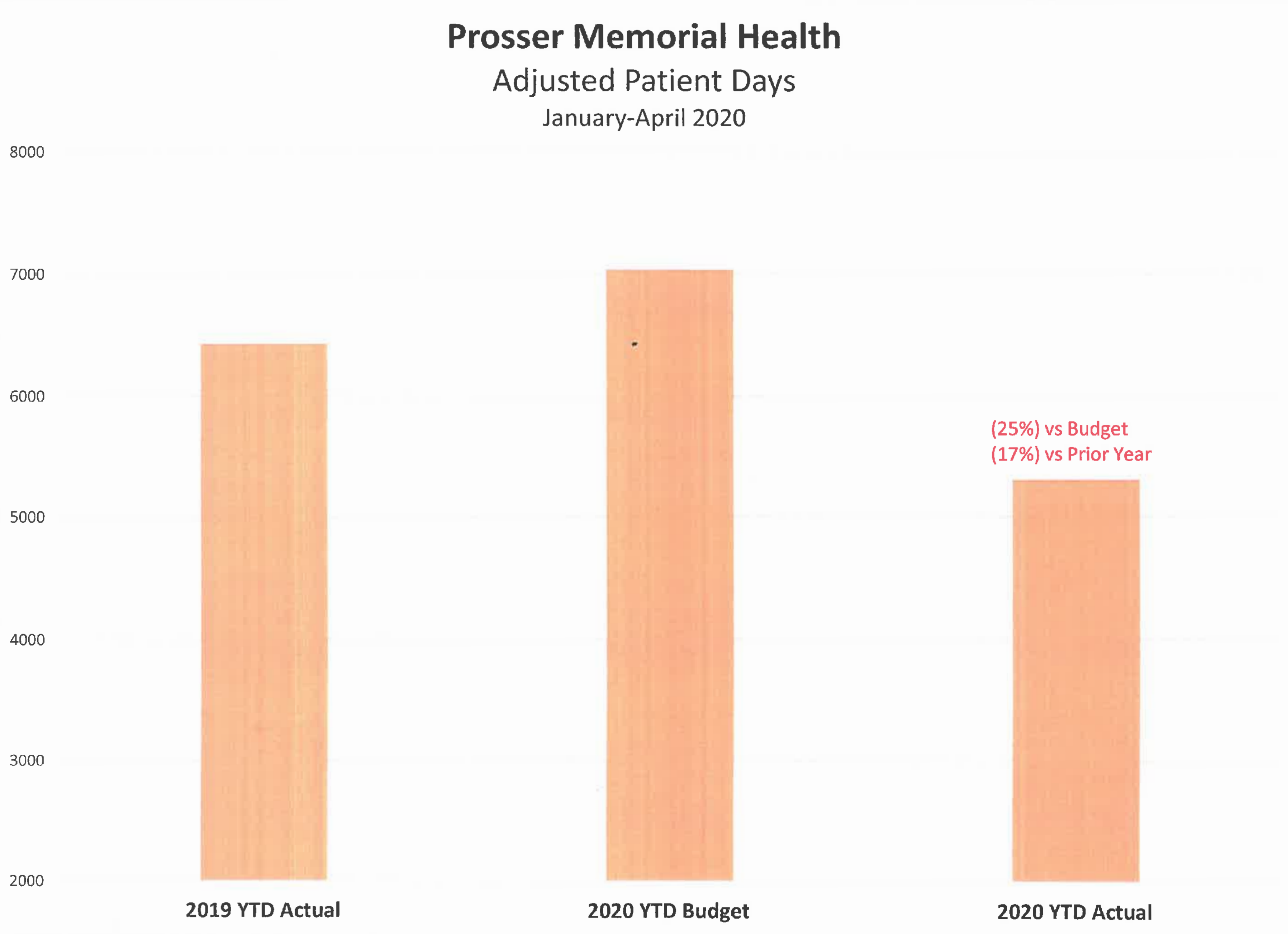
Further Questions
If you have questions, please contact AHA at 800-424-4301.

800 10th Street, NW, Suite 400, Washington, DC 20001

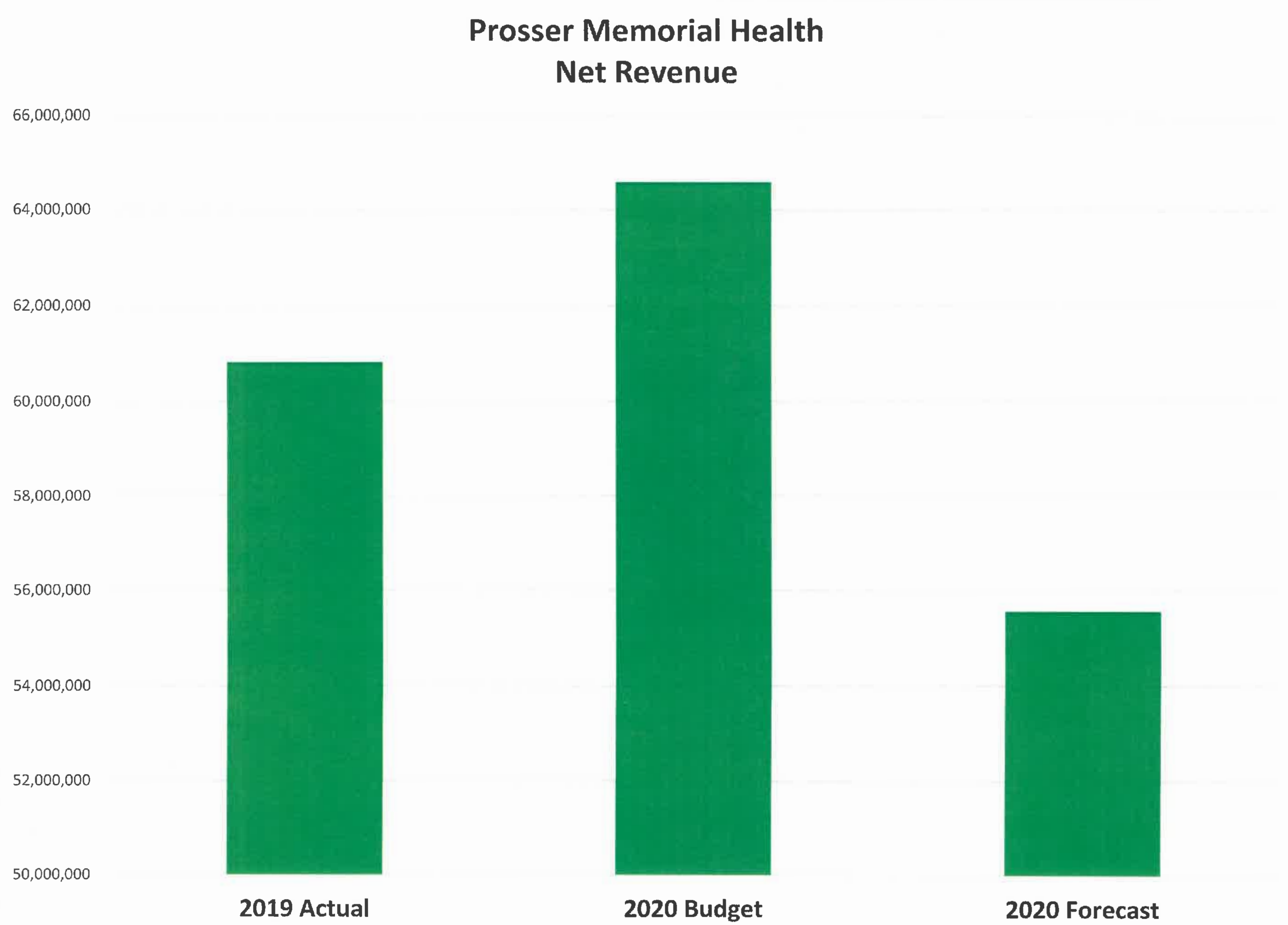


Attachment I

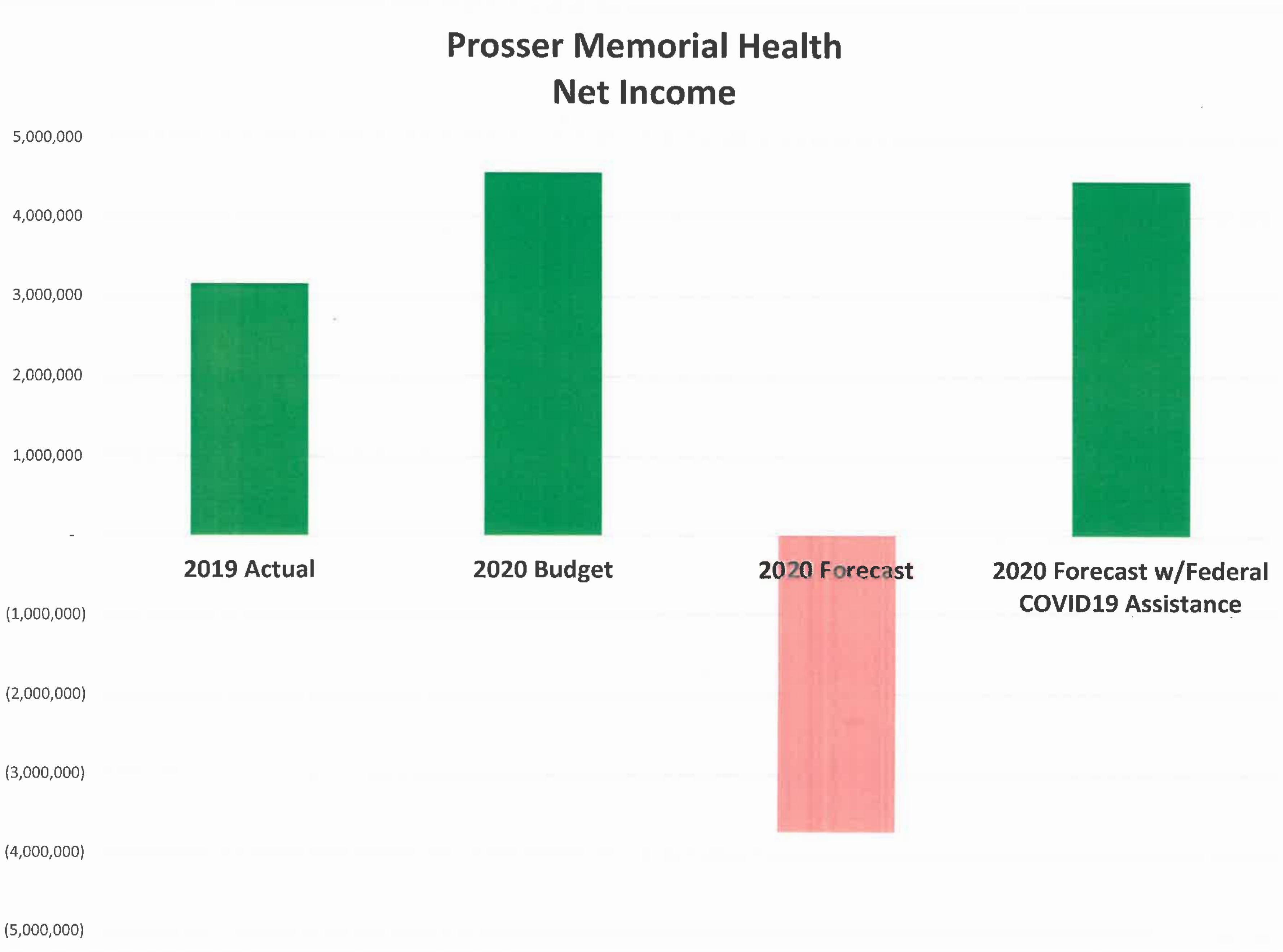



Prosser Memorial Health
Adjusted Patient Days
January-April 2020
8000
7000
6000
5000
4000
3000
2000
(25%) vs Budget
(17%) vs Prior Year
2019 YTD Actual
2020 YTD Budget
2020 YTD Actual

Attachment K



Attachment L



STATEMENT OF OPERATIONS

	Actual 2018	Actual 2019	Budget 2020			Projected 2020		
Gross Patient Services Revenue								
Inpatient	29,604,722	32,299,988	34,564,819	2,264,831	7.0%	29,416,736	(5,148,083)	-15%
Outpatient	88,786,759	109,767,804	125,833,980	16,066,176	14.6%	109,482,967	(16,351,013)	-13%
Total Gross Patient Services Revenue	**118,391,481**	**142,067,791**	**160,398,799**	**18,331,008**	**12.9%**	**138,899,703**	**(21,499,096)**	**-13%**
								IP *OP* *Total*
Contractual Allowances								
Medicare	20,525,466	27,928,741	32,236,053	4,307,311	15.4%	28,035,235	(4,200,817)	-13%
Medicaid	26,511,175	31,140,292	35,645,007	4,504,715	14.5%	30,588,777	(5,056,230)	-14%
Negotiated Rates	14,177,999	16,817,667	20,591,779	3,774,112	22.4%	16,874,695	(3,717,084)	-18%
Other Adjustments	1,230,238	1,343,734	2,251,696	907,962	67.6%	2,224,237	(27,459)	-1%
Gross Contractual Allowances	**62,444,878**	**77,230,435**	**90,724,536**	**13,494,100**	**17.5%**	**77,722,944**	**(13,001,591)**	**-14%**
Charity Care	2,108,996	1,671,832	2,001,181	329,350	19.7%	2,274,498	273,317	14%
Bad Debt	2,325,567	4,031,596	4,220,415	188,818	4.7%	4,320,137	99,723	2%
Total Deductions From Revenue	**66,879,441**	**82,933,863**	**96,946,132**	**14,012,269**	**16.9%**	**84,317,580**	**(12,628,552)**	**-13%**
Net Patient Services Revenue	**51,512,040**	**59,133,929**	**63,452,668**	**4,318,739**	**7.3%**	**54,582,123**	**(8,870,545)**	**-14%**
HHS Federal Funds						5,202,730	5,202,730	
Other Grants related to COVID19						116,000	116,000	
Paycheck Protection Program (Net of Medicare)						2,857,606	2,857,606	
Other Operating Revenue	704,674	1,680,884	1,140,583	(540,301)	-32.1%	959,232	(181,352)	-16%
Net Revenue	**52,216,714**	**60,814,813**	**64,593,251**	**3,778,438**	**6.2%**	**63,717,690**	**(875,561)**	**-1%**
Operating Expenses								
Salaries	23,106,905	27,475,682	28,602,691	1,127,009	4.1%	28,286,858	(315,833)	-1%
Benefits	6,299,128	6,260,014	6,623,166	363,152	5.8%	6,245,354	(377,812)	-6%
Purchased Labor	3,345,598	2,843,126	2,359,009	(484,117)	-17.0%	2,397,065	38,056	2%
Sub-Total Labor Costs	**32,751,631**	**36,578,823**	**37,584,866**	**1,006,044**	**2.8%**	**36,929,278**	**(655,589)**	**-2%**
Professional Fees - Physicians	3,477,937	4,047,076	3,799,311	(247,765)	-6.1%	3,992,935	193,625	5%
Professional Fees - Other	741,499	509,434	542,457	33,023	6.5%	576,874	34,417	6%
Supplies	5,194,133	7,040,429	7,749,096	708,667	10.1%	7,663,018	(86,079)	-1%
Purchased Services - Utilities	480,365	491,784	536,197	44,413	9.0%	409,810	(126,387)	-24%
Purchased Services - Other	4,093,714	3,320,394	3,364,521	44,127	1.3%	3,314,496	(50,026)	-1%
Rentals & Leases	1,888,737	2,132,297	2,262,944	130,648	6.1%	2,194,419	(68,526)	-3%
Insurance License & Taxes	584,572	738,376	733,737	(4,639)	-0.6%	1,013,432	279,695	38%
Depreciation & Amortization	1,988,410	2,443,594	2,720,000	276,406	11.3%	2,729,428	9,428	0%
Other Operating Expenses	1,292,044	1,259,784	1,470,060	210,276	16.7%	1,146,645	(323,415)	-22%
Sub-Total Non-Labor Expenses	**19,741,411**	**21,983,167**	**23,178,324**	**1,195,157**	**5.4%**	**23,041,056**	**(137,267)**	**-1%**
Total Operating Expenses	**52,493,042**	**58,561,990**	**60,763,190**	**2,201,200**	**3.8%**	**59,970,334**	**(792,856)**	**-1%**
Operating Income (Loss)	**(276,328)**	**2,252,823**	**3,830,061**	**1,577,238**	**70.0%**	**3,747,356**	**(82,705)**	**-2%**
Non Operating Income								
Tax Revenue	821,456	846,680	833,589	-13,091	-1.5%	849,124	15,535	2%
Investment Income	215,615	335,335	272,476	(62,859)	-18.7%	136,210	(136,266)	-50%
Interest (Expense)	(171,572)	(355,362)	(403,586)	(48,225)	13.6%	(279,385)	124,201	-31%
Other Non Operating (Expense)	(161,830)	71,875	25,870	(46,005)	-64.0%	4,278	(21,592)	-83%
Total Non Operating Income	**703,669**	**898,528**	**728,349**	**(170,179)**	**-18.9%**	**710,227**	**(18,122)**	**-2%**
Net Income (Loss)	**$ 427,341**	**$ 3,151,351**	**$ 4,558,410**	**$ 1,407,059**	**44.6%**	**4,457,583**	**(100,827)**	**-2%**
Operating Margin	*-0.54%*	*3.81%*	*6.04%*			*6.87%*		
Total Margin	*0.82%*	*5.18%*	*7.06%*			*7.00%*		

	January	February	March	April	May	June	July	August	September	October	November	December	2020
Gross Patient Services Revenue													
Inpatient	2,864,636	3,010,011	2,635,344	2,206,745	2,200,000	2,200,000	2,200,000	2,200,000	2,400,000	2,500,000	2,500,000	2,500,000	29,416,736
Outpatient	10,071,001	9,445,153	8,882,599	5,357,211	6,500,000	8,500,000	8,900,000	9,894,766	9,981,918	10,836,255	10,330,009	10,784,054	109,482,967
Total Gross Patient Services Revenue	**12,935,637**	**12,455,164**	**11,517,943**	**7,563,956**	**8,700,000**	**10,700,000**	**11,100,000**	**12,094,766**	**12,381,918**	**13,336,255**	**12,830,009**	**13,284,054**	**138,899,703**
	5%	*16%*	*-7%*	*-24%*	*-28%*	*-28%*	*-22%*	*-24%*	*-17%*	*-19%*	*-12%*	*-14%*	*-15%*
	1%	*0%*	*-14%*	*-49%*	*-41%*	*-24%*	*-13%*	*-6%*	*-5%*	[illegible]	*-1%*	*2%*	*-13%*
	[illegible]	*4%*	*-13%*	*-44%*	*-38%*	*-25%*	[illegible]	[illegible]	[illegible]	[illegible]	*-3%*	*-1%*	*-13%*
Contractual Allowances													
Medicare	2,632,393	2,720,808	1,872,267	995,183	1,806,725	2,374,532	2,269,477	2,442,276	2,682,040	2,869,009	2,662,698	2,707,828	28,035,235
Medicaid	2,462,158	2,881,363	2,564,561	2,088,300	1,542,372	2,209,747	2,271,777	2,491,971	2,965,665	3,172,406	2,944,278	2,994,181	30,588,777
Negotiated Rates	1,970,832	1,535,802	1,259,890	363,732	824,000	1,197,000	1,310,850	1,436,095	1,713,236	1,832,668	1,700,881	1,729,709	16,874,695
Other Adjustments	152,100	143,288	395,710	40,602	178,537	179,145	182,613	189,368	187,341	200,401	185,990	189,142	2,224,237
Gross Contractual Allowances	**7,217,483**	**7,281,261**	**6,092,428**	**3,487,817**	**4,351,633**	**5,960,424**	**6,034,716**	**6,559,710**	**7,548,281**	**8,074,484**	**7,493,847**	**7,620,861**	**77,722,944**
Charity Care	70,465	207,726	147,685	40,927	304,500	304,500	274,050	246,645	166,498	178,105	165,298	168,099	2,274,498
Bad Debt	366,493	154,253	325,725	268,555	478,500	478,500	430,650	387,585	351,138	375,617	348,606	354,515	4,320,137
Total Deductions From Revenue	**7,654,441**	**7,643,240**	**6,565,838**	**3,797,299**	**5,134,633**	**6,743,424**	**6,739,416**	**7,193,940**	**8,065,918**	**8,628,206**	**8,007,750**	**8,143,475**	**84,317,580**
Net Patient Services Revenue	**5,281,196**	**4,811,924**	**4,952,105**	**3,766,657**	**3,565,367**	**3,956,576**	**4,360,584**	**4,900,827**	**4,316,000**	**4,708,050**	**4,822,259**	**5,140,579**	**54,582,123**
HHS Federal Funds				2,200,384			636,949	379,829	979,521	955,496	50,551		5,202,730
Other Grants related to COVID19				6,000	110,000		*Need to deduct 55% if CMS requires cost basis carve out ($2,861,502)*						116,000
Paycheck Protection Program (Net of Medicare)					*1,428,803*	*1,428,803*	*Deducted 55% CMS cost basis carve out ($3,492,629)*						*2,857,606*
Other Operating Revenue	54,446	48,156	79,111	53,953	48,412	160,502	48,412	48,412	160,502	48,412	48,412	160,502	959,232
Net Revenue	**5,335,642**	**4,860,080**	**5,031,216**	**6,026,994**	**5,152,581**	**5,545,881**	**5,045,945**	**5,329,067**	**5,456,023**	**5,711,957**	**4,921,221**	**5,301,082**	**63,717,690**
	106%	*101%*	*93%*	*113%*	*91%*	*96%*	*97%*	*99%*	*100%*	*100%*	*93%*	*97%*	*99%*
		Lost Revenue	*(351,441)*	*680,285*	*(486,010)*	*(223,837)*	*(148,478)*	*(55,714)*	*16,259*	*16,258*	*(368,381)*	*(189,445)* $	*(1,110,504)*
Operating Expenses	[illegible]	[illegible]	[illegible]	*-6%*	*-12%*	[illegible]	*-1%*	[illegible]	[illegible]	[illegible]	*1%*	[illegible]	*-1%*
Salaries	2,390,097	2,319,195	2,438,079	2,243,147	2,168,323	2,272,973	2,319,494	2,368,492	2,417,265	2,511,995	2,407,466	2,430,331	28,286,858
Benefits	577,012	555,392	440,583	739,833	319,583	333,583	472,392	553,569	560,145	572,543	558,863	561,856	6,245,354
Purchased Labor	249,096	283,557	329,407	261,699	94,829	139,536	166,316	173,393	171,270	184,952	169,854	173,157	2,397,065
Sub-Total Labor Costs	**3,216,205**	**3,158,144**	**3,208,069**	**3,244,679**	**2,582,735**	**2,746,093**	**2,958,202**	**3,095,454**	**3,148,680**	**3,269,490**	**3,136,183**	**3,165,344**	**36,929,278**
	6%	[illegible]	[illegible]	[illegible]	[illegible]	*-15%*	*-4%*	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Professional Fees - Physicians	389,778	279,808	267,635	419,725	419,725	316,609	316,609	316,609	316,609	316,609	316,609	316,609	3,992,935
Professional Fees - Other	43,960	58,785	19,051	93,438	45,205	45,205	45,205	45,205	45,205	45,205	45,205	45,205	576,874
Supplies	619,449	675,545	762,215	527,615	527,615	685,900	628,709	644,644	639,864	670,672	636,677	644,113	7,663,018
Purchased Services - Utilities	43,249	43,969	40,757	31,315	31,315	31,315	31,315	31,315	31,315	31,315	31,315	31,315	409,810
Purchased Services - Other	261,428	230,546	359,733	222,165	280,078	280,078	280,078	280,078	280,078	280,078	280,078	280,078	3,314,496
Rentals & Leases	194,404	170,987	167,981	152,417	188,579	188,579	188,579	188,579	188,579	188,579	188,579	188,579	2,194,419
Insurance License & Taxes	60,430	99,269	87,383	85,150	85,150	85,150	85,150	85,150	85,150	85,150	85,150	85,150	1,013,432
Depreciation & Amortization	222,577	227,538	224,010	228,367	228,367	228,367	228,367	228,367	228,367	228,367	228,367	228,367	2,729,428
Other Operating Expenses	104,447	103,657	107,679	92,318	92,318	92,318	92,318	92,318	92,318	92,318	92,318	92,318	1,146,645
Sub-Total Non-Labor Expenses	**1,939,722**	**1,890,104**	**2,036,444**	**1,852,510**	**1,898,352**	**1,953,520**	**1,896,330**	**1,912,265**	**1,907,485**	**1,938,293**	**1,904,298**	**1,911,734**	**23,041,056**
	[illegible]	*0%*	*4%*	*-4%*	*-3%*	*0%*	*-1%*	[illegible]	[illegible]	[illegible]	*-1%*	*-1%*	*-1%*
Total Operating Expenses	**5,155,927**	**5,048,248**	**5,244,513**	**5,097,189**	**4,481,087**	**4,699,613**	**4,854,532**	**5,007,719**	**5,056,165**	**5,207,783**	**5,040,480**	**5,077,078**	**59,970,334**
	104%	*105%*	*103%*	*101%*	*86%*	*90%*	*97%*	*99%*	*100%*	*100%*	*100%*	*100%*	
Operating Income (Loss)	**179,715**	**(188,168)**	**(213,297)**	**929,805**	**671,494**	**846,268**	**191,413**	**321,348**	**399,858**	**504,175**	**(119,259)**	**224,004**	**3,747,356**
Non Operating Income													
Tax Revenue	71,840	65,599	77,314	73,881	70,061	70,061	70,061	70,061	70,061	70,061	70,061	70,061	849,124
Investment Income	22,527	22,036	19,425	18,000	18,000	18,000	18,000	-	-	-	-	222	136,210
Interest (Expense)	(32,996)	(19,892)	(33,218)	(35,750)	(19,691)	(19,691)	(19,691)	(19,691)	(19,691)	(19,691)	(19,691)	(19,691)	(279,385)
Other Non Operating (Expense)	(222)	-	-	500	500	500	500	500	500	500	500	500	4,278
Total Non Operating Income	**61,149**	**67,743**	**63,521**	**56,631**	**68,870**	**68,870**	**68,870**	**50,870**	**50,870**	**50,870**	**50,870**	**51,092**	**710,227**
Net Income (Loss)	**240,864**	**(120,425)**	**(149,776)**	**986,436**	**740,364**	**915,138**	**260,283**	**372,218**	**450,728**	**555,045**	**(68,389)**	**275,096**	**4,457,583**
Operating Margin	*3.40%*	*-3.91%*	*-4.31%*	*24.69%*	*18.83%*	*21.39%*	*4.39%*	*6.56%*	*9.26%*	*10.71%*	*-2.47%*	*4.36%*	*6.87%*
Total Margin	*4.51%*	*-2.48%*	*-2.98%*	*16.37%*	*14.37%*	*16.50%*	*5.16%*	*6.98%*	*8.26%*	*9.72%*	*-1.39%*	*5.19%*	*7.00%*

Attachment N

Organization	Purpose	Award	Received	Outstanding Amt	ETA	Date Rec'd	Repayment	Funding Type	Other Notes
Greater Columbia Accountability of Health	Telehealth Application Funding for relief during the COVID19 crisis	$ 6,000	$ 6,000	$ -	*April 2020*	4/3/2020	$ -	EFT	Alana and Kevin applied for receipt
HHS	Stimulus Payment	$ 760,801	$ 760,801	$ -	*April 2020*	4/10/2020	$ -	EFT	Attestation completed within 30 days of funds received (completed 4/17/2020)
HHS	Stimulus Payment	$ 271,197	$ 271,197	$ -	*April 2020*	4/24/2020	$ -	EFT	Attestation completed within 30 days of funds received (completed 4/27/2020)
CMS Medicare Advanced Benefits	Advance of Medicare Payments	$ 6,596,297	$ 6,596,297	$ -	*April 2020*	4/21/2020	$ (6,596,297)	EFT	Three months worth of Medicare payments advanced to PMH. Due to be repaid in November 2020 with zero forgiveness
US Bank SBA Payroll Protection Program Loan (PPPL)	Payroll Protection Forgiveness Loan	$ 6,350,235	$ 6,350,235	$ -	*May 2020*			EFT	Original submission amount $5,951,625 but based on US Bank calculator actual submission amount was higher (employer paid taxes accounted for post 100K salary cap); 15 documents submitted 4/21 as requested most recently
HRSA (WA DOH)	SHIP	$ 90,000		$ 90,000	*May 2020*		$ -	CHECK	1. Other than confirming your hospital list from the FY 2020 NCC, we (HRSA) will not need any application information up front. There will be follow up information requested as a condition on your award and quarterly reporting requirements for the hospitals receiving SHIP COVID-19 funds.
WSHA	ASPR PPE purchase from WSHA	$ 20,000		$ 20,000	*May 2020*		$ -	CHECK	2. HRSA will issue NoA for the SHIP COVID-19 funds within 2-4 weeks. Paid $8,254 for delivered WSHA PPE 4/16/2020
HHS	CARES Provider Relief Fund - Rural Allocation	$ 4,170,732	$ 4,170,732	$ -	*May 2020*		$ -	EFT	Each CAH will receive at least $1,000,000 with the average CAH/Rural Hospital to receive $4,000,000 and each Rural Health Clinic to receive at least $100,000 with the average to be about $160,000. We received $4,170,732. NARHC.ORG (National Association of Rural Health Clinics)
US Bank SBA Economic Injury Disaster Loan (EIDL)	Payroll Protection Forgiveness Loan	$ 10,000	$ 10,000	$ -	*May 2020*		$ -	EFT	US Bank SBA grant deposited into our account.
				$ -					
				$ -					
				$ -					
				$ -					
				$ -					
				$ -					
				$ -					
	Totals	$ 18,275,263	$ 18,165,263	$ 110,000			$ (6,596,297)		

Attachment O

PROSSER MEMORIAL HOSPTIAL 2019-2020 PRACTICE TRANSFORMATION GRANT DASHBOARD

Last revised 5/2020 mf

PRACTICE TRANSFORMATION GRANT Cohort 1-Year 2

Greater Columbia Accountable Community of Health (GCACH)

- GCACH is a regional coalition consisting of representatives from a variety of sectors, working together to improve population health.
- GCACH covers nine counties in Southeast Washington and 710,000 lives.
- Approximately 248,078 or 35% of these residents receive Medicaid benefits; 54% are children.
- Patient-Centered Medical Home (PCMH) is the foundation for the GCACH's Transformation efforts, with the goal of:

1. Better Patient Care;
2. Improved population health;
3. Lower healthcare costs.

Medicaid Transformation Project (MPT

- The MTP is a five-year agreement with the CMS that provides up to $1.5 billion of investments in local health systems to benefit Medicaid clients.
- The project is led by nine Accountable Communities of Health of which the GCACH is one.
- Prosser Memorial Health is a participating organization in this project as part of the GCACH coalition.

Practice Centered Medical Home Transformation (PCMH):

- The PCMH is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.
- This Practice Transformation project will utilize 8 milestones to help Prosser Memorial Health transform into an effective Practice Centered Medical Home.
- This project is well aligned with our mission to "Improve the health of our community."

Milestone 1: Budget	
Staffing-$50,000	• PCC-Practice Transformation Facilitator 0.5FTE added to the Care Transitions Team; • Wages related to education/meeting participation of other staff;
Quality Improvement-$84,000	• Education hours for front line care givers enhancing care and education to high risk patient populations; • Supplies and educational aids for patient education;
Community Integrating Software-$15,454	• Implementation and fee for CPP/Community Software.
Total: $149,454	

Milestone 2: Access and Continuity	Goal	Data Source/Responsibility
2A.1.a Empanelment Status	NA	Empanelment refers to the number of patients assigned to a care team. This does not apply to the hospital patients.
2A.1.6 Empanelment Status Year 2	NA	

PROSSER MEMORIAL HOSPTIAL 2019-2020 PRACTICE TRANSFORMATION GRANT DASHBOARD

Last revised 5/2020 mf

2A.2a Risk Stratification Methodology Types:		
Number of ED Visits	100% EDIE	EDIE System-Sasha Thomasson
Number of Hospitalizations	100% 30 Day unintended readmissions	Concurrent Case Management Review/Epic Report-Tonya Thompson-Speights
Congestive Heart Failure Admissions	100% Inpatient admissions	Concurrent Case Management/Epic Report-Jill Pagel
Sepsis Admissions/Transfer	100% Admissions/Transfer	Concurrent Case Management/Epic Report-Christi Doornink/Sasha Thomasson
Pneumonia Admissions	100% Admissions	Concurrent Case Management/Epic Report-Tonya Thompson-Speights/Marla Davis
Maternal/Newborn Discharges	100% Discharges	Delivery Log-Cindy Raymond

Narrative:

Prosser Memorial Health has expanded and refined our risk stratification process, with the addition of pneumonia, congestive heart failure, and maternal/newborn discharges. Thirty-day readmissions, high ED utilization patients and sepsis admissions continue to be the top three risk stratified population targets.

Patients are identified using the EHR reporting system. All re-admission within 30 days are considered the highest stratum. These patients meet with social series and case management prior to discharge to help ensure a successful discharge plan. Each case is subsequently reviewed by the Medical Staff Quality Assurance Committee to identify any missed opportunities to avoid readmission after the first discharge.

Number of ED visits represented by 4 or more visits in a 12-month period is identified using the EDIE report. These patients represent the second highest risk stratum, as these patients, who for various reasons have not been successfully managed in the outpatient setting. The EDIE program allows for identification at the time of ED presentation providing the ED provider with the patient's history and plan of care customized for that specific patient. This information is utilized to develop an ED discharge plan and follow-up care. Subsequent to the visit social services reviews these patients for opportunities and resources to extend to the patient.

Patients with admitted to the hospital sepsis, pneumonia, or congestive heart failure represent opportunities to improve outcomes with active management and partnership with the patient and family. Management of these patient populations begins on presentation to the ED, with the implementation of evidence-based practice guidelines for ensuring timely care to reduce mortality and morbidity of these deadly disease process'. Patients are managed through admission and discharged with a follow up plan which directs them back to their PCP for health management.

2A.2.b Risk Stratification Statistics:	Goal	Q1	Q2	Q3	Q4	Total	Care Management Strategies
30-day Unintended Readmissions	95%	100% 8/8				100%	
ED utilization by EDIE patients	95%	100% 354				100%	
Sepsis Admissions/Transfers	95%	100% 5/5				100%	
Pneumonia	95%	100% 5/5				100%	

Congestive Heart Failure	95%	NA 0/0				NA	
Maternal-Newborn Discharges	95%	100% 102/102				100%	

2A.3.1 Opportunities for those at Highest Risk:

Planned care for chronic conditions and preventative care-conducting a daily team-based huddle: A daily interdisciplinary team huddle is conducted M-F at 0930. The team includes the hospitalist, RN, Case Manager, Social Service, and pharmacist. Additional members may include dietician, physical therapist, occupational therapist, speech therapist, respiratory therapist, and/or community paramedic. A similar discharge planning team is assembled to assess and plan for Swing bed patients every other week. Tonya Thompson-Speights

Panned care for chronic conditions and preventative care- Use a personalized plan of care for each patient: A personalized care plan is developed and completed for every admission regardless of diagnosis. Marla Davis

Risk-Stratified Care Management-Manage care across transitions: All patients receive a customized discharge plan which includes post discharge follow up with the next provider of care. Patients who do not have a PCP or need specialty care post discharge have appointments and/or referrals set up prior to discharge. Marla Davis/Cindy Raymond/Sasha Thomasson

Patient and Caregiver Engagement-Involve patient and family in decision making in all aspects of care: Providers (hospitalist, Surgeon, Obstetrician, or Pediatrician) meet with the patient and family for care planning. When needed Social Services will reach out to family members or set up a care conference with the physician. Our Care Transitions team (Case Management and Social Services) help facilitate the needs and preferences of the patient and family. Jill Page

2A.3.2 Care management activities being utilized:

Patient couching: Patient couching is utilized by our Patient Care Facilitator as indicated for EDIE follow up. It is also utilized by speech, physical, occupational, and/or dietary therapy services when indicated to support the patient's recovery goals. Sasha Thomasson

Education: All RN and RT staff provide and document patient education. Marla Davis/Cindy Raymond

Care Plan Development: For hospitalized patients care planning is facilitated by the RN assigned to the patient and documented in the Epic patient record. Additions are made by all disciplines provided care as appropriate. EDIE care plans are documented in the ED system. Marla Davis/Cindy Raymond/Sasha Thomasson

Home Visits: Home visits are made by the Community Paramedics based on a patient or nurse referral. Most visits are initiated post-inpatient admission but may occur due to a referral by a clinic or ED provider. When helpful, other disciplines will visit join the paramedic on the home visit to provide education or assessment. Jeff Fitzgerald/Bryan Scheer

Post-discharge contact: Discharge phone calls are attempted on all discharges from the Family Birthplace, Acute Care, Swing Bed Program, Outpatient Surgical Services, and the Emergency Department. These calls are documented in the Epic patient record and follow up needs are addressed as identified. Every attempt is made to ensure patients have a next provider of care for follow-up (either an appointment is made, or a referral is provided). Marla Davis/Cindy Raymond, Christi Doornink-Osborn, Sara Dawson, Sasha Thomasson

Childbirth Education Classes: Childbirth classes are provided free of charge in both English and Spanish. This is a one day class held on a Saturday. Cindy Raymond

PROSSER MEMORIAL HOSPTIAL 2019-2020 PRACTICE TRANSFORMATION GRANT DASHBOARD

2A.3.3 Care Providers-hospital based	Goal	Q1	Q2	Q3	Q4	
APRN/NP	0	0				
Medical Assistant	4	4				1-AC; 1-FBP;2-ED
Physician	10	10				3-Hospitalists; 7-ED Providers
Physician Assistant	0	0				
Registered Nurse	25	8				2-ED; 2-FBP; 2-OR; 2 Care Transitions
Health Educator	1	1				Jill Pagel
Behavioral Health Specialist	0	0				
Community Paramedic	6	6				Paramedics completing home visits

Narrative:

2B.1 Bi-Directional Integration of Behavioral Health:

2B.1.1 Health integration model:

- Co-Location of Primary Care and Behavioral Health: An ARNP speciating in mental health is available at each PMH family practice clinic.
- Other form of integration-MHP evaluation on Discharge: Comprehensive Mental Health has a MHP on duty 24/7 who is available to provide emergency mental health evaluations and referrals. All patients identified at risk for suicide have a MHP evaluation and a follow up plan established prior to discharge from either an inpatient unit or the Emergency department.

2B.1.2 Evidence-based instrument or tool to systematically assess patients and monitor or adjust care:

- Patient Health Questionnaire for Depression (PHQ-2/PHQ-9) Marla Davis/Christi Doornink-Osborn
- Post-partum depression screening Cindy Raymond

2B.1.3 Screening	Goal	Q1	Q2	Q3	Q4	Total	
(PHQ-2/PHQ-9)	90%	UTD					Embedded in Epic admit assessment
Edinburgh Postnatal Depression Scale	90%	UTD					Included in the FBP discharge education book

2B.1.4 How are behavioral health services organized and who provides the service?

- Screening (Physician & RN):
- Evaluation/diagnosis (Physician/Community MHP):
- Referral Coordination: (RN/Contracted Resource/Social Service)

2B.1.5 Which assessment of behavioral health integration have we used to assess our practice?

- Patient Centered Medical Home Assessment (See attachment)

2B.1.6 How are patients in need of integrated behavioral health services identified?

- Positive Screen:
- Presence of specific diagnosis: (Depression & Suicidal Ideation)
- Patients requesting help.

2B.1.7 Narrative identifying how many patients are currently receiving integrated behavioral health services and being tracked in your EHR or standalone registry:

2B.1.8 Evidence-based instrument or screening tools used to systematically assess patient and monitor or adjust care:
- Depression (PHQ-2/PHQ-9)-RN-identify need for care
- Cognitive function testing-Speech Therapy-Identify need for care & Engage patients in the need for care:

2B.1.9 Evidence-based practice for medication management if appropriate
- Patients referrals to outpatient clinics after ED visits or inpatient admission.

2B.1.10 How and when does the practice do systematic case review and consultation, and outreach to patients who have dropped treatment?
- Weekly:

2B.1.11 Who is on the review team: Jill Pagel/Sasha Thomasson/Marla Davis/Cindy Raymond
- Patient Care Coordinator-RN
- Social Services-Patient Educator
- Physician-ED, inpatient, or clinic providers as indicated based on patient need.

2B.1.12 Identification and outreach to patients lost to follow-up: Jill Pagel/Sasha Thomasson
- Patient Care Coordinator-RN
- Social Services-Patient Educator

2B.1.13 Follow up via phone call or mailed letter: (Not applicable to this care setting).

2B.1.14 Who does outreach?
- Patient Care Coordinator-RN Sasha Thomasson
- Social Services-Patient Educator Jill Pagel

2B.1.15 What measures will you use to assess the integration of behavioral health and the impact of behavioral health services on your patient population? These might be measures of integration such as percentage of patients with a diagnosis of depression who are managed within the practice, key process measures such as percentage of patients with follow up within two weeks of initiating treatment, or measures of effective management, such as percentage of patients with depression who show improvement in scores on PHQ 9 over a specific period of time. (These are examples only and the identification of useful and effective measures for your practice will be a topic of the learning community.):

Hospital: Currently a monthly review of all patients presenting for suicidal ideation is completed to ensure an appropriate mental health/safety plan was establish prior to discharge. In Q4 we expanded the assessment of patients flagged on the EDIE report. We have an RN who is evaluating the treatment plan and patient compliance. The RN will either reach out to the patient and or their therapist when patient appears to be struggling with the outpatient treatment plan.

2B.1.16 Report showing integration of bi-directional care for narrative: **Need to develop**

2B.1.17 How have we increased our practice capacity to implement this program in the past quarter (MAT training, identification of MAT referral, or Opioid Resource Network (ORN) is mandatory: **Need to develop**

2B2.1a Self-management Support:
- The practice develops and maintains formal and informal linkages to external resources to support self-management

PROSSER MEMORIAL HOSPTIAL 2019-2020 PRACTICE TRANSFORMATION GRANT DASHBOARD Last revised 5/2020 mf

2B2.1b Narrative:

The practice develops and maintains formal and informal linkages to external linkages to external resources to support self-management which include the following: PMH Clinic Network, PMH Social Services, Post-Discharge phone follow-up Calls; Community Paramedic Pgm; EDIE; Consistent Care Svcs-ED Care Coordination Agreement; DSHS; Aging & Long Term Care; Home Health; Hospice; Residential Facilities (Assisted Living, Nursing Home, Adult Family Homes); Diabetes Education Center (Astria Sunnyside and Kadlec)

2B2.2 High risk areas that re a focus for self-management support; # patients with that condition; what triggers self-management support

- ED Utilization/EDIE Patients: 354 patients; visit to the ED
- 30 Day un-intended readmission: Approximately 2.5% of inpatient admissions; unintended admission
- Maternal-Newborn Care: Approximately 436/year; Maternal-Newborn Discharge

2B2.3 Care management for disease specific conditions completed outside of evaluation and management visits:

Hospital Admissions:	Goal	Q1	Q2	Q3	Q4	Total	
Post-Discharge phone calls	10%	156					RN; MA; Pt. Educator
Community Paramedic Visits	10%	96					Paramedic
Community Paramedic Phone Follow-up	10%	NA					Paramedic
ED Visits:	**Goal**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	
Post-Discharge phone calls	10%	1029					RN; MA
EDIE specific follow up	10%	354					RN-Patient Care Coordinator
Consistent Care Referrals	10%	1					Contract Referral

2B2.4 What cross condition strategies are used to support self-management and who uses them: **Need to expand**

- Between visit couching: (RN-Patient Care Coordinator, Social Services/Health Educator)
- Goal setting and action plan development: (RN-Patient Care Coordinator, Social Services/Health Educator)
- Goal setting and care/plan development documented in the EHR: (RN, Therapy Services, Dieticians, Social Services/Health Educator, Respiratory Therapy, Pharmacy)

2B2.5 What approach are we using to assist patients in assessing their need for support for self-management:

- In planning **Need to develop**

2B2.6 What evidence-based counseling approaches are being used for self-management support:

- Teach Back: Not yet implemented. Training sessions had to be rescheduled due to COVID-19 reallocation of resources. We will be providing education via a team meeting platform by the end of Q2. (Jill Pagel)

2B2.7 What specific self-management tools are you using and who on the team uses this tool? These can range from simple worksheets to help patients identify their agenda for a visit to web-based tools for the development of a shared care plan. List self-management tools you are using. For each tool listed, identify who on the team uses this tool:

- After Visit Summary (AVS): (RN)
- Understanding Mother & Baby Care (A guide to the first days and weeks): (RN)

2B2.8 What community-based resources do you make available to your patients for support for self-management and how do you link patients to this resource? Identify three to five community-based resources. List community-based resources you make available to your patients. For each community-based resource, indicate how the link between the patient and the resource is made. Select one per resource:

- Comprehensive Mental Health (Mental Health Services): Formal referral without feedback
- Maternal -Child Support Services: Formal referral without feedback
- Tri-Cities Home Health: Formal referral without feedback (feedback goes to PCP)
- Astria Home Health of Sunnyside: Formal referral without feedback (feedback goes to PCP)
- Consistent Care Services: Formal referral with feedback

2B2.9 How have you added to your practice capacity for support of self-management in the past quarter? Need to expand

- Training: The Family Birthplace Staff all received education on providing patient education, discharge follow-up, and post-partum depression screening.

2B2.10 What measures are you using to track the impact of support for self-management on care processes, health outcomes or costs for the conditions that you identified? Note that these can be the same measures tracked in Milestone 5.

2B2.11 Upload report showing the impact of self-management support based on the measures selected in Question 10. (This is mandatory):

2B2.12 What new capacity has been developed in your practice this quarter in the provision of support of self-management: Need to expand

- Revised the post-discharge phone call process in the ED, AC, Swing, and FBP to ensure more effective patient interaction and interdisciplinary communication.

2B.3.a Medication Management

2B.3.a.1 Choose one of the following that indicates how your practice accomplishes medication management and review:

- Option A: The practice has integrated a clinical pharmacist or pharmacist as a part of the care team. Lindsay Mckie

2B.3.a.2 Narrative:

- We have an onsite pharmacist 40 hours a week with 24/7 access to tele-pharmacy support as well.
- The onsite pharmacist reviews all inpatient medical records for the following:
  1. Medication reconciliation is completed at admission and discharge.
  2. Laboratory values that support medication management.
- Identifies patients high risk patients needing medication management (MORO, Kidney Failure, Multidrug use, failed outpatient therapy, etc.)
- The pharmacist is an active participant in daily interdisciplinary rounds, providing recommendations and guidance as appropriate. Also participates in weekly Swing Bed (Rehabilitative) case management interdisciplinary rounds.
- The pharmacist has oversite of the hospital's medication safety program, and a rigorous quality assurance process is in place. This process includes identification, investigation, and corrective action planning for all mediation errors and/or medication related adverse events. This work is reported not less than quarterly to the Pharmacy & Therapeutics Committee and the Joint Conference Committee (Medical Staff, Board, & Administration).
- MAT trained clinicians are available in the area through community partners such as Comprehensive Health, but our organization is attempting to add a MAT provider within the year and an additional 2 within 3 years.
- Our hospital and providers participate in the Washington State Department of Health Prescription Monitoring Program.

