BOARD OF COMMISSIONERS
PUBLIC HOSPITAL DISTRICT NO. 1 OF PEND OREILLE COUNTY

May 25, 2017

In Attendance: Commissioners: Thomas Garrett; Lois Robertson, Terry Zakar, Raymond King and Lynnette Elswick; Thomas Wilbur, CEO; Directors: Kim Manus, CFO; Walter Price, Chris Wagar; Others: Luke Zarecor, DZA, Auditor/Certified Public Account; Casi Densley, Diane Waldrup, Vicki Richter, Lisa Morse, Trina Gleese, Melody Brown, Casey Scott, Jen Allbee, Jenny Smith, Lori Stratton, and Nancy Shaw.

Excused: Clayton Kersting, Chief of Medical Staff; Joseph Clouse, HR Director.

CALL TO ORDER:

Chairperson Garrett called the meeting to order at approximately 12:30 p.m.

READING OF LEGAL NOTICE:

The regular meeting legal notice was distributed as required.

APPROVAL OF AGENDA / CONSENT AGENDA:

The meeting Agenda, Auditors Report and Uncompensated Report were included.

The following consent agenda items were approved as presented by a motion made, seconded and passed.

Auditors Report: April 2017: Warrants #201493-#201899 and wire transfers #1468-#1484 in the amounts of $1,009,170.85 and $1,664,569.35, respectively, plus an automatic loan payment deduction of $40,000 for a grand total of $2,713,740.20.

Bad Debt/Charity Care: all-inclusive April 2017 District Write-off's for $113,418.54.

APPROVAL OF PREVIOUS MEETING MINUTES

The regular meeting minutes of April 27, 2017 were approved by motion, seconded and passed.

BUSINESS FROM THE AUDIENCE:

Annual Financial Statement Audit. Luke Zarecor of DZA (Dingus, Zarecor & Associates CPA) presented to the Board the District's Financial Statements and DZA's Independent Auditors' Report for the 2015-16 accounting period. He noted that the report would be relatively brief as there were only minor adjustments required to the internal reported year end financials; he complimented Kim and the Finance Team for a job well done.

Highlights: balance sheets were reviewed with only minor differences between years. The biggest difference occurred in patient accounts receivables and the allowance for uncollectible accounts. Luke noted that Medicare billings are paid throughout the year using historical District costs, while most insurance plans pay based upon a percent of charges. If costs increase throughout the year, there will

be a lag in in final Medicare settlement (higher payments when costs rise, lower payments if costs decrease). Kim informed Luke that an interim cost report had been filed with Medicare.

Liabilities, Deferred Inflows and Net Position were unremarkable. Days in AP were 33 in 2015; and 30 in 2016. Gross revenues remained consistent between 2015-2016; the District's $2.0M decrease in Operating Income (3,062,077 to $967,150) was partly attributable to transitioning the ED to MD providers. Kim noted that the District reacquired physician billing effective September 1, 2016 – this limited reserving contractual adjustments for professional fees. Luke noted that compared with other critical access hospitals, the District operates efficiently, especially when considering the spectrum of services the District continues to provide.

Luke stressed the benefits to maintaining a healthy financial outlook will likely be the key to surviving the many changes and challenges facing the healthcare industry. Luke pointed out there are difference between Medicare/Medicaid as third party payors, where they provide payments at amounts different from established rates. These payment streams, along with 340B revenues are forecasted to see pressure in the next decade, or less. The Medicare Trust Fund is not sustainable at the current rate and payments models will likely move toward accountable care organizations (ACO's) that focus on keeping patients healthy.

Kim Manus noted our success has relied upon the commitment of our Board members. Commissioner Elswick thanked and commended Kim and the Finance team for their efforts in maintaining the District's financial viability.

Luke directed the group to the final pages in the Auditor's Report and noted any significant issues discovered during the audit must be identified and reported as public information. Again, he noted there was nothing reportable during the District's 2015-16 financial statement audit.

The following set of comparative graphs/charts were reviewed: Total Margin, Operating Margin (including and excluding 340B Revenues and Expenses), Days Cash on Hand, Current Asset/Liability Ratios, Capital Expenditures, Long Term Debt to Net Position, Days Revenue in AR, Contractual Adjustment Percentages, Bad Debt Percentage of Revenue, FTE, and Salaries and Benefits.

