SUPPLEMENTAL

BOARD OF COMMISSIONERS' REGULAR MEETING
May 26, 2016 – 5:00 p.m.
KVH Conference Rooms A/B
AGENDA

1. **Call Regular Meeting to Order**

2. ****Approval of Agenda:** **(1-2)**
   - (Items to be pulled from the Consent Agenda)

3. ****Consent Agenda:**
   a. Minutes of Board Meetings: April 28, 2016 (Special Meeting); April 28, 2016; May 9, 2016 (Special Meeting) **(3-8)**
   b. Approval of Checks **(9)**
   c. Report: Foundation **(10)**
   d. Report: Clinic Operations **(11)**
   e. Minutes: Finance Committee **(12)**

4. **Quality:**
   a. Rhonda Holden, Chief Nursing Officer, Cathy Bambrick, Chief Operating Officer, Dr. Don Solberg, Chief Medical Officer, Mandee Olsen, Director of Quality Assurance:
      - Mandee Olsen: Patient Story
      - QI Council Committee – **QI Council Minutes added** **(13-14)**
      - QI Council Dashboard **(15-16)**
      - WSHA Partnership for Patients **(17-47)**
      - Rhonda Holden : Hospice Survey
      - Rhonda Holden: Virtual Care Update

5. **Public Comment/Announcements (5:30 p.m.)**

6. **Dingus, Zarecor & Associates:** Audit Presentation **(See Exhibit "A" Attached)**

7. **Chief Executive Officer's Report:**
   a. Paul Nurick, CEO: CEO Report **(48)**
   - Cathy Bambrick, COO: HR Dashboard **(49-50)**

8. **Chief of Staff Report:**
   a. Dr. Timothy O'Brien, Chief of Staff
   - **Medical Staff Exec. Committee Report **(51)**
   - Reappointment Policy and Procedure and Pre-application Policy **(52-54)**

9. **Financials:**
   a. Libby Allgood, CFO: Treasurer's Report **(55)**
   b. Finance Committee

10. **Education:**
    a. Report on Attendance at the WSHA CEO & Trustee Patient Safety Summit – Pam Wilson, Erica Libenow, Matt Altman, Bob Davis, Paul Nurick
    b. Report on Attendance at the Washington State Medical Association Leadership Development Conference – Matt Altman

11. **Public Policy:**

12. **Old Business:**
    a. Board Meeting Evaluation Summary **(56-68)**

13. **New Business:**

14. **Articles and Communications:** **(69-84)**

15. **Completion of Board Meeting Evaluation Summary**

16. **Recess to Executive Session:** Personnel; Real Estate; Quality Improvement RCW 42.30.110(g)(b); RCW 70.44.062(2)

17. **Convene to Open Session**

18. **Adjournment**

EMERGING HEALTHCARE ISSUES – POTENTIAL TOPICS

Population Health
Patient Centered Med. Home/Behavioral Health
Information Technology
ED Patient Issues/Protocol
Development of a Continuing Care Network

Kittitas Valley Healthcare
Board of Commissioners
Special Board Meeting
April 28, 2016
Café Conference Room

BOARD MEMBERS PRESENT: Matt Altman, Liahna Armstrong, Bob Davis

KVH STAFF PRESENT: Paul Nurick, Carrie Barr

GUEST: Dr. Joann Falkenburg

At 11:00 a.m., President Liahna Armstrong called the Special Board meeting to order. She announced that the purpose of the meeting was to hear a presentation by Dr. Joann Falkenburg.

Dr. Falkenburg presented a talk on "Preparing Leadership for Care Model Change Management."

With no further business and no action being taken, the meeting was adjourned at 12:00 p.m.

Respectfully submitted,

Franki Storlie/Bob Davis
Exec. Coordinator/Secretary, Board of Commissioners

Kittitas Valley Healthcare
Board of Commissioners
April 28, 2016
KVH Conference Rooms A/B

BOARD MEMBERS PRESENT: Matt Altman, Liahna Armstrong, Bob Davis, Erica Libenow, Pam Wilson

KVH STAFF PRESENT: Paul Nurick, Libby Allgood, Cathy Bambrick, Randi Christensen, Rhonda Holden

MEDICAL STAFF PRESENT: Dr. Timothy O'Brien

1. At 5:00 p.m., President Liahna Armstrong called the regular Board meeting to order.
2. **Approval of Agenda:**

   ACTION: On motion of Bob Davis and second of Erica Libenow, the Board members unanimously approved the agenda as revised.
3. **Consent Agenda**:

   ACTION: On motion of Pam Wilson and second of Erica Libenow, the Board members unanimously approved the Consent Agenda.
4. **Patient Story**:

   Arla Dunlop shared her patient story using the new KVH virtual care. She reported that she had an eye infection on a weekend. She used the KVH virtual care and was connected to a physician who prescribed medicine for her eye infection. She said the experience was well worth her efforts and the results were successful.

   The Board members reviewed the QI Council summary and dashboards.
5. **Public Comment/Announcements**:

   Ron and Kathy Mace of 707 Whitman Street stated that they were representing the neighborhood. They said that neighbors were concerned about the construction of the proposed clinic causing the vacating of Spokane Street, lowering the value of their homes, and the effect it will have on eliminating or reducing neighborhood parking.

   Nancy Wieking stated that the letter font size was too small for senior citizens to read in order for them to complete a recent community survey that was sent out by the hospital to the public regarding the KVH future campus.

   Roger Weaver said he was there to speak on behalf of the Parkland Condominium residents regarding the construction of the proposed clinic. He stated that the hospital should expect some hurdles in their permit and building process in relation to the SEPA permit process related to critical areas and restrictive covenants on the proposed building site real estate. He said the neighborhood residents were concerned about the value of neighboring real estate decreasing due to the construction. He asked that the hospital be a good neighbor by not declaring eminent domain in order to build the proposed new clinic. He also stated that there has been a noise problem due to construction and trucks

on the hospital campus early in the morning prior to 7:00 a.m. President Armstrong asked that Mr. Weaver contact the hospital CEO to discuss the noise concerns.

Master Facility Planning:

Cathy Bambrick, Amy Diaz and Mandee Olsen shared the timeline and plans for the proposed construction of a new KVH clinic. Cathy reported that a date has not yet been set for the SEPA permit process. A community survey has been sent out in order to get input from citizens regarding a future KVH campus. Amy reported that there will also be focus groups, and other surveys conducted with KVH employees and the public. Mandee shared the timeline for the permitting and construction process.

6. **Emerging Healthcare Topic:**

Libby Allgood gave a PowerPoint presentation regarding Value Based Purchasing. She stated that the Centers for Medicare and Medicaid Services link Medicare's payment system to a value-based system to improve healthcare quality for the care provided in the inpatient hospital setting. She reported that participating hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide. KVH participated in a value based payment readiness assessment sponsored by the Washington State Hospital Association. She stated that KVH is not ready for any of the five models proposed, but could be ready for likely models to emerge in the near future.

7. **Chief Executive Officer's Report**:

Paul Nurick reported that the Team Health contract for the Emergency Department physicians expires July 1, 2016, and that the hospital is acting quickly to employ some of the physicians who have been working under this contract. He announced that recruitment is taking place for several areas including pediatrics. Paul announced that KVH was again designated as a Top 100 CAH Hospital nationwide by the National Rural Health Association iVantage organization. Paul and Matt Altman reported that the recent community healthcare roundtable held at the Hearthstone Cottage was well received. The next roundtable will be at KVH on May 17th.

The Board members reviewed the Human Resources Dashboard. Erica Libenow inquired about exit interviews for employees and asked if both written and/or in-person exit interviews could be conducted in the future. Cathy Bambrick responded this could be done and stated that only around 30% of employees will actually participate in an exit interview.

Cathy Bambrick reported that a Joint Districts Committee meeting was held between Public Hospital Districts No. 1 and 2 on April 12 with two commissioners from each district attending as well as Paul Nurick and Cathy Bambrick. Erica Libenow and Bob Davis reported it was a good meeting with important information being exchanged between the two districts especially in the area of emergency medical services. Randi Christensen will be taking Erica Libenow and Liahna Armstrong on a tour of the KVH Family Practice Clinic in Cle Elum.

8. **Chief of Staff Report:**

ACTION: On motion of Bob Davis and second of Matt Altman, the Board members unanimously approved the initial appointments for Drs. Keven Walsh, Tobun Cheung, Grace Herci, Ihab Ibrahim, Sheldon Jensen, and Lucas McCarthy, and reappointments for Drs. David Frick, John Boardman,

Margaret Kang, Anthony Longo, Mark Uhlman, and Paul Schmitt as recommended by the Medical Executive Committee.

After discussion regarding requiring physicians to be Board certified, it was agreed that Dr. O'Brien will review practices at other hospitals and will revise the policy regarding board certification. He will bring back the revisions and suggestions to the Board at a future date.

9. **Financials:**

Libby Allgood presented a short financial summary for the month of March noting that the month's operations resulted in an operating gain of $207,488 which produced an operating margin of 3.5%. overall for the hospital. She reported that total clinic visits in March were 290 below budget.

ACTION: On motion of Pam Wilson and second of Bob Davis, the Board members unanimously approved Resolution No. 16-07 regarding surplus property.

10. **Education:**

ACTION: On motion of Pam Wilson and second of Matt Altman, the Board members unanimously approved the attendance of any interested Board members at the WSHA Summer Rural Conference in Chelan on June 26-29.

The Rural Advocacy Days in Washington, D.C. in mid-September were discussed with the possibility that one or two Board members may be interested in attending.

11. **Public Policy:**

None.

12. **Old Business:**

a. Board Operations:

The Board members agreed that they would continue with the starting time of the Board meetings being scheduled for 5:00 p.m. with the public comment portion of the meeting taking place at 5:30 p.m.

After some discussion regarding Board members being accessible to the community stakeholders, it was agreed that the Board members will schedule coffee hours at Jerrol's Bookstore in order for community members and KVH employees to visit with the Board members. The coffee hours will be advertised and will be scheduled three times per month with one of the days being on a Saturday.

The Board members agreed to have President Armstrong review the proposal and cost of services for professional consultant, Kimberly McNalley, to assist the Board members with Board operations.

Paul Nurick reported that Frank Jones plans to start videotaping the Board meetings in May.

Board members asked that their KVH email addresses be listed on the KVH website.

b. Board Meeting Evaluation Summary:

The Board members reviewed the Board meeting evaluation summary. Liahna Armstrong stated that she plans to review and revise the summary form.

13. **New Business:**

None.

14. **Clippings, Articles, Correspondence and Board Meeting Evaluation Form:**

The Board members reviewed the various clippings and correspondence items. The Board members completed the Board Meeting Evaluation Summary.

President Armstrong recessed the meeting at 7:55 p.m. for ten minutes. She announced that the meeting would be recessed into executive session for one hour to discuss personnel, quality improvement and real estate. RCW 42.30.110(g)(b); RCW 70.44.062(2)

At 8:55 p.m., the executive session was extended for an additional hour.

At 9:55 p.m., the meeting was reconvened into open session. With no further action and business, the meeting was adjourned at 9:55 p.m.

CONCLUSIONS:

1. Motion passed to approve the Board agenda as revised.
2. Motion passed to approve the Consent Agenda.
3. Motion passed to approve the initial appointments and reappointments for medical staff as cited above and recommended by the Medical Executive Committee.
4. Motion passed to approve Resolution No. 16-07 regarding surplus property.
5. Motion passed to approve the attendance of any interested Board members at the WSHA Summer Rural Conference in Chelan on June 26-29.

Respectfully submitted,

Franki Storlie/Bob Davis
Executive Coordinator/Secretary, Board of Commissioners

Kittitas Valley Healthcare
Board of Commissioners
Special Board Meeting
May 9, 2016

BOARD MEMBERS PRESENT: Matt Altman, Liahna Armstrong, Bob Davis, Erica Libenow, Pam Wilson

KVH STAFF PRESENT: Paul Nurick, Cathy Bambrick

President Liahna Armstrong called the meeting to order at 4:32 p.m. She stated that the purpose of the meeting was to conduct an executive session regarding personnel and real estate. (RCW 42.30.110(g)(b). She also asked that an item be added to the agenda regarding Board attendance at an upcoming conference.

ACTION: On motion of Bob Davis and second of Pam Wilson, the Board members unanimously approved the attendance of Matt Altman at the Washington State Medical Association conference on May 20 and 21, 2016, in Chelan Washington.

At 4:45 p.m., the meeting was convened into executive session for 15 minutes to discuss real estate.

At 5:00 p.m., the meeting was reconvened into open session.

ACTION: On motion of Erica Libenow and second of Pam Wilson, the Board members unanimously approved Resolution No. 16-08 for acquisition of real estate for district purposes.

At 5:10 p.m., the Board convened into executive session for three hours to discuss personnel.

At 8:10 p.m., the meeting was reconvened into open session. With no further business, the meeting was adjourned at 8:10 p.m.

Respectfully submitted,

Franki Storlie/Bob Davis
Exec. Coordinator/Secretary, Board of Commissioners

Kittitas Valley Healthcare
Your Home for Health

DATE OF BOARD MEETING: May 26, 2016

ACCOUNTS PAYABLE CHECKS/EFTS TO BE APPROVED:

#1	CHECK NUMBERS	219751-220649	NET AMOUNT:	$3,669,909.21

PAYROLL CHECKS/EFTS TO BE APPROVED:

#1	CHECK NUMBERS	76134-76159	NET AMOUNT:	$33,182.29
#2	CHECK NUMBERS	76160-76189	NET AMOUNT:	$38,334.31
#3	PAYROLL DIRECT DEPOSIT	EFT	NET AMOUNT:	$860,406.64
#4	PAYROLL DIRECT DEPOSIT	EFT	NET AMOUNT:	$924,857.55
#5	PAYROLL TAXES	EFT	NET AMOUNT:	$359,023.26
#6	PAYROLL TAXES	EFT	NET AMOUNT:	$412,180.27
		SUB-TOTAL:	$2,627,984.32	

TOTAL CHECKS & EFTs: $6,297,893.53

Prepared by

Sharoll Cummins

Sharoll Cummins
Staff Accountant

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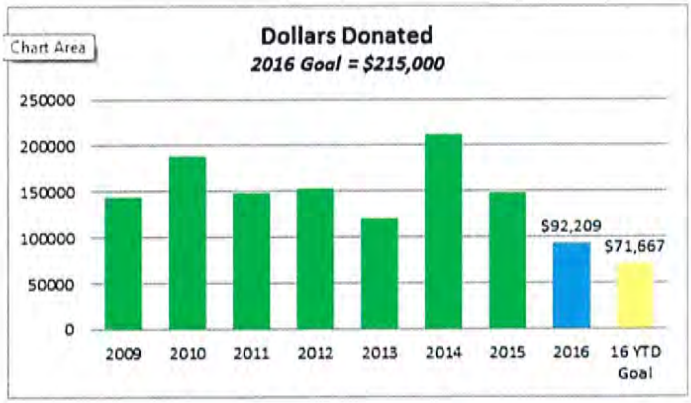
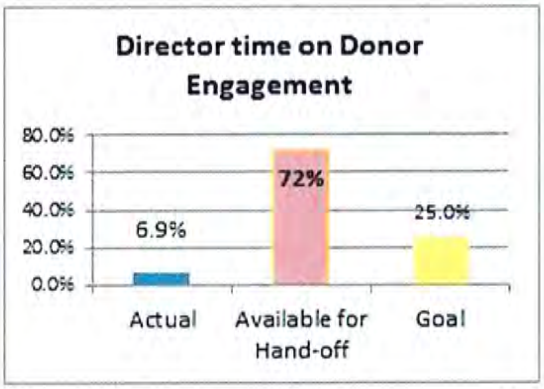
THE FOUNDATION KVH

Board of Commissioners Report, May 26, 2016

2016 Goals/Metrics

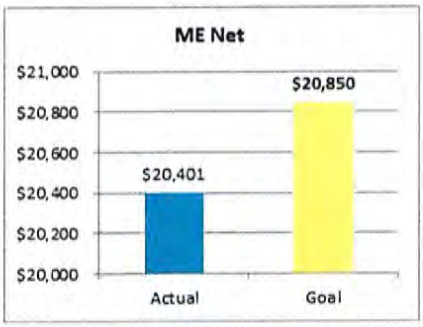
1. *Develop and implement an effective communication strategy that involves leadership and Board members and incorporates outreach to donors, prospective donors and the community.*
2. *Enhance and sustain relationships with new and existing door by tailoring outreach to meet their individual preferences.*

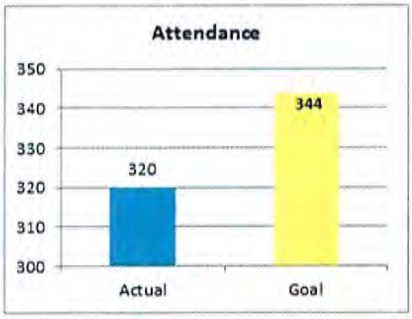




Magical Evening – April 16, 2016

Thank you to everyone for your participation in the 13th Magical Evening Gala. Event metrics are below.





Respectfully submitted,

Michele Wurl

Director, The Foundation at KVH

Chief of Clinic Operations Report to the Board of Commissioners
May 26, 2016

April Operations:

The clinics were below their budgeted visits for the month of April by 9% which puts us year to date 7.94% below budget. We had 1 provider out in Internal Medicine, 1 provider out in Family Medicine Ellensburg, 1 provider out in Ortho, and 1 provider out in Women's Health for a total of 3 providers out for at least a week in all clinics combined.

New patient appointments for April were below budget by 1 visit, for a total of 327 new patients for the month. Orthopedics saw the most growth with 87 new patients. General Surgery saw the least growth at 32 patients.

Clinic Revenue for the month of April is below budget by 1.13%, year-to-date is below budget by 5.44%. Average charge per visit is $259.41; Family Medicine Ellensburg having the lowest cost per visit at $192.61 and Cardiopulmonary being the highest at $984.13.

GENERAL UPDATES:

- ICD-10 - Providers are still doing well with the change. April saw no errors due to ICD-10.
- We completed the recommended Care Model Redesign project and embarked on our first master site planning RPIW surrounding this new model.

RECRUITING UPDATES:

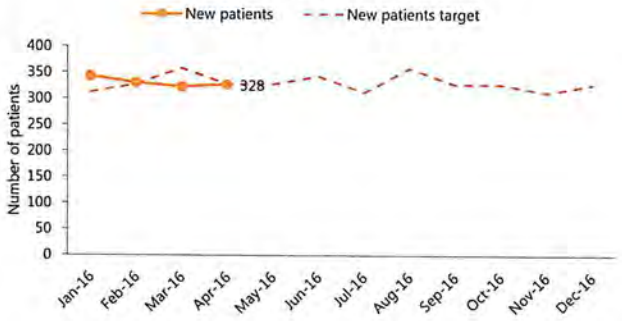
- We have an accepted job offer with a Certified Nurse Midwife who is expected to start with our Women's Health Clinic in mid-June. She will be going up to Cle Elum at least one half day a month to start.
- We are in the negotiation process with a part time ARNP for Family Medicine Ellensburg.

Respectfully submitted,

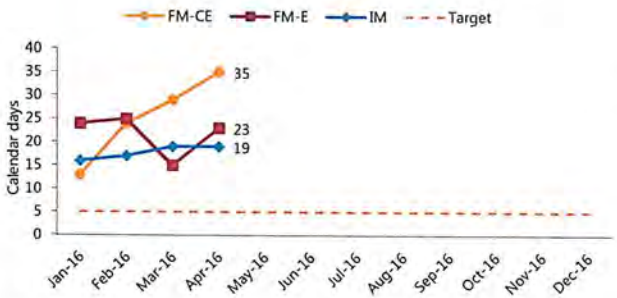
Randi Christensen RN

Clinic Operations Dashboard

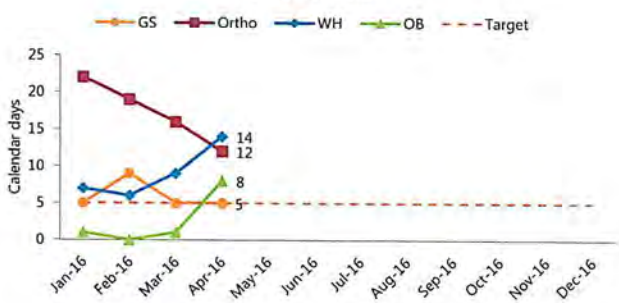
New patients



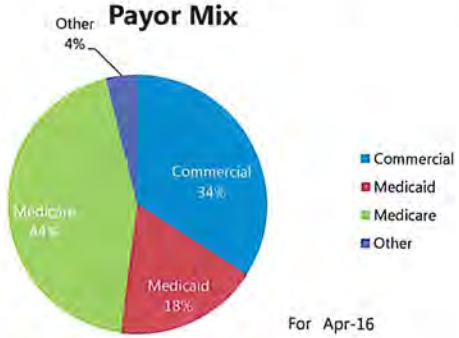
Third available appointment
for new patients



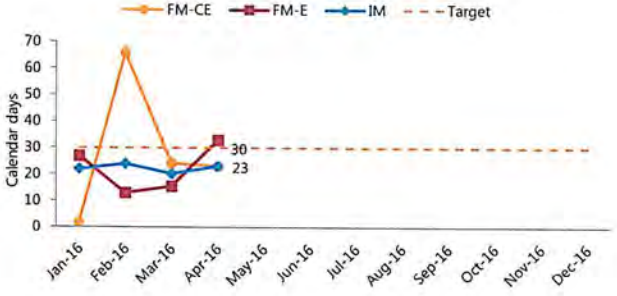
Third available appointment
for new patients



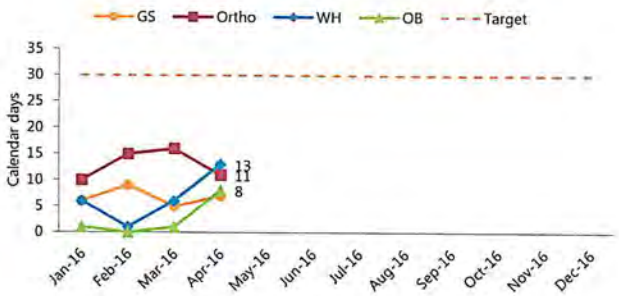
Payor Mix



Third available appointment
for established patients



Third available appointment
for established patients



11a

Kittitas Valley Healthcare
Finance Committee Meeting Minutes
April 26, 2016

Present: Pam Wilson, Bob Davis, Bob Crowe, JoAnn Wise, Paul Nurick, Libby Allgood, Randi Christensen.

The meeting was called to order by Pam Wilson at 7:32 am.

The agenda was approved as presented.

The minutes of the March 29, 2016 meeting were approved as presented.

March 2016 Financial Summary

Key Metrics:

1. Operating Margin: March 3.5%, YTD 2.6%
2. Days Cash on Hand: 177.2
3. AR Days (Hospital Only): 46.5

Operating Highlights:

1. PHD 1 District March operations resulted in an operating gain of $207,488, a $43,180 negative budget variance. This produced an operating margin of 3.5% which is under the budgeted margin of 4.0%.

2. Charity and Uncompensated Care was $89,248 over budget in March making the year to date $63,806 over budget.

3. March Admissions were 23.3% below budget resulting in a 20.9% negative variance in inpatient days. Year to date admissions are 92, or 25.8% below budget and 21.6% below March of last year. The negative variance in Admissions and Patient Days was the result of lower than budgeted volume for inpatient surgery cases. Outpatient surgery procedures exceeded budget by 24.3%.

4. Overall operating expenses for March were below budget by $270,576. Supplies continue to be under budget due to low patient volumes. Purchased Services are over budget by $87,293, of that variance, $60,520 is due to temporary labor.

5. Total clinic visits in March were 290 below budget. Year to date the visits are 207 below March year to date of the previous year. Clinic operations for the month resulted in an operating loss of $125,579, a negative budget variance of $393.

Surplus Resolution:

Surplus resolution16-07 was presented for review and discussion. The request was approved for recommendation to the Board of Commissioners for approval.

The meeting was adjourned at 8:37 am.

March 2016 Data Summary

Senior Leaders in RPIW

- Indicators with significant improvement
- Long Bone Pain Management 53 minutes to 23 minutes
- Chest Pain Median EKG timing 8 minutes to 4 minutes
- Sepsis Bundle 71 % to 75 %
- Stroke Dysphagia 100 %
- Stroke tPA IV Thrombolytic 100 %--again supporting GWTG Silver Award for 2015 Data
- No HAI / Falls
- Restraints 100 %

Summary of Improvement Opportunities:

- Areas not meeting goals-- A1c / One needle stick
- First Quarter End Report of Immunization of A3 of January 13, 2016
  3 failures of 40 cases Sampled = 93%
- **Sepsis Bundle Sepsis Task Force**
  Quality Improvement Education at the UW on April 1, 2016
  Improvement Work Scheduled for May 9

Review of Action Decision Log for MU

1. Possible Improvement for E Prescribing and Patient Portal

Patient Story/Case Study:

No patient story submitted

CE 5/5/16

Flu Vaccination Summary

Actual data reported to CDC for employees who worked in the hospital facility for one or more days between October 1, 2015 and March 31, 2016:

	Number of employees	Percent
Number who worked at the healthcare facility for at least 1 day between October 1, 2015 and March 31, 2016	604	100%
Number who receive an influenza vaccination at this facility	450	74.5%
Number who provided a written report or documentation of influenza vaccination elsewhere	89	14.7%
Total vaccinated at KVH or elsewhere	***539***	***89.2%***
Number who have a medical contraindication to the influenza vaccine	5	0.8%
Number who declined to receive the influenza vaccine	41	6.8%
Number with unknown influenza vaccination status	20	3.3%

2014-2015 flu season data reported for employees who worked in the facility for one or more days between October 1, 2014 and March 31, 2015:

	Number of employees	Percent
Number who worked at the healthcare facility for at least 1 day between October 1, 2014 and March 31, 2015	610	100%
Number who receive an influenza vaccination at this facility	450	73.8%
Number who provided a written report or documentation of influenza vaccination elsewhere	84	13.8%
Total vaccinated at KVH or elsewhere	***534***	***87.5%***
Number who have a medical contraindication to the influenza vaccine	8	1.3%
Number who declined to receive the influenza vaccine	44	7.2%
Number with unknown influenza vaccination status	24	3.9%

Quality Improvement Council	MEETING MINUTES	May 6, 2016
Present: Paul Nurick, Libby Allgood, Mandee Olsen, Matt Altman, Dr. Don Solberg, Liahna Armstrong, Dr. Tim O'Brien, **Guests:** Julie Hiersche, Lindsey Haney, Dr. John Asriel, Dr. Annaliese Stone, Jeanette DeFoe **Absent:** Rhonda Holden, Cathy Bambrick, Randi Christensen, Vicky Machorro, **Recording Secretary:** Michael Christiansen **Minutes Reviewed by:** Mandee Olsen		
ITEM	DISCUSSION	ACTION ITEM/ RESPONSIBLE PARTY
• Called to order	The meeting was called to order by Liahna Armstrong at 4:10 pm	
• Agenda & Minutes	Agenda was approved with an amendment to move Karen Schock's Honoring Choices Pacific Northwest report out to after the approval of minutes. The minutes were approved as presented.	
OLD BUSINESS		
• Dashboard Review	**Handouts**: March 2016 Dashboard Review **Discussion**: Mandee reviewed the data on the November 2015 dashboard. Measures that continue to meet goal were: all inpatient core measures were met which includes appropriate recommended care for stroke, surgical care and venous thromboembolism. There have been 3 HAI's in the past three months. Readmissions have dropped, and there were no falls in March. Hand Hygiene data has stayed consistently high reporting levels. There was one needlestick in March, it was a non-employee provider but it still counted. **Conclusion**: Continue to monitor.	
• Safety Summary Report	**Discussion:** Mandee Olsen reviewed the WSHA Patient Safety Comparison Report, comparing 2015 Q4 quality measures from numerous hospitals throughout Washington	

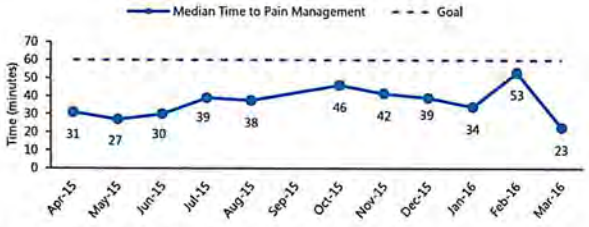
	State. KVH met the top quality goals of many of these metrics including: CAUTI, CLABSI, CDI, MRSA, Colon SSI, VAE, adverse drug event for anticoagulants, hypoglycemic agents and opioids, Pressure Ulcers, and Post-Op PE or DVT. Areas of improvement for KVH: Severe Sepsis Mortality which KVH had one in 2015 Q4, Hip & Knee SSI, Inpatient Falls (though we didn't meet this goal, our fall didn't necessarily cause a serious injury), Early Elective Delivery, Episiotomy for Spontaneous Vaginal Delivery, and NTSV C-section Rate for Nulliparous. **Conclusion:** This data will go to the next Board meeting for further review.	
NEW BUSINESS		
• Infection Control Committee Report	**Handouts:** KVH Surveillance Data 2016 **Discussion:** Julie Hiersche reviewed with the council several topics being investigated by Infection Control. First, the sanitation issues with reusable blood pressure cuffs, there is a wide range of microorganisms that can survive on the cuffs ranging from 1.5 hours to 5 months. Hand hygiene huddle with patients and families was reviewed, which will also be a topic at the Ed Fair along with the importance of washing hands after removing gloves, proper method for using gel, and PAPRs. The Surveillance 2016 data was then reviewed which tracks various infections within the hospital. There were 2 Blood Borne pathogen issues, one due to the IV needle not retracting properly, the other was an accident involving an allergy shot that somehow pierced through the patient's entire arm. There were also 3 Hospital acquired infections, an SSI-ORIF ankle, SSI-inguinal hernia, and a Total Hip Arthroplasty. There are 4 new ongoing SSI prevention	

	strategies: implementing a new kind of patient warming blankets, total joint patients are now receiving at least 2 grams of Ancef pre-operatively, new bouffant hats are now in use, and doctor's hats are no longer stocked in the OR. The past Flu season was then reviewed. Compared to previous years, this flu season began late. In 2014 there was a spike of cases in December, but this month it didn't occur until March. Further, there was never enough cases for Dr. Larson to enact the Flu-Control plan New TB tests were discussed for expediting the new employee onboarding process. Instead of using the Skin Test, the Quantiferon Gold blood test was looked at. Though the test is significantly more expensive than the skin test, it only requires one visit and can save time for the new employees and save man hours for current employees. Antibiotic stewardship has started gathering information on antibiotic usage, a full report will be completed in July. **Conclusion:** Flu plan will be reviewed at board to address issues of staff declining flu vaccines.	
• CHCW Residency Program Proposed Quality Improvement Project – Inpatient Sleep Deprivation	**Discussion:** Dr. Asriel introduced his resident Dr. Stone, who pitched their new quality measuring project proposal on inpatient sleep deprivation. Sleep and rest is crucial to the recovery process, and there are numerous possible events which can interrupt a patient's sleep, from noise, taking vitals, or simply discomfort from their diagnosis. The program would use CHCW's ideas with KVH's resources on studying and implementing an improvement plan that would focus on patient comfort and recovery. **Conclusion:** The plan was endorsed by consensus	

• Meaningful use	**Discussion:** Jeanette Defoe announced that we had successfully attested to 2015 Meaningful Use. She also discussed some changes to meaningful use measuring. In October of 2015 the threshold of patient portal was reduced to 1 patient discharge for the patient portal, and in 2017 the threshold will increase to 5% of all patients pts discharged from inpatient or observation will need to be reported. Similarly, in e-perscribing we didn't have attest who was prescribing in 2015 and 2016, but we will have to do this for 2017.	
• PQRS – Physician Quality Reporting System	**Discussion:** Lindsey Haney gave an explanation and history of PQRS. Established in 2006, PQRS required all physicians in Medicare FFS to submit quality data to CMS as an incentive program, but just this year it also implemented penalties into the program. A -2 % payment adjustment being implemented in 2016 will remain in effect until 2019. KVH received notice late in 2014 regarding our not reporting PQRS measures. This resulted in approximately a $10,000 decrease in our payments for 2015 based on 2013 data, which brought on Lindsey and a team built from individuals from different departments to complete PQRS reporting and explore solutions to avoid 2016 penalties. Our last data pull brought up questions of our performance and the accuracy of our reporting. Part of this is due to the fact that collecting data from our current EHRs can be difficult, and this has been taken into consideration for selection of our new EHR system. **Conclusion:** Continue collecting data and reporting PQRS measures	
CLOSING		
• Adjourned at 5:14 pm	Next meeting is August 4th 2016 @1600	

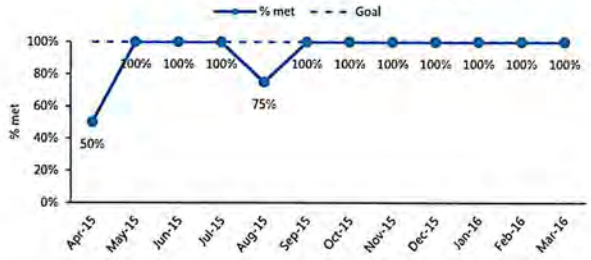
QI Council

Median Time to Pain Management (Long Bone Fracture) ↓



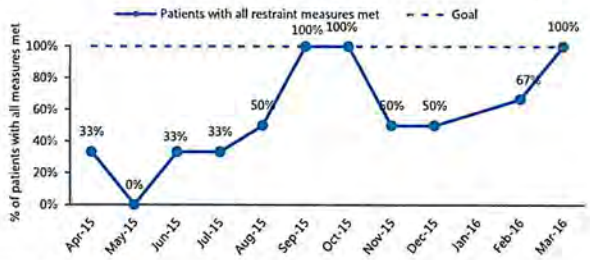
# of pts	9	9	7	2	10	0	7	6	5	11	5	8

Stroke Dysphagia Screening ↑



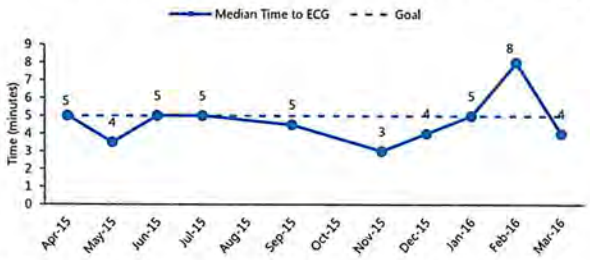
# of pts	2	2	2	4	4	4	2	3	3	2	3	1

Restraints ↑



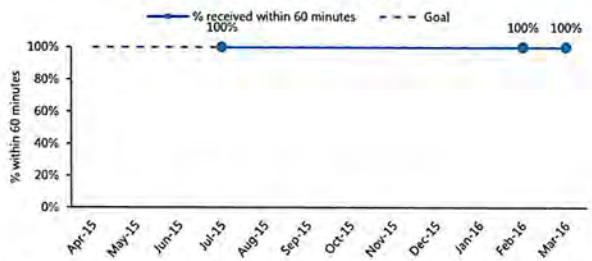
# possible	6	1	3	3	2	3	1	2	2	0	3	2

Median Time to ECG (Chest Pain) ↓



# of pts	5	4	3	3	0	6	0	2	5	6	3	5

Stroke IV Thrombolytics ↑



# of pts	0	0	0	1	0	0	0	0	0	0	1	1

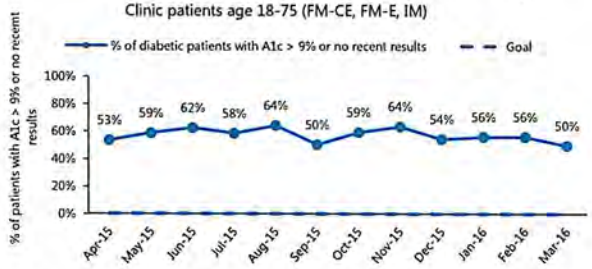
Falls ↓

Sepsis Bundle ↑

# possible								3	5	7	4	

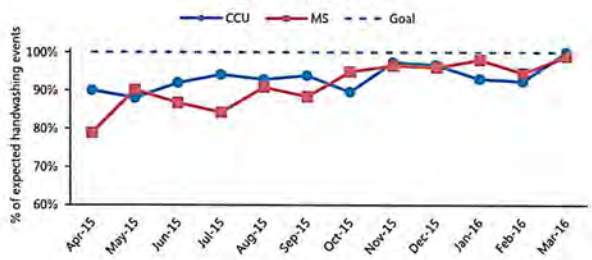
A1c in Diabetic Patients ↓

Clinic patients age 18-75 (FM-CE, FM-E, IM)

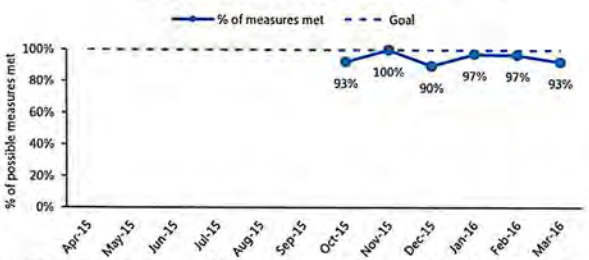


# possible	150	157	130	137	143	140	140	125	114	155	151

Hand Hygiene ↑

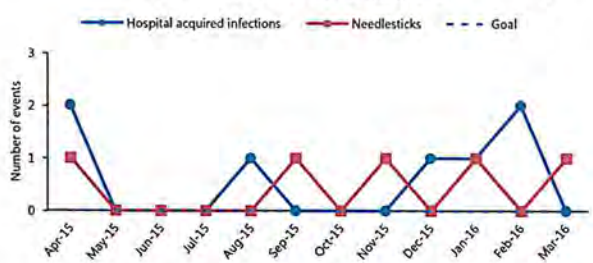


Immunizations Bundle ↑

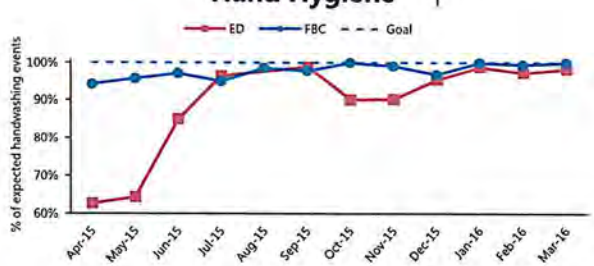


# possible	0	0	0	0	0	0	40	38	39	39	32	40

HAIs and Needlesticks ↓

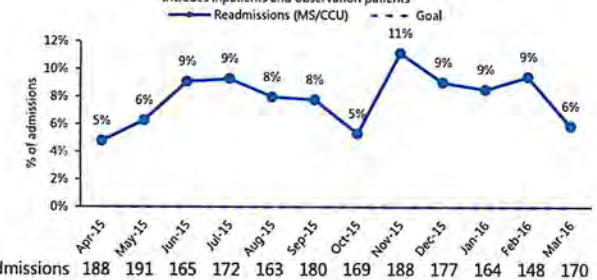


Hand Hygiene ↑



Readmissions Within 30 Days ↓

Includes inpatients and observation patients

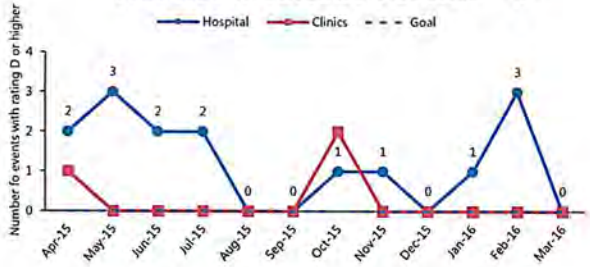


	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
admissions	188	191	165	172	163	180	169	188	177	164	148	170

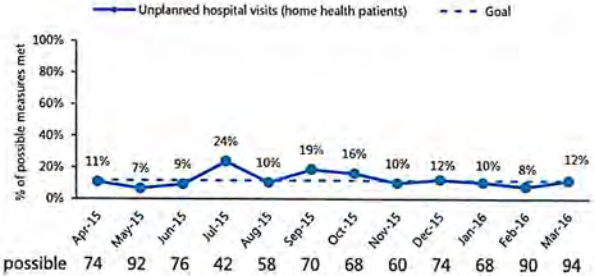
Elective Deliveries ↓

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
12 mo. rolling average	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	1.4%	1.5%	1.6%

Adverse Medication Events ↓

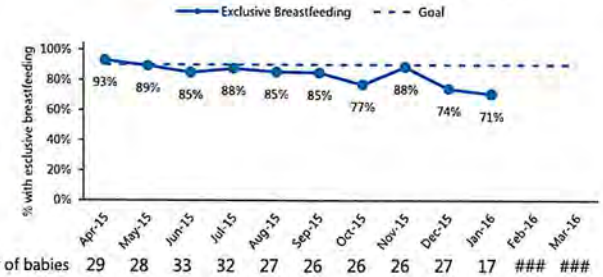


Unplanned Hospital Care Bundle ↓



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
# possible	74	92	76	42	58	70	68	60	74	68	90	94