2B.3.a.2a Comprehensive medication management services do we provide: Need to improve

Lindsay Mckie/Cindy Raymond/Sara Dawson/Marla Davis/Christi Doornink-Osborn

- Medication reconciliation:
- Coordination of medications across transitions of care setting and providers:
- Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
- Provider use of other guidelines for prescribing opioids: Pain management specialist referral
- Referral to MAT referrals

2B.3.a2b Narrative:

- Medication Reconciliation is completed on admission, discharge, and at each transition of care within an admission.
- Coordination of medications across transitions of care settings and providers is facilitated via the EMR EPIC which is accessible by our organization's clinic system and two of our major referral sources. We are able to fax medication history via the EMR to providers with other systems. Patients are provided a printed medication list at discharge, as well as provided access to an electronic patient portal which updates with each patient encounter to our system.
- Key Clinical decision support features for opioid prescribing guidelines: Our hospital providers follow the WADOB Opioid prescribing guidelines.
- Referrals to MAT: MAT trained clinicians are available in the area through community partners such as Comprehensive Health, but our organization is attempting to add a MAT provider within the year and an additional 2 within 3 years.

2B.3.a.3 How does your practice engage pharmacists as part of the care team? (i.e. collaborated, integrated, contractual, tele-pharmacy):

- Direct hire

2B.3. a.4How many hours per week is the pharmacist engaged for coordination of care of medication management?

- 40 hours a week we have on onsite pharmacist assisting with medication management. We have the availability to request pharmacy assistance after hours by request.

2B.3. a.5 How does the pharmacist on our team engage in patient care? **Need to expand** Lindsay Mckie

- Medication review and recommendations in the EHR
- Pre-appointment review and planning without the patient present (OSP patients)
- Daily interdisciplinary team meetings.

2B.3. a. 6 How are patients selected for medication management services beyond routine medication reconciliation? Lindsay Mckie
Need to expand and create tracking mechanism

- Patients who have not achieved a therapeutic goal for a chronic condition: CHF; 30-day readmissions if applicable
- High risk medications
- Complex medication regimens

2B.3. a.7Collaborative Drug Therapy Management is contracted or staffed pharmacists? Lindsay Mckie

- No: intend to do this but have not yet started

2B.3. a.8a Does your practice target care transitions for comprehensive medication management services? Lindsay Mckie

- No, In planning

2B.3. a.8b If you answered 'Yes' to 8.a. above, who receives these services?

- NA

2B.3. a.9 What process measures does you practice use to improve medication effectiveness and safety: Lindsay Mckie/Kristie Mellema/Merry Fuller

- Tracking and trending of medication errors.
- Retro quality review of Medication Reconciliation.
- Narcan use as an opioid reversal agent.
- Warfin with INR above therapeutic levels
- Hypoglycemic events after insulin administration.

Milestone 3 24/7 Access by Patients and Enhanced Access

3A.1 Please confirm that your practice's patients continue to have 24 hour/7 days a week access to a care team practitioner who has real-time access to their E.H.R.:

- Yes

3A.2 Please tell us how your practice is providing enhanced patient access (Care provided to patients outside of visits):

- Patient portal
- Lactation support is available by phone or visit.

3A.3 Please report the third next available appointment for the following types:

- Acute Visits-Immediate in the ED/OB
- Adult Well-visits-NA
- Well-child visits-NA
- New Patient Visits-Immediate in the ED/OB

3A.4 On average about how many hours per week does staff spend providing care outside of visits?

	#	Q1	Q2	Q3	Q4	Total	
Physician	8	14hr					Review of post discharge diagnostics and revised treatment plan (ED)
RN	8	17hr					Follow up calls to provide post discharge diagnostic and revised treatment plan. (ED/OR); EDIE FU
LPN	3	0					
MA	6	5					Follow up calls to provide post discharge diagnostics and revised treatment plan. (ED)
Health Educator	0	0					
Behavioral Health Professional	0	0					
Administrative	6	0					
Pharmacist	1	0					
Community Paramedic Program	8	10					CPP visits and phone calls
Social Worker	1	10					Post discharge follow up and problem solving.

3A.5 What workforce training does your organization need to provide patient centered care?

- **Diabetic Educator**

3A.6 Enhanced access or care provided outside of normal hours is a new concept for patients and their families. How does tyour practice communicate enhanced access to patients and families?

- Poster in office/treatment & waiting rooms
- Hand-outs
- Website
- Verbally from staff

Milestone 4 Patient Centered Interactions

4A.1 Conduct a monthly practice-based survey of patients: Merry Fuller

- **How is the survey being conducted:** Patients surveys are completed through a third party vendor, (Professional Research Consultants, Inc.)? CMS guidelines are used for the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) surveys and are completed by phone interview. Those without CMS restrictions are surveyed by phone and email.
- **What population is receiving the survey:** Surveys are used for the following populations: Inpatients from Acute Care and Obstetrics (HCAHPS), Emergency Dept, , Swing Bed.
- **How many surveys were sent out and how many returned:** 234 phone Surveys were completed this quarter (No mail survey for the hospital population).
- **QI initiatives implemented as a result of PFAC and/or practice-based survey:**
  Our 2020 Strategic Plan includes the following initiatives based on patient feedback:
  1. Enhancing the practice of compassion amongst all those providing care.
  2. Establishing self-registration and increasing pre-registration for planned admissions or outpatient visits.
  3. Improving the accuracy of Medication Reconciliation across the organization, including patient medication education.
  4. Improved post-discharge communication and follow.
  5. Improved quality and efficiency of the hospital discharge process.
  6. Implementation of self-management tools.
  7. Patient/family education on the use of the patient portal (My-chart).
  8. Assess the availability of existing patient transportation options and the feasibility of implementing additional options.
  9. Increase the number of nurse educators.
  10. Improved dietary services.
  11. Identify and implement opportunities to increase patient comfort.
  12. Enhanced language support.
  13. Increase patient rounding to identify and resolve obstacles to care.
  14. Enhance patient flow in the ED.
  15. Assess and implement innovative staffing to ensure the effective staffing in each patient care area.

4A.2 Decision aids being utilized: Jill Pagel, Cindy Raymond, Rusti Wilson, Marla Davis

- Injoy: Understanding Mother and Baby Care, A guide to the first days and weeks
- Smoking: TBA
- CHF: TBA

4A.3 Patients instructed on decision aids	Goal	Q1	Q2	Q3	Q4	Total	
Postpartum Depression	90%	100% 102/102					FBP staff education provided 3/2020
Smoking Cessation	90%	NA					
Management of Heart Failure	90%	NA					

Milestone 5 Reporting Quality Improvement

5A1.1 The organization will attest to operating an internal QI Team that includes organizational clinicians, IT, senior leadership, finance, etc. Kristi Mellema

- Attest Yes: The organization operates an internal QI Team

5A1.2Year 2: Please attest that your organization conducts internal Quality Improvement meetings. These meetings should occure without the Practice Transformation Navigators.

- Attest Yes: The organization conducts internal Quality Improvement meetings (Please note the configuration of these teams changes in Q1 due to COVID-19 response needs and meeting restrictions.

5A2.1 For this milestone, your practice is required to provide a practitioner or care team reports on at least three measures at least quarterly to support improvement in care. In this past quarter, for which quality measures did your practitioner(s) or care team(s) focus their quality improvement activities? Select all that applies: Please provide practitioner or care team reports to your Practice Transformation Navigator: Kristi Mellema/Merry Fuller

- In-patient hospital utilization
- Outpatient ED visits
- All-cause readmission rate
- ED returns with admission or transfer

5A2.2 Your practice should review all CQM's for your entire practice site on a regular basis. Identify how often your practice is reviewing all CPC CQM's for the practice site: Kristi Mellema/Merry Fuller

- Weekly by the Care Transitions Team and ED Director
- Monthly by Practice Transformation Quality Team
- No less than quarterly by Joint Conference Committee (Administration, Medical Staff, Board of Commissioners)

5A2.3 Identify who in your practice does the work of making data from the HER available to guide and inform efforts to improve care and utilization, either on a systematic basis (provider or practice utilization reports) or to answer a specific question that might arise (e.g., "Who are my patients with an A1C greater than 9?").

- Clinical Managers- Cindy Raymond, Rusti Wilson, Marla Davis, Christi Doornink-Osborn, Sara Dawson
- RN-Karla Greene
- Care Transitions Team- Tonya Thompson-Speights/Sasha Thomasson/Jill Pagel
- CNO-Merry Fuller

- CQO-Kristi Mellema
- CIO-Keven Hardiek
- Pharmacist-Lindsay Mckie

5A2.4 Care Team Quality Reports: Merry Fuller

- No less than Quarterly (uploaded the following reports: Patient Care Scorecard; Strategic Plan Scorecard; UR Dashboard; 2019 Strategic Plan; 2020 Strategic Plan)

5A3.1 Actively engage with Practice Transformation Navigator to implement and update the PTIW document throughout the demonstration

- Attest Yes: We actively engaged with our transformation navigator prior to the diversion of resources.

5A3.2 Active engagement with Practice Transformation Navigator monthly:

- Attest No: All resources diverted to COVID-19 response for half of Q1

Milestone 6 Care Coordination

6A1 Please attest that the organization is using Collective Medical?

- Attest No: The organization is not using Collective Medical

6A2 Please attest that your practice is using at least one of the following tools: EDIE, Pre-Manage and/or Direct Secure Messaging?

- Attest Yes: We are using EDIE (Emergency Department Information Exchange) Sasha Thomasson

6A3 Please attest that your organization is using One Health Port: Need to implement Tonya Thompson-Speights

- Attest No: The organization is not using One Health Port

6A4 Build on the following care coordination selections: Sasha Thomasson

- Track the percent (%) of patients with ED visits who received follow-up contact within one week of discharge
- Identify ED patients without PCP and make referral
- Contact at least 75% of patients who were hospitalized in target hospital(s) within 72 hours of discharge
- Identify inpatients patients without PCP and make referral
- Enact care compacts/collaborative agreements with at least two groups of high-volume specialists in different specialties to improve coordination and transitions of care

	Goal	Q1	Q2	Q3	Q4	Total	
# ED patients with no PCP/ # referrals		TBA/TBA					
# Inpatients with no PCO/# referrals		TBA/TBA					
6A4A1	**Goal**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	
# ED patients with D/C phone Calls (Minus EDIE)		39% 1029/2619					Christi Doornink-Osborn
# EDIE patient with D/C phone calls		TBA					Sasha Thomasson

6A4A2 Follow-up contact with patient within one week of ED discharge. On a quarterly basis, identify the methods that your practice uses of obtaining ED discharge information. Select all that apply. (For the hospital, how we communicate ED visits):

- Fax
- Health Information Exchange

- EDIE

6A4B1	Goal	Q1	Q2	Q3	Q4	Total	
# Inpatients AC with D/C phone Calls		101/164					Marla Davis
# Swing Patients with D/C phone Calls		6/9					Jill Pagel
# FBP D/C phone Calls		Combined AC					Cindy Raymond

6A4B2Follow-up contact with patient within one week of Hospital discharge. On a quarterly basis, identify the methods that your practice uses of obtaining ED discharge information. Select all that apply. (For the hospital, how we communicate Hospital visits):

- Fax
- Health Information Exchange
- EDIE

6A4C1 Enter care compacts/agreements with at least two high-referral community partners. Your practice will enact Care Compact and Agreements with at least two groups of high-referral Community Partners and /or Natural Community Partners in different specialties to improve the coordination and transitions of care for your patient population. Merry Fuller

- Comprehensive Mental Health
- Kadlec
- Prosser Memorial Health Clinic Network

Milestone 7 Learning Collaboratives/Trainings/Mentoring

7A1a Participated in at least on learning session/webinar in your region per month: Shared Care Plans, Shared Decision-Making Aids, and Self-Management Tools. Need to assign to team members.

- Our practice site has not yet participated in the mandatory learning collaboratives

7A1b Explanation:

- All resources were reassigned to our COVID-19 response mid-February. We are now able to redirect our attention to these mandatory educational opportunities.

7A2 Contribute a minimum of one document of experiential story spotlighting a success over the year:

- **TBA**

7A3 Fully engage with the GCACH Practice Transformation Team, including by providing regular status information as requested, for the purpose of monitoring progress toward milestone completion and/or for the purpose of providing support to meet the milestones.

- **Ongoing**

7A4a Please attest that member(s) of your QI and/or clinical teams participated in at least four Leadership Council meetings. Please provide names and title of those individuals attending above.

- **TBA**

7A4a1 Names of participants:

- **TBA**

7A4b Attest that at least one provider attends at least four learning collaboratives provided by the GCACH.

- TBA

7A4b1 Name of participants:

- TBA

Milestone 8 Health Information Technology

8A1.1 ONC-certified EHR: Kevin Hardiek

- Attest Yes: We are using an ONC-certified EHR

8A1.2 With which settings are we able to securely exchange patient information: Kevin Hardiek/Andrea Valle

- Acute Care hospital/ED
- Rehabilitation hospital
- Specialty hospital
- Ambulatory Surgery center
- Public health department
- Pharmacy

8A1.3 Meet with the Practice Transformation Navigator to discuss and identify infrastructure and resources required during the Medicaid Transformation period.

- Attest Yes: WE have met with the Practice Transformation Navigator to discuss infrastructure and resource needs.

Attachment P

PMH has received donations from businesses and individuals during the COVID-19 pandemic

Businesses (21)

Ace Hardware
Becky's Coffee
Big Weezy's Barbecue
Castle Catering
Chukar Cherries
Davey's
Dutch Brothers
El Caporal
Farmers Insurance
Grandview Chamber
Jades British Girl
Jeremy's Public House
KD Floral
Mustangs for Mustangs
Pepsi
Prosser FFA
Prosser School District
Sister To Sister
Sunheaven Farms, LLC
TNG Heating & Air Conditioning
The Orchards in Grandview

Individuals (13)

Dr. Sharon Dietrich
Jean Feaster
Mallissa Garcia
Lynne Geddis
Mary Lou Gnoza
Randy & Connie Hecker
Polly McKinney
Kevin Morris
Drew & Meghan Puterbaugh
Barb Sawyer
Tillie Smith
Anjie & Jesse Torres
Carl Wagner

Attachment Q

PMH Staff -

Our whole community is proud of you + what you do! Thank you for protecting us + taking care of us every single day. Hope these masks will help. We love you!

Mustangs for Mustangs

4/26/20

To: Craig Marks, CEO
Dr. Terry Murphy, Chief of Staff

Message: Kudos and Appreciation to you on the April 2020 Home Town Health Issue pertinent to Covid-19. So Glad West Richland was included in your mail-outs. The issue was specific, practical and very well written. It covered all aspects, was highlighted well and easy for anyone to read and implement the guidelines. The attached copy in Spanish was a bonus for many, I'm sure. It was very timely for our area as we have not reached a peak and need to be "on guard" to protect each other, Always!

Thank you for the excellent communication and the time taken to do so inspite of the challenges in care giving at your clinic.

My prayers for your good health and heart felt appreciations for your (all the staff!) dedication and unselfish care provided during this disastrous and challenging time with the Covid 19 virus.

I'm grateful for my healthy, active life style at 83+ yrs but if I was young, younger I'd be right with my fellow nurses caring for those inflicted with the virus.

Blessings to you all!

Elaine Bolley, West Richland

But it's the special people
who help you along the way,
and it's the most
important people
who care enough
to give of themselves
unconditionally.

Thank you
for being one of those
special people.

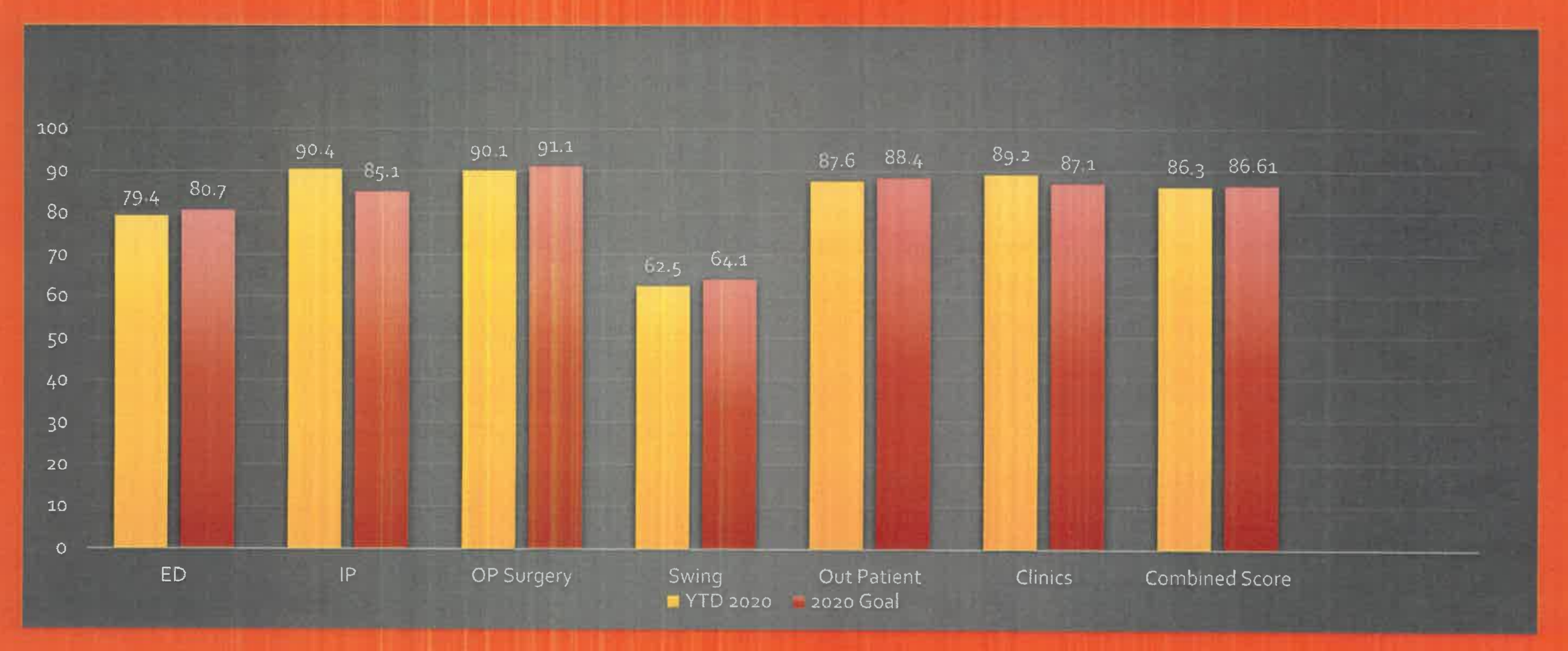
To the medical staff who
helped me during my stay.
Thank you so much!
Special thanks to
Dr. Hashmi
Maryanne R.N.
to Shelly R.N.
and Terri R.T.
who held my hand
when I needed it!!
Stay Safe + God Bless
Jo Coffman

Attachment R

PATIENT SATISFACTION

Prosser Memorial Health April 2020

MF2



INPATIENT COMBINED

GOAL: >85.1%

April 2020-95.7%

Would Recommend

Response	Count
Definitely Yes	22
Probably Yes	1
Probably No	0
Definitely No	0

Target: 20

Legend: Target, Definitely Yes, Other

Q1 2020-90.4%

Would Recommend

Response	Count
Definitely Yes	132
Probably Yes	13
Probably No	1
Definitely No	0

Target: 126

Legend: Target, Definitely Yes, Other

EMERGENCY DEPARTMENT

GOAL: > 80.7%

April 2020-77.4%

Likelihood of Recommending to Friends/Relatives

Excellent	Very Good	Good	Fair	Poor
21	3	6	1	0

Target: 20

Target · Excellent · Other

YTD 2020-79.4%

Likelihood of Recommending to Friends/Relatives

Excellent	Very Good	Good	Fair	Poor
100	35	24	5	6

Target: 108

Target · Excellent · Other

ACUTE CARE

GOAL: >79.7%

April 2020-90%

Would Recommend

	Definitely Yes	Probably Yes	Probably No	Definitely No
Count	9	1	0	0

Target: 9

Legend: Target, Definitely Yes, Other

YTD 2020-86.9%

Would Recommend

	Definitely Yes	Probably Yes	Probably No	Definitely No
Count	73	10	1	0

Target: 72

Legend: Target, Definitely Yes, Other

FAMILY BIRTHPLACE

GOAL: 92.2%

April 2020-100%

Would Recommend

	Definitely Yes	Probably Yes	Probably No	Definitely No
Responses	13	0	0	0
Target	12			

Legend: Target, Definitely Yes, Other

YTD 2020-95.2%

Would Recommend

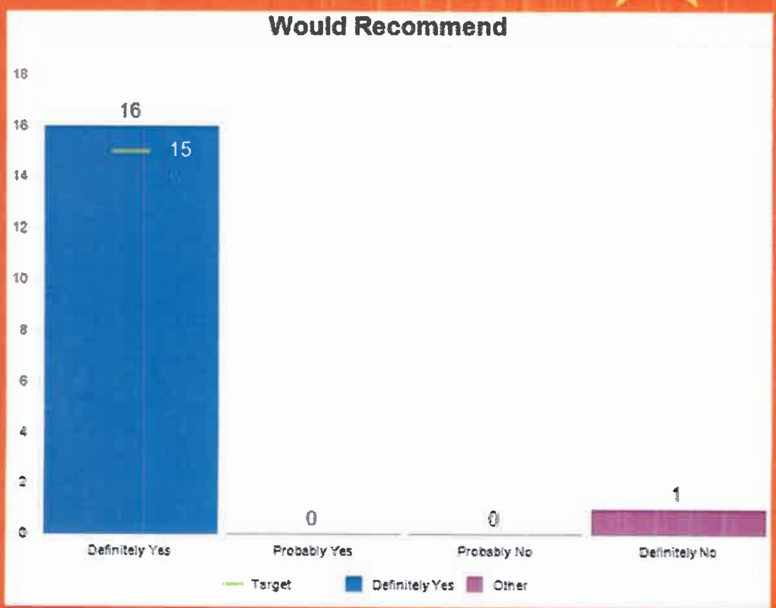
	Definitely Yes	Probably Yes	Probably No	Definitely No
Responses	59	3	0	0
Target	57			

Legend: Target, Definitely Yes, Other

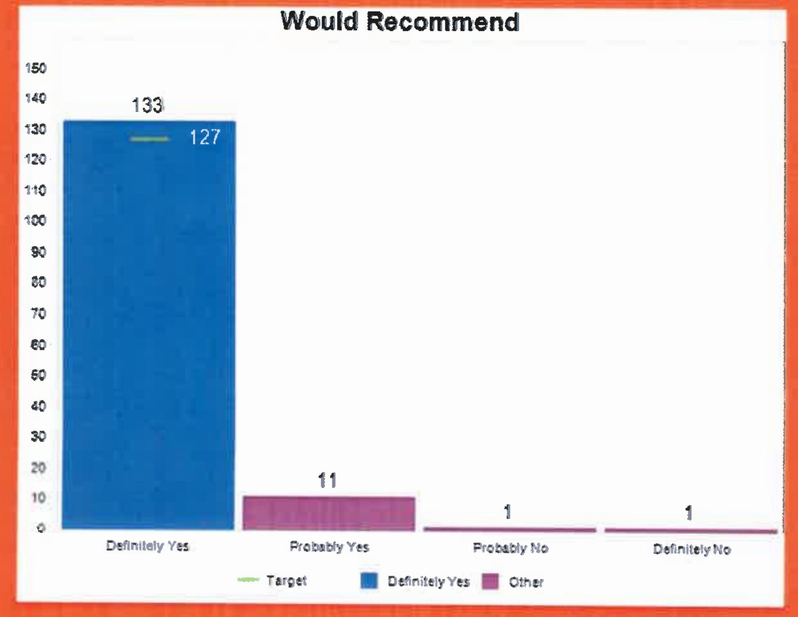
SURGICAL SERVICES

GOAL: >91%

April 2020-94.1%



Q1 2020-90.1%



SWING BED PROGRAM

GOAL: >94.1%

April 2020-0%

Likelihood of Recommending

	Excellent	Very Good	Good	Fair	Poor
Count		0	1	0	0

Target: 1

Legend: Target, Excellent, Other

YTD 2020-62.5%

Likelihood of Recommending

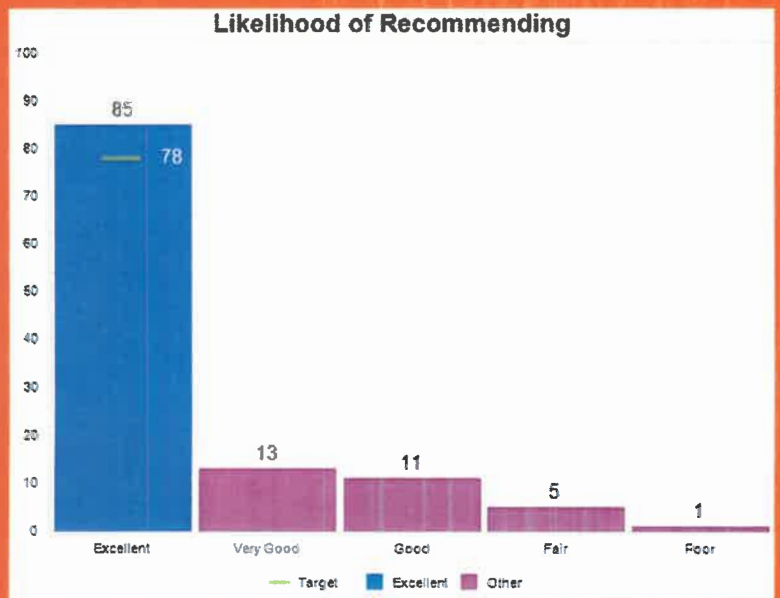
	Excellent	Very Good	Good	Fair	Poor
Count	5	0	1	0	2

Legend: Target, Excellent, Other

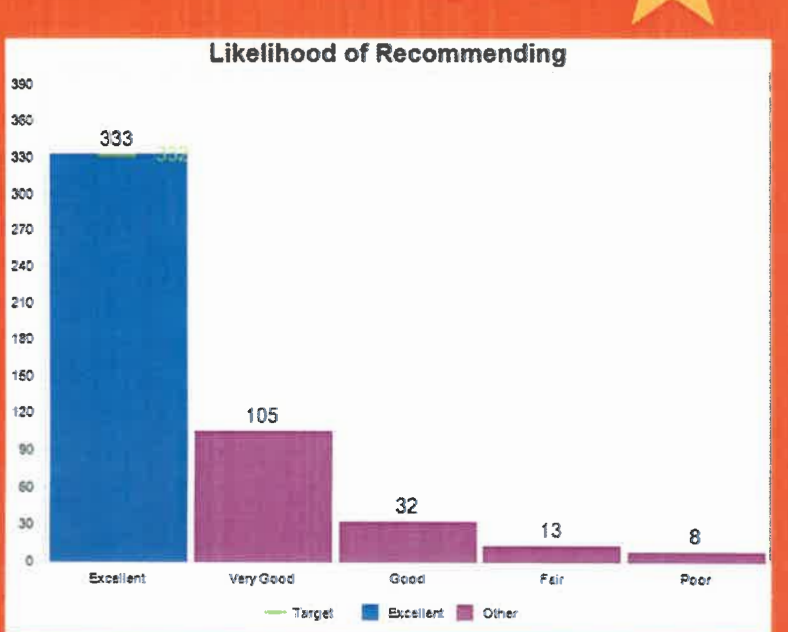
CLINIC ROLL-UP

GOAL: > 87.1%

April 2020-85.2%



YTD 2020-89.2 %



OUT PATIENT SERVICES

GOAL: > 88.4%

April 2020- 85%

Likelihood of Recommending to Friends/Relatives

Rating	Count
Excellent	17
Very Good	1
Good	2
Fair	0
Poor	0

Target: 13

Legend: Target, Excellent, Other

YTD 2020- 87.6%

Likelihood of Recommending to Friends/Relatives

Rating	Count
Excellent	66
Very Good	20
Good	11
Fair	0
Poor	1

Target: 64

Legend: Target, Excellent, Other

Attachment S

2020 HOSPITAL WEEK

This is how we care.

Send your high school picture to Annie Tiemersma by Noon on Friday May 8th. We will collect all pictures submitted and then post on Sharepoint during Hospital Week. Whomever matches the most correct pictures with staff names will win a $50 Visa Gift Card. Second place will receive $25 and 3rd place will receive a $10 gift card to the Busy Bean.

MONDAY, MAY 11

Breakfast: 7:00 AM – 9:00 AM - Department Leaders will deliver breakfast to you based on your order form. (The order forms were emailed to all staff and are posted on Sharepoint)

Parade: Step outside the hospital at 11:00 AM for a little fresh air and community appreciation.

Food Drive: Let's fill up the gift shop with non-perishable food items for our local food banks this week! Drop off your items in the gift shop from 7:00 AM – 3:00 PM. After hours please leave your donations with the house supervisor to put in the gift shop.

May Madness Cornhole Tournament: Find a partner and let Community Relations know your schedule Monday and Tuesday and you'll be assigned a time to play your match in the courtyard area. We will limit the number of games we have going at one time and no additional spectators. Each clinic will receive a PMH Cornhole game and bean bags to participate too! Email your teams and your scores to Shannon Hitchcock at the end of the day. We will use all safety precautions including wiping down the boards and having hand sanitizer available. **Masks will need to be worn while you are playing.**

TUESDAY, MAY 12

Blissful Bites: Donuts are still a go. Busy Bean drinks are free – 1 per employee. Donuts and drinks will be delivered to the Prosser and Grandview Clinics. Blissful Bites will serve at the hospital 7:00am - 9:00am and Benton City Clinic 11:00am - 12:00pm.

Food Drive: Continues for non-perishable canned goods to benefit local food pantries.

May Madness Cornhole Tournament: Tournament continues.

WEDNESDAY, MAY 13

Staff Lunch: Staff Lunch will be provided in individual bento boxes from Jade's. If you have food allergies please let Shannon Hitchcock know by Monday May 11th. Meals will be distributed to the evening shift at 8:00 PM. We hope to distribute your hospital gift at this time too. Fingers crossed our shipping deadline is met!

Food Drive: Continues for non-perishable canned goods to benefit local food pantries.

May Madness Cornhole Tournament: Tournament continues.

THURSDAY, MAY 14

PMH Puzzle Mania: Staff are invited to participate in a timed contest to complete a unique and challenging puzzle. The top 12 finishers will receive PMH Logowear valued at $25.

PMH Foundation Scholarships: Will be awarded outside in the front entrance area of the hospital.

Food Drive: Continues for non-perishable canned goods to benefit local food pantries.

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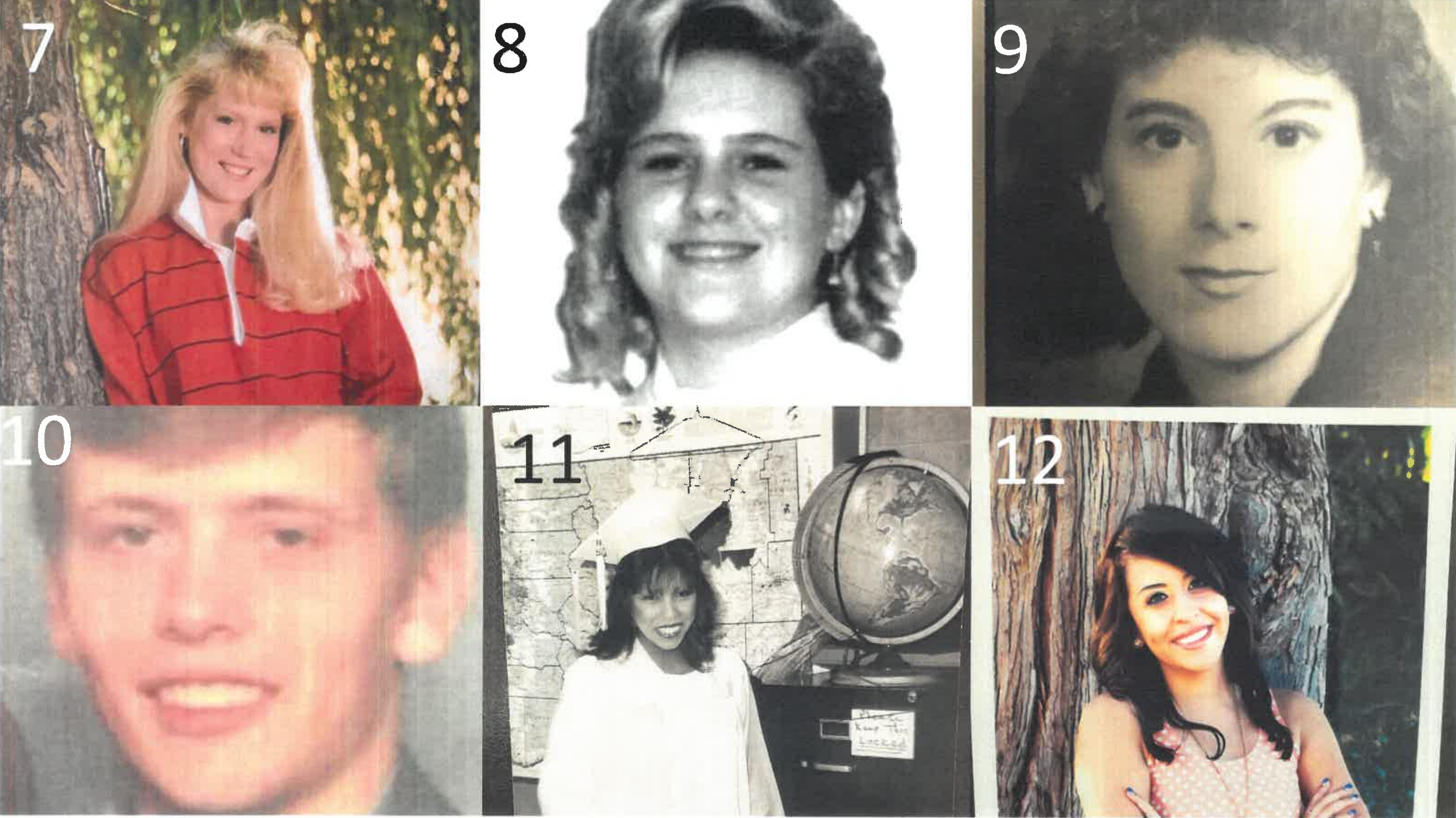
FRIDAY, MAY 15

Ice Cream Social: 12:00 PM – 1:30 PM in the Vineyard. Night Shift – treats will be delivered to your departments. Healthy treat options will also be available.

Foundation Friday and Spirit Day: Wear your PMH logo wear and jeans if you're a donor. Increase your payroll deduction by 5% and receive a short-sleeved Foundation t-shirt just in time for summer!

Attachment T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Senior Photo Game

Answer Key

1. Tonya Thompson-Speights, Care Transition Team.
2. Nora Newhouse, Human Resources.
3. Jeff Fitzjarrald, Emergency Medical Services.
4. Rochelle Kmetz, Human Resources.
5. Marla Davis, Acute Care.
6. Rocky Snider, Human Resources.
7. Sara Dawson, Surgical Services.
8. Dr. Whitaker, Emergency Department.
9. Karolynn Thompson, Patient Financial Services.
10. David Rollins, Administration.
11. Andrea Valle, Health Information Management.
12. Alicia Valle, Patient Registration.
13. Sasha Thomasson, Care Transition Team.
14. Donna Williams, Patient Registration.
15. Jim Schab, Diagnostic Imaging.
16. Merry Fuller, Administration.
17. Crystal Blanco, Human Resources.
18. Lindsay McKie, Pharmacy.
19. Jill Pagel, Care Transition Team.
20. ShaRonda Lewis, Diagnostic Imaging.
21. Marta Meza, Patient Financial Services.
22. Carol Allen, Administration.
23. Kristal Oswalt, Prosser Clinic.
24. Phillip Braem, Information Technology.
25. Molly Schutt, Prosser Clinic.
26. Lynn Smith, Medical Staff.
27. Amanda Hibbs, Diagnostic Imaging.
28. Angela Carey, Pharmacy.
29. Miranda Smith, Diagnostic Imaging.
30. Kristi Tuor, Information Technology.
31. Tricia Hawley, Specialty Clinic.
32. Shannon Hitchcock, Community Relations.
33. Stephanie Titus, Accounting.

34. Annie Tiemersma, Community Relations.

35. Sara Parrazal, Acute Care.

36. Lindsey Schutt, Family Birthplace.

37. Christi Doornink-Osborn, Emergency Department.

38. Craig Marks, Administration.

Senior Photo Bonus Game

Answer Key

1. Gloria Zuniga, Prosser Clinic.

2. Dr. Wenger, Emergency Department.

3. Amanda Schilperoort, Acute Care.

4. Timothy Shipley, Emergency Medical Services.

5. Darla Don, Materials Management.

6. Cassandra Cazares, Acute Care.

7. Dr. Sollers, Women's Health Center.

8. Aurora Weddle, Diagnostic Imaging.

9. Dorien Garcia, Health Information Management.

10. Laura Montanaro, Grandview Clinic.

11. Alex Carballo, Diagnostic Imaging.

12. Meagan Bronkhorst, Materials Management.

13. Nancy Sanchez, Patient Registration.

14. Steve Broussard, Maintenance.

15. Mara Ripplinger, Laboratory.

16. Tasha Sears, Materials Management.

17. Wendy Clapp, Materials Management.

18. Diana Ramirez, Patient Financial Services.

19. Maria Rubalcaba, Patient Financial Services.

20. Casey Hollenbeck, Nursing Administration.

Attachment U

Hospital Week

Cornhole Tournament

Grand Champions: Craig Marks & Kevin Hardiek
2nd Place: Alana Pumphrey & Veronica Reyna
3rd Place: Jim Schab & Joe Fitch
4th Place: David Rollins & Stephanie Titus

Puzzle Mania

Becca Warnick
Carolina Pineda
Diana Wilson
Laura Montanaro
Lourdes Tiatenchi
Maggie Sanchez
Maira Cabanillas
Mara Ripplinger
Mariann Vanguardia
Maricela Rivera
Miranda Smith
Tasha Sears
Wendy Clapp

Senior Photo Game Round One

Carolina Pineda
Dorien Garcia
Jennifer Kernan
Jim Schab
Meagan Bronkhorst
Miranda Smith

Senior Photo Game Bonus Round

Lizbet Razo
Maira Cabanillas
Meagan Bronkhorst
Tasha Sears

Attachment V

National Donut Day

June 5th

In honor of National Donut Day,
Blissful Bites will serve at the hospital from 7:00 am - 9:00 am and Benton City Clinic at 11:00 am - 12:00 pm. Donuts will be delivered to the Grandview Clinic and Prosser Clinics.

This is how we care.

Attachment W

THE PULSE

PROSSER MEMORIAL HEALTH EMPLOYEE NEWSLETTER

MAY 2020

Community Support

On Saturday, April 11, 2020, over 30 cars drove by in a "Thank You First Responders Parade"

Thank you to everyone who donated to first responders and healthcare workers at Davy's Burger Ranch!

Also a big thanks to Grandview community member Kevin Morris and Big Weezy's Barbecue for feeding the hospital and clinic teams lunch and dinner! What an amazing and delicious gift!

Thank you to Superintendent Matt Ellis for sending in the cavalry: Dave Schell and the maintenance department, the building principals, and Prosser School District nurses who marshaled all available Personal Protective Equipment and delivered it to Prosser Memorial Hospital.

Perla Zepeda Farmers Insurance in Sunnyside is treating community heroes (Hospital workers, first responders and law enforcement) with lunch, gift cards and coffee.

Community Support

With barbecue season here, having a working BBQ is a necessity. When Prosser ACE Hardware heard from Jim Schab that PMH's BBQ wasn't in working order they went above and beyond by gifting us a brand new one!

Emergency Department Team

While it's unknown when life will resume to normal Flicka Arquette, Stephanie Honey-Morrow, Silvia Cervantes and Jaron Raymond are finding ways to have fun and smile.

ASPIRE Awards

Our ASPIRE program recognizes team members who demonstrate our core values of Accountability, Service, Promoting Teamwork, Integrity, Respect and Excellence.

Accountability

Service

Promote Teamwork

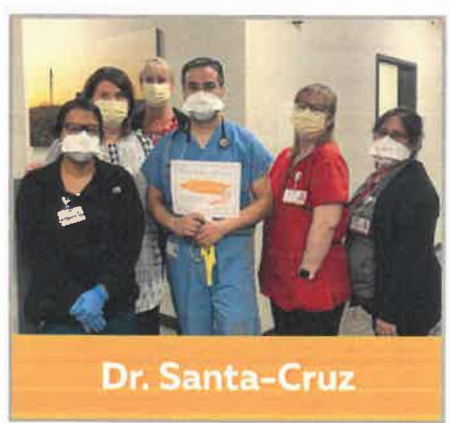
Integrity

Respect

Excellence

Sasha Thomasson

Brian Brindle



Dr. Santa-Cruz

Congratulations to Sasha Thomasson, our Patient Care Coordinator, for receiving a Silver ASPIRE Award! Sasha was recognized for her continued efforts assisting a patient access the resources they need, meeting this patient at doctor's appointments to ensure a continuum of care, and making herself available when other needs arise. Sasha has gone above and beyond helping this patient get the care they need. Thank you Sasha! You're an amazing caregiver and we are so thankful you are part of our PMH family.

We also took a pause out of our "COVID-19 New Normal" day to recognize two outstanding members of the Prosser Memorial Health family. Brian Brindle, Echo Tech-R in our Diagnostic Imaging Department, was recognized by Pediatrician Dr. Carl for coming in on his day off to perform a pediatric echo on a patient. Congratulations Brian for receiving a Gold ASPIRE Award for being there when the team and the patient needed you! We also recognized Dr. Santa-Cruz with a Silver ASPIRE Award. After working a 12 hour day at the Grandview Clinic he stayed after hours for a pregnant patient who was not feeling well. Thank you Dr. Santa-Cruz! Both of you are great role models for living our ASPIRE values!

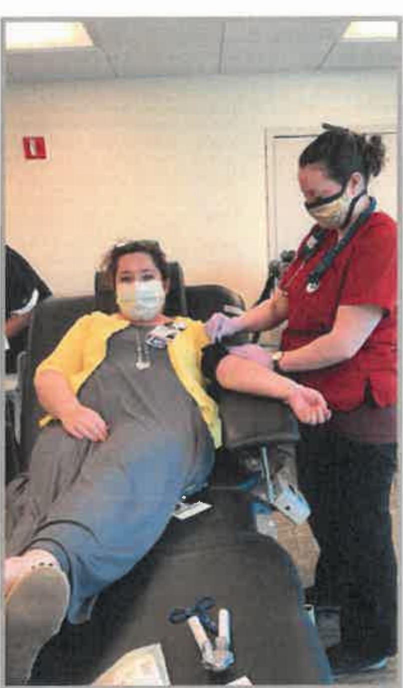
Happy Retirement Francie & Alan!

Francie Poole, Executive Assistant retired! Although we couldn't have a traditional retirement party due to social distancing, Francie's day was made special by each of you who said farewell and decorated a card.

Alan Steen, CRNA, retired after spending 31 years at Prosser Memorial Health. Thank you Alan for serving your patients, staff and out community with exceptional care, passion and dedication. On behalf of your entire PMH family, it has been an honor and a privilege to work with you!

Blood Drive

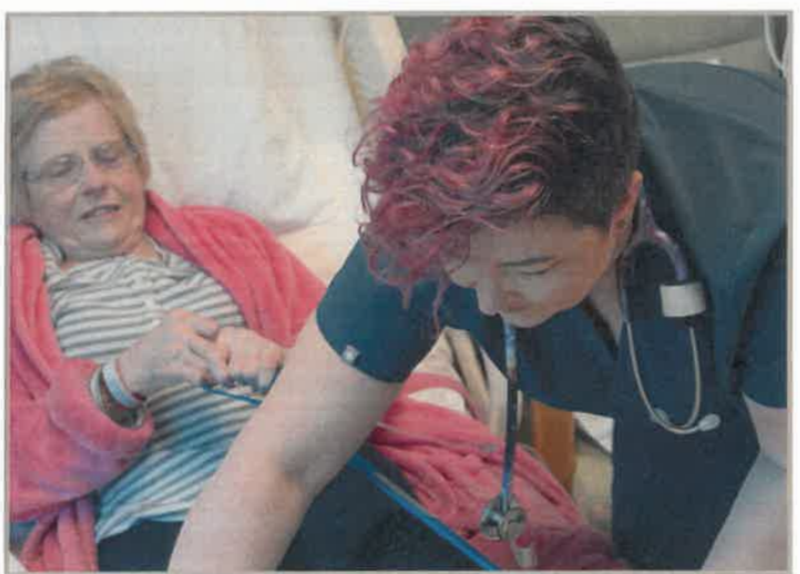
PMH hosted a blood drive for employees in partnership with the Red Cross. Thank you to everyone who donated and supported the Red Cross in this effort. A special shoutout to Sara Dawson, Shannon Hitchcock and Sofie Flores for your help!



Administrative Professional's Day

We unofficially refer to Carol as "Chief Cat Herder" as she masters the task of keeping the Administration Team focused, on time, and responsive. That is no easy task but she does it with patience and grace everyday! Thank you Carol Allen for everything you do! We're so glad you're part of our family.

2020 | Year of the Nurse



2020 has been deemed the Year of the Nurse and is the 200th anniversary of Florence Nightingale's birth. Our team of nurses are dedicated to providing compassionate patient care every day. If you haven't already, view the video of Stephanie Turner our PMH's facebook.

This is how we care.

Prosser Memorial Health, in partnership with the Prosser School District, Thrive Coalition, Boys & Girls Club of Prosser and Comprehensive Mental Health will launch an online mental health initiative for youth in our community May 7, 2020.

Mustangs Matter is an interactive, social media-based platform where teens can talk to local mental healthcare providers like Heather Morse, ARNP at the Prosser Clinic and discuss a variety of different topics facing youth today. Mustangs Matter has an Instagram page with IGT Live to view the discussions in real time and submit questions and comments. The videos will also be available on the Mustangs Matter website: www.mustangsmatter.org. The website also has a number of resources for youth and parents, phone numbers and a dedicated email, mustangsmatter@gmail.com, where someone can reach out directly if they need additional resources or have a concern they would like addressed privately.