Following several comments and questions, the Board thanked Luke for the informative presentation.

Annual Collection Practices and Charity Care Policy Update. Lisa Morse, Patient Financial Services manager presented the District collection practices and charity care report for 2015-16. She explained that our patient financial counselors exhaust every possible avenue in the collection efforts, including offering financial application assistance for Medicaid clients and working accounts for up to 120 days prior to turning any account to collection. She noted the District contracts with two collection agencies: Chapman Financial Services and Automated Accounts.

Lisa noted that we try to send approximately 50% of our turned accounts to each group. Chapman had a bad debt recovery rate of 30% in 2015 and 18% in 2016. Automated Accounts reported a recovery rate of 30% in 2015 and slightly higher in 2016; it was noted that several factors can attribute to a decrease in recovery rates – i.e. statues, employment status, etc.

Lisa provided a breakdown of total accounts pending legal action for garnishments and judgments; there were 12 cases in 2015 and 8 in 2016. Lisa noted that she is satisfied with the services our collection agencies provide. Lisa shared Legislative information, noting that under Federal requirements we must notify all patients, regardless of insurance status, of our financial assistance programs. Lisa participated in a State-wide work group in 2015 that focused on standardization of financial assistance application forms and our new District policies reflect those changes. The DOH also approved the District Financial Services policy this year.

Lisa explained that we also employ two in-house financial counselor/assisters – Diane Schaaf and Melody Brown; in addition, WA State funds a Health Care Authority assister who helps with re-certification and patient assistance. The District also participates in the Breast and Cervical Health Program. Lisa invited the Board to request any additional information or reports.

The Board thanked Lisa and her team for a job well done.

COMMITTEE REPORTS:

Joint Conference/Planning – Dr. Kersting was not able to attend the meeting; there was nothing significant to report.

Finance – Tom W. reviewed with the group a set of comparative District financial statements [7-year financial history (2010-16)], along with Trimester 1, 2017. The highlights:

Balance sheet: our lowest 'days' operating expenses in 'cash-on-hand' was 61days in 2010. Since then, the District has invested $10.7M (net) to upgrade property, plant, and equipment (including technology); during the same period our cash reserves (operating + Board reserve) has increased by $5.8M (to $9.5M, and with 'days cash on hand' now closer to 110 days). That is $16.5M in net facility investments and increase in cash reserves while adding only $2.1M to long-term debt (net) during the same period. We have been able to significantly improve our facilities and keep pace with technology and have done it without borrowing – a great thing; our balance sheet remains very solid.

Income statements: Tom noted our Income/(Loss) from Operations in the form historically included in Board materials differs from the audited financial presentation. We do this to more accurately reflect our operations in their basic form – the total cost to perform care services vs. the revenues collected for said services (w/o taxes, interest income, grants, 340B revenue, etc.). During the past 23 years NHHS has had income from operations only 5 times. Once M&O taxes, grants, 340B and other revenues are added does the District move into the black; typically to 2-4% annually. That has been our history.

Tom shared the Tri-1, 2017 financials, which show a $744K loss from operations, net income of $264K. While this is not good (nor acceptable), as has always been the case for hospitals reimbursed based upon costs – it is never as good, nor as bad, as it seems at first glance. Case in point, Tom provided the Board with 2012-2017, T-1 income statements. In all five years, the T-1 data was much worse than the annualized YE financial data. Tom noted that this has generally been our case, we struggle in T-1, make bank in T-2 (during summer months when ED visits pick up and the snow birds

return to the area), and then we hold steady in T-3. Until we can get six months under our belt and do an interim cost settlement, we really don't know where we stand. Tom reminded the Board that we make no real attempt at estimating cost settlements until after the first six months.

He provided his quick and dirty "analysis" of the situation: if T-1 trends held (Net Income $264K), $780K annualized and depreciation is added back (+$1.6M), District free cash flow (prior to paying debt service and buying PP&E) would be $2.38M. With that, we would then make existing principal payments ($720K), routine capital purchases ($750K), and new debt service payments ($705K) -- to match principal & interest if our new bonds were issued this year. With everything "paid," our net cash flow would be around $150K to the positive. Not great, but not in the "panic zone" either.