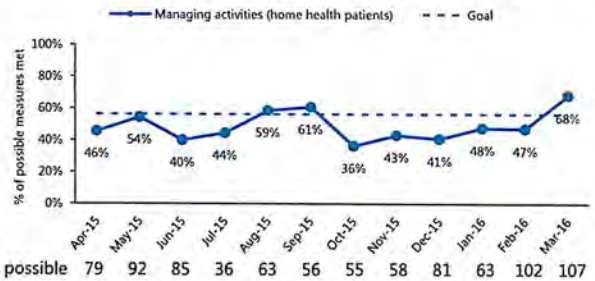
Exclusive Breastfeeding ↑



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
# of babies	29	28	33	32	27	26	26	26	27	17	###	###

Care and Service Reports ↓

Managing Daily Activities Bundle ↑

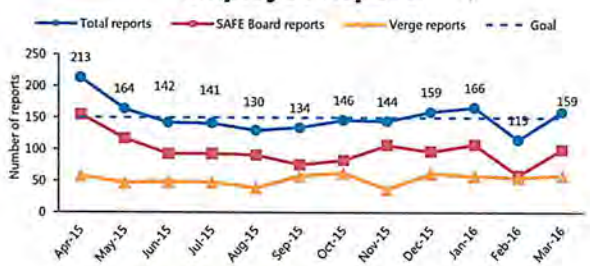


	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
# possible	79	92	85	36	63	56	55	58	81	63	102	107

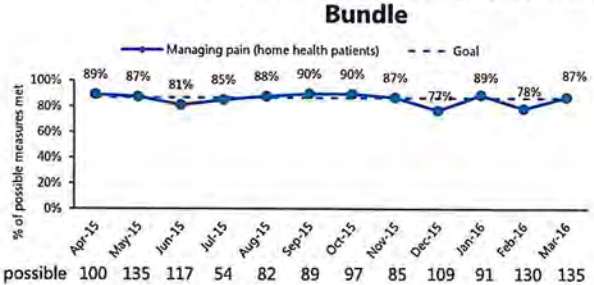
Treating Wounds and Preventing Pressure Bundle ↑

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
# possible	62	84	64	36	50	55	62	52	72	64	83	77

Employee Reports ↑

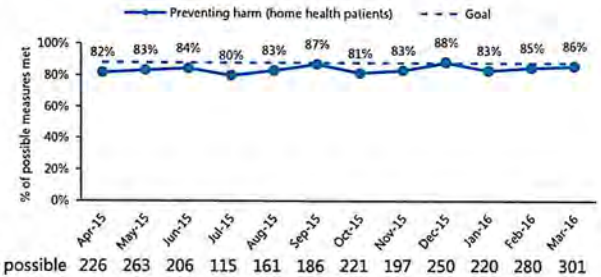


Managing Pain and Treating Symptoms Bundle ↑



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
# possible	100	135	117	54	82	89	97	85	109	91	130	135

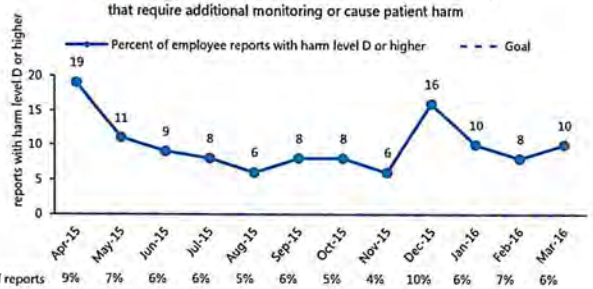
Preventing Harm Bundle ↑



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
# possible	226	263	206	115	161	186	221	197	250	220	280	301

Reports of occurences ↓

that require additional monitoring or cause patient harm



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
% of reports	9%	7%	6%	6%	5%	6%	5%	4%	10%	6%	7%	6%

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Patient Safety Comparison Report

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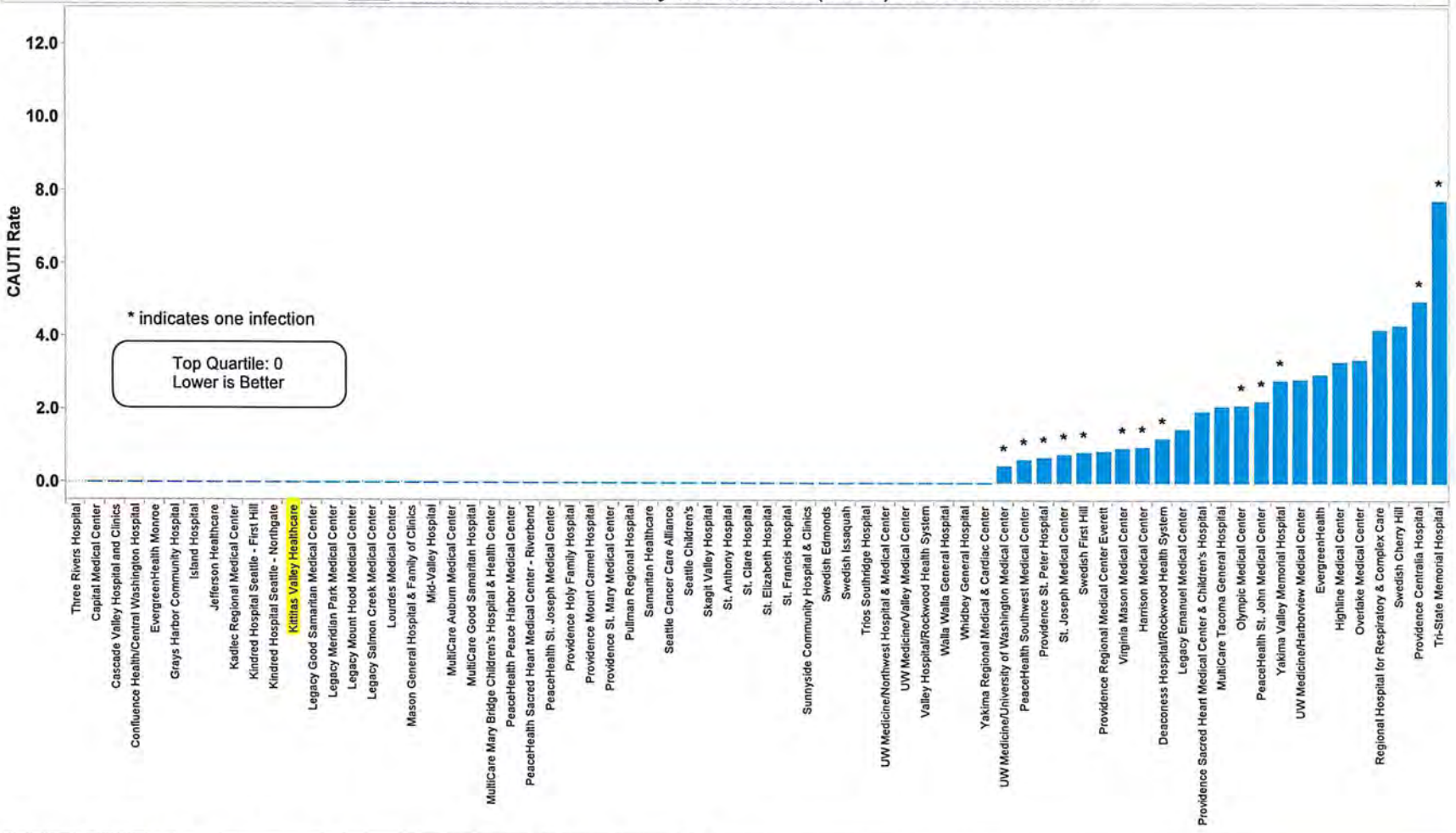
Patient Safety Summary Report - April 2016 Release

ICU: Catheter- Associated Urinary Tract Infection (CAUTI) - 2015 Q4 Distribution



Definition: Total number of catheter associated urinary tract infections per 1,000 urinary catheter days.
Data Source: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN).

Washington State Hospital Association - for questions or support in improving results, please contact CarolW@wsha.org.

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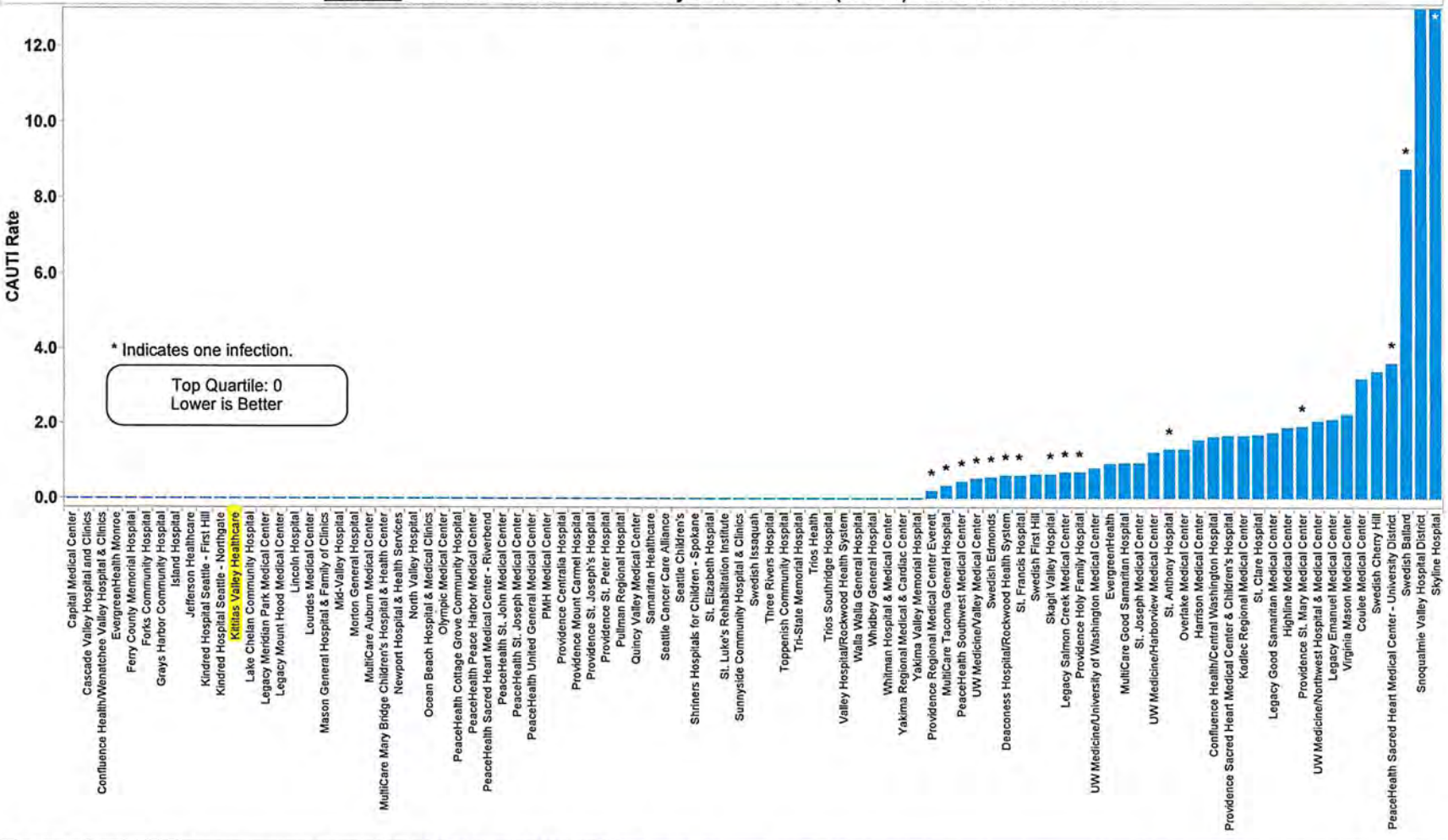
Non ICU: Catheter- Associated Urinary Tract Infection (CAUTI) - 2015 Q4 Distribution



Definition: Total number of catheter associated urinary tract infections per 1,000 urinary catheter days.
Data Source: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN).

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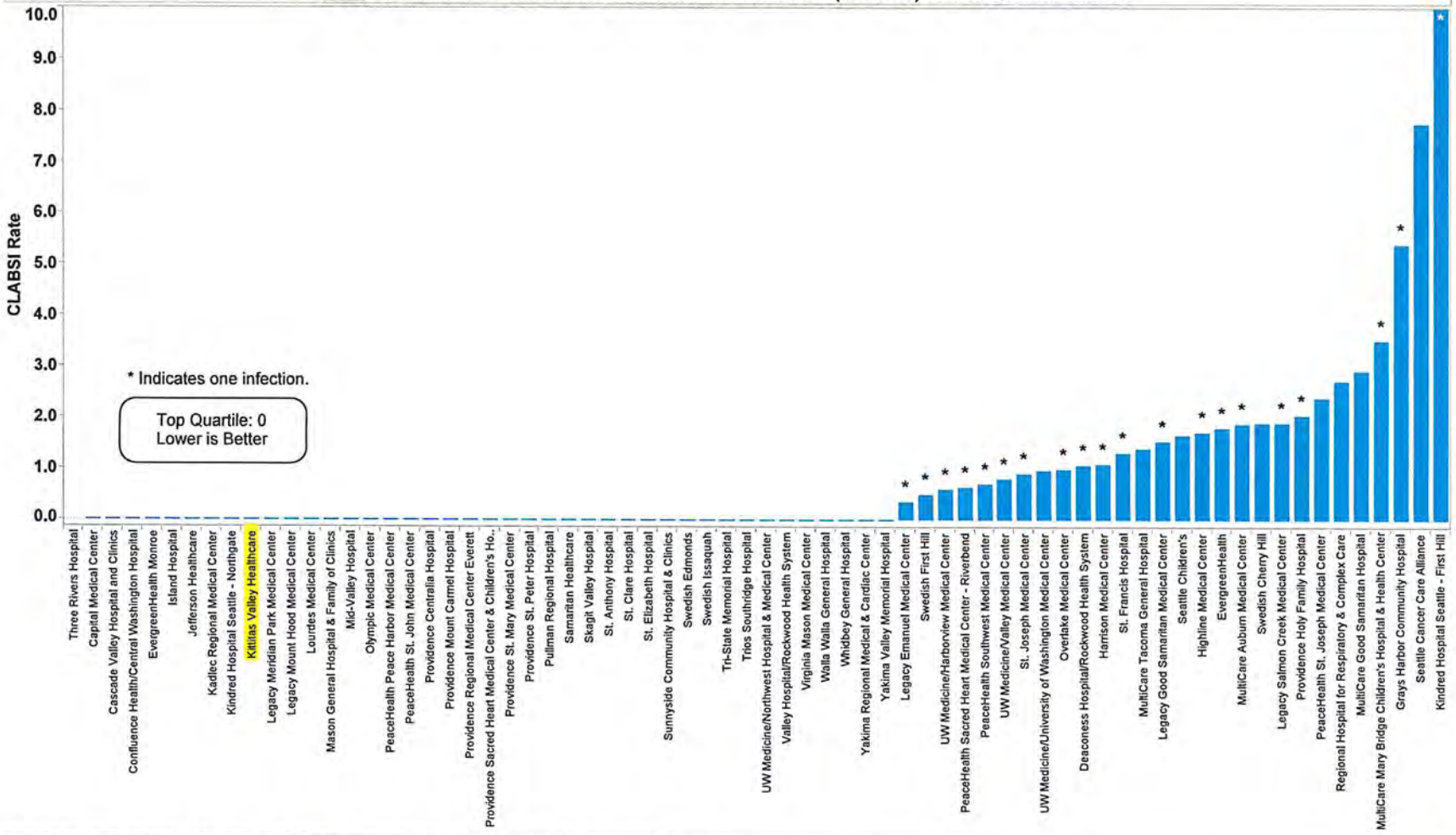
ICU: Central Line- Associated Bloodstream Infections (CLABSI) - 2015 Q4 Distribution



Definition: Total number of central line associated bloodstream infections per 1,000 central line days.
Data Source: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN).

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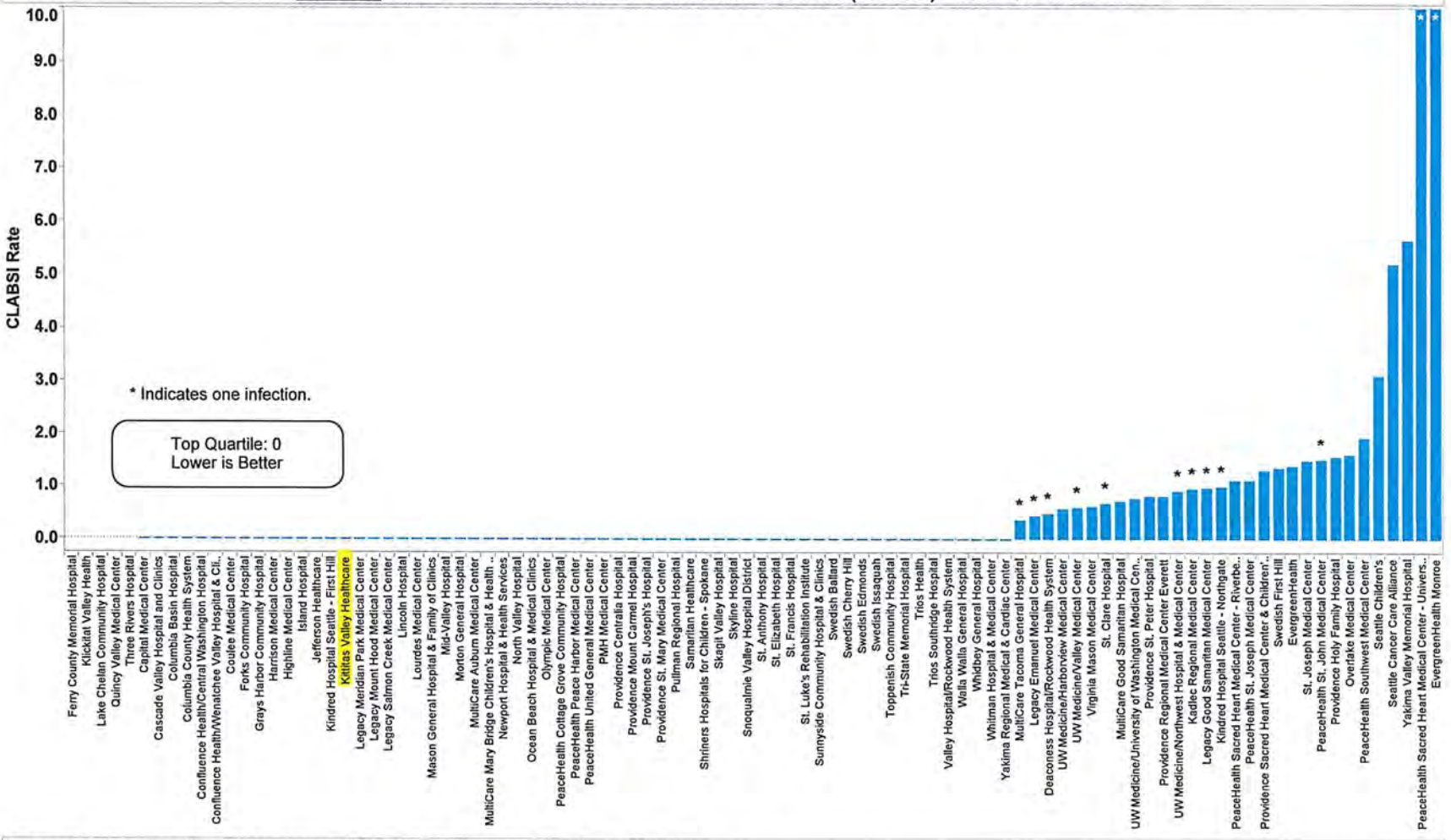
Non ICU: Central Line- Associated Bloodstream Infections (CLABSI) - 2015 Q4 Distribution



Definition: Total number of central line associated bloodstream infections per 1,000 central line days.
Data Source: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN).

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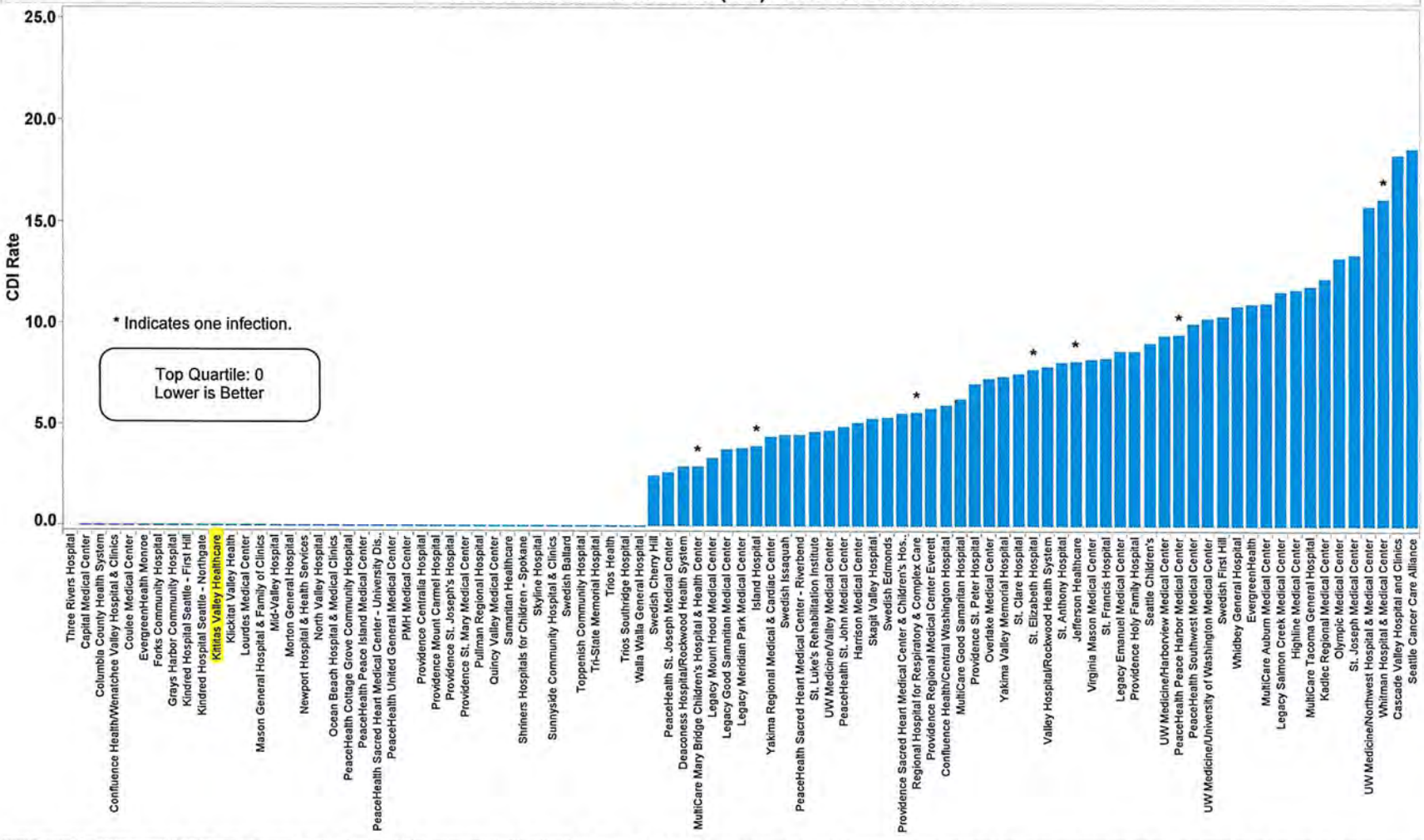
Clostridium *difficile* Infection (CDI) - 2015 Q4 Distribution



Definitions: Total number of all healthcare facility-onset (HO) Clostridium difficile infections (CDI) laboratory-identified (LabID) events (per month in the facility) per 10,000 patient days (for the facility).
Data source: Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN).

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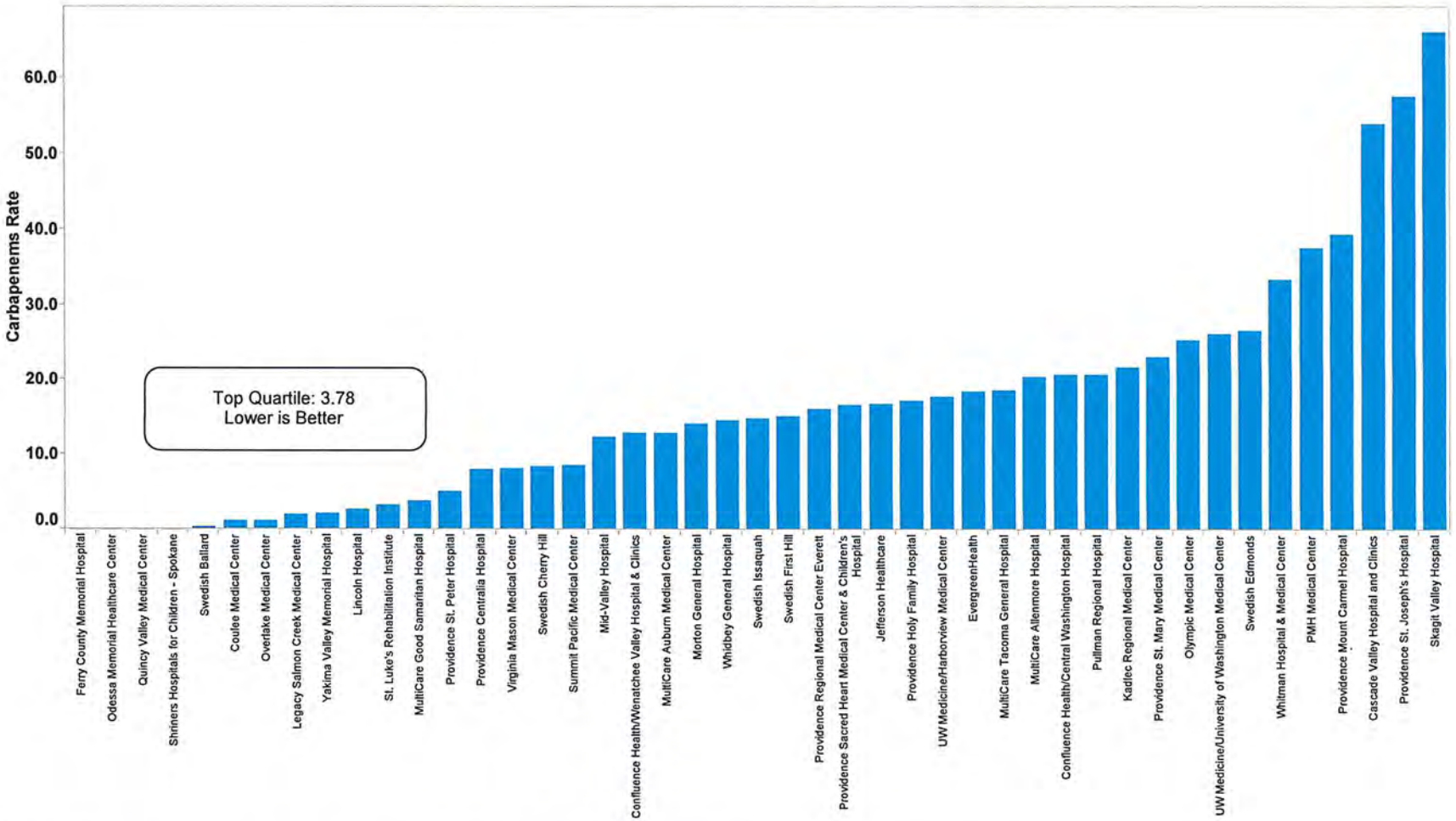
Antimicrobial Stewardship: Carbapenems Days of Therapy - 2015 Q4 Distribution



Defintion: Total number of carbapenems days of therapy per 1,000 patient days.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS).

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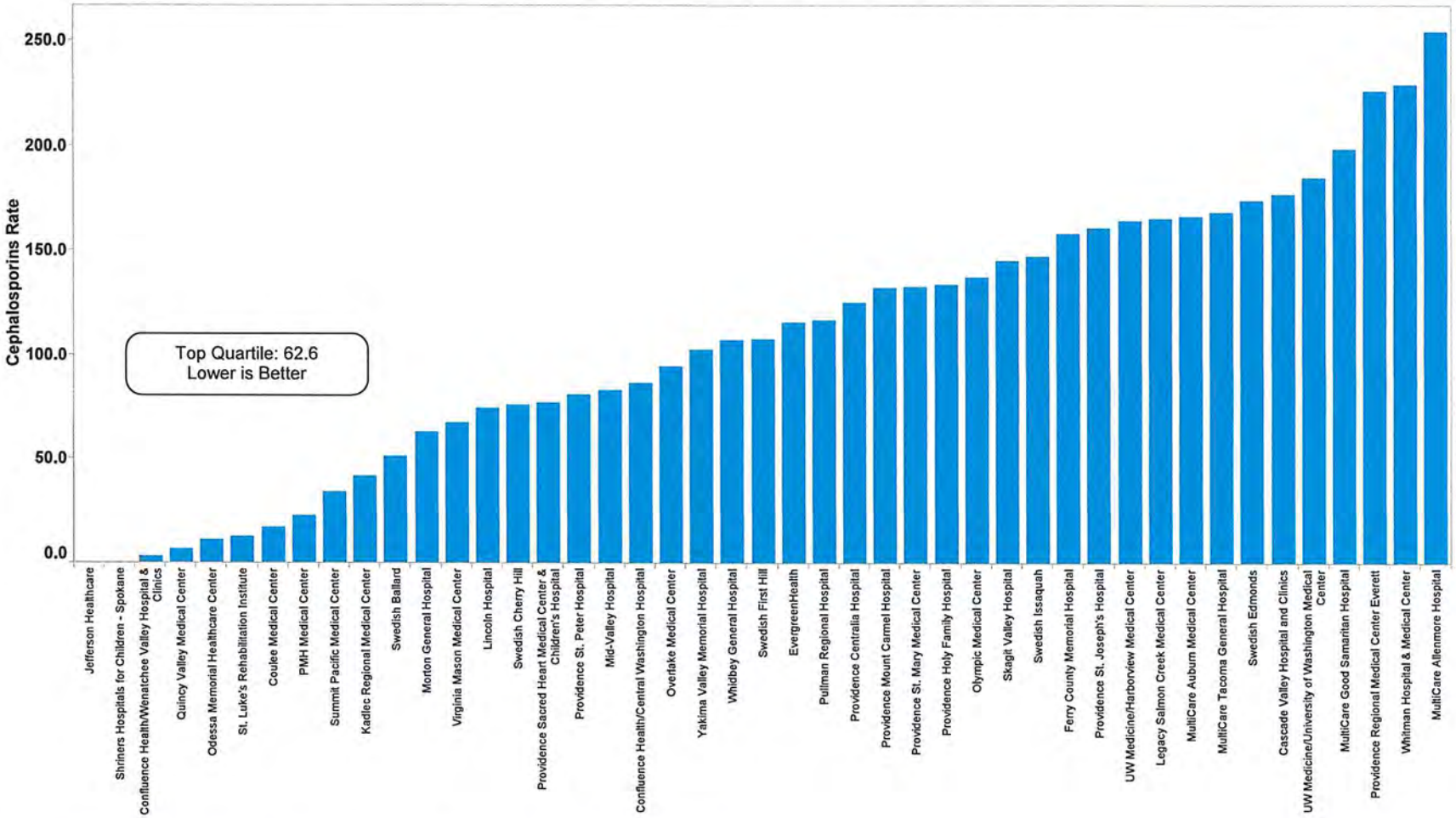
Antimicrobial Stewardship: Cephalosporins Days of Therapy - 2015 Q4 Distribution



Defintion: Total number of cephalosporins days of therapy per 1,000 patient days.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS).

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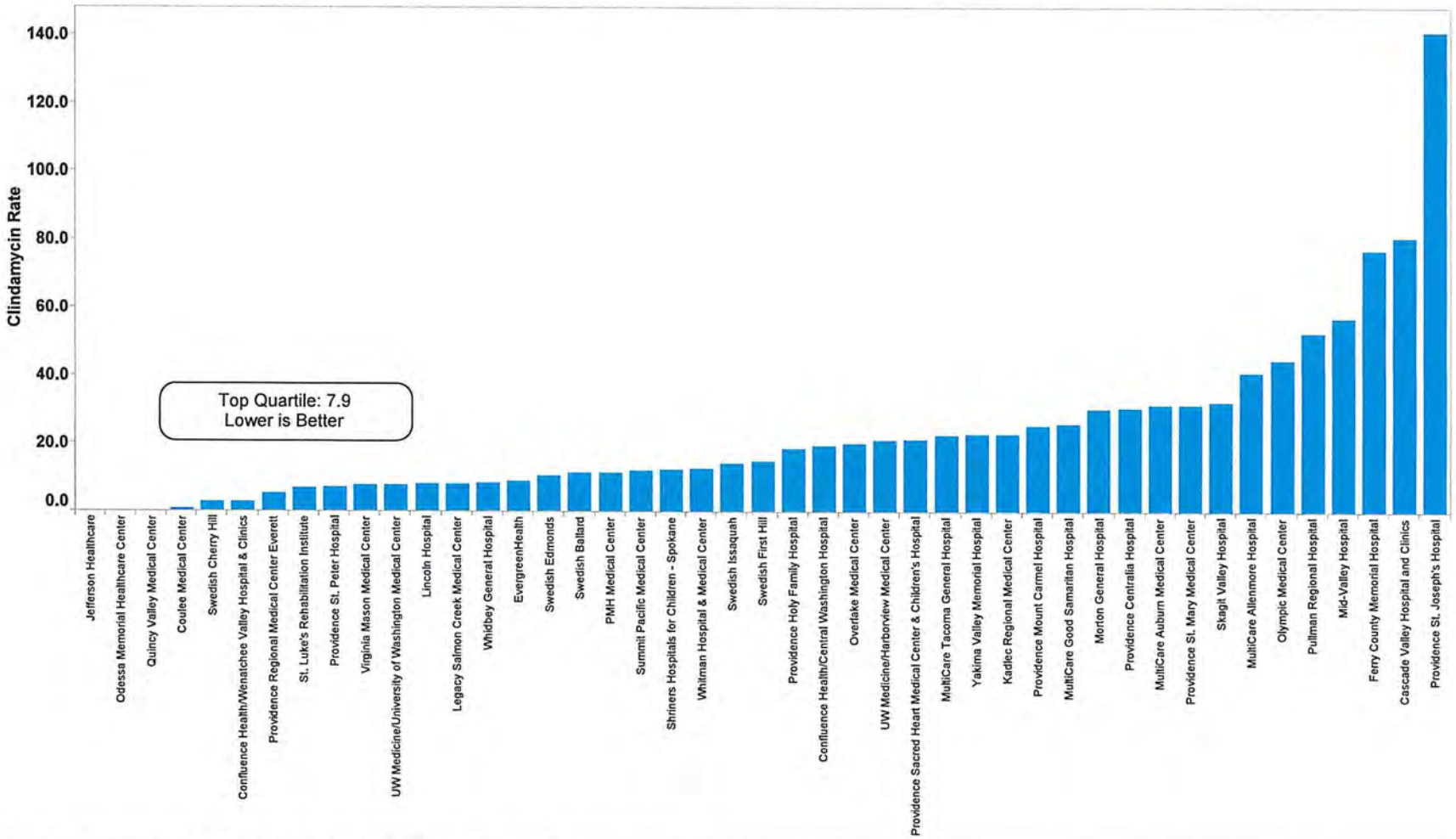
Antimicrobial Stewardship: Clindamycins Days of Therapy - 2015 Q4 Distribution



Defintion: Total number of clindamycin days of therapy per 1,000 patient days.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS).

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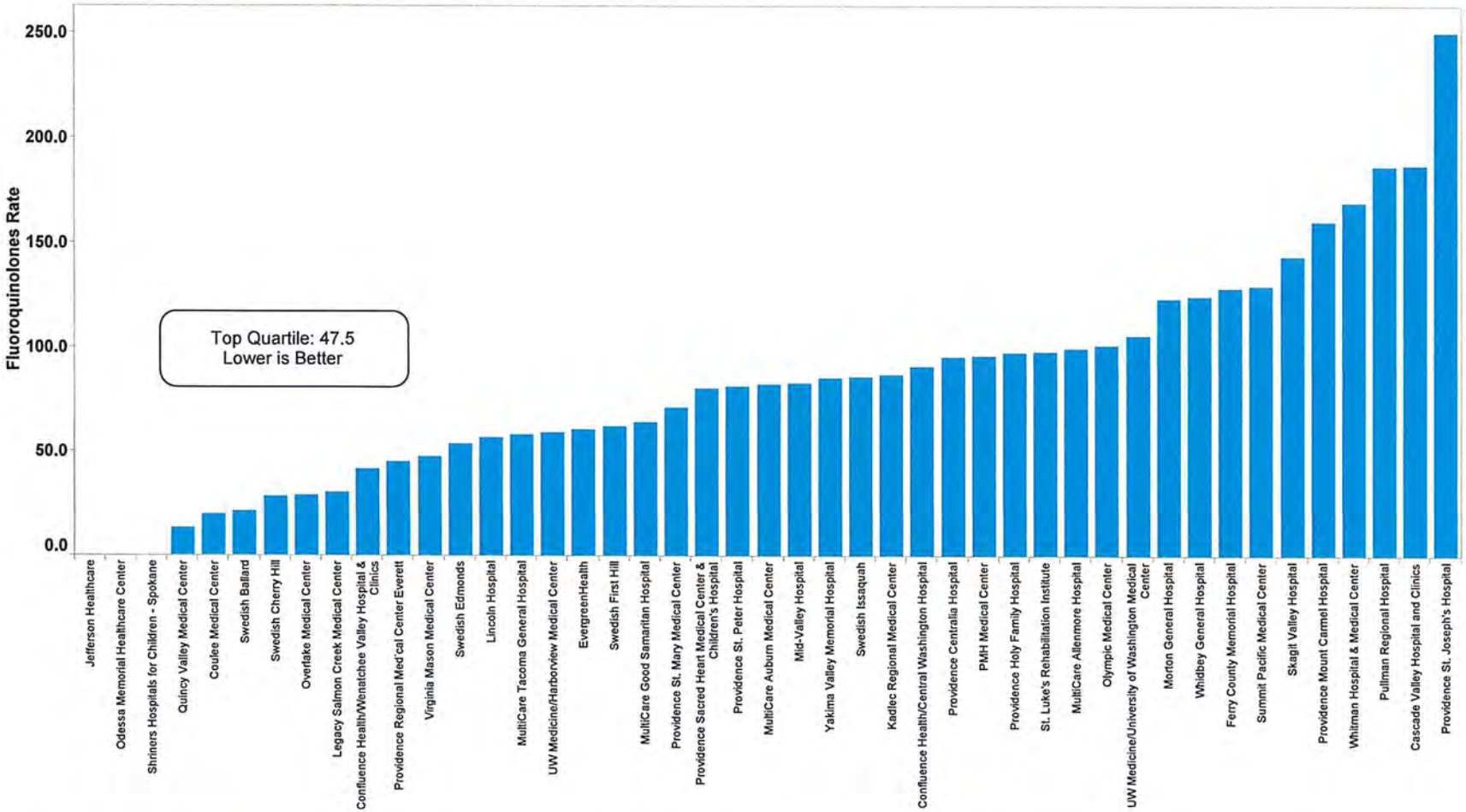
Antimicrobial Stewardship: Fluoroquinolones Days of Therapy - 2015 Q4 Distribution



Defintion: Total number of fluoroquinolones days of therapy per 1,000 patient days.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS).