National Superhero Day!

In honor of National Superhero Day, the Administration team honored PMH staff by delivering ice cream to departments and clinics.

PMH STAFF

Please remember to schedule your mammograms and to see your primary care doctor.

EMPLOYEE BOTOX DISCOUNTS

Specials valid for the week of May 11 - 15 with Pam Morris and Jessica Luther (by appointment only).

BOTOX®

$10/Unit

(Botox® service is generally 20-25 units per visit)

JUVÉDERM® XC

$450

JUVÉDERM® ULTRA PLUS

$475

2020 HOSPITAL WEEK

MONDAY, MAY 11

Breakfast: 7:00 AM – 9:00 AM - Department Leaders will deliver breakfast to you based on your order form. (The order forms were emailed to all staff and are posted on Sharepoint)
Parade: Step outside the hospital at 11:00 AM for a little fresh air and community appreciation.

Food Drive: Let's fill up the gift shop with non-perishable food items for our local food banks this week! Drop off your items in the gift shop from 7:00 AM – 3:00 PM. After hours please leave your donations with the house supervisor to put in the gift shop.

May Madness Cornhole Tournament: Find a partner and let Community Relations know your schedule Monday and Tuesday and you'll be assigned a time to play your match in the courtyard area. We will limit the number of games we have going at one time and no additional spectators. Each clinic will receive a PMH Cornhole game and bean bags to participate too! Email your teams and your scores to Shannon Hitchcock at the end of the day. We will use all safety precautions including wiping down the boards and having hand sanitizer available. **Masks will need to be worn while you are playing.**

TUESDAY, MAY 12

Blissful Bites: Donuts are still a go. Busy Bean drinks are free – 1 per employee. Donuts and drinks will be delivered to the Prosser and Grandview Clinics. Blissful Bites will be in Benton City at 10:30 AM and drinks will be delivered.

Food Drive: Continues for non-perishable canned goods to benefit local food pantries.
May Madness Cornhole Tournament: Tournament continues.

WEDNESDAY, MAY 13

Staff Lunch: Staff Lunch will be provided in individual bento boxes from Jade's. If you have food allergies please let Shannon Hitchcock know by Monday May 11th. Meals will be distributed to the evening shift at 8:00 PM. We hope to distribute your hospital gift at this time too. Fingers crossed our shipping deadline is met!

Food Drive: Continues for non-perishable canned goods to benefit local food pantries.
May Madness Cornhole Tournament: Tournament continues.

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This is how we care.

Anniversaries

Happy 1 Year

Gabriela Corona
Prosser Clinic CMA

Michaela Capello
Radiology Echo Tech

Happy 2 Years

Bethany Foster
Paramedic

Jaron Raymond
Emergency Department RN

Jazzmine Cruz
Laboratory Assistant

Gena Stephenson
Admitting Patient Registrar

Evelia Galvez
Acute Care Tech

Eileen Lai
EMT

Happy 3 Years

Heather Morse
ARNP

Kevin Hardiek
Director of Information Technology

Happy 4 Years

Justin Herzog
Radiology CT Technologist

Macayla Hunt
Dietary Aide

Happy 5 Years

Juanita Degollado
Dietary Aide

Danielle Palacios
Family Birthplace RN

Liliana Rangel
Emergency Department RN

Neil Taylor
Paramedic

Kimberly Safford
RN Resource Nurse

Happy 6 Years

Peter Park
Patient Care Coordinator

Lynn Smith
Medical Staff Coordinator

Happy 8 Years

Steven Zirker
Benton City Clinic
Physician Assistant

Happy 9 Years

David Stowman
Radiology CT Technologist

Happy 10 Years

Diana Ramirez
Revenue Integrity Analyst

Happy 11 Years

Raquel McGraw
Laboratory QA QC Technologist

Bryan Scheer
Interim EMS Director

Happy 12 Years

Angelita Rojas-Gonzalez
Laundry Worker

Happy 19 Years

David Moon
EMT B2

Happy 20 Years

Jason Raver
Advanced EMT

Birthdays

Christopher Wells
Surgical Services RN

Lindsey Schutt
Family Birthplace RN

Karolynn Thompson
Patient Billing Services Collector

Mariann Vanguardia
Laboratory Microbiologist

Rochelle Kmetz
Chief Human Resources Officer

Heather Calhoon
Outpatient Special Procedures RN

Cathleen Fierro
Family Birthplace RN

Linda Bouchard
Revenue Cycle Director

Dr. Wali Martin
Emergency Department

Selene Chavez
Family Birthplace RN

Lyndsay Oswalt
Benton City Clinic CMA

Hope Ramirez
Benton City Clinic CMA

Joshua Ammann
Paramedic

Jesse Hale Jr.
Laboratory Medical Lab Technician

Paul Weisz
Maintenance Mechanic

Lucia Magana
Prosser General Surgery Center CMA

Laura Sosa
Grandview Clinic CMA

Dr. Min
Prosser Clinic

Kaylee Swan
Patient Billing Services Collector

Irma Mendoza
Grandview Clinic Patient Registrar

Ana Martin
Emergency Department Tech

Bryan Scheer
Interim Director of EMS

ShaRonda Lewis
Diagnostic Imaging Ultrasound Tech

Brittney Balmes
Diagnostic Imaging CT Technologist

Bethany Foster
Paramedic

Kale Guerin
Paramedic

Nina Klewin
Paramedic

Thailee Wright
Prosser General Surgery Center CMA

Robert Roy
Cardiopulmonary Respiratory Therapist

Free 20oz Busy Bean Coffee on your birthday!

Publicity

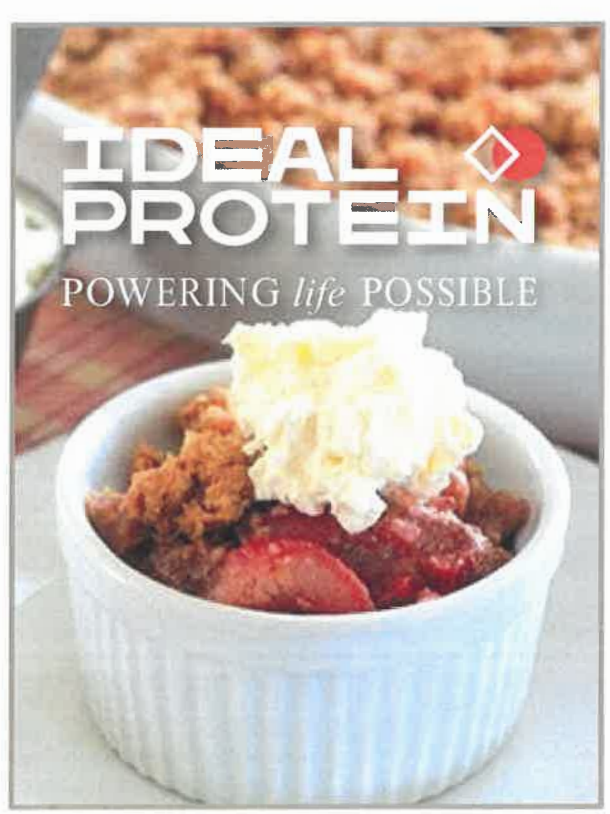
The Yakima Herald-Republic featured an article on how Prosser Memorial Health has responded to COVID-19. The Respiratory/COVID-19 Care Clinic team has done an exceptional job demonstrating excellence and teamwork.

Heather Morse, Psychiatric NP and Pam Morris, ARNP hosted a Facebook Live discussing Mental and Physical Wellness. While it's unknown if life will resume to what it once was, Heather and Pam gave advice on how to cope with the new normal.

The Spokesman Review wrote an article about how Prosser Memorial Health is facing COVID-19.

Access your benefits information by checking SharePoint Benefits and Retirement pages. Contact Nora Newhouse if you have any questions, ext: 6688.

Healthy Rhubarb Crisp



Prep Time: 20 mins
Cook Time: 50 mins
Total Time: 1 hr 10 mins

Crisp Topping

3/4 Cup Almond Flour
1/4 Cup Shredded Coconut Unsweetened
1/4 Cup Chopped Pecans
1/3 Cup Swerve Sweetener
1/2 Tsp Cinnamon
¼ Tsp Salt
5 Tbsp Chilled Butter and Cut into small pieces

Rhubarb Filling

2 pounds chopped rhubarb
1/3 cup powdered Swerve (more if you like it sweeter)

Healthy Rhubarb Crisp
Amount Per Serving
(1 serving = 1/9th of recipe)
Calories: 171
Calories from Fat: 130
% Daily Value*
Fat: 14.4g - 22%
Carbohydrates: 7.7g - 3%
Fiber: 3.5g - 14%
Protein: 3.4g - 7%

Crisp Topping

Preheat the oven to 300F and line a baking sheet with parchment paper.
In a food processor, combine the almond flour, shredded coconut, chopped pecans, sweetener, cinnamon, and salt. Pulse a few times to combine. Sprinkle with the butter pieces and then process until the mixture resembles coarse crumbs.
Spread the mixture on the prepared baking sheet and cover with another piece of parchment. Use a rolling pin or your hands to press down firmly so that the mixture sticks together. Remove the top sheet of paper.
Bake 20 to 30 minutes, or until edges are golden brown. Remove and let cool completely - the mixture will continue to crisp up as it cools.

Rhubarb Filling

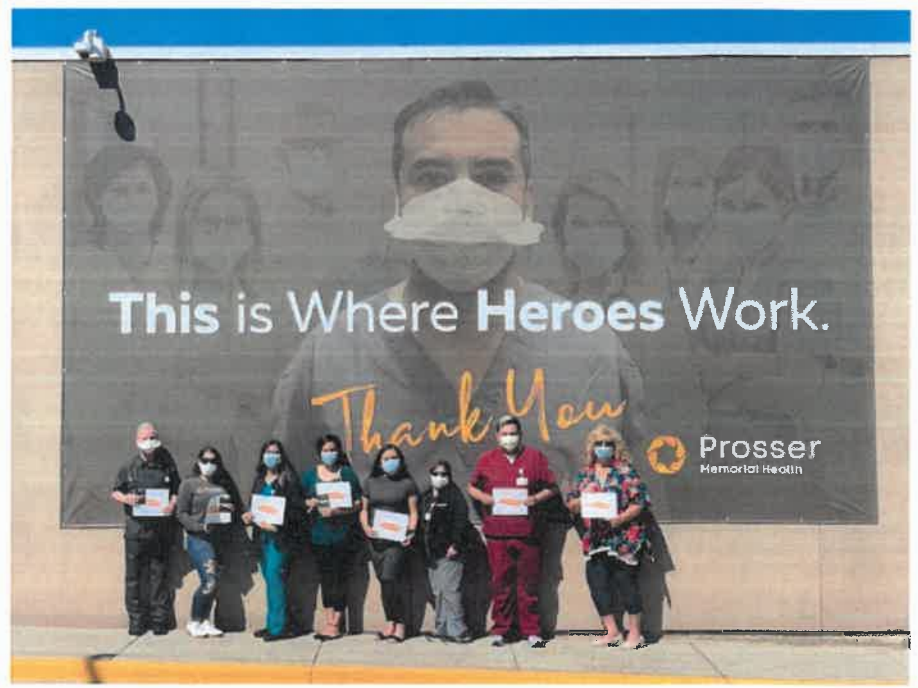
Preheat the oven to 350F. Spread the rhubarb in a 9x13 inch glass or ceramic baking dish and sprinkle with the sweetener. Toss to combine.
Cover tightly with foil and bake 30 to 35 minutes, or until the mixture is bubbling and rhubarb is tender. Remove the filling from oven and remove foil. Break the cooled topping into pieces with your hand and place over filling to cover completely. Serve warm, topped with whipped cream or keto vanilla ice cream.

ProsserHealth.org

Attachment X

Platinum ASPIRE Award Recipients

Left to Right: Dr. O'Connor, Daisy Magana, Claudia Blackburn



Left to Right: Steve Zirker, Gloria Zuniga, Jaqueline Rodriguez, Mireya Aguilar, Monique Saenz, Isabel De La Cruz, Daniel Solis and Pam Morris. Not pictured: Dr. Johansing and Laura Sosa

Attachment Y

UNIFORM PROGRAM

2021

May 18, 2020

Here are six reasons for color-coded uniforms in hospitals:

1. The Patient Experience

The patient's perception of his or her caregivers is affected by the caregiver's appearance, perceived skill and the patient's ability to distinguish between his or her healthcare providers.

Patient satisfaction, which is influenced by the patient's perceptions, is one element of the entire patient experience. Hospitals routinely administer patient satisfaction surveys to outgoing patients. In these surveys, patients often comment on their caregivers' lack of professional appearance, as well as the inability to identify who was in their room. Conversely, organizations that make the change to standardized uniforms report increased patient satisfaction in these areas.

Why do patient perception and patient satisfaction matter? Healthcare is a competitive space. People who have a good experience with their caregivers and their hospital stays overall are more likely to recommend the facility that treated them. More importantly, research shows the patient experience is an indicator of quality and associated with better health outcomes.

2. Patient Safety

Studies show that patients have trouble distinguishing their caregivers when there is no uniform standardization. This presents a safety concern when patients, their families and other caregivers are unable to identify the primary, licensed person responsible for providing accurate and consistent care.

Caregiver identification is of importance in pediatric and labor and delivery units. If an organization employs a clear role-based uniform standard, including embroidered logo, it is much harder for an unwelcome visitor to blend in with, or even impersonate, care providers.

3. Employee Satisfaction

While organizations are discussing plans to color-code, staff commonly express dissent and anxiety over the proposed change. However, once dress codes are in place, even the most skeptical of staff members often experience a change of heart.

Employees see the enhanced atmosphere of professionalism and subsequent improvement in patient perception of the organization. And with the addition of color by discipline, staff enjoy a sense of team unity and pride with their fellow RNs, radiologists or physical therapists, along with easier identification of fellow employees.

"We actually receive comments from employees that they think it looks professional, it was a good decision to make, there's pride in wearing the logoed uniforms and in having the patients know which caregivers are nurses versus techs.

4. Magnet Status

Many hospitals strive for Magnet status awarded by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) which recognizes quality patient care, nursing excellence and innovation. Further, Magnet status is used as criteria in several other hospital rating systems, including Leapfrog Hospital Survey and U.S. News & World Report.

To achieve Magnet status, hospitals must demonstrate nursing best practices, the highest standards of professionalism and exemplary quality of care. Hospitals seeking the designation recognize the need for a standardized uniform program as part of their commitment to excellence. And when hospitals can boast of achieving a "Magnet culture," studies show they excel in the areas of patient care, safety and satisfaction.

5. Medicare and Medicaid Incentives

Patient experience is officially measured by the HACAHPS survey, which includes questions about a patient's communication with nurses and doctors, the cleanliness and quietness of the hospital environment, the patient's overall rating of the hospital and his or her likelihood of recommending the hospital. All of the questions are tied to the patient's perception of his or her care providers and the organization as a whole.

6. Branding

Image matters. A patient's perception of an organization and its brand becomes reality. Magnet status reflects positively on your brand. Professionally dressed staff in standardized uniforms featuring a brand's embroidered logo present a powerful picture of expertise and authority to patients and visitors. Health care is increasingly competitive; how an organization is represented by its employees affects patient satisfaction, patient outcomes and, ultimately, the bottom line.

SUBJECT:	Departmental Uniform & Color Coding	NO:	
☒ Policy ☐ Procedure ☐ Protocol/Pre-Printed Order ☐ Other:			
☒ New ☐ Supersedes # ;		Effective Date	
Author	Rusti Wilson/ Wendy Clapp	Date of Electronic Distribution	
Dept. Manager		Medical Director/ CAH Oversight	
Administrative		Policy Committee	
Committee		Other	

Audit Review:	Initials:						
	Date:						

DRAFT

Policy

Designated departments will wear specific colors in order to assist with patient care delivery and identification of personnel by patients and families.

All employees must dress and maintain a personal appearance that is professionally appropriate for his/her department. Department specific policies will not supersede or contradict the Departmental Uniform & Color Coding policy. Exceptions to the dress requirements caused by individual departmental needs requiring deviation from these standards may be approved by Administration. When an exception is approved, it is put into departmental policy format and reviewed with the HR Director.

Uniform Definition

A **uniform** is a special set of clothes which some people, for example soldiers or the police, wear to work in and which some children wear at school. You can refer to the particular style of clothing which a group of people wear to show they belong to a group or a movement as their **uniform**.

Goal

Create an environment of caring and clinical excellence, making it easier for patients to differentiate one specialty or department from another.

Implementation Timeline

January 1, 2021 (adjustable timeline)

Departmental Uniform & Color Coding

Uniform & Color by Discipline guidelines will be in full compliance. Failure to comply with this policy may result in progressive disciplinary action. Occupations color selection was done by designated job function not location.

Upon hire or during the first year of employment. The allowance funding will be available for designated employees to purchase uniforms from the identified vendor/vendors. Newly hired

employees will need to order their assigned clothing at the beginning of their new hire process to assure they have them by their start date.

Additional uniforms may be ordered from the program vendor/vendors at the employee's expense throughout the year.

An authorized LOGO is optional and paid for by the hospital. If selected it must be embroidered on the upper left side of the top.

No alternate color, trimming, or stitching is allowed. Any color/print shirt, short or long sleeved shirt, and/or athletic sleeves, may be worn under uniform tops.

Note: Departments must carry a supply of uniforms *in their designated color for short term contracted staff to utilize. Long term contracted staff will be required to purchase their own uniforms in the contracted department designated color.*

Per CFO request the Surgery Department, Maintenance Department and EMS weren't included in the cost analysis.

Ordering

- The selected vendor/vendors will set up an online ordering system with the selected styles and colors for each identified department employees.
- Upon initial start-up of the program, Materials Management will set up a system for employees to try on the vendor uniforms in their selected sizes and place their orders. For new employees after the initial start-up, Human Resources will incorporate this process into the onboarding of the employee to ensure that uniforms are ordered in a timely manner upon starting employment. Fit kits from vendor will be kept in the Human Resources area.

Note: Employees purchasing their uniforms outside of the selected vendor are at risk of not being complaint with the program and policy.

Cost Analysis

DEPARTMENT	FT STF	AVRG $$	FULL TIME	PT STAFF	AVRG $$	PART TIME TOTAL	PD Staff	AVRG $$	PER DIEM TOTAL	TOTAL
			4 SETS			3 SETS			2 SETS	
RN & LPN	48	$38.96	$7,480.32	11	38.96	$1,285.68	32	38.96	$2,493.44	$11,259.44
CMA & TECHS	36	$38.96	$5,610.24	14	38.96	$1,636.32	0	38.96	$0.00	$7,246.56
LABORATORY	14	$38.96	$2,181.76	5	38.96	$584.40	6	38.96	$467.52	$3,233.68
RADIOLOGY	14	$38.96	$2,181.76	0	38.96	$0.00	13	38.96	$1,012.96	$3,194.72
CARDIOPULMONARY	7	$38.96	$1,090.88	0	38.96	$0.00	2	38.96	$155.84	$1,246.72
ENVIRO SVC / LINEN	10	$52.96	$2,118.40	3	52.96	$476.64	2	52.96	$211.84	$2,806.88
SUPPLY CHAIN	3	$52.96	$635.52	0	52.96	$0.00	2	52.96	$211.84	$847.36
REGISTRATION**	23	$52.96	$4,872.32	4	52.96	$635.52	0	52.96	$0.00	$5,507.84
DIETERY	5	$52.96	$1,059.20	5	52.96	$794.40	2	52.96	$211.84	$2,065.44
PHARMACY	2	$38.96	$311.68	1	38.96	$116.88	1	38.96	$77.92	$506.48
THERAPY SERVICES	21	$52.96	$4,448.64	2	52.96	$317.76	0	52.96	$0.00	$4,766.40
Average Allowance per Emp			$175.00			$130.00			$81.00	**$42,681.52**
									Total Cost	**$42,681.52**

Prosser
Memorial Health

UNIFORM PROGRAM
2021

ABOUT US

Group Uniforms Powered by SmartScrubs

Smarter Solutions for Uniform Programs

Our group programs are designed specifically for your organization's needs, implemented effectively and efficiently, and driven by the industry leader in innovative and customized solutions from start to finish.

SmartScrubs® specializes in group uniform programs for health care organizations across multiple industries including medical, dental, veterinary and long-term care. An industry leader and innovator, SmartScrubs implements complex uniform programs simply and efficiently using custom solutions and tools such as the Fitting Edge® mobile app. A group uniform program Powered by SmartScrubs can increase patient satisfaction, improve the patient experience and strengthen your brand.

Assortment Cost / Most Popular Styles

		CHEROKEE AUTHENTIC WORKWEAR PROFESSIONALS	CHEROKEE AUTHENTIC WORKWEAR REVOLUTION	Infinity by CHEROKEE
1 set	up to XL	$30.96	$34.96	$49.96
	2X +	$34.96	$38.96	$53.96
2 sets	up to XL	$61.92	$69.92	$99.92
	2X +	$69.92	$77.92	$107.92
3 sets	up to XL	$92.88	$104.88	$149.88
	2X +	$104.88	$116.88	$161.88
4 sets	up to XL	$123.84	$139.84	$199.84
	2X +	$139.84	$155.84	$215.84

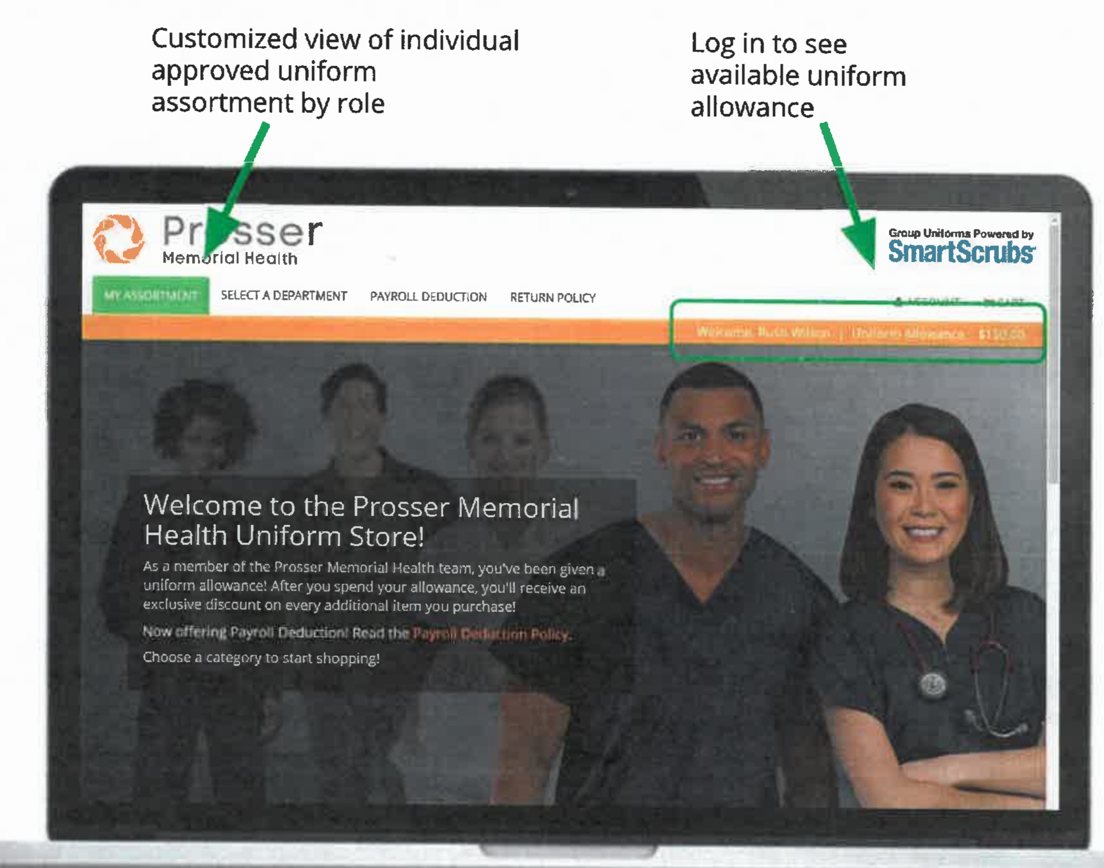
Cost does not include embroidery, taxes or shipping.

UNIFORM ALLOWANCES

- Staff may use their allowance only on the assortment that has been assigned to their role. If they try to use their allowance on an item that is not approved for their role, an error message appears and will not allow them to proceed.

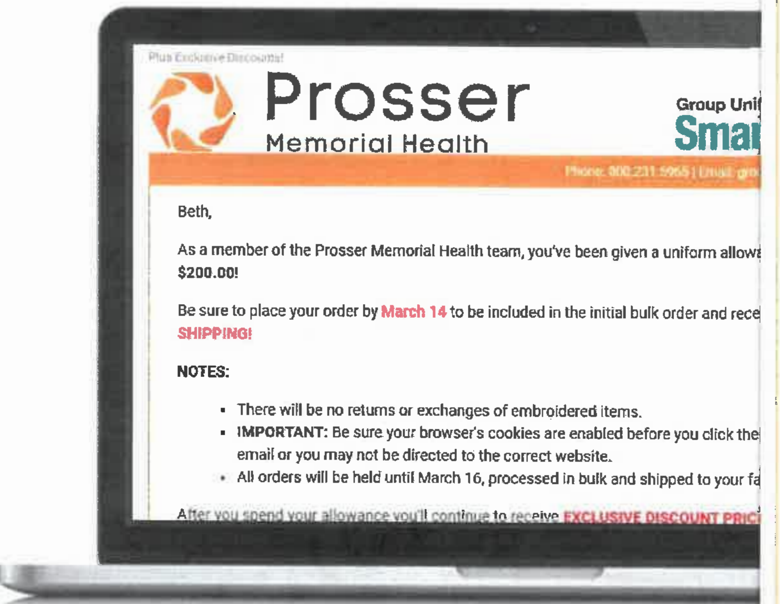
- If a staff members would like to purchase additional uniforms beyond what their allowance will cover, they will be prompted to pay for the difference out of pocket.

- Staff enjoy the negotiated discount price on all purchases placed on the site, whether using their allowance or paying out of pocket.



PROGRAM COMMUNICATION

Customized email communications provide your employees with a summary of their available allowance amount, login instructions and customer service contact information.



Plus Exclusive Discounts!

Group Uniforms Powered by **SmartScrubs**

Phone: 800.231.5965 | Email: groups@smartscrubs.com

Beth,

As a member of the Prosser Memorial Health team, you've been given a uniform allowance of **$200.00!**

Be sure to place your order by **March 14** to be included in the initial bulk order and receive **FREE SHIPPING!**

NOTES:

- There will be no returns or exchanges of embroidered items.
- **IMPORTANT:** Be sure your browser's cookies are enabled before you click the links in this email or you may not be directed to the correct website.
- All orders will be held until March 16, processed in bulk and shipped to your facility.

After you spend your allowance you'll continue to receive **EXCLUSIVE DISCOUNT PRICING** when you purchase additional uniforms using the Prosser Memorial Health Uniform Store.

How to Use Your Allowance:

1. Sign in to your account at the Prosser Memorial Health Uniform Store:

   If this is the first time you're accessing your online account, Click Here to set a new password and sign in.

   If you've previously set a new password and signed in, Click Here to access the store again. If you need to set a new password, follow the prompts on the Sign In page.
2. See your available uniform allowance in the top right corner of the page.
3. Click "My Assortment" in the top menu and select from your approved uniform options.
4. Add your product selections to your cart. Your savings are already built into the product prices and your logo will be automatically added to your top(s).
5. Your allowance will be automatically added to your order total at checkout.
6. Enter payment information for any remaining balance after your allowance has been applied.

ORGANIZED DELIVERY

Save time and eliminate confusion with bundled shipping: SmartScrubs bundles each employee's uniforms separately and clearly labels each bundle with the employee's name.

We make it simple and efficient to distribute your orders. Employee bundles can be boxed by manager, department or custom specification.

TIMELINE

Colors / Styles finalized Allowances set Roster data file received	30 days	Order window opens; launch emails sent	30 days	Order cutoff; all orders placed	30 days	Orders shipped	7-10 days	Employees in uniform

REFERENCES

CASE STUDY

University-based medical center improves brand image and patient satisfaction with custom uniform program Powered by SmartScrubs

Challenges

- Present a brand image more fitting of a world-renowned university
- Improve patient satisfaction
- Gain staff buy-in
- Find a vendor able to meet custom needs

Solutions

- Initiate a color-coded uniform program with custom logo embroidery
- Share patient satisfaction survey results with staff
- Hold a fashion show and allow employees to vote on styles and colors
- Employ SmartScrubs to create a custom size, color and style
- Enable employees to order their uniforms on the SmartScrubs custom uniform portal
- Use SmartScrubs' multi-location delivery options to ship uniforms directly to employees' homes

Results

- More than 3,000 employees in at least 20 departments wear color-coded uniforms with logo embroidery
- Nurses outfitted in custom-made brand color
- Sense of pride among medical center staff
- Higher patient satisfaction scores
- Improved staff identifiability for visiting physicians
- Independent ordering ability for staff and less time required of administrators

CHEROKEE WORKWEAR PROFESSIONALS			
SmartScrubs #	**Vendor #**	**Description**	**Price**
71375	WW665	Ladies V-Neck Top	$13.98
71455	WW655	Ladies Mock Wrap Top	$14.98
71443	WW340	Ladies Snap Front Warm-up Jacket	$18.98
71506	WW050	Ladies Natural Rise Tapered Leg Drawstring Pant	$15.98
71180	WW160	Ladies Mid Rise Straight Leg Drawstring Pant	$16.98
71171	WW170	Ladies Mid Rise Straight Leg Pull-on Cargo Pant	$15.98
71536	WW685	Ladies Maternity Mock Wrap Top	$23.98
71535	WW220	Ladies Maternity Straight Leg Pant	$23.98
71376	WW675	Men's 1-Pocket V-Neck Top	$15.98
71359	WW695	Men's 3-Pocket V-Neck Top	$16.98
71359T	WW695T	Men's 3-Pocket V-Neck Top- TALL	$18.98
71407	WW700	Men's Underscrub Knit Top (Tee)	$13.98
71460	WW360	Men's Snap Front Warm-up Jacket	$19.98
71490	WW190	Men's Tapered Leg Drawstring Cargo Pant	$19.98

CHEROKEE WORKWEAR REVOLUTION			
SmartScrubs #	**Vendor #**	**Description**	**Price**
71363	WW620	Ladies V-Neck Top	$15.98
71364	WW610	Ladies Mock Wrap Top	$16.98
71797	WW710	Ladies V-Neck Top w/ Princess Seams	$17.98
71244	WW602	Ladies Round Neck Top	$18.98
71365	WW310	Ladies Snap Front Warm-up Jacket	$19.98
71367	WW110	Ladies Mid Rise Pull-on Cargo Pant	$17.98
71368	WW120	Ladies Mid Rise Drawstring Cargo Pant	$18.98
71405	WW105	Ladies Mid Rise Tapered Leg Drawstring Pant	$18.98
71248	WW011	Ladies Natural Rise Tapered Leg Pull-on Pant	$22.98
71344	WW005	Ladies Mid Rise Straight Leg Drawstring Pant	$23.98
71366	WW690	Men's 1-Pocket V-Neck Top	$17.98
71671	WW670	Men's 3-Pocket V-Neck Top	$18.98
71379	WW380	Men's Snap Front Warm-Up Jacket	$22.98
71798	WW320	Men's Zip Front Jacket	$26.98
71369	WW140	Men's Fly Front Drawstring Cargo Pant	$21.98
71257	WW012	Men's Natural Rise Straight Leg Pant	$23.98

Scrubs: Add $2 for sizes 2X-5X. Career Apparel: Add $2 for sizes 2X-3X, $4 for sizes 4X-5X, $6 for 6X.
Add $3.50 for embroidery on all tops and jackets. Prices do not include tax or shipping.

Group Uniforms Powered by **SmartScrubs**

INFINITY BY CHEROKEE - ANTIMICROBIAL			
SmartScrubs #	**Vendor #**	**Description**	**Price**
71006	2624A	Ladies Round Neck Top	$22.98
71007	2625A	Ladies Mock Wrap Top	$23.98
71151	CK623A	Ladies V-Neck Top	$24.98
71354	CK865A	Ladies Rib-Knit Neckline V-Neck Top	$23.98
71008	2626A	Ladies Long Sleeve Underscrub Knit Tee	$16.98
71837	CK370A	Ladies Zip Front Warm-Up Jacket	$29.98
71009	2391A	Ladies Rib Knit Collar Zip Front Warm-Up Jacket	$28.98
71358	CK065A	Ladies Mid Rise Tapered Leg Pull-on Pant	$27.98
71023	1123A	Ladies Low-Rise Drawstring Pant	$26.98
71024	1124A	Ladies Low-Rise Pull-On Pant	$24.98
71136A	CK110A	Ladies Mid Rise Tapered Leg Jogger Pant	$27.98
71991	CK910A	Men's Zip Chest Pocket V-Neck Top	$25.98
71152	CK900A	Men's V-Neck Top	$25.98
71465	CK650A	Men's Long Sleeve Underscrub Knit Top	$19.98
71153	CK305A	Men's Zip Front Warm-up Jacket	$33.98
71157	CK200A	Men's Fly Front Pant	$29.98
71674	CK004A	Men's Natural Rise Jogger Pant	$31.98

LAB COATS			
SmartScrubs #	**Vendor #**	**Description**	**Price**
71346	1346	Cherokee Unisex 40"	$17.98
71446	1446	Cherokee Unisex 40" - w/ Soil Release	$18.98
71440	4403	Cherokee Workwear Premium Unisex Lab Coat - 38"	$28.98
49476	15113	Meta Ladies 37" - Performance Poplin	$17.98
49476T	15113T	Meta Ladies 37" - Performance Poplin - Tall	$19.98
49964	1964	Meta Ladies 37" - Fine Line Twill	$26.98
49964T	1964T	Meta Ladies 37" - Fine Line Twill - Tall	$27.98
49593	17010	Meta Ladies 39" w/ Nano-Care	$29.98
48004	885	Meta Pro Ladies 35" Tri-Blend Stretch Lab Coat	$31.98
71439	4439	Cherokee Workwear Premium Ladies Lab Coat - 33"	$26.98
71378	1401A	Infinity by Cherokee Ladies Antimicrobial Lab Coat - 40"	$28.98
49590	17020	Meta Men's 40" w/ Nano-Care	$30.98
49467	1963	Meta Men's 38" - Fine Line Twill	$26.98
49467T	1963T	Meta Men's 38" - Fine Line Twill - Tall	$30.98
49483	15112	Meta Men's 38" - Performance Poplin	$17.98
49483T	15112T	Meta Men's 38" - Performance Poplin - Tall	$19.98
47069	762	Meta Men's 40" Knot Button iPad Lab Coat	$30.98

POLOS			
SmartScrubs #	**Vendor #**	**Description**	**Price**
74488	LST640	Sport-Tek Ladies PosiCharge RacerMesh Polo	$11.98
74500	L500	Port Authority Ladies Silk Touch Polo	$13.98
74767	LK600	Port Authority Ladies EZPerformance Pique Polo	$14.98
74748	L568	Port Authority Ladies Cotton Touch Performance Polo	$18.98
74489	ST640	Sport-Tek Men's PosiCharge RacerMesh Polo	$11.98
74504	K500	Port Authority Men's Silk Touch Polo	$13.98
74806	K600	Port Authority Men's EZPerformance Pique Polo	$14.98
TBD	K568	Port Authority Men's Cotton Touch Performance Polo	$18.98

Scrubs: Add $2 for sizes 2X-5X. Career Apparel: Add $2 for sizes 2X-3X, $4 for sizes 4X-5X, $6 for 6X.
Add $3.50 for embroidery on all tops and jackets. Prices do not include tax or shipping.

Group Uniforms Powered by SmartScrubs

BUTTON-UPS			
SmartScrubs #	Vendor #	Description	Price
74578	L612	Port Authority Ladies 3/4 Sleeve Easy Care Shirt	$19.98
74660	LW100	Port Authority Ladies Long Sleeve Carefree Poplin Shirt	$18.98
74676	L665	Port Authority Ladies 3/4-Sleeve SuperPro Twill Shirt	$25.98
74587	L640	Port Authority Ladies Crosshatch Easy Care Shirt	$28.98
74661	W100	Port Authority Men's Long Sleeve Carefree Poplin Shirt	$18.98
74661	W100	Port Authority Men's Long Sleeve Care Free Poplin Shirt	$18.98
74665	S663	Port Authority Men's SuperPro Twill Shirt	$25.98

PANTS			
SmartScrubs #	Vendor #	Description	Price
74897	8280	Edwards Garment Ladies Pinnacle Pull-On Pant	$27.98
74893	8760	Edwards Garment Ladies Repreve Stretch Microfiber Dress Pant	$38.98
74896	2588	Edwards Garment Men's Repreve Stretch Microfiber Dress Pant	$38.98
74886	8525	Edwards Garment Ladies Washable Dress Pant	$48.98
74888	2525	Edwards Garment Men's Washable Dress Pant	$48.98

EVS			
SmartScrubs #	Vendor #	Description	Price
74853	7890	Ladies Color Block Tunic	$32.98
74867	4890	Men's Color Block Service Shirt	$32.98
74956	8886	Ladies Pull On Pant	$19.98
74989	2889	Unisex Housekeeping Pant with Cargo Pocket	$17.98

CULINARY			
SmartScrubs #	Vendor #	Description	Price
49928	3301	Edwards Garment Unisex Classic 10-Button Chef Coat	$22.98
74883	2000	Edwards Garment Unisex Basic Baggy Chef Pant	$22.98
74933	HT04	Edwards Garmet Unisex Beanie Chef Cap - Velcro Back	$6.98
74929(BLACK)	3331	Edwards Unisex 12 Button Short Sleeve Chef Coat With Mesh	$25.98
74929(WHITE)	3331	Edwards Unisex 12 Button Short Sleeve Chef Coat With Mesh	$22.98
74931	9008	Edwards 1-Pocket Long Bistro Apron	$9.98
74924	1305	Edwards Unisex Button Front Shirt with Mesh Back	$14.98
74923(BLACK)	1302	Edwards Unisex Snap Front Shirt with Mesh Back	$14.98
74923(WHITE)	1302	Edwards Unisex Snap Front Shirt with Mesh Back	$12.98

MAINTENANCE			
SmartScrubs #	Vendor #	Description	Price
74524	SP24	Red Kap Men's Short Sleeve Industrial Work Shirt	$17.98
TBD	SY60	Red Kap Short Sleeve Solid Ripstop Shirt	$27.98
74540	PT20	Red Kap Men's Industrial Work Pant	$22.98
74579	PT88	Red Kap Men's Industrial Cargo Pant	$28.98

Scrubs: Add $2 for sizes 2X-5X. Career Apparel: Add $2 for sizes 2X-3X, $4 for sizes 4X-5X, $6 for 6X.
Add $3.50 for embroidery on all tops and jackets. Prices do not include tax or shipping.

AFTON DUNHAM

99802 Hillview Drive Kennewick, WA 99338 (509) 528-5888 afty13_ball@hotmail.com

Family Nurse Practitioner (FNP)
Completion May 2019

- A passionate, enthusiastic Nurse Practitioner that is committed to patient-centered care and evidence-based practice. Over 10 years of practice as a registered nurse in the Emergency Department setting taking on various leadership opportunities. Competent in executing department standards of practice and health care operations. I thrive in team environments that are fast paced, that require efficient planning, critical thinking, and rapid decision-making skills.

QUALIFICATIONS

- Emergency Medicine
- Patient Education and Safety
- Holistic, Patient-Centered Care
- Team Leadership
- Provider Collaboration/Communication
- Clinical Preceptor
- Process Improvements

EDUCATION & CERTIFICATIONS

- Maryville University, Masters FNP program, St. Louis, MO — present
  clinical experience available upon request
- ACLS, BLS, PALS certifications, KRMC Tri-Cities, WA — 2020
- Sexual Assault Nurse Examiner Training — 2016
- Certified Emergency Nursing certification — 2015
- Advanced Trauma Care Nursing certification — 2015
- Western Governors University, BSN program — 2014 – 2015
- Columbia Basin College, Tri-Cities, WA — 2007 – 2011
  Associates Degree in Nursing

PROFESSIONAL EXPERIENCE

Prosser Memorial Health, Prosser, WA — 2019 – current
- Registered Nurse: Emergency Department

Trios Health, Kennewick, WA — 2019 – current
- Registered Nurse: Emergency Department

Kadlec Regional Medical Center, Richland, WA — 2011 – 2019
- Registered Nurse: Emergency Department

Kadlec Regional Medical Center, Richland, WA — 2009 – 2011
- Nurse Tech Licensure: able to perform all skills that have been signed off in CBC nursing school

VOLUNTEER EXPERIENCE & COMMITTEE INVOLVEMENT

- Member of Sexual Assault Committee, KRMC Richland, WA — 2017 – 2019
- Member of Caring Reliably Committee, KRMC Richland, WA — 2017 – 2019
- Member of ED Sepsis Taskforce, KRMC Richland, WA — 2017 – 2019
- Member of Kadlec Sepsis Committee, KRMC Richland, WA — 2016 – 2019
- Rapid Performance Improvement Team (RPI), KRMC Richland, WA — 2016 – 2019
- City of Richland Youth Basketball 4th & 5th Grade girls — 2009 – 2010

Attachment AA

Medical Staff Engagement and Retention Plan

2020

GOAL:

To create a homogeneous, dynamic and adaptive culture, based on our Mission, Vision and Values, with a solid foundation centered on our six pillars of excellence to increase medical staff satisfaction and retention.

This plan will be guided by the Medical Staff Engagement Team with evidence based, successful strategies to promote teamwork, collaboration, leadership, and problem solving to promote Medical Staff satisfaction and retention. All Medical Staff are encouraged to participate in this plan. It will consider state of the art technology to allow us to provide the highest quality of care in a respectful and timely manner. Considering the medical provider as a valued and indispensable part of team. It will promote a transparent process with provider wellness and work and life balance.

The Chief Medical Officers will be role models of excellence for the medical staff.

DEFINITIONS:

Culture of Wellness: Organizational work environment, values, and behaviors that promote self-care, personal and professional growth and compassion for our colleagues, our patients and ourselves.

Efficiency of Practice: Workplace systems, processes, and practices that promote safety, quality, effectiveness, positive patient and colleague interactions, and work-life balance.

Personal Resilience: Individual skills, behaviors, and attitudes that contribute to physical, emotional, and professional well-being.

PLAN:

Provider Code of Conduct-

Define the Ideal Physician Qualities (Confident, personal, respectful, thorough, humane, empathetic and forthright). Reflect our current Mission, Vision and Values, with emphasis on cultural, gender, transgenerational and religious sensitivity. With specific attention to avoidance of bullying, harassment of any kind and to deter any behavior that can create internal or external damage to our organization. To promote transparency, error prevention, and fluidity of our patient care. To encourage scientific excellence and camaraderie.

New Provider On-boarding-

Onboarding is as systemic process with the goal of achieving an excellent fit for both the provider and organization. It promotes a better understanding of our culture, mission, vision and values, and cultivates long-term relationship building, access to information, and fosters a feeling of belonging.

Have a Buddy- A buddy is someone to help the provider to get to know the culture PMH. This person can be from a different department and will help acclimate over the next year to social activities of our organization, makes new providers feel welcome and promote cohesiveness across departments within PMH.

Have a Mentor- A peer that will help navigate the job processes and procedures.

Check-Ins- Conduct integration meetings with HR, hiring director and buddy. Coaching and support should be ongoing until onboarding is accomplished.

Check in timeline:

	HR	Buddy	Mentor	Clinic Director
First Day	• Introduces Buddy • Complete HR orientation • Lunch with provider	• Gives tour • Introduces to staff • Lunch with provider		• Meet provider in HR, review position, overview of first 30-90 days. • Lunch with provider
First Week	• Follow up with provider, answer questions.	• Introduces provider to team members • Invite to social activities of PMH.	• Meet with provider • Set up weekly meetings	
First Three Months	• Touch basis on provider acclimation and engagement.	• Continues integrating into social activities	• Track progress • Set up monthly meetings	
Beyond Three Months	• Seeks feedback on onboarding process	• Support provider for yearly cycle to ensure provider feels welcome and supported.	• Available for occasional questions	• Conduct Stay Interview • Provide performance feedback

Orientation to our community and area of service, fostering involvement and altruism to enhance and strengthen our community ties.

Provider Mentorship Program-

To develop and initiate regular ongoing educational programs about the culture and philosophy of the clinical area and organization, electronic medical record (EPIC) maintenance and development. Regular continued medical, clinical and leadership skills related luncheons and meetings. Regular training and understanding of their work area flow and process. Vignettes and mock drills.

Identify future leaders and get them involved. Encourage participation and offer career development opportunities.

Provider Satisfaction Survey-

Completed annually by all members of the medical staff. Assess engagement of medical staff, gives them a voice, and gives leadership tangibles for change/improvement.

Physician Rounding-

Build trust, increase communication, recognition of others. Leadership team will identify and appoint mentors (i.e.: Clinic Medical Director, Chief Medical Officers, Department Directors, etc.).

Physician Stay Interviews-

Informal interviews that offer understanding on why provider will stay and what might cause them to leave, builds trust between leadership and provider, and improves retention and productivity. How provider views leadership impacts how they view their employment relationship. Create a stay plan from interview responses.

Typical Questions:

Why do you choose to stay at Prosser Memorial Health?
Why might you leave or what may entice you away?
What is most energizing about your work?
What more do you want to learn?
Are we fully utilizing your talents?
What are your career goals?

What, if anything, is inhibiting your success?
Where can we support you more?
How do you like to be recognized?
What can the organization do to support you better?

Medical Staff Socials-

Build camaraderie, trust and communication between medical staff.

Physician Recognition-

Utilize ASPIRE recognition program to celebrate success, accomplishments and reward excellent performance.

Provider Wellness Program-

To encourage a healthy and balanced lifestyle. Identify risk factors for provider burnout (caregiver fatigue) such as substance abuse and provider mental problems. Promote access to fitness and wellness programs, including a Physician Support group.

Provider Service Excellence-

Utilize Prosser Memorial Health Service Recovery program.

Medical Staff Engagement Team Retention Assessment-

Does anyone in the community relate to the provider on a personal level?
Does the provider feel there is emotional support from partners and the community?
Are the provider's family and partner included in social events?
Is the family happy- do they have a sense of belonging to the community?
Can the provider find adequate time for family and recreation?
Are there any unmet expectations and are the original contract terms being met?
Are referral patterns established and appropriate?
Does the community utilize the provider's scope of services fully?
Do on-call providers need additional professional support or professional enrichment?
Does the provider have a retirement plan?