Tom noted our T-1 financial trend is not acceptable; however, we should have some positive notes coming: we are rolling into summer (T-2) and we have two new providers beginning their practices after Labor Day; which should bode well for future clinic volumes. He also noted our 2016 provider additions are not at peak productivity levels but clinic visits are steadily increasing.

FTE's / Productivity: Tom provided an FTE summary by division from 2004-2017, with breakdowns by four periods: 2004-2006, the first three full years in which the District operated all current facilities under one umbrella (w/clinics and RMV); 2007-2009, FTE expansion and post-housing crash (reduced FTE's by 30 in early 2009); 2010-2014, our pre-VBP model run; and finally the 2015-2017, year-by-year when we have been trying to determine how/what a VBP (ACO and CCO model) operates.

Tom pointed out during 2004-2006, it required 43 FTE's to operate two clinics (pre-EHR) w/2,200 visits/month; we are now at 42 FTE's w/three care coordinators and running at 2,300 visits/month. So we have realized cost savings with the EHR implementation; our trough years ran at 35-36 FTE's. Tom explained that positions shifted from support, health information, and medical assistants to accommodate the changes over the years. The combined LTC/RMV residential care support has remained at a relatively steady 58 FTEs. He noted our manager group is meeting June 6-7 to review District strategic goals and value based purchasing transformation models and how we operate.

Tom indicated he has been discussing ALF licensure requirements with DSHS/State. He noted that we remain one of the few District facilities still in the residential care business and asked Luke Z. about what trends DZA is witnessing? Luke noted that most rural CAH's are looking to PPS hospitals to accommodate swing bed patients under ACO models. Rurals are able to provide full spectrum care and, in essence, sell this model to larger PPS hospitals with trained nursing staff that make a difference in quality outcomes and ultimately impact reimbursement.

Tom noted that when we did our analysis back in 2012-13, if we had closed the LTC, 55-70 jobs would have been lost [$2.5-$3M salaries/benefits] having a $6.0-$8.0M local economic impact, and saving the District only $180K cash [net, w/overhead cost savings]. He couldn't understand how it makes financial sense to place LTC residents in swing bed status? The long term costs would be too high under any vetted ACO model ($300/day vs. $1,500/day), there could be no long term benefit to performing those services in the ACU setting. Tom stressed that we will continue to provide residential care services. Luke did indicate that, typically, small communities that close residential care facilities see a downward spiral to the local economy, as clinic volumes, ancillary services, etc. can decrease dramatically.

Kim welcomed and the Board introduced themselves to Casi Densley, our new Controller.

Quality Assurance –Heidi Hedlund, Quality Manager reported that we recently received the Surgical Site Infection Prevention Quality award from the Washington State Hospital Association. The team applied for a Coverys Patient Safety Grant, which resulted in a proactive approach to testing patients for MRSA prior to scheduled surgery. Patients testing positive are treated with prophylactics to reduce and minimize infections. During 2016, our infection rate was 1.1% and to date, is 0.0%. The official award will be presented at the Rural Summer Conference in Chelan at the end of June and representatives from WSHA plan to attend the June meeting of the Board. Heidi is planning to apply for funding next year, as well.

Jennifer Allbee reported that following concerns about patient falls, a team was formed to identify the causes and implement changes in the ACU. Pete Peterson, Jackie Naccarato, John Wuenneke and Yvonne Elliott are leading the charge and we have seen an immediate reduction in falls as a result of their efforts. Jen explained that when a fall occurs, nurses form a "team huddle" involving a check list of pain medications, bathroom use, monitoring for increased confusion, etc. In addition, nurses round hourly. In an effort to increase awareness, signage indicating the number of fall-free days was posted; the staff are rewarded and recognized for milestones. Jenn reported that last year at this time there were 9 falls in Acute Care; this year there have been 4 reported falls. The Board complimented and thanked the Falls Team for their diligent effort and positive results.

An Executive Session will be required following the meeting for approximately 15-20 minutes to discuss personnel matters.