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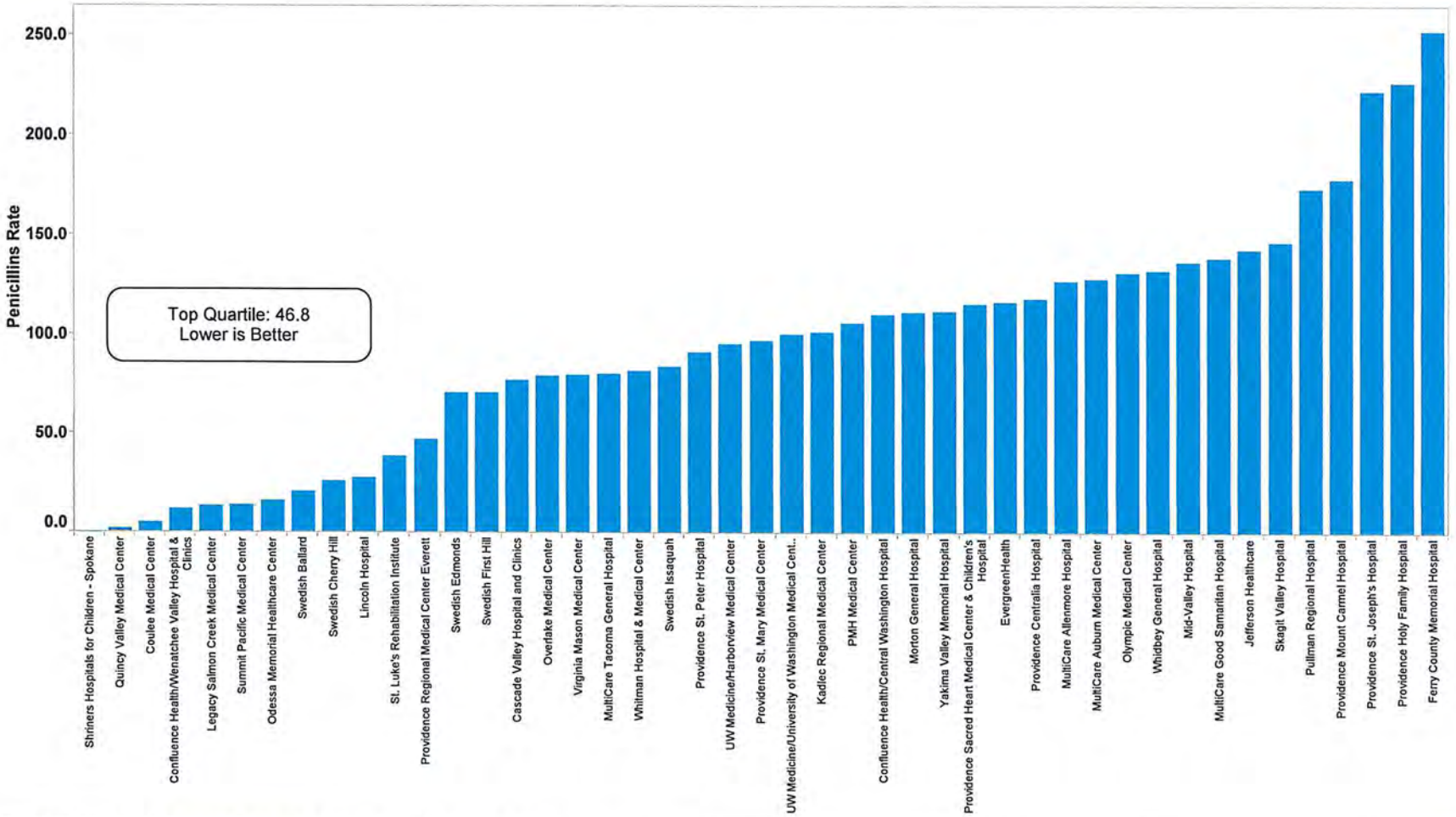
Antimicrobial Stewardship: Penicillins Days of Therapy - 2015 Q4 Distribution



Defintion: Total number of penicillins days of therapy per 1,000 patient days.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS).

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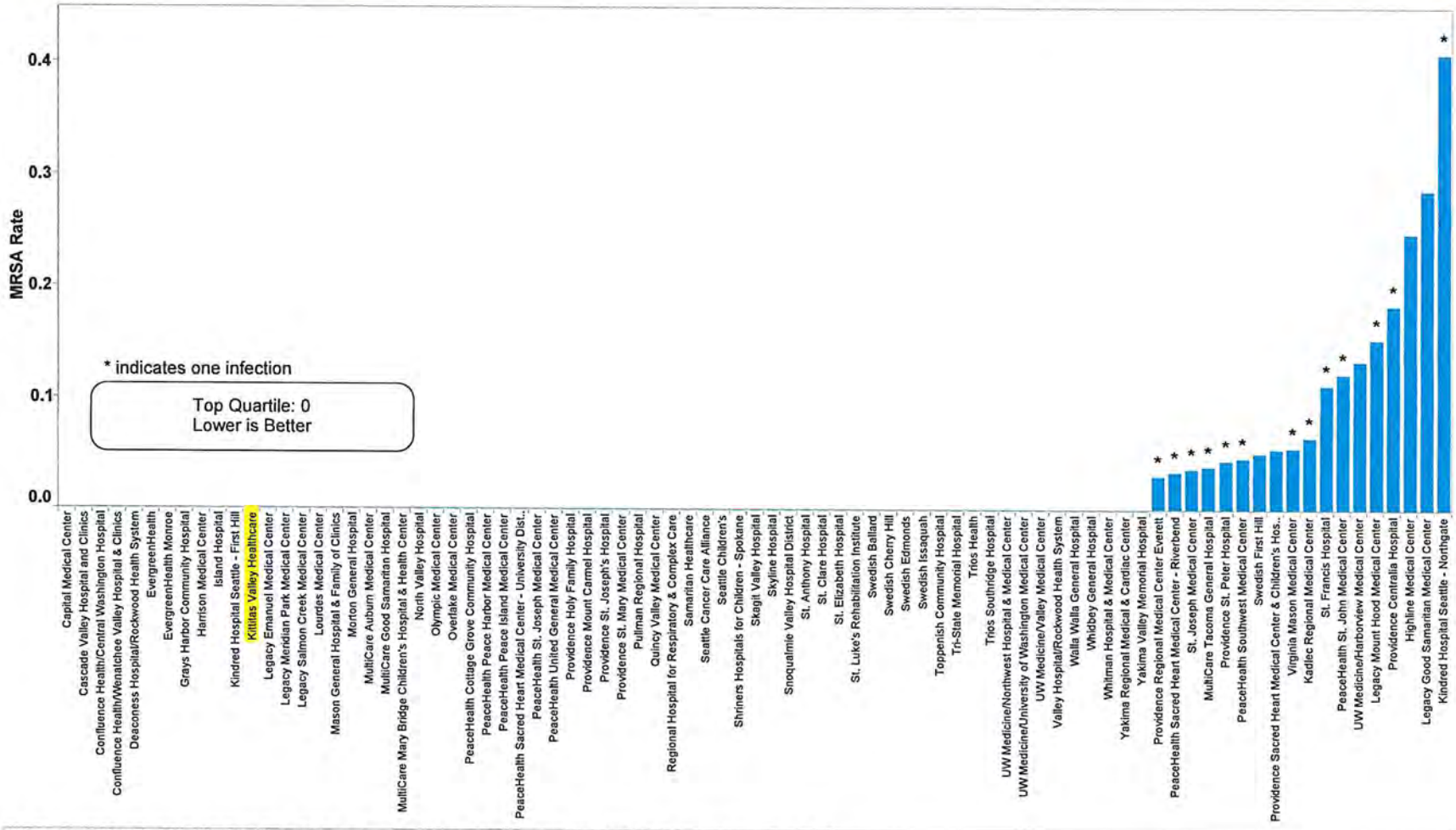
Methicillin-Resistant Staphylococcus Aureus (MRSA) - 2015 Q4 Distribution



Defintion: MSRA Blood Incident LabID Rate is the number of MSRA Blood Incident LabID Count per 1,000 patient days.
Data Source: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN).

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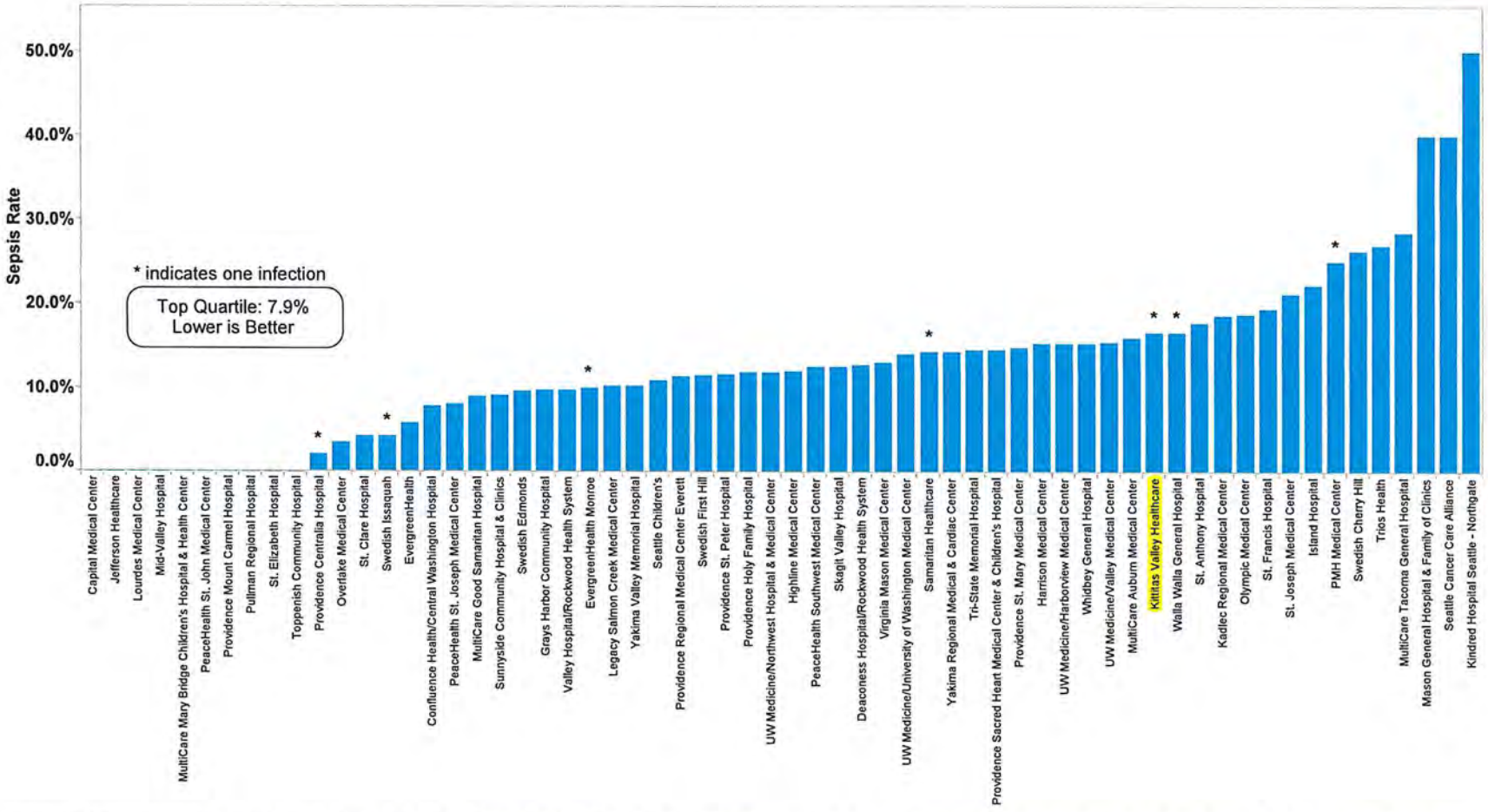
Severe Sepsis Mortality - 2015 Q3 Distribution



Definition: Hospital deaths related to Severe Sepsis (995.92) and Septic Shock (785.52) (All Ages) from the number of patients diagnosed with Severe Sepsis and Septic Shock (V66.7 Excludes Comfort Care Patients).
Data Source:Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS).

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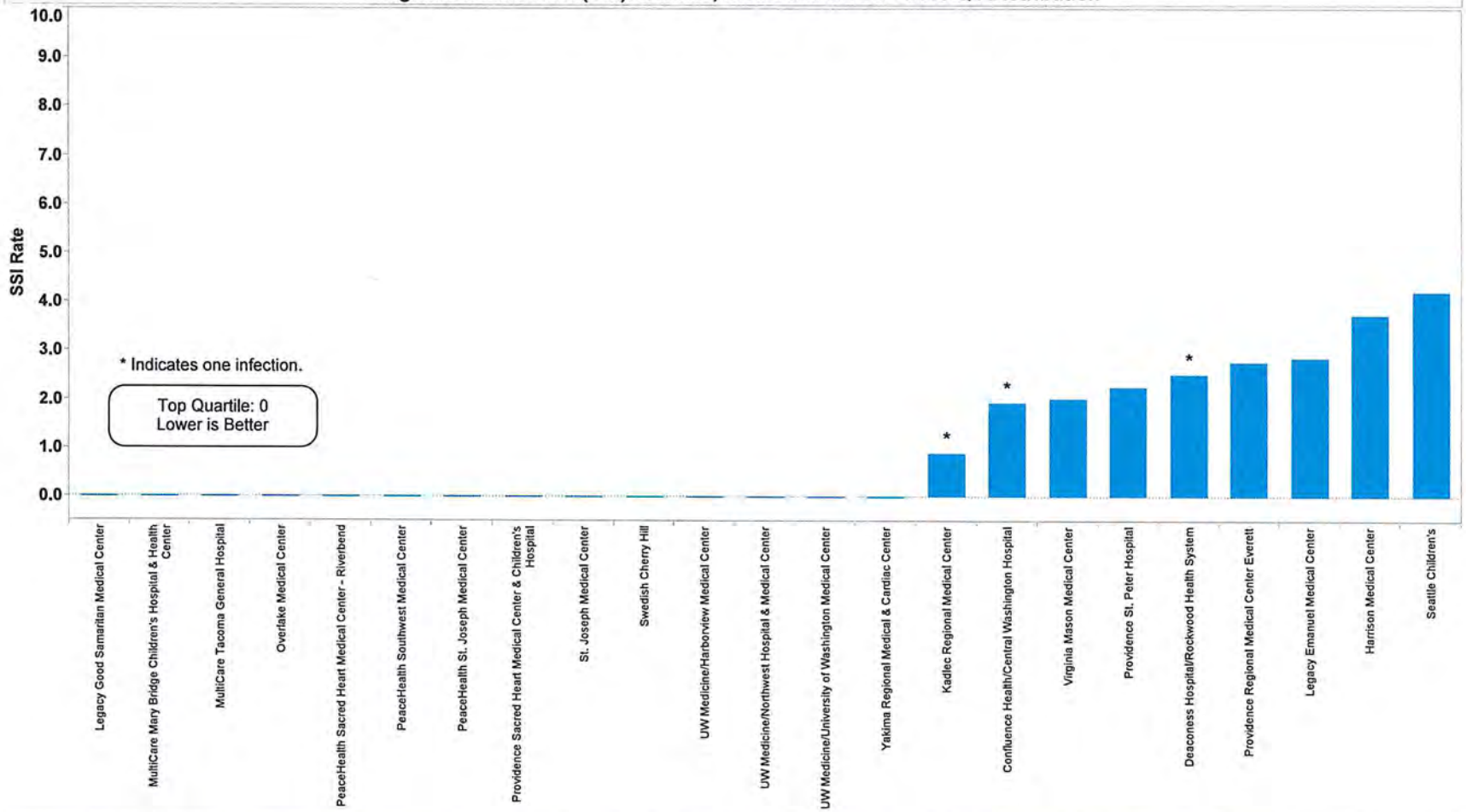
Patient Safety Summary Report - April 2016 Release

Surgical Site Infection (SSI): Cardiac, CBGB and CBGC - 2015 Q4 Distribution



Definition: Number of surgical site infections (Cardiac surgery, Coronary artery bypass graft with both chest and donor site incisions [CBGB], Coronary artery bypass graft with chest incision only [CBGC]) per 100 operative procedures.
Data Source: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN).

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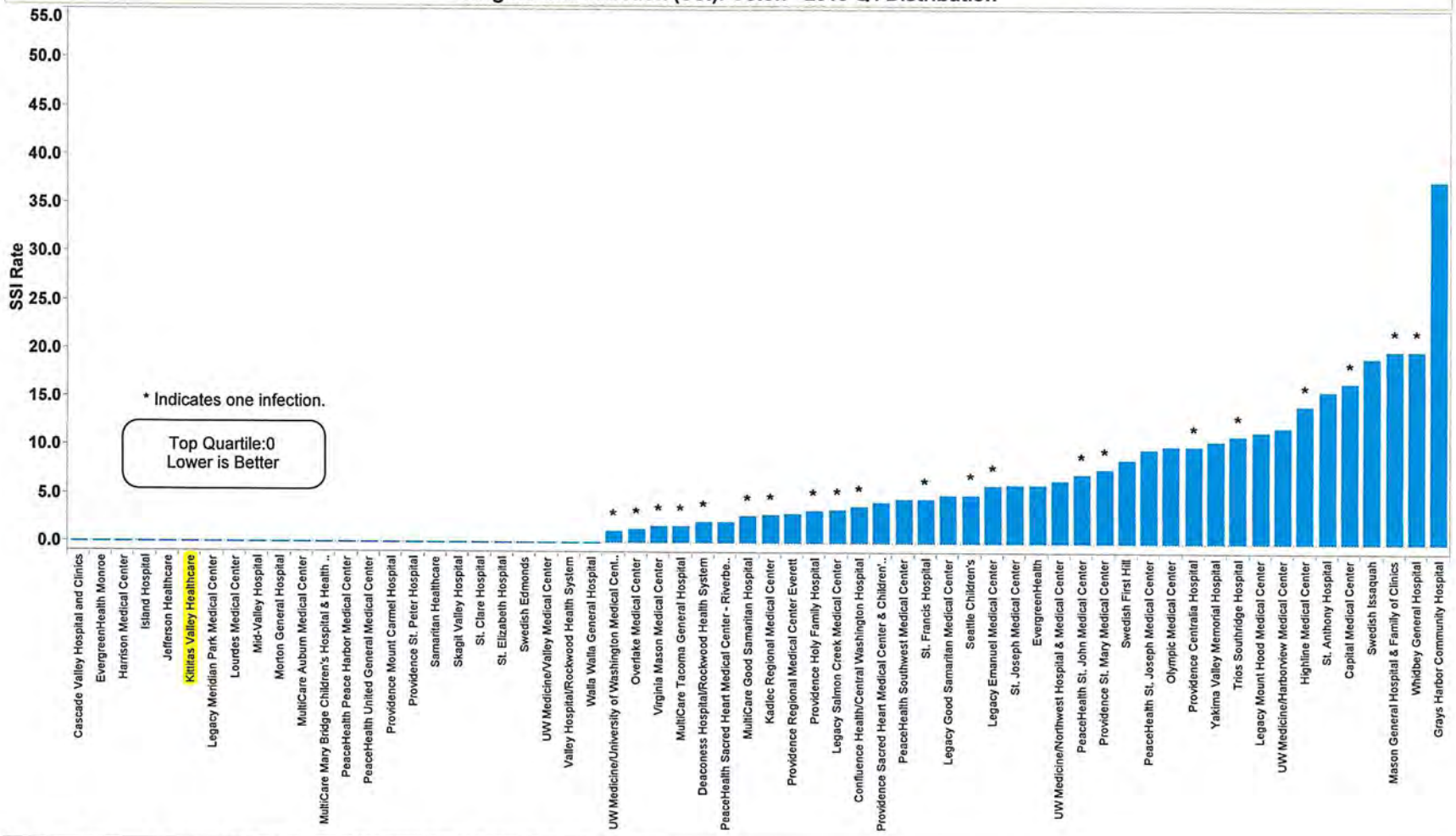
Surgical Site Infection (SSI): Colon - 2015 Q4 Distribution



Definition: Number of surgical site infections (Colon surgery) per 100 operative procedures.
Data Source: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN).

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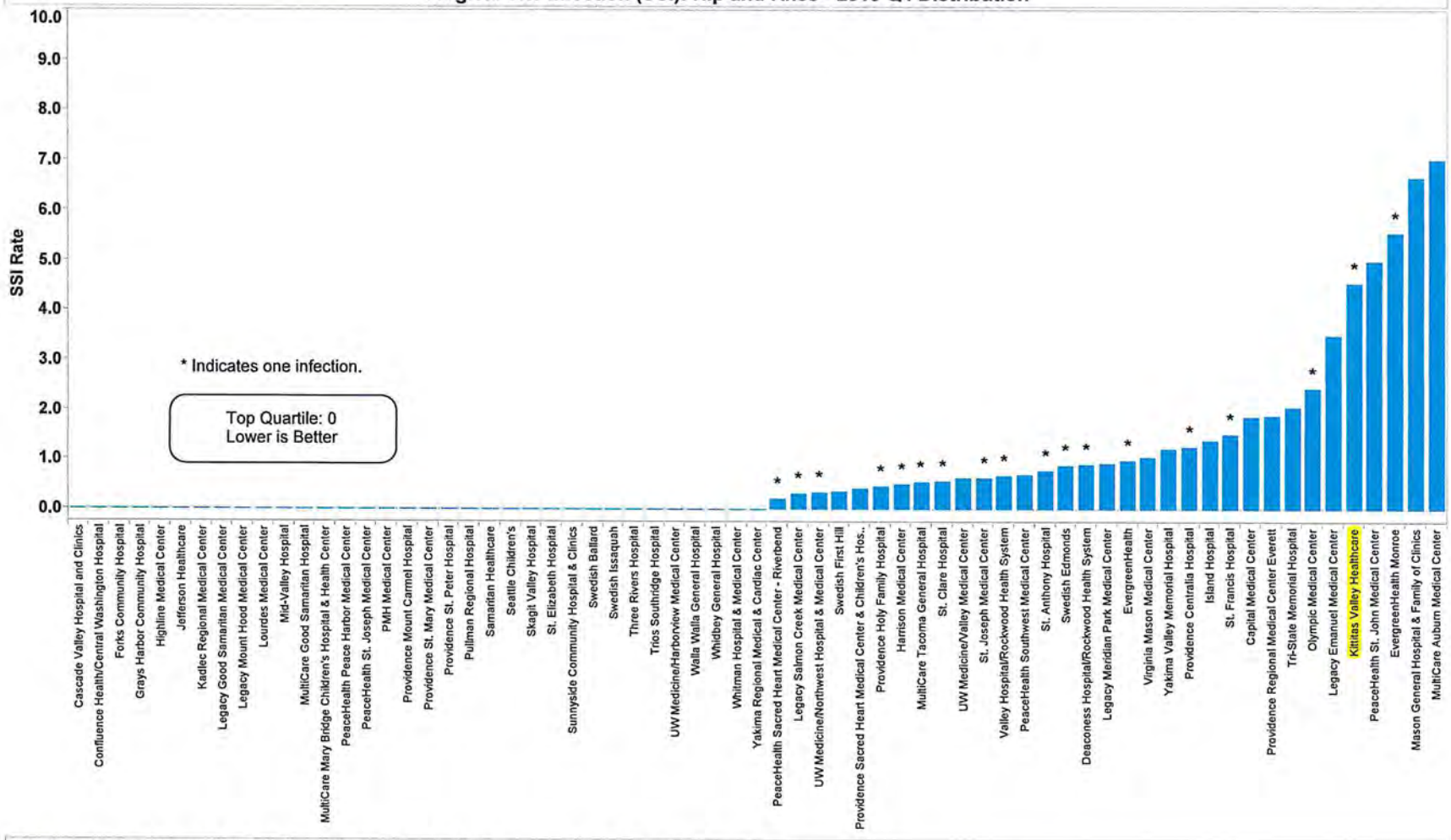
Patient Safety Summary Report - April 2016 Release

Surgical Site Infection (SSI): Hip and Knee - 2015 Q4 Distribution



Definition: Number of surgical site infections (Hip prosthesis and Knee prosthesis) per 100 operative procedures.
Data Source: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN).

Washington State Hospital Association - for questions or support in improving results, please contact CarolW@wsha.org.

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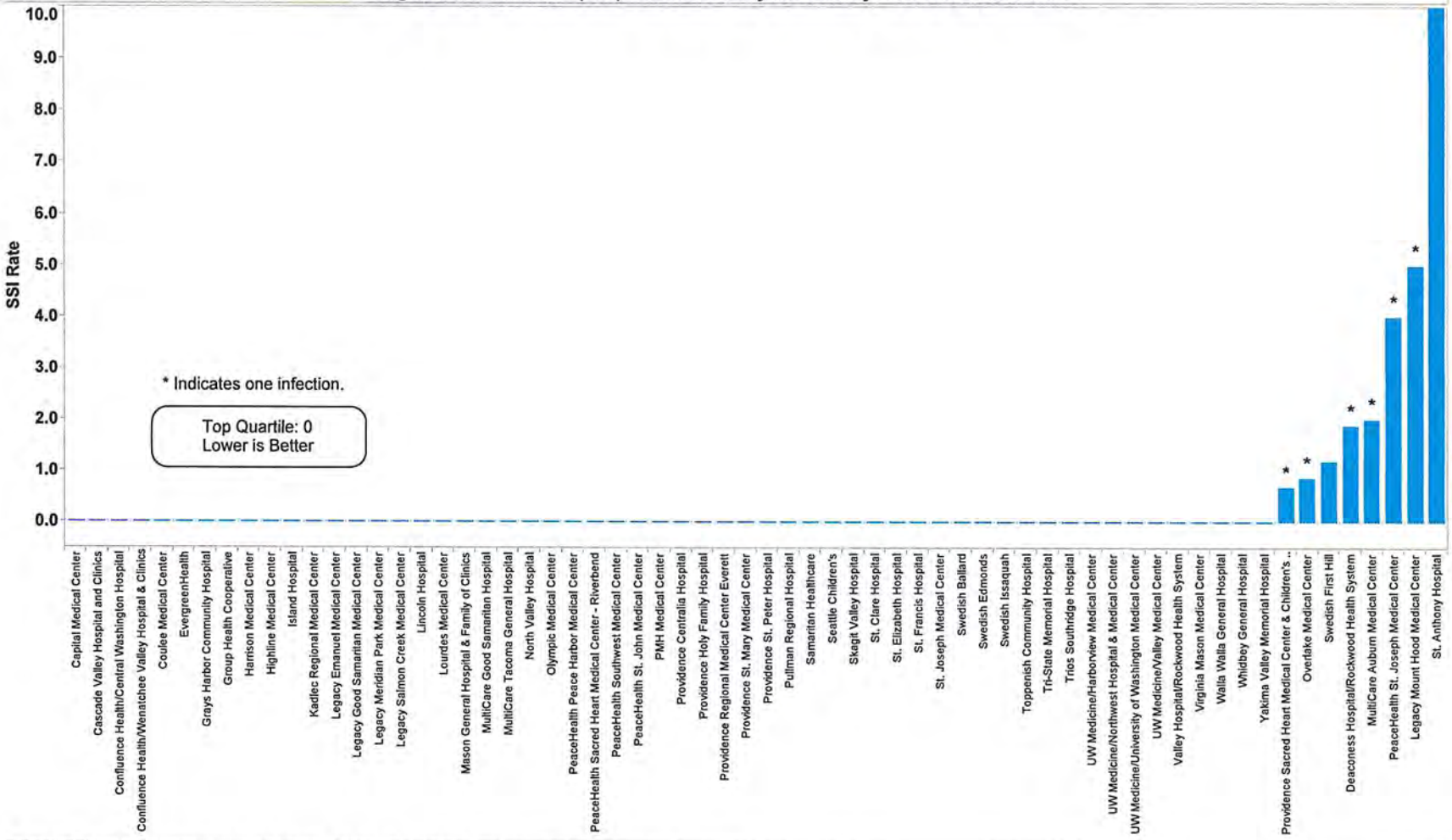
Patient Safety Summary Report - April 2016 Release

Surgical Site Infection (SSI): Abdominal Hysterectomy - 2015 Q4 Distribution



Definition: Number of surgical site infections (Abdominal hysterectomy) per 100 operative procedures.
Data Source: Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN).

Washington State Hospital Association - for questions or support in improving results, please contact CarolW@wsha.org.

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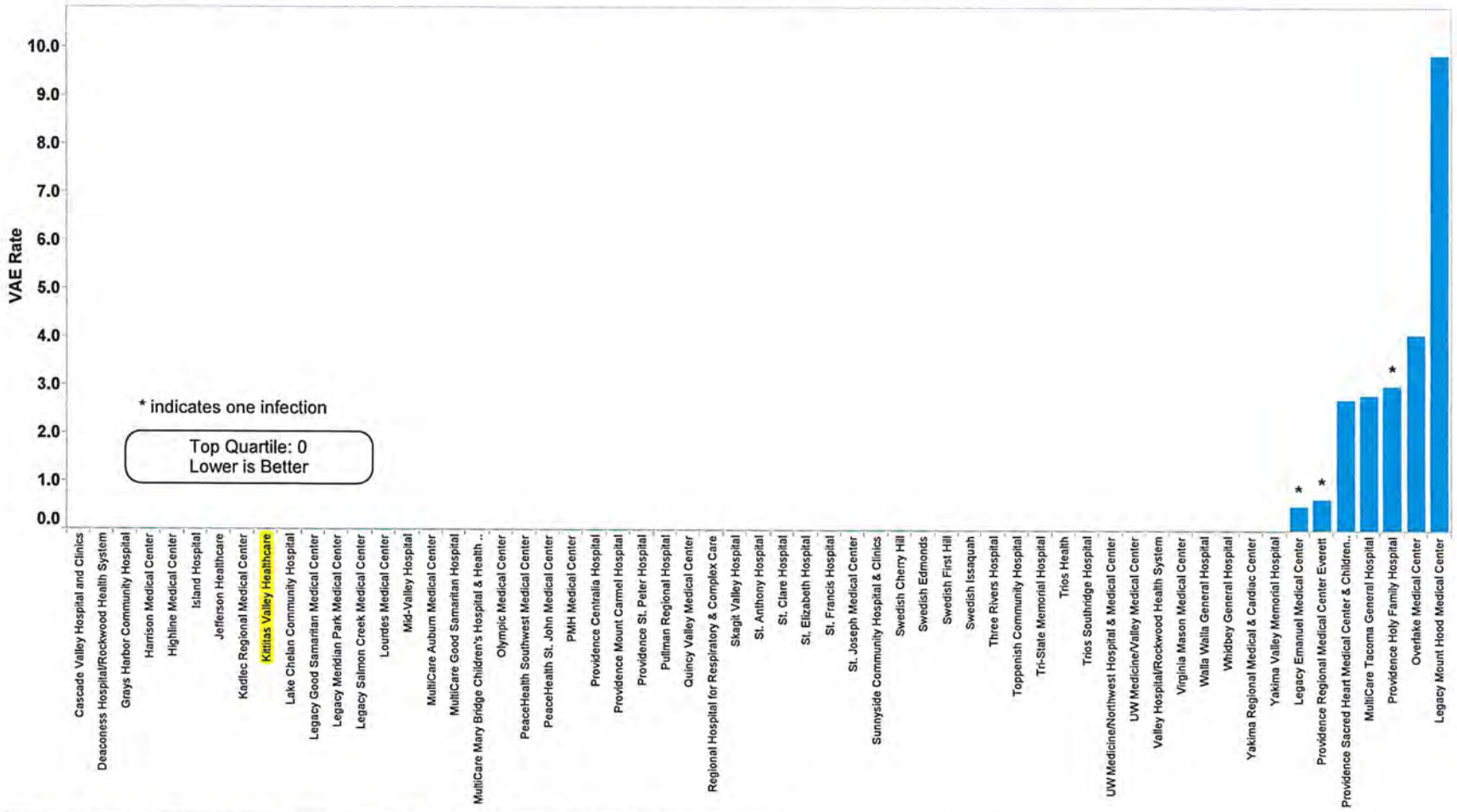
Ventilator Associated Events (VAE): Infection-Related Ventilator Associated Condition IVAC - 2015 Q4 Distribution



Defintion: Total number of confirmed ventilator associated events (IVAC) per 1,000 ventilator days.
Data Source: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN).

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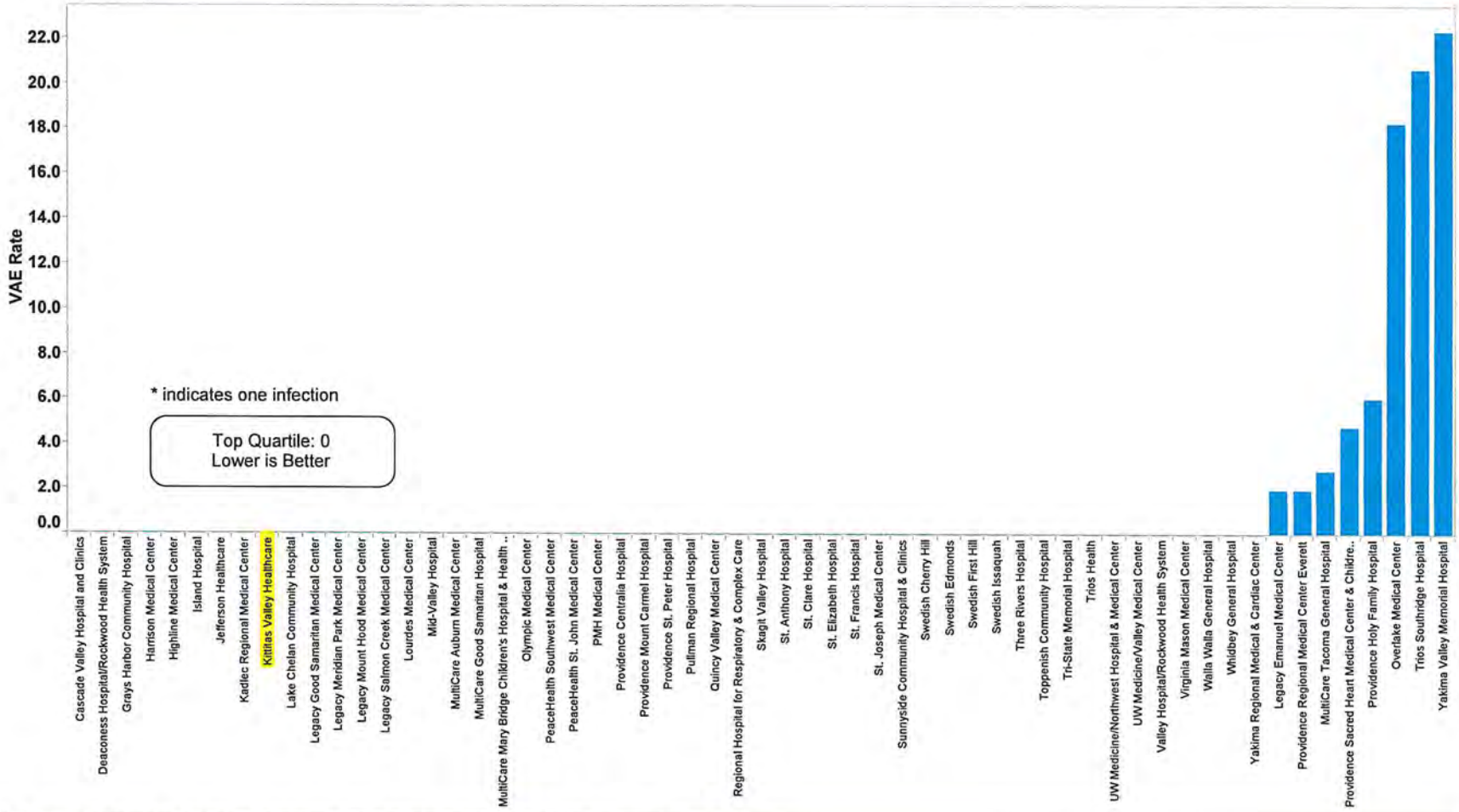
Ventilator Associated Events (VAE):Ventilator-Associated Condition VAC- 2015 Q4 Distribution



Defintion: Total number of confirmed ventilator associated events (VAC) per 1,000 ventilator days.
Data Source: Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN).

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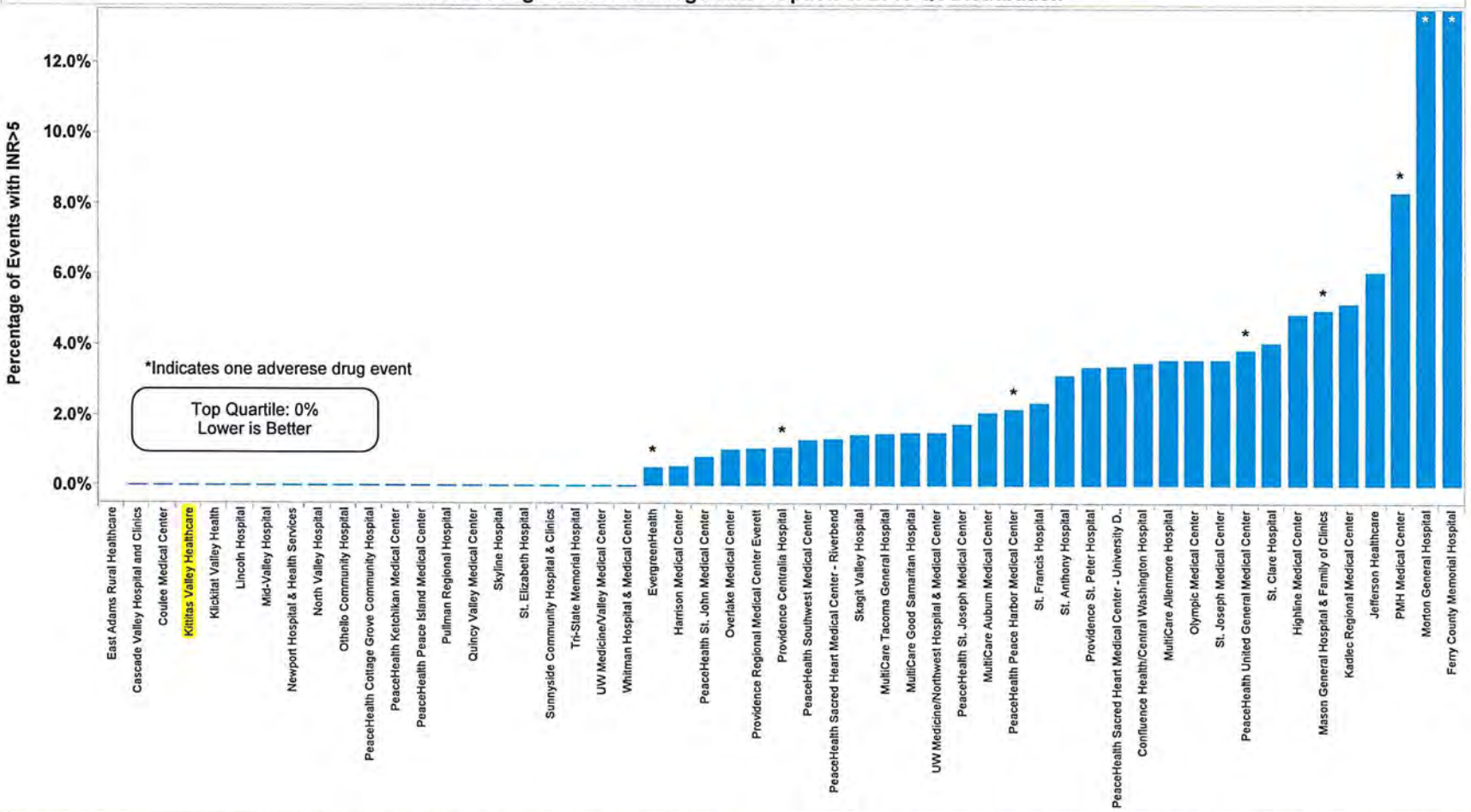
Adverse Drug Events Anticoagulants - Option 1: 2015 Q4 Distribution



Definition: Number of patient events with an INR >5 after any warfarin administration (for patients cared for in an inpatient area) over the number of patients (cared for in an inpatient area) on warfarin. A patient that has multiple elevated INRs will be counted as one event until it drops below 3.5 and rises above 5 again. Exclusions: emergency department readings, patients admitted for trauma, patients with liver failure diagnosis, and patients given argatroban before warfarin.
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System.