Vision

Patients
Employees
Medical Staff
Quality
Services
Financial

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

Mission: To improve the health of our community.

Medical Staff Engagement Team

Purpose

This team is responsible for ensuring that the highest level of service is consistently provided to Medical Staff, and for developing ideas to continually improve that service. The team shall align and promote our Mission, Vision and Values, along with the six pillars of excellence; Patient Loyalty; Medical Staff Development; Employee Development; Quality; Services; and Financial Stewardship. The team will identify what Medical Staff needs are and remove barriers to establish a strong cohesive work force. We want our Medical Staff to be exceptionally pleased with every encounter at PMH. The team will focus on retention and recruitment strategies to support the needs and longevity of the Medical Staff within PMH and our service area. Medical Staff Engagement Team will commit to: Transparency, Innovation, Healthy Workplace, Individual Health and Teamwork.

Medical Staff Engagement Team will identify:

A) Medical Staff satisfaction barriers.
B) PMH "dynamic cultural standards" which make an excellent and desirable place to practice.
C) Strategies to create wellness, collegiality and excellence with physician development.
D) Training tools needed to provide excellent care.
E) Provider recognition program to recognize contributions within Prosser Memorial Health

Functions

- Participate in recruitment efforts based on the PMH Medical Staff Model and community needs assessment.
- Develop a Physician retention plan which includes work/life balance, competitive income, workplace excellence and collegiality in a progressive medical community.
- Review results of Medical Staff engagement survey, create action plans around opportunities for improvement. Make recommendations to the Administrative Team, Board Members and CEO to accomplish provider satisfaction and retention.
- Promote the PMH Medical Staff through a variety of marketing methods, as outlined in the 2018 Marketing Plan.
- Integrate the four core concepts of Patient- Family Centered Care into every aspect of care provided at PMH Medical Center; Respect and Dignity, Information Sharing, Participation and Collaboration.
- Develop a new provider onboarding and mentoring process.
- Develop a Physician wellness program.
- Develop a Physician rounding process.
- Develop Medical Staff led educational seminars and luncheons with CME quality and value.
- Enhance recognition and appreciation of the Medical Staff.
- Work with IT to develop EPIC specific training tailored for Medical Staff needs and desires.

Report Frequency and Format

The Medical Staff Engagement Team will document minutes of meetings and report summary level items to the Leadership Team or appropriate committees as determined by Administration.

Frequency and Time

The Medical Staff Engagement Team will meet monthly on a Friday from 7:00 AM- 8:00 AM to include small focus groups with Providers. The team allows teleconferencing to enhance participation, although, physical presence will be encouraged.

Patients
Employees
Medical Staff
Quality
Services
Financial

Mission: To improve the health of our community.

Values

Accountability
Service
Promote Teamwork
Integrity
Respect
Excellence

Procedure

Robert's Rules of Order Revised (latest edition) shall govern procedures at the committee meetings.

Quorum

The presence in person of at least fifty percent (50%) of the committee members shall be necessary to constitute a quorum for committee transition of business. In the absence of such a quorum, any meeting may be adjourned from time to time by a majority vote of present members.

Voting

Questions at the committee meeting at which a quorum is present shall be decided by majority vote of the team members. Team members shall not appoint a proxy or vote via proxy.

2020 Medical Staff Team Members (proposed)

- **Dr. Jacobo Rivero – ACMO, Engagement**
- **Dr. Sandeep Joshi**
- **Dr. Caroline O'Connor**
- **Dr. Heidi Weaver**
- **Dr. Derek Weaver**
- **Ryan McDonald CRNA**
- **Pamela Morris ARNP**
- **Diane Microlis, APNP**
- **Merry B Fuller, Chief Nursing Officer/Chief Operations Officer**
- **Rochelle Kmetz – Chief Human Resources Officer**
- **Shannon Hitchcock – Chief Communication Officer**
- **Kevin Hardiek – Chief Information Officer**
- **Lynn Smith – Medical Staff Services**
- **Alana Pumphrey – Director of Clinic Operations**
- **Christi A Doornink – Osborn – ED Director/Provider Recruitment**

Provider Wellness and Retention Project

Jacobo Rivero, MD, FAAFP, ACMO
Christi Doornink-Osborn, BSN, RN

Burnout: **Exhaustion of physical or emotional strength or motivation, usually a result of prolonged stress or frustration.**

Symptoms

- Limited Mental Acuity
- Emotional Drainage
- Disengagement
- Physical Exhaustion

Strongest Determinants of Burnout

- Low self-compassion
- Sleep related impairment

Consequences

- Lower patient satisfaction and care quality
- Higher medical error rates and malpractice risk
- Higher physician and staff turnover
- Alcohol and drug abuse and addiction
- Family disruption
- Professional career change
- Depression
- Suicide

2016 Physician Wellness Survey

Full Report

THE STANFORD WELLNESS MODEL

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Stanford Physician Wellness Committee

is founded on:

"advancing wellness and quality of life for physicians and for patients are synergistic goals"

Survey Statistics

- Washington State
  - 43% Experiencing burnout
  - 34% Reported professional fulfillment
  - 42% Likelihood of leaving organization within 2 years
- Nationally
  - 36% Experiencing burnout
  - 41% reported professional fulfillment

Prosser Memorial Health Medical Staff Satisfaction

- 2019
  - 89% Medical Staff Satisfaction
- 2018
  - 90.6% Medical Staff Satisfaction

- Medical Staff Favorable Areas:
  - Agreement with MV&V of PMH
  - High level of respect
  - Patient satisfaction is a top priority
  - Good place to practice
  - Satisfied with current relationship with PMH
  - Administration actions show they care
  - Communication is effective between medical staff and nurses

Medical Staff Engagement and Retention Plan

- Design a wellness and retention program that will be open to changes and future growth of organization and community.

  - Code of Conduct
  - On-boarding
  - Provider Mentorship Program
  - Provider Satisfaction Survey
  - Provider Rounding
  - Medical Staff Socials
  - Physician Recognition
  - Provider Wellness Program
  - Provider Service Excellence
  - Medical Staff Engagement Team Retention Assessment

Medical Staff Engagement Team

2020 Challenges and Solutions

- **Challenges**
  - Consistent monthly meeting
  - Provider Mentoring
  - On-boarding
  - Consistent provider rounding

- **Solutions and Ideas**
  - Teleconferencing and Microsoft Teams
  - Invite more medical staff to participate
  - Invite interdepartmental staff to participate
  - Potential second Assistant Chief Medical Officer join the team

2020 Team Members

- Dr. Jacobo Rivero, Assistant Chief Medical Officer
- Dr. Sandeep Joshi
- Dr. Caroline O'Connor
- Dr. Heidi Weaver
- Ryan McDonald, CRNA
- Pamela Morris, ARNP
- Diane Microlis, ARNP
- Merry Fuller, Chief Nursing Officer/Chief Operating Officer
- Rochelle Kmetz, Chief Human Resources Officer
- Shannon Hitchock, Chief Communication Officer
- Kevin Hardiek, Chief Information Officer
- Lynn Smith, Medical Staff Services
- Alana Pumphrey, Director Clinical Operation
- Christi Doornink-Osborn, ED Director/Provider Recruitment

Prosser

Memorial Health

ProsserHealth.org

Attachment BB

Prosser Memorial Health Feasibility Study

Presented by:
Joe Lodge, CPA and
Luke Zarecor, CPA

Overview

- Key Assumptions
  - Inflation rates
  - New providers and volume changes
  - Physician recruitment plan
  - Constructions costs and timing
  - COVID-19
  - Conservative Estimates

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Overview

- Forecast Financial Statements and Ratios
  - Statements of Net Position
  - Statements of Revenues, Expenses, and Changes in Net Position
  - Net Patient Service Revenue
  - Debt Service Coverage Ratio
  - Days Cash on Hand

Key Assumptions

Key Assumptions

- Inflation rates
  - 3% annual charge rate increases
  - 3% annual expense increases for professional fees, purchased services, billable supplies, pharmaceuticals, and utilities
  - 3.5% annual expense increases for salaries and wages
  - 4.8% annual expense increases for employee benefits
  - 2% annual expense increases for repairs and maintenance, taxes and licenses, insurance, software, and other expenses
  - 0% increase for rentals and leases

Key Assumptions (continued)

- New providers and volume changes
  - 23 new providers being added in the RHCs, the surgery clinic, the Heart/Cancer Center, and the ER, with 17 of these in 2020 and 2021
  - Salaries and revenue estimated for these new providers
  - Clinic visits to increase as follows:

	2021	2022	2023	2024
Benton City RHC	3%	3%	25%	3%
Prosser RHC	83%	5%	12%	5%
Grandview RHC	6%	42%	6%	6%
Surgery Clinic	43%	22%	19%	6%
Heart/Cancer Clinic	201%	67%	0%	0%

  - Ancillary department volumes to increase consistent with population growth and increases in providers

Key Assumptions (continued)

- Physician recruitment plan

	FY 2020	
Emergency Medicine - Vacant	1.0	Prosser Memorial Health
ENT	1.0	PMH Specialty Clinic
PA/NP	1.0	Mabton Clinic
Women's Health	1.0	Benton City
Women's Health	1.0	Grandview Clinic
Pediatrician	1.0	Grandview Clinic
Mental Health Counselor	1.0	Prosser Clinic
PA/NP	2.0	Prosser Clinic – Urgent/After Hours Clinic
Subtotal	9.0	
	FY 2021	
Family Practice	1.0	Prosser Clinic
Ophthalmology	1.0	PMH Specialty Clinic
Urology	1.0	PMH Specialty Clinic
Dermatology	1.0	Prosser Clinic
Endocrinology	1.0	Prosser Clinic
Neurology	0.5	Prosser Clinic - Telehealth
Rheumatology	0.5	Prosser Clinic - Telehealth
Hematology/Oncology	1.0	Prosser Cancer Center
Subtotal	7.0	
	FY 2022	
Internal Medicine	1.0	Grandview Clinic
Nephrology	1.0	PMH Specialty Clinic
Cardiology	1.0	Prosser Heart Center/Grandview Clinic
Pulmonology	1.0	Prosser Clinic
Subtotal	4.0	
	FY 2023	
Family Practice	1.0	Benton City Clinic
Gastroenterology	1.0	PMH Specialty Clinic
Subtotal	2.0	

Key Assumptions (continued)

- Construction costs and timing
  - $60,015,000 total costs, including $6,500,000 for equipment and fixtures, and $2,000,000 for capitalized interest
  - $2,000,000 from capital campaign, $12,700,000 from equity contribution, including $1,700,000 for land purchase, the balance from USDA and other funding
  - Loans at interest rates of 3 - 3.5%
  - Timeline:
    - Now – December 2021 – USDA application, pre-construction
    - January 2022 – December 2023 – construction
    - January 2024 – building opens

Key Assumptions (continued)

- COVID-19
  - April – May – low volumes
  - June – November – gradual return to normal
  - December – return to normal operations
  - Grants and Loans
    - HHS Federal Funds - $5,203,000
    - Other Grants - $116,000
    - Paycheck Protection Program - $6,350,000
  - Paycheck protection program loan will be offset against costs on Medicare cost report – $1,600,000 effect on 2020 income (Medicare effect), $1,850,000 effect on 2022 income (Medicaid managed care effect)

Key Assumptions (continued)

- Conservative estimates
  - No volume growth assumed for "new facility effect"
  - Using 3% annual charge rate increase
  - Interest rates of 3 - 3.5% are higher than current rates

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Forecast Financial Statements

Statements of Net Position

	Compiled			Compiled				
ASSETS	Historical Year 2017	Historical Year 2018	Historical Year 2019	Forecast Year 2020	Forecast Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024
Current assets								
Cash and cash equivalents	$ 2,282,799	$ 1,279,823	$ 817,760	$ 4,733,000	$ 5,153,000	$ 5,483,000	$ 5,813,000	$ 6,055,000
Investments	-	335,780	437,639	438,000	438,000	438,000	438,000	438,000
Receivables:								
Patients, less allowances for uncollectible accounts	8,121,908	8,166,553	10,744,795	7,477,000	9,228,000	9,500,000	10,292,000	10,976,000
Estimated third-party payor settlements	305,494	622,040	-	-	-	-	-	-
Taxes	23,124	24,789	26,908	25,000	26,000	26,000	27,000	27,000
Other	171,564	30,756	195,041	50,000	50,000	50,000	50,000	50,000
Inventories	291,763	357,940	413,831	426,000	434,000	444,000	455,000	467,000
Physician advances	-	192,798	220,234	206,000	153,000	119,000	33,000	17,000
Prepaid expenses	304,717	304,724	902,449	902,000	738,000	900,000	900,000	738,000
Total current assets	11,501,369	11,315,203	13,758,657	14,257,000	16,220,000	16,960,000	18,008,000	18,768,000
Noncurrent assets								
Cash and cash equivalents limited as to use for capital acquisitions	11,999,425	1,376,480	1,250,261	1,250,000	1,250,000	1,250,000	1,250,000	1,250,000
Cash and cash equivalents restricted by bond agreement for capital acquisitions	976,204	-	346,920	347,000	347,000	347,000	347,000	347,000
Investments limited as to use for capital acquisitions	-	12,534,987	13,880,674	19,385,000	19,093,000	11,995,000	16,065,000	22,831,000
Physician advances	-	190,267	156,015	141,000	86,000	33,000	17,000	-
Prepaid expenses, net of current portion	-	-	324,504	81,000	-	325,000	81,000	-
Capital assets, net	13,367,798	14,313,800	18,314,760	19,753,000	21,530,000	43,380,000	71,893,000	66,519,000
Total noncurrent assets	26,343,427	28,415,534	34,273,134	40,957,000	42,306,000	57,330,000	89,653,000	90,947,000
Total assets	**$ 37,844,796**	**$ 39,730,737**	**$ 48,031,791**	**$ 55,214,000**	**$ 58,526,000**	**$ 74,290,000**	**$ 107,661,000**	**$ 109,715,000**

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Statements of Net Position (continued)

LIABILITIES, DEFERRED INFLOW OF RESOURCES, AND NET POSITION		Compiled				Compiled		
	Historical Year 2017	Historical Year 2018	Historical Year 2019	Forecast Year 2020	Forecast Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024
Current liabilities								
Accounts payable	$ 1,160,673	$ 915,866	$ 1,192,142	$ 1,240,000	$ 1,254,000	$ 1,284,000	$ 1,315,000	$ 1,347,000
Accrued payroll and related liabilities	1,105,709	1,586,757	2,282,536	2,072,000	2,364,000	2,557,000	2,723,000	2,843,000
Accrued leave	845,705	953,506	1,233,493	1,131,000	1,267,000	1,358,000	1,432,000	1,480,000
Estimated third-party payor settlements	856,120	1,148,700	472,704	1,600,000	-	-	-	-
Accrued interest payable	21,099	20,307	19,670	38,000	-	264,000	1,253,000	-
Current portion of long-term debt	245,000	255,000	806,614	837,000	873,000	909,000	2,164,000	2,237,000
Current portion of capital lease obligations	-	673,075	418,578	258,000	318,000	329,000	340,000	352,000
Total current liabilities	4,234,306	5,553,211	6,425,737	7,176,000	6,076,000	6,701,000	9,227,000	8,259,000
Noncurrent liabilities								
Long-term debt, net of current portion	6,571,624	6,312,292	11,152,228	10,311,000	9,434,000	21,736,000	49,068,000	49,428,000
Capital lease obligations, net of current portion	-	336,449	-	1,212,000	1,448,000	1,119,000	779,000	427,000
Total noncurrent liabilities	6,571,624	6,648,741	11,152,228	11,523,000	10,882,000	22,855,000	49,847,000	49,855,000
Total liabilities	10,805,930	12,201,952	17,577,965	18,699,000	16,958,000	29,556,000	59,074,000	58,114,000
Deferred inflow of resources								
Deferred electronic health records incentive revenue	990,600	660,400	330,200	-	-	-	-	-
Net position								
Net investment in capital assets	6,530,075	6,716,677	5,917,670	7,097,000	9,457,000	19,023,000	18,289,000	14,075,000
Restricted for debt service	-	-	-	-	-	-	-	-
Unrestricted	19,518,191	20,151,708	24,205,956	29,418,000	32,111,000	25,711,000	30,298,000	37,526,000
Total net position	26,048,266	26,868,385	30,123,626	36,515,000	41,568,000	44,734,000	48,587,000	51,601,000
Total liabilities, deferred inflow of resources, and net position	**$ 37,844,796**	**$ 39,730,737**	**$ 48,031,791**	**$ 55,214,000**	**$ 58,526,000**	**$ 74,290,000**	**$ 107,661,000**	**$ 109,715,000**

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Statements of Revenues, Expenses and Changes in Net Position

	Compiled			Compiled				
	Historical Year 2017	Historical Year 2018	Historical Year 2019	Forecast Year 2020	Forecast Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024
Operating revenues								
Net patient service revenue	$ 47,220,568	$ 51,512,050	$ 59,133,934	$ 54,582,000	$ 67,361,000	$ 69,349,000	$ 75,134,000	$ 80,125,000
Electronic health records incentive payments	991,835	330,200	330,200	330,000	-	-	-	-
Grants	43,881	19,341	1,040,213	510,000	600,000	250,000	250,000	250,000
Other	595,059	451,283	343,701	333,000	333,000	333,000	333,000	333,000
Total operating revenues	48,851,343	52,312,874	60,848,048	55,755,000	68,294,000	69,932,000	75,717,000	80,708,000
Operating expenses								
Salaries and wages	20,444,314	23,287,263	27,475,681	28,287,000	31,682,000	33,947,000	35,803,000	37,006,000
Employee benefits	4,714,799	6,118,772	6,260,013	6,245,000	7,716,000	8,665,000	9,577,000	10,374,000
Professional fees	7,530,166	7,565,035	7,399,636	6,967,000	6,902,000	7,109,000	7,322,000	7,541,000
Purchased services	4,050,206	4,093,715	4,568,821	4,600,000	4,847,000	4,977,000	5,111,000	5,249,000
Supplies	4,750,644	4,960,397	5,566,480	5,980,000	6,087,000	6,237,000	6,392,000	6,550,000
Insurance	255,248	241,381	312,599	420,000	370,000	377,000	385,000	393,000
Utilities	465,846	520,065	535,779	410,000	550,000	567,000	584,000	601,000
Depreciation and amortization	2,063,342	1,988,410	2,443,594	2,810,000	2,384,000	2,370,000	2,276,000	5,374,000
Repairs and maintenance	489,253	309,142	279,995	318,000	317,000	324,000	330,000	337,000
Licenses and taxes	284,240	343,191	425,776	593,000	425,000	434,000	443,000	452,000
Leases and rentals	1,859,223	1,998,258	2,157,531	2,194,000	2,008,000	2,008,000	2,008,000	2,008,000
Other	967,318	1,176,943	1,161,324	1,147,000	1,373,000	1,401,000	1,429,000	1,457,000
Total operating expenses	47,874,599	52,602,572	58,587,229	59,971,000	64,661,000	68,416,000	71,660,000	77,342,000
Operating income (loss)	976,744	(289,698)	2,260,819	(4,216,000)	3,633,000	1,516,000	4,057,000	3,366,000

Statements of Revenues, Expenses and Changes in Net Position (continued)

	Compiled			Compiled				
	Historical Year 2017	Historical Year 2018	Historical Year 2019	Forecast Year 2020	Forecast Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024
Nonoperating revenues (expenses)								
Taxation for maintenance and operations	784,095	821,455	846,680	849,000	851,000	868,000	885,000	903,000
Investment income (loss)	17,530	192,001	423,828	136,000	514,000	517,000	382,000	470,000
Interest expense	(178,423)	(167,241)	(351,114)	(420,000)	(418,000)	(658,000)	(1,344,000)	(1,698,000)
Gain (loss) on disposal of assets	1,000	(150,726)	61,850	-	-	-	-	-
Gift shop revenue	-	63,687	81,282	81,000	81,000	81,000	81,000	81,000
Gift shop expenses	-	(62,863)	(83,634)	(84,000)	(84,000)	(84,000)	(84,000)	(84,000)
Contributions made to others	-	(15,327)	(19,263)	(19,000)	(19,000)	(19,000)	(19,000)	(19,000)
Fundraising and other Foundation expenses	-	(12,910)	(4,613)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)
Contributions	-	441,741	39,406	-	-	-	-	-
Debt issuance costs	-	-	-	-	-	(50,000)	(600,000)	-
Total nonoperating revenues (expenses), net	624,202	1,109,817	994,422	538,000	920,000	650,000	(704,000)	(352,000)
Excess of revenues over expenses before capital grants	1,600,946	820,119	3,255,241	(3,678,000)	4,553,000	2,166,000	3,353,000	3,014,000
Capital grants and contributions	-	-	-	-	500,000	1,000,000	500,000	-
Change in net position before COVID-19 adjustments	1,600,946	820,119	3,255,241	(3,678,000)	5,053,000	3,166,000	3,853,000	3,014,000
Grants related to COVID-19 pandemic	-	-	-	5,319,000	-	-	-	-
Loan forgiveness related to COVID-19 pandemic	-	-	-	4,750,000	-	-	-	-
Change in net position	1,600,946	820,119	3,255,241	6,391,000	5,053,000	3,166,000	3,853,000	3,014,000
Net position, beginning of year	24,447,320	26,048,266	26,868,385	30,124,000	36,515,000	41,568,000	44,734,000	48,587,000
Net position, end of year	**$ 26,048,266**	**$ 26,868,385**	**$ 30,123,626**	**$ 36,515,000**	**$ 41,568,000**	**$ 44,734,000**	**$ 48,587,000**	**$ 51,601,000**

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Net Patient Service Revenue

	Years Ending December 31,				
	Forecast Year 2020	Forecast Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024
Gross patient service revenue	138,900,000	171,289,000	180,937,000	191,119,000	200,083,000
Contractual allowances					
Medicare	$ 28,035,000	$ 34,108,000	$ 35,974,000	$ 37,996,000	38,193,000
Medicaid	30,589,000	37,783,000	43,525,000	43,996,000	46,131,000
Other commercial	19,099,000	22,616,000	23,947,000	25,393,000	26,630,000
Total contractual allowances	77,723,000	94,507,000	103,446,000	107,385,000	110,954,000
Bad debt	4,320,000	6,171,000	5,333,000	5,633,000	5,898,000
Charity care	2,275,000	3,250,000	2,809,000	2,967,000	3,106,000
Net patient service revenue	**$ 54,582,000**	**$ 67,361,000**	**$ 69,349,000**	**$ 75,134,000**	**80,125,000**

Debt Service Coverage Ratio

	Historical Year 2017	Historical Year 2018	Historical Year 2019	Forecast Year 2020	Forecast Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024
Debt service coverage								
Net income available for debt service								
Excess of revenues over expenses before capital grants	$ 1,600,946	$ 820,119	$ 3,255,241	$ (3,678,000)	$ 4,553,000	$ 2,166,000	$ 3,353,000	$ 3,014,000
Grants related to COVID-19 pandemic	-	-	-	5,319,000	-	-	-	-
Loan forgiveness related to COVID-19 pandemic	-	-	-	4,750,000	-	-	-	-
Add back:								
Depreciation and amortization	2,063,342	1,988,410	2,443,594	2,810,000	2,384,000	2,370,000	2,276,000	5,374,000
Interest expense	178,423	167,241	351,114	420,000	418,000	658,000	1,344,000	1,698,000
Bond issuance costs	-	-	-	-	-	50,000	600,000	-
Net income available for debt service	3,842,711	2,975,770	6,049,949	9,621,000	7,355,000	5,244,000	7,573,000	10,086,000
Annual debt service requirements:								
Debt service payments:								
Principal payments	802,031	667,844	1,281,525	1,326,376	1,095,000	1,191,000	1,238,000	2,504,000
Interest expense	178,423	167,241	351,114	420,000	418,000	658,000	1,344,000	1,698,000
Total annual debt service payments	980,454	835,085	1,632,639	$ 1,746,376	$ 1,513,000	$ 1,849,000	$ 2,582,000	$ 4,202,000
Number of times annual debt service covered	**3.9**	**3.6**	**3.7**	**5.5**	**4.9**	**2.8**	**2.9**	**2.4**

Days Cash on Hand

	Historical Year 2017	Historical Year 2018	Historical Year 2019	Forecast Year 2020	Forecast Year 2021	Forecast Year 2022	Forecast Year 2023	Forecast Year 2024
Days unrestricted cash and cash equivalents on hand								
Cash and cash equivalents	$ 2,282,799	$ 1,279,823	$ 817,760	$ 4,733,000	$ 5,153,000	$ 5,483,000	$ 5,813,000	$ 6,055,000
Cash and cash equivalents limited as to use for capital acquisitions	11,999,425	1,376,480	1,250,261	1,250,000	1,250,000	1,250,000	1,250,000	1,250,000
Investments limited as to use for capital acquisitions	-	12,534,987	13,880,674	19,385,000	19,093,000	11,995,000	16,065,000	22,831,000
Total cash and investments on hand	14,282,224	15,191,290	15,948,695	25,368,000	25,496,000	18,728,000	23,128,000	30,136,000
Total operating expenses	47,874,599	52,602,572	58,587,229	59,971,000	64,661,000	68,416,000	71,660,000	77,342,000
Interest expense	178,423	167,241	351,114	420,000	418,000	658,000	1,344,000	1,698,000
Less depreciation and amortization	(2,063,342)	(1,988,410)	(2,443,594)	(2,810,000)	(2,384,000)	(2,370,000)	(2,276,000)	(5,374,000)
Operating expenses	45,989,680	50,781,403	56,494,749	57,581,000	62,695,000	66,704,000	70,728,000	73,666,000
Days unrestricted cash and cash equivalents on hand	**113**	**109**	**103**	**161**	**148**	**102**	**119**	**149**

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DINGUS, ZARECOR &
ASSOCIATES
Contact
Information
Joe Lodge, CPA, Senior Manager
509.321.9475
jlodge@dzacpa.com
www.dzacpa.com

Attachment CC

Market Overview and Assessment
July 2019

Prepared by:

In the spring of 2019, Prosser Memorial Health (PMH) based in Prosser, WA retained Health Facilities Planning & Development (HFPD) to collect, analyze, summarize and report its Service Area's demographic, socioeconomic, health status and inpatient and outpatient use patterns and volumes. The Report is also to include market share and future volume estimates for PMH. This request relates to PMH's pending United States Department of Agriculture (USDA) financing application.

This Report provides and summarizes the requested data and is divided into three sections, as follows:

- **Section 1:** Overview of PMH and the Primary Service Area (PSA)
- **Section 2:** PSA Resident Inpatient and Outpatient Volumes, PMH Market Shares and Competitor Profiles, and
- **Section 3**: Future Volumes (TBD)

Data sources used in this Report include inpatient hospital discharge data supplied by the State of Washington (Comprehensive Hospital Abstract Reporting System-CHARS, inpatient, 2014-2018), Claritas 2018 population estimates, Truven Outpatient Estimates, US Census data, the US Department of Defense, Robert Wood Johnson's Community Health Rankings and the Washington Employment Security Department.

Where possible, data is provided just for the primary service area (PSA). For some data points, data is only available at the County level (Benton County and part of Yakima County) and is so noted.

DRAFT

In summary, the data shows that:

- Jody to write when data complete

DRAFT

Section 1: Overview of PMH and the Primary Service Area

A. Prosser Memorial Health (PMH) Brief History

The Prosser Hospital Association was established in 1943 to raise funds to allow for the establishment of a community hospital. Prosser Memorial Health (PMH) was opened in 1947, and one year later the Prosser Public Hospital District (the District) was approved by the voters and the Prosser Hospital Association was disbanded.

B. PMH Today

PMH is a 25 bed Critical Access Hospital (CAH), meaning that it is rural, operates 25 or fewer beds, meets other applicable requirements and is paid allowable costs from Medicare and Medicaid. The intent of the CAH program is to mitigate financial vulnerability of rural hospitals, thereby assuring that essential services exist in rural communities.

Today, PMH provides family medicine, advanced surgical care, obstetrics, and emergency care. PMH's mission is *to improve the health of our community*, and its vision is to *become one of the top 100 Critical Access Hospitals in the country.*

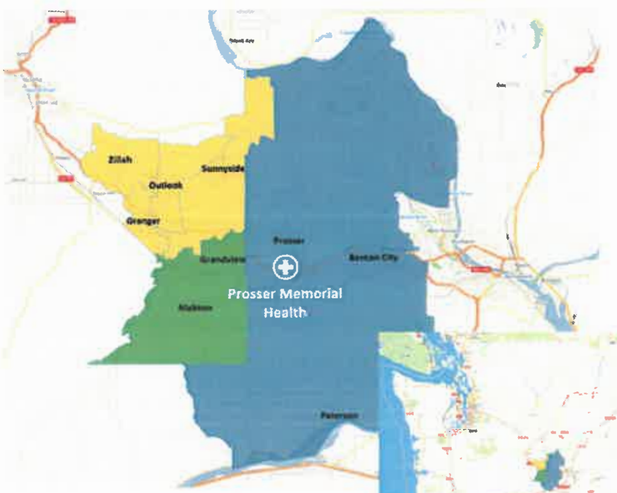
PMH is located in western Benton County. Its services include a broad array of primary care, acute care, outpatient, and post-acute care, including:

- Level 4 Trauma Center
- Emergency Cardiac Level II
- Emergency Stroke Level III
- Inpatient & Outpatient Surgery
- Obstetrics
- Swing Beds
- Behavioral Health
- Teleradiology

PMH did operate a long-term care unit until October 2010 when it closed the 36 bed nursing home.

Primary Service Area/Public Hospital District Definition

Figure 1: The Primary Service Area



The legal boundaries of the District include the communities of Prosser, Benton City and Paterson. Each of these communities is located in Benton County. **Table 1** shows the patient origin, by zip code and county, for PMH's inpatient discharges. As seen in the table, approximately 40% of PMH's inpatients come from the Prosser zip code. The larger District as well as the adjacent communities of Grandview and, Mabton, located in adjacent Yakima County represent the area from which: 1) more than 70% of its inpatients reside and 2) wherein PMH has at least a 15% market share (for non district zip codes). For purposes of this study, these communities were defined as the **Primary Service Area (PSA).**

In addition, and, again, based on the patient origin data in **Table 1**, the communities of Granger, Outlook, Sunnyside, and Zillah, all located in neighboring Yakima County, are considered PMH's **Secondary Service Area (SSA).** 18% of its inpatients reside in the SSA. HFPD did not include these communities in the PSA because PMH's market share is less than the 15% cut off used to define the PSA. The PSA and the SSA are illustrated in **Figure 1.** For the PSA, the District is outlined in blue, the remainder of the PSA is outlined in green, and the SSA is outlined in yellow. Throughout the remainder of this Report and unless otherwise noted, the focus of the analysis is the PSA. In the report, the terms "PSA" and "Service Area" will be used interchangeably.

Table 1
PMH 2018 Discharges and Market Share Based on Patient Origin

Zip	City	County Name	Discharges	PMH Market Share	Running Total
99350	Prosser	Benton	404	39.1%	40.5%
99320	Benton City	Benton	30	3.5%	43.5%
99345	Paterson	Benton	1	3.7%	43.6%
		District Subtotal	**435**	**22.8%**	**43.6%**
98930	Grandview	Yakima	233	22.1%	63.8%
98935	Mabton	Yakima	53	17.0%	69.1%
		PSA Subtotal	**721**	**22.0%**	**72.2%**
98932	Granger	6.6%	19	6.6%	74.1%
98938	Outlook	10.5%	16	10.5%	75.8%
98944	Sunnyside	8.2%	133	8.2%	85.6%
98953	Zillah	3.3%	13	3.3%	90.3%
		SSA Subtotal	**181**	7.4%	**90.3%**
		Other Benton	51		95.4%
		Other Yakima	12		96.6%
		All Other Counties	33		100.0%
		Grand Total	**998**		**100.0%**

Source: Washington State Inpatient CHARS 2018. Excludes all newborns.

As defined by the Federal Health Resources & Services Administration (HRSA), the entirety of both Benton and Yakima Counties are rural[1] and each has Health Professional Shortage Area (HSPA) designation for primary care, mental health, and dental care. HRSA data is only available at the county level. **Table 2** reflects the service area HPSA designations and scoring. The highest score (greatest shortage) for a HPSA is 25.

Table 2
HPSA Designation by Select County

Geography	HPSA	Designation Type	Approval Date	Score
Benton County	Primary Care	Geographic: Entire County	10/02/2017	16
	Dental Care	Geographic: Entire County	8/31/2017	18
	Mental Health	Geographic: Entire County	8/27/2017	17
Yakima County	Primary Care	Low Income Population HPSA	09/24/2017	17
	Dental Care	Low Income Population HPSA	07/26/2017	19
	Mental Health	Geographic: Entire County	08/23/2017	18

Source: HPSA Find (https://datawarehouse.hrs.gov/tools/analyzers/hspafind.aspx).

[1] Rural Health Information Hub "Am I Rural" – Report.

C. Demographics - PSA

As depicted in **Table 3**, in 2018, the PSA had a population of just over 45,000. Nearly 56% of the population is Hispanic. Since the 2010 census, the PSA's total population has grown by 7.2%, while the Hispanic population grew by 16.0% and the population age 65+ grew by 32%. In comparison to the PSA's 7.2% growth, the State grew by 10.7%; however, the growth in the PSA far surpasses the average growth rate in communities served by the State's other CAHs (4.6%). The PSA is expected to continue to grow (5.3%) through 2023, with the fastest growth occurring in the 65+ and Hispanic populations. Again, and for comparison, the State is expected to grow by 6.0% between 2018-2023. In contrast to many rural communities in the state, the population of females of childbearing age (15-44) has also grown and is expected to continue to grow.

Table 3
PSA Population Estimates

	2010	Pct. of Tot Pop	2018 Est	Pct. of Tot Pop	Pct. Chg. 2010-2018	2023 Proj.	Pct. of Tot Pop	Pct. Chg. 2018-2023
Tot. Pop.	**41,978**	**100.0%**	**45,003**	**100.0%**	**7.2%**	**47,380**	**100.0%**	**5.3%**
Pop. By Age								
0-17	13,570	32.3%	13,840	30.8%	2.0%	14,272	30.1%	3.1%
18-44	14,520	34.6%	15,857	35.2%	9.2%	16,893	35.7%	6.5%
45-64	9,727	23.2%	9,812	21.8%	0.9%	9,803	20.7%	-0.1%
65-74	2,463	5.9%	3,466	7.7%	40.7%	3,945	8.3%	13.8%
75-84	1,226	2.9%	1,500	3.3%	22.3%	1,917	4.0%	27.8%
85+	472	1.1%	528	1.2%	11.9%	550	1.2%	4.2%
Tot. 0-64	37,817	90.1%	39,509	87.8%	4.5%	40,968	86.5%	3.7%
Tot. 65 +	4,161	9.9%	5,494	12.2%	32.0%	6,412	13.5%	16.7%
Hispanic	21,674	51.7%	25,138	55.9%	16.0%	27,765	58.6%	10.5%
Fem. 15-44	8,248	19.6%	8,782	19.5%	6.5%	9,332	19.7%	6.3%

Source: Nielsen Claritas 2018

As seen in **Table 4**, within the PSA, Prosser and Grandview have a higher percentage of Hispanic residents that the PSA as a whole. Mabton and Benton City/Paterson are growing faster than the PSA as a whole.

Table 4
PSA Population Comparisons

	2018 Total Population	2023 Total Population	% Change 18-23	2018 Hispanic Population	% of Total	2023 Hispanic Population	% Change 18-23
99350 – Prosser	14,674	15,578	6.2%	6,735	45.9%	7,594	12.8%
99320 – Benton City	10,043	10,651	6.1%	2,354	23.4%	2,774	17.8%
99345 – Patterson *	-	-	-	-	-	-	-
Subtotal District	**24,717**	**26,229**	**12.3%**	**9,089**	36.8%	**10,368**	14.1%
98930 – Grandview	15,767	16,430	4.2%	12,330	78.2%	13,399	8.7%
98935 – Mabton	4,519	4,721	4.5%	3,719	82.3%	3,998	7.5%
Subtotal PSA	**45,003**	**47,380**	**5.3%**	**25,138**	55.9%	**27,765**	10.5%
Benton County	197,826	211,302	6.8%	43,589	22.0%	51,275	17.6%
Yakima County	254,171	263,678	3.7%	126,944	49.9%	140,088	10.4%
Washington	7,445,902	7,895,335	6.0%	964,803	13.0%	1,111,083	15.2%

*Source: Nielsen Claritas 2018. *Reported with Prosser (99350).*

D. Demographics-SSA

As depicted in **Table 5**, in 2018, the SSA had a population of just over 38,000. More than 75% of the population is Hispanic. Since the 2010 census, the SSA's total population grew by 5.5%, while the Hispanic population grew by 13.3% and the population age 65+ grew by nearly 17%. The growth in the SSA is less than the growth rate of the PSA. The SSA is expected to continue to grow (4.6%) through 2023, with the fastest growth still occurring in the 65+ and Hispanic populations. Again, and as with the PSA, women of childbearing age are expected to continue to grow as well.

Table 5
SSA Population

	2010	Pct. of Tot Pop	2018 Est	Pct. of Tot Pop	Pct. Chg. 2010-2018	2023 Proj.	Pct. of Tot Pop	Pct. Chg. 2018-2023
Tot. Pop.	**36,228**	**100.0%**	**38,232**	**100.0%**	**5.5%**	**39,980**	**100.0%**	**4.6%**
Pop. By Age								
0-17	13,088	36.1%	13,191	34.5%	0.8%	13,450	33.6%	2.0%
18-44	13,068	36.1%	14,052	36.8%	7.5%	14,812	37.0%	5.4%
45-64	6,836	18.9%	7,211	18.9%	5.5%	7,524	18.8%	4.3%
65-74	1,742	4.8%	2,207	5.8%	26.7%	2,436	6.1%	10.4%
75-84	1,035	2.9%	1,097	2.9%	6.0%	1,295	3.2%	18.0%
85+	459	1.3%	474	1.2%	3.3%	463	1.2%	-2.3%
Tot. 0-64	32,992	91.1%	34,454	90.1%	4.4%	35,786	89.5%	3.9%
Tot. 65 +	3,236	8.9%	3,778	9.9%	16.7%	4,194	10.5%	11.0%
Hispanic	25,219	69.6%	28,577	74.7%	13.3%	31,137	77.9%	9.0%
Fem. 15-44	7,353	20.3%	7,833	20.5%	6.5%	8,209	20.5%	4.8%

Source: Nielsen Claritas 2018.

Table 6 demonstrates that within the SSA, Sunnyside, the largest of the communities, is growing at a slower rate than the other communities. More than four-fifths of Sunnyside's population is Hispanic.

Table 6
SSA Population Comparisons

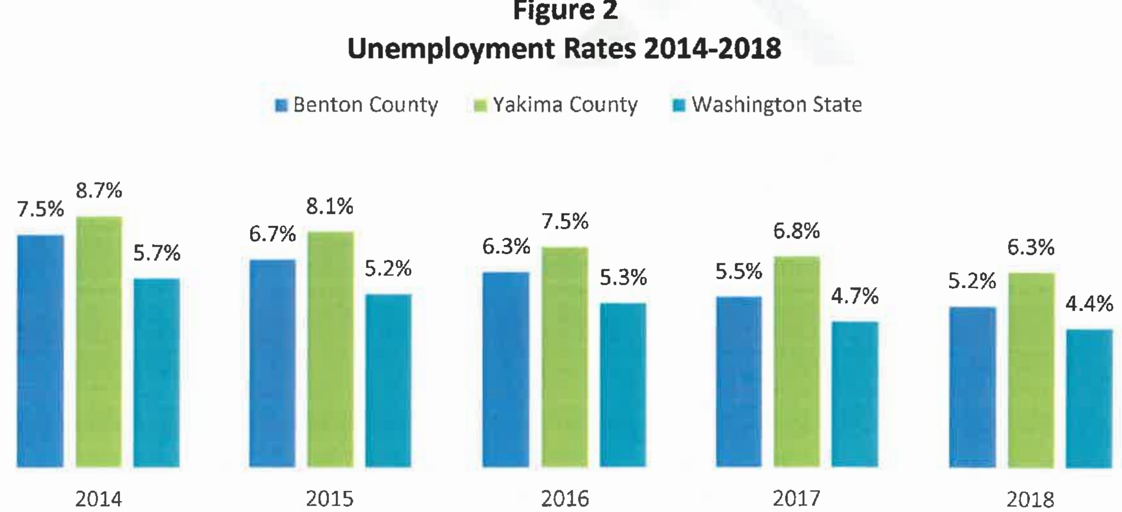
	2018 Total Population	2023 Total Population	% Change 18-23	2018 Hispanic Population	% of Total	2023 Hispanic Population	% Change 18-23
98944 – Sunnyside	22,341	23,015	3.0%	18,141	81.2%	19,293	6.4%
99353 – Zillah	7,839	8,300	5.9%-	4,172	53.2%	4,837	15.9%-
98932- Granger	5,644	6,141	8.8%	4,600	81.5%	5,152	12.0%
98938 – Outlook	2,408	2,524	4.8%	1,664	69.1%	1,855	11.5%
Subtotal SSA	**38,232**	**39,980**	**4.6%**	**28,577**	**74.7%**	**31,137**	**9.0%**
Benton County	197,826	211,302	6.8%	43,589	22.0%	51,275	17.6%
Yakima County	254,171	263,678	3.7%	126,944	49.9%	140,088	10.4%
Washington	7,445,902	7,895,335	6.0%	964,803	13.0%	1,111,083	15.2%

Source: Nielsen Claritas 2018.

E. Socioeconomic Characteristics

Unemployment data is available only at the County level. Though unemployment rates have improved since 2014, rates in Benton and Yakima County are still higher than that of Washington State. Benton County's unemployment has gone from 7.5% in 2014 to 5.2% in 2018 (a decrease of 30.7%). Comparatively, Washington State's rate went from 5.7% in 2014 to 4.4% in 2018 (a decrease of 22.8%). Yakima County has also decreased since 2014, going from 8.7% to 6.3% (a decrease of 27.6%). The data is summarized in **Figure 2**.

Figure 2
Unemployment Rates 2014-2018



Source: U.S. Bureau of Labor Statistics, Seasonally Adjusted, Average Annual

Table 7 shows the PSA's major employers, which is generally agricultural or public in nature.

Table 7
Employers, by Number of Employees within the PSA

Employer	Employees
Ste. Michelle Wine Estates	1,100
Walmart Grocery Distribution Center	719
Grandview School PSA	562
Zirkle Fruit	380
FruitSmart	368
Prosser School PSA	316
Prosser Memorial Hospital	300
WSU/IAREC	207
Benton County Government	144
Tree Top, Inc.	125
Milne Fruit	120
Yakima Valley Farm Worker's Clinic	116
Conrad Adams Fruit	100 + 316 seasonal
Chukar Cherries	100
Bleyhel Farm Services	89
J M Smucker Company	75
Yakima Valley College	70
Welch Grape	60
City of Grandview	58
Benton Rural Electric	54
City of Prosser	50
Shonan (USA)	50

Source: www.trytricitiessites.org; www.portofgrandview.org; www.prosser.org

The average household income for the entirety of Benton County, Yakima County, and the PSA is lower than the State **(Table 8)**. Within the PSA, the communities of Prosser and Grandview are lower than Benton County and the State.

Table 8
Average Household Income by Area, 2018

	Average HH Income
98930 – Prosser	$54,251
99345 – Benton City	*
99350 – Preston	$66,230
District	$60,524
98935 – Grandview	$55,145
99320 – Mabton	$70,380
PSA	$62,656
Benton County	$79,097
Yakima County	$64,030
Washington	$88,288

*Source: Nielsen Claritas 2018. *Reported with Preston (99350).*

E. Health Status

The Robert Wood Johnson Foundation's County Health Rankings compares and ranks counties (relative to the health of other counties in the same state) on more than 30 health status indicators. 2019 summary composite scores for Benton County and Yakima County, compared to the State, are identified in **Table 9**.

Benton County is among the middle-tier of the 39 counties in the State regarding health outcomes and health factors, meaning they are similar to Washington State on many measures while Yakima County is in the lowest quartile. Out of Washington's 39 Counties, Benton County ranks 15th in health outcomes and 20th in health factors while Yakima County is ranked 32nd in health outcomes and 38th in health factors. Health outcomes include mortality and morbidity and include such factors as premature death, poor or fair health, poor physical or mental health days and low birthweight. Health factors include: clinical care (uninsured adults, primary care provider rates, preventable hospital stays and diabetic screenings), health behaviors (adult smoking, obesity, binge drinking, motor vehicle deaths, teen pregnancy and chlamydia).

Table 9
County Health Status Indicators

	Washington	Benton	Yakima
Health Measures			
% Fair/Poor Health	14%	13%	21%
% Smokers	14%	13%	15%
% Obese	28%	30%	32%
Health Risks			
% Physically Inactive	16%	17%	22%
% Excessive Drinking	18%	20%	17%
Access to Care			
Primary Care Ratio	1218:1	1467:1	1580:1
Dentist Ratio	1237:1	1396:1	1489:1
Mental Health Ratio	310:1	466:1	376:1
Percent Uninsured	7%	7%	13%
Preventive Measures			
Preventable Hospitalization Stays	2914	4162	3773
% Flu Vaccinations	44%	49%	46%
% Mammography	39%	46%	38%
Community Measures			
HS Graduation Rate	79%	77%	79%
% Unemployed	4.8%	5.5%	6.8%
% Children in Poverty	14%	17%	26%
% Single-Parent Households	28%	31%	39%
Teen Birth Rate (per 1,000)	20	28	46

Source: County Health Rankings 2019

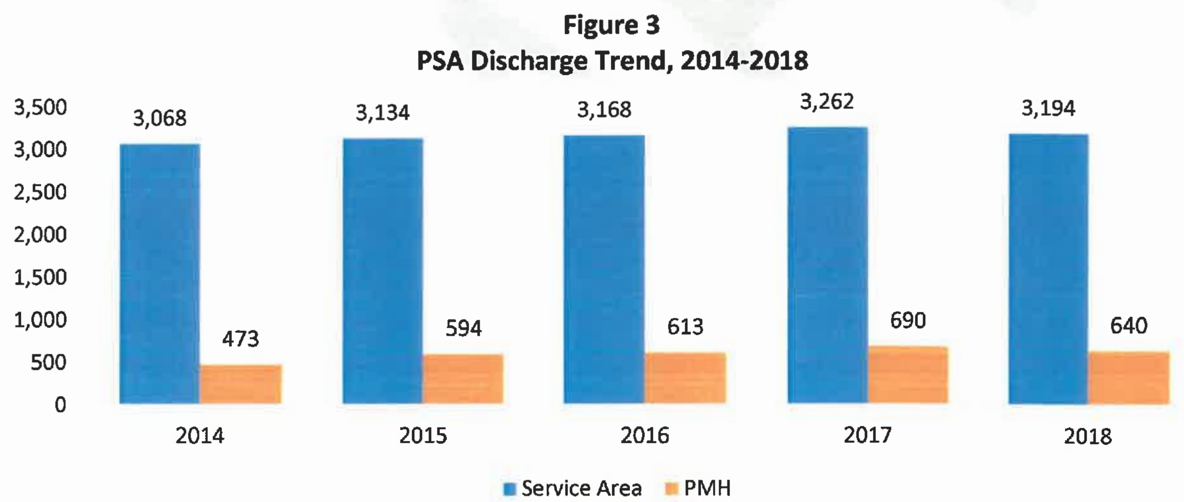
Section 2: PSA Volumes, PMH Market Shares and Competitor Profiles

A. PSA Inpatient Volumes

Hospital inpatient data was obtained from the Washington State Comprehensive Hospital Abstract Reporting System (CHARS) for the period of 2014 to 2018[2]. This data represents every hospitalization occurring in a Washington hospital regardless of payer.