SUPERINTENDENT REPORT

Care Coordination: Tom W. announced that we have approx. 20 patients enrolled in the Molina CCO/ Health Home program. Under this model, client care coordination involves enrollment and scheduled monthly follow-ups around a health action plan. Payment for these services is approx. $2,500/year.

Under our Medicare ACO, 2017 target measures have been set, many of which we already beat in 2016. Tom noted that our cost savings targets are not very large (3% - our ACO group historic vs. national trend) so it remains to be seen if there will be significant payments moving forward.

Finance: we have set an informal long-term goal to have 135 days cash on hand; we have been as high as 125 days and are holding steady at around 110. For perspective, Tom explained that one day of cash operating expenses is approx. $85K (10 days cash on hand = $850K).

ALF Project: Tom distributed final bid summary information. Our goal was to construct a 54-unit assisted living facility, all studio apartments w/private baths. During programming, initial design, and final design the A&E team estimated a "building cost" of $9M (w/an independent cost review at final design in March). However, on May 16 we received five bids, the lowest coming in at $10.3M; $10.5 w/desired alternates. The low three bids were very close (+/-2.3%); all are reputable contractors. At a price $1.5M greater than estimated (w/sales tax, $1.8-$2.0M over budget) we have to put our project on hold to look for cost-savings; specifically, reduced square footage.

The A&E Team met with the low bidder, who indicated the market has seen an increase in sub-contractor bids for which the general contractor has little control. He indicated prices have increased 10-15% over the past year. Tom noted that at the time the project was promoted, we didn't expect prices would increase by 20%+ over a two-year period. Our project timing is not good. Tom is considering options and recommendations for a viable, cost-efficient building that is acceptable.

Tom provided the Board copies of the bond resolution approved by voters in April, 2016. The resolution provides great flexibility; however, our stated goal was to build a 54 unit, assisted living facility (three 18-unit neighborhoods, one of which was for memory care). The $10M bond, not to exceed a 25 year life, was expected to fund a substantial portion of the costs and the District was prepared to pick up the final $1.0M of the $11.0M project. With the bids we have in hand, total all-in costs on the project will be closer to $13.0M.

Tom explained that due to the higher projected cost the Design Team and Finance Committee have reviewed four A&E proposed options: #1 – remove 4 studio rooms from each end of the building and reconfigure the next four rooms to double occupancy [i.e.- 10 single units and 4 double-occupancy (8-units) per neighborhood]. The design team indicated that double occupancy works well for memory care residents - ease of monitoring and care provision. This option would decrease square footage and save approximately $1M. Option #4, would keep 36 units on the main level, 18 on the second floor, and eliminate the fourth roughed-in neighborhood; estimated cost savings: approx. $1.2-$1.8M. Tom noted Option #4 is the simplest alternative but it leaves little room for future expansion.

Commissioner Elswick requested clarification, she indicated Option #2 was also discussed at the Finance Committee meeting; Commissioner King added that Option #2 was desirable as it afforded the greatest future expansion. Tom noted that following discussion with the Design Team, there was a potential benefit (design and function) to having double-occupancy for a portion of the units. He noted ALF construction requires 220 sf. of living space, plus a kitchenette and bathroom. An enhanced adult residential care (EARC) also falls under the ALF code regulations but allows for two residents per room under the same general construction requirements, but a central kitchen is adequate.

Ultimately, Tom noted the State will make any final licensing determinations. He has had discussions with the DSHS Home and Community Services (HCS) and Residential Care Services (RCS) departments. In his conversations he indicated that our desire remains to serve the same population we have taken care of for the past 35 years, from assisted to long term care. Tom proposed continuing full spectrum care for our residents using an ALF license and EARC and ALF services contracts. He noted the State requires contracted ALF's to provide intermittent nursing care – our facility will provide 24/7 nursing care. He said all of his conversations with HCS/RCS staff had been very productive. They do want to help; they have seen a number of rural facilities close over the last several years and they know the need remains in our rural communities.

A meeting is slated with HCS/RCS representatives on June 12th and we will bring our Operations/ Design Team (internal), Architect, and Doug Hammond to determine the requirements for the building and licensing. Tom will report back to the Board next month after learning more information.