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Decision Support

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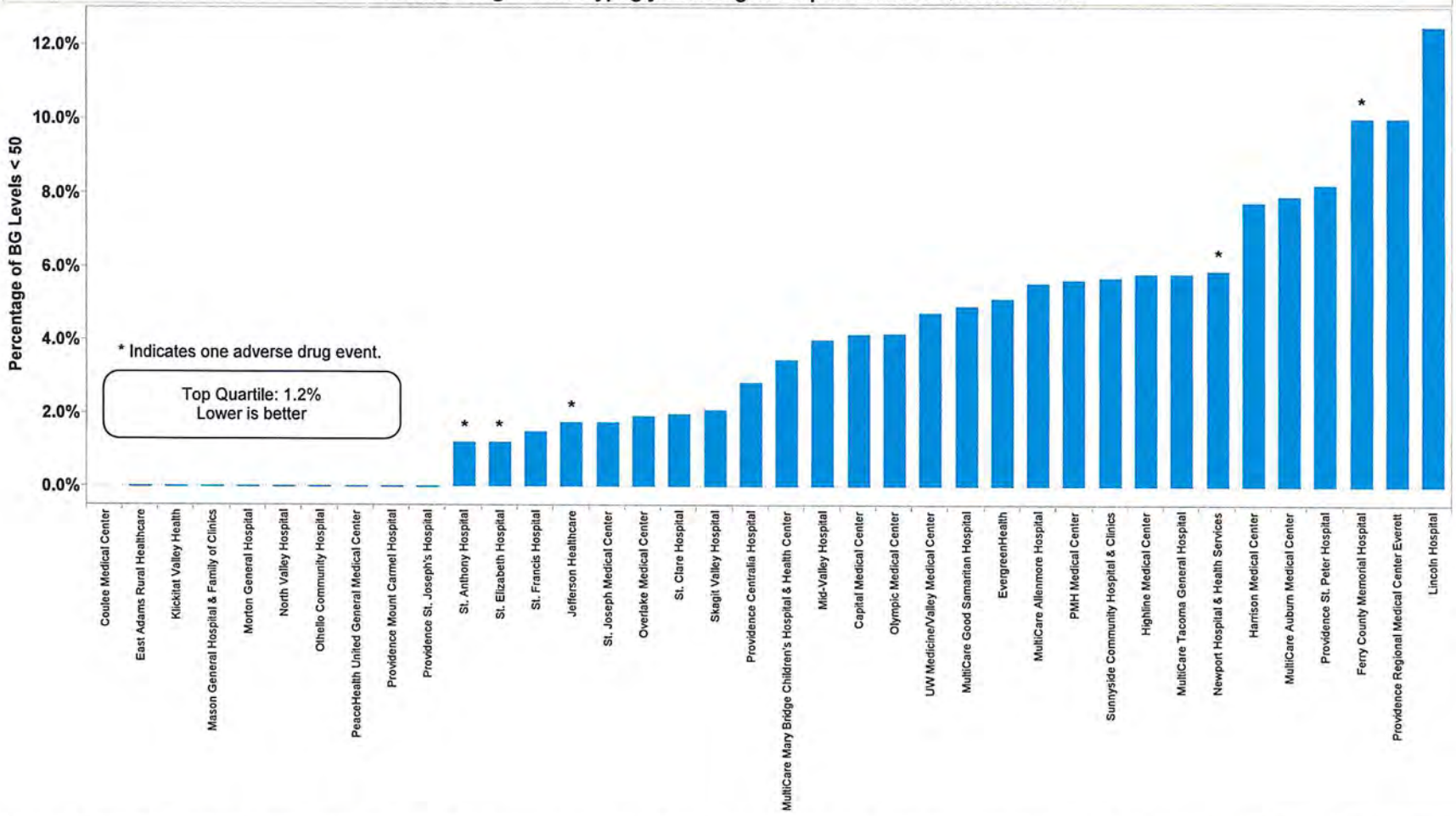
Patient Safety Summary Report - April 2016 Release

Adverse Drug Events Hypoglycemic Agent - Option 1: 2015 Q4 Distribution



Definition: Number of patient blood glucose (BG)* levels of <50 mg/dl after any hypoglycemic agent administration (patients cared for in an inpatient area) over the number of patients (cared for in an inpatient area) receiving hypoglycemic agents (oral & insulin).
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System.

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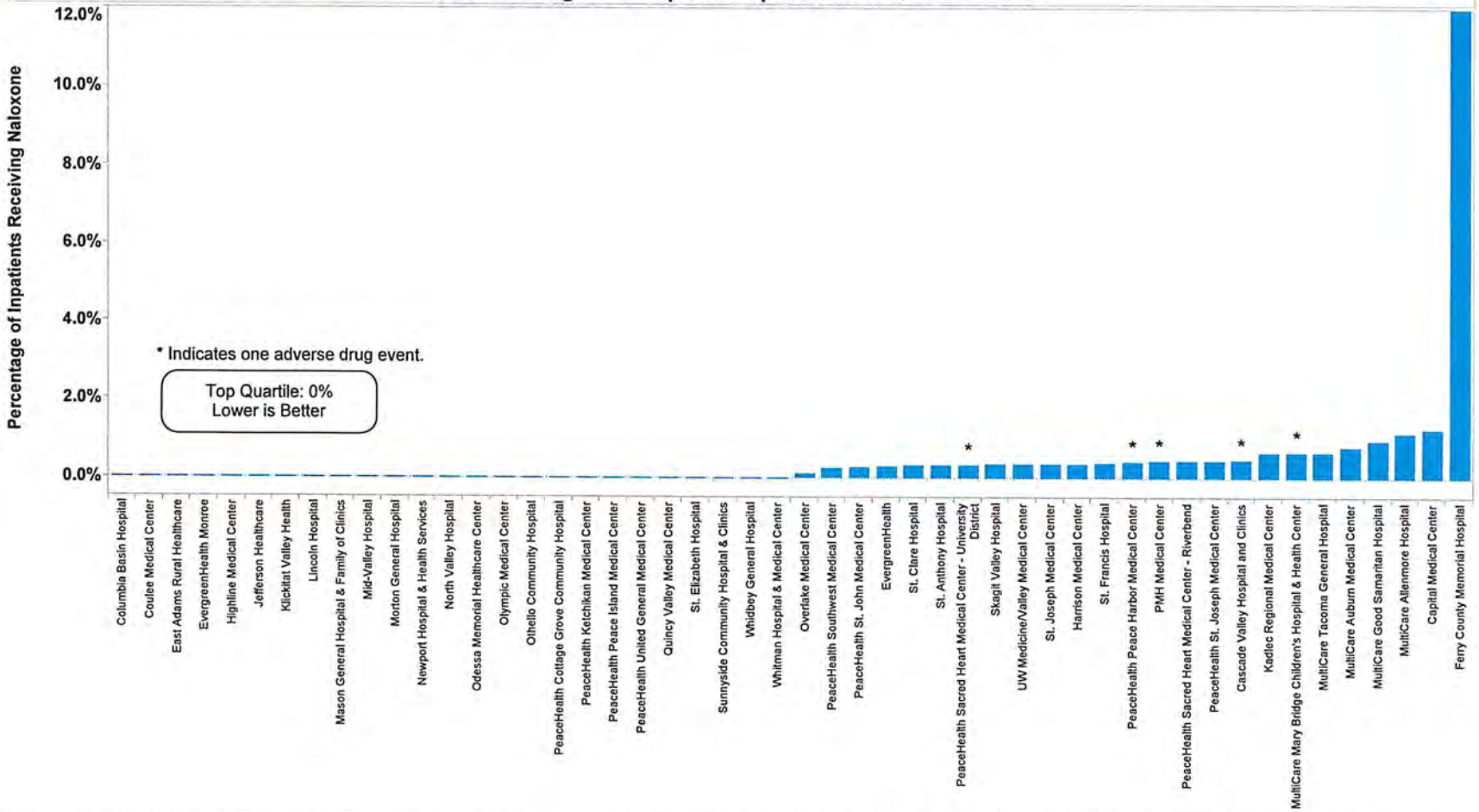
Patient Safety Summary Report - April 2016 Release

Adverse Drug Events Opioids - Option 1: 2015 Q4 Distribution



Definition: Number of patients (cared for in an inpatient area) who received naloxone after any opioid administration over number of patients (cared for in an inpatient area) receiving opioids. Exclusions: naloxone given in PACU and procedural areas, given (via IV infusion) for epidural-related itching symptoms,all doses given in the ED or within 24 hours of admission for a diagnosis of suicide attempt, opiate abuse, dependence, poisoning, or overdose.
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System.

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Decision Support

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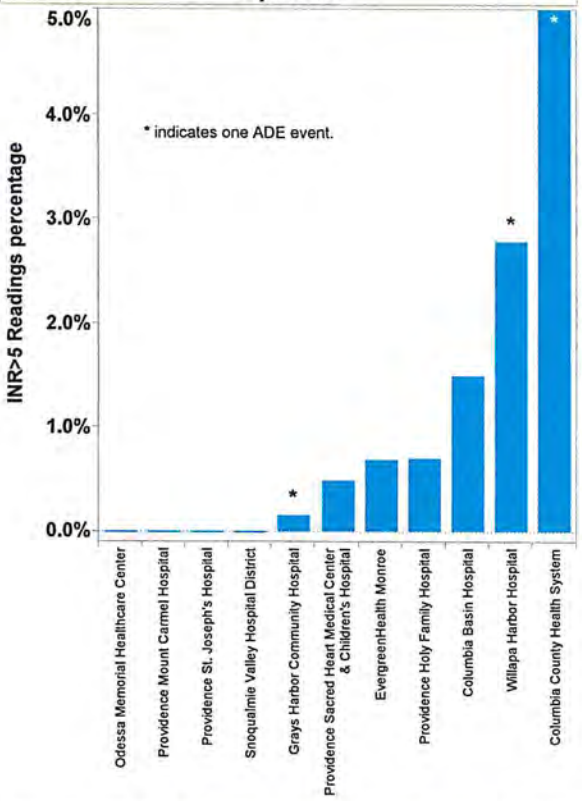
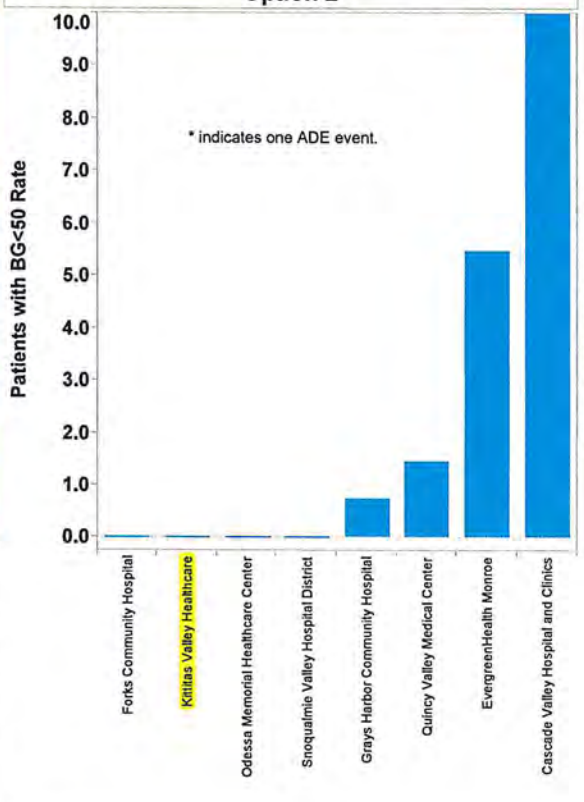
Patient Safety Summary Report - April 2016 Release

2015 Q4 Distributions

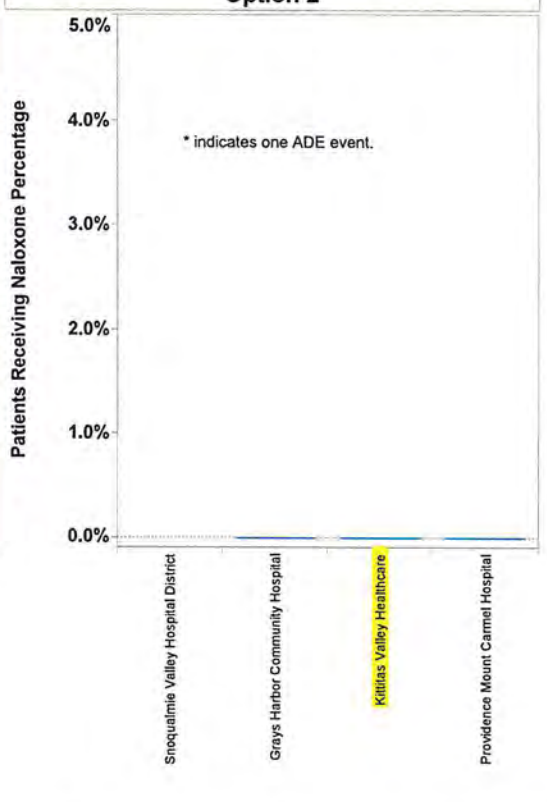
Adverse Drug Events Anticoagulants: Option 2



Adverse Drug Events Hypoglycemic Agents: Option 2



Adverse Drug Events Opioids: Option 2



Anticoagulants ADE #2 Description: Total number of INR>5 readings (for patients cared for in an inpatient area) over total number of INR readings (for patients cared for in an inpatient area).

Opioid ADE #2 Description: Total number of patients (cared for in an inpatient area) receiving naloxone after PCA administration over total patient days (cared for in an inpatient area) receiving PCA opioids.

Hypoglycemic ADE #2 Description: Total number of BG (blood glucose) levels of <50 mg/dl (for patients cared for in an inpatient area) per 1,000 total patient days (excluding healthy newborns and ED readings).
Data Source (All): Washington State Hospital Association (WSHA) Quality Benchmarking System (QBS).

Washington State Hospital Association - for questions or support in improving results, please contact CarolW@wsha.org.

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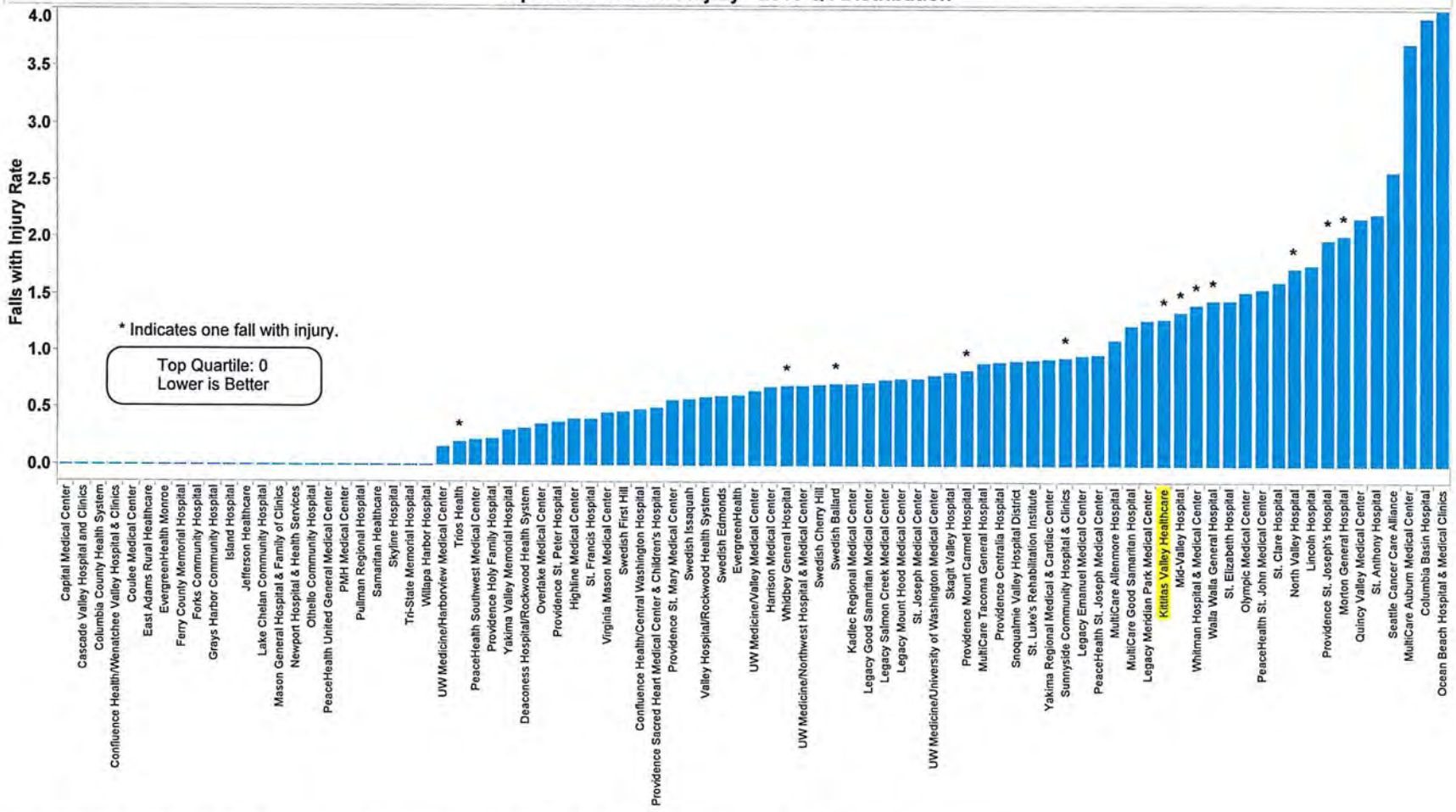
Inpatient Falls with Injury - 2015 Q4 Distribution



Definition: Total number of falls with an injury level of minor or greater by type of unit during the calendar month per 1,000 patient days.
Data Source: Washington State Hospital Association (WSHA) Quality Benchmarking System (QBS) and National Database of Nursing Quality Indicators/Collborative Alliance for Nursing Outcomes (CAL-NOC).

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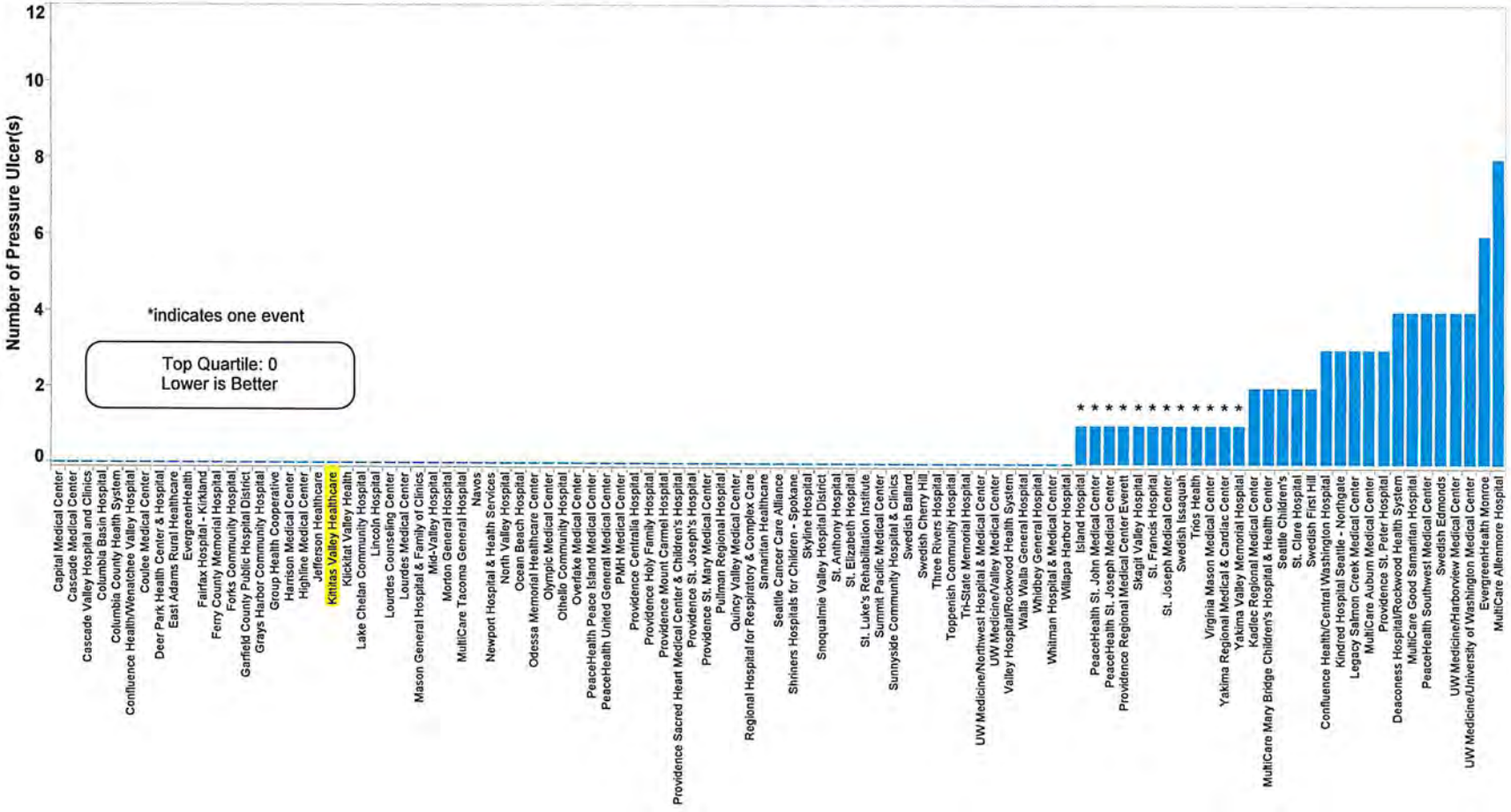
Patient Safety Summary Report - April 2016 Release

Pressure Ulcer Stage III and IV (or unstageable) - 2015 Q3 Distribution



Definition: Pressure Ulcers stage III or IV (or unstagable) aquired after admission to a healthcare setting. National Quality Forum/Serious Reportable Events.
Data Source: Washington State Department of Health, Adverse Events and Incident Reporting System.

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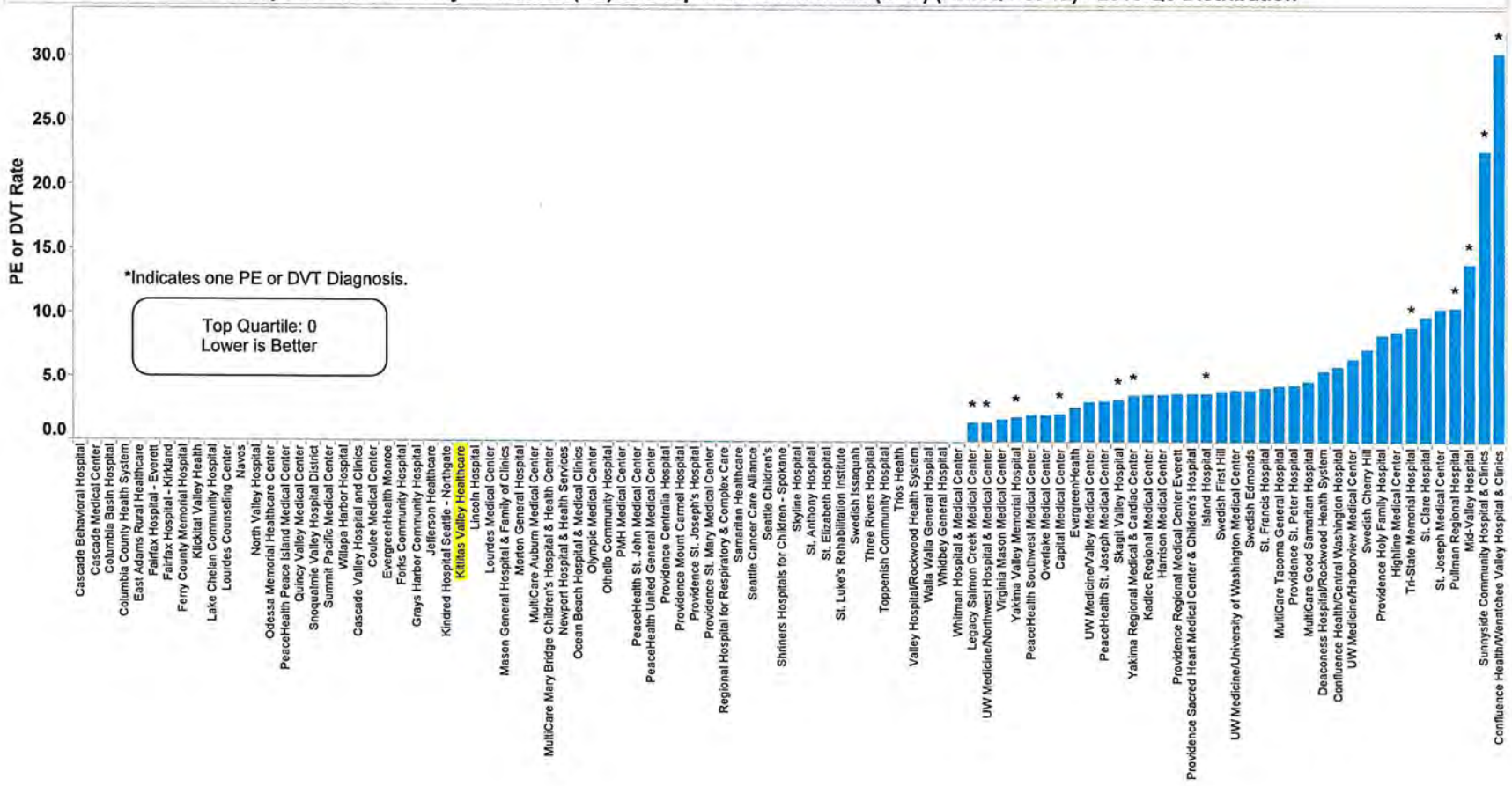
Postoperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) (AHRQ PSI-12) - 2015 Q3 Distribution



Definition: AHRQ Patient Safety Indicator #12, Discharges with ICD-9-CM codes for PE or DVT in any secondary diagnosis field per 1,000 surgical discharges age 18 and older by specific MS-DRGs and an ICD-9-CM code for an operating room procedure.
Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS).

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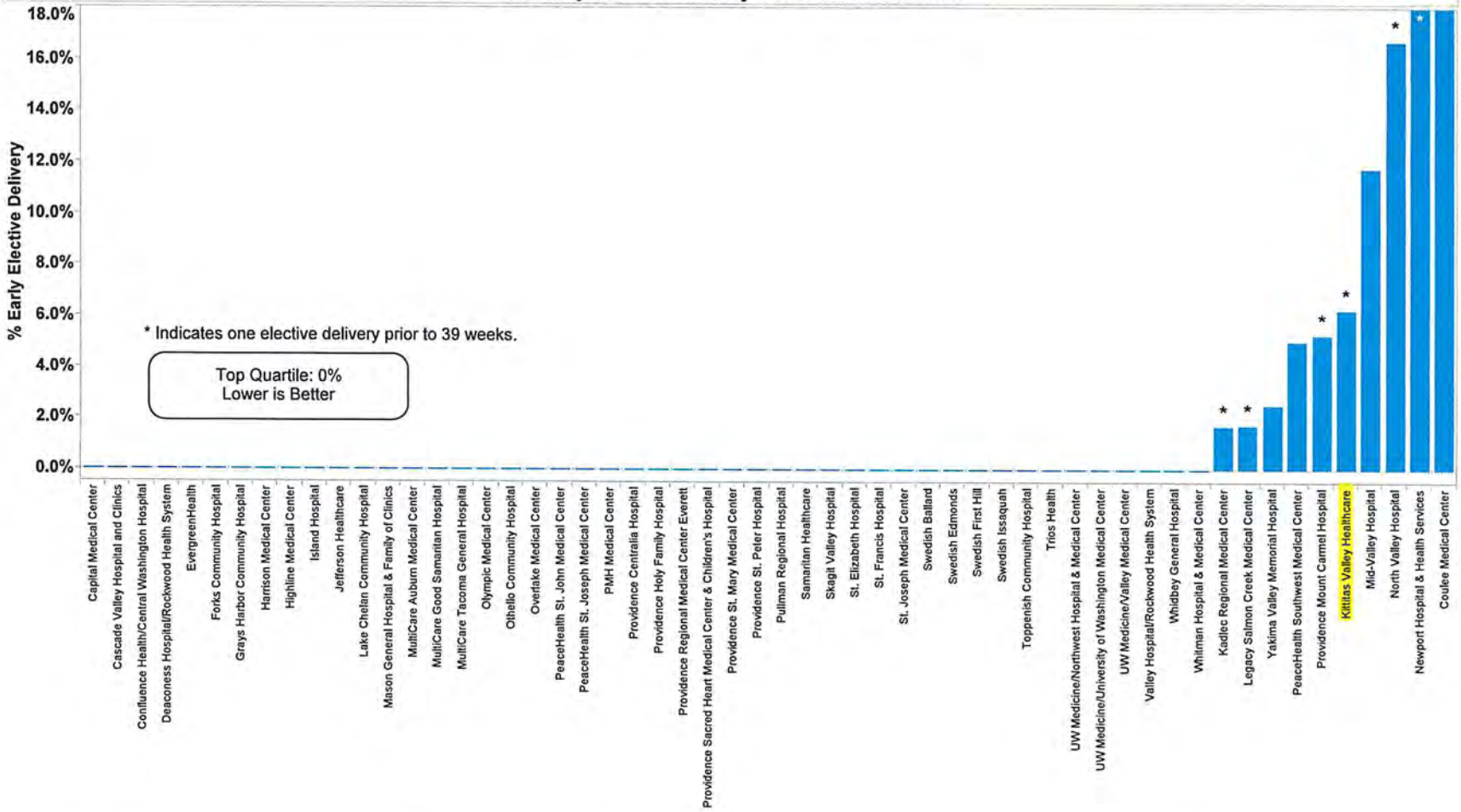
OB: Early Elective Delivery - 2015 Q4 Distribution



Definition: The Joint Commission, PC-01 Elective Delivery, percentage of patients with elective vaginal deliveries or elective cesarean sections at >=37 and <39 weeks of gestation.
Data Source: Washington State Hospital Association's (WSHA) Quality Benchmarking System (QBS).

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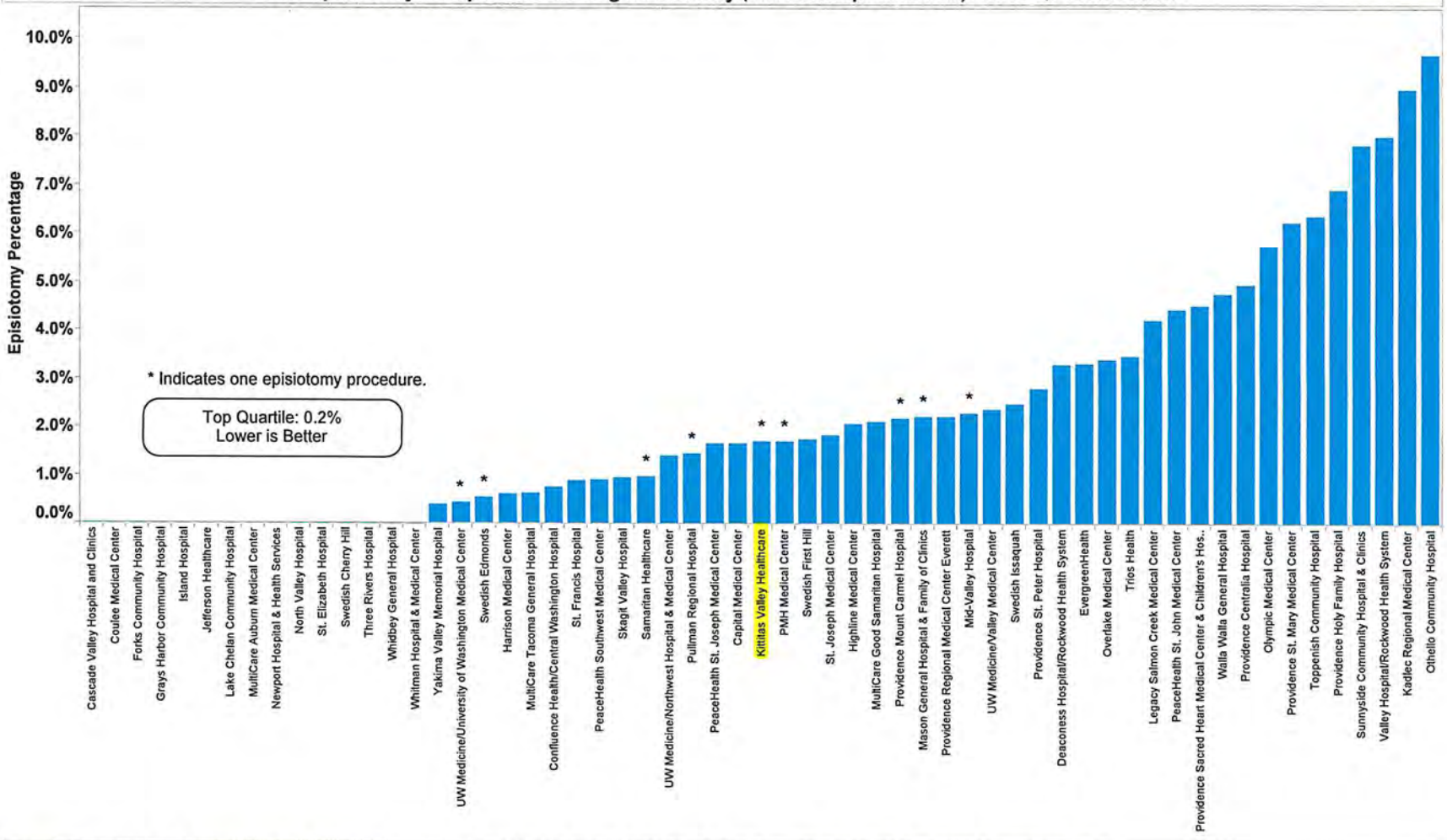
Patient Safety Summary Report - April 2016 Release

OB: Episiotomy for Spontaneous Vaginal Delivery (without forceps or vacuum) - 2015 Q3 Distribution



Definition: Percentage of vaginal deliveries (excluding those coded with shoulder dystocia and the use of instruments) during which an episiotomy is performed.
Data Source: Washington State Department of Health Comprehensive Hospital Abstract Reporting System (CHARS).

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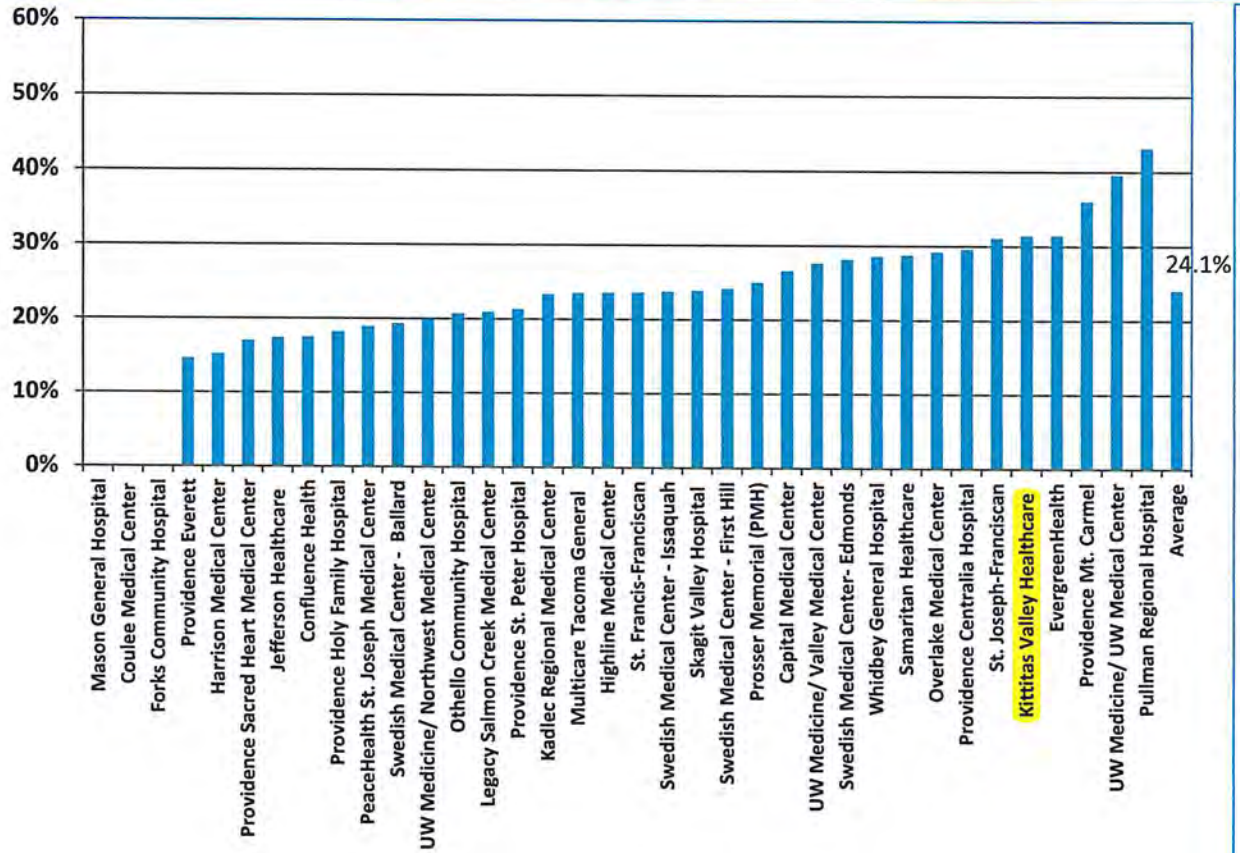
Decision Support

Safe Deliveries Roadmap

NTSV C-section Rate for Nulliparous (first) Deliveries

July-October 2015 Distribution



Hospitals with Missing Data July-October 2015 for NTSV C-section rate, Primary TSV C-section rate and/or Unexpected Newborn Complications rate

Cascade Valley Hospital and Medical Clinics
Deaconess Hospital/Rockwood Health System
Grays Harbor Community Hospital
Island Hospital
Lake Chelan Community Hospital
Mid Valley Hospital
MultiCare Auburn Medical Center
MultiCare Good Samaritan Medical Center
Newport Hospital
North Valley Hospital
Olympic Medical Center
PeaceHealth Southwest Medical Center
PeaceHealth St. John Medical Center
Providence St. Mary Medical Center
St. Elizabeth Hospital, Franciscan
Sunnyside Community Hospital and Clinics
Three Rivers Hospital
Toppenish Community Hospital
Trios Health-Kennewick
Valley Hospital/Rockwood Health System
Walla Walla General Hospital
Whitman Hospital and Medical Center
Yakima Valley Memorial Hospital

Definition: Numerator: Number of patients with a cesarean delivery among the denominator. **Denominator:** Number of deliveries among Nulliparous (first birth) women at term >=37 wks gestational age excluding breech presentations, twins and other multiples (NTSV).

Data Sources: WSHA-MDC (WSHA-Maternal Data Center) and WSHA-QBS (WSHA-Quality Benchmarking System) as of February 29, 2016

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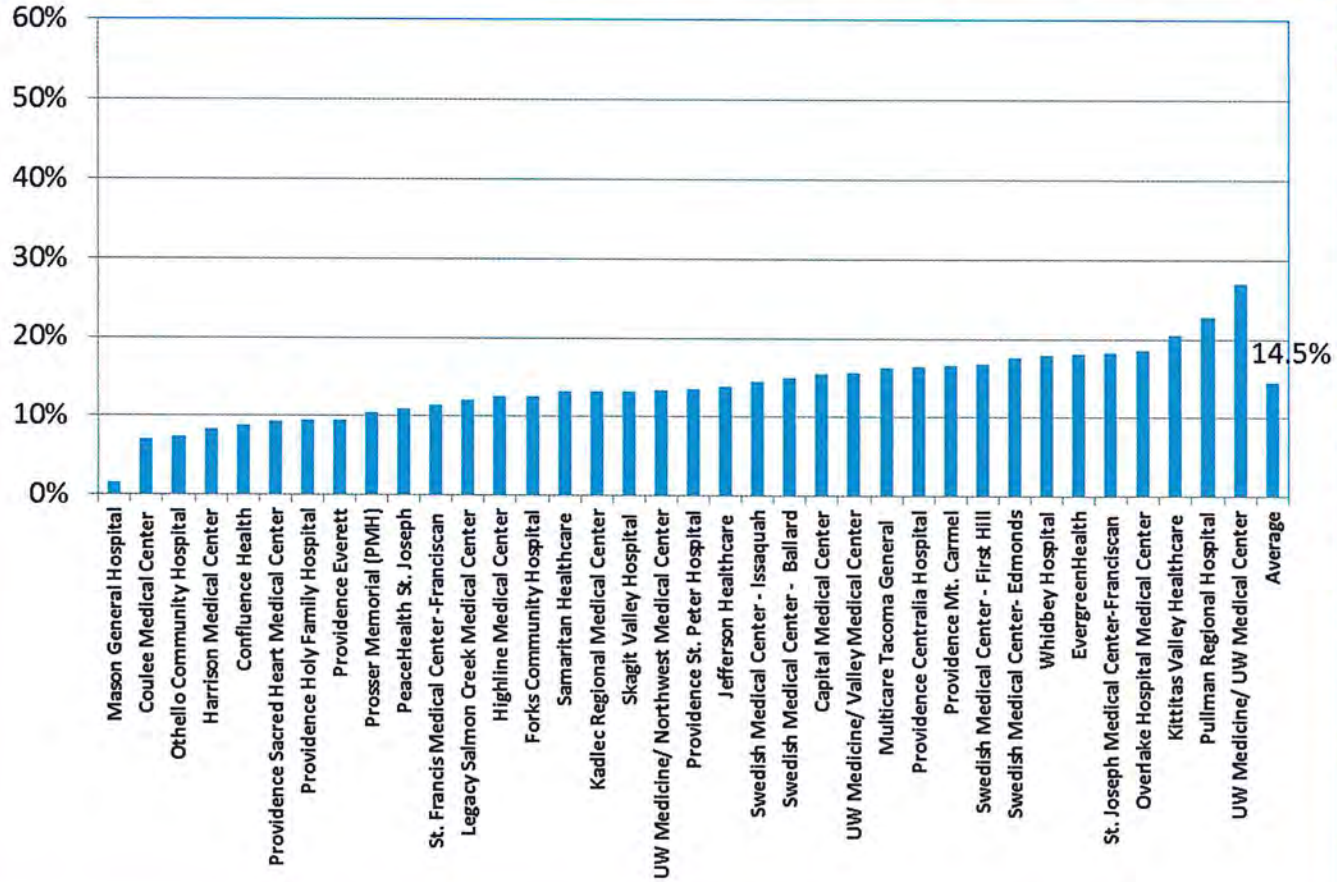
Safe Deliveries Roadmap

Primary C-section Rate (TSV) for Deliveries without Prior C-section

July-October 2015 Distribution



Hospitals with Missing Data July-October 2015 for NTSV C-section rate, Primary TSV C-section rate and/or Unexpected Newborn Complications rate

Cascade Valley Hospital and Medical Clinics
Deaconess Hospital/Rockwood Health System
Grays Harbor Community Hospital
Island Hospital
Lake Chelan Community Hospital
Mid Valley Hospital
MultiCare Auburn Medical Center
MultiCare Good Samaritan Medical Center
Newport Hospital
North Valley Hospital
Olympic Medical Center
PeaceHealth Southwest Medical Center
PeaceHealth St. John Medical Center
Providence St. Mary Medical Center
St. Elizabeth Hospital, Franciscan
Sunnyside Community Hospital and Clinics
Three Rivers Hospital
Toppenish Community Hospital
Trios Health-Kennewick
Valley Hospital/Rockwood Health System
Walla Walla General Hospital
Whitman Hospital and Medical Center
Yakima Valley Memorial Hospital

Definition: Numerator: Number of patients with a first cesarean delivery among the denominator. **Denominator:** Number of deliveries among women at term >=37 wks gestational age who have not had a prior cesarean delivery excluding breech presentations, twins and other multiples (TSV).