Total inpatient discharges for patients residing in the PSA totaled 2,918 in 2018. Discharges in the PSA increased by nearly % between 2014 and 2017 before declining in 2018[3]. (**Figure 3**). PMH's discharges from PSA residents increased by more than 35% during the 2014-2018 and then decreased as well in 2018. PMH total discharges (regardless of where the patients resided) increased by nearly 57% over the period of 2014 to 2018.

Figure 3
PSA Discharge Trend, 2014-2018



Source: Washington CHARS State database, 2014-2018, excludes all newborns, swing beds and observation.

Total inpatient days generated by PSA residents are shown in **Figure 4**. Among PSA residents, total days increased by 8.2% between 2014 to 2017, and were relatively flat between 2017 and 2018. Similar to its discharges, PMH's PSA resident days increased by 33% between 2014 and 2017 but decreased by 8.5% between 2017 and 2018. PMH total days (regardless of where the patients reside) increased by nearly 35%, excluding swing bed census, from 2014 to 2018.

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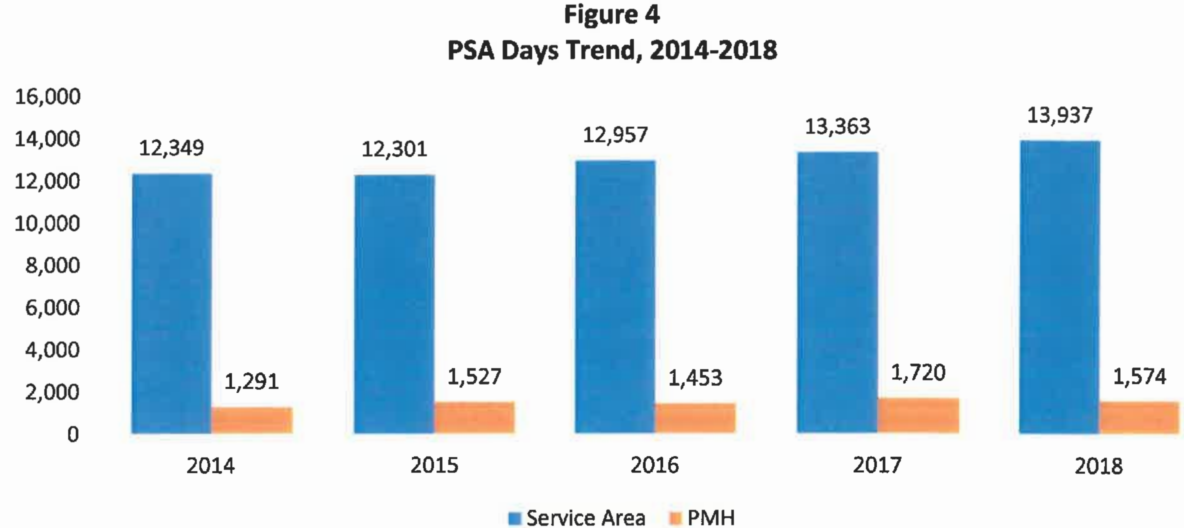
[2] Less than 1% of PSA discharges went to an Oregon Hospital.

[3] Please note that Astria Sunnyside did not report any inpatient data for the second half of 2018; likely due to issues related to its electronic medical record conversion. In this report, Astria Sunnyside's utilization in the PSA has been doubled to account for the underreporting. Therefore, total PSA discharges and patient days for 2018 are estimated.

Figure 4
PSA Days Trend, 2014-2018



Source: Washington CHARS State database, 2014-2018, excludes all newborns, swing beds and observation.

B. Hospitals Serving the PSA

Table 10 depicts the hospitals providing the predominance of care to PSA residents. It also depicts their change in inpatient discharges and patient days between 2014 and 2018. The top hospitals serving the PSA include PMH, Kadlec Regional Medical Center (Richland), and Astria Sunnyside Hospital (Sunnyside). Additionally, there are other providers in the Tri-Cities (Trios Health, Lourdes Medical Center, and Lourdes Counseling Center) and other Yakima County providers (Astria Regional Medical Center and Yakima Valley Memorial Hospital) with market share.

PMH experienced the largest **increase** in discharges when compared to its peer hospitals in the PSA, gaining 167 discharges from 2014 to 2018. Overall, the market is estimated to have gained 126 discharges over the same period with Sunnyside Hospital and Other Yakima providers losing the most discharges. Nearly 65% of the increase in inpatient PSA resident discharges for PMH came from Prosser residents.

Table 10
Change in PSA Inpatient Discharges 2014 to 2018

Hospital Name	Change in PSA Resident Discharges 2014-2018	2014 Market Share	2018 Market Share
PMH Medical Center	167	15.4%	20.0%
Spokane Tertiary	69	1.7%	3.8%
Kadlec Regional Medical Center	51	36.9%	37.0%
Seattle Tertiary	25	6.4%	7.0%
Other Tri-Cities	23	7.4%	7.8%
All Other	19	1.6%	2.1%
Other Yakima	-86	8.1%	5.0%
Astria Sunnyside Hospital	-142	22.6%	17.3%
Total Service Area	**126**	**100.0%**	**100.00%**

Source: Washington CHARS State database, 2014-2018, excludes all newborns, swing beds and observation.

As depicted in **Table 11**, PMH's average daily census (ADC) of PSA patients increased between 2014-2018, from 3.5 to 4.3 in 2018 (22.9% increase). PMH's total ADC increased from 4.2 in 2014 to 5.6 in 2018 (33.3% increase). Its average length of stay increased actually decreased from 2.94 in 2014 to 2.73 in 2018.

Table 11
PMH PSA & Total Selected Inpatient Statistics

Year	Age	ADC		Days		Discharges	
		PSA	Total	PSA	Total	PSA	Total
2014	0 to 64	1.7	2.2	618	789	273	338
	65 plus	1.8	2.0	673	734	200	215
	Total	**3.5**	**4.2**	**1,291**	**1,523**	**473**	**553**
2015	0 to 64	2.0	2.9	748	1,060	355	513
	65 plus	2.1	2.4	779	859	239	262
	Total	**4.2**	**5.3**	**1,527**	**1,919**	**594**	**775**
2016	0 to 64	2.4	3.2	866	1,165	411	556
	65 plus	1.6	1.9	587	678	202	230
	Total	**4.0**	**5.0**	**1,453**	**1,843**	**613**	**786**
2017	0 to 64	2.6	3.7	954	1,341	441	641
	65 plus	2.1	2.4	766	889	249	290
	Total	**4.7**	**6.1**	**1,720**	**2,230**	**690**	**931**
2018	0 to 64	2.4	3.5	875	1,265	409	605
	65 plus	1.9	2.2	699	787	231	262
	Total	**4.3**	**5.6**	**1,574**	**2,052**	**640**	**867**

Source: Washington CHARS State database, 2014-2018, excludes all newborns, swing beds and observation.

For all PSA residents, regardless of which hospital they went to, the largest services lines were General Medicine, OB/Delivery, Orthopedics, Gastroenterology, General Surgery, and Cardiology. **Table 12** shows PSA resident discharges by service line from 2014 to 2018, with the fastest growing services lines (since 2014), in terms of number of discharges, being Orthopedics and Cardiology. Decreases occurred in OB, GI and general medicine, gastroenterology, among others.

Table 12
PSA Discharges by Major Service Line, 2014 and 2018

Service Line	2014 Discharges	2018 Discharges	Change 2014-2018	PMH 2014 Market Share	PMH 2018 Market Share
General Medicine	746	773	3.6%	20.1%	25.0%
OB/Delivery	641	609	-5.0%	19.5%	39.6%
Orthopedics	329	377	14.6%	13.4%	11.9%
Gastroenterology	300	266	-11.3%	14.7%	17.7%
General Surgery	228	250	9.6%	5.3%	6.8%
Cardiology	176	236	34.1%	18.8%	17.4%
Neurosciences	131	152	16.0%	10.7%	17.1%
Oncology	85	109	28.2%	4.7%	6.4%
Other	70	105	50.0%	5.7%	4.8%
Interventional Cardiology	68	86	26.5%	0.0%	0.0%
Psychiatry	72	60	-16.7%	6.9%	3.3%
Cardiac Surgery	47	44	-6.4%	0.0%	0.0%
Other OB	40	38	-5.0%	27.5%	23.7%
Rehabilitation	41	34	-17.1%	12.2%	0.0%
Urology	34	30	-11.8%	5.9%	0.0%
Gynecology	60	25	-58.3%	33.3%	28.0%
Total	**3,068**	**3,194**	**3.6%**	**15.4%**	**20.0%**

Source: Washington CHARS State database, 2014-2018, excludes all newborns, swing beds and observation.

Similarly, the largest service lines at PMH for PSA residents were OB/Delivery, General Medicine, Orthopedics, Gastroenterology, and Cardiology (**Table 13**). Since 2014, PMH's fastest growing service lines have been OB/Delivery and General Medicine.

Table 13
PMH PSA Discharges by Major Service Line, 2014 and 2018

Service Line	2014 Discharges	2018 Discharges	Change in Discharges 2014-2018
OB/Delivery	125	241	116
General Medicine	150	193	43
Orthopedics	44	45	3
Gastroenterology	44	47	1
Cardiology	33	41	8
Neurosciences	14	26	12
General Surgery	12	17	5
Other OB	11	9	-2
Gynecology	20	7	3
Oncology	4	7	-13
Other	4	5	1
Urology	2	0	-3
Psychiatry	5	2	-2
Rehabilitation	5	0	-5
Total	**473**	**640**	**167**

Source: Washington CHARS State database, 2014-2018, excludes all newborns, swing beds and observation.

C. Inpatient Market Share of PSA Residents

Table 14 depicts market share and top competitors for each major inpatient service line. The data shows that Kadlec Regional Medical Center (Kadlec), a tertiary regional provider located in Richland, is the predominate provider with a market share of 37%. PMH's market share increased from 15.4% in 2014 to 20.0% in 2018; an increase of 30%, but it remains second with an overall market share of approximately 20%. During the same period, it is estimated that Astria Sunnyside lost nearly a quarter of its market share.

Table 14
PSA Market Share by Hospital & Service Line, 2014 to 2018, (Discharges)

		PMH	Kadlec Regional Medical Center	Astria Sunnyside Hospital	Other Tri-Cities	Other Yakima County	Spokane Tertiary	Seattle Tertiary	All Other
Cardiac Surgery	**2014**	0.0%	59.6%	0.0%	0.0%	27.7%	6.4%	6.4%	0.0%
	2018	0.0%	47.7%	4.5%	0.0%	6.8%	25.0%	15.9%	0.0%
Cardiology	**2014**	18.8%	36.4%	26.1%	3.4%	10.8%	1.7%	1.7%	1.1%
	2018	17.4%	46.6%	17.8%	4.7%	7.6%	1.3%	3.8%	0.8%
Gastroenterology	**2014**	14.7%	45.3%	20.3%	3.3%	9.0%	0.7%	6.0%	0.7%
	2018	17.7%	40.2%	22.6%	4.5%	5.3%	3.4%	5.6%	0.8%
General Medicine	**2014**	20.1%	42.2%	22.1%	3.5%	6.7%	1.5%	3.1%	0.8%
	2018	25.0%	38.3%	19.7%	5.4%	4.5%	2.8%	3.0%	1.3%
General Surgery	**2014**	5.3%	44.7%	14.0%	2.6%	9.2%	4.4%	18.0%	1.8%
	2018	6.8%	40.4%	14.4%	5.6%	4.8%	7.2%	18.4%	2.4%
Gynecology	**2014**	33.3%	23.3%	28.3%	5.0%	8.3%	0.0%	1.7%	0.0%
	2018	28.0%	40.0%	16.0%	8.0%	0.0%	4.0%	4.0%	0.0%
Interventional Cardiology	**2014**	0.0%	55.9%	0.0%	1.5%	39.7%	0.0%	2.9%	0.0%
	2018	0.0%	51.2%	18.6%	7.0%	5.8%	10.5%	4.7%	2.3%
Neurosciences	**2014**	10.7%	38.2%	10.7%	3.8%	5.3%	3.1%	23.7%	4.6%
	2018	17.1%	44.1%	5.3%	3.3%	4.6%	7.2%	17.1%	1.3%
OB/Delivery	**2014**	19.5%	24.6%	45.4%	6.7%	2.8%	0.2%	0.6%	0.2%
	2018	39.6%	23.6%	29.6%	2.6%	3.1%	0.2%	0.8%	0.5%
Oncology	**2014**	4.7%	48.2%	8.2%	12.9%	14.1%	2.4%	9.4%	0.0%
	2018	6.4%	44.0%	7.3%	5.5%	2.8%	8.3%	20.2%	5.5%
Orthopedics	**2014**	13.4%	33.1%	10.6%	18.8%	8.8%	0.9%	9.7%	4.6%
	2018	11.9%	38.5%	4.8%	25.7%	5.6%	2.1%	8.2%	3.2%
Other	**2014**	5.7%	37.1%	12.9%	1.4%	8.6%	7.1%	24.3%	2.9%
	2018	4.8%	39.0%	17.1%	2.9%	7.6%	10.5%	14.3%	3.8%
Other OB	**2014**	27.5%	30.0%	30.0%	2.5%	7.5%	0.0%	2.5%	0.0%
	2018	23.7%	26.3%	10.5%	2.6%	13.2%	7.9%	5.3%	10.5%
Psychiatry	**2014**	6.9%	12.5%	4.2%	56.9%	4.2%	1.4%	4.2%	9.7%
	2018	3.3%	18.3%	0.0%	45.0%	10.0%	1.7%	3.3%	18.3%
Rehabilitation	**2014**	12.2%	51.2%	0.0%	19.5%	2.4%	0.0%	7.3%	7.3%
	2018	0.0%	58.8%	0.0%	14.7%	8.8%	0.0%	14.7%	2.9%
Urology	**2014**	5.9%	26.5%	5.9%	5.9%	17.6%	17.6%	20.6%	0.0%
	2018	0.0%	26.7%	13.3%	6.7%	6.7%	10.0%	30.0%	6.7%
Total	**2014**	**15.4%**	**36.9%**	**22.6%**	**7.4%**	**8.1%**	**1.7%**	**6.4%**	**1.6%**
	2018	**20.0%**	**37.0%**	**17.3%**	**7.8%**	**5.0%**	**3.8%**	**7.0%**	**2.1%**

Source: Washington CHARS State database, 2014-2018, excludes all newborns, swing beds and observation.

Inpatient Payer Mix of PSA Residents

Data in **Table 15** shows that Medicare is the primary payer for discharges in the PSA, followed closely by Commercial & HMO. Over half of all discharges are paid by Medicare and Medicaid.

Table 15
Provider Inpatient Payer Mix (Discharges) of PSA Residents, 2014 and 2018

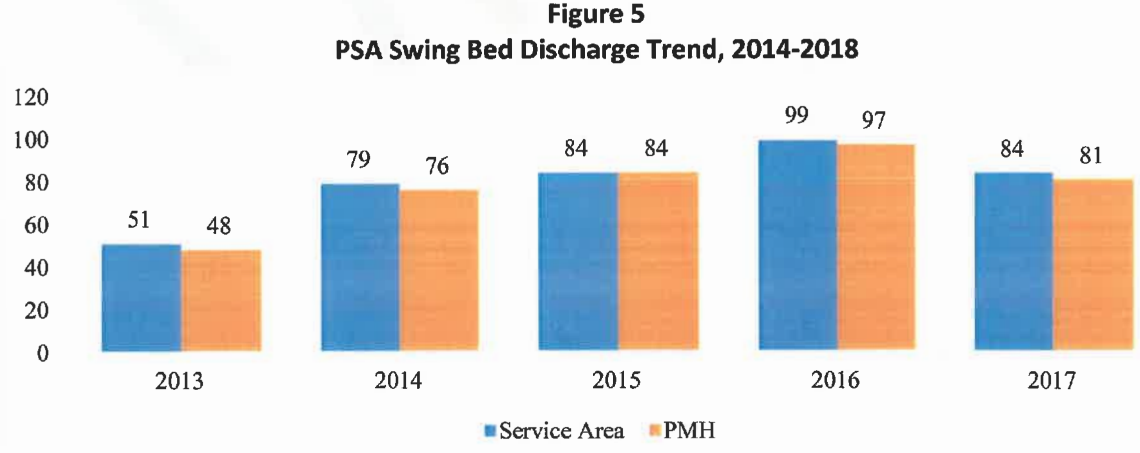
	Commercial & HMO		Medicaid		Medicare		Self-Pay & Other	
	2014	**2018**	**2014**	**2018**	**2014**	**2018**	**2014**	**2018**
PMH	52.4%	50.0%	12.3%	7.3%	34.2%	39.1%	1.1%	3.6%
Kadlec Regional Medical Center	36.1%	45.6%	10.2%	4.3%	47.7%	47.0%	6.0%	3.0%
Astria Sunnyside Hospital	16.6%	9.1%	50.0%	51.4%	29.4%	37.7%	4.0%	1.8%
Other Tri-Cities	48.7%	27.7%	15.0%	16.1%	33.6%	50.6%	2.7%	5.6%
Other Yakima County	44.9%	47.8%	20.2%	12.4%	32.0%	37.9%	2.8%	1.9%
Spokane Tertiary	33.3%	29.2%	37.3%	40.0%	23.5%	26.7%	5.9%	4.2%
Seattle Tertiary	30.5%	38.3%	34.0%	29.7%	31.5%	27.5%	4.1%	4.5%
All Other	29.2%	32.8%	18.8%	31.3%	41.7%	32.8%	10.4%	3.0%
PSA Total	**35.3%**	**40.2%**	**22.8%**	**14.9%**	**37.6%**	**41.5%**	**4.2%**	**3.4%**

Source: Washington CHARS State database, 2014-2018, excludes all newborns, swing beds and observation.

D. PSA Swing Bed Volumes

Total swing bed discharges for PSA residents totaled 84 in 2018. Discharges in the entire PSA have increased by 65% since 2014 (**Figure 5**). PMH has a dominant market share of PSA resident swing bed discharges (96.4% in 2018) and overall, has seen a significant increase in swing bed discharge volume since 2014.

Figure 5
PSA Swing Bed Discharge Trend, 2014-2018



Source: Washington CHARS State database, 2014-2018. Kept swing bed unit only.

E. PSA Outpatient Volumes

To estimate outpatient PSA volume, HFPD obtained 2014, 2016-2017 outpatient estimates from IBM Truven Analytics' Outpatient Profiles, Code Profiles[4]. Truven collects governmental and select commercial outpatient claims data at the CPT code level which, after some adjustments for unavailable claims, produces estimates by zip code for specific CPT codes. **Table 16** shows the largest service lines (by volume) include lab, physical therapy, X-Ray, ED, and outpatient surgery (minor[5]).

Table 16
PSA Market Outpatient Volumes & PMH Market Share, 2014, 2016-2017

Service Line	2014 PSA Volumes	PMH Market Share	2016 PSA Volumes	PMH Market Share	2017 PSA Volumes	PMH Market Share
Lab Tests	248,505	TBD	312,066	TBD	327,086	TBD
Physical Therapy sessions	81,186	TBD	94,147	TBD	91,197	TBD
X-Ray Procedures	24,835	TBD	23,499	TBD	23,446	TBD
Emergency Department[6]	21,232	TBD	20,973	TBD	21,743	TBD
Outpatient Surgery procedures, minor	19,697	TBD	15,702	TBD	14,417	TBD
Outpatient Surgery procedures, major	7,824	TBD	7,712	TBD	7,558	TBD
CT Procedures	4,334	TBD	7,157	TBD	7,384	TBD
Ultrasound - Other procedures	5,113	TBD	7,355	TBD	5,793	TBD
Mammography Procedures	5,772	TBD	5,118	TBD	5,064	TBD
MRI Procedures	3,410	TBD	4,139	TBD	3,958	TBD
Ultrasound - OB procedures	3,370	TBD	3,150	TBD	3,644	TBD
Gastroenterology Endoscopy Procedures	2,836	TBD	2,856	TBD	2,945	TBD
Echocardiography	2,739	TBD	3,010	TBD	2,710	TBD
Chemotherapy visits	1,990	TBD	1,395	TBD	1,411	TBD
Cardiac Rehab visits	635	TBD	1,304	TBD	1,252	TBD
Occupational Therapy sessions	365	TBD	455	TBD	406	TBD
Nuclear Medicine	404	TBD	273	TBD	297	TBD
Total	**434,246**	**TBD**	**510,312**	**TBD**	**520,310**	**TBD**

Source: Truven Analytics outpatient estimates 2014, 2016-2017.

[4] Truven market data is only available for 2014, 2016, and 2017.
[5] Truven defines minor surgery as those occurring in Hospital Outpatient Departments and Physician offices; while major surgery is defined as those procedures occurring in ORs.
[6] Truven updated its Emergency Department methodology in 2016 for WA State counties, including Benton and Yakima County.

Table 17 shows the current PSA volumes for new and established patient office visits.

Table 17
District Outpatient Office Visit by Type & PMH Market Share 2014, 2016-2017

Office Visit Type	2014 PSA Volumes	PMH Market Share	2016 PSA Volumes	WH Market Share	2017 PSA Volumes	WH Market Share
New Patient	22,142	TBD	22,084	TBD	21,185	TBD
Established Patient	169,946	TBD	139,473	TBD	140,312	TBD
Total	**192,087**	TBD	**161,558**	TBD	**161,497**	TBD

Source: Truven Analytics outpatient estimates 2014, 2016-2017.

F. Competitor Profiles

An overview of the main competitors is included below:

Kadlec Regional Medical Center
Kadlec Regional Medical Center (Kadlec), located in Richland, WA, opened in 1944 to care for Hanford workers and their families. Kadlec offers primary and specialty care including open-heart surgery and interventional cardiology, the region's only level III Neonatal Intensive Care Unit, acute rehabilitation, an all digital outpatient imaging center, as well as a number of other services and programs. In early 2014, Kadlec affiliated with Providence Health & Services with the goal being controlling health care costs and providing improved services to Kadlec's service area.

In 2017, Kadlec established two express clinics, one in Richland and one in Kennewick (both with same day appointments, published pricing and operating 8am to 8pm, seven days per week). Today, Kadlec operates 48 clinics in six communities and offers 26 specialties.

Kadlec is currently licensed for 270 beds, with 254 available[7]. Over the past 10 years, Kadlec has increased its licensed bed capacity from 203 to 270. Kadlec has a Certificate of Need application pending requesting another 67 bed increase. Approximately 58% of Kadlec's patients come from Benton County and 7.7% from PMH's PSA. Kadlec's market share of Benton County is approximately X% and its market share of the PSA is 37%.

Kadlec is 26.7 miles and 31 minutes from PMH under normal drive times.

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[7] Kadlec submitted a certificate of need application requesting approval to add 67 acute care beds in three phases. The original decision date was March 2019. Based on current timelines, a decision is likely by late summer/early fall 2019.

Astria Sunnyside Hospital
Astria Sunnyside Hospital was formed with the consolidation of two hospitals (Valley Memorial Hospital and Sunnyside General Hospital) in 1986. Astria Sunnyside became a critical access hospital (CAH) in 2004 and offers a Level IV Emergency Room, Intensive Care Unit, a Level 1 Cardiac facility, a Cancer Center, a Family Birth Center, Nephrology, inpatient and outpatient surgical services, wound Care including a hyperbaric chamber, an intensive outpatient behavioral health services and outpatient hearing and speech services.

Astria's 2018 market share of Benton County is less than 1% and its market share of the PSA is 17%.

Astria Sunnyside Hospital became an affiliate of non-profit Astria Health in September 2017. In May 2019, Astria Health filed for Chapter 11 bankruptcy citing issues with an electronic health records system and a company it hired to manage its revenue cycle last year. Astria Health indicated a large number of accounts receivable claims had not been processed resulting in a cash flow shortage. Astria Health expects to emerge from bankruptcy by the end of 2019.

Astria Sunnyside Hospital is 17.3 miles and 23 minutes from PMH under normal drive times.

Trios Health
Formerly Kennewick General Hospital, and owned and operated by Kennewick Public Hospital District, Trios served Kennewick, Pasco, and Richland—and surrounding communities. Trios is a an 110 acute bed hospital, operating two campuses (Southridge, which opened in 2014 and Auburn Campus, which offers women's and children's services). In the Spring of 2018, Trios Health filed for bankruptcy and it was acquired by LifePoint in August 2018.

Trios' market share of Benton County is approximately 24% and its market share of the PSA is 4.5%.

LifePoint Health, also acquired Lourdes Medical Center and Lourdes Counseling Center in late 2018. Lourdes Medical Center, a 25 bed CAH that also operates a 10 bed acute rehabilitation unit) is located in Pasco, Franklin County (adjacent to Benton County). LifePoint also owns and operates Lourdes Counseling Center, a 32 bed psychiatric hospital located in Richland.

Trios Health is 33.4 miles and 33 minutes from PMH under normal drive times.

Section 3: Future Projections

TBD

DRAFT

Attachment DD

Balance Sheet
April 30, 2020

Assets

	4/30/2020	3/31/2020	4/30/2019
Cash & Temporary Investments	8,034,564	634,157	709,030
Gross Patient Accounts Receivable	22,471,592	26,273,031	19,692,399
Less Allowances for Uncollectible	(14,026,000)	(15,926,000)	(10,720,552)
Net Patient Receivables	8,445,592	10,347,031	8,971,847
Taxes Receivable	567,267	800,717	582,831
Receivable from 3rd Party Payor	1,522,131	1,045,193	798,040
Inventory	415,352	407,556	360,050
Prepaid Expenses	1,319,050	1,265,525	1,519,611
Other Current Assets	4,320,787	195,794	142,215
Total Current Assets	24,624,743	14,695,973	13,083,624
2014 LTGO Bond Funds	-	-	-
Whitehead Fund - LGIP	1,211,402	1,210,592	1,178,393
Funded Depreciation - Cash	583,587	2,318,284	1,784,135
Funded Depreciation - TVI	13,728,889	11,725,523	11,053,793
Bank of America Escrow Account	-	-	-
US Bank GE Escrow Account	1,019,839	-	-
Board Designated Assets	16,543,717	15,254,399	14,016,321
Land	3,128,341	3,128,341	2,728,341
Property Plant & Equipment	42,666,277	42,315,656	36,289,107
Accumulated Depreciation	(27,461,417)	(27,335,605)	(25,016,592)
Net Property Plant & Equipment	18,333,201	18,108,392	14,000,856
Investment & Other Non Current Assets	-	-	-
Unamortized Financing Costs	-	-	-
Intangible Assets	-	-	-
Other Assets	-	-	-
Total Assets	**$ 59,501,661**	**$48,058,764**	**$ 41,100,801**

Liabilities & Fund Balance

	4/30/2020	3/31/2020	4/30/2019
Current Portion of Bonds Payable	270,000	270,000	255,000
Current Portion of Notes & Capitalized Leases	418,578	418,578	384,985
Current Portion of GE US Bank Debt	138,294		
Current Portion of Bank Of America Debt	44,764	89,114	-
Accounts Payable	882,641	1,124,089	1,005,347
Payroll & Related Liabilities	2,820,345	2,810,432	2,303,818
Deferred Tax Revenue	555,726	625,192	555,431
Cost Report Payable	7,394,264	821,280	420,334
Other Payables to 3rd Parties	465,709	465,709	830,700
Deferred EHR Medicare Revenue	220,133	247,650	550,333
Deferred COVID Revenue	3,002,345	-	-
Accrued Interest Payable	98,349	78,679	101,536
Other Current Liabilities	-	-	-
Total Current Liabilities	16,311,148	6,950,723	6,407,484
Non Current Liabilities			
Bonds Payable net of CP	6,036,672	6,037,015	6,310,876
Capital Lease net of CP	-	-	169,056
GE US Bank net of CP	1,096,379	-	-
Bank of America net of CP	5,473,403	5,473,403	-
Total Non Current Liabilities	12,606,454	11,510,418	6,479,932
Total Liabilities	28,917,602	18,461,141	12,887,416
Fund Balance			
Unrestricted Fund Balance	30,584,059	29,597,623	28,213,385
Restricted Fund Balance	-	-	-
Total Fund Balance	30,584,059	29,597,623	28,213,385
Total Liabilities & Fund Balance	**$59,501,661**	**$48,058,764**	**$41,100,801**

Balance Sheet
April 30, 2020

Assets

	4/30/2020	3/31/2020	12/31/2019
Cash & Temporary Investments	8,034,564	634,157	790,127
Gross Patient Accounts Receivable	22,471,592	26,273,031	26,420,075
Less Allowances for Uncollectible	(14,026,000)	(15,926,000)	(15,682,980)
Net Patient Receivables	8,445,592	10,347,031	10,737,095
Taxes Receivable	567,267	800,717	26,908
Receivable from 3rd Party Payor	1,522,131	1,045,193	832,383
Inventory	415,352	407,556	401,623
Prepaid Expenses	1,319,050	1,265,525	1,608,293
Other Current Assets	4,320,787	195,794	204,486
Total Current Assets	24,624,743	14,695,973	14,600,915
2014 LTGO Bond Funds	-	-	-
Whitehead Fund - LGIP	1,211,402	1,210,592	1,205,889
Funded Depreciation - Cash	583,587	2,318,284	44,372
Funded Depreciation - TVI	13,728,889	11,725,523	13,880,674
Bank of America Escrow Account	-	-	346,920
US Bank GE Escrow Account	1,019,839	-	-
Board Designated Assets	16,543,717	15,254,399	15,477,855
Land	3,128,341	3,128,341	3,128,341
Property Plant & Equipment	42,666,277	42,315,656	41,862,864
Accumulated Depreciation	(27,461,417)	(27,335,605)	(26,677,266)
Net Property Plant & Equipment	18,333,201	18,108,392	18,313,939
Investment & Other Non Current Assets	-	-	-
Unamortized Financing Costs	-	-	-
Intangible Assets	-	-	-
Other Assets	-	-	-
Total Assets	**$ 59,501,661**	**$48,058,764**	**$ 48,392,709**

Liabilities & Fund Balance

	4/30/2020	3/31/2020	12/31/2019
Current Portion of Bonds Payable	270,000	270,000	270,000
Current Portion of Notes & Capitalized Leases	418,578	418,578	418,578
Current Portion of GE US Bank Debt	138,294		
Current Portion of Bank Of America Debt	44,764	89,114	177,395
Accounts Payable	882,641	1,124,089	1,217,346
Payroll & Related Liabilities	2,820,345	2,810,432	3,516,028
Deferred Tax Revenue	555,726	625,192	-
Cost Report Payable	7,394,264	821,280	839,378
Other Payables to 3rd Parties	465,709	465,709	465,709
Deferred EHR Medicare Revenue	220,133	247,650	330,200
Deferred COVID Revenue	3,002,345	-	-
Accrued Interest Payable	98,349	78,679	19,670
Other Current Liabilities	-	-	-
Total Current Liabilities	16,311,148	6,950,723	7,254,304
Non Current Liabilities			
Bonds Payable net of CP	6,036,672	6,037,015	6,038,044
Capital Lease net of CP	-	-	-
GE US Bank net of CP	1,096,379	-	-
Bank of America net of CP	5,473,403	5,473,403	5,473,403
Total Non Current Liabilities	12,606,454	11,510,418	11,511,447
Total Liabilities	28,917,602	18,461,141	18,765,751
Fund Balance			
Unrestricted Fund Balance	30,584,059	29,597,623	29,626,958
Restricted Fund Balance	-	-	-
Total Fund Balance	30,584,059	29,597,623	29,626,958
Total Liabilities & Fund Balance	**$59,501,661**	**$48,058,764**	**$48,392,709**

Statement of Operations

April 30, 2020

Month Ending Actual	Month Ending Budget	Month Ending Variance	%	Prior Year	%		Year to Date Actual	Year to Date Budget	Year to Date Variance	%	Prior Year	%
						Gross Patient Services Revenue						
$ 2,206,745	$ 2,886,162	$ (679,417)	-24%	$ 2,646,540	-17%	Inpatient	$ 10,716,736	$ 11,043,459	$ (326,723)	-3%	$ 10,664,565	0%
5,357,211	10,507,137	(5,149,926)	-49%	9,466,787	-43%	Outpatient	33,755,965	40,203,957	(6,447,992)	-16%	36,126,567	-7%
7,563,956	13,393,299	(5,829,343)	-44%	12,113,327	-38%	**Total Gross Patient Services Revenue**	44,472,701	51,247,416	(6,774,715)	-13%	46,791,132	-5%
						Deductions from Revenue						
						Contractual Allowances						
995,183	2,691,710	1,696,527	63%	1,932,240	-48%	Medicare	8,120,650	10,299,419	2,178,769	21%	7,754,834	5%
2,088,300	2,976,358	888,058	30%	2,694,779	-23%	Medicaid	9,796,382	11,388,580	1,592,198	14%	10,852,926	-10%
363,732	1,719,414	1,355,682	79%	1,582,034	-77%	Negotiated Rates	5,430,256	6,579,073	1,148,817	17%	5,750,281	-6%
40,602	188,017	147,415	78%	128,732	-68%	Other Adjustments	850,286	719,417	(130,869)	-18%	539,006	58%
3,487,817	7,575,499	4,087,682	54%	6,337,785	-45%	**Gross Contractual Allowances**	24,197,574	28,986,489	4,788,915	17%	24,897,047	-3%
3,487,817	7,575,499	4,087,682	54%	6,337,785	-45%	**Net Contractual Allowances**	24,197,574	28,986,489	4,788,915	17%	24,897,047	-3%
40,927	167,099	126,172	76%	162,640	-75%	Charity Care	466,803	639,377	172,574	27%	565,755	-17%
268,555	352,405	83,850	24%	547,800	-51%	Bad Debt	1,115,026	1,348,422	233,396	17%	1,522,455	-27%
3,797,299	8,095,003	4,297,704	53%	7,048,225	-46%	**Total Deductions From Revenue**	25,779,403	30,974,288	5,194,885	17%	26,985,257	-4%
3,766,657	5,298,296	(1,531,639)	-29%	5,065,102	-26%	**Net Patient Services Revenue**	18,693,298	20,273,128	(1,579,830)	-8%	19,805,875	-6%
2,260,337	59,304	2,201,033	3711%	86,500	2513%	Other Operating Revenue	2,440,359	349,308	2,091,051	599%	433,295	463%
6,026,994	**5,357,600**	**669,394**	**12%**	**5,151,602**	**17%**	**Net Revenue**	**21,133,657**	**20,622,436**	**511,221**	**2%**	**20,239,170**	**4%**
						Operating Expenses						
2,243,147	2,390,359	147,212	6%	2,179,819	3%	Salaries	9,387,961	9,275,652	(112,309)	-1%	8,782,409	7%
739,833	552,287	(187,546)	-34%	565,090	31%	Benefits	2,315,378	2,178,153	(137,225)	-6%	2,172,610	7%
261,699	196,977	(64,722)	-33%	302,987	-14%	Purchased Labor	1,123,759	753,703	(370,056)	-49%	1,143,357	-2%
3,244,679	3,139,623	(105,056)	-3%	3,047,896	6%	Sub-Total Labor Costs	12,827,098	12,207,508	(619,590)	-5%	12,098,376	6%
419,725	316,609	(103,116)	-33%	229,381	83%	Professional Fees - Physicians	1,356,945	1,266,437	(90,508)	-7%	1,004,269	35%
93,438	45,205	(48,233)	-107%	45,719	104%	Professional Fees - Other	215,234	180,819	(34,415)	-19%	203,818	6%
527,615	641,457	113,842	18%	552,765	-5%	Supplies	2,466,242	2,551,041	84,799	3%	2,090,570	18%
31,315	44,683	13,368	30%	30,452	3%	Purchased Services - Utilities	159,289	178,732	19,443	11%	152,346	5%
222,165	280,078	57,913	21%	288,215	-23%	Purchased Services - Other	1,073,873	1,123,898	50,025	4%	1,149,257	-7%
152,417	188,579	36,162	19%	203,415	-25%	Rentals & Leases	685,789	754,315	68,526	9%	748,368	-8%
85,150	61,442	(23,708)	-39%	63,315	34%	Insurance License & Taxes	321,680	242,204	(79,476)	-33%	209,211	54%
228,367	226,667	(1,700)	-1%	187,921	22%	Depreciation & Amortization	902,491	906,667	4,176	0%	737,771	22%
92,318	122,503	30,185	25%	38,231	141%	Other Operating Expenses	416,959	490,020	73,061	15%	368,713	13%
1,852,510	1,927,223	74,713	4%	1,639,414	13%	Sub-Total Non-Labor Expenses	7,598,502	7,694,133	95,631	1%	6,664,323	14%
5,097,189	**5,066,846**	**(30,343)**	**-1%**	**4,687,310**	**9%**	**Total Operating Expenses**	**20,425,600**	**19,901,641**	**(523,959)**	**-3%**	**18,762,699**	**9%**
929,805	**290,754**	**639,051**	**220%**	**464,292**	**100%**	**Operating Income (Loss)**	**708,057**	**720,795**	**(12,738)**	**-2%**	**1,476,471**	**-52%**
						Non Operating Income						
73,881	69,466	4,415	6%	73,419	1%	Tax Revenue	288,282	277,863	10,419	4%	287,266	0%
18,000	22,706	(4,706)	-21%	25,735	-30%	Investment Income	82,340	90,825	(8,485)	-9%	86,859	-5%
(35,750)	(33,632)	(2,118)	6%	(20,307)	76%	Interest Expense	(122,078)	(134,529)	12,451	-9%	(81,229)	50%
500	537	(37)	-7%	-	0%	Other Non Operating Income (Expense)	500	2,147	(1,647)	-77%	(5,463)	-109%
56,631	**59,077**	**(2,446)**	**-4%**	**78,847**	**-28%**	**Total Non Operating Income**	**249,044**	**236,306**	**12,738**	**5%**	**287,433**	**-13%**
$ 986,436	**$ 349,831**	**$ 636,605**	**182%**	**$ 543,139**	**82%**	**Net Income (Loss)**	**$ 957,101**	**$ 957,101**	**$ -**	**0%**	**$ 1,763,904**	**-46%**

Statement of Cash Flows
April 30, 2020

CURRENT MONTH Actual	NET INCOME TO NET CASH BY OPERATIONS	YEAR TO DATE Actual
986,436	**NET INCOME (LOSS)**	**957,101**
228,367	Depreciation Expense	902,491
-	Amortization	-
(500)	Loss (Gain) on Sale of Assets	(500)
1,214,303	**TOTAL**	**1,859,092**
	WORKING CAPITAL	
(2,528,363)	Decrease (Increase) in Assets	2,779,391
9,360,425	Increase (Decrease) in Liabilities	9,056,844
8,046,365	**NET CASH PROVIDED BY OPERATIONS**	**13,695,327**
	CASH FLOWS FROM INVESTING ACTIVITIES	
(350,621)	Capital Purchasing	(803,413)
500	Proceeds on Capital Assets Sold	500
(26,358)	Investment Activity	(5,601,954)
(376,479)	**NET CASH USED BY INVESTING ACTIVITIES**	**(6,404,867)**
7,669,886	**NET CHANGE IN CASH**	**7,290,460**
	CASH BALANCE	
15,888,556	**BEGINNING**	**16,267,982**
23,558,442	**ENDING**	**23,558,442**
7,669,886	**NET CASH FLOW**	**7,290,460**

Statement of Cash Flows - 12 Month Trend
April 30, 2020

	May-19 Actual	Jun-19 Actual	Jul-19 Actual	Aug-19 Actual	Sep-19 Actual	Oct-19 Actual	Nov-19 Actual	Dec-19 Actual	Jan-20 Actual	Feb-20 Actual	Mar-20 Actual	CURRENT Apr-20 Actual
NET INCOME TO NET CASH BY OPERATIONS												
NET INCOME (LOSS)	442,822	477,668	(345,192)	69,889	203,716	281,784	(360,709)	369,020	240,864	(120,425)	(149,776)	(181,950)
Depreciation Expense	203,764	204,612	207,114	207,017	214,609	222,284	222,109	224,314	222,577	227,538	224,010	228,367
Amortization	-	-	-	-	-	-	-	-	-	-	-	-
Loss (Gain) on Sale of Assets	-	-	-	-	-	-	-	-	-	-	-	(500)
TOTAL	646,586	682,280	(138,078)	276,906	418,325	504,068	(138,600)	593,334	463,441	107,113	74,234	45,917
WORKING CAPITAL												
Decrease (Increase) in Assets	817,036	(706,993)	1,045,324	28,438	(1,351,916)	(492,108)	14,884	(645,214)	(518,949)	(469,109)	555,768	1,642,369
Increase (Decrease) in Liabilities	636,479	811,419	241,723	(731,841)	666,840	109,671	83,018	(772,023)	(648,957)	83,249	262,126	6,358,079
NET CASH PROVIDED BY OPERATIONS	2,100,101	786,706	1,148,969	(426,497)	(266,751)	121,631	(40,698)	(823,903)	(704,465)	(278,747)	892,128	8,046,365
CASH FLOWS FROM INVESTING ACTIVITIES												
Capital Purchasing	(3,727,384)	(57,898)	(429,262)	(151,396)	(842,075)	(193,078)	(380,203)	207,539	(292,919)	(35,283)	(124,590)	(350,621)
Proceeds on Capital Assets Sold	-	-	-	-	-	-	-	-	-	-	-	500
Investment Activity	3,419,309	(354)	(3,588)	(2,916)	(2,597)	427,679	248,949	152,962	137,518	165,135	(343)	(26,358)
NET CASH USED BY INVESTING ACTIVITIES	(308,075)	(58,252)	(432,850)	(154,312)	(844,672)	234,601	(131,254)	360,501	(155,401)	129,852	(124,933)	(376,479)
NET CHANGE IN CASH	1,792,026	728,454	716,119	(580,809)	(1,111,423)	356,232	(171,952)	(463,403)	(859,866)	(148,895)	767,195	7,669,886
CASH BALANCE												
BEGINNING	14,725,351	16,517,377	17,245,831	17,961,950	17,381,141	16,269,718	16,625,950	16,453,998	15,990,595	15,270,256	15,121,361	15,888,556
ENDING	16,517,377	17,245,831	17,961,950	17,381,141	16,269,718	16,625,950	16,453,998	15,990,595	15,130,729	15,121,361	15,888,556	23,558,442
NET CASH FLOW	1,792,026	728,454	716,119	(580,809)	(1,111,423)	356,232	(171,952)	(463,403)	(859,866)	(148,895)	767,195	7,669,886

Direct Cash Flow Statement
April 30, 2020

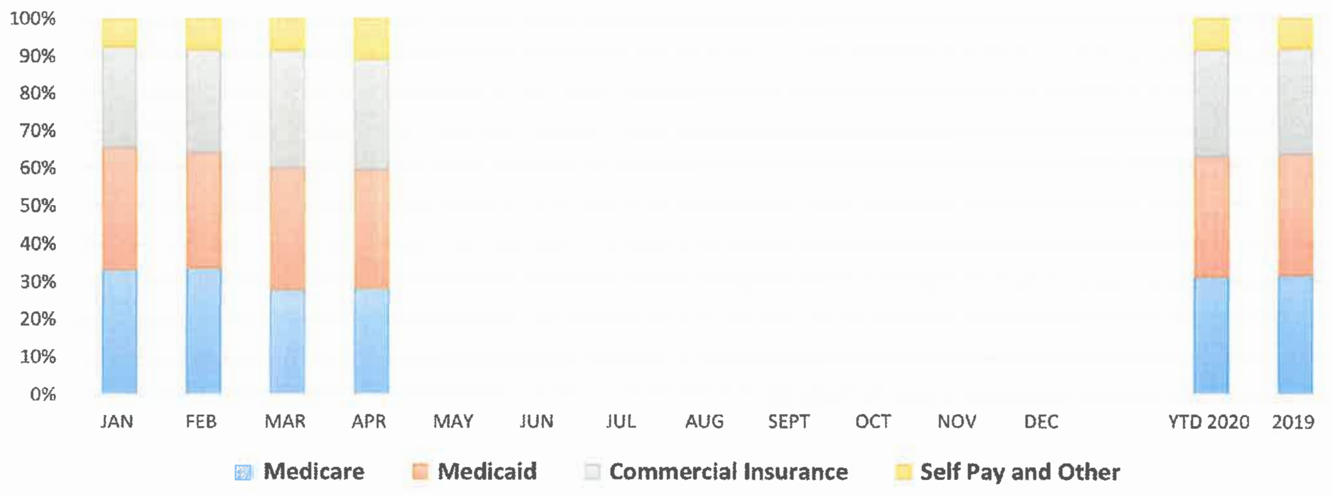
	August 31, 2019 Actual	September 30, 2019 Actual	October 31, 2019 Actual	November 30, 2019 Actual	December 31, 2019 Actual	January 31, 2020 Actual	February 29, 2020 Actual	March 31, 2020 Actual	April 30, 2020 Actual
CASH FLOWS FROM OPERATING									
PAYMENTS RECEIVED									
Commercial		1,425,376	1,658,587	1,712,336	2,110,960	2,164,596	1,790,819	2,042,936	2,163,134
Medicaid		974,783	1,332,291	1,150,609	1,223,633	1,287,731	1,116,011	1,207,273	1,200,088
Medicare		501,236	1,299,895	1,316,188	1,730,631	1,555,473	597,037	1,403,309	1,326,305
VA		41,311	10,616	28,210	26,049	24,261	82,909	34,277	86,268
Worker's Comp		74,716	98,824	126,432	66,062	396,141	180,120	165,706	151,215
Self Pay		263,000	265,218	630,997	265,490	37,674	182,202	162,759	149,324
Other Non Patient Payments		497,206	364,841	287,781	660,275	212,931	210,958	475,782	7,921,843
Cash Received (Patients, Insurance, Other)	5,118,733	3,777,628	5,030,272	5,252,553	6,083,101	5,678,807	4,160,056	5,492,042	12,998,177
Patient Refunds	(14,770)	(5,755)	(106,029)	(7,988)	(6,268)	(4,845)	(4,203)	(4,127)	(1,869)
AP Expenses	(2,057,213)	(1,766,953)	(2,130,931)	(2,649,740)	(2,850,985)	(2,559,258)	(1,989,807)	(2,101,189)	(2,556,196)
Settlement LumpSum Payments					(1,187,000)	-	-	-	-
Payroll Expenses	(3,418,696)	(2,216,802)	(2,186,535)	(2,329,107)	(2,652,323)	(3,566,717)	(2,279,658)	(2,437,474)	(2,362,138)
Loan/Interest Expense	(57,467)	(57,467)	(57,467)	(57,467)	(57,467)	(114,934)	-	(57,467)	(57,467)
NET CASH PROVIDED BY OPERATING	(429,413)	(269,348)	549,310	208,251	(670,942)	(566,947)	(113,612)	891,785	8,020,507
CASH FLOWS FROM INVESTING ACTIVITIES									
Capital Purchasing	(151,396)	(842,075)	(193,078)	(380,203)	207,539	(292,919)	(35,283)	(124,590)	(350,621)
NET CASH USED BY INVESTING ACTIVITIES	(151,396)	(842,075)	(193,078)	(380,203)	207,539	(292,919)	(35,283)	(124,590)	(350,621)
NET CHANGE IN CASH	(580,809)	(1,111,423)	356,232	(171,952)	(463,403)	(859,866)	(148,895)	767,195	7,669,886
CASH BALANCE									
BEGINNING	17,961,950	17,381,141	16,269,718	16,625,950	16,453,998	15,990,595	15,270,256	15,121,361	15,888,556
ENDING	17,381,141	16,269,718	16,625,950	16,453,998	15,990,595	15,130,729	15,121,361	15,888,556	23,558,442
NET CASH FLOW	(580,809)	(1,111,423)	356,232	(171,952)	(463,403)	(859,866)	(148,895)	767,195	7,669,886
		-	-			-	-	-	-