Commissioner Garrett stated that Option #4 should be considered as an alternative, even though it does not lend to future expansion, (which may not be the District's vision for the future). Tom W.

responded, noting that our primary business remains the hospital and clinic. Tom explained that his goal will be to clearly outline our mission at the State level that provides flexibility in the rural setting and does not jeopardize our hospital's mission and vision.

For perspective, Tom recapped the project costs and amount spent to date: the project price tag is $13.1M, including bond issue costs which will be netted from bond proceeds. On a positive note, our Moody's rating is Aa (their second highest rating) and Stable, and with interest rates dropping we could have sold our bonds at a $450K premium ($10M in bonds will net us $10.25M in proceeds after applying issue costs). We have already spent $450K on project programming/A&E, so that is cooked into days cash on hand. Our initial target was to spend approx. $800K out of pocket, our now $2.0M shortfall equates to approx. 25 days cash on hand. We will have further updates next month.

OLD/NEW BUSINESS:

Provider Recruitment: Drs.' Aaron and Tessa Reinke will relocate to the area early in September. We also have an orthopedic surgeon beginning practice, pending credentialing. Two general surgeons from Sandpoint are also in process to sign a services contract; in the interim, Locums coverage will be provided (under Dr. Stacy Zabriskie's license).

SEIU Contract: There was only one very minor economic change to the agreement previously discussed and the nurses have voted to approve. The contract is pending ratification by the Board. Commissioner Garrett expressed his disappointment allowing the contract to be retroactive back to Jan. 1st – he would like to see contract negotiations finish on a more expedient timeline.

Legislative Update: There is little information to report at this time; Tom is hopeful that the State budget may be decided by the end of June.

ACTION ITEM AGENDA

1) **Reauthorization of District Collection Policies** – Tom explained that the District policies meet all parameters of the Washington State Hospital Association.

ACTION: A motion made, seconded and passed unanimously reauthorized the District's Collection Policies.

2) **2017-19 RN Contract Approval** – There were no questions following review of the final details of the contract.

ACTION: Via motion, made and seconded the 2017-19 SEIU RN contract was approved unanimously.

3) **Resolution No. 2017-04** – Appoint District Treasurer, Casi Densley.

ACTION: Via motion, Resolution No. 2017-04 was unanimously approved to appoint District Treasurer, Casi Densley; reaffirm Trina Gleese as Deputy Treasurer, reaffirm District Auditor Kim Manus, CFO, and reaffirm District Deputy Auditor Thomas Wilbur, CEO.

4) **2017 Non-Contract Staff Incentive Compensation Plan** – 2017 targets were reviewed and discussed at the April Commissioner meeting. Pre-determined values and ranges for potential incentives will be based up operating results. Tom noted the plan contains seven total measures (two extra for managers).

ACTION: Via motion, made and seconded, the Board unanimously approved the 2017 District Incentive Compensation Plan.

OTHER BUSINESS:
Chris Wagar announced that Phoenix Protective Services will begin providing security guard services effective June 1, 2017 from 8 pm until 8 am daily.

Per the recommendation of the Medical Staff Executive Committee, the Commissioners approved:

Re-appointments – TeleNeurology:

John Zurasky, MD	Benjamin Atkinson, MD	Minal Bhanushali, MD
Jennifer Pary, MD	Archit Bhatt, MD	Amit Kansara, MD
Theodore Lowenkopf, MD		

Initial Appointment – Provisional Status, Orthopedic Clinic/Surgery:
Michael Schicker, DO (Pending Insurance Acceptance)

Resignation:
Connie Emerson, MD – Off-site Radiology (resigned January 2017)

EXECUTIVE SESSION
The meeting moved to Executive session at approximately 2:43 pm. to discuss personnel matters.

RETURN TO OPEN SESSION
The Board returned to open session at 3:05 pm. and there was no action taken.

NEXT MEETING DATE-
The next regular meeting of the Commission will occur on June 22, 2017.

ADJOURNMENT
There being no further business, the meeting adjourned at 3:05 pm.

Minutes recorded by Nancy Shaw, Executive Administrative Assistant and Tom Wilbur, CEO.

Thomas Garrett, President
Board of Commissioners

Terry Zakar, Secretary
Board of Commissioners