Data Sources: WSHA-MDC (WSHA-Maternal Data Center) and WSHA-QBS (WSHA-Quality Benchmarking System) as of February 29, 2016

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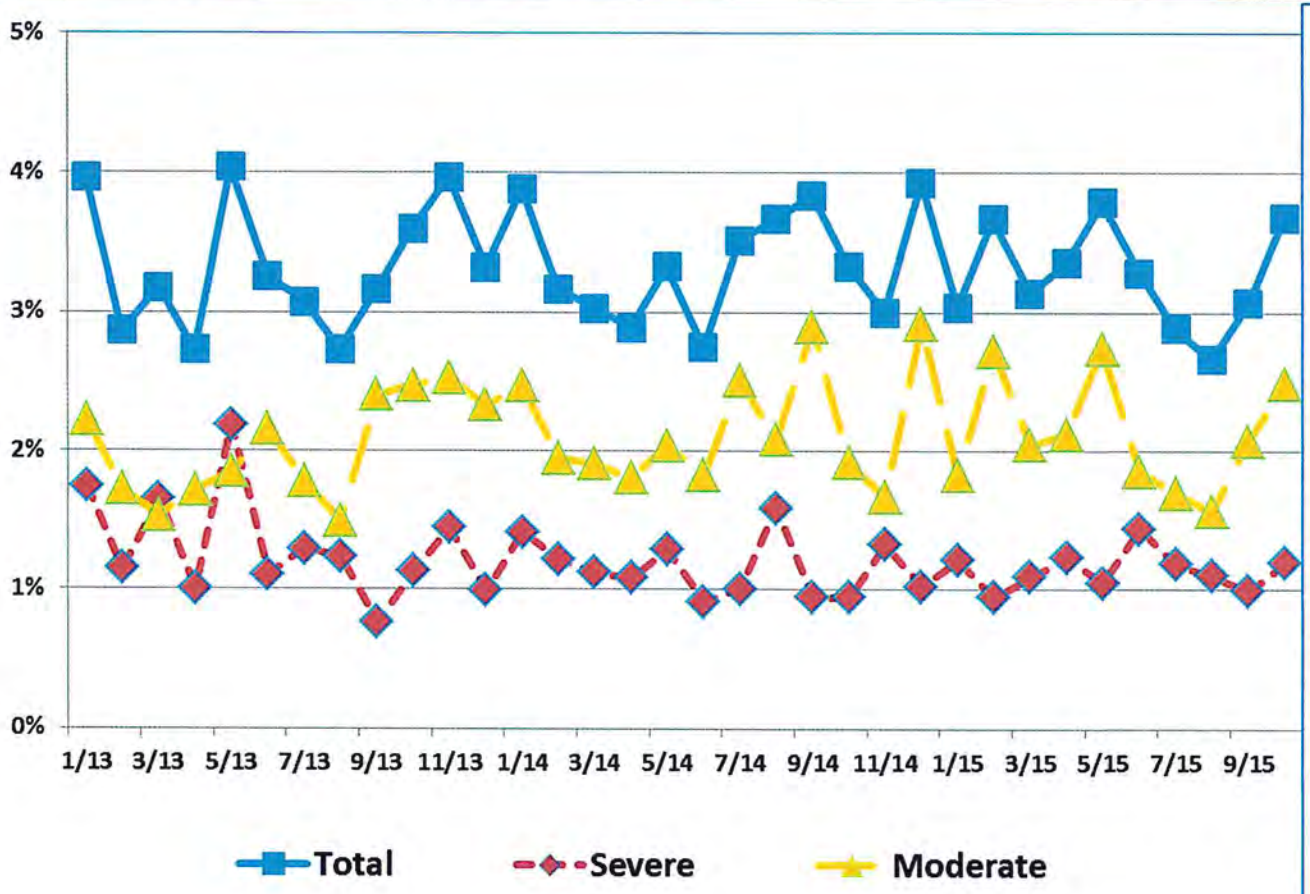
Do You Know Your Newborn Complication Rate ?
Safe Deliveries Roadmap
Newborn Complications Rate (Total, Severe and Moderate) January 2013 - October 2015



Hospitals with Missing Data July-October 2015 for NTSV C-section rate, Primary TSV C-section rate and/or Unexpected Newborn Complications rate

Cascade Valley Hospital and Medical Clinics
Deaconess Hospital/Rockwood Health System
Grays Harbor Community Hospital
Island Hospital
Lake Chelan Community Hospital
Mid Valley Hospital
MultiCare Auburn Medical Center
MultiCare Good Samaritan Medical Center
Newport Hospital
North Valley Hospital
Olympic Medical Center
PeaceHealth Sourthwest Medical Center
PeaceHealth St. John Medical Center
Providence St. Mary Medical Center
St. Elizabeth Hospital, Franciscan
Sunnyside Community Hospital and Clinics
Three Rivers Hospital
Toppenish Community Hospital
Trios Health-Kennewick
Valley Hospital/Rockwood Health System
Walla Walla General Hospital
Whitman Hospital and Medical Center
Yakima Valley Memorial Hospital

Definition: Numerator: Number of newborns with severe or moderate complications among the denominator. **Denominator:** Number of term newborns >= 37 weeks gestational age without preexisting conditions (birth defects, prematurity, small for dates, multiples, and maternal drug use).
Data Sources: WSHA-MDC (WSHA-Maternal Data Center) and WSHA-QBS (WSHA-Quality Benchmarking System) as of February 29, 2016

EXHIBIT "A"

Audit Report – Financial Statements 2015

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Board of Commissioners
Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Ellensburg, Washington

We have audited the financial statements of Kittitas County Public Hospital District No. 1 doing business as Kittitas Valley Healthcare (the District) for the year ended December 31, 2015. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards and *Government Auditing Standards,* as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated December 4, 2015. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the District are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during 2015. We noted no transactions entered into by the District during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the District's financial statements were:

- Management's estimate of the allowance for uncollectable patient accounts receivable and contractual allowances is based on historical collection rates and an analysis of the collectability of existing accounts receivable.
- Management's estimate for third-party payor settlements is based on interim payments, District expenses, and patient statistical data.
- Management's estimate of employee health insurance claims incurred but not reported (IBNR) is based on historical claims data.

We evaluated the key factors and assumptions used to develop the allowance for uncollectable accounts and contractual adjustments, third-party payor settlements, and employee health insurance claims incurred but not reported, in determining that it is reasonable in relation to the financial statements taken as a whole.

The statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

Disagreements with Management

For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditors' report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated May 12, 2016.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the District's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the District's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters

We applied certain limited procedures to the management's discussion and analysis, which is required supplementary information (RSI) that supplements the basic financial statements. Our procedures consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We did not audit the RSI and do not express an opinion or provide any assurance on the RSI.

Restriction on Use

This information is intended solely for the use of Board of Commissioners and management of the District 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
May 12, 2016

DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Board of Commissioners
Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Ellensburg, Washington

In planning and performing our audit of the financial statements of Kittitas County Public Hospital District No. 1 doing business as Kittitas Valley Healthcare (the District) for the year ended December 31, 2015, 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.

However, during our audit, we became aware of several matters that are opportunities for strengthening internal controls and operating efficiency. This letter does not affect our report dated May 12, 2016, 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:

NextGen System Contractual Adjustments and Bad Debt – Currently, the NextGen system is set up so that all contractual adjustments and bad debt are recorded in one account for each clinic in the general ledger. Accounting standards require that revenue is presented at the net amount by payor. Further, those standards also require separate presentation of bad debt adjustments. The current setup does not fulfill these requirements. For financial statement preparation, subsidiary reports were gathered to manually separate the contractual adjustments by payor, and to separate bad debt from the contractual adjustments. These classifications should be setup in the system for better reporting accuracy.

Home Health and Hospice Cash Clearing Accounts – There are two cash clearing accounts with insignificant balances as of December 31, 2015. The District was not tracking and reconciling deposits and postings for home health or hospice, and did not identify timing difference balances maintained in those accounts. We recommend the District implement a cash posting reconciliation process that identifies timing differences between cash postings and accounts receivable postings. This will allow the District to identify the balance composition at each month end to ensure balances are appropriate.

Home Health Deferred Revenue – Currently the District does not have a process in place to track and identify whether any deferred revenue should be recognized. We recommend implementing a system to identify any amounts received for approved episodes of care, which relate to future periods. Revenue should be deferred until the services have been earned and performed.

General Checking Bank Reconciliation – On the December 2015 general checking bank reconciliation we noted $185,000 of deposits received in the District's bank account, which had not been posted to patient accounts, and which had not been reconciled. Most of these represent timing difference between when amounts are received from third party payors, and when those payments are posted. However, some of the transactions date back to the beginning of 2015, indicating these items have been shown as unapplied payments throughout most of 2015. Such transactions should have been applied to the proper patient accounts during the year.

We recommend tracking these through a clearing account in the future, to enable differences resulting from the timing of payments to be properly offset against the related receivable balance. This account should be reconciled daily to ensure all accounts receivable postings are properly matched with cash received.

Fixed asset disposals – In review of the capital additions in 2015, it appeared several of these items may have been replacements of equipment or other fixed assets recorded in previous years. However, there were no disposals recognized for those asset items removed from service. We recommend the District implement procedures to ensure capital assets taken out of service are properly reflected in the accounting records. Items should be removed from the financial records as soon as they are taken out of service.

This report is intended solely for the information and use of the Board of Commissioners, and management of the District, and is not intended to be, and should not be, used by anyone other than these specified parties.

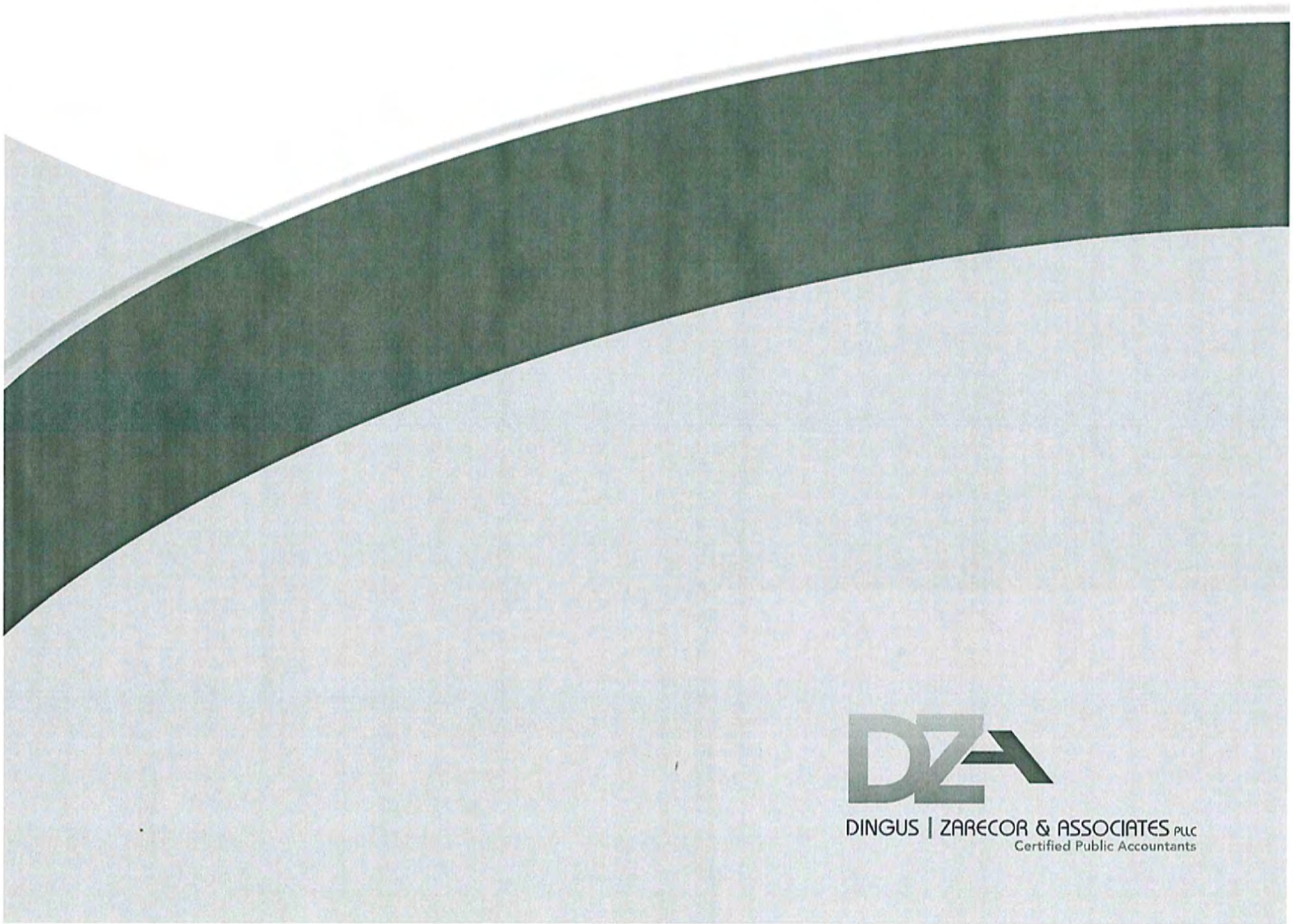
Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
May 12, 2016

Kittitas County
Public Hospital District No. 1
doing business as
Kittitas Valley Healthcare

Financial Statements and
Independent Auditors' Reports

December 31, 2015 and 2014



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DINGUS | ZARECOR & ASSOCIATES PLLC
Certified Public Accountants

Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Table of Contents

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Certified Public Accountants

INDEPENDENT AUDITORS' REPORT

Board of Commissioners
Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Ellensburg, Washington

Report on the Financial Statements

We have audited the accompanying financial statements of Kittitas County Public Hospital District No. 1 doing business as Kittitas Valley Healthcare (the District) as of and for the years ended December 31, 2015 and 2014, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the basic financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

12015 East Main, Suite A | Spokane Valley, WA 99206 | 509.242.0874 | www.dzacpa.com

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of December 31, 2015 and 2014, and the changes in its financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 through 9 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 12, 2016, on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters for the year ended December 31, 2015. We issued a similar report for the year ended December 31, 2014, dated April 9, 2015, which has not been included with the 2015 financial and compliance report. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing for each year, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
May 12, 2016

Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Management's Discussion and Analysis
December 31, 2015 and 2014

Introduction

Kittitas County Public Hospital District No. 1 doing business as Kittitas Valley Healthcare (the District) is a public hospital district serving over 42,500 Kittitas county residents. Licensed for 50 beds with critical access hospital designation the District currently operates 25 acute care beds. In addition to the hospital the District operates three rural health clinics, a women's health clinic, a general surgery clinic, an orthopedic clinic, and an urgent care clinic (providing in person and virtual care). The District also provides the following specialty services: physical therapy, speech therapy, occupational therapy, home health, and hospice.

The following Management's Discussion and Analysis provides an overview of the financial position and activities of the District for the year ended December 31, 2015. Please read it in conjunction with the District's basic financial statements, which begin on page 10.

The following sections are included within this discussion:

- Results of operations for the year ended December 31, 2015
- Opportunities and challenges
- Volumes and statistics
- Overview of required financial statements

The District is committed to transparency in financial reporting and effective stewardship of its assets, and believes this discussion provides such information.

Results of Operations for the Year Ended December 31, 2015

- The District's net position increased in each of the past two years with a $5,094,564 or 11% increase in 2015, and a $6,379,460, or 15%, increase in 2014.
- The District reported operating income of $3,667,892 in 2015, and $4,735,118 in 2014. Operating income decreased by $1,067,226 in 2015, and increased by $810,574 in 2014.
- Nonoperating revenues (net of expenses) increased by $18,400 or 1% in 2015 compared to 2014.

Opportunities and Challenges

Kittitas Valley Healthcare saw a significant volume shift from inpatient to outpatient in 2015. In 2015 the ratio of outpatient revenue to total revenue reached 80%, increasing from 76.2% in 2014. This reflects the anticipated emphasis on treating patients in outpatient settings and reducing inpatient utilization.

The District reinitiated a Master Site Planning process in 2015 and chose to focus initially on the ambulatory setting in line with the focus on outpatient care. The Board approved the Master Site vision in March 2016 and approved moving forward with more detailed planning for Phase 1, including the construction of a medical office building where the various outpatient clinics can be co-located. In order to support the desired model of care the District is also evaluating various possibilities for a "single platform" for our electronic health records. It is anticipated that a recommendation will be made by year end.

Opportunities and Challenges (continued)

Regular focus groups held with District residents have shown increasing support for the provision and utilization of virtual care over the past several years. The organization planned for implementation of a virtual care offering that would function similarly to an urgent care during 2015. The new service was launched in April 2016.

The District continues to be challenged by the shortage of primary care physicians and is actively recruiting for these positions.

The District has had strong performance the past several years, as evidenced by its selection as a top critical access hospital by iVantage Health Analytics and the National Rural Health Association for the fifth time. The District has placed in the top 100 of 1,300 critical access hospitals nationwide in each of the five listings, being one of only seven critical access hospitals in the nation with this distinction. Areas of performance considered for the rankings include quality of care, health outcomes after hospitalization, patient satisfaction, affordability, market share, and financial stability.

Volumes and Statistics

Following are the key operating statistics for the years ended December 31, 2015 and 2014, respectively:

	2015	2014
Inpatient and operating room activity		
Admissions	1,299	1,433
Patient days (without Newborns)	3,348	4,141
Average daily Inpatient Census	9.2	11.3
Average daily Observation Census	2.6	2.3
Ambulatory and emergency services		
Emergency visits	13,618	12,250
Outpatient visits	75,770	77,642
Clinic visits	60,540	59,069
Staffing		
Full time equivalents	439	447

The District's basic financial statements consist of three statements — a Statement of Net Position; a Statement of Revenues, Expenses, and Changes in Net Position; and a Statement of Cash Flows. These financial statements and related notes provide information about the activities of the District, including resources held by the District that are designated for specific purposes by contributors, grantors, or enabling legislation.

The Statement of Net Position and Statement of Revenues, Expenses, and Changes in Net Position

Our analysis of the District's finances begins below. The Statement of Net Position and the Statement of Revenues, Expenses, and Changes in Net Position report information about the District's resources and its activities for the period. The Statement of Revenues, Expenses, and Changes in Net Position shows whether the District was able to recover all of its costs through patient service and other revenue. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All of the current year's revenues and expenses are taken into account regardless of when the cash is received or paid.

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

These statements report the District's net position and changes in net position. The difference between the District's assets and liabilities is one way to measure the District's financial health, or financial position. Over time, increases or decreases in the District's net position are one indicator of whether its financial health is improving or deteriorating. You will need to consider other nonfinancial factors, however, such as changes in the District's patient base and measures of the quality of service provided to the community, as well as local economic factors to assess the overall health of the District.

The Statement of Cash Flows

The final required statement is the Statement of Cash Flows. The statement reports cash receipts, cash payments, and net changes in cash resulting from operations, investing, and financing activities. This statement provides meaningful information on how the District's cash was generated and how it was used.

The District's Net Position

The District's net position is the difference between its assets and liabilities reported in the Statement of Net Position on pages 10 and 11. The District's net position increased by $5,094,564, or 11% in 2015 and by $6,379,460, or 15% in 2014 as shown in Table 1.

The significant changes in assets and liabilities in 2015 were as follows:

- Total assets for the District were $65,615,003 at the end of 2015, an increase of $2,921,852 over the balance of $62,693,151 at the end of 2014.

  Current assets increased $502,556 from $19,928,701 to $20,431,257 in 2015. Net patient receivables of $7,079,048 in 2015 decreased $1,171,397 from $8,250,445 at the end of 2014.

  Noncurrent assets increased $2,419,296 to $45,183,746 from $42,764,450 in 2015.

- Total liabilities for the District were $12,660,606 in 2015, a decrease of $2,172,712 from the balance of $14,833,318 in 2014.

  Current liabilities decreased $701,567 from $7,607,062 at the end of 2014 to $6,905,495 at the end of 2015. Accrued payroll liabilities decreased $636,573 from $1,916,548 to $1,279,975 at the end of 2015. Accounts payable decreased $219,087 from $1,448,711 at the end of 2014 to $1,229,624 at the end of 2015.

  Long-term debt obligations decreased $1,471,145 from $7,226,256 in 2014 to a balance of $5,755,111 in 2015 reflecting the payment of principal on outstanding debt.

Table 1. Assets, Liabilities, and Net Position

	2015	2014	2013
Assets			
Current assets	$ **20,431,257**	$ 19,928,701	$ 15,069,432
Capital assets, net	**22,083,402**	22,572,861	23,496,917
Other noncurrent assets	**23,100,344**	20,191,589	18,054,043
Total assets	$ **65,615,003**	$ 62,693,151	$ 56,620,392
Liabilities			
Current liabilities	$ **6,905,495**	$ 7,607,062	$ 6,346,536
Long-term obligations, net of current maturities	**5,755,111**	7,226,256	8,793,483
Total liabilities	**12,660,606**	14,833,318	15,140,019
Net position			
Net investment in capital assets	**14,431,217**	13,396,583	13,030,407
Restricted	**387,978**	374,221	373,901
Unrestricted	**38,135,202**	34,089,029	28,076,065
Total net position	**52,954,397**	47,859,833	41,480,373
Total liabilities and net position	$ **65,615,003**	$ 62,693,151	$ 56,620,392

Operating Results and Changes in the District's Net Position

In 2015, the District's net position increased by $5,094,564, or 11%, as shown in Table 2. The District's net position increased by $6,379,460 or 15%, in 2014.

Table 2. Operating Results and Changes in Net Position

	2015	2014	2013
Operating revenues			
Net patient service revenues	$ 68,576,546	$ 68,647,024	$ 62,950,761
Other operating revenues	833,162	145,329	1,155,184
Total operating revenues	69,409,708	68,792,353	64,105,945
Operating expenses			
Salaries and benefits	41,341,486	39,867,520	37,757,875
Supplies	8,380,628	8,776,846	7,754,267
Depreciation	2,689,974	2,715,867	2,888,878
Other operating expenses	13,329,728	12,697,002	11,780,381
Total operating expenses	65,741,816	64,057,235	60,181,401
Operating income	3,667,892	4,735,118	3,924,544
Nonoperating revenues (expenses)			
Taxation	1,253,497	1,184,875	1,122,432
Investment income	241,828	288,993	(93,326)
Rental income, net	204,752	197,624	201,940
Interest expense	(327,179)	(398,560)	(461,249)
Gain (loss) on disposal of capital assets	(7,882)	73,684	(6,128)
Total nonoperating revenues, net	1,365,016	1,346,616	763,669
Change in net position before capital grants and contributions	5,032,908	6,081,734	4,688,213
Capital grants and contributions	61,656	297,726	411,114
Change in net position	5,094,564	6,379,460	5,099,327
Net position, beginning of year	47,859,833	41,480,373	36,381,046
Net position, end of year	$ 52,954,397	$ 47,859,833	$ 41,480,373

Operating Income

The first component of the overall change in the District's net position is operating income – the difference between net patient service revenues and the expenses incurred to perform those services. In each of the past two years, the District has reported operating income. Operating income decreased $1,067,226 from 2014 to 2015.

The primary components of the change in operating income for 2015 compared to 2014 are:

- Net patient revenue decreased $70,478.
- Salaries and wages increased $679,155.
- Employee benefits overall increased $794,811.
- Purchased service expenses increased $472,755.
- Supplies expense decreased $396,218.

Nonoperating Revenues and Expenses

Nonoperating revenues consist primarily of property taxes levied for repayment of the District's Bonds, interest revenue, and rental income. Net nonoperating revenues and expenses increased by $18,400, or 1% in 2015.

The District's Cash Flows

Changes in the District's cash flows are consistent with changes in operating incomes and nonoperating revenues and expenses discussed earlier.

Capital Asset and Debt Administration

Capital Assets

Net capital assets decreased in 2015 by $489,459 or 2% from 2014. Capital purchases for 2015 totaled $2,209,947. This amount includes construction in progress. Depreciation expense for 2015 totaled $2,689,974.

At the end of 2015, the District had $22,083,402 invested in capital assets, net of accumulated depreciation, as detailed in Note 5 to the financial statements. In 2015, the District placed into service new moveable equipment costing $1,328,940. In 2014, the District placed into service new moveable equipment costing $909,393.

Major capital expenditures in 2015 included a new ultrasound imaging system for $167,255, a time and attendance system for $285,548, meaningful use equipment for $541,507 and operating room software and hardware for $144,160.

Debt

At December 31, 2015, the District had $5,755,111 in long-term debt obligations, a reduction of $1,471,145 from December 31, 2014.

The District's formal debt issuances cannot be issued without approval of the District's Board of Commissioners. The amount of debt issued is subject to limitations that apply to the District. There have been no changes in the District's debt ratings in the past two years.

Contacting the District's Financial Management

This financial report is designed to provide our patients, suppliers, taxpayers, and creditors with a general overview of the District's finances and to show the District's accountability for the money it receives. If you have questions about this report or need additional information, contact the District administration at 603 South Chestnut Street, Ellensburg, Washington 98926.

Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Statements of Net Position
December 31, 2015 and 2014

ASSETS	2015	2014
Current assets		
Cash and cash equivalents	$ 9,419,986	$ 9,319,236
Receivables:		
Patients, net of estimated uncollectibles of approximately $2,347,000 and $2,476,000, respectively	7,079,048	8,250,445
Estimated third-party payor settlements	1,650,000	333,143
Electronic health records incentive payment	390,000	-
Other	60,363	187,908
Inventories	910,035	989,316
Prepaid expenses	579,945	520,530
Investments restricted for debt service	341,880	328,123
Total current assets	20,431,257	19,928,701
Noncurrent assets		
Investments internally designated for capital acquisitions	23,054,246	20,145,491
Taxes receivable restricted for debt service	46,098	46,098
Capital assets, net	22,083,402	22,572,861
Total noncurrent assets	45,183,746	42,764,450
Total assets	$ 65,615,003	$ 62,693,151

See accompanying notes to basic financial statements.

Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Statements of Net Position (Continued)
December 31, 2015 and 2014

LIABILITIES AND NET POSITION	2015	2014
Current liabilities		
Accounts payable	$ 1,229,624	$ 1,448,711
Accounts payable, capital	444,808	399,437
Accrued payroll and related liabilities	1,279,975	1,916,548
Accrued vacation	1,713,652	1,666,853
Estimated third-party payor settlements	785,170	178,326
Electronic health records incentive payment payable	-	446,602
Accrued interest	27,708	32,348
Current portion of long-term debt	1,424,558	1,518,237
Total current liabilities	6,905,495	7,607,062
Noncurrent liabilities		
Long-term debt net of current portion and bond premium	5,755,111	7,226,256
Total liabilities	12,660,606	14,833,318
Net position		
Net investment in capital assets	14,431,217	13,396,583
Restricted under bond agreements	387,978	374,221
Unrestricted	38,135,202	34,089,029
Total net position	52,954,397	47,859,833
Total liabilities and net position	$ 65,615,003	$ 62,693,151

See accompanying notes to basic financial statements.

Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2015 and 2014

	2015	2014
Operating revenues		
Net patient service revenue, net of provision for bad debts of approximately $2,135,000 and $2,651,000, respectively	$ 68,576,546	$ 68,647,024
Grants	10,916	87,947
Electronic health records incentive payment	390,000	(446,602)
Other	432,246	503,984
Total operating revenues	69,409,708	68,792,353
Operating expenses		
Salaries and wages	33,359,405	32,680,250
Employee benefits	7,982,081	7,187,270
Professional fees	2,810,657	2,809,457
Purchased services	4,116,090	3,643,335
Supplies	8,380,628	8,776,846
Insurance	544,527	670,444
Leases and rentals	1,074,810	994,375
Depreciation	2,689,974	2,715,867
Repairs and maintenance	2,059,754	1,970,726
Utilities	865,124	849,832
Licenses and taxes	900,293	856,786
Education and travel	340,178	455,308
Other	618,295	446,739
Total operating expenses	65,741,816	64,057,235
Operating income	3,667,892	4,735,118
Nonoperating revenues (expenses)		
Taxation for maintenance and operations	25,384	15,162
Taxation for debt service	1,228,113	1,169,713
Investment income	241,828	288,993
Rental income	204,752	197,624
Interest expense	(327,179)	(398,560)
Gain (loss) on disposal of capital assets	(7,882)	73,684
Total nonoperating revenues, net	1,365,016	1,346,616
Change in net position before capital grants and contributions	5,032,908	6,081,734
Capital grants and contributions	61,656	297,726
Change in net position	5,094,564	6,379,460
Net position, beginning of year	47,859,833	41,480,373
Net position, end of year	$ 52,954,397	$ 47,859,833

See accompanying notes to basic financial statements.

Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Statements of Cash Flows
Years Ended December 31, 2015 and 2014

	2015	2014
Increase (Decrease) in Cash and Cash Equivalents		
Cash flows from operating activities		
Cash received from and on behalf of patients	$ 69,037,930	$ 68,608,677
Cash received from other revenue	449,868	468,128
Cash received from operating grants	10,916	87,947
Cash paid to and on behalf of employees	(41,821,337)	(39,932,270)
Cash paid to suppliers and contractors	(21,909,577)	(20,815,224)
Cash (refunded for) received from electronic health records incentive payment	(446,602)	173,530
Net cash provided by operating activities	5,321,198	8,590,788
Cash flows from noncapital financing activities		
Taxes received for maintenance and operations	25,384	15,162
Cash flows from capital and related financing activities		
Purchase of capital assets	(2,163,026)	(1,318,690)
Principal payments on long-term debt	(1,611,411)	(1,632,007)
Interest paid	(285,232)	(456,222)
Proceeds from capital grants and contributions	61,656	297,726
Taxes received for bond principal and interest	1,228,113	1,167,135
Net cash used in capital and related financing activities	(2,769,900)	(1,942,058)
Cash flows from investing activities		
Purchase of investments	(5,563,757)	(1,997,742)
Proceeds from sale and maturity of investments	2,655,000	-
Interest received	228,073	154,025
Rents received	204,752	197,624
Net cash used in investing activities	(2,475,932)	(1,646,093)
Net increase in cash and cash equivalents	100,750	5,017,799
Cash and cash equivalents, beginning of year	9,319,236	4,301,437
Cash and cash equivalents, end of year	$ 9,419,986	$ 9,319,236

See accompanying notes to basic financial statements.

Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Statements of Cash Flows (Continued)
Years Ended December 31, 2015 and 2014

	2015	2014
Reconciliation of Operating Income to Net Cash Provided by Operating Activities		
Operating income	$ 3,667,892	$ 4,735,118
Adjustments to reconcile operating income to net cash provided by operating activities		
Depreciation	2,689,974	2,715,867
Provision for bad debts	2,134,810	2,650,748
Decrease (increase) in assets:		
Receivables:		
Patient accounts, net	(963,413)	(2,637,540)
Estimated third-party payor settlements	(1,316,857)	(6,960)
Electronic health records incentive payment	(390,000)	173,530
Other	127,545	(145,779)
Inventories	79,281	(73,722)
Prepaid expenses	(59,415)	195,995
Increase (decrease) in liabilities:		
Accounts payable	(219,087)	536,351
Accrued payroll and related liabilities	(636,573)	128,998
Accrued vacation	46,799	(83,825)
Estimated third-party payor settlements	606,844	(44,595)
Electronic health records incentive payable	(446,602)	446,602
Net cash provided by operating activities	$ 5,321,198	$ 8,590,788

See accompanying notes to basic financial statements.

1. Reporting Entity and Summary of Significant Accounting Policies:

a. Reporting Entity

Kittitas County Public Hospital District No. 1 doing business as Kittitas Valley Healthcare (the District) is organized as a municipal corporation pursuant to the laws of the state of Washington for municipal corporations.

The District is a critical access hospital with 25 acute-care, critical care, and birthing center beds. Services offered by the Hospital include medical, surgical, labor/delivery and nursery care, 24-hour emergency, laboratory, imaging services, physical therapy, respiratory care, home health, hospice, cardiac rehabilitation, clinics, and a wellness program. Members of the medical staff include specialists in emergency medicine, family practice, internal medicine, general surgery, gynecology, orthopedics, urology, radiology, pathology, and inpatient hospitalization. The District owns and operates three rural health clinics, three provider based clinics, and an urgent care center.

As organized, the District is exempt from federal income tax. The Board of Commissioners is made up of five community members elected to six-year terms.

Related organization – The Kittitas Valley Community Hospital Foundation (the Foundation) is a legally separate organization exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code that acts primarily as a fundraising organization to supplement the resources that are available to the District in support of its programs. The Board consists of 15 to 25 members, of which no more than 25% can be associated with Kittitas Valley Healthcare as an employee or medical staff member. At all times, a majority of the Foundation Board of Directors shall be directly appointed by the Board of Commissioners of Kittitas County Public Hospital District No. 1 and the balance by the Foundation Board of Directors. The Foundation is not material to the District and is therefore not reported as a component unit of the District.

b. Summary of Significant Accounting Policies

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise fund accounting – The District's accounting policies conform to accounting principles generally accepted in the United States of America as applicable to proprietary funds of governments. The District uses enterprise fund accounting. Revenue and expenses are recognized on the accrual basis using the economic resources measurement focus.

Cash and cash equivalents – Cash and cash equivalents include investments in highly liquid debt instruments with an original maturity of three months or less. Cash receipts are deposited directly to the District's depository accounts at banks. Periodically, such cash is transferred to the operating accounts and warrants are issued against these accounts.

1. **Reporting Entity and Summary of Significant Accounting Policies (continued):**

   b. **Summary of Significant Accounting Policies (continued)**

   Investments – Investments in debt and equity securities are reported at fair value. Interest, dividends, and gains and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenue when earned.

   Inventories – Inventories consist of medical supplies, drugs, and food and are stated at cost using the first-in, first-out method.

   Investments internally designated for capital acquisitions – Assets internally designated for capital acquisitions are assets set aside by the Board of Commissioners in a funded depreciation account for future capital improvements, over which the Board retains control and could subsequently use for other purposes.

   Investments and taxes receivable restricted for debt service – Such assets are set aside for repayment of bond principal and interest as required by bond indenture.

   Capital assets – The District capitalizes assets whose costs exceed $5,000 and with an estimated useful life of at least two years; lesser amounts are expensed. Capital assets are stated at cost or estimated fair value at the date of donation. Expenditures for maintenance and repairs are charged to operations as incurred; betterments and major renewals are capitalized. When such assets are disposed of, the related costs and accumulated depreciation or amortization are removed from the accounts and the resulting gain or loss is classified in nonoperating revenues or expenses.

   Compensated absences – The District's nonunion contract employees earn paid time off (PTO) based upon years of service. The related liability is accrued during the period in which it is earned. Depending on years of service, PTO accrues from 200 to 480 hours per year. The District's policy is to permit employees to carry these hours from one year to the next. After using at least 80 hours of PTO, employees may cash out between 40 and 120 hours of PTO, as long as they leave 24 hours in their PTO bank. Union contract employees earn vacation instead of PTO, which is also earned based upon years of service. Vacation accrues from 80 to 200 hours per year, depending on years of service. Union contract employees also receive time off for eight holidays, and may choose to save the holiday and instead accrue up to 48 hours per year of holiday time. On termination of employment, an employee or union contract employee shall be paid all accrued, but unused hours provided he/she has given the notice required by personnel policies and the employee has not been terminated for cause.

   Net position – Net position of the District is classified into three components. *Net investment in capital assets* consists of capital assets net of accumulated depreciation and reduced by the balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted net position* is noncapital net position that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District. *Unrestricted net position* is the remaining net position that does not meet the definition of *net investment in capital assets* or *restricted.*

1. **Reporting Entity and Summary of Significant Accounting Policies (continued):**

   b. **Summary of Significant Accounting Policies (continued)**

   Operating revenues and expenses – The District's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions, including grants for specific operating activities associated with providing healthcare services — the District's principal activity. Nonexchange revenues, including taxes and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide healthcare services, other than financing costs.

   Restricted resources – When the District has both restricted and unrestricted resources available to finance a particular program, it is the District's policy to use restricted resources before unrestricted resources.

   Grants and contributions – From time to time, the District receives grants from the state of Washington and others, as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are restricted to specific capital acquisitions are reported after nonoperating revenues and expenses. Grants that are for specific projects or purposes related to the District's operating activities are reported as operating revenue. Grants that are used to subsidize operating deficits are reported as nonoperating revenue. Contributions, except for capital contributions, are reported as nonoperating revenue.

   Subsequent events – The District has evaluated subsequent events through May 12, 2016, the date on which the financial statements were available to be issued.

2. **Deposits and Investments:**

   The *Revised Code of Washington,* Chapter 39, authorizes municipal governments to invest their funds in a variety of investments including federal, state, and local government certificates, notes, or bonds; the Washington State Local Government Investment Pool; savings accounts in qualified public depositories; and certain other investments. The District maintains an investment policy designed to maximize return and limit the following types of risks:

   Custodial credit risk – Custodial credit risk is the risk that, in the event of a failure of the counterparty, the District will not be able to recover the value of the deposits or investments that are in the possession of an outside party. All District deposits are entirely covered by the Federal Deposit Insurance Corporation or by collateral held in multiple financial institution collateral pools administered by the Washington Public Deposit Protection Commission, and all investments are insured, registered, or held by the District's agent in the District's name. The District's investment policy does not contain policy requirements that would limit the exposure to custodial risk for investments.

   Credit risk – Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is typically measured by the assignment of a rating by a nationally recognized statistical rating organization. The District does have a policy specifically requiring or limiting investments of type.

2. Deposits and Investments (continued):

Concentration of credit risk – The inability to recover the value of deposits, investments, or collateral securities in the possession of an outside party caused by a lack of diversification (investments acquired from a single issuer). The District does have a policy limiting the amount it may invest in any one issuer or multiple issuers.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates could adversely affect an investment's fair value. The District does have a policy specifically managing its exposure to fair value losses arising from changing interest rates.

The District had the following investments:

	2015				
		Investment Maturities (in Years)			
	Carrying Amount	Less Than One	One to Five	More Than Five	Investment Ratings
Fannie Mae	$ 1,009,119	$ -	$ 1,009,119	$ -	AAA
Federal Farm Credit Bank	7,059,819	-	7,059,819	-	AAA
Federal Home Loan Mortgage	5,604,884	-	5,604,884	-	AAA
Federal National Mortgage Association	8,693,649	-	8,693,649	-	AAA
Financing Corporation (FICO)	1,028,655	-	1,028,655	-	AAA
Totals	**$ 23,396,126**	**$ -**	**$ 23,396,126**	**$ -**	

	2014				
		Investment Maturities (in Years)			
	Carrying Amount	Less Than One	One to Five	More Than Five	Investment Ratings
Fannie Mae	$ 1,010,693	$	$ 1,010,693	$	AAA
Federal Farm Credit Bank	5,559,415	-	5,559,415	-	AAA
Federal Home Loan Mortgage	3,578,025	-	3,578,025	-	AAA
Federal National Mortgage Association	8,703,678	-	8,703,678	-	AAA
Financing Corporation (FICO)	1,621,803	-	1,621,803	-	AAA
Totals	**$ 20,473,614**	**$ -**	**$ 20,473,614**	**$ -**	

2. Deposits and Investments (continued):

The carrying amounts of deposits and investments shown above are included in the District's statements of net position as follows:

	2015	2014
Deposits:		
Cash and cash equivalents	$ 9,419,986	$ 9,319,236
Investments:		
Restricted for debt service	341,880	328,123
Designated for capital acquisitions	23,054,246	20,145,491
Total investments	23,396,126	20,473,614
Total deposits and investments	**$ 32,816,112**	**$ 29,792,850**

3. Patient Accounts Receivable:

Patient accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectibility of patient accounts receivable, the District analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the District analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which include both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the District records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts. The District's allowance for uncollectible accounts for self-pay patients has not changed significantly from prior years. The District does not maintain a material allowance for uncollectible accounts from third-party payors, nor did it have significant writeoffs from third-party payors.