Key Operating Statistics
April 30, 2020

Month Ending Actual	Month Ending Budget	Month Ending Variance	Month Ending %	Key Volumes	Year to Date Actual	Year to Date Budget	Year to Date Variance	Year to Date %	Prior Year	Change
158	204	(46)	-23%	Inpatient Acute Days	767	822	(55)	-7%	862	-11%
96	172	(76)	-44%	Inpatient Swing Days	512	694	(182)	-26%	604	-15%
254	376	(122)	-32%	**Total Inpatient Days**	1,279	1,516	(237)	-16%	1,466	-13%
70	82	(12)	-14%	Inpatient Admissions	302	330	(28)	-9%	333	-9%
68	82	(14)	-17%	Inpatient Discharges	302	330	(28)	-9%	334	-10%
10	12	(2)	-20%	Swing Bed Discharges	39	50	(11)	-23%	47	-17%
871	1,745	(874)	-50%	Adjusted Patient Days	5,308	7,036	(1,729)	-25%	6,432	-17%
8.47	12.53	(4.06)	-32%	Average Daily Census	10.57	12.53	(1.96)	-16%	12.22	-13%
233	380	(147)	-39%	Adjusted Discharges	1,253	1,532	(279)	-18%	1,465	-14%
2.32	2.49	(0.17)	-7%	Average Length of Stay - Hospital	2.54	2.49	0.05	2%	2.58	-2%
9.60	13.77	(4.17)	-30%	Average Length of Stay - Swing Bed	13.13	13.77	(0.64)	-5%	12.85	2%
34%	50%	-16%	-32%	Acute Care Occupancy (25)	42%	50%	-8%	-16%	49%	-13%
36	37	(1)	-3%	Deliveries	138	149	(11)	-7%	137	1%
32	124	(92)	-74%	Surgical Procedures	331	501	(170)	-34%	482	-31%
526	1,008	(482)	-48%	Emergency Dept Visits	3,531	4,068	(537)	-13%	3,891	-9%
7,900	12,094	(4,194)	-35%	Laboratory Tests	41,361	48,778	(7,417)	-15%	47,622	-13%
1,358	2,087	(729)	-35%	Radiology Exams	8,210	8,417	(207)	-2%	7,386	11%
588	1,048	(460)	-44%	PMH Specialty Clinic	3,907	4,228	(321)	-8%	3,729	5%
643	991	(348)	-35%	PMH - Benton City Clinic Visits	3,695	3,999	(304)	-8%	3,694	0%
842	1,038	(196)	-19%	PMH - Prosser Clinic Visits	3,870	4,186	(316)	-8%	3,890	-1%
474	610	(136)	-22%	PMH - Grandview Clinic Visits	2,550	2,459	91	4%	1,745	46%
455	699	(244)		PMH - Women's Health Clinic Visits	2,366	2,819	(453)		730	224%
				LABOR FULL-TIME EQUIVALENT						
260.26	290.82	30.56	11%	Employed Staff FTE's	265.70	290.82	25.12	9%	253.48	5%
29.74	30.48	0.74	2%	Employed Provider FTE	29.66	30.48	0.82	3%	24.02	23%
290.00	321.30	31.30	10%	All Employee FTE's	295.36	321.30	25.94	8%	277.50	6%
252.30	273.11	20.81	8%	Productive FTE's	259.47	273.11	13.64	5%	248.84	4%
7.10	20.86	13.76	66%	Outsourced Therapy FTE's	16.01	20.86	4.85	23%	15.88	1%
4.44	1.56	(2.88)	-185%	Contracted Staff FTE's	5.89	4.07	(1.82)	-45%	3.32	77%
11.54	22.42	10.88		All Purchased Staff FTE's	21.90	22.42	3.03	14%	19.20	14%
6.23	4.58	(1.65)	-36%	Contracted Provider FTE's	6.93	4.58	(2.35)	-51%	5.85	18%
307.77	348.30	40.53	12%	All Labor FTE's	324.19	348.30	26.62	8%	302.55	7%

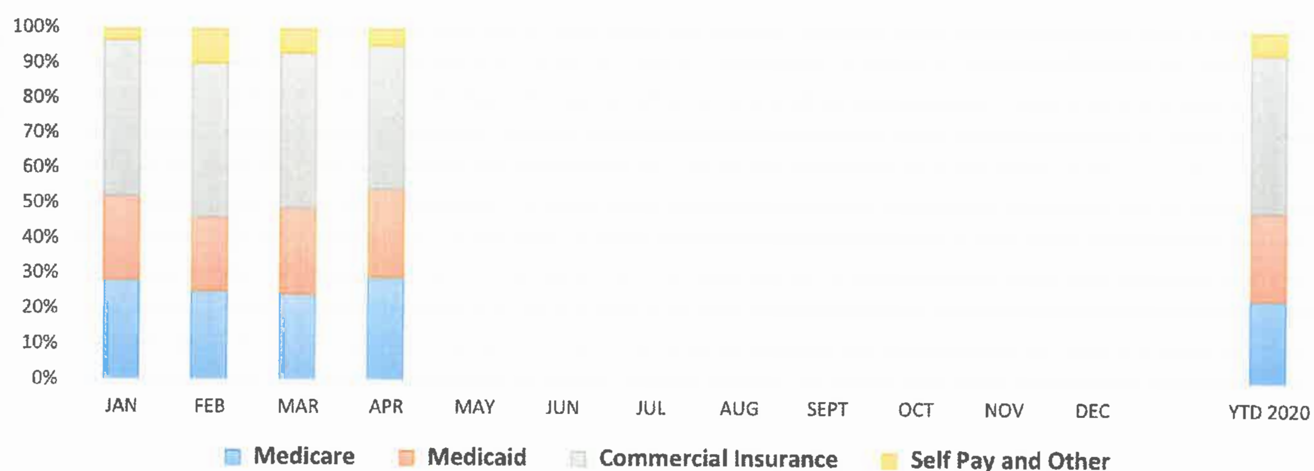
Prosser Memorial Health
Revenue by Financial Class
April 30, 2020

Month	Medicare	Medicaid	Commercial Insurance	Self Pay and Other	Total
JAN	33.3%	32.3%	27.1%	7.4%	100.0%
FEB	33.6%	30.5%	27.7%	8.1%	100.0%
MAR	27.9%	32.0%	31.7%	8.4%	100.0%
APR	28.1%	31.3%	29.7%	10.8%	100.0%
MAY					
JUN					
JUL					
AUG					
SEPT					
OCT					
NOV					
DEC					
YTD 2020	31.1%	31.6%	28.9%	8.4%	100.0%
2019	31.5%	31.8%	28.6%	8.1%	100.0%



Prosser Memorial Health
Net Revenue by Financial Class
April 30, 2020

Month	Medicare	Medicaid	Commercial Insurance	Self Pay and Other	Total
JAN	28.2%	23.9%	44.7%	3.2%	100.0%
FEB	25.2%	20.8%	44.1%	9.8%	100.0%
MAR	24.4%	24.3%	44.6%	6.8%	100.0%
APR	29.2%	24.9%	41.2%	4.7%	100.0%
MAY					
JUN					
JUL					
AUG					
SEPT					
OCT					
NOV					
DEC					
YTD 2020	23.5%	24.6%	45.5%	6.4%	100.0%
2019	29.4%	21.7%	38.8%	10.2%	100.0%



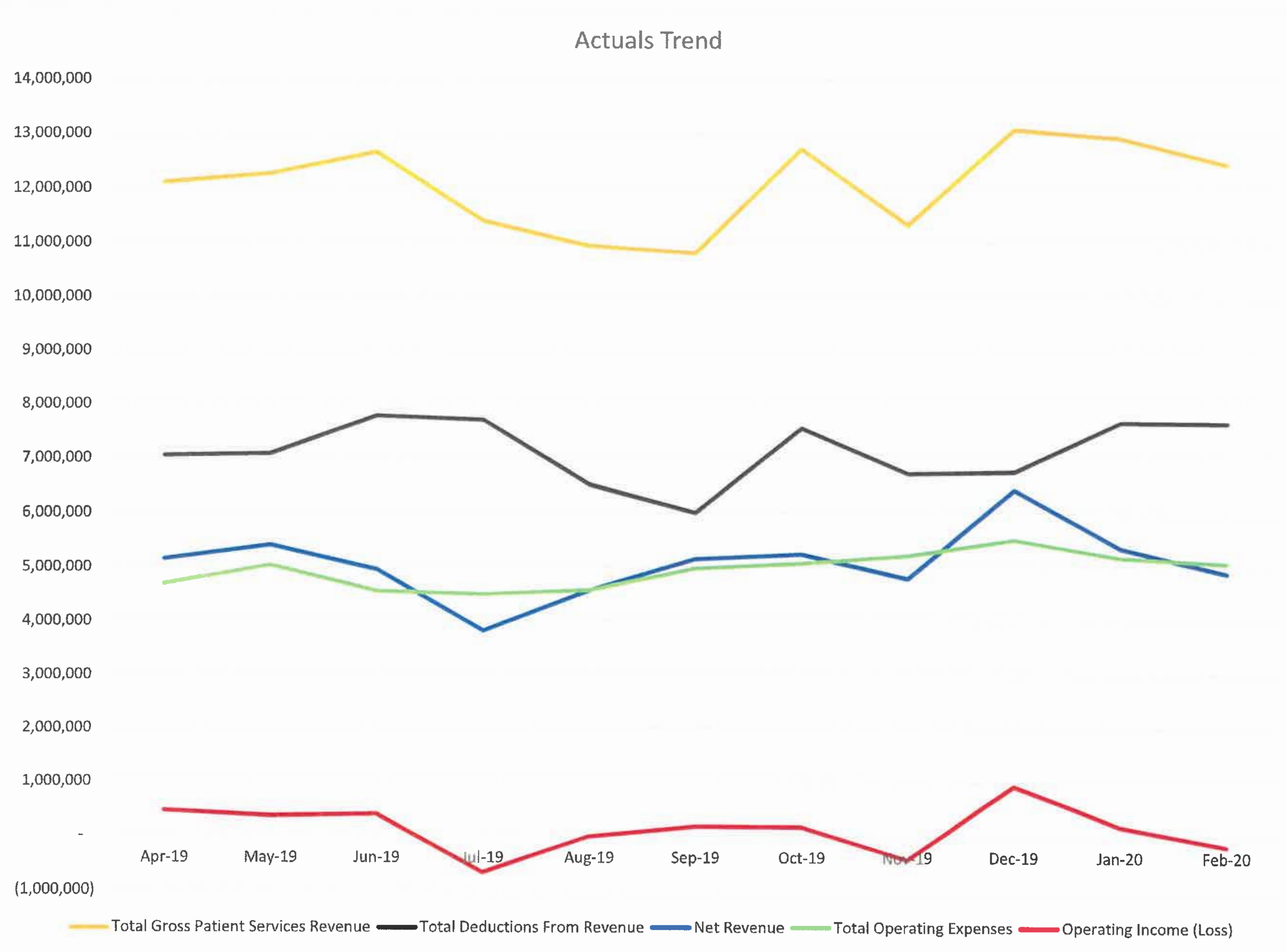
Financial Operations

April 30, 2020

	YTD 2019	YTD 2020	YTD Budget 2020
Utilization			
Admissions	333	302	330
Adjusted Admissions	1,461	1,253	1,532
Average Daily Census	7.1	6.3	6.8
Adjusted Occupied Beds	31.3	26.3	31.5
Average Length of Stay (days)	2.6	2.5	2.5
Outpatient Revenue %	77.2%	75.9%	78.5%
Total Yeild (net patient revenue)	-28.3%	-30.9%	-26.9%
Hospital Case Mix Index	TBD	0.99	1.00
Financial Performance ($000)			
Net Patient Revenue	19,806	18,693	20,273
Total Operating Revenue	20,239	21,134	20,622
Total Operating Expense	18,763	20,426	19,902
Income (Loss) from Operations	1,476	708	721
Excess of Revenue Over Expenses	1,764	957	957
EBIDA (Operating Cash Flow)	2,214	1,611	1,627
Additions to Property, Plant, and Equipment	201	803	247
Balance Sheet ($000)			
Unrestricted Cash and Investments	709	8,035	3,915
Accounts Receivable (gross)	19,692	22,472	17,104
Net Fixed Assets	14,001	18,333	12,758
Current and Long-Term Liabilities (excluding LT debt)	6,407	16,311	5,413
Long-Term Debt	6,311	6,037	6,441
Total Liabilities	12,718	22,348	11,854
Net Worth	28,213	30,584	29,769
Key Ratios			
Operating Margin (%)	7.3%	3.4%	3.5%
Excess Margin (%)	8.7%	4.5%	4.6%
Operating EBIDA Margin (Operating Cash Flow)	10.9%	7.6%	7.9%
Net Accounts Receivable (days)	53.64	48.35	52.64
Current Ratio (x)	2.04	1.51	1.55
Cash on Hand (days)	98.85	152.33	120.39
Cushion Ratio (x)	181.28	201.33	53.80
Return on Equity (%)	6.25%	3.13%	13.33%
Capital Spending Ratio	2.26	2.31	5.13
Average Age of Plant (Years)	11.30	10.14	10.84
Debt Service	2.76	1.31	4.58
Debt-to-Capitalization (%)	20%	29%	27.07%
Patient Revenue Sources by Gross Revenue (%)			
Medicare	31.5%	31.1%	31.5%
Medicaid	31.8%	31.6%	31.7%
Commercial Insurance	28.6%	28.9%	28.7%
Self-pay and Other	8.1%	8.4%	8.1%
Labor Metrics			
Productive FTE's (incl contract labor)	273.89	288.30	300.11
Total FTE's (incl contract labor)	302.55	324.19	348.30
Labor Cost (incl benefits) per FTE - Annualized	39,988.02	39,566.61	35,048.83
Labor Cost (incl benefits) as a % of Net Operating Revenue	59.8%	60.7%	59.2%
Net Operating Revenue per FTE	66,895.29	65,189.11	59,208.83
Operating Expense per FTE	62,015.20	63,005.03	57,139.37

Contacts:

David Rollins Chief Financial Officer (509) 786-6605
Stephanie Titus Director of Finance (509) 786-5530


Actuals Trend
14,000,000
13,000,000
12,000,000
11,000,000
10,000,000
9,000,000
8,000,000
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
-
(1,000,000)
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Total Gross Patient Services Revenue
Total Deductions From Revenue
Net Revenue
Total Operating Expenses
Operating Income (Loss)

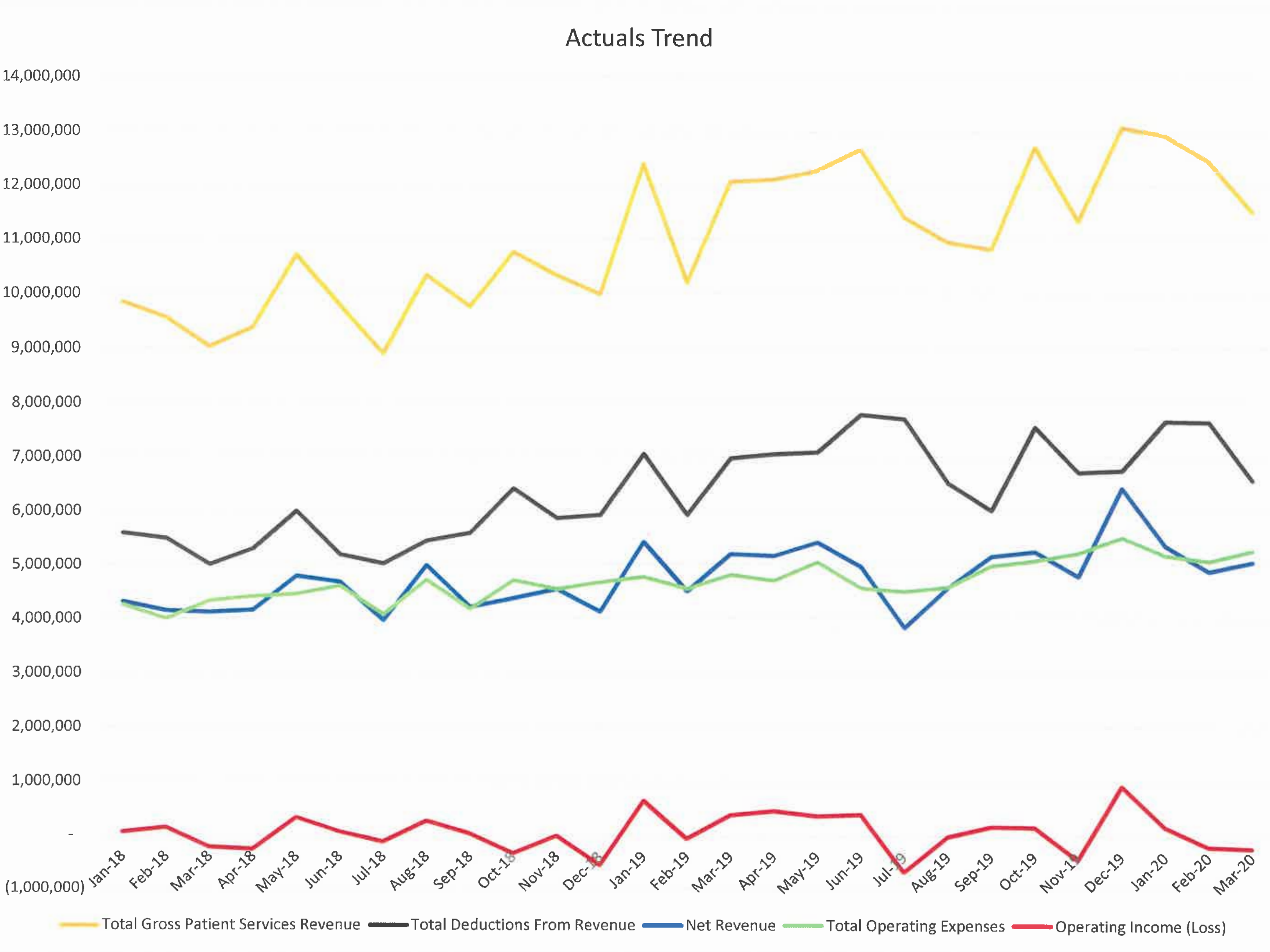
Statement of Operations 13-month Trend

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Gross Patient Services Revenue													
Inpatient	$ 2,646,540	$ 2,718,209	$ 2,911,854	$ 2,482,862	$ 2,526,300	$ 2,501,168	$ 3,012,630	$ 2,617,549	$ 2,864,852	$ 2,864,636	$ 3,010,011	$ 2,635,344	$ 2,206,745
Outpatient	9,466,787	9,556,019	9,755,418	8,926,505	8,421,340	8,313,652	9,717,569	8,716,943	10,233,791	10,071,001	9,445,153	8,882,599	5,357,211
Total Gross Patient Services Revenue	12,113,327	12,274,228	12,667,272	11,409,367	10,947,640	10,814,820	12,730,199	11,334,492	13,098,643	12,935,637	12,455,164	11,517,943	7,563,956
Deductions from Revenue				*33%*									
Contractual Allowances													
Medicare	1,932,240	2,185,255	2,734,096	3,079,031	2,000,591	2,181,816	2,860,807	2,234,020	2,611,913	2,632,393	2,720,808	1,772,267	995,183
Medicaid	2,694,779	2,813,930	2,730,768	2,699,644	2,250,702	1,633,944	2,626,636	3,351,182	2,593,535	2,462,158	2,881,363	2,364,561	2,088,300
Negotiated Rates	1,582,034	1,395,739	1,611,274	1,450,628	1,484,291	1,882,777	1,698,297	490,384	1,053,995	1,970,832	1,535,802	1,559,890	363,732
Other Adjustments	128,732	195,205	178,721	29,827	236,997	96,291	117,115	12,337	(62,054)	152,100	143,288	395,710	40,602
Gross Contractual Allowances	6,337,785	6,590,129	7,254,859	7,259,130	5,972,581	5,794,828	7,302,855	6,087,923	6,197,389	7,217,483	7,281,261	6,092,428	3,487,817
Charity Care	162,640	92,529	174,075	182,086	238,673	112,577	89,746	182,296	34,095	70,465	207,726	147,685	40,927
Bad Debt	547,800	400,496	350,421	258,214	299,799	89,162	154,222	442,390	514,437	366,493	154,253	325,725	268,555
Total Deductions From Revenue	7,048,225	7,083,154	7,779,355	7,699,430	6,511,053	5,996,567	7,546,823	6,712,609	6,745,921	7,654,441	7,643,240	6,565,838	3,797,299
Net Patient Services Revenue	5,065,102	5,191,074	4,887,917	3,709,937	4,436,587	4,818,253	5,183,376	4,621,883	6,352,722	5,281,196	4,811,924	4,952,105	3,766,657
Other Operating Revenue	86,500	210,581	59,968	105,043	119,837	321,886	44,074	144,372	60,565	54,446	48,156	79,111	2,260,337
Net Revenue	**5,151,602**	**5,401,655**	**4,947,885**	**3,814,980**	**4,556,424**	**5,140,139**	**5,227,450**	**4,766,255**	**6,413,287**	**5,335,642**	**4,860,080**	**5,031,216**	**6,026,994**
Operating Expenses													
Salaries	2,179,819	2,253,650	2,219,872	2,258,057	2,186,403	2,272,947	2,282,644	2,333,751	2,596,017	2,390,097	2,319,195	2,438,079	2,243,147
Benefits	565,090	600,425	348,108	337,751	397,207	450,455	611,076	503,958	765,786	577,012	555,392	440,583	739,833
Purchased Labor	302,987	330,783	(147,171)	264,578	236,659	264,793	217,501	246,218	268,266	249,096	283,557	329,407	261,699
Sub-Total Labor Costs	3,047,896	3,184,858	2,420,809	2,860,386	2,820,269	2,988,195	3,111,221	3,083,927	3,630,069	3,216,205	3,158,144	3,208,069	3,244,679
Professional Fees - Physicians	229,381	274,105	695,166	329,173	355,202	332,200	310,244	352,355	377,019	389,778	279,808	267,635	419,725
Professional Fees - Other	45,719	70,838	4,280	51,982	40,503	5,802	27,900	57,445	37,367	43,960	58,785	19,051	93,438
Supplies	552,765	532,887	527,249	535,093	493,079	700,353	725,859	764,707	622,645	619,449	675,545	762,215	527,615
Purchased Services - Utilities	30,452	39,689	44,875	41,243	44,577	39,600	42,598	48,996	37,860	43,249	43,969	40,757	31,315
Purchased Services - Other	288,215	296,855	264,637	245,545	251,437	299,771	233,945	314,069	269,828	261,428	230,546	359,733	222,165
Rentals & Leases	203,415	203,018	199,712	117,451	173,040	166,916	168,981	168,019	186,792	194,404	170,987	167,981	152,417
Insurance License & Taxes	63,315	70,410	67,274	59,519	77,077	69,509	69,709	52,025	63,642	60,430	99,269	87,383	85,150
Depreciation & Amortization	187,921	203,764	204,612	207,114	207,017	214,609	222,284	222,109	224,314	222,577	227,538	224,010	228,367
Other Operating Expenses	38,231	156,828	117,660	37,964	101,333	144,048	143,821	135,294	40,759	104,447	103,657	107,679	92,318
Sub-Total Non-Labor Expenses	1,639,414	1,848,394	2,125,465	1,625,084	1,743,265	1,972,808	1,945,341	2,115,019	1,860,226	1,939,722	1,890,104	2,036,444	1,852,510
Total Operating Expenses	**4,687,310**	**5,033,252**	**4,546,274**	**4,485,470**	**4,563,534**	**4,961,003**	**5,056,562**	**5,198,946**	**5,490,295**	**5,155,927**	**5,048,248**	**5,244,513**	**5,097,189**
Operating Income (Loss)	**464,292**	**368,403**	**401,611**	**(670,490)**	**(7,110)**	**179,136**	**170,888**	**(432,691)**	**922,992**	**179,715**	**(188,168)**	**(213,297)**	**929,805**
Non Operating Income													
Tax Revenue	73,419	68,970	69,231	69,975	70,601	69,701	71,945	69,785	69,205	71,840	65,599	77,314	73,881
Investment Income	25,735	25,756	25,933	34,296	31,673	31,189	20,703	21,943	24,574	22,527	22,036	19,425	18,000
Interest Expense	(20,307)	(20,307)	(20,307)	(20,974)	(34,475)	(76,310)	(34,270)	(34,166)	(33,322)	(32,996)	(19,892)	(33,218)	(35,750)
Other Non Operating Income (Expense)	-	-	1,200	-	9,200	-	52,518	14,420	-	(222)	-	-	500
Total Non Operating Income	**78,847**	**74,419**	**76,057**	**83,297**	**76,999**	**24,580**	**110,896**	**71,982**	**60,457**	**61,149**	**67,743**	**63,521**	**56,631**
Net Income (Loss)	**$ 543,139**	**$ 442,822**	**$ 477,668**	**$ (587,193)**	**$ 69,889**	**$ 203,716**	**$ 281,784**	**$ (360,709)**	**$ 983,449**	**$ 240,864**	**$ (120,425)**	**$ (149,776)**	**$ 986,436**
Total Margin	10.4%	8.1%	9.5%	-15.1%	1.5%	3.9%	5.3%	-7.5%	15.2%	4.5%	-2.4%	-2.9%	16.2%
Margin (Non Operating Income)	9.0%	6.8%	8.1%	-17.6%	-0.2%	3.5%	3.3%	-9.1%	14.4%	3.4%	-3.9%	-4.2%	15.4%
Salaries as a % of Net Revenue	42.3%	41.7%	44.9%	59.2%	48.0%	44.2%	43.7%	49.0%	40.5%	44.8%	47.7%	48.5%	37.2%
Labor as a % of Net Revenue	59.2%	59.0%	48.9%	75.0%	61.9%	58.1%	59.5%	64.7%	56.6%	60.3%	65.0%	63.8%	53.8%
Operating Expense change from prior month	-2%	7%	-10%	-1%	2%	9%	2%	3%	6%	-6%	-2%	4%	-3%
Gross Revenue change from prior month	-2%	1%	3%	-10%	-4%	-1%	18%	-11%	16%	-1%	-4%	-8%	-34%
Net Revenue change from prior month	-5%	5%	-8%	-23%	19%	13%	2%	-9%	35%	-17%	-9%	4%	20%

Statement of Operations 13-month Trend

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Gross Patient Services Revenue															
Inpatient	$ 2,649,056	$ 3,196,297	$ 1,985,267	$ 2,518,991	$ 2,476,560	$ 2,296,762	$ 2,293,180	$ 2,564,577	$ 2,199,386	$ 2,655,432	$ 2,306,357	$ 2,462,857	$ 2,805,007	$ 2,358,378	$ 2,854,540
Outpatient	7,192,749	6,365,326	7,041,262	6,863,249	8,232,769	7,492,308	6,603,901	7,779,626	7,556,855	8,104,982	8,032,543	7,521,189	9,600,095	7,842,409	9,217,275
Total Gross Patient Services Revenue	9,841,806	9,561,622	9,026,529	9,382,240	10,709,329	9,789,070	8,897,081	10,344,203	9,756,241	10,760,414	10,338,900	9,984,046	12,405,102	10,200,787	12,071,815
Deductions from Revenue															
Contractual Allowances															
Medicare	1,901,629	1,920,370	1,440,526	1,208,587	1,708,794	1,768,316	1,573,964	1,582,566	1,704,781	1,944,619	1,969,496	1,785,133	1,971,116	1,738,928	2,112,550
Medicaid	2,310,739	2,104,259	2,185,818	2,398,148	2,558,227	1,818,406	2,040,812	2,156,050	2,075,074	2,662,844	1,877,145	2,252,988	2,899,685	2,327,243	2,931,219
Negotiated Rates	966,859	982,737	797,828	1,305,139	1,321,261	774,554	1,264,743	1,333,393	1,175,475	1,386,029	1,359,686	1,510,294	1,552,640	1,348,830	1,266,778
Other Adjustments	84,798	129,658	63,442	112,868	139,334	433,558	(315,910)	179,340	115,143	57,602	180,136	16,262	92,414	77,405	230,222
Gross Contractual Allowances	5,264,024	5,137,024	4,487,614	5,024,742	5,727,616	4,794,834	4,563,609	5,251,349	5,070,473	6,051,094	5,386,463	5,564,677	6,515,855	5,492,406	6,540,769
Charity Care	215,618	56,981	242,614	82,351	117,945	143,796	233,901	268,268	230,422	146,984	112,044	258,073	93,177	201,657	108,281
Bad Debt	117,547	294,535	269,099	171,684	137,334	257,380	216,422	(79,861)	279,881	210,678	357,428	93,441	441,449	222,935	320,505
Total Deductions From Revenue	5,588,567	5,488,540	4,998,964	5,291,694	5,995,013	5,181,524	5,013,167	5,437,941	5,580,689	6,408,672	5,855,852	5,916,128	7,050,481	5,916,998	6,969,555
Net Patient Services Revenue	4,253,239	4,073,083	4,027,565	4,090,546	4,714,316	4,607,546	3,883,914	4,906,262	4,175,552	4,351,742	4,483,048	4,067,918	5,354,621	4,283,789	5,102,260
Other Operating Revenue	63,102	70,510	85,984	60,254	69,187	64,769	75,154	71,433	27,403	15,523	53,132	48,223	57,568	207,241	81,986
Net Revenue	**4,316,340**	**4,143,592**	**4,113,549**	**4,150,800**	**4,783,503**	**4,672,315**	**3,959,068**	**4,977,695**	**4,202,955**	**4,367,265**	**4,536,180**	**4,116,141**	**5,412,189**	**4,491,030**	**5,184,246**
Operating Expenses															
Salaries	1,852,041	1,753,421	2,052,394	1,789,019	1,976,461	1,875,317	1,828,430	1,923,424	2,031,907	2,133,776	2,076,313	2,011,547	2,281,456	2,093,289	2,226,046
Benefits	510,882	512,928	559,830	662,558	441,838	460,593	389,174	528,570	355,032	716,260	547,005	629,185	568,447	543,711	495,169
Purchased Labor	226,042	226,311	170,992	337,830	311,999	344,506	300,096	303,677	303,418	240,470	297,944	282,311	248,740	281,586	326,169
Sub-Total Labor Costs	2,588,965	2,492,660	2,783,216	2,789,407	2,730,298	2,680,416	2,517,700	2,755,671	2,690,357	3,090,506	2,921,262	2,923,043	3,098,643	2,918,586	3,047,384
Professional Fees - Physicians	248,573	209,601	220,205	267,036	265,134	559,465	208,340	384,582	253,437	333,054	259,282	269,228	325,484	247,794	201,610
Professional Fees - Other	23,747	31,498	59,359	43,530	141,228	94,315	103,388	71,649	116,408	2,638	28,227	25,510	41,088	42,352	74,658
Supplies	575,648	532,778	412,424	414,530	504,518	375,495	362,832	413,425	322,730	465,177	401,370	413,200	486,215	492,092	559,498
Purchased Services - Utilities	39,273	36,617	40,877	39,177	35,537	40,608	43,356	46,139	33,459	41,638	33,499	50,186	42,316	41,519	38,059
Purchased Services - Other	353,133	263,365	345,972	367,871	290,127	364,921	315,184	340,721	338,653	360,624	358,231	394,913	281,204	303,668	286,171
Rentals & Leases	141,074	140,785	160,532	157,815	164,350	167,537	141,642	125,829	136,000	170,571	189,630	192,971	209,981	163,949	171,022
Insurance License & Taxes	58,411	47,107	45,289	55,566	40,092	52,790	48,067	49,821	37,416	49,528	47,919	52,566	26,041	53,573	66,280
Depreciation & Amortization	164,670	171,839	171,143	184,241	174,020	174,640	184,448	183,804	184,246	184,278	184,408	183,883	183,109	182,457	184,284
Other Operating Expenses	60,395	69,272	89,126	84,587	102,169	88,134	146,509	335,480	53,071	(3,089)	111,378	155,016	68,524	94,182	167,776
Sub-Total Non-Labor Expenses	1,664,923	1,502,862	1,544,927	1,614,353	1,717,175	1,917,905	1,553,766	1,951,450	1,475,420	1,604,419	1,613,944	1,737,473	1,663,962	1,621,586	1,749,358
Total Operating Expenses	**4,253,888**	**3,995,522**	**4,328,143**	**4,403,760**	**4,447,473**	**4,598,321**	**4,071,466**	**4,707,121**	**4,165,777**	**4,694,925**	**4,535,206**	**4,660,516**	**4,762,605**	**4,540,172**	**4,796,742**
Operating Income (Loss)	**62,452**	**148,070**	**(214,593)**	**(252,960)**	**336,030**	**73,994**	**(112,398)**	**270,574**	**37,178**	**(327,660)**	**974**	**(544,375)**	**649,584**	**(49,142)**	**387,504**
Non Operating Income															
Tax Revenue	67,560	67,424	67,423	67,425	67,425	67,425	67,425	67,045	71,669	71,077	67,525	72,031	69,224	69,238	75,385
Investment Income		-					-	49,481	2,527	2,789	2,760	113,000	3,074	37,560	20,490
Interest Expense	(18,406)	(18,152)	(6,844)	4,673	11,011	15,961	(559)	6,438	(14,852)	(14,852)	(14,852)	(29,296)	(20,307)	(20,307)	(20,307)
Other Non Operating Income (Expense)	(3,125)	(25,650)	-	2,630	(129,621)	9,250	(3,691)	8,242	5,772	(1,363)	13,778	(38,052)	(1,363)	(1,363)	(2,737)
Total Non Operating Income	**46,029**	**23,623**	**60,579**	**74,728**	**(51,185)**	**92,636**	**63,175**	**131,206**	**65,116**	**57,651**	**69,211**	**117,683**	**50,628**	**85,128**	**72,831**
Net Income (Loss)	**$ 108,481**	**$ 171,693**	**$ (154,014)**	**$ (178,232)**	**$ 284,845**	**$ 166,630**	**$ (49,223)**	**$ 401,780**	**$ 102,294**	**$ (270,009)**	**$ 70,185**	**$ (426,692)**	**$ 700,212**	**$ 35,986**	**$ 460,335**
Total Margin	2.5%	4.1%	-3.7%	-4.2%	6.0%	3.5%	-1.2%	7.9%	2.4%	-6.1%	1.5%	-10.1%	12.8%	0.8%	8.8%
Margin (Non Operating Income)	1.4%	3.6%	-5.2%	-6.1%	7.0%	1.6%	-2.8%	5.4%	0.9%	-7.5%	0.0%	-13.2%	12.0%	-1.1%	7.5%
Salaries as a % of Net Revenue	43%	42%	50%	43%	41%	40%	46%	39%	48%	49%	46%	49%	42%	47%	43%
Labor as a % of Net Revenue	60%	60%	68%	67%	57%	57%	64%	55%	64%	71%	64%	71%	57%	65%	59%
Supplies as % of Gross Revenue	5.8%	5.6%	4.6%	4.4%	4.7%	3.8%	4.1%	4.0%	3.3%	4.3%	3.9%	4.1%	3.9%	4.8%	4.6%
Operating Expense change from prior montl	-11%	-6%	8%	2%	1%	3%	-11%	16%	-12%	13%	-3%	3%	2%	-5%	6%
Gross Revenue change from prior month	-21%	-3%	-6%	4%	14%	-9%	-9%	16%	-6%	10%	-4%	-3%	24%	-18%	18%
Net Revenue change from prior month	-20%	-4%	-1%	1%	15%	-2%	-15%	26%	-16%	4%	4%	-9%	31%	-17%	15%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Gross Patient Services Revenue													
Inpatient	$ 2,646,540	$ 2,718,209	$ 2,911,854	$ 2,482,862	$ 2,526,300	$ 2,501,168	$ 3,012,630	$ 2,617,549	$ 2,864,852	$ 2,864,636	$3,010,011	$2,635,344	$2,206,745
Outpatient	9,466,787	9,556,019	9,755,418	8,926,505	8,421,340	8,313,652	9,717,569	8,716,943	10,233,791	10,071,001	9,445,153	8,882,599	5,357,211
Total Gross Patient Services Revenue	12,113,327	12,274,228	12,667,272	11,409,367	10,947,640	10,814,820	12,730,199	11,334,492	13,098,643	12,935,637	12,455,164	11,517,943	7,563,956
Deductions from Revenue													
Contractual Allowances													
Medicare	1,932,240	2,185,255	2,734,096	3,079,031	2,000,591	2,181,816	2,860,807	2,234,020	2,611,913	2,632,393	2,720,808	1,772,267	995,183
Medicaid	2,694,779	2,813,930	2,730,768	2,699,644	2,250,702	1,633,944	2,626,636	3,351,182	2,593,535	2,462,158	2,881,363	2,364,561	2,088,300
Negotiated Rates	1,582,034	1,395,739	1,611,274	1,450,628	1,484,291	1,882,777	1,698,297	490,384	1,053,995	1,970,832	1,535,802	1,559,890	363,732
Other Adjustments	128,732	195,205	178,721	29,827	236,997	96,291	117,115	12,337	(62,054)	152,100	143,288	395,710	40,602
Gross Contractual Allowances	6,337,785	6,590,129	7,254,859	7,259,130	5,972,581	5,794,828	7,302,855	6,087,923	6,197,389	7,217,483	7,281,261	6,092,428	3,487,817
Charity Care	162,640	92,529	174,075	182,086	238,673	112,577	89,746	182,296	34,095	70,465	207,726	147,685	40,927
Bad Debt	547,800	400,496	350,421	258,214	299,799	89,162	154,222	442,390	514,437	366,493	154,253	325,725	268,555
Total Deductions From Revenue	7,048,225	7,083,154	7,779,355	7,699,430	6,511,053	5,996,567	7,546,823	6,712,609	6,745,921	7,654,441	7,643,240	6,565,838	3,797,299
Net Patient Services Revenue	5,065,102	5,191,074	4,887,917	3,709,937	4,436,587	4,818,253	5,183,376	4,621,883	6,352,722	5,281,196	4,811,924	4,952,105	3,766,657
Other Operating Revenue	86,500	210,581	59,968	105,043	119,837	321,886	44,074	144,372	60,565	54,446	48,156	79,111	2,260,337
Net Revenue	**5,151,602**	**5,401,655**	**4,947,885**	**3,814,980**	**4,556,424**	**5,140,139**	**5,227,450**	**4,766,255**	**6,413,287**	**5,335,642**	**4,860,080**	**5,031,216**	**6,026,994**
Operating Expenses													
Salaries	2,179,819	2,253,650	2,219,872	2,258,057	2,186,403	2,272,947	2,282,644	2,333,751	2,596,017	2,390,097	2,319,195	2,438,079	2,243,147
Benefits	565,090	600,425	348,108	337,751	397,207	450,455	611,076	503,958	765,786	577,012	555,392	440,583	739,833
Purchased Labor	302,987	330,783	(147,171)	264,578	236,659	264,793	217,501	246,218	268,266	249,096	283,557	329,407	261,699
Sub-Total Labor Costs	3,047,896	3,184,858	2,420,809	2,860,386	2,820,269	2,988,195	3,111,221	3,083,927	3,630,069	3,216,205	3,158,144	3,208,069	3,244,679
Professional Fees - Physicians	229,381	274,105	695,166	329,173	355,202	332,200	310,244	352,355	377,019	389,778	279,808	267,635	419,725
Professional Fees - Other	45,719	70,838	4,280	51,982	40,503	5,802	27,900	57,445	37,367	43,960	58,785	19,051	93,438
Supplies	552,765	532,887	527,249	535,093	493,079	700,353	725,859	764,707	622,645	619,449	675,545	762,215	527,615
Purchased Services - Utilities	30,452	39,689	44,875	41,243	44,577	39,600	42,598	48,996	37,860	43,249	43,969	40,757	31,315
Purchased Services - Other	288,215	296,855	264,637	245,545	251,437	299,771	233,945	314,069	269,828	261,428	230,546	359,733	222,165
Rentals & Leases	203,415	203,018	199,712	117,451	173,040	166,916	168,981	168,019	186,792	194,404	170,987	167,981	152,417
Insurance License & Taxes	63,315	70,410	67,274	59,519	77,077	69,509	69,709	52,025	63,642	60,430	99,269	87,383	85,150
Depreciation & Amortization	187,921	203,764	204,612	207,114	207,017	214,609	222,284	222,109	224,314	222,577	227,538	224,010	228,367
Other Operating Expenses	38,231	156,828	117,660	37,964	101,333	144,048	143,821	135,294	40,759	104,447	103,657	107,679	92,318
Sub-Total Non-Labor Expenses	1,639,414	1,848,394	2,125,465	1,625,084	1,743,265	1,972,808	1,945,341	2,115,019	1,860,226	1,939,722	1,890,104	2,036,444	1,852,510
Total Operating Expenses	**4,687,310**	**5,033,252**	**4,546,274**	**4,485,470**	**4,563,534**	**4,961,003**	**5,056,562**	**5,198,946**	**5,490,295**	**5,155,927**	**5,048,248**	**5,244,513**	**5,097,189**
Operating Income (Loss)	**464,292**	**368,403**	**401,611**	**(670,490)**	**(7,110)**	**179,136**	**170,888**	**(432,691)**	**922,992**	**179,715**	**(188,168)**	**(213,297)**	**929,805**
Non Operating Income													
Tax Revenue	73,419	68,970	69,231	69,975	70,601	69,701	71,945	69,785	69,205	71,840	65,599	77,314	73,881
Investment Income	25,735	25,756	25,933	34,296	31,673	31,189	20,703	21,943	24,574	22,527	22,036	19,425	18,000
Interest Expense	(20,307)	(20,307)	(20,307)	(20,974)	(34,475)	(76,310)	(34,270)	(34,166)	(33,322)	(32,996)	(19,892)	(33,218)	(35,750)
Other Non Operating Income (Expense)	-	-	1,200	-	9,200	-	52,518	14,420	-	(222)	-	-	500
Total Non Operating Income	**78,847**	**74,419**	**76,057**	**83,297**	**76,999**	**24,580**	**110,896**	**71,982**	**60,457**	**61,149**	**67,743**	**63,521**	**56,631**
Net Income (Loss)	**$ 543,139**	**$ 442,822**	**$ 477,668**	**$ (587,193)**	**$ 69,889**	**$ 203,716**	**$ 281,784**	**$ (360,709)**	**$ 983,449**	**$ 240,864**	**$ (120,425)**	**$ (149,776)**	**$ 986,436**
Total Margin	10.4%	8.1%	9.5%	-15.1%	1.5%	3.9%	5.3%	-7.5%	15.2%	4.5%	-2.4%	-2.9%	16.2%
Margin (Non Operating Income)	9.0%	6.8%	8.1%	-17.6%	-0.2%	3.5%	3.3%	-9.1%	14.4%	3.4%	-3.9%	-4.2%	15.4%
Salaries as a % of Net Revenue	42%	42%	45%	59%	48%	44%	44%	49%	40%	45%	48%	48%	37%
Labor as a % of Net Revenue	59%	59%	49%	75%	62%	58%	60%	65%	57%	60%	65%	64%	54%
Supplies as % of Gross Revenue	4.6%	4.3%	4.2%	4.7%	4.5%	6.5%	5.7%	6.7%	4.8%	4.8%	5.4%	6.6%	7.0%
Operating Expense change from prior montl	-2%	7%	-10%	-1%	2%	9%	2%	3%	6%	-6%	-2%	4%	-3%
Gross Revenue change from prior month	0%	1%	3%	-10%	-4%	-1%	18%	-11%	16%	-1%	-4%	-8%	-34%
Net Revenue change from prior month	-1%	5%	-8%	-23%	19%	13%	2%	-9%	35%	-17%	-9%	4%	20%