3. Patient Accounts Receivable (continued):

Patient accounts receivable reported as current assets by the District consisted of these amounts:

	2015	2014
Receivables from patients and their insurance carriers	$ 6,824,973	$ 8,362,564
Receivables from Medicare	1,823,040	1,360,156
Receivables from Medicaid	777,668	1,003,725
Total patient accounts receivable	9,425,681	10,726,445
Less allowance for uncollectible accounts	2,346,633	2,476,000
Patient accounts receivable, net	**$ 7,079,048**	$ 8,250,445

4. Property Taxes:

The County Treasurer acts as an agent to collect property taxes levied in the County for all taxing authorities. Taxes are levied annually on January 1 on property values listed as of the prior May 31. Assessed values are established by the County Assessor at 100% of fair market value. A revaluation of all property is required every four years.

Taxes are due in two equal installments on April 30 and October 31. Collections are distributed monthly to the District by the County Treasurer.

The District is permitted by law to levy up to $0.75 per $1,000 of assessed valuation for general District purposes. Washington State Constitution and Washington State Law, RCW 84.55.010, limit the rate. The District currently levies taxes at a lower rate, as is listed below. Further amounts of tax must be authorized by the vote of the people.

The District's portion of the regular tax levy available for maintenance and operations was $0.0022 per $1,000 on a total assessed valuation of $3,548,013,624 and $3,448,977,267 for a total regular levy of $7,930 and $7,667 in 2015 and 2014, respectively. The District also receives local timber taxes in addition to the regular tax levy.

The District's bond levy was $0.3482 and $0.3396 per $1,000 on a total assessed valuation of $3,522,755,024 and $3,419,506,314, for a total bond levy of $1,226,725 and $1,161,514 in 2015 and 2014, respectively.

Property taxes are recorded as receivables when levied. Since state law allows for sale of property for failure to pay taxes, no estimate of uncollectible taxes is made.

5. Capital Assets:

All capital assets, other than land and construction in progress, are being depreciated using the straight-line method over the estimated useful life of the equipment. Useful lives have been estimated as follows:

Land improvements	5 to 25 years
Buildings and improvements	5 to 40 years
Fixed equipment	5 to 20 years
Major movable equipment	3 to 20 years

Capital asset additions, retirements, transfers, and balances were as follows:

	Balance December 31, 2014	Additions	Retirements	Transfers	Balance December 31, 2015
Capital assets not being depreciated					
Land	$ 1,081,416	$ -	$ -	$ -	$ 1,081,416
Construction in progress	770,174	1,789,726	(109)	(1,165,214)	1,394,577
Total capital assets not being depreciated	1,851,590	1,789,726	(109)	(1,165,214)	2,475,993
Capital assets being depreciated					
Land improvements	409,791	-	-	-	409,791
Buildings and improvements	25,492,196	99,461	-	79,503	25,671,160
Fixed equipment	4,807,243	77,531	(385,726)	-	4,499,048
Major movable equipment	20,627,283	243,229	(85,226)	1,085,711	21,870,997
Total capital assets being depreciated	51,336,513	420,221	(470,952)	1,165,214	52,450,996
Less accumulated depreciation for					
Land improvements	(392,563)	(3,231)	-	(3,770)	(399,564)
Buildings and improvements	(11,344,214)	(866,877)	-	6,774	(12,204,317)
Fixed equipment	(3,140,429)	(229,261)	380,010	(4,295)	(2,993,975)
Major movable equipment	(15,738,036)	(1,590,605)	81,619	1,291	(17,245,731)
Total accumulated depreciation	(30,615,242)	(2,689,974)	461,629	-	(32,843,587)
Total capital assets being depreciated, net	20,721,271	(2,269,753)	(9,323)	1,165,214	19,607,409
Capital assets, net	$ 22,572,861	$ (480,027)	$ (9,432)	$ -	$ 22,083,402

5. Capital Assets (continued):

Capital asset additions, retirements, transfers, and balances were as follows:

	Balance December 31, 2013	Additions	Retirements	Transfers	Balance December 31, 2014
Capital assets not being depreciated					
Land	$ 1,081,416	$ -	$ -	$ -	$ 1,081,416
Construction in progress	223,301	770,174	-	(223,301)	770,174
Total capital assets not being depreciated	1,304,717	770,174	-	(223,301)	1,851,590
Capital assets being depreciated					
Land improvements	409,791	-	-	-	409,791
Buildings and improvements	25,317,588	149,204	-	25,404	25,492,196
Fixed equipment	4,719,990	84,003	-	3,250	4,807,243
Major movable equipment	20,003,907	714,746	(286,017)	194,647	20,627,283
Total capital assets being depreciated	50,451,276	947,953	(286,017)	223,301	51,336,513
Less accumulated depreciation					
Land improvements	(385,562)	(3,231)	-	(3,770)	(392,563)
Buildings and improvements	(10,471,208)	(876,027)	-	3,021	(11,344,214)
Fixed equipment	(2,910,637)	(229,357)	-	(435)	(3,140,429)
Major movable equipment	(14,491,669)	(1,607,252)	359,701	1,184	(15,738,036)
Total accumulated depreciation	(28,259,076)	(2,715,867)	359,701	-	(30,615,242)
Total capital assets being depreciated, net	22,192,200	(1,767,914)	73,684	223,301	20,721,271
Capital assets, net	$ 23,496,917	$ (997,740)	$ 73,684	$ -	$ 22,572,861

Significant construction in progress at December 31, 2015, consisted of the following:

- Energy Services Project, which includes installation of a new central chilled water plant. This project is expected to be completed by April 2016, with an estimated cost to complete of $2,900,000.
- Data center infrastructure upgrades, which is expected to be completed by April 2016, with minimal additional cost remaining.
- A new human resources information system, which is expected to be complete in December 2016, with an estimated cost to complete of approximately $192,000.
- Master facility planning, which will consist of expansion of the existing facilities. This project is in the planning stage, and as such, an estimated date and cost of completion cannot be accurately estimated.

6. Long-term Debt:

A schedule of changes in the District's long-term debt is as follows:

	Balance December 31, 2014	Additions	Reductions	Balance December 31, 2015	Amounts Due Within One Year
Bonds and notes payable					
2005 Limited Tax General Obligation and Revenue Bonds	$ 84,135	$ -	$ (84,135)	$ -	$ -
2008 Unlimited Tax General Obligation Refunding Bonds	4,695,000	-	(1,010,000)	3,685,000	1,110,000
Bond Premium	143,369	-	(46,587)	96,782	-
2009 Limited Tax General Obligation and Revenue Bonds	3,698,899	-	(301,012)	3,397,887	314,558
Notes payable	123,090	-	(123,090)	-	-
Total long-term debt	**$ 8,744,493**	**$ -**	**$ (1,564,824)**	**$ 7,179,669**	**$ 1,424,558**

	Balance December 31, 2013	Additions	Reductions	Balance December 31, 2014	Amounts Due Within One Year
Bonds and notes payable					
2005 Limited Tax General Obligation and Revenue Bonds	$ 411,791	$ -	$ (327,656)	$ 84,135	$ 84,135
2008 Unlimited Tax General Obligation Refunding Bonds	5,610,000	-	(915,000)	4,695,000	1,010,000
Bond Premium	196,892	-	(53,523)	143,369	-
2009 Limited Tax General Obligation and Revenue Bonds	3,986,949	-	(288,050)	3,698,899	301,012
Notes payable	224,391	-	(101,301)	123,090	123,090
Total long-term debt	**$ 10,430,023**	**$ -**	**$ (1,685,530)**	**$ 8,744,493**	**$ 1,518,237**

6. **Long-term Debt (continued):**

Long-term debt – The terms and due dates of the District's long-term debt are as follows:

- Unlimited Tax General Obligation Bonds (Refunding), dated May 15, 2008 (the 2008 Bonds), in the original amount of $8,570,000, for the purpose of improvements and expansion of District facilities and the refinancing of existing debt. In conjunction with this bond issuance, the Unlimited Tax General Obligation Bonds dated December 1, 1998, were refunded. The 2008 Bonds are payable annually on December 1 in the remaining principal amounts ranging from $1,110,000 in 2016 to $1,355,000 in 2018. Interest at rates ranging from 4.00% to 5.25% is due semiannually on June 1 and December 1. The District irrevocably pledged to levy and collect taxes annually without limitations to rate or amount in sufficient amounts to pay the bond principal and interest payments when due. Such collections are reported as assets restricted as to use.
- Limited Tax General Obligation and Revenue Bonds, dated October 27, 2009, in the original amount of $5,000,000, for the purpose of improvements and expansion of District facilities. The bonds are payable annually on December 1 in the remaining principal amounts ranging from $314,558 to $447,332 through 2024. Interest at 4.50% is due semiannually on June 1 and December 1. The District has irrevocably pledged to include in its budget and levy taxes annually on all of the property within the District subject to taxation in amounts that will be sufficient to pay the principal and interest on the bonds as they become due.
- Limited Tax General Obligation and Revenue Bonds, dated October 27, 2009, in the original amount of $5,000,000, for the purpose of improvements and expansion of District facilities. These bonds were paid off in 2015.
- Note payable to De Lage Landen dated October 1, 2010. This note payable was paid off in 2015.
- Note payable to De Lage Landen dated November 11, 2010. This note payable was paid off in 2015.

6. Long-term Debt (continued):

Aggregate annual principal and interest payments over the terms of long-term debt are as follows:

Years Ending December 31,	Unlimited Tax General Obligation Refunding Bonds		
	Principal	Interest	Total
2016	$ 1,110,000	$ 179,588	$ 1,289,588
2017	1,220,000	135,186	1,355,186
2018	1,355,000	71,138	1,426,138
	$ 3,685,000	**$ 385,912**	**$ 4,070,912**

Years Ending December 31,	Limited Tax General Obligation and Revenue Bonds		
	Principal	Interest	Total
2016	$ 314,558	$ 152,905	$ 467,463
2017	328,713	138,750	467,463
2018	343,505	123,958	467,463
2019	358,962	108,500	467,462
2020	375,116	92,347	467,463
2021-2024	1,677,033	192,816	1,869,849
	$ 3,397,887	**$ 809,276**	**$ 4,207,163**

7. **Commitments Under Noncancellable Operating Leases:**

Following is a summary of future minimum obligations under noncancellable operating leases for equipment and buildings:

Years Ending December 31,	Amount
2016	$ 693,328
2017	616,616
2018	548,460
2019	508,400
2020	422,508
2021-Thereafter	4,027,104
	$ 6,816,416

8. **Deferred Compensation Plan and Pension Plan:**

The District sponsors a deferred compensation plan called the Kittitas Valley Community Hospital Pension Plan (the Plan). The Plan is a defined contribution plan. Benefits depend solely on amounts contributed by the District to the Plan plus investment earnings. The Plan is administered by the District. Employees over the age of 21 are eligible to participate after two years of service. Currently, the District contributes 7% of the nonphysician employee's monthly base salary to the Plan. Employees vest 25% after two years of service with an additional 25% each year thereafter until fully vested after five years of service. Benefit terms, including contribution amounts for the Plan are established and may be amended by the District's Board of Commissioners. Additionally, contribution amounts are negotiated as part of the union contracts, and would have to be re-negotiated in order to change them for these employees. Nonvested District contributions and accumulated interest for employees who leave employment before five years of service are used to reduce the District's current period contribution requirement. Such forfeitures amounted to approximately $20,000 in 2015.

The District also sponsors a deferred compensation plan called the KVCH Pension Plan (the Physician's Plan) for all employed physicians. The Physician's Plan is a defined contribution plan. Benefits depend solely on amounts contributed by the District to the Physician's Plan plus investment earnings. The Physician's Plan is administered by the District. All employed physicians are eligible to participate after their first hour of service. Currently, the District contributes 10% of the employed physician's base salary to the Physician's Plan. Employees are vested immediately, and all contributions to the Physician's Plan are considered 100% vested. Benefit terms, including contribution amounts for the Physician's Plan are established and may be amended by the District's Board of Commissioners.

The District contributed approximately $1,879,000 and $1,875,000 for 2015 and 2014, respectively, to the Plan and the Physician's Plan. It is the District's policy to currently fund pension contributions accrued.

8. Deferred Compensation Plan and Pension Plan (continued):

The District also sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457. The name of the plan is Kittitas Valley Community Hospital Deferred Compensation Plan. The plan permits employees to defer a portion of their salary until future years. The deferred compensation is not available to employees until termination, retirement, death, or unforeseeable emergency. Employees become eligible to participate in the plan beginning on the first day of employment. Employee contributions to the plan totaled approximately $1,012,000 and $971,000 for the years ended December 31, 2015 and 2014, respectively.

The plans are administered by the District. Compensation deferred under the plans and all income attributable to the plans are held in trust for the exclusive benefit of the participants and their beneficiaries and are not subject to claims by the District's creditors. While the District has no liability for losses under the plans, it does have the duty of due care that would be required of an ordinary prudent investor.

9. Healthcare Self-insurance:

On January, 1, 2015, the District began partially self-insuring the cost of employee healthcare benefits. The District self-insures the first $100,000 in claims per eligible participant. The District also purchases annual stop-loss insurance coverage for all claims in excess of $100,000 per eligible participant. The liability on the statement of net position includes an accrual for claims that have been incurred but not reported and is included in the accrued payroll and related liabilities balance. Claims liabilities are re-evaluated periodically to take into consideration recently settled claims, frequency of claims, and other economic and social factors.

Changes in the District's claim liability amount are as follows:

		2015
Claim liability, beginning of year	$	-
Current year claims and changes in estimates		**3,175,497**
Claims payments		**(2,889,497)**
Claim liability, end of year	$	**286,000**

10. Net Patient Service Revenue:

The District recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the District recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the District's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the District records a significant provision for bad debts related to uninsured patients in the period the services are provided. The District's provision for bad debts and writeoffs have decreased from 2014 to 2015 primarily due to Medicaid expansion and the Affordable Care Act. The District has not changed its charity care and uninsured discount policies during the year ended December 31, 2015.

10. Net Patient Service Revenue (continued):

Patient service revenue, net of contractual adjustments and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	2015	2014
Patient service revenue (net of contractual adjustments and discounts):		
Medicare	$ 27,803,358	$ 29,062,102
Medicaid	8,384,073	7,962,298
Other third-party payors	30,428,097	30,523,492
Patients	4,734,532	4,988,096
	71,350,060	72,535,988
Less:		
Charity care	638,704	1,238,216
Provision for bad debts	2,134,810	2,650,748
Net patient service revenue	**$ 68,576,546**	$ 68,647,024

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

- *Medicare* – The District is paid on a cost reimbursement method for substantially all hospital, and rural health clinic services provided to Medicare beneficiaries. The District is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare Administrative Contractor. Nonrural health clinic physicians are paid under a fee schedule. Home health and hospice services are paid under prospective payment systems.
- *Medicaid* – Inpatient and outpatient services provided to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The District is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the District and review thereof by the State of Washington Health Care Authority. Rural health clinic services are paid on a prospectively set rate per visit.

The District also has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established charges, fee schedule, and prospectively determined daily rates.

Laws and regulations governing Medicare, Medicaid, and other programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient service revenue decreased by approximately $293,000 in 2015 and increased by approximately $829,000 in 2014, due to differences between original estimates and final settlements or revised estimates.

10. Net Patient Service Revenue (continued):

The District provides charity care to patients who are financially unable to pay for the healthcare services they receive. The District's policy is not to pursue collection of amounts determined to qualify as charity care. Accordingly, the District does not report these amounts in net operating revenues or in the allowance for uncollectible accounts. The District determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including salaries and wages, benefits, supplies, and other operating expenses, based on data from its costing system. The costs of caring for charity care patients for the years ended December 31, 2015 and 2014, were approximately $351,000 and $652,000, respectively. The District received a small rural indigent disproportionate share hospital payment from the state of Washington to subsidize charity services in the amount of approximately $224,000 and $286,000 during the years ended December 31, 2015 and 2014, respectively.

11. Electronic Health Records Incentive Payment:

The District recognized Medicare and Medicaid electronic health records (EHR) incentive payments during the years ended December 31, 2015 and 2014. The EHR incentive payments are provided to incent hospitals to become meaningful users of EHR technology, not to reimburse providers for the cost of acquiring EHR assets. EHR incentive payments are therefore reported as operating revenue.

The District recognizes the Medicare incentive payment on the date that the District has successfully complied with meaningful use criteria during the entire EHR reporting period. The District first attested to meaningful use with Medicare in September 2012. The Medicare EHR reporting period is through December 31 of each year.

The Medicare incentive payment recognized is an estimate and subject to audit by Centers for Medicare and Medicaid Services (CMS). The Medicare EHR incentive payment is based on the days and charity care reported in the Medicare cost report and the undepreciated cost of the EHR equipment submitted to CMS. Medicare incentive revenue of approximately $390,000 was recognized in 2015. The District recognized a liability to CMS of approximately $447,000 in 2014 as a result of CMS's audit of the EHR assets claimed in 2012.

12. Risk Management and Contingencies:

Medical malpractice claims – The District has professional liability insurance coverage with Washington Casualty Company. The policy provides protection on a "claims-made" basis whereby claims filed in the current year are covered by the current policy. If there are occurrences in the current year, these will only be covered in the year the claim is filed if claims-made coverage is obtained in that year or if the District purchases insurance to cover prior acts. The current professional liability insurance provides $1,000,000 per claim of primary coverage with an annual aggregate limit of $5,000,000. The policy has no deductible per claim.

The District also has excess professional liability insurance with Washington Casualty Company on a "claims-made" basis. The excess malpractice insurance provides $10,000,000 per claim of primary coverage with an aggregate limit $10,000,000. The policy has no deductible per claim.

12. Risk Management and Contingencies (continued):

Risk management – The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Workers' compensation risk transfer pool – The District has a self-insured workers' compensation plan for its employees. The District participates in the Public Hospital District Workers' Compensation Trust, which is a risk transfer pool administered by the Washington State Hospital Association. The District pays its share of actual workers' compensation claims, maintenance of reserves, and administrative expenses. Payments by the District charged to workers' compensation expense were approximately $174,000 and $184,000 (net of an approximately $110,000 dividend) in 2015 and 2014, respectively.

Industry regulations – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditations, and government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the District is in compliance with fraud and abuse statutes, as well as other applicable government laws and regulations.

While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions known or unasserted at this time.

13. Concentration of Risks:

Patient accounts receivable – The District grants credit without collateral to its patients, most of whom are local residents, and are insured under third-party payor agreements. The majority of these patients are geographically concentrated in and around Kittitas County.

The mix of receivables from patients was as follows:

	2015	2014
Medicare	26 %	23 %
Medicaid	14	14
Other third-party payors	40	41
Patients	20	22
	100 %	100 %

Physicians – The District is dependent on local physicians practicing in its service area to provide admissions and utilize hospital services on an outpatient basis. A decrease in the number of physicians providing these services or change in their utilization patterns may have an adverse effect on hospital operations.

Collective bargaining unit – The District has two collective bargaining agreements with the Washington State Nurses Association (the WSNA) and Teamsters Local 760 (Teamsters).

Effective January 1, 2014, the District renewed its contract with the WSNA for its nursing employees. The contract is effective through December 31, 2016.

Effective January 1, 2012, the District renewed its contract with the Teamsters labor union which applies to all hospital employees except the following positions: supervisors, confidential employees, RNs, LPNs, office clerical, security, laboratory, imaging, surgical technicians, home care, clinics, engineering, physical rehabilitation, central supply and pharmacy. The contract expired on December 31, 2015, and is currently being renegotiated. A renewed contract is expected to be signed in 2016.

As of December 31, 2015 and 2014, approximately 36%, respectively, of the Districts' employees were represented by the union under these collective bargaining agreements with the WSNA and Teamsters.

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Certified Public Accountants

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Commissioners
Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Ellensburg, Washington

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Kittitas County Public Hospital District No. 1 doing business as Kittitas Valley Healthcare (the District) as of and for the year ended December 31, 2015, and the related notes to the financial statements, which collectively comprise the District's basic financial statements, and have issued our report thereon dated May 12, 2016.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the District's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency or a combination of deficiencies in internal control that is less severe than a material weakness, yet important enough to merit the attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or, significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

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Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Dingus, Zarecor & Associates PLLC

Spokane Valley, Washington
May 12, 2016

Kittitas County Public Hospital District No. 1
doing business as Kittitas Valley Healthcare
Summary Schedule of Prior Audit Findings
Year Ended December 31, 2015

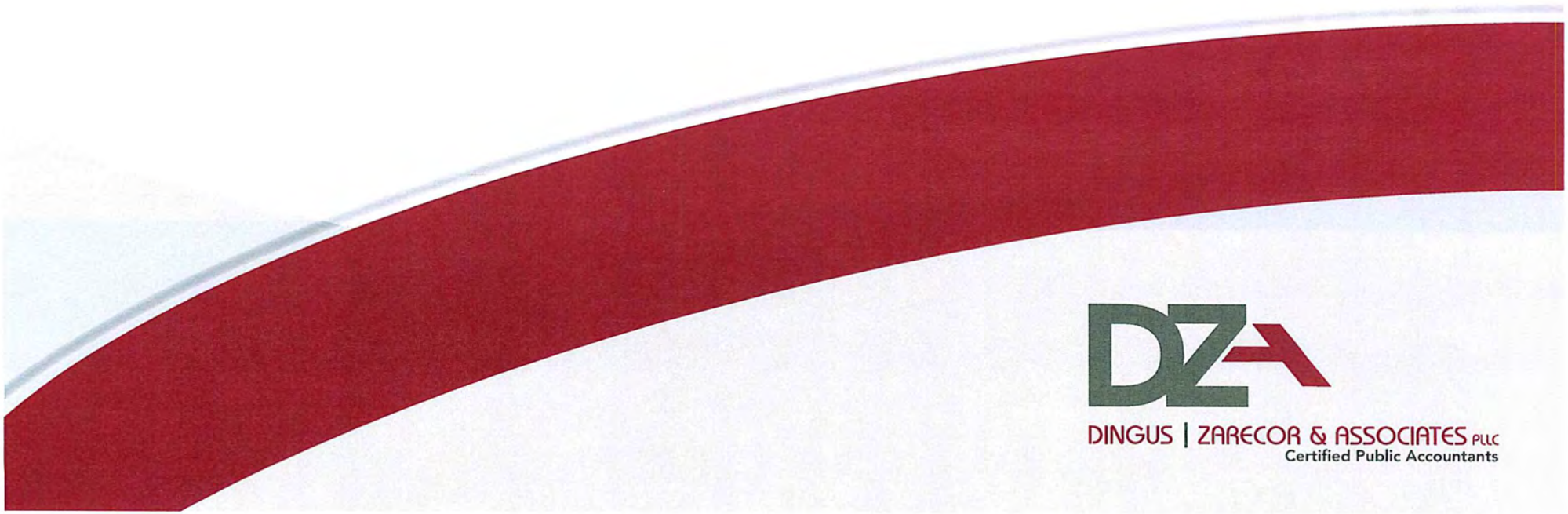
The audit for the year ended December 31, 2014, reported one finding that was resolved during the current year. There are no matters to report in this schedule for the year ended December 31, 2015.

14-01 Auditor Detected Adjusting Journal Entries - Resolved

Kittitas Valley Healthcare

Financial Indicators

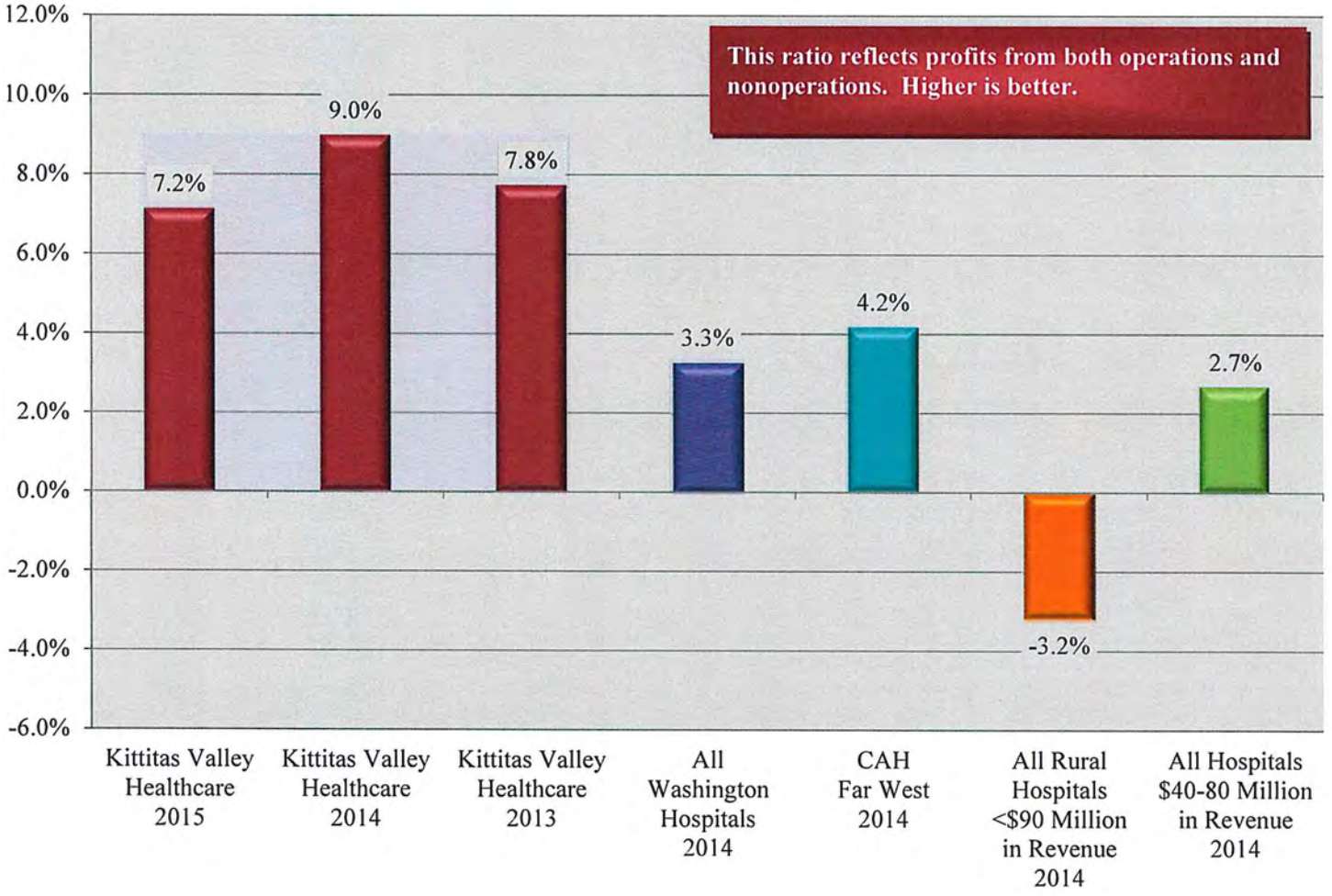
December 31, 2015



Kittitas Valley Healthcare

Total Margin

Change in Net Position
Total Revenues



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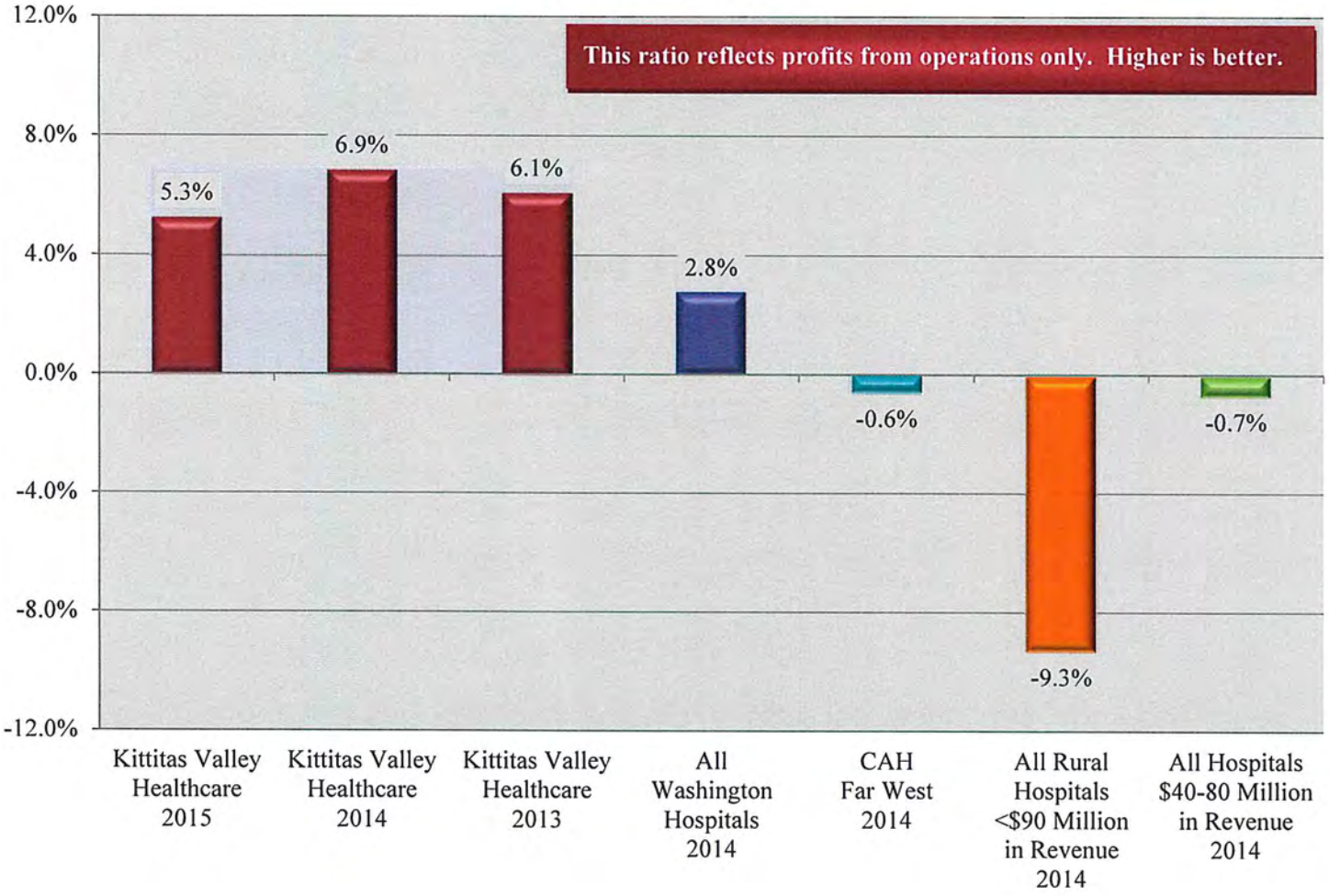
Kittitas Valley Healthcare

Operating Margin

Operating Income (Loss)
Total Operating Revenues



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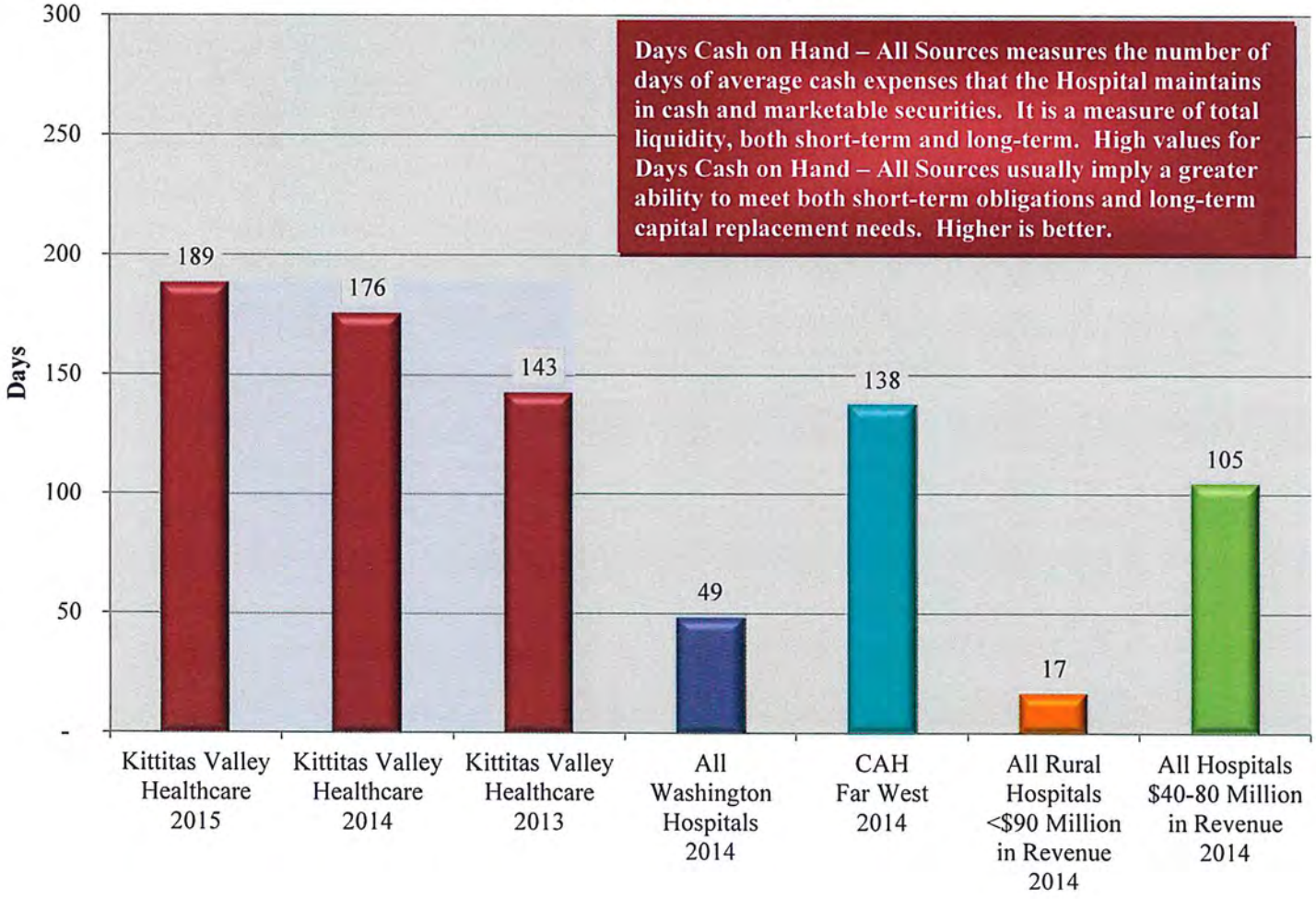
Days Cash on Hand – All Sources

$$\frac{\text{Cash + Short-term Investments + Noncurrent Cash and Investments}}{\text{(Total Expenses - Depreciation) / 365}}$$



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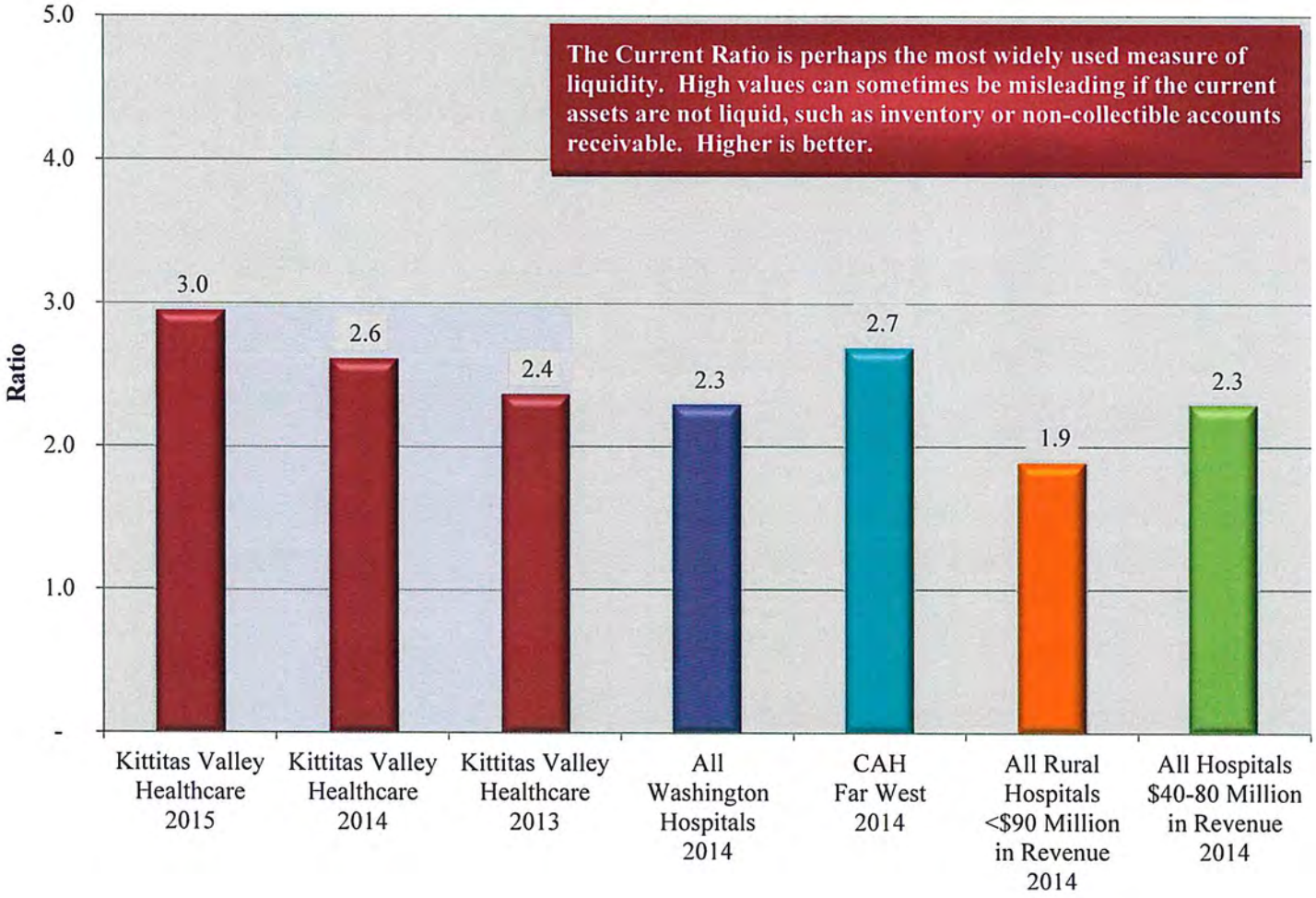
Kittitas Valley Healthcare