Actuals Trend
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7,000,000
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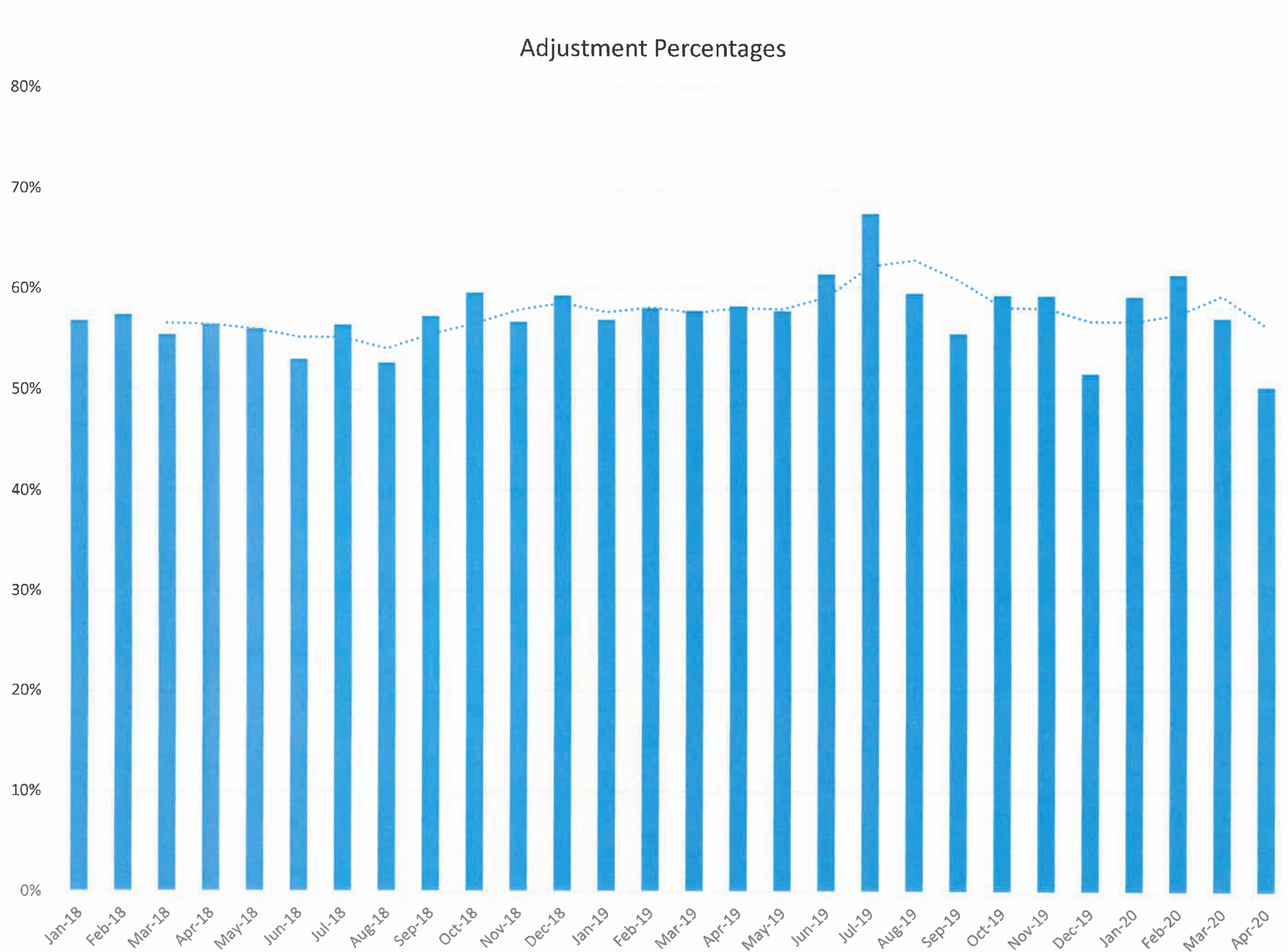
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Total Gross Patient Services Revenue
Total Deductions From Revenue
Net Revenue
Total Operating Expenses
Operating Income (Loss)


Adjustment Percentages
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan-18
Feb-18
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Apr-18
May-18
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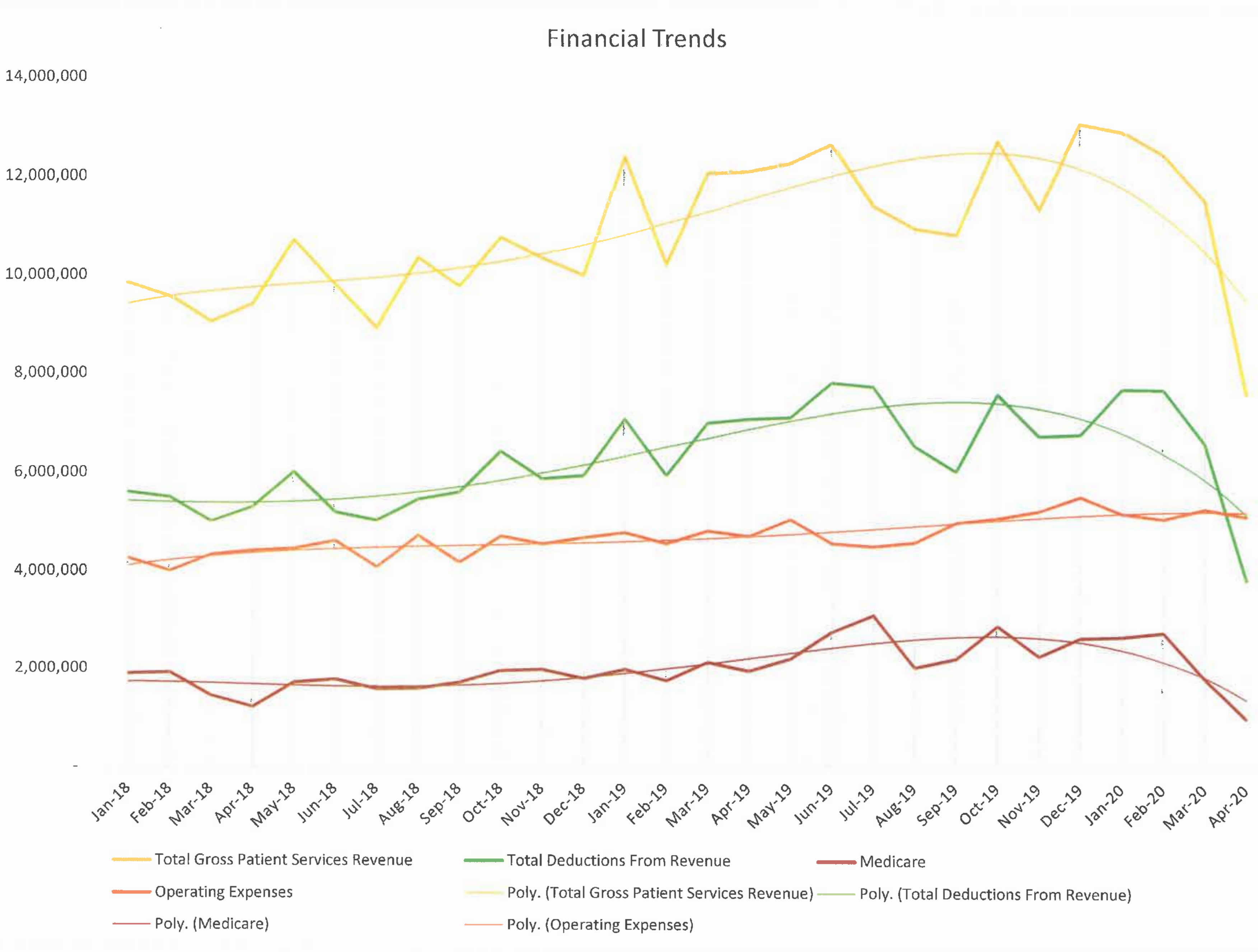
Financial Trends
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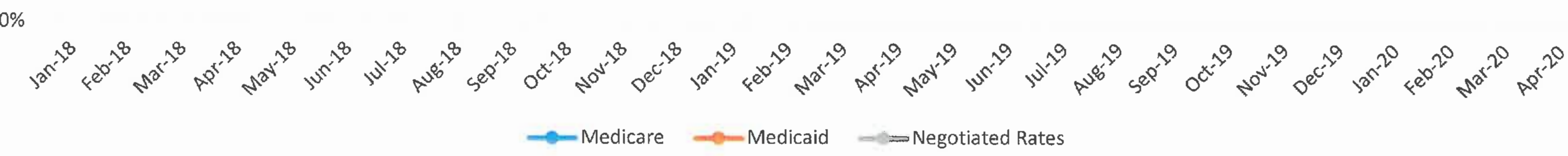
Feb-20
Mar-20
Apr-20
Total Gross Patient Services Revenue
Total Deductions From Revenue
Medicare
Operating Expenses
Poly. (Total Gross Patient Services Revenue)
Poly. (Total Deductions From Revenue)
Poly. (Medicare)
Poly. (Operating Expenses)

Adjustments


35%
30%
25%
20%
15%
10%
5%
0%
Jan-18
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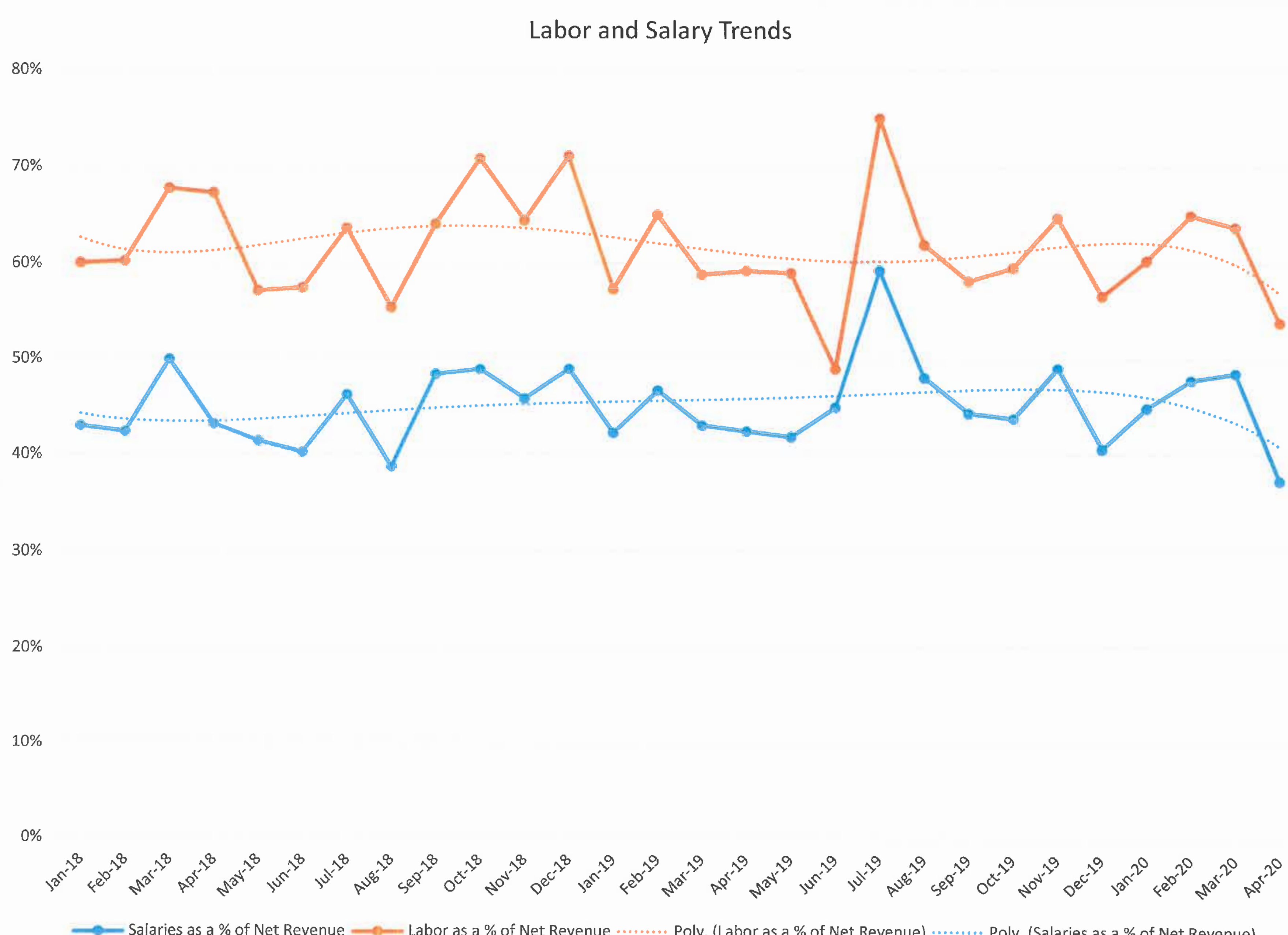
Mar-20
Apr-20
Medicare
Medicaid
Negotiated Rates



Labor and Salary Trends
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
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May-19
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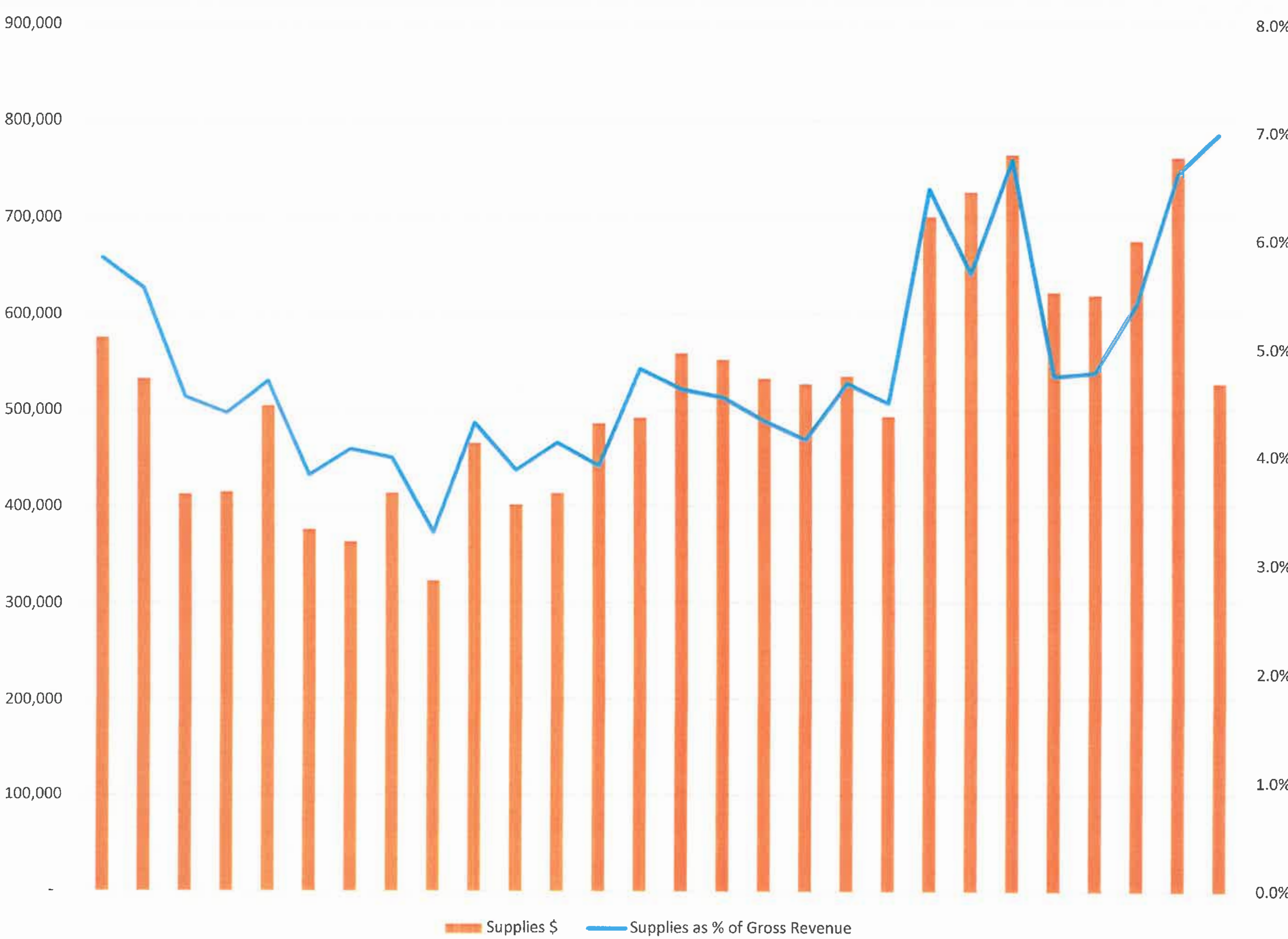
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
Salaries as a % of Net Revenue
Labor as a % of Net Revenue
Poly. (Labor as a % of Net Revenue)
Poly. (Salaries as a % of Net Revenue)


900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
-
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Supplies $
Supplies as % of Gross Revenue

STATEMENT OF OPERATIONS

	Actual 2018	Actual 2019	Budget 2020			Projected 2020		
Gross Patient Services Revenue								
Inpatient	29,604,722	32,299,988	34,564,819	2,264,831	7.0%	29,416,736	(5,148,083)	-15%
Outpatient	88,786,759	109,767,804	125,833,980	16,066,176	14.6%	109,482,967	(16,351,013)	-13%
Total Gross Patient Services Revenue	**118,391,481**	**142,067,791**	**160,398,799**	**18,331,008**	**12.9%**	**138,899,703**	**(21,499,096)**	**-13%**
								IP
								OP
								Total
Contractual Allowances								
Medicare	20,525,466	27,928,741	32,236,053	4,307,311	15.4%	28,035,235	(4,200,817)	-13%
Medicaid	26,511,175	31,140,292	35,645,007	4,504,715	14.5%	30,588,777	(5,056,230)	-14%
Negotiated Rates	14,177,999	16,817,667	20,591,779	3,774,112	22.4%	16,874,695	(3,717,084)	-18%
Other Adjustments	1,230,238	1,343,734	2,251,696	907,962	67.6%	2,224,237	(27,459)	-1%
Gross Contractual Allowances	**62,444,878**	**77,230,435**	**90,724,536**	**13,494,100**	**17.5%**	**77,722,944**	**(13,001,591)**	**-14%**
Charity Care	2,108,996	1,671,832	2,001,181	329,350	19.7%	2,274,498	273,317	14%
Bad Debt	2,325,567	4,031,596	4,220,415	188,818	4.7%	4,320,137	99,723	2%
Total Deductions From Revenue	**66,879,441**	**82,933,863**	**96,946,132**	**14,012,269**	**16.9%**	**84,317,580**	**(12,628,552)**	**-13%**
Net Patient Services Revenue	**51,512,040**	**59,133,929**	**63,452,668**	**4,318,739**	**7.3%**	**54,582,123**	**(8,870,545)**	**-14%**
HHS Federal Funds						5,202,730	5,202,730	
Other Grants related to COVID19						116,000	116,000	
Paycheck Protection Program (Net of Medicare)						2,857,606	2,857,606	
Other Operating Revenue	704,674	1,680,884	1,140,583	(540,301)	-32.1%	959,232	(181,352)	-16%
Net Revenue	**52,216,714**	**60,814,813**	**64,593,251**	**3,778,438**	**6.2%**	**63,717,690**	**(875,561)**	**-1%**
Operating Expenses								
Salaries	23,106,905	27,475,682	28,602,691	1,127,009	4.1%	28,286,858	(315,833)	-1%
Benefits	6,299,128	6,260,014	6,623,166	363,152	5.8%	6,245,354	(377,812)	-6%
Purchased Labor	3,345,598	2,843,126	2,359,009	(484,117)	-17.0%	2,397,065	38,056	2%
Sub-Total Labor Costs	**32,751,631**	**36,578,823**	**37,584,866**	**1,006,044**	**2.8%**	**36,929,278**	**(655,589)**	**-2%**
Professional Fees - Physicians	3,477,937	4,047,076	3,799,311	(247,765)	-6.1%	3,992,935	193,625	5%
Professional Fees - Other	741,499	509,434	542,457	33,023	6.5%	576,874	34,417	6%
Supplies	5,194,133	7,040,429	7,749,096	708,667	10.1%	7,663,018	(86,079)	-1%
Purchased Services - Utilities	480,365	491,784	536,197	44,413	9.0%	409,810	(126,387)	-24%
Purchased Services - Other	4,093,714	3,320,394	3,364,521	44,127	1.3%	3,314,496	(50,026)	-1%
Rentals & Leases	1,888,737	2,132,297	2,262,944	130,648	6.1%	2,194,419	(68,526)	-3%
Insurance License & Taxes	584,572	738,376	733,737	(4,639)	-0.6%	1,013,432	279,695	38%
Depreciation & Amortization	1,988,410	2,443,594	2,720,000	276,406	11.3%	2,729,428	9,428	0%
Other Operating Expenses	1,292,044	1,259,784	1,470,060	210,276	16.7%	1,146,645	(323,415)	-22%
Sub-Total Non-Labor Expenses	**19,741,411**	**21,983,167**	**23,178,324**	**1,195,157**	**5.4%**	**23,041,056**	**(137,267)**	**-1%**
Total Operating Expenses	**52,493,042**	**58,561,990**	**60,763,190**	**2,201,200**	**3.8%**	**59,970,334**	**(792,856)**	**-1%**
Operating Income (Loss)	**(276,328)**	**2,252,823**	**3,830,061**	**1,577,238**	**70.0%**	**3,747,356**	**(82,705)**	**-2%**
Non Operating Income								
Tax Revenue	821,456	846,680	833,589	-13,091	-1.5%	849,124	15,535	2%
Investment Income	215,615	335,335	272,476	(62,859)	-18.7%	136,210	(136,266)	-50%
Interest (Expense)	(171,572)	(355,362)	(403,586)	(48,225)	13.6%	(279,385)	124,201	-31%
Other Non Operating (Expense)	(161,830)	71,875	25,870	(46,005)	-64.0%	4,278	(21,592)	-83%
Total Non Operating Income	**703,669**	**898,528**	**728,349**	**(170,179)**	**-18.9%**	**710,227**	**(18,122)**	**-2%**
Net Income (Loss)	**$ 427,341**	**$ 3,151,351**	**$ 4,558,410**	**$ 1,407,059**	**44.6%**	**4,457,583**	**(100,827)**	**-2%**
Operating Margin	*-0.54%*	*3.81%*	*6.04%*			*6.87%*		
Total Margin	*0.82%*	*5.18%*	*7.06%*			*7.00%*		

	January	February	March	April	May	June	July	August	September	October	November	December	2020
Gross Patient Services Revenue													
Inpatient	2,864,636	3,010,011	2,635,344	2,206,745	2,200,000	2,200,000	2,200,000	2,200,000	2,400,000	2,500,000	2,500,000	2,500,000	29,416,736
Outpatient	10,071,001	9,445,153	8,882,599	5,357,211	6,500,000	8,500,000	8,900,000	9,894,766	9,981,918	10,836,255	10,330,009	10,784,054	109,482,967
Total Gross Patient Services Revenue	**12,935,637**	**12,455,164**	**11,517,943**	**7,563,956**	**8,700,000**	**10,700,000**	**11,100,000**	**12,094,766**	**12,381,918**	**13,336,255**	**12,830,009**	**13,284,054**	**138,899,703**
	5%	*16%*	*-7%*	*-24%*	*-28%*	*-28%*	*-22%*	*-24%*	*-17%*	*-19%*	*-12%*	*-14%*	*-15%*
	1%	*0%*	*-14%*	*-49%*	*-41%*	[illegible]	*-13%*	*-6%*	*-5%*	*-3%*	*-1%*	*2%*	*-13%*
	3%	[illegible]	*-13%*	*-44%*	*-38%*	[illegible]	*-15%*	*-10%*	*-7%*	*-7%*	*-3%*	[illegible]	*-13%*
Contractual Allowances													
Medicare	2,632,393	2,720,808	1,872,267	995,183	1,806,725	2,374,532	2,269,477	2,442,276	2,682,040	2,869,009	2,662,698	2,707,828	28,035,235
Medicaid	2,462,158	2,881,363	2,564,561	2,088,300	1,542,372	2,209,747	2,271,777	2,491,971	2,965,665	3,172,406	2,944,278	2,994,181	30,588,777
Negotiated Rates	1,970,832	1,535,802	1,259,890	363,732	824,000	1,197,000	1,310,850	1,436,095	1,713,236	1,832,668	1,700,881	1,729,709	16,874,695
Other Adjustments	152,100	143,288	395,710	40,602	178,537	179,145	182,613	189,368	187,341	200,401	185,990	189,142	2,224,237
Gross Contractual Allowances	**7,217,483**	**7,281,261**	**6,092,428**	**3,487,817**	**4,351,633**	**5,960,424**	**6,034,716**	**6,559,710**	**7,548,281**	**8,074,484**	**7,493,847**	**7,620,861**	**77,722,944**
Charity Care	70,465	207,726	147,685	40,927	304,500	304,500	274,050	246,645	166,498	178,105	165,298	168,099	2,274,498
Bad Debt	366,493	154,253	325,725	268,555	478,500	478,500	430,650	387,585	351,138	375,617	348,606	354,515	4,320,137
Total Deductions From Revenue	**7,654,441**	**7,643,240**	**6,565,838**	**3,797,299**	**5,134,633**	**6,743,424**	**6,739,416**	**7,193,940**	**8,065,918**	**8,628,206**	**8,007,750**	**8,143,475**	**84,317,580**
Net Patient Services Revenue	**5,281,196**	**4,811,924**	**4,952,105**	**3,766,657**	**3,565,367**	**3,956,576**	**4,360,584**	**4,900,827**	**4,316,000**	**4,708,050**	**4,822,259**	**5,140,579**	**54,582,123**
HHS Federal Funds				2,200,384			636,949	379,829	979,521	955,496	50,551		5,202,730
Other Grants related to COVID19				6,000	110,000		*Need to deduct 55% if CMS requires cost basis carve out ($2,861,502)*						116,000
Paycheck Protection Program (Net of Medicare)					*1,428,803*	*1,428,803*	*Deducted 55% CMS cost basis carve out ($3,492,629)*						*2,857,606*
Other Operating Revenue	54,446	48,156	79,111	53,953	48,412	160,502	48,412	48,412	160,502	48,412	48,412	160,502	959,232
Net Revenue	**5,335,642**	**4,860,080**	**5,031,216**	**6,026,994**	**5,152,581**	**5,545,881**	**5,045,945**	**5,329,067**	**5,456,023**	**5,711,957**	**4,921,221**	**5,301,082**	**63,717,690**
	106%	*101%*	*93%*	*113%*	*91%*	*96%*	*97%*	*99%*	*100%*	*100%*	*93%*	*97%*	*99%*
		Lost Revenue	*(351,441)*	*680,285*	*(486,010)*	*(223,837)*	*(148,478)*	*(55,714)*	*16,259*	*16,258*	*(368,381)*	*(189,445)* $	*(1,110,504)*
Operating Expenses	[illegible]	[illegible]	[illegible]	*-6%*	*-12%*	*-8%*	*-1%*	*-1%*	[illegible]	*1%*	*1%*	[illegible]	*-1%*
Salaries	2,390,097	2,319,195	2,438,079	2,243,147	2,168,323	2,272,973	2,319,494	2,368,492	2,417,265	2,511,995	2,407,466	2,430,331	28,286,858
Benefits	577,012	555,392	440,583	739,833	319,583	333,583	472,392	553,569	560,145	572,543	558,863	561,856	6,245,354
Purchased Labor	249,096	283,557	329,407	261,699	94,829	139,536	166,316	173,393	171,270	184,952	169,854	173,157	2,397,065
Sub-Total Labor Costs	**3,216,205**	**3,158,144**	**3,208,069**	**3,244,679**	**2,582,735**	**2,746,093**	**2,958,202**	**3,095,454**	**3,148,680**	**3,269,490**	**3,136,183**	**3,165,344**	**36,929,278**
	6%	[illegible]	[illegible]	*3%*	*-20%*	[illegible]	*-4%*	[illegible]	[illegible]	[illegible]	*0%*	[illegible]	*-2%*
Professional Fees - Physicians	389,778	279,808	267,635	419,725	419,725	316,609	316,609	316,609	316,609	316,609	316,609	316,609	3,992,935
Professional Fees - Other	43,960	58,785	19,051	93,438	45,205	45,205	45,205	45,205	45,205	45,205	45,205	45,205	576,874
Supplies	619,449	675,545	762,215	527,615	527,615	685,900	628,709	644,644	639,864	670,672	636,677	644,113	7,663,018
Purchased Services - Utilities	43,249	43,969	40,757	31,315	31,315	31,315	31,315	31,315	31,315	31,315	31,315	31,315	409,810
Purchased Services - Other	261,428	230,546	359,733	222,165	280,078	280,078	280,078	280,078	280,078	280,078	280,078	280,078	3,314,496
Rentals & Leases	194,404	170,987	167,981	152,417	188,579	188,579	188,579	188,579	188,579	188,579	188,579	188,579	2,194,419
Insurance License & Taxes	60,430	99,269	87,383	85,150	85,150	85,150	85,150	85,150	85,150	85,150	85,150	85,150	1,013,432
Depreciation & Amortization	222,577	227,538	224,010	228,367	228,367	228,367	228,367	228,367	228,367	228,367	228,367	228,367	2,729,428
Other Operating Expenses	104,447	103,657	107,679	92,318	92,318	92,318	92,318	92,318	92,318	92,318	92,318	92,318	1,146,645
Sub-Total Non-Labor Expenses	**1,939,722**	**1,890,104**	**2,036,444**	**1,852,510**	**1,898,352**	**1,953,520**	**1,896,330**	**1,912,265**	**1,907,485**	**1,938,293**	**1,904,298**	**1,911,734**	**23,041,056**
	[illegible]	*0%*	*4%*	*-4%*	*-3%*	*0%*	*-1%*	[illegible]	*-1%*	*-1%*	*-1%*	*-1%*	*-1%*
Total Operating Expenses	**5,155,927**	**5,048,248**	**5,244,513**	**5,097,189**	**4,481,087**	**4,699,613**	**4,854,532**	**5,007,719**	**5,056,165**	**5,207,783**	**5,040,480**	**5,077,078**	**59,970,334**
	104%	*105%*	*103%*	*101%*	*86%*	*90%*	*97%*	*99%*	*100%*	*100%*	*100%*	*100%*	
Operating Income (Loss)	**179,715**	**(188,168)**	**(213,297)**	**929,805**	**671,494**	**846,268**	**191,413**	**321,348**	**399,858**	**504,175**	**(119,259)**	**224,004**	**3,747,356**
Non Operating Income													
Tax Revenue	71,840	65,599	77,314	73,881	70,061	70,061	70,061	70,061	70,061	70,061	70,061	70,061	849,124
Investment Income	22,527	22,036	19,425	18,000	18,000	18,000	18,000	-	-	-	-	222	136,210
Interest (Expense)	(32,996)	(19,892)	(33,218)	(35,750)	(19,691)	(19,691)	(19,691)	(19,691)	(19,691)	(19,691)	(19,691)	(19,691)	(279,385)
Other Non Operating (Expense)	(222)	-	-	500	500	500	500	500	500	500	500	500	4,278
Total Non Operating Income	**61,149**	**67,743**	**63,521**	**56,631**	**68,870**	**68,870**	**68,870**	**50,870**	**50,870**	**50,870**	**50,870**	**51,092**	**710,227**
Net Income (Loss)	**240,864**	**(120,425)**	**(149,776)**	**986,436**	**740,364**	**915,138**	**260,283**	**372,218**	**450,728**	**555,045**	**(68,389)**	**275,096**	**4,457,583**
Operating Margin	*3.40%*	*-3.91%*	*-4.31%*	*24.69%*	*18.83%*	*21.39%*	*4.39%*	*6.56%*	*9.26%*	*10.71%*	*-2.47%*	*4.36%*	*6.87%*
Total Margin	*4.51%*	*-2.48%*	*-2.98%*	*16.37%*	*14.37%*	*16.50%*	*5.16%*	*6.98%*	*8.26%*	*9.72%*	*-1.39%*	*5.19%*	*7.00%*

Organization	Purpose	Award	Received	Outstanding Amt	ETA	Date Rec'd	Repayment	Funding Type	Other Notes
Greater Columbia Accountability of Health	Telehealth Application Funding for relief during the COVID19 crisis	$ 6,000	$ 6,000	$ -	*April 2020*	4/3/2020	$ -	EFT	Alana and Kevin applied for receipt
HHS	Stimulus Payment	$ 760,801	$ 760,801	$ -	*April 2020*	4/10/2020	$ -	EFT	Attestation completed within 30 days of funds received (completed 4/17/2020)
HHS	Stimulus Payment	$ 271,197	$ 271,197	$ -	*April 2020*	4/24/2020	$ -	EFT	Attestation completed within 30 days of funds received (completed 4/27/2020)
CMS Medicare Advanced Benefits	Advance of Medicare Payments	$ 6,596,297	$ 6,596,297	$ -	*April 2020*	4/21/2020	$ (6,596,297)	EFT	Three months worth of Medicare payments advanced to PMH. Due to be repaid in November 2020 with zero forgiveness
US Bank SBA Payroll Protection Program Loan (PPPL)	Payroll Protection Forgiveness Loan	$ 6,350,235	$ 6,350,235	$ -	*May 2020*			EFT	Original submission amount $5,951,625 but based on US Bank calculator actual submission amount was higher (employer paid taxes accounted for post 100K salary cap); 15 documents submitted 4/21 as requested most recently
HRSA (WA DOH)	SHIP	$ 90,000		$ 90,000	*May 2020*		$ -	CHECK	1. Other than confirming your hospital list from the FY 2020 NCC, we (HRSA) will not need any application information up front. There will be follow up information requested as a condition on your award and quarterly reporting requirements for the hospitals receiving SHIP COVID-19 funds.
WSHA	ASPR PPE purchase from WSHA	$ 20,000		$ 20,000	*May 2020*		$ -	CHECK	2. HRSA will issue NoA for the SHIP COVID-19 funds within 2-4 weeks. Paid $8,254 for delivered WSHA PPE 4/16/2020
HHS	CARES Provider Relief Fund - Rural Allocation	$ 4,170,732	$ 4,170,732	$ -	*May 2020*		$ -	EFT	Each CAH will receive at least $1,000,000 with the average CAH/Rural Hospital to receive $4,000,000 and each Rural Health Clinic to receive at least $100,000 with the average to be about $160,000. We received $4,170,732. NARHC.ORG (National Association of Rural Health Clinics)
US Bank SBA Economic Injury Disaster Loan (EIDL)	Payroll Protection Forgiveness Loan	$ 10,000	$ 10,000	$ -	*May 2020*		$ -	EFT	US Bank SBA grant deposited into our account.
HHS	Stimulus Payment	$ 49,461	$ 49,461	$ -	*May 2020*		$ -	EFT	CARES Act: Rural specific relief funds for rural health clinics
				$ -					
				$ -					
				$ -					
				$ -					
				$ -					
				$ -					
	Totals	$ 18,324,724	$ 18,214,724	$ 110,000			$ (6,596,297)		

Office of the Washington State Auditor
Pat McCarthy

3/10/19

Board of Commissioners
Prosser Public Hospital District
Prosser, Washington

<u>Management Letter</u>

This letter includes a summary of specific matters that we identified in planning and performing our accountability audit of the Prosser Public Hospital District from January 1, 2018 through December 31, 2018. We believe our recommendations will assist you in improving the District's internal controls in these areas.

We will review the status of these matters during our next audit. We have already discussed our comments with and made suggestions for improvements to Hospital District officials and personnel. If you have any further questions, please contact me at (509) 734-7104.

This letter is intended for the information and use of management and the governing body and is not suitable for any other purpose. However, this letter is a matter of public record and its distribution is not limited.

Sincerely,

Ginny Waltman

Ginny Waltman, Audit Manager

Attachment

Preliminary Draft - Please do not duplicate, distribute, or disclose.

Preliminary Draft - Please do not duplicate, distribute, or disclose.

Management Letter
Prosser Public Hospital District
January 1, 2018 through December 31, 2018

Foundation contract

Hospital districts may establish separate nonprofit entities under state law (RCW 39.34.030 and RCW 70.44.240). Many hospital districts contract with foundations to provide services such as fundraising, as well as other benefits for the hospital district. Hospital districts do not have express authority to perform services engaged in by a foundation and cannot donate resources to foundations without compensation. However, foundations may provide services or resources in exchange for adequate compensation.

In September 2017, the Hospital District established the Prosser Memorial Health Foundation (Foundation) as a separate nonprofit. The purpose of the Foundation is to raise funds exclusively for the Hospital District. In exchange for services, the Foundation operates the gift shop in the Hospital and allows Hospital District employees to volunteer their time in fundraising activities. Additionally, the Hospital District provides the Foundation's Executive Director, who is a Hospital District employee, to assist with administrative services. The Foundation pays the Hospital District for the Executive Director's time spent on Foundation business.

During our audit, we identified the Hospital District:

- Did not have a written agreement with the Foundation that outlines each party's responsibilities and exchange of services
- Gave the Foundation $21,500 to fund the gift shop's initial inventory purchase. Article 8 Section 7 of the Washington State Constitution prohibits any local government entity from bestowing a gift or lending money, property, or the entity's credit to a private party. Therefore, the gift is unallowable.
- Did not have a process to track volunteer time to ensure Hospital District employees do not perform volunteer activities during work hours
- Did not monitor the Foundation to ensure it is in active standing with the Secretary of State

We recommend the Hospital District:

- Update its written agreement to include an explanation of each party's services and how they demonstrate adequate compensation
- Seek recovery of the $21,500 that it gifted the Foundation for initial inventory for the gift shop
- Establish a process to track employee volunteer time to ensure the time spent is outside work hours
- Establish a process to monitor the Foundation to ensure compliance with contract agreements and ensure the Foundation is in active status with the Secretary of State

Attachment FF

SCOPE OF SERVICES AGREEMENT

This Scope of Services Agreement ("Agreement") is made and entered into effective the 1st day of April, 2019 by and between Prosser Public Hospital District No. 1, Benton County, Washington d/b/a Prosser Memorial Health (the "Hospital") and Prosser Memorial Health Foundation, a Washington non-profit support organization (the "Foundation").

WHEREAS, Foundation was formed as a support organization for Hospital under state law and under the Federal Internal Revenue Code; and

WHEREAS, the Foundation is dependent upon the resources of Hospital to conduct its operations and its fundraising activities including, but not limited to, an Executive Director, a Chief Financial Officer, use of office space, recordkeeping capabilities, certain ancillary personnel, marketing services, supplies and equipment and other services; and

WHEREAS, governmental entities like Hospital do not have the authority to perform certain services engaged in by Foundation and cannot donate resources to nonprofit organizations like Foundation without receiving fair market value consideration for those items or services; and

WHEREAS, the Hospital benefits from all the activities of the Foundation and those benefits should increase if the Foundation is able to carry out its purposes without having to develop an administrative infrastructure separate and apart from that of the Hospital.

NOW, THEREFORE, in consideration of the above and for other good and valuable consideration the parties hereby agree as follows:

1. Office Space. Hospital hereby agrees to provide office space to Foundation in consideration for rent paid in cash and/or services provided by Foundation to Hospital as described on Schedule 1 attached hereto, Hospital will provide to Foundation such amount of office space as Hospital deems appropriate to enable Foundation to carry out its services hereunder. The specific location and amount of space is set forth on Schedule 1. In the event the Board of Directors of the Foundation determines that additional space is necessary, the Board of Directors shall contact the Hospital and the Hospital will determine whether additional space is required. Foundation agrees that it will only utilize the space designated by Hospital and no other space unless it receives prior written authority from Hospital.

2. Supplies, Equipment and Insurance. Hospital agrees to provide to Foundation the basic supplies and equipment and insurance coverages necessary for the Foundation to carry out its purposes. The specific supplies, equipment and insurance provided by Hospital to Foundation and the cost of the supplies, equipment and insurance is set forth on Schedule 1.

3. Executive Director. Hospital shall also provide to Foundation an individual to serve as the Executive Director of the Foundation. The cost of the Executive Director shall be set forth on Schedule 1. This individual shall be primarily employed by Hospital and compensated through the Hospital's compensation program. However, the Executive Director shall be responsible to the Board of Directors of Foundation. The Hospital CEO may at any time

withdraw the services of the Executive Director and appoint a new Executive Director for the Foundation. The scope of duties and the time devoted by the Executive Director to Foundation shall be determined by the Hospital after consultation with the Foundation. The specific qualifications and duties of the Executive Director are attached hereto as Exhibit A.

4. Additional Personnel. The Hospital shall provide to the Foundation such additional personnel as the parties deem appropriate including a Chief Financial Officer and a Busy Bean/Gift Shop Coordinator for such amount of time and for such consideration as is described on Schedule 1. The Hospital CEO shall have the authority to remove and replace the Chief Financial Officer at his discretion after discussing the proposed action with the Foundation Board.

5. Fair Market Value. The parties acknowledge that for all purposes hereunder, Foundation will pay fair market value consideration for all items and services it receives from the Hospital. Foundation shall use investment income earned by Foundation and shall not use the corpus of the Foundation to pay for items or services provided by Hospital without the prior written consent of the Hospital. The parties also acknowledge that both parties will be receiving goods and services from the other party and instead of paying cash for each individual item or service, the parties may offset the fair market value of the items or services against what is provided by other party. Any remaining amount owed by one party to the other shall be paid in cash with the reconciliation to occur quarterly.

6. Certain Expenditure of Funds. The Foundation acknowledges that it is a support organization for the Hospital. The Foundation has held itself out to the public that its role is to exclusively support the Hospital and has filed documents with the Internal Revenue Service stating that it will exclusively support the Hospital. Therefore, the Foundation agrees that it will make no expenditures for any purposes that are not directly in furtherance of the purposes and objectives of the Hospital and to the extent there is any question regarding the nature of expenditures made by the Foundation, the Foundation and the Hospital shall meet to determine whether such expenditures or the plan for such expenditures are consistent with the purposes and objectives of Hospital.

7. Items and Services Provided by Foundation. Foundation and Hospital acknowledge that Foundation will provide certain services and items including support volunteers for Hospital which will include staffing the gift shop and other activities on the Hospital premises as described on Schedule 2. Hospital will pay fair market value for the items and services Foundation provides to Hospital as described on Schedule 2. Although all volunteers will report to Foundation, it is acknowledged that all activities of the volunteers and all revenue generated by the volunteers shall belong to and be reported to the Foundation which, in turn, shall report all related revenues and expenses to the Hospital. The Foundation will implement a policy and procedure to assure that no Hospital employees are providing volunteer services during scheduled work time. To the extent there is any dispute between any volunteer and the Foundation or any other issue associated with the activities of a volunteer that cannot be resolved by the Foundation, the Foundation shall immediately contact the Hospital and obtain its assistance in resolving any such issue. The Foundation will appoint a Volunteer Advisory Committee to the Foundation Board that will provide suggestions to the Board relating to

expenditures for Hospital purposes from revenues generated by volunteer activities. The Advisory Committee will have no formal voting authority.

8. Intellectual Property. The Foundation may use the name of the Hospital and may develop names for events sponsored by or for the benefit of the Hospital so long as the Foundation receives written approval for such use from Hospital. At all times the names of each activity and the name of the Hospital and any other names associated with events sponsored by Foundation shall belong to and owned by Hospital. Upon the termination of the Foundation for any reason, the Hospital retains the right to use and control all such names. To the extent any intellectual property is developed by the Foundation, the development must be in the best interest of the Hospital and all rights of ownership of the intellectual property shall remain with the Hospital at all times.

9. Meeting of Foundation Board. The Foundation agrees that at any meetings of the Foundation Board the Executive Director may be present at the meeting as well as any authorized officer of the Hospital. The Foundation shall give to the CEO of the Hospital notice of any Foundation meetings and a brief description of the content to be discussed at the meeting. Nothing herein is intended to eliminate or restrict the authority of the Foundation to act as a separate legal entity or restrict its Board making independent decisions regarding the activities of the Foundation to the extent not otherwise inconsistent with this Agreement.

10. Term and Termination. This Agreement shall begin on the effective date first above stated and shall continue for a term of five (5) years and thereafter shall renew for additional five (5) year terms unless terminated as provided herein. Either party shall have the right to terminate this Agreement at any time by providing ninety (90) days prior written notice to the other party. Upon termination of this Agreement for any purpose, all assets of the Foundation and all other legal rights of the Foundation shall immediately revert to Hospital and Foundation shall indemnify Hospital for any liability or expenses incurred by Hospital relating to the termination event.

11. Confidentiality. The Foundation and its Board agree that Foundation and its Board will access confidential information regarding Foundation activities, hospital activities and, potentially, patient information. The Foundation and its Board agree to keep all such information confidential and to comply with The Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Foundation will assure its volunteers also sign agreements requiring they keep information confidential.

12. Accounting. The Hospital shall retain accountants as necessary to account for all activities of the Foundation and to file all appropriate reports and tax returns with appropriate governmental agencies. Foundation shall be given copies of all such documentation and reports.

13. Governing Law. For all purposes, this Agreement shall be governed by the laws of the State of Washington. Jurisdiction for any legal proceedings shall be Prosser, Washington.

IN WITNESS WHEREOF, the undersigned parties hereby execute this Agreement effective the day and year first above written.

Prosser Public Hospital District No. 1, d/b/a Prosser Memorial Health	Prosser Memorial Health Foundation
By: ______________________ Authorized Representative	By: ______________________ Authorized Representative

EXHIBIT A

1. **Qualifications and Duties of Executive Director**. The Executive Director provided by the Hospital to assist the Foundation shall have the following minimum qualifications and duties:

   1.1 To provide clerical support to the Foundation, Board Members, and Sub-Committee Members.

   1.2 To schedule Foundation and Sub-Committee meetings and take notes and draft minutes for each meeting.

   1.3 To complete and distribute agendas for each meeting.

   1.4 Maintain an updated mailing list of Board Members, and keep a detailed and updated database of Donors.

   1.5 Assist the Board in locating Foundation resource, training/educational materials and information.

   1.6 Coordinate training and educational activities.

   1.7 Schedule donor meetings in conjunction with Foundation Board Members and Sub-Committee members.

   1.8 Attend meetings between the Foundation Board Members and potential donors.

   1.9 Keep records of donor paperwork, budgeting and accounting and required filings with state and federal agencies for the Foundation.

   1.10 Create marketing and public relations campaigns for increasing donations to the Foundation.

   1.11 To take such other actions as directed by the Foundation Board.

1.12 Have adequate computer skills and training to accomplish the duties as described above including but not limited to experience with the following Microsoft Office Suite programs: work, excel, access, publisher and accounting.

1.13 Be able to type 50 words per minute.

1.14 Experience with utilization of a multiline telephone system, facsimile machine, and copier.

1.15 Work evenings and weekends when requested.

1.16 Have working knowledge of marketing and promotional concepts and the ability to apply that knowledge to obtain results from the marketing and promotional campaigns.

1.17 Have good interpersonal communication skills.

2. **Supervision of Executive Director**. Hospital shall supervise the Executive Director on a day to day basis and shall be solely responsible for hiring and firing Executive Director in accordance with Hospital policy. Foundation shall have the authority to instruct Executive Director to take or not take certain action on behalf of the Foundation and Hospital shall not interfere with the instructions from the Foundation to the Executive Director so long as the instructions are in furtherance of the purposes of Foundation. Both parties agree that Executive Director during the course of Executive Director's employment may obtain confidences from either party. Neither party shall instruct the Executive Director to disclose a confidence of the other party. Neither party shall discipline the Executive Director for the Executive Director's failure to disclose confidential information regarding the other party.