Current Ratio

$$\frac{\text{Current Assets}}{\text{Current Liabilities}}$$



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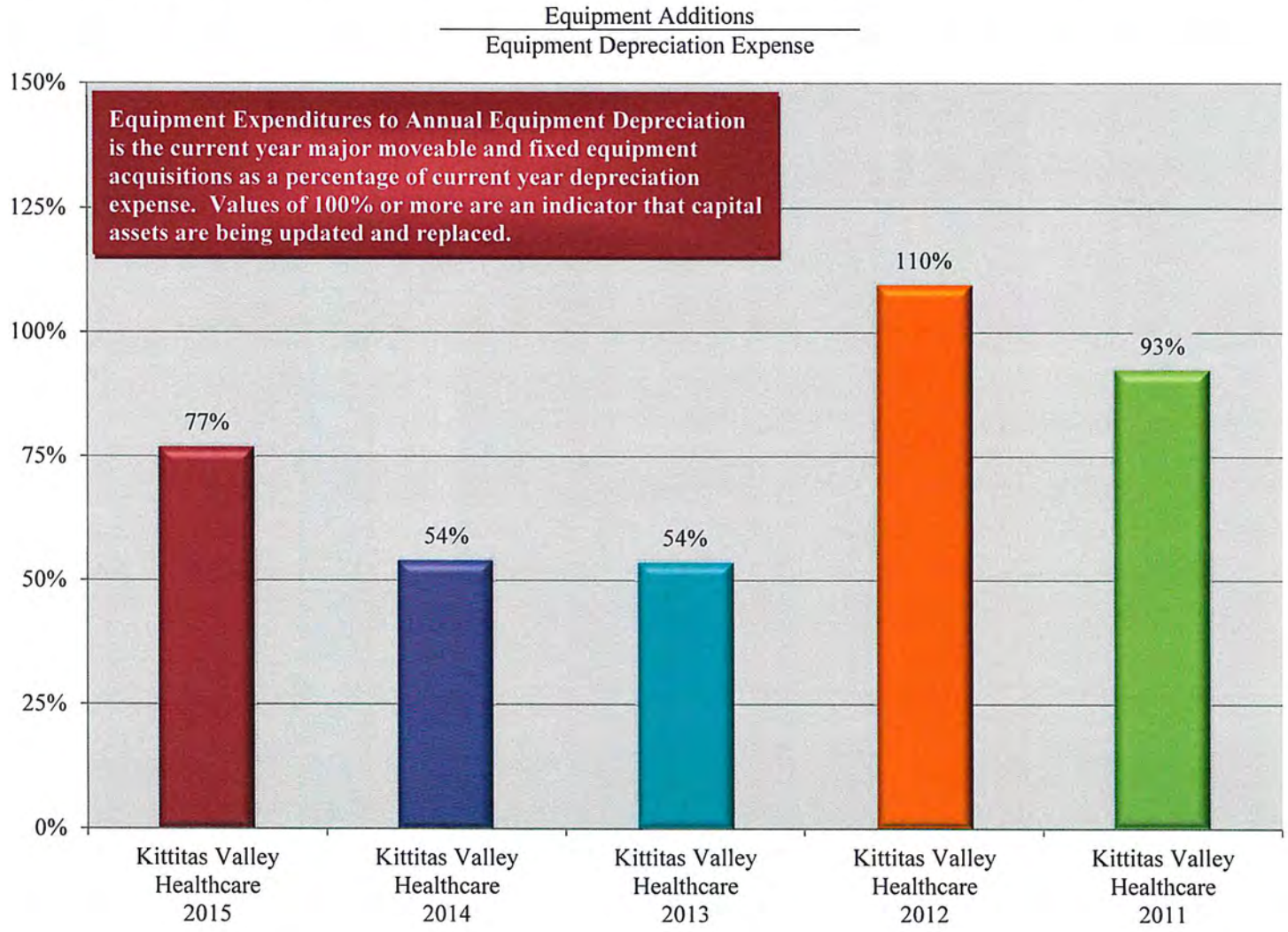
Capital Equipment Expenditures Percentage of Annual Depreciation



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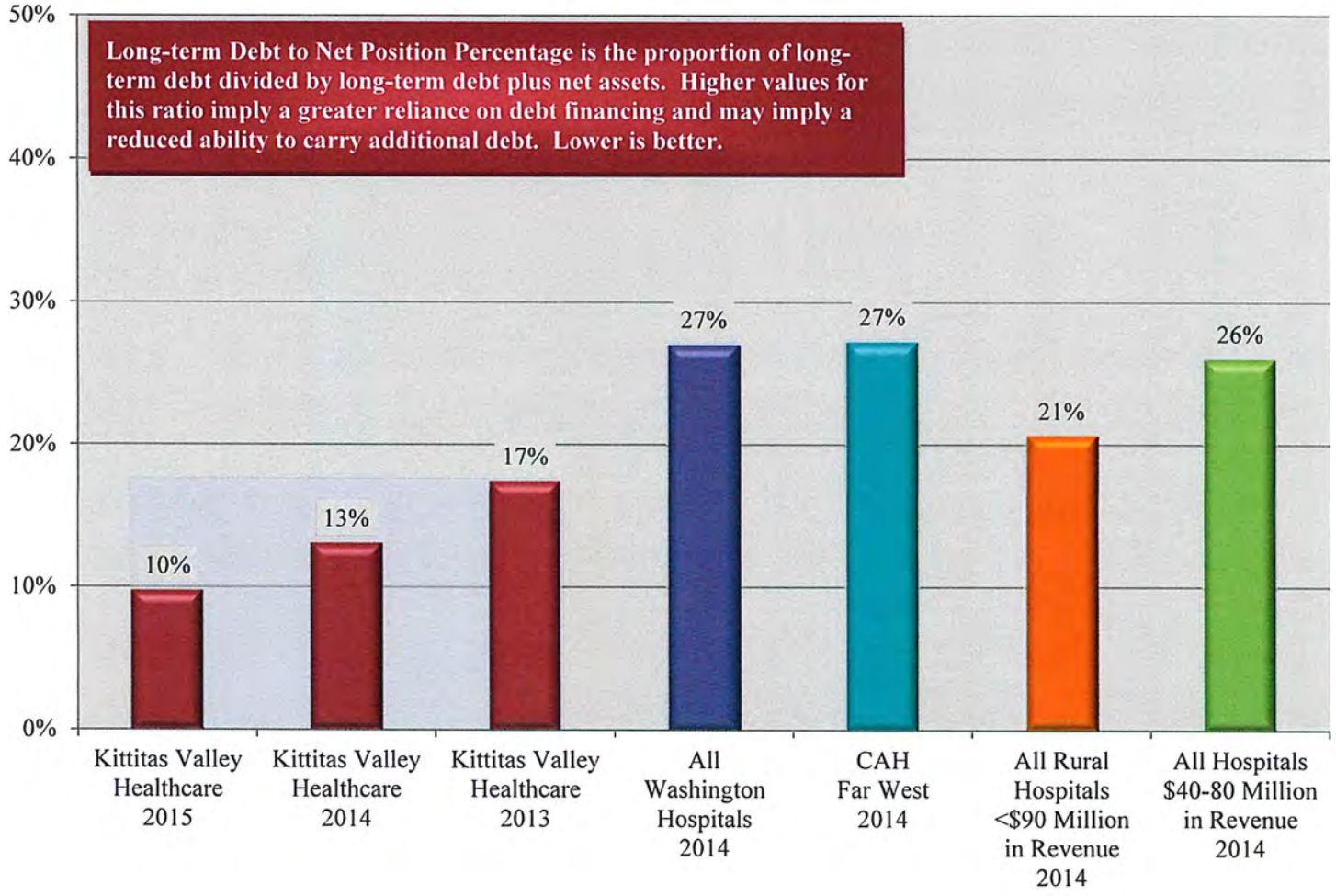
Long-term Debt to Net Position Percentage

$$\frac{\text{Long-term Debt}}{\text{Long-term Debt + Net Position}}$$



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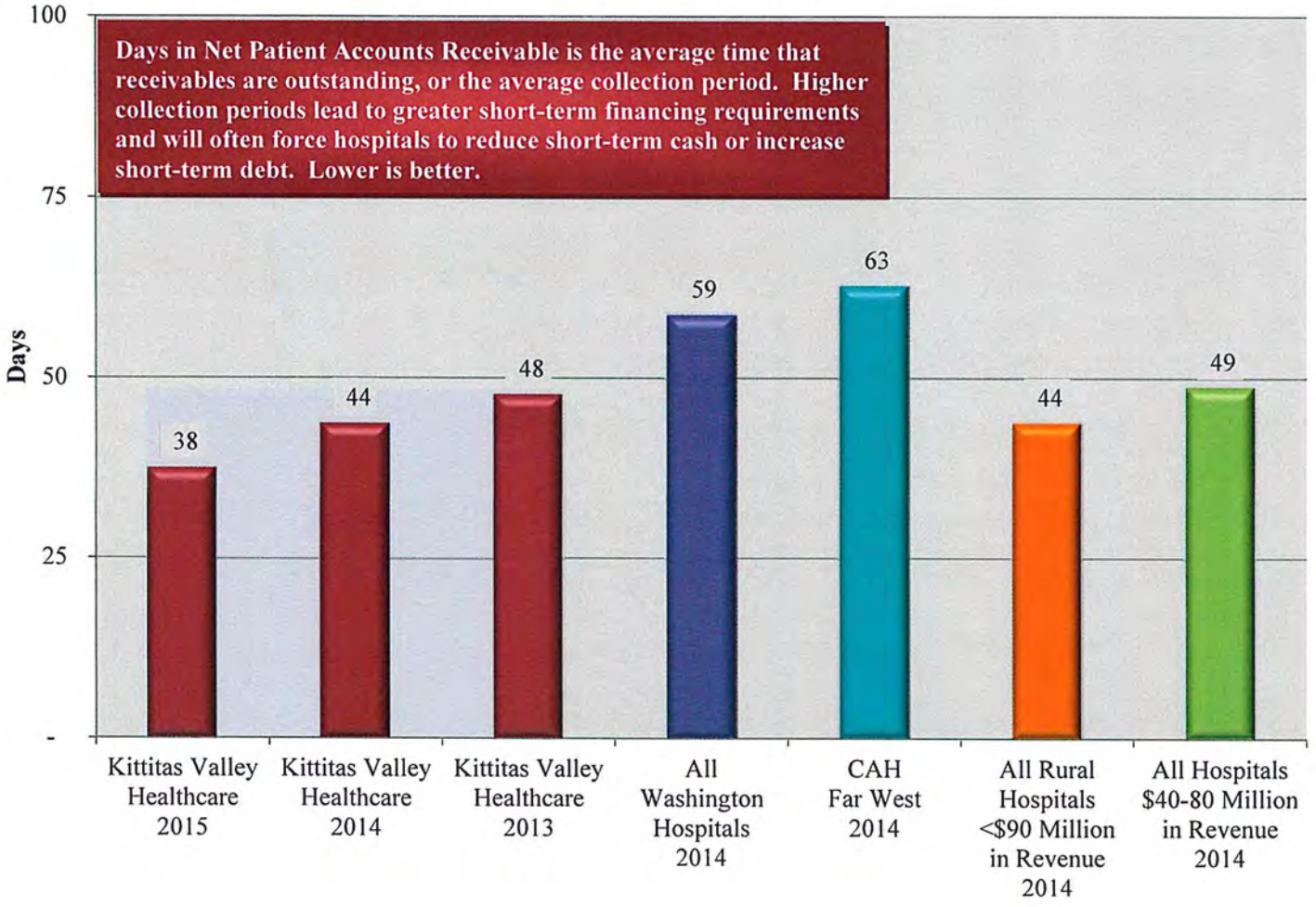
Days in Net Patient Accounts Receivable

Net Patient Accounts Receivable
Net Patient Service Revenues / 365



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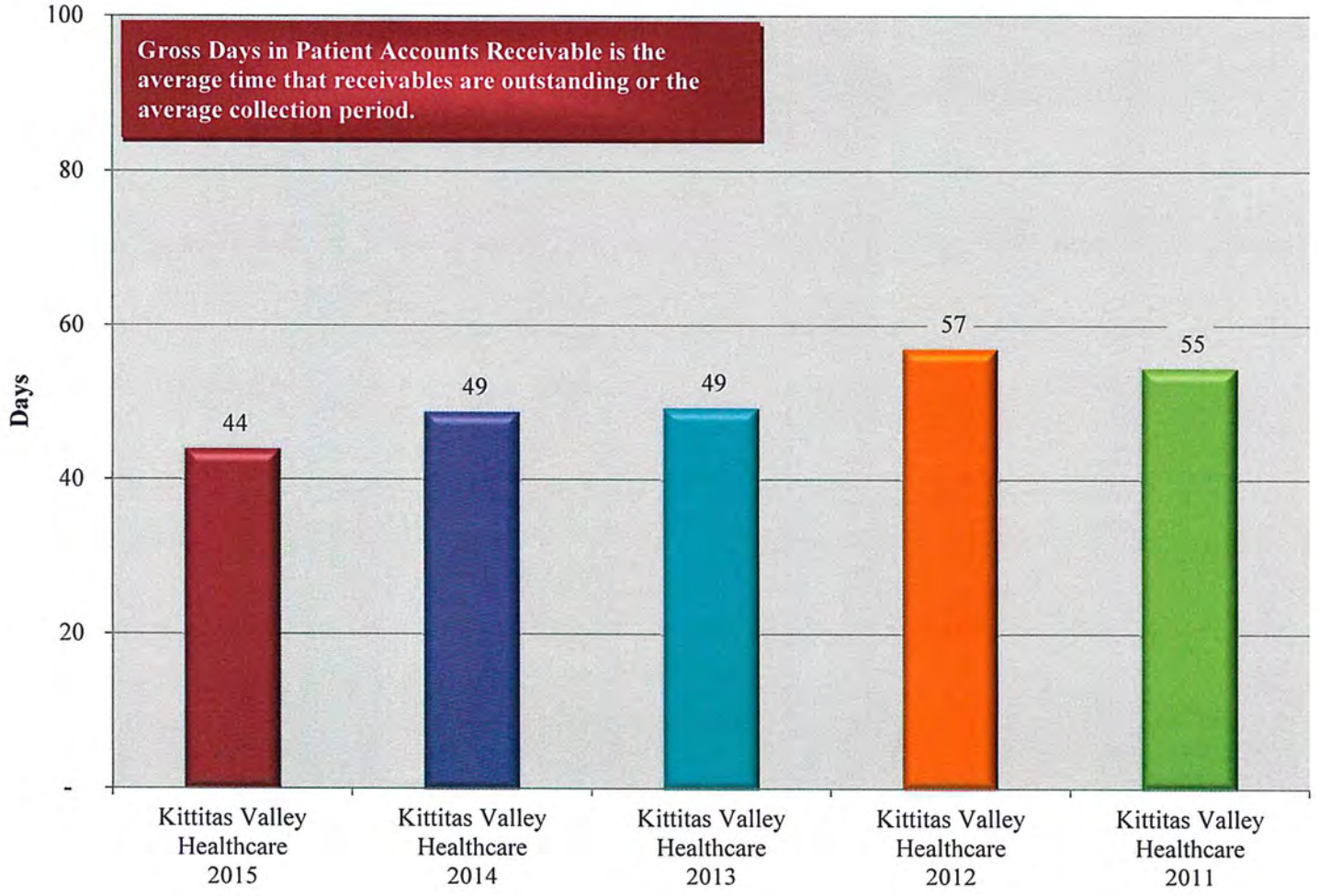
Gross Days in Patient Accounts Receivable

$$\frac{\text{Gross Patient Accounts Receivable}}{\text{Gross Patient Service Revenues / 365}}$$



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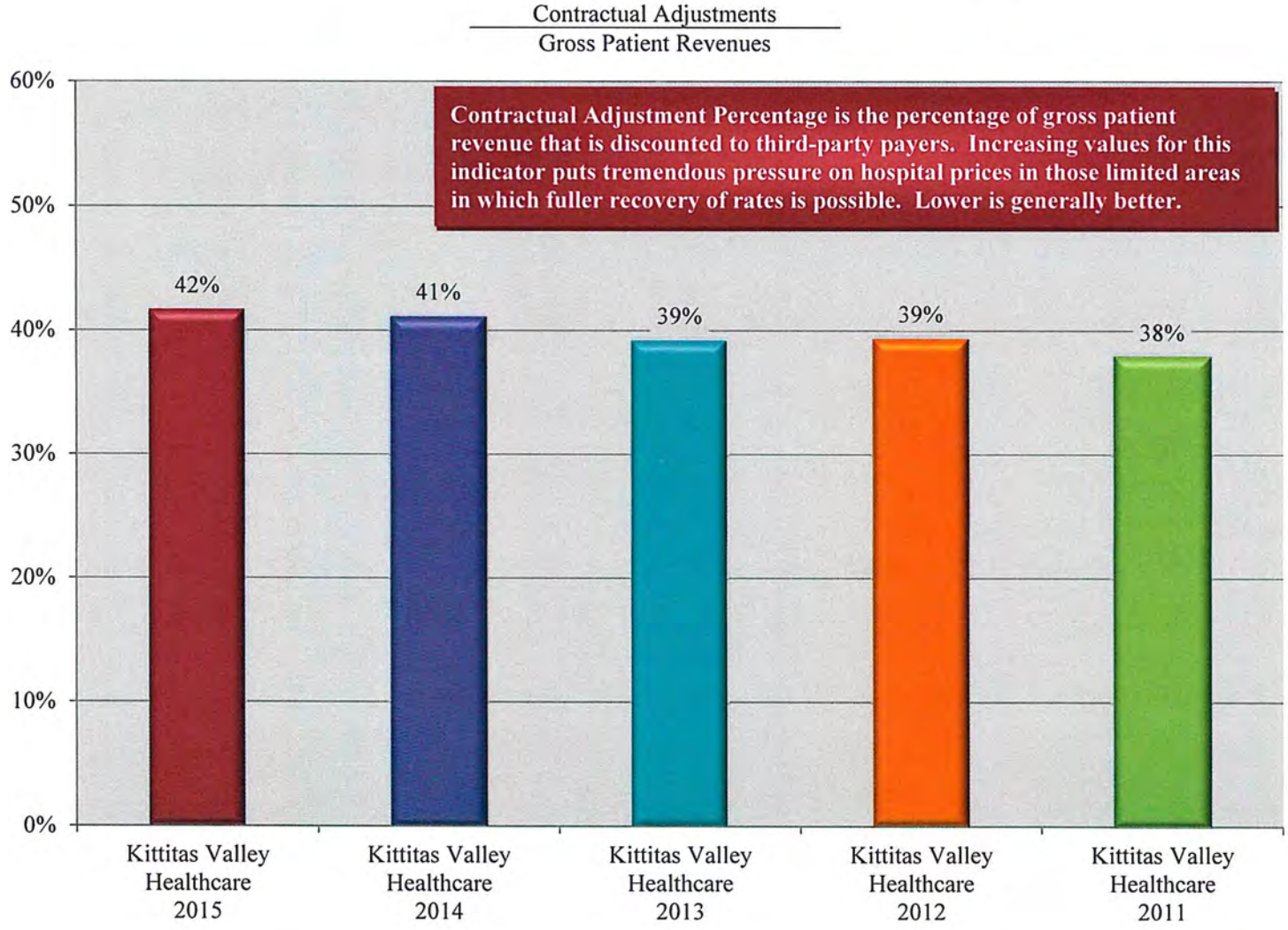
Kittitas Valley Healthcare

Contractual Adjustment Percentage



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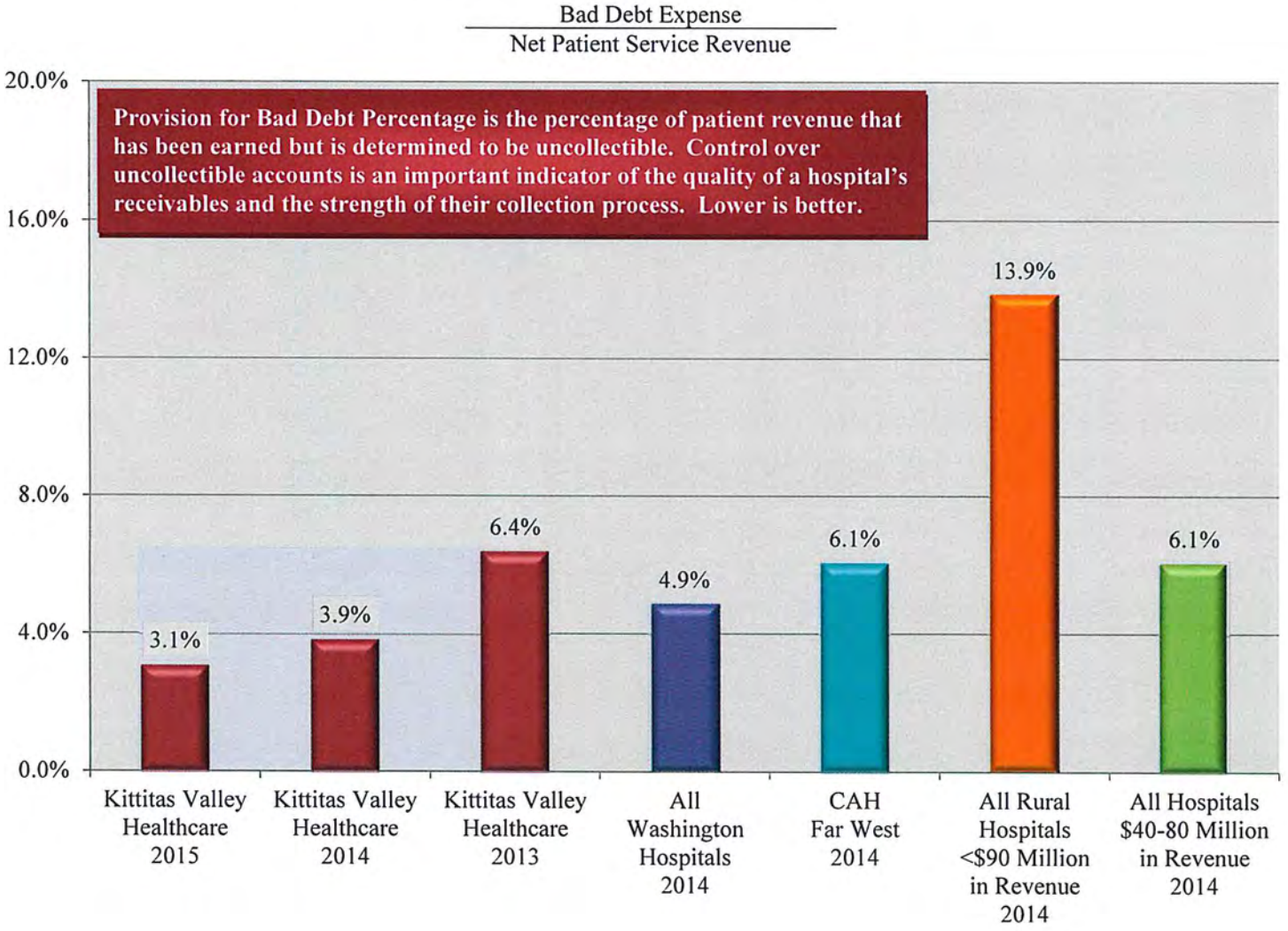
Kittitas Valley Healthcare

Bad Debt Percentage of Revenue



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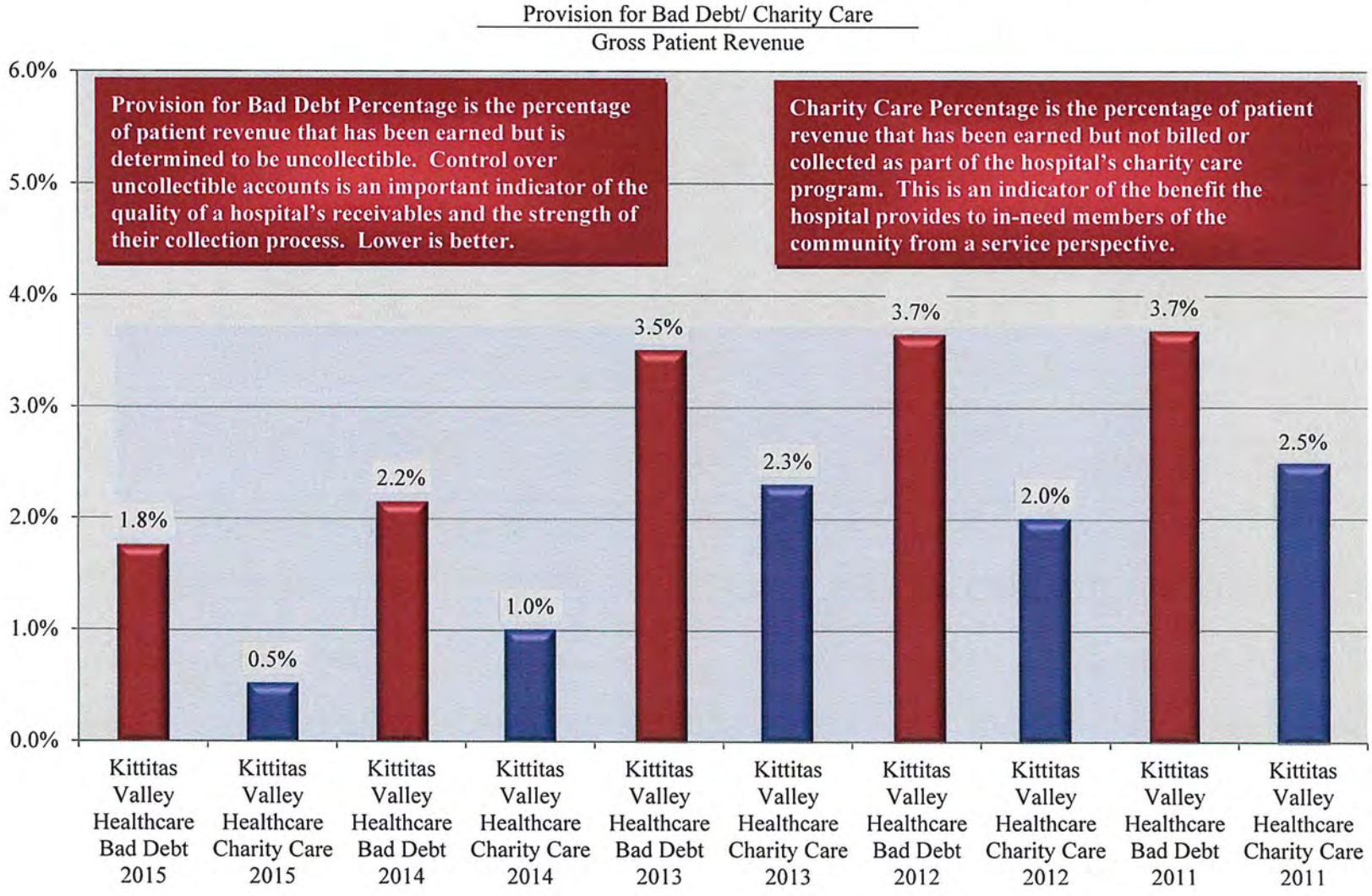
Bad Debt and Charity Percentage of Revenue



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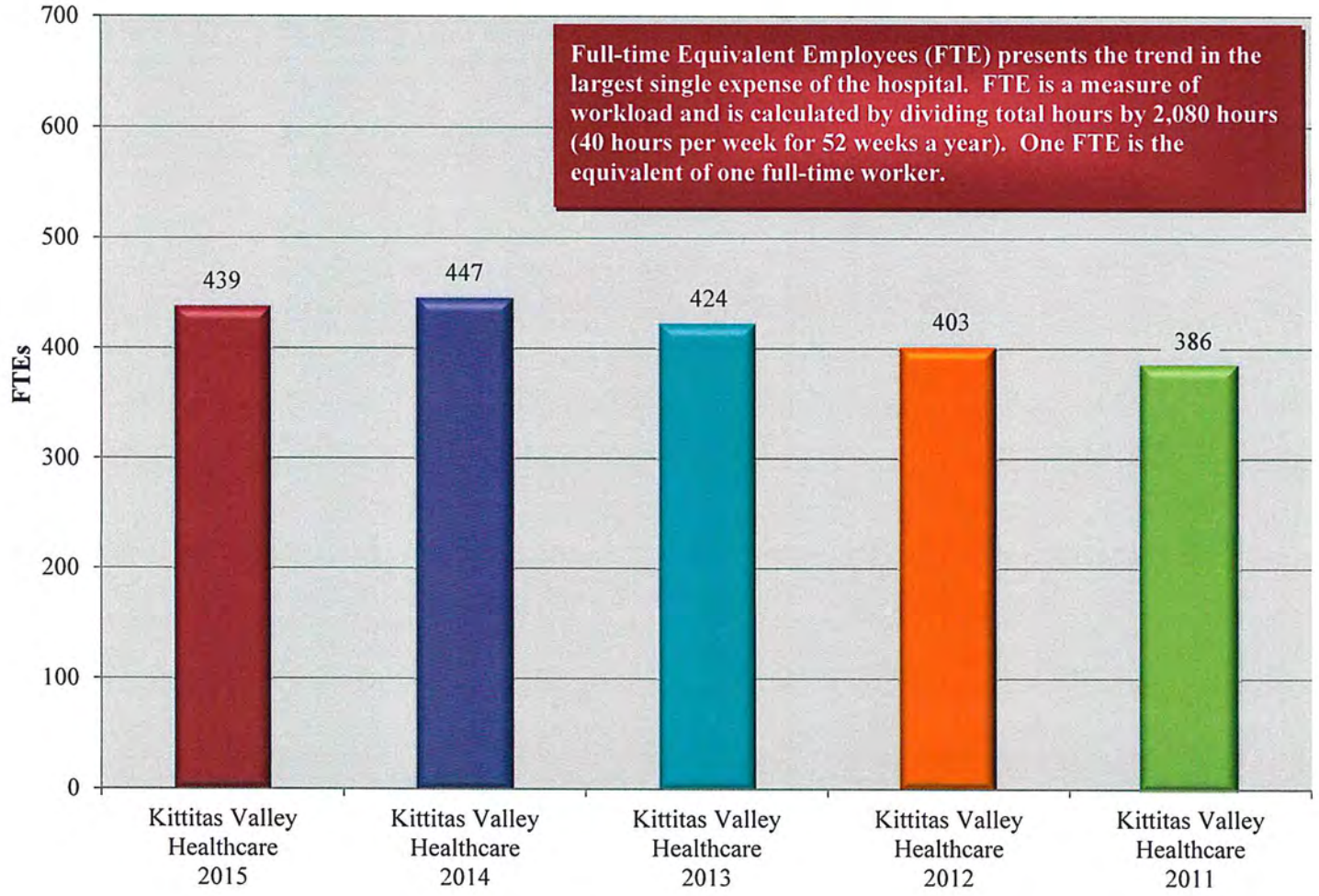
Full-time Equivalent Employees (FTE)



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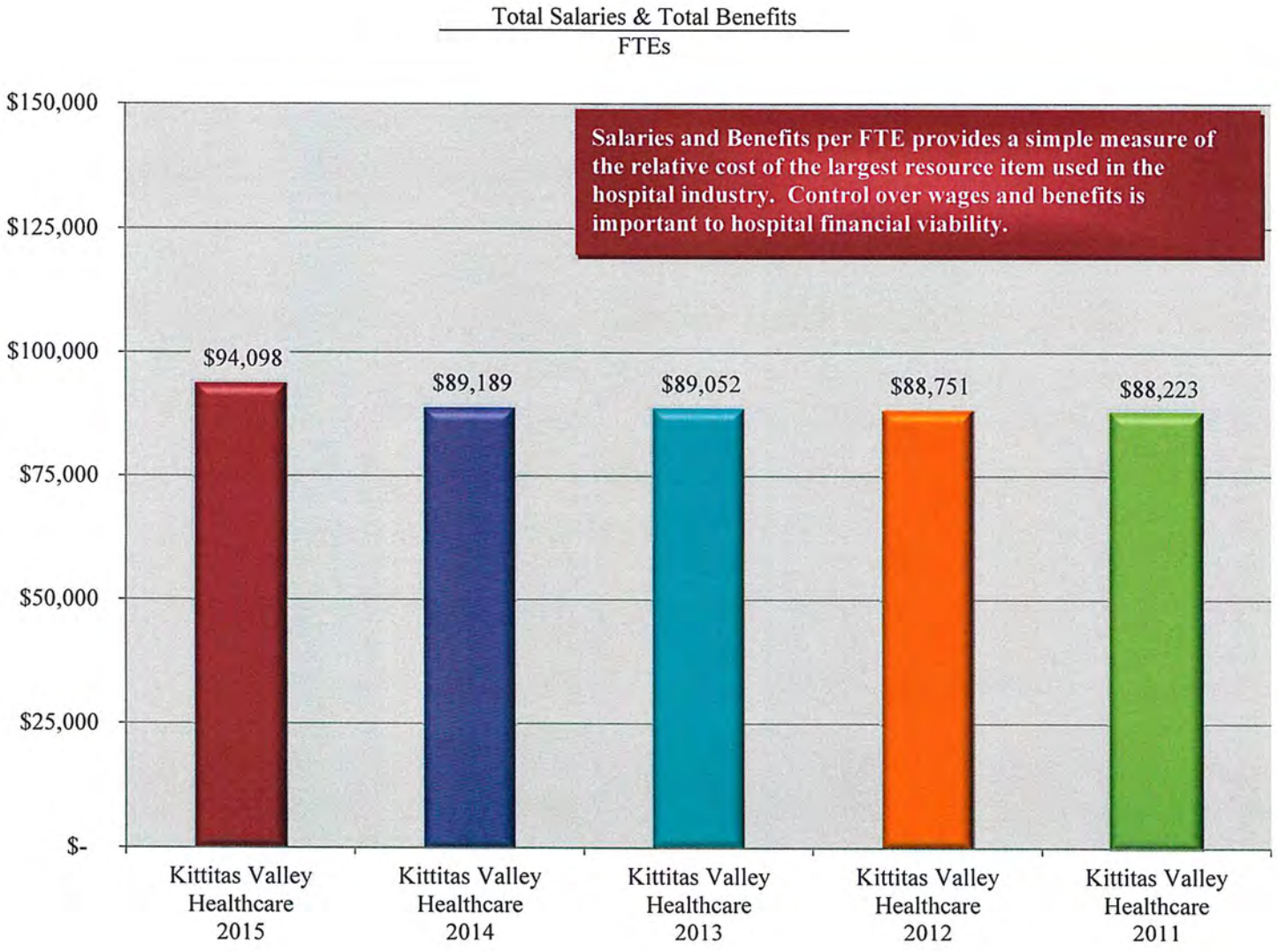
Salaries and Benefits per FTE



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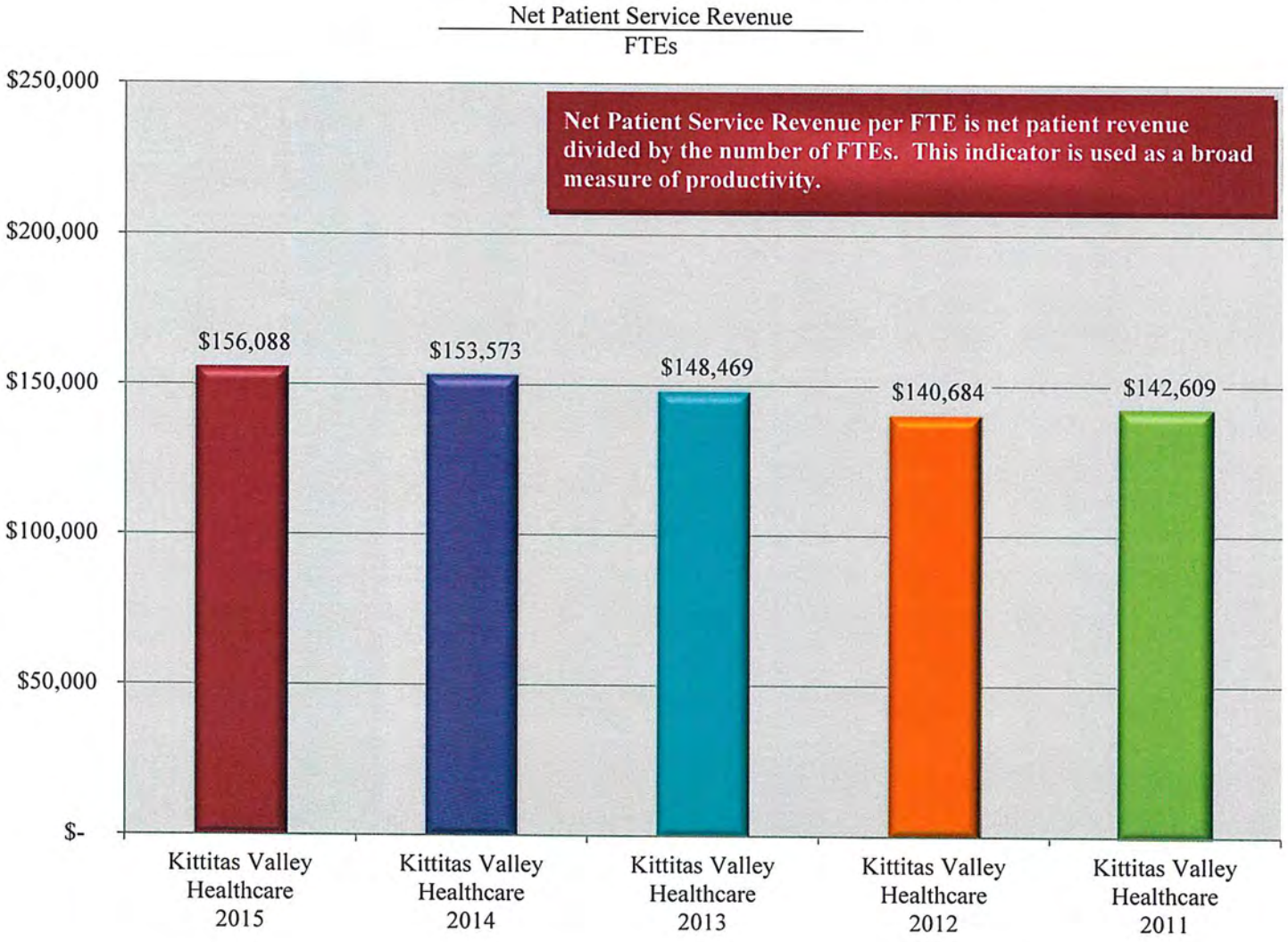
Net Patient Service Revenue per FTE



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CEO Report

May 26, 2016

1. **Master Facilities Planning**. It is important to note the progress made in facilities planning. I will ask Don Solberg, CMO, to report on the KVH provider engagement meeting on May 10. Cathy Bambrick, COO, will then describe the 3P Event – Clinical Application of Concepts and Future State Operations, an intense five-day workshop held May 16 through May 20. Two other facilities planning items will be addressed: the preferred approach to construction management and the decision on making the MOB a single-story or two-story structure. Any updates on property acquisition and the community hearing and review process will also be provided as available.

2. **Top Performing Hospitals**. (Attachment). There is a close relationship between High Reliability Organizations and Top Performing Hospitals. Best practices in High Reliability Organizations lead to minimum to zero preventable harm to patients. The practices are well-known but, sadly, are followed incompletely, intermittently or not at all by many hospitals. They include protocols relating to procedures familiar to all of us, such as briefings, de-briefings, and checklists derived from those employed by pilots in the commercial airline industry.

KVH is a Top Performing Hospital. We continue to improve day by day, year after year to the point that we are recognized nationally among the very best of like and similar institutions. The leadership of KVH does not take for granted the efforts of each and every employee to strive for zero preventable patient harm and to aspire to provide the optimal patient experience.

Next month we will take the opportunity to tease out the components of the National Rural Health Association iVantage methodology for ranking hospitals and tie it directly back to the KVH mission and vision of providing excellent patient care in a rapidly changing environment.

3. **Emergency Medicine Physician Recruitment**. We will report on progress to date in retaining through employment agreements our existing physicians. Additionally, we will provide an update on recruiting a new department medical director as well as securing other physicians to fill out the roster.

Top Performing Hospitals

Creating a Blueprint for Sustainability and Value

Across the rural health safety net, there is no better illustration of the value that rural facilities provide to their communities than the **Top 100 Critical Access Hospitals** and the **Top 100 Rural & Community Hospitals**.

Amidst uncertainty, transition and strain, these top performers are excelling in managing risk, achieving higher quality, securing better outcomes, increasing patient satisfaction, and operating at a lower cost than their peers. These two groups serve as a benchmark for other rural facilities as they strive to achieve similar results and provide a blueprint for successfully navigating the uncertainty of the new healthcare.

Critical Access Hospital and Rural & Community. What's the difference?

In the past, our Top 100 list has focused exclusively on Critical Access Hospitals. But in reviewing the **Hospital Strength INDEX** as part of this year's **Rural Relevance Study**, the performance of rural hospitals not classified as CAHs was hard to ignore. Just as we see with CAHs, the top performers within this group are demonstrating a tremendous level of value in the face of downward pressure on hospital revenue. Going forward, we will be recognizing these Rural & Community hospitals as part of our yearly release of the Top 100.

Within the context of the Rural Relevance Study, we follow the federal definition for **Critical Access Hospitals**, which includes special Medicare reimbursement rules and parameters such as the number of beds (a maximum of 25) and the average length of stay for patients (a maximum of 72 hours).

Rural & Community facilities are also federally designated but are reimbursed by the standard Prospective Payment System (PPS) of Diagnostic Resource Group (DRG)-based reimbursements. And the number of beds at these hospitals does not exceed 200.

We are pleased to recognize these top performing hospitals and to support the celebration of their achievement in their community. To see the press release, click here.

48a

And to view the 2016 list of Top 100 hospitals in each category, **click** the corresponding logo below.