SCHEDULE 1

Hospital Provided Services

Administrative and Support Staff	$ 104,455
Insurance (Coverage/Board Members)	$ 400
Office Supplies	$ 1,010
Rental Space	$ 8,196
TOTAL	**$ 114,061**

2020

Administrative and Support Staff

Position	**Hourly Rate**	**Weekly Hours**	**Annualized**	**Total Expense**
Executive Director	$ 64	8	416	$ 26,208
CR Outreach Assistant	$ 17	1	52	$ 884
Chief Financial Officer	$ 64	2	104	$ 6,552
Busy Bean/Gift Shop Coordinator	$ 23	40	2,080	$ 49,920
Benefits				*$ 20,891*
			TOTAL	**$ 104,455**

Insurance

Board Member Quantity	10
Cost Per Member	*$ 40*
Total	**$ 400**

Office Supplies

Printing	$ 350
Telephone	$ 420
Other	$ 240
Total	**$ 1,010**

Rental Space

Area	**Square Footage**
Gift Shop	206
Busy Bean	306
Storage Room	115
Vineyard Room Closet	56
Total Square Footage	**683**
Rental Cost (FMV Cost $12/per sq. ft)	**$ 8,196**

SCHEDULE 2

Foundation Provided Services

Auxiliary Support	$ 64,025
Therapy Dog Service	$ 1,300
Chaplain	$ 13,000
Advertising	$ 8,000
Capital Expenditures	$ 15,000
TOTAL	**$ 101,325**

2020

Auxiliary Support

Position	Hourly Rate	Weekly Hours	Annualized	Total Expense
Concierge Support	$ 22	40	2,080	$ 45,760
Per Diem Med/Surg Assistant	$ 21	5	260	$ 5,460
Benefits				*$ 12,805*
			TOTAL	**$ 64,025**

Dog Therapy Service

Position	Hourly Rate	Weekly Hours	Annualized	Total Expense
Therapy Dog Service	$ 25	1	52	$ 1,300

Chaplain

Position	Hourly Rate	Weekly Hours	Annualized	Total Expense
Chaplain	$ 50	5	260	$ 13,000

Advertising

Advertisement	$ 8,000
Total	**$ 8,000**

Capital

Capital	15,000
Total	**$ 15,000**

Hospital Provided Services (Schedule 1)	$ 114,061
Foundation Provided Services (Schedule 2)	$ 101,325
Net Expenditures Total (Due to Hospital)	($ 12,736)
FOUNDATION SUPPORT PAYMENT TO HOSPITAL	$ 12,736

AMENDED AND RESTATED

BYLAWS

OF

PROSSER MEMORIAL HEALTH FOUNDATION

(a Washington Nonprofit Corporation)

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CERTIFICATE

AMENDED AND RESTATED

BYLAWS

OF

PROSSER MEMORIAL HEALTH FOUNDATION

ARTICLE 1
Offices and Records

1.1 Registered Office and Registered Agent. The initial registered office and the initial registered agent of Prosser Memorial Health Foundation (the "Corporation") in the State of Washington shall be as prescribed in the Articles of Incorporation. The initial registered office and the initial registered agent, and any subsequent registered office and registered agent, of the corporation in Washington may be changed from time to time by the Board of Directors. The address of the registered office and the name of the registered agent shall be on file in the office of the Secretary of State of Washington pursuant to applicable provisions of law. Unless otherwise permitted by law, the address of the registered office of the Corporation in Washington and the address of the office of the registered agent in Washington shall be identical. If the registered agent is an individual, he or she shall be a Washington resident.

1.2 Corporate Offices. The Corporation may have such corporate offices anywhere within and without the state of Washington as the Board of Directors from time to time may appoint or the business of the corporation may require. The principal office of the corporation may be determined from time to time by the Board of Directors.

1.3 Records. The Corporation shall keep, as permanent records of the Corporation, minutes of the meetings of the Member, the Board of Directors and of committees of the Board of Directors and a record of all actions taken by the Member or by the Board of Directors or any committee thereof without a meeting, and the corporation shall maintain appropriate accounting records. The Corporation shall also keep, at its principal or registered office in Washington, such records and information as it may from time to time be required by law to keep at such location, if any. The records of the Corporation shall be maintained in written form or in any other form that is capable of being converted into written form within a reasonable time.

1.4 Corporate Seal. The Corporation may have a corporate seal which shall be in the form prescribed by the Board of Directors. Said seal may be used by causing it or a facsimile thereof to be impressed or affixed or in any manner reproduced.

ARTICLE 2
Members

2.1 Qualifications for Membership. The sole member of the Corporation shall be Prosser Public Hospital District of Benton County, Washington d/b/a Prosser Memorial Health (the "Member").

2.2 Place of Meetings. All annual and other meetings of the Member shall be held at the time and at the place, inside or outside the State of Washington, determined by the Member.

2.3 Annual Meetings. The annual meeting of the Member shall be held in December each year or at such other time as determined by the Member. If for any reason no meeting of the Member is held at such time, but the Member nevertheless designates a meeting of the Member held at another time as the annual meeting thereof (regardless of when such designation is made), then such meeting shall be considered to be a special meeting of the Member for purposes of determining by whom such meeting may be called and the time at which such meeting may be held. The purposes of the annual meeting shall be to appoint Directors and to transact such other business as may come before the meeting.

2.4 Special Meetings. Special meetings of the Member may be called at any time by the President, by the Board of Directors, or by the Member. Special meetings may be called for any purpose or purposes, but business transacted at any special meeting shall be confined to the purposes stated in the notice of such meeting, unless the transaction of other business is consented to by the Member.

2.5 Member's Action by Consent in Lieu of Meeting. Any action required by law to be taken at a meeting of the Member, or any action which may be taken at a meeting of the Member, may be taken without a meeting if a consent in writing, setting forth the action so taken, shall be signed by the Member. Such consent shall have the same force and effect as a vote of the Member at a meeting duly held, and the Secretary shall cause to file such consent with the minutes of the meetings of the Member.

ARTICLE 3
Board of Directors

3.1 Powers of the Board. The property and activities of the Corporation shall be controlled and managed by the Board of Directors. The Board of Directors shall have and is vested with all and unlimited powers and authorities, except as may be expressly limited by the Member, the law, the Articles of Incorporation, or these Bylaws, to do or cause to be done any and all lawful acts and things for and on behalf of the Corporation, to exercise or cause to be exercised any or all of its powers, privileges, and franchises, and to seek the effectuation of its objects and purposes.

3.2 Number and Qualifications.

(a) The number of Directors to constitute the first Board of Directors shall be as prescribed in the Articles of Incorporation. The number of Directors to constitute the Board of Directors of the Corporation may be increased or decreased by the Member at any time and from time to time, but such number shall not be fewer than three.

(b) A Director does not need to be a resident of the State of Washington. A Director must be at least 18 years of age.

3.3 Appointment of Directors; Removal.

(a) The Directors of the Corporation shall be appointed by the Member. At each annual meeting of the Member, the Member shall appoint successor Directors to replace each Director whose term in office then expires. The Member may additionally at any time fill any vacancy on the Board of Directors, regardless of how such vacancy was created. Other than Directors appointed to fill a vacancy, all Directors shall be selected from a slate of nominees presented by the Board of Directors to the Member. If the Member does not find a sufficient number of the nominees suitable to fill all of the positions up for appointment, the Board of Directors shall continue to present additional slates of nominees until all the positions have been filled. In the event that the Board of Directors fails to present a slate of nominees, the Member may appoint any individuals that satisfy the requirements of Section 3.2. All appointments shall be in writing and shall be delivered by the Member to the Board of Directors.

(b) The Member may remove any Director at any time, with or without cause, by providing written notice of the removal to the Board of Directors.

3.4 Tenure of Directors.

(a) There shall be staggered terms of office for directors so that one-half of the directorships shall be up for appointment every other year (or if the number does not evenly divide by halves, the Board shall be divided as close to halves as possible). The Directors were initially divided into two classes by the Member in a Statement of Action by the Member dated effective September 7, 2017. The term of office of those of the first class shall expire at the 2020 annual meeting of the Member. The term of office of the second class shall expire at the 2021 annual meeting of the Member. At each succeeding annual meeting of the Member where Directors are up for appointment, the Directors appointed shall be appointed for a term of two years to succeed those whose terms expire. A Director appointed to fill a vacancy or a newly-created position on the Board of Directors shall be appointed for the unexpired term, if any, of his or her predecessor in office or for a term that ends on the date of the next annual meeting of the Member where Directors are up for appointment, respectively. Each Director shall hold office for the term set forth in this section and thereafter until

his or her successor shall have been elected and qualified, or until such Director's earlier death, resignation, or removal.

(b) A Director may not serve more than eight consecutive years. After serving eight consecutive years, a Director must vacate his or her position for at least two years before seeking re-appointment for another term.

(c) The attendance of a Director at any annual, regular, or special meeting of the Board of Directors, such Director's written approval of the minutes or written waiver of notice of any such meeting, or such Director's execution of a written consent to directors' action in lieu of a meeting shall constitute acceptance of the office of Director.

3.5 Board of Director Meetings.

(a) The annual meeting of the Board of Directors shall be held in December each year, commencing with the year 2017, and such meeting shall be held at the principal office of the Corporation or, if no such principal office has been designated, at the registered office of the Corporation in Washington or at such other location or on such other date as is specified by the Board or by the Member. If for any reason no meeting of the Board of Directors is held at such time or place, but the Directors or Member nevertheless designate a meeting of the Board of Directors held at another time or place as the annual meeting thereof (regardless of when such designation is made), then such meeting shall be considered to be a special meeting of the Board of Directors for purposes of determining by whom such meeting may be called and the time and place at which such meeting may be held. The purposes of the annual meeting shall be to elect officers, recommend to the Member a slate of Directors, to determine actions to be taken to carry out the purposes of the Corporation, and to transact such other business as may come before the meeting.

(b) Regular meetings of the Board of Directors shall be held at such time and place as the Board of Directors may designate from time to time.

(c) Special meetings of the Board of Directors may be called, and may only be called, by or at the request of the President, by any three Directors or by the Member. Such meetings shall be held at such time and place as may be designated in the notice thereof given pursuant to section 3.6.

(d) Actions of the Board of Directors taken at any meeting of the Board of Directors that is held at a time or place other than the time or place at which such meeting is required to be held pursuant to the provisions of these Bylaws shall be valid if notice of such meeting is waived pursuant to the provisions hereof.

3.6 Notice of Board of Director Meetings.

(a) The annual meeting of the Board of Directors contemplated by the provisions of the first sentence of section 3.5(a) shall be held without notice. If, however, a meeting of the Board of Directors is designated by the Directors as the annual meeting thereof pursuant to the provisions of the second sentence of section 3.3(a), then notice of such meeting shall be given to the Directors by the person or persons who call such meeting (or a person on behalf of the Member) at least two days before the date of such meeting.

(b) Regular meetings of the Board of Directors may be held without notice.

(c) Notice of each special meeting of the Board of Directors shall be given to the Directors by the persons or persons who call such meeting at least two days before the date of such meeting.

(d) If any meeting of the Board of Directors is permitted to be held without notice but notice of such meeting is nevertheless given, the giving of such notice shall not affect the validity of actions taken at the meeting, even if the notice is inaccurate in any respect or is improperly given.

(e) Notice of any meeting of the Board of Directors may be oral or written and shall state the date, time, place, and purpose of the meeting. Notice of any meeting of the Board of Directors may be communicated in person, by telephone, telecopy, email, or other form of wire or wireless communication, or by mail or private carrier. Oral notice shall be effective, *i.e.*, shall be deemed to be given to the recipient, when communicated. Written notice shall be sent to a Director at his or her United States mailing address, fax number, email address, or other address shown on the corporation's records and shall be effective, *i.e.*, shall be deemed to be given to the recipient, upon the earliest to occur of: receipt of such notice by such Director; the fifth day after deposit of such notice in the United States mail, as evidenced by the postmark, if mailed correctly addressed and with first class postage affixed; the date shown on the return receipt, if such notice is sent by registered or certified mail, return receipt requested, and the receipt is signed by or on behalf of the addressee; or the thirtieth day after deposit of such notice in the United States mail, as evidenced by the postmark, if mailed correctly addressed and with other than first class, registered, or certified postage affixed.

3.7 Waiver of Notice. Any notice required to be given to a Director by any provision of these Bylaws, the Articles of Incorporation, or any law may be waived in a written instrument signed by such Director, whether before, at, or after the meeting for which such notice is required to be given, if the instrument is filed with the minutes of the meeting or in the Corporation's records. Attendance of a Director at any meeting shall constitute a waiver of notice of such meeting except where such Director upon arriving at the meeting or prior to the vote on a matter not noticed in

conformity with these Bylaws objects to the lack of notice and does not vote for or assent to the objected to action.

3.8 Action of Directors by Consent in Lieu of Meeting. Any action which is required to be or which may be taken at a meeting of the Board of Directors may be taken without a meeting if all of the members of the Board of Directors take such action and, to evidence such action, sign a written consent (which may be signed in two or more counterparts) that describes the action taken. Each such consent shall have the same force and effect as a unanimous vote of the Directors at a meeting of the Board of Directors duly held and may be stated as such in any document executed on behalf of the corporation. The Secretary shall file such consents with the minutes of meetings of the Board of Directors of the corporation.

3.9 Meetings by Telecommunications Equipment. Unless otherwise provided in the Articles of Incorporation, any or all members of the Board of Directors may participate in any meeting of the Board of Directors by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other. A Director who participates in a meeting in this manner shall be deemed to be present in person at the meeting.

3.10 Quorum; Action of Board. A majority of the Directors shall, unless a greater number as to any particular matter is required by law, the Articles of Incorporation, or these Bylaws, constitute a quorum for the transaction of business at any meeting of the Board of Directors. The affirmative vote of a majority of the Directors present at any meeting of the Board of Directors shall be the act of the Board of Directors if a quorum is present when the vote is taken, except as may be otherwise specifically provided by law, the Articles of Incorporation, or these Bylaws. Less than a quorum of the Board of Directors may adjourn a meeting successively until a quorum is present.

ARTICLE 4
Committees

4.1 Committees. The Board of Directors may designate one or more standing or special committees and appoint members of the Board of Directors to serve on them. Each such committee shall have two or more members, all of whom shall serve at the pleasure of the Board of Directors. Each committee shall have such power and authority as is specified by the Board of Directors upon the establishment of such committee, subject to the Articles of Incorporation and applicable law.

4.2 Committee Action. Each committee of the Board of Directors shall keep regular minutes of its meetings which shall be kept in the minute books or files of the corporation. The provisions of Article 3 relating to actions by written consent in lieu of meetings and participation in meetings by means of conference telephone or similar communications equipment shall apply to committees of the Board of

Directors and members thereof. The Secretary or an Assistant Secretary of the corporation may act as secretary for any committee if the committee so requests.

ARTICLE 5
Officers

5.1 Elected Officers.

(a) The officers of the Corporation shall at all times include a President, a Vice President, a Treasurer, and a Secretary. If the Board of Directors desires, the titles of Chairman and Vice Chairman of the Board may be used for the President and a Vice President. One or more additional Vice Presidents and one or more Assistant Secretaries and Assistant Treasurers may be elected by the Board of Directors from time to time as it deems necessary or advisable. The same individual may simultaneously hold more than one office in the corporation, except that the offices of President and Secretary shall not be held by the same individual.

(b) An elected officer shall be deemed qualified when such officer begins the duties of the office to which such officer has been elected and furnishes any bond required by the Board of Directors. The Board of Directors may require of such person, in addition to a bond, a written acceptance of office and a promise to discharge faithfully the duties of such office. Each officer of the corporation must be a member of the Board of Directors.

5.2 Term of Office. Each elected officer of the Corporation shall hold office for a term of two (2) years but if no election of a new officer occurs, the existing officers shall continue to serve thereafter until his or her successor shall have been elected and qualified, unless such officer earlier resigns or is removed by the Board of Directors. No officer may serve more than four (4) two (2) year terms in any one (1) office.

5.3 Appointed Officers and Agents. The Board of Directors from time to time may also appoint such other officers and agents for the corporation as it shall deem necessary or advisable. All appointed officers and agents shall hold their respective positions at the pleasure of the Board of Directors, and they shall have and exercise such powers and have and perform such duties as shall be determined from time to time by the Board of Directors or by an elected officer empowered by the Board of Directors to make such determinations.

5.4 Removal. Any officer or agent elected or appointed by the Board of Directors and any employee may be removed or discharged by the Board of Directors or by the Member whenever in its judgment the best interests of the Corporation would be served thereby. Such removal shall be without prejudice to the contract rights, if any, of the person so removed.

5.5 Delegation of Authority to Hire, Discharge, and Designate Duties. The Board of Directors from time to time may delegate to the President, or other officer or

executive employee of the corporation authority to hire and discharge and to fix and modify the duties of employees of the corporation under the jurisdiction of such officer or executive employee. The Board of Directors may also delegate to such an officer or executive employee similar authority with respect to obtaining and retaining for the corporation the services of attorneys, accountants, and other professionals and experts. In the absence of any designation, the President shall have such general authority with respect to all employees and independent contractors whose services, in the discretion of the President, are required by the corporation.

5.6 The Chairman of the Board. The Chairman of the Board, if any, shall have all the authority, powers, and duties of the President if no separate President is elected by the Board and shall have such other authority, powers, and duties as the Board of Directors may determine, and any act required or permitted by law to be done by the President may be done instead by the Chairman of the Board. The Chairman of the Board shall preside at all meetings of the members and Board of Directors. The Member has the authority to preclude the election of a President or remove a President if a Chairman of the Board is elected.

5.7 The Vice Chairman of the Board. The Vice Chairman of the Board, if any, shall have such authority and powers and perform such other duties as the Board of Directors shall from time to time prescribe.

5.8 The President.

(a) The President or the Chairman of the Board if no separate President is elected by the Board shall be the chief executive officer of the Corporation unless the Board of Directors elects a chairman of the Board and designates the Chairman of the Board as the sole or joint chief executive officer. The President shall have such general executive authority, powers, and duties of supervision and management as are usually vested in the office of the chief executive officer of a corporation and shall carry into effect all actions, directions, and resolutions of the Board of Directors. The President shall have such other or further duties and authority as may be prescribed elsewhere in these Bylaws or from time to time by the Board of Directors. If at any time there is no Chairman of the Board, or in the absence of the Chairman of the Board, the President shall preside at all meetings of the members and Board of Directors.

(b) Although the President shall have the authority, powers, and duties set forth in the preceding paragraph, it is contemplated that the corporation's business and activities will be managed on a day-to-day basis by the Executive Director of the corporation. The President shall monitor the Executive Director's activities conducted on behalf of the corporation to the extent deemed by the President to be necessary or appropriate. Subject to action taken by the Board of Directors, the President may provide direction to the Executive Director from time to time, as the President deems to be necessary or appropriate, regarding the performance of the Executive Director's duties.

5.9 The Vice Presidents/Vice Chairman. The Vice Presidents shall have such authority and powers and perform such duties as the Board of Directors shall from time to time prescribe. If there is only one Vice President or Vice Chairman then he or shall, in the event of the absence, death, disability, or inability to act of the President, perform the duties and exercise the authority and powers of the President. Similarly, if there is a Vice Chairman, in the event of the absence, death or disability or inability to act of the Chairman, the Vice Chairman shall perform the duties and exercise the authority and powers of the Chairman.

5.10 The Secretary and Assistant Secretaries.

(a) The Secretary shall have the general authority, powers, duties, and responsibilities of a secretary of a corporation. The Secretary shall attend all meetings of the members and Board of Directors, and he or she shall record or cause to be recorded and shall maintain the minutes of all meetings and written consents to action without a meeting of the Member and Board of Directors in minute books or files of the corporation to be kept for that purpose. The Secretary shall perform like duties for each committee of the Board of Directors when requested by the Board of Directors or such committee to do so. The Secretary shall have the authority and power to authenticate records of the corporation.

(b) The Secretary shall bear the principal responsibility to give, or cause to be given, notice of all meetings of the Member and Board of Directors for which notice is required, but this shall not affect the authority of others to give such notice as is authorized elsewhere in these Bylaws. The Secretary shall see that all books, records, lists, and information required by the Articles of Incorporation or law to be maintained at the principal office of the corporation in Washington or elsewhere are so maintained. The Secretary shall keep in safe custody the seal of the corporation, if any, and, when duly authorized to do so (including authorization given by the President or other executive officer of the corporation), shall affix the same to any instrument requiring it, and when so affixed, the Secretary shall attest the same by the Secretary's signature. The Secretary shall perform such other duties and have such other authority as may be prescribed elsewhere in these Bylaws or from time to time by the Board of Directors or the President, under whose direct supervision the Secretary shall be.

(c) The Assistant Secretaries, in the order determined by the Board of Directors, shall, in the event of the absence, death, disability, or inability to act of the Secretary, perform the duties and exercise the authority and powers of the Secretary. In addition, they shall perform such other duties and have such other authority as the Board of Directors may from time to time prescribe.

5.11 The Treasurer and Assistant Treasurers.

(a) The Treasurer, if any, shall have the general authority, powers, duties, and responsibilities of a treasurer of a corporation and shall, unless

otherwise provided by the Board of Directors, be the chief financial and accounting officer of the corporation. The Treasurer shall have the responsibility for the safekeeping of the funds and securities of the corporation and shall keep or cause to be kept full and accurate accounts of receipts and disbursements in books belonging to the corporation. The Treasurer shall keep, or cause to be kept, all other books of account and accounting records of the corporation and shall deposit or cause to be deposited all monies and other intangible assets of the corporation in the name and to the credit of the corporation in such depositories as may be designated by the Board of Directors (except for assets, such as the corporation's name, that are not susceptible to such deposit).

(b) The Treasurer shall disburse, or permit to be disbursed, the funds of the corporation as may be ordered or authorized generally by the Board of Directors. The Treasurer shall render to the chief executive officer of the corporation or the Board of Directors, whenever asked by either to do so, an account of the financial condition of the corporation and an account of all transactions of the Treasurer and those under the Treasurer's supervision. The Treasurer shall perform such other duties and shall have such other responsibility and authority as may be prescribed elsewhere in these Bylaws or from time to time by the Board of Directors.

(c) If required by the Board of Directors, the Treasurer shall give the corporation a bond, in a sum and, if required by the Board of Directors, with one or more sureties satisfactory to the Board of Directors, for the faithful performance of the duties of office and for the restoration to the corporation, in the case of such Treasurer's death, resignation, retirement, or removal from office, of all books, papers, vouchers, money, and other property of whatever kind in the possession or under the control of such Treasurer that belong to the corporation. The cost, if any, of said bond shall be paid by the corporation.

(d) The Assistant Treasurers, in the order determined by the Board of Directors, shall, in the event of the absence, death, disability, or inability to act of the Treasurer, perform the duties and exercise the authority and powers of the Treasurer. In addition, they shall perform such other duties and have such other authority as the Board of Directors shall from time to time prescribe.

5.12 Duties of Officers May be Delegated. If any officer of the corporation shall be absent or unable to act, or if the Board of Directors so elects for any other reason that it may deem sufficient, the Board of Directors may delegate, for the time being, some or all of the functions, authority, powers, duties, and responsibilities of any officer to any other officer or to any other agent or employee of the corporation or other responsible person.

ARTICLE 6
Executive Director and Chief Financial Officer

The Board of Directors and CEO of the Member will jointly appoint an Executive Director and a Chief Financial Officer for the corporation. The Executive Director shall, among other duties, carry out the goals and programs of the corporation pursuant to the job description adopted by the Board of Directors. In this regard, the Executive Director shall manage, and shall have such general executive authority, powers, and duties of supervision and management as are necessary or appropriate in order for the Executive Director to manage, the property, business, and activities of the corporation on a day-to-day basis. The Executive Director shall have such other or further authority, power, and duties (and the authority and powers of the Executive Director shall be subject to such limitations) as may be prescribed elsewhere in the Bylaws or from time to time by the Board of Directors (including in the job description for the position of Executive Director adopted by the Board of Directors). The Chief Financial Officer shall handle day-to-day financial operations of the corporation and execute financial instruments approved by the Board of Directors. The CEO of the Member can remove the Executive Director and/or Chief Financial Officer at any time after consultation with the Board.

ARTICLE 7
Indemnification

The corporation shall indemnify and protect any member, director, officer, employee, or agent of the corporation, or any person who serves at the request of the corporation as a director, officer, employee, member, manager, or agent of another corporation, partnership, limited liability company, joint venture, trust, employee benefit plan, or other enterprise, to the fullest extent permitted by the laws of the State of Washington.

ARTICLE 8
General

8.1 Checks. All checks, bank drafts, and other orders for the payment of money shall be signed by such officer or officers or such other person or persons as the Board of Directors may from time to time designate. If no designation is made and unless and until the Board of Directors otherwise provides, each of the President and Chief Financial Officer shall individually have power to sign all such instruments which are executed or made in the ordinary course of the corporation's business for the corporation.

8.2 Fiscal Year. For accounting and income tax purposes, the corporation shall operate on such fiscal year as may be designated from time to time by the Board of Directors.

8.3 Amendments. The Bylaws of the corporation may from time to time be altered or amended in any respect or repealed in whole or in part, and new Bylaws may be adopted, by the Member.

8.4 Interpretation. As used in these Bylaws, the term "and" means and/or and the term "or" means and/or, as appropriate.

CERTIFICATE

I hereby certify that I am the Secretary of Prosser Memorial Health Foundation, a Washington nonprofit corporation, and the keeper of its corporate records; that the Amended and Restated Bylaws to which this Certificate is attached were duly adopted by said corporation's Board of Directors as and for the Bylaws of the corporation effective as of July 1, 2019; and that these Bylaws constitute the Bylaws of the corporation and are now in full force and effect.

____

______________________, Secretary

Board of Commissioners
Prosser Public Hospital District
doing business as Prosser Memorial Health
Prosser, Washington

In planning and performing our audit of the financial statements of Prosser Public Hospital District doing business as Prosser Memorial Health (the District) for the year ended December 31, 2019, we considered its internal control in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on internal control.

During our audit, we became aware of opportunities for strengthening the District's internal controls and operating efficiency. This letter does not affect our report dated March 17, 2020, on the financial statements of the District.

We will review the status of these comments during our next audit engagement. Our comments are summarized as follows:

Bank Reconciliations

Bank reconciliations were not completed accurately throughout the year. Monthly bank reconciliation is a key internal control for accurate financial reporting.

We recommend the District develop policies and procedures to ensure completion of the bank reconciliation, with no significant unresolved variances, for each month. Accounting and revenue cycle staff will need to coordinate their efforts for the bank reconciliation process to be successful. The difficulties presented in bank reconciliation often are due to inconsistencies in cash posting batches compared to actual bank deposits. To alleviate this, a daily reconciliation of cash posting batches to the bank deposits will be necessary. Procedures for accounting for and resolving timely cash deposits received without the necessary information to post to patient accounts (for example, electronic fund transfers received before the accompanying remittance advice is received), Medicare, and other third-payor take-backs will also be necessary.

Written Policies and Procedures

The District does not have current written policies and procedures for key transaction cycles. Written policies and procedures are necessary for consistent performance of key transaction cycles and related key internal controls. We recommend the District develop written policies and procedures for at least the following key transaction cycles:

- Financial close and manual journal entries
- Accounts payable and cash disbursements
- Payroll
- Cash receipting and posting
- Charge capture (see below)
- Billing
- Information technology

We can provide the key transaction cycle information we have gathered through the audits as a starting point.

Charge Capture Controls

The District does not currently have a formalized process and procedures for the charge capture process. To maintain maximum billing quality and efficiency, employees entering charges should perform various procedures with a high level of standardization. This consistency is possible if, along with hands-on training, employees have documentation of policies and procedures to follow. We recommend documentation of policies and procedures related to the charge capture be developed and updated regularly.

There is no formal charge capture committee. There should be a committee that reviews the charge description master (CDM) to ensure it contains all of the services the District offers. We recommend a charge capture committee be formed with representation from nursing, patient financial services, health information management, compliance, and administration.

There are no written procedures for the CDM. There should be written policies and procedures describing how chargeable items are added, removed, and updated in the CDM.

Accounts Payable

The accounts payable clerk prepares checks for signature and presents them to the Senior Accountant for review and the CFO for signature. The accounts payable checks are then returned to the accounts payable clerk after signing for mailing. Returning signed checks to accounts payable increases the opportunity for the accounts payable clerk to alter the checks before mailing. We recommend signed checks not be returned to the accounts payable clerk and instead be mailed by a different individual.

Certain accounts payable are accrued using the average of historical invoices. The accrual currently used appears to be based on older invoices. We recommend the District update the averages used on a rolling basis to ensure accounts payable accruals are accurate.

Investments

Government Accounting Standards Board Statement No. 72, *Fair Value Measurement and Application*, requires the District to record investments at their fair market value. Currently, investments are being recorded at cost with accrued interest to account for changes in fair market value. To be in compliance with current accounting standards, we recommend investments are compared to bank statements and adjusted directly to their fair market value without accrued interest.

Prepaid Expenses

The District has a number of prepaid deposits for rent and utilities outstanding as of December 31, 2019. We recommend reviewing the list of deposits to determine if they are still current. Prepaid expenses could be overstated if deposits that are not current are still recorded.

Accounts Receivable

There were significant credit balances in the patient accounts receivable aging by payor. Credit balances in accounts receivable should be reviewed monthly to ensure the District is not understating the accounts receivable balance, causing the allowance to be understated as well.

We can assist with identifying credit balances and other unusual accounts on a periodic basis.

Long-term Debt

The conditional sales agreement with Bank of America requires the District set up an installment payment fund to be used for the payments on the bond. No such fund has been set up. We recommend the District create an installment payment fund in order to be in compliance with all aspects of the conditional sales agreement.

Lease Standard Implementation

The District will be required to implement Governmental Accounting Standards Board Statement No. 87, *Leases*, in the year ending December 31, 2020. The District will also be required to restate the year ending December 31, 2019, when implementing the new lease accounting standard. The District will need to be prepared to account for currently reported operating leases as capital leases on January 1, 2020.

We expect a material amount of lease obligations and the related assets will be added to the District's statement of net position in 2020.

We recommend the District develop and implement a plan to evaluate all leases during 2020. The implementation plan should include the following:

- Develop a system (spreadsheet or software) for monitoring leases.
- Prepare an inventory of all leased equipment and real estate.
- Review lease expense accounts while preparing the inventory.
- Develop written policies and procedures for all staff involved in equipment and real estate leases (accounting, department managers, purchasing, etc.).
- Review existing service and supplies agreements for implicit equipment leases (an example is a laboratory analyzer provided if a certain amount of reagents are purchased from a vendor). Develop a lease capitalization threshold. This would allow for leases with total payments under a certain dollar threshold to be expensed as paid (the current practice for operating leases).

The District has very significant real estate leases. Such leases often contain renewal options which will need to be evaluated to determine *if it is reasonably certain, based on all relevant factors,* that the lessee will exercise the option or not.

We can assist with the implementation of the new lease standard.

Closing

We wish to thank the Chief Financial Officer, Controller, and their departments for their support and assistance during our audit.

This report is intended solely for the information and use of the Board of Commissioners, management, and others of Prosser Public Hospital District doing business as Prosser Memorial Health, and is not intended to be and should not be used by anyone other than these specified parties.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
March 17, 2020

Prosser
Memorial Health

2020 DZA Management Letter Taskforce – Quality Initiative

"It's safe to come out - the auditors have gone."

Our Friends - DZA

DZA

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Tom Dingus, Owner

Luke Zarecor, Owner

Management Work Plan to Resolve Deficiencies

- The Director of Finance has formed a team, the Audit Compliance Taskforce, to collaborate and address all items as identified in the DZA Management Letter resulting from the 2019 Audit.
- The first Audit Compliance Taskforce meeting occurred May 19 and will be recurring mid-month throughout the remainder of the year.
- All DZA recommendations have been assigned a group to work through them specifically with deadlines of deliverables due back to the committee for review.
- Additionally, it has been identified in order to complete many of the policy recommendations, Standards of Procedures (SOPs) are needing completion and/or revisions. These SOPs have been identified and split into their own individual projects amongst the team accordingly.
- Each taskforce meeting will review, provide feedback as needed, approve to proceed with next steps, and ultimately formally publish the Policies as recommended with the SOPs that align with each.
- The Director of Finance will also provide to the Board Finance Committee project updates each month to review and assess progress.
- The Audit Compliance Taskforce will continue each year and adapt as required for any additional items identified resulting from our annual audits to organize, address, and to ensure future compliance as required by the following audit or deadlines as indicated.

DZA Recommendation Task Force

- Stephanie Titus
- Linda Bouchard
- Diana Ramirez
- Lydia Bartlett
- Maria Rubalcaba
- Jamie Willoughby
- Michelle Risk
- Yolanda Montiel
- Mary Lee Dawsey

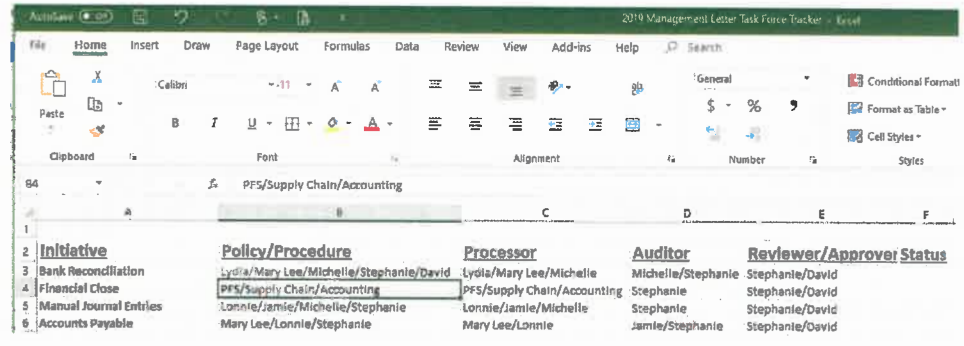
Break It Down

- Recommendation
- Policy/Procedure
- Processor
- Auditor
- Review/Approver

- Identifying the Initiatives –
  - Bank Reconciliation
  - Financial Close
  - Manual Journal Entries
  - Accounts Payable
  - Cash Disbursements
  - Payroll
  - Cash Receipting and Posting
  - Billing
  - Information Technology
  - Charge Capture
  - Investments
  - Prepaids
  - Accounts Receivable
  - Long Term Debt
  - Lease Standard Implementation

Established Recommendation Tracker

- Page 1 Recommendation Identifier:
  - Recommendation
  - Policy/Procedure
  - Processor
  - Auditor
  - Review/Approver
- Recommendations By Worksheet
  - Key Identifier Checklists
  - Completed Check Box



Initiative	Policy/Procedure	Processor	Auditor	Reviewer/Approver	Status
Bank Reconciliation	Lydia/Mary Lee/Michelle/Stephanie/David	Lydia/Mary Lee/Michelle	Michelle/Stephanie	Stephanie/David	
Financial Close	PFS/Supply Chain/Accounting	PFS/Supply Chain/Accounting	Stephanie	Stephanie/David	
Manual Journal Entries	Lonnie/Jamie/Michelle/Stephanie	Lonnie/Jamie/Michelle	Stephanie	Stephanie/David	
Accounts Payable	Mary Lee/Lonnie/Stephanie	Mary Lee/Lonnie	Jamie/Stephanie	Stephanie/David	

Key Indentifier Checklist:	Completed:
Daily Bank Rec Process	
Weekly Bank Rec Process	
Monthly Bank Rec Process	
Variance Treatment and Review	
Revenue Cycle Staff Process completion	
Accounting Staff Process completion	
Audit process completion	
Clinic deposits receipt and posting requirement	
EFT/EOB process posting and review	
Medicare/Medicaid posting and review	
Other third party posting and review	
Take back process posting and review	

Bank Reconciliation

- Policy/Procedure
  - Lydia/Mary Lee/Michelle/Stephanie/David
- Processor
  - Lydia/Mary Lee/Michelle
- Auditor
  - Michelle/Stephanie
- Review/Approver
  - Stephanie/David

- As of August 2019, we transitioned the bank reconciliation process back to an internal process taking over from Northwest CPA which had been the functioning reconciler of the bank accounts since 2018. DZA had been reconciling prior from 2016 - 2018
- Adapted a daily, weekly, and monthly process for reconciling. Accounting is able to report cash posting errors real time to PFS for adjustments to occur within 24 hours of identification
- Reconciled all "holding" suspense accounts utilized in Patient EHR systems. The 2019 audit resulted in findings of an adjustment; now with our new process, balances do not remain older than 72 hours
  - Balances posted to holding account are reported to PFS Manager and Accountant per cash poster notification. Once resolution (EOB properly identified), balance of posting is reversed and properly applied to patient account
- Completed monthly reconciliations are now timely done within 10 business days following each month end and are properly reviewed by Director of Finance. All adjustments are posted within the proper month during the month soft closing process
- Documentation of Policy and Procedures has now begun
  - Timeline Completion by June 15 to present to Task Force

Financial Close

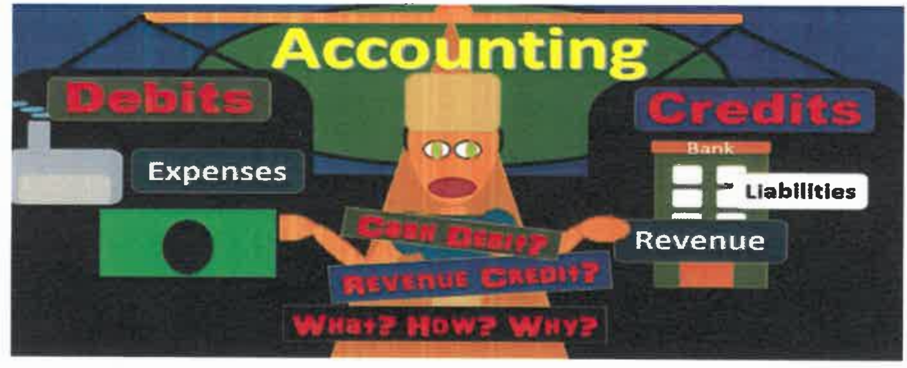
- Policy/Procedure
    - PFS/Supply Chain/Accounting
- Processor
    - PFS/Supply Chain/Accounting
- Auditor
    - Stephanie
- Review/Approver
    - Stephanie/David

- Financial Month Close checklist is now established
    - System Close Schedule Established
    - Month End Schedule Established
    - Quarterly and Year-End Schedule work in progress
- Documentation of Policy and Procedures has now begun
- Timeline Completion by July 15 to present to Task Force

Manual Journal Entries

- Policy/Procedure
  - Lonnie/Jamie/Michelle/Stephanie
- Processor
  - Lonnie/Jamie/Michelle
- Auditor
  - Stephanie
- Review/Approver
  - Stephanie/David

- Manual journal entries are printed and reviewed monthly. Controls are established in system on who enters, reviews, and approves
- Documentation of Policy and Procedures has now begun
- Timeline Completion by June 15 to present to Task Force



Accounts Payable

- Policy/Procedure
  - Mary Lee/Lonnie/Stephanie
- Processor
  - Mary Lee/Lonnie
- Auditor
  - Jamie/Stephanie
- Review/Approver
  - Stephanie/David

Procedures -

- Proper controls, entering, review, and approval are established
- Timeline Completion of procedures by June 15 to present to Task Force

Policy -

- Limitations within number of FTEs are being addressed to best delegate controls and audit processes as necessary
- System limitations within Lawson limits the differentiation of possible roles but again additional audit processes are being strategically placed as required
- Timeline Completion of policy by August 15 to present to Task Force

Cash Disbursements

- Policy/Procedure
  - Mary Lee/Lonnie/Stephanie
- Processor
  - Mary Lee/Lonnie
- Auditor
  - Jamie/Stephanie
- Review/Approver
  - Stephanie/David

- Proper controls, entering, review, and approval are established
- Timeline Completion of procedures by June 15 to present to Task Force
- Timeline Completion of policy by August 15 to present to Task Force

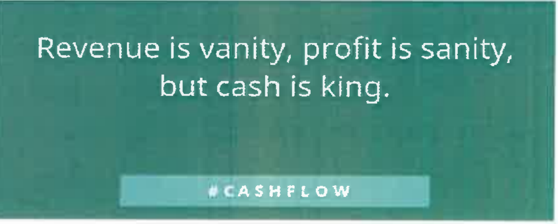
Payroll

- Policy/Procedure
  - Michelle/Stephanie
- Processor
  - Michelle
- Auditor
  - Stephanie
- Review/Approver
  - Stephanie/David/Ro

- Proper controls, entering, review, and approval are established
- Timeline Completion of procedures by June 15 to present to Task Force
- Timeline Completion of policy by August 15 to present to Task Force

Cash Receipting and Posting

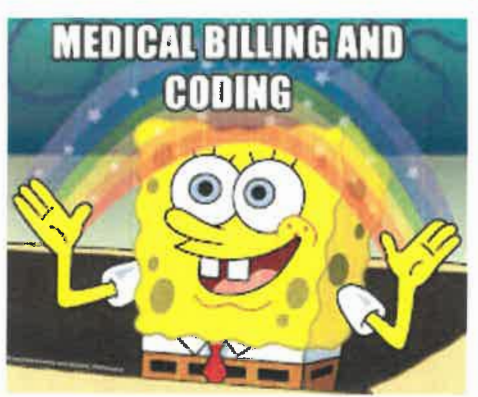
- Policy/Procedure
  - Lydia/Linda/Michelle/Stephanie
- Processor
  - Lydia/Michelle
- Auditor
  - Michelle/Stephanie
- Review/Approver
  - Stephanie/David



- Proper controls, entering, review, and approval are established. Documentation of process being completed by end of May
- Limitations within number of FTEs are being addressed to best delegate controls and audit processes as necessary
- System limitations within Lawson limits the differentiation of possible roles but again additional audit processes are being strategically placed as required

Billing

- Policy/Procedure
  - Maria/Linda
- Processor
  - Maria
- Auditor
  - Diana/Linda
- Review/Approver
  - Linda/Stephanie



- Proper controls, entering, review, and approval are established. Documentation of process being completed by end of May
- Limitations within number of FTEs are being addressed to best delegate controls and audit processes as necessary
- System limitations within Lawson limits the differentiation of possible roles but again additional audit processes are being strategically placed as required

Information Technology

- Policy/Procedure
  - IT/Kevin
- Processor
  - IT
- Auditor
  - Kevin/Stephanie
- Review/Approver
  - Stephanie/David/Kevin

- Proper controls, entering, review, and approval are established. Documentation of process being completed by end of May
- Limitations within number of FTEs are being addressed to best delegate controls and audit processes as necessary
- System limitations within Lawson limits the differentiation of possible roles but again additional audit processes are being strategically placed as required

Charge Capture

- Policy/Procedure
  - Diana/Linda/Stephanie
- Processor
  - Diana
- Auditor
  - Linda/Stephanie
- Review/Approver
  - Linda/Stephanie/David

- Committee was established December 2019.
- Review and Charge capture meetings are held monthly or more frequently as needed
- Committee meetings are at Leadership level and CDM was provided to all Leaders for proper review and approval. All revisions and approvals were done and received by 2/29/2020
- Committee will now begin process and procedure documentation to be completed by Q3 2020

Investments

- Policy/Procedure
  - Stephanie/David
- Processor
  - Lonnie/Stephanie
- Auditor
  - Stephanie/David
- Review/Approver
  - Stephanie/David/Craig/Board

- Interest Accrual process is in review as well as the possibility of updating policy to adapt the understanding investments will not be liquidated prior to maturity

"The market's been all over the place, today."

Prepaids

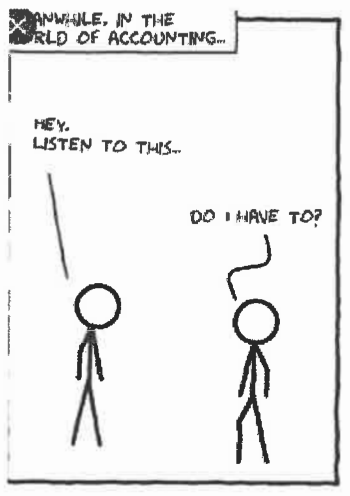
- Policy/Procedure
  - Lonnie/Stephanie
- Processor
  - Mary Lee/Lonnie
- Auditor
  - Stephanie
- Review/Approver
  - Stephanie/David

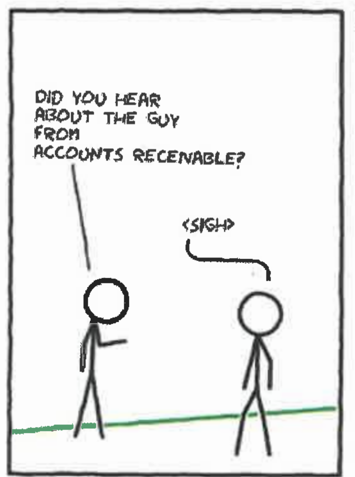
- Prepaids are reviewed monthly with reconciliations approved by Director of Finance
- Audit of All prepaids and deposits is completed every year to ensure no deposit remain unnecessarily. All prepaids at the time of audit and now are 100% accurate

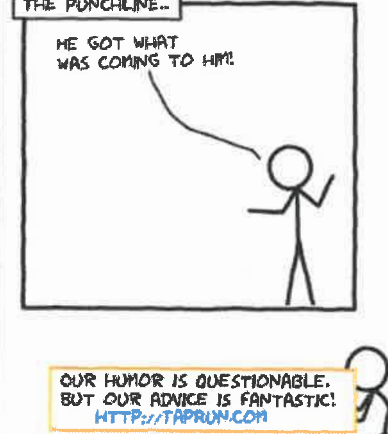
Accounts Receivable

- Policy/Procedure
  - Diana/Linda
- Processor
  - PFS
- Auditor
  - Stephanie
- Review/Approver
  - Stephanie/David

- Clean up of credit balances is a project for 2020. The new PFS Manager has been given the initiative and directive to have this completed by YE







Long Term Debt

- Policy/Procedure
  - Lonnie/Stephanie
- Processor
  - Lonnie
- Auditor
  - Stephanie
- Review/Approver
  - Stephanie/David

- Application for new reserve account submitted to US Bank for reserve holdings related to installment payment fund. Will be classified as operational cash on the Balance Sheet once established

Did you hear about the frog who had $50,000 in debt?

Lease Standard Implementation

- Policy/Procedure
  - Lonnie/Stephanie
- Processor
  - Lonnie
- Auditor
  - Stephanie
- Review/Approver
  - Stephanie/David

- All leases have been identified
- District expects to adhere to the GASB/FASB ruling of requirement (currently being pushed out to a future date)