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Recognizing Value in Rural Healthcare

Critical Access Hospital	State
Gunnison Valley Hospital	CO
Pikes Peak Regional Hospital	CO
Audubon County Memorial Hospital	IA
Avera Holy Family Hospital	IA
Cherokee Regional Medical Center	IA
Clarke County Hospital	IA
Dallas County Hospital	IA
Floyd Valley Hospital	IA
Genesis Medical Center-Dewitt	IA
Greater Regional Medical Center	IA
Henry County Health Center	IA
Jones Regional Medical Center	IA
Myrtue Medical Center	IA
Orange City Area Health System	IA
Palo Alto County Hospital	IA
Pella Regional Health Center	IA
Washington County Hospital and Clinics	IA
Winneshiek Medical Center	IA
St Luke's McCall	ID
Steele Memorial Medical Center	ID
Abraham Lincoln Memorial Hospital	IL
Cameron Memorial Community Hospital	IN
Margaret Mary Health	IN
Gove County Medical Center	KS
Greeley County Health Services	KS
Newman Regional Health	KS
Norton County Hospital	KS
Martha's Vineyard Hospital	MA
Bridgton Hospital	ME
Redington Fairview General Hospital	ME
Rumford Hospital	ME
Stephens Memorial Hospital	ME
Waldo County General Hospital	ME
Aspirus Grand View Hospital	MI
Charlevoix Area Hospital	MI
Eaton Rapids Medical Center	MI
Munising Memorial Hospital	MI

Critical Access Hospital	State
Sparrow Clinton Hospital	MI
St Francis Hospital	MI
Mayo Clinic Health System - St James	MN
Pipestone County Medical Center	MN
Perry County Memorial Hospital	MO
Barrett Memorial Hospital	MT
Central Montana Medical Center	MT
Livingston Healthcare	MT
Marcus Daly Memorial Hospital	MT
Mountainview Medical Center	MT
Sidney Health Center	MT
Angel Medical Center	NC
Ashe Memorial Hospital	NC
Transylvania Regional Hospital	NC
Carrington Health Center	ND
Jamestown Regional Medical Center	ND
Sanford Mayville	ND
The Mercy Hospital of Devils Lake	ND
Boone County Health Center	NE
Crete Area Medical Center	NE
Howard County Medical Center	NE
Memorial Health Care Systems	NE
Providence Medical Center	NE
York General Hospital	NE
Androscoggin Valley Hospital	NH
Huggins Hospital	NH
Monadnock Community Hospital	NH
Speare Memorial Hospital	NH
The Memorial Hospital	NH
Valley Regional Hospital	NH
Miners Colfax Medical Center	NM
Community Hospitals and Wellness Centers	OH
H B Magruder Memorial Hospital	OH
Wyandot Memorial Hospital	OH
Harper County Community Hospital	OK
Grande Ronde Hospital	OR
Peacehealth Cottage Grove - Medical Center	OR
Providence Hood River Memorial Hospital	OR
Muncy Valley Hospital	PA
Madison Community Hospital	SD
Mitchell County Hospital District	TX
Delta Community Medical Center	UT

Critical Access Hospital	State
Gunnison Valley Hospital	UT
Moab Regional Hospital	UT
Copley Hospital	VT
Porter Hospital	VT
Kittitas Valley Community Hospital	WA
North Valley Hospital	WA
Providence Mount Carmel Hospital	WA
Tri-State Memorial Hospital	WA
Whitman Hospital And Medical Center	WA
Aspirus Langlade Hospital	WI
Aspirus Medford Hospital & Clinics	WI
Black River Memorial Hospital	WI
Calumet Medical Center	WI
Good Samaritan Health Center	WI
Mayo Clinic Health System - Red Cedar	WI
Ministry Door County Medical Center	WI
Ministry Eagle River Memorial Hospital	WI
Tomah Memorial Hospital	WI
Westfields Hospital And Clinic	WI
Jefferson Medical Center	WV
Johnson County Healthcare Center	WY

Human Resources Dashboard Report
April 2016

Highlights

- There were positions 14 posted, with 7 being filled or closed during the month. KVH is currently recruiting for 43 positions.
- There were 3 new worker compensation claims with 0 days of time loss.
- Monthly evaluations were at 31% for the month. (14 out of 45)

Prepared by:
Human Resources
5/18/2016

Workforce Development

Timely evaluations ↑

By month of hire, employees receiving an evaluation in or up to three months before their annual anniversary month.

Up-to-date evaluations →

Employees receiving an evaluation during the calendar year.

Positions accepted within 49 days →

Positions with an acceptance date within 49 days of posting.

Average days to acceptance **40**

Of **169** *positions that were accepted in the past 12 months.*

Separation rate ↓

Non-standard productive pay

(call back, double time, overtime, overtime meeting)

These 10 departments represent **70.9%** *of the non-standard pay for the payroll period ending on* **03/19/2016**

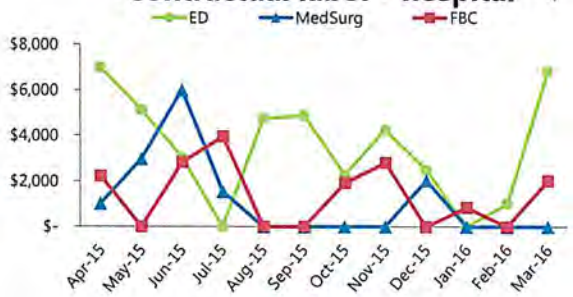
1	HOME HEALTH SERVICE*	$ 3,878.61
2	ICU CCU	$ 3,833.64
3	MED SURG	$ 3,031.65
4	EMERGENCY SERVICE	$ 2,319.48
5	KVH FAMILY MEDICINE –ELLENSBUI	$ 1,597.29
6	HOUSE SUPERVISORS	$ 1,449.97
7	LABORATORY	$ 1,406.22
8	SURGICAL SERVICE*	$ 1,248.79
9	FAMILY BIRTHING CENTER	$ 1,004.42
10	HOSPICE*	$ 835.29

These 10 departments represent **75.3%** *of the non-standard pay for the last year of payroll.*

1	EMERGENCY SERVICE	$ 110,516.26
2	MED SURG	$ 94,949.68
3	HOME HEALTH SERVICE*	$ 84,658.39
4	FAMILY BIRTHING CENTER	$ 68,760.94
5	ICU CCU	$ 57,331.93
6	LABORATORY	$ 33,825.32
7	PHARMACY	$ 29,103.85
8	SURGICAL SERVICE*	$ 21,313.11
9	KVH FAMILY MEDICINE –ELLENSBUI	$ 18,794.70
10	SURGICAL OUTPATIENT*	$ 18,579.41

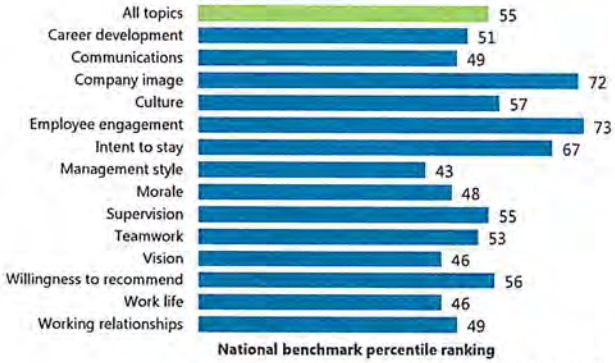
*Call back pay excluded

Contractual labor - hospital ↓



Contractual labor - non-hospital ↓

Employee satisfaction



Last updated 04/26/2016

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NOTIFICATION OF CREDENTIAL FILES FOR REVIEW

Date: May 16, 2016

TO: Board of Commissioners

FROM: Shannon Carlson, CPCS
Medical Staff Services

The Medical Executive Committee has reviewed the applications for appointment or reappointment for the practitioners listed below. They recommend to the Board that these practitioners be granted appointment and privileges. Please stop by my office (upstairs in the Administrative area) prior to the next Board meeting if you wish to review these credentials files.

PRACTITIONER	STATUS	APPT/REAPPT
James Atkisson, MD	Provisional/Active Locum	Initial Appointment
Tomas King, DO	Provisional/Associate	Initial Appointment
Brian Staley, MD	Provisional/Associate	Initial Appointment
Heidee Hanson PA-C	Provisional/AHP	Initial Appointment
Theresa "Tina" Fought, CNM	Provisional/AHP	Initial Appointment
Ken Harris, MD	Active	Reappointment
Elise Herman, MD	Active	Reappointment
Micahlyn Powers, MD	Active	Reappointment
Monica de Baca, MD	Associate	Reappointment
John Merrill-Steskal, MD	Ambulatory	Reappointment

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Reappointment Policy and Procedure

Medical Staff Services

Type: Policy
Status: Official
Last Reviewed:

All appointments are for a period not to exceed two years.

INFORMATION COLLECTION AND VERIFICATION

1. **From medical staff practitioners:** On or before sixty days prior to the expiration of a medical staff appointment, the Medical Staff Coordinator shall notify the appointee of the date of expiration. At least 30 days prior to the expiration date, the appointee shall furnish the following information in writing:
    a. Complete information to update the practitioner's credentials file;
    b. Specific request for the clinical privileges sought on reappointment, with any basis for change; and
    c. Requests for changes in staff category or department assignments.

    Practitioners will be assessed at each 2 year reappointment a fee as per the Medical Staff Dues and Fees Policy. A practitioner's failure to provide the above information, without good cause, shall be deemed a voluntary resignation from the staff and shall automatically result in expiration of appointment unless explicitly extended for not more than two 30-day periods by action of the Medical Executive Committee. The Medical Staff Coordinator verifies all information and notifies the staff appointee of any information inadequacies or problems. The staff appointee shall have the burden of producing adequate information and resolving any doubts about the data.

2. **From internal and/or external sources:** The Medical Staff Coordinator shall collect from each staff practitioner's credentials file, and other relevant sources, information regarding the individual's professional and collegial activities, performance and conduct in this and/or other hospitals. Such information shall include, but not be limited to:
    a. Patterns of care as demonstrated in findings of quality/utilization monitoring activities;
    b. Medical records/hospital reports;
    c. Continuing education activities including maintenance of Board Certification, allowing for temporary compassionate exceptions on a case by case basis
    d. Attendance at required medical staff and department meetings;
    e. Service on medical staff, department, and hospital committees;
    f. Timely and accurate completion of medical records;
    g. Compliance with all applicable bylaws, policies, rules & regulations and procedures; and
    h. Information from the National Practitioner Data Bank.

In the event that all required information is not returned within 30 days, the practitioner's assistance will be requested and will indicate a date by which all information must be received. If the information is still not received by the specified date, the reappointment request will not be processed and appointment will terminate.

All returned documents shall be reviewed and verified as described in the **INITIAL APPOINTMENT POLICY**.

Practitioner Profile: A Practitioner Profile shall be compiled showing clinical activity and quality/utilization monitoring information in cooperation of the medical staff coordinator and the quality management director.

DEPARTMENT CHAIR RECOMMENDATION

The completed file including all documentation mentioned above shall be sent to the department chair for review.

Department action: The chair of the department in which the staff provider requests or has exercised privileges shall review the appointee's file as described above and shall forward to the Executive Committee a written report of the staff provider's performance, also indicating if he or she knows of any present or potential physical or behavioral problem affecting the practitioner's ability to perform professional and medical staff duties appropriately. The report must also indicate the practitioner's current clinical competence and ability to safely exercise requested clinical privileges. The department chair may seek external consultation regarding the provider's performance.

Executive Committee action: The Executive Committee shall review the appointee's file, the department reports, and all relevant information available to it and shall forward to the Board of Commissioners a written report with recommendations for reappointment or non-reappointment, and for staff category, department assignment and clinical privileges.

Should the Executive Committee require time to gather additional information regarding the reappointment applicant, such that the practitioner's appointment and privileges have expired, an automatic extension will apply. The extension will remain in effect until the Board has made its recommendation.

If the Executive Committee's recommendation is deemed adverse under the terms in the Medical Staff Bylaws, the provisions of the Medical Staff Bylaws will become effective.

FINAL PROCESSING AND BOARD OF COMMISSIONERS ACTION

Final processing of requests for reappointment shall follow the same procedure set forth for initial appointment.

Effective Date:	**01/23/2007**		**Dept: of Record:**	**Medical Staff Services**			
			Policy Owner:	**Michael ChristiansenShannon ~~Carlson~~**			
Print Date:			**Revision By:**	**~~Shannon Carlson~~Michael Christiansen**		**Revision Date:**	**05/16/2016 ~~07/14/2014~~**
			Reviewed By:	**Medical Executive Committee (MEC)**		**Review Date:**	**05/16/2016 ~~11/17/2014~~**
			Committee Review:	**MEC**		**Date Approved:**	**11/17/2014**
			Committee Review:			**Date Approved:**	

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is on the KVH Intranet.

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Pre-application Policy

Medical Staff Services

Type: Policy
Status: Official
Last Reviewed:

PURPOSE:

This Hospital permits application to the Medical Staff from M.D.s, D.O.s, D.D.S.s, and D.P.M.s.

Other practitioners, specifically Allied Health Professionals, will be permitted to apply for specific clinical privileges, as outlined in the **ALLIED HEALTH PROFESSIONALS POLICY.**

Field Code Changed

POLICY:

The potential applicant must:

1. Be board eligible/certified or be completing the last 3 months of an ACGME or AOA approved residency; Medical Staff are expected to maintain board certification or qualifications by the American Board of their specialty or the American Osteopathic Associate Board or certification by an equivalent board. Reciprocity agreements with international boards will be accepted.
2. Have actively practiced at least 18 of the last 24 months (residency or private practice);
3. Be currently licensed to practice in the State of Washington and have a current Federal DEA number, if applicable;
4. Maintain professional liability insurance in the amount of $1 million per occurrence and $3 million aggregate ;
5. Have established or plan to establish an office and principal residence in Kittitas County if applying for active staff;
6. Have DSHS provider number, Medicare provider number, and UPIN, or to have applied for these to practice at KVH;
7. If not a US citizen, supply evidence of fulfilling all INS requirements for practice at KVH.

Upon receipt of a completed pre-application form, the Medical Staff Coordinator will verify its contents.

In the event the requirements listed above are not met, the potential applicant will be notified and given an opportunity for an informal discussion with the Chief of Staff and the CEO.

If the requirements are met, the Medical Staff Coordinator will send the applicant a full Washington Practitioner Application to proceed with the privileging process. If the visa is conditional upon employment, then privileges are conditional thereupon.

Effective Date:	06/01/2002	**Document Owner:**	Carlson, Shannon	**Revision Date(s):**	07/18/2011
Print Date:	5/16/2016~~8/15/2011~~				02/22/2013
					03/03/2016

April 2016 Financial Summary

Key Metrics:

1. Operating Margin: April -0.72%, YTD 1.79%
2. Days Cash on Hand: 162.0
3. AR Days (Hospital Only): 47.9

Operating Highlights:

1. PHD 1 District April operations resulted in an operating loss of $42,160, a $92,056 negative budget variance. This produced an operating margin of -0.72% compared to the budgeted margin of 0.82% for April. The budget margin is lower in April primarily due to the provider quarterly incentive pay.

2. April Admissions were 23.3% below budget resulting in a 28.0% negative variance to inpatient days. Year to date admissions are 119, or 25.2% below budget and 19.5% below April of last year. The negative variance in Admissions and Patient Days was the result of lower than budgeted volume for inpatient surgery cases. Outpatient surgery procedures exceeded budget by 19.6%.

3. Overall operating expenses for April were below budget by $79,767 while net operating revenue was under budget by $171,823. Quarterly provider performance incentives were paid in April totaling $134,232.46.

4. Total clinic visits in April were 481 below budget. Year to date the visits are 675 below April year to date of the previous year. Clinic operations for the month resulted in an operating loss of $391,872, a negative budget variance of $77,002. Year to date the Medicaid enhancement payments that offset contractual adjustments are $99,948 below budget.

Kittitas Valley Healthcare

Key Statistics and Indicators

April 2016

		Current Month			Year to Date			Prior YTD		
	Activity Measures	**Actual**	**Budget**	**Var. %**	**Actual**	**Budget**	**Var. %**	**Actual**	**Var. %**	
01	Admissions	89	116	-23.3%	354	473	-25.2%	440	-19.5%	01
02	Patient Days - W/O Newborn	224	311	-28.0%	933	1,257	-25.8%	1,165	-19.9%	02
03	Avg Daily IP Census	7.5	10.4	-28.0%	7.7	10.4	-25.8%	9.7	-20.6%	03
04	Average Length of Stay	2.5	2.7	-6.1%	2.6	2.7	-0.8%	2.6	-0.5%	04
05	Deliveries	23	31	-25.8%	88	128	-31.3%	118	-25.4%	05
06	Case Mix	1.10	0.98	12.4%	1.04	0.98	6.1%	0.94	10.6%	06
07	Surgery Minutes - Inpatient	2,957	4,708	-37.2%	11,635	18,989	-38.7%	14,367	-19.0%	07
08	Surgery Minutes - Outpatient	7,709	6,828	12.9%	29,852	27,537	8.4%	23,025	29.7%	08
09	Surgery Procedures - Inpatient	24	45	-46.7%	96	179	-46.4%	148	-35.1%	09
10	Surgery Procedures - Outpatient	128	107	19.6%	490	435	12.6%	353	38.8%	10
11	ER Visits	1,188	1,164	2.1%	4,666	4,695	-0.6%	4,377	6.6%	11
12	Laboratory	38,861	38,670	0.5%	154,763	155,968	-0.8%	155,125	-0.2%	12
13	Radiology	26,887	24,985	7.6%	101,883	100,777	1.1%	100,253	1.6%	13
14	Rehab	3,352	3,391	-1.2%	13,484	13,676	-1.4%	12,383	8.9%	14
15	Outpatient Visits	6,195	6,344	-2.3%	25,483	25,588	-0.4%	25,648	-0.6%	15
16	Outpatient Percent of Total Revenue	83.3%	77.9%	6.8%	82.5%	77.9%	5.8%	79.1%	4.3%	16
17	Clinic Visits	4,944	5,425	-8.9%	20,213	21,957	-7.9%	20,888	-3.2%	17
18	Adjusted Patient Days	1,339	1,409	-5.0%	5,330	5,698	-6.5%	5,574	-4.4%	18
19	Equivalent Observation Days	88	79	11.0%	275	318	-13.4%	308	-10.6%	19
20	Avg Daily Obs Census	2.9	2.6	11.0%	2.3	2.6	-13.4%	2.5	-10.6%	20
	Financial Measures									
21	Salaries as % of Net Pt Revenue	52.2%	51.7%	-0.9%	51.0%	49.4%	-3.1%	50.1%	-1.7%	21
22	Salaries/Bene as % of Net Pt Revenue	64.5%	63.0%	-2.3%	62.7%	60.6%	-3.5%	61.1%	-2.6%	22
23	Revenue Deduction %	45.9%	44.7%	-2.6%	45.3%	44.7%	-1.4%	44.1%	-2.8%	23
24	Operating Margin	-0.7%	0.8%	-187.0%	1.8%	3.3%	-45.6%	4.3%	-58.3%	24
	Operating Measures									
25	Productive FTE's	398.1	409.8	2.9%	394.4	409.8	3.8%	387.0	-1.9%	25
26	Non-Productive FTE's	45.3	48.6	6.7%	46.4	48.6	4.4%	50.9	8.9%	26
27	Paid FTE's	443.4	458.4	3.3%	440.8	458.4	3.8%	437.9	-0.6%	27
28	Operating Expense per Adj Pat Day	$ 4,430	$ 4,265	-3.9%	$ 4,258	$ 4,150	-2.6%	$ 3,878	-9.8%	28
29	Net Revenue per Adj Pat Day	$ 4,398	$ 4,300	2.3%	$ 4,336	$ 4,291	1.0%	$ 4,052	7.0%	29
30	A/R Days-Hospital Only	47.9	50.0	4.2%	47.9	50.0	4.2%	49.8	3.8%	30
31	Days Cash on Hand	162.0	170.0	-4.7%	162.0	170.0	-4.7%	180.7	-10.4%	31

Kittitas Valley Healthcare
Income Statement
April 2016

	Current Month				Year-to-Date				Prior Y-T-D	
	Actual	Budget	Variance	Variance %	Actual	Budget	Variance	Variance %	Actual	
Patient Services Revenue:										
Inpatient Revenue	1,784,936	2,372,628	(587,692)	-24.77%	7,257,103	9,569,600	(2,312,497)	-24.17%	8,302,499	1
Outpatient Revenue	8,882,946	8,378,556	504,390	6.02%	34,199,654	33,811,957	387,698	1.15%	31,417,783	2
Total Patient Services Revenue	$ 10,667,882	$ 10,751,184	$ (83,302)	-0.77%	$ 41,456,757	$ 43,381,556	$ (1,924,799)	-4.44%	$ 39,720,281	3
Deductions from Revenue:										
Contractual Adjustments	4,595,100	4,546,727	(48,373)	-1.06%	17,710,708	18,343,472	632,764	3.45%	16,675,755	4
Provision for Bad Debts	158,207	184,426	26,219	14.22%	606,509	743,852	137,344	18.46%	507,342	5
Charity and Uncompensated Care	107,665	57,377	(50,288)	-87.64%	345,515	231,421	(114,094)	-49.30%	253,404	6
Prior Yr Cost Rep Settle	-	-	-	-	-	-	-	-	-	7
Other Allowances	36,332	21,981	(14,351)	-65.29%	136,138	88,656	(47,482)	-53.56%	85,042	8
Total Deductions from Revenue	$ 4,897,304	$ 4,810,511	$ (86,793)	-1.80%	$ 18,798,870	$ 19,407,401	$ 608,531	3.14%	$ 17,521,543	9
Net Patient Services Revenue	5,770,578	5,940,673	(170,095)	-2.86%	22,657,888	23,974,155	(1,316,268)	-5.49%	22,198,738	10
Other Operating Revenue	117,942	119,669	(1,728)	-1.44%	451,725	478,677	(26,952)	-5.63%	383,175	11
Total Operating Revenue	$ 5,888,520	$ 6,060,343	$ (171,823)	-2.84%	$ 23,109,613	$ 24,452,833	$ (1,343,220)	-5.49%	$ 22,581,913	12
Operating Expenses:										
Salaries & Wages	3,011,519	3,072,605	61,086	1.99%	11,544,311	11,852,930	308,619	2.60%	11,123,411	13
Employee Benefits	711,961	672,618	(39,344)	-5.85%	2,661,841	2,669,073	7,233	0.27%	2,440,501	14
Professional Fees	370,475	301,931	(68,544)	-22.70%	1,272,417	1,179,595	(92,822)	-7.87%	928,256	15
Supplies	804,902	797,808	(7,094)	-0.89%	2,703,590	3,330,381	626,791	18.82%	2,752,567	16
Utilities	60,352	72,299	11,947	16.52%	273,795	306,803	33,008	10.76%	289,937	17
Purchased Services	426,667	525,695	99,028	18.84%	2,105,053	2,105,626	573	0.03%	2,010,508	18
Depreciation	227,142	227,284	141	0.06%	905,728	909,135	3,407	0.37%	882,771	19
Rent/Lease	86,154	84,148	(2,006)	-2.38%	353,778	319,291	(34,486)	-10.80%	333,388	20
Insurance	74,913	52,876	(22,037)	-41.68%	228,812	221,021	(7,791)	-3.52%	193,219	21
Travel & Education	42,864	54,423	11,559	21.24%	148,555	170,253	21,699	12.74%	106,342	22
Licenses & Taxes	72,535	80,452	7,917	9.84%	290,753	287,908	(2,845)	-0.99%	294,786	23
Interest	24,204	24,214	10	0.04%	88,017	96,855	8,838	9.12%	116,252	24
Other Direct Expenses	16,992	44,093	27,101	61.46%	120,036	201,017	80,981	40.29%	141,377	25
Total Operating Expenses	$ 5,930,680	$ 6,010,446	$ 79,767	1.33%	$ 22,696,684	$ 23,649,889	$ 953,205	4.03%	$ 21,613,314	26
Operating Income	$ (42,160)	$ 49,896	$ (92,056)	-184.50%	$ 412,928	$ 802,944	$ (390,015)	-48.57%	$ 968,599	27
Operating Margin %	-0.72%	0.82%			1.79%	3.28%			4.3%	
Non-Operating Revenue/Exp	121,362	130,000	(8,638)	-6.64%	623,526	520,000	103,526	19.91%	584,435	28
Net Income	$ 79,202	$ 179,896	$ (100,694)	-55.97%	$ 1,036,454	$ 1,322,944	$ (286,489)	-21.66%	$ 1,553,034	29
Unit Operating Income										
Hospital	470,698	447,133	23,565	5.27%	1,692,137	1,910,554	(218,417)	-11.43%	1,738,953	30
Clinic Group	(391,872)	(314,869)	(77,002)	-24.46%	(850,597)	(804,446)	(46,151)	-5.74%	(602,269)	31
Home Care Grp	26,532	7,118	19,414	272.73%	(102,678)	32,893	(135,571)	-412.16%	123,172	32
Hospitalist	(147,713)	(90,985)	(56,729)	-62.35%	(292,618)	(312,304)	19,686	6.30%	(291,256)	33
Urgent Care	195	1,499	(1,304)	-86.98%	(33,316)	(23,754)	(9,562)	-40.25%	0	34
Totals	$ (42,160)	$ 49,896	$ (92,056)	-184.50%	$ 412,928	$ 802,944	$ (390,015)	-48.57%	$ 968,599	35

Balance Sheet
April 2016

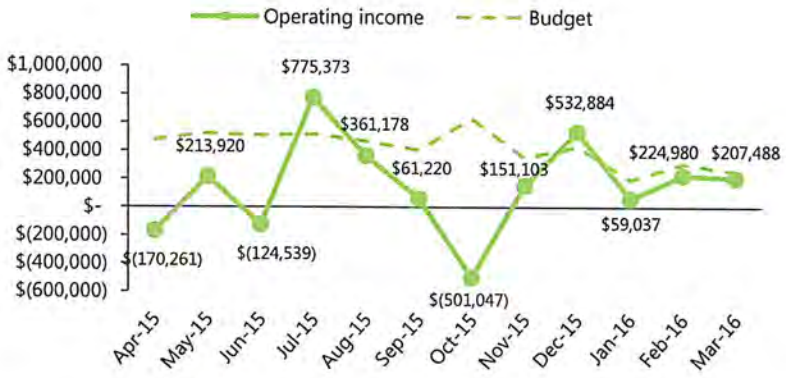
		Current Month	Prior Year End	Change	
	Current Assets:				
1	Cash	3,730,418	7,562,435	(3,832,017)	1
2	Patient Accounts Receivable	9,230,554	7,079,248	2,151,306	2
3	Other Receivable	350,219	106,463	243,756	3
4	Inventories	996,346	910,035	86,311	4
5	Prepaid Expenses and Deposits	1,099,200	579,944	519,255	5
6	**Total Current Assets**	**15,406,736**	**16,238,125**	**(831,390)**	**6**
	Assets Whose Use is Limited:				
7	Investments	25,442,698	25,253,677	189,021	7
8	**Total Assets Whose Use Is Limited**	**25,442,698**	**25,253,677**	**189,021**	**8**
	Property, Plant & Equipment:				
9	Property, Plant and Equipment	57,699,644	54,926,987	2,772,657	9
10	Less Accumulated Depreciation	33,749,315	32,843,586	905,728	10
11	**Net Property, Plant & Equipment**	**23,950,329**	**22,083,400**	**1,866,929**	**11**
	Other Assets				
12	Bond Issue Costs, Less Amortization	0	0	0	12
13	**Total Other Assets**	**0**	**0**	**0**	**13**
14	**Total Assets**	**64,799,764**	**63,575,203**	**1,224,561**	**14**
	Current Liabilities:				
15	Accounts Payable	1,998,582	1,720,776	277,806	15
16	Cost Reimbursement Payable	51,884	51,884	0	16
17	Accrued Salaries	(0)	603,984	(603,984)	17
18	Accrued Employee Benefits	775,471	674,274	101,198	18
19	Accrued Vacations	2,012,638	1,713,651	298,987	19
20	Current Maturities of Long-Term Debt	1,424,558	1,424,558	0	20
21	Current Maturities of Capital Leases	0	0	0	21
22	**Total Current Liabilities**	**6,263,133**	**6,189,127**	**74,007**	**22**
	Other Liabilities:				
23	Accrued Interest 2008 UTGO & 2009 LTGO B	138,539	27,708	110,831	23
24	2008 UTGO Refunding Bonds Premium	82,766	96,782	(14,016)	24
25	Deferred Revenue - Home Health	29,330	201	29,129	25
26	**Total Other Liabilities**	**250,635**	**124,692**	**125,944**	**26**
	Long-Term Debt & Capital Leases:				
27	Long-Term Debt - 2008 UTGO Bonds	2,260,442	2,260,442	0	27
28	Long-Term Debt - 2009 LTGO Bonds	3,397,887	3,397,887	0	28
29	Long-Term Debt - Energy Project	(0)	(0)	0	29
30	Long-Term Debt - Dell	(0)	(0)	0	30
31	Long-Term Debt - PACS System	0	11,844	(11,844)	31
32	**Total Long-Term Debt & Leases**	**5,658,329**	**5,670,173**	**(11,844)**	**32**
	Fund Balances:				
33	Equity - Hospital Operations	51,591,212	47,859,832	3,731,381	33
34	Income (Loss) Year-to-Date	1,036,454	3,731,381	(2,694,926)	34
35	**Total Fund Balance**	52,627,667	51,591,212	1,036,454	35
36	**Total Liabilities & Fund Balance**	64,799,764	63,575,203	1,224,561	36

Cash Flow
Year to Date, April 2016

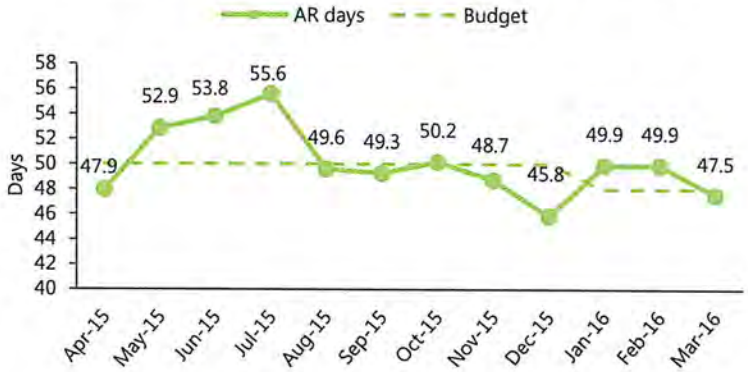
		Cash	Add	Subtract
1	**Net Book Income**	**1,036,454**	**1,036,454**	
	Add Back Non Cash Expenses			
2	Depreciation	905,728	905,728	
3	Provision For Bad Debt			
4	Loss on Sale of Assets			
5	**Net Cash From Operations**	**1,942,183**		
	Increase in Current Assets = ( )			
6	Patient Accounts & Other Receivables	(2,151,306)		(2,151,306)
7	Other Receivables	(243,756)		(243,756)
8	Inventories	(86,311)		(86,311)
9	Prepaid Expenses & Deposits	(519,255)		(519,255)
10	**Total Current Assets**	**(3,000,628)**		
11	Investments	**(189,021)**	0	(189,021)
	Purchase of Property, Plant & Equipment:	**(2,772,657)**		(2,772,657)
12	**Net Property, Plant & Equipment**	**(2,772,657)**		
13	Bond Issue Costs, Less Amortization	**0**		
14	**Total Assets**	**(4,020,124)**		
	Decrease in Current Liabilities: = ( )			
15	Accounts Payable	277,806	277,806	
16	Cost Reimbursement Payable	0		
17	Accrued Salaries	(603,984)		(603,984)
18	Accrued Employee Benefits	101,198	101,198	
19	Accrued Vacations	298,987	298,987	
21	Current Maturities of Long-Term Debt	0		
22	Current Maturities of Capital Leases	0		
23	**Total Current Liabilities**	**74,007**		
	Decrease in Other Liabilities:= ( )			
24	Accrued Interest on 1998, 1999 UTGO Bonds	110,831	110,831	
25	2008 UTGO Refunding Bonds Premium	(14,016)		(14,016)
26	Deferred Revenue - Home Health	29,129	29,129	
27	**Total Other Liabilities**	**125,944**		
	Decrease in LT Debt & Cap Leases:= ( )			
28	Long-Term Debt - 2008 UTGO Bonds	0		
29	Long-Term Debt - 2009 LTGO Bonds	0		
30	Long-Term Debt - Energy Project	0		
31	Long-Term Debt - Dell	0		
32	Long-Term Debt - PACS System	(11,844)		(11,844)
32	**Total Long-Term Debt & Leases**	**(11,844)**		
33	**Total Liabilities**	**188,106**		
34	**Net Change in Cash**	**(3,832,017)**	**2,760,133**	**(6,592,150)**
35	Beginning Cash On Hand	7,562,435		
36	**Ending Cash On Hand**	3,730,418		

Financial Stewardship

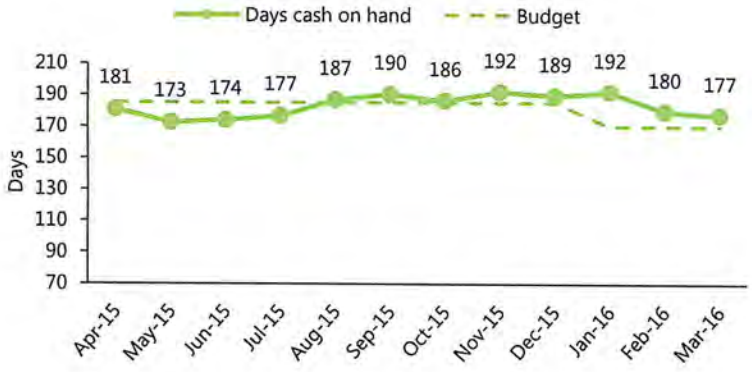
Operating income ↑



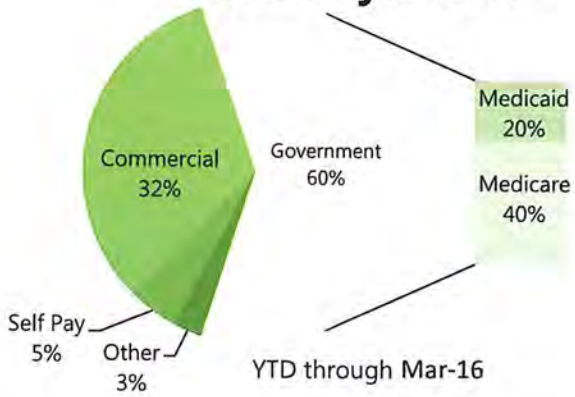
Accounts receivable days ↓



Days cash on hand ↑



2016 Payer Mix



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Last updated 5/19/2016

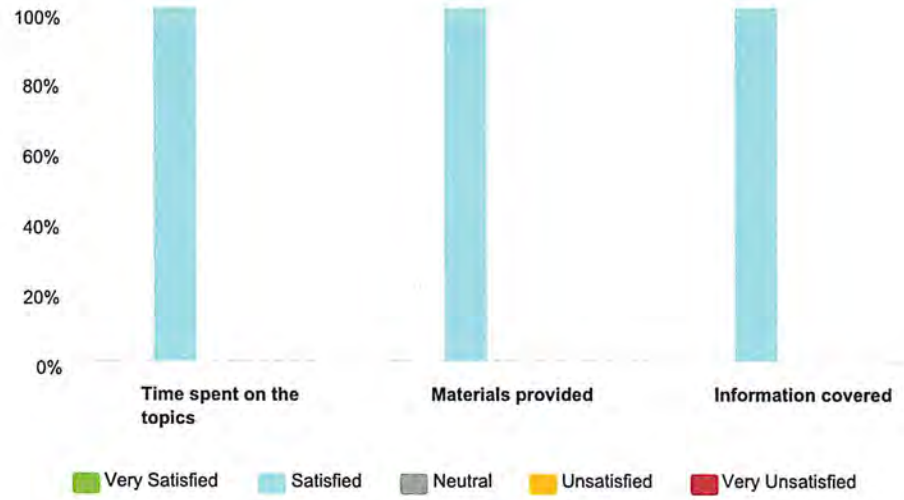
Board Evaluation Results

Results from April 2016 meeting

Includes board responses to a survey specific to the last meeting and dashboards displaying data for the past 12 months.

Q1 How satisfied are you with the QUALITY agenda items covered?

Answered: 1 Skipped: 0

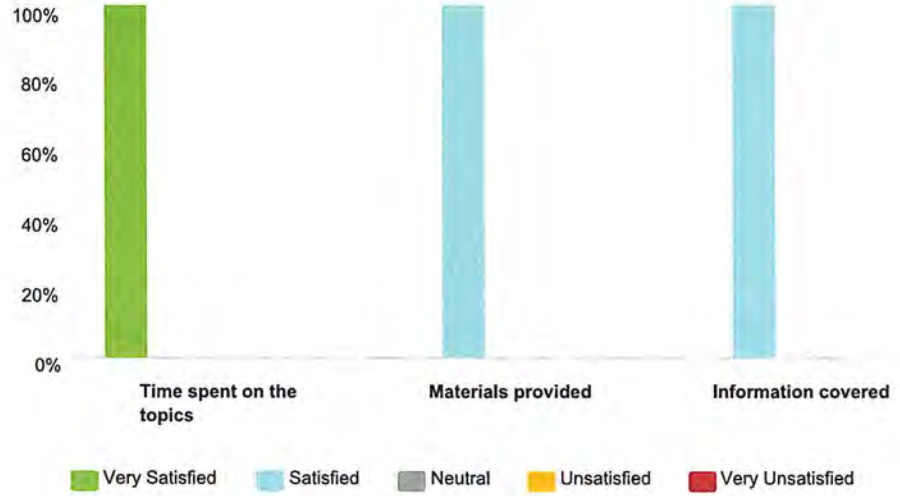


	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	Total
Time spent on the topics	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1
Materials provided	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1
Information covered	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1

#	Comments (please specify):	Date
	There are no responses.	

Q2 How satisfied are you with the EMERGING HEALTHCARE ISSUES agenda items covered?

Answered: 1 Skipped: 0

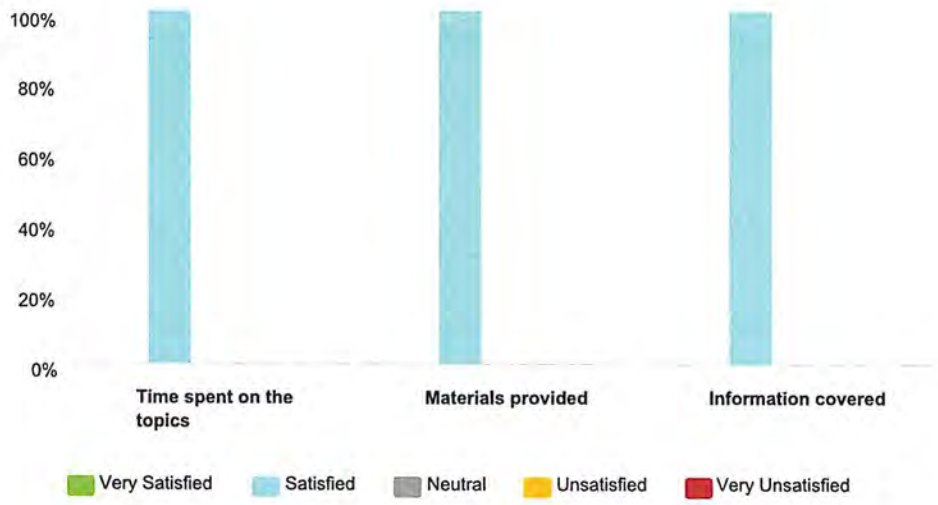


	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	Total
Time spent on the topics	100.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	1
Materials provided	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1
Information covered	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1

#	Comments (please specify):	Date
	There are no responses.	

Q4 How satisfied are you with the FINANCIAL agenda items covered?

Answered: 1 Skipped: 0

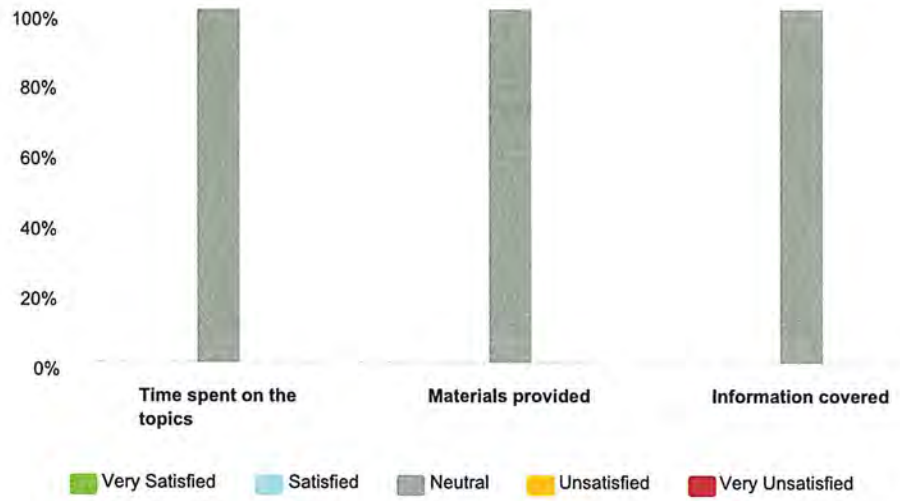


	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	Total
Time spent on the topics	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1
Materials provided	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1
Information covered	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1

#	Comments (please specify):	Date
	There are no responses.	

Q5 How satisfied are you with the PUBLIC POLICY agenda items covered?

Answered: 1 Skipped: 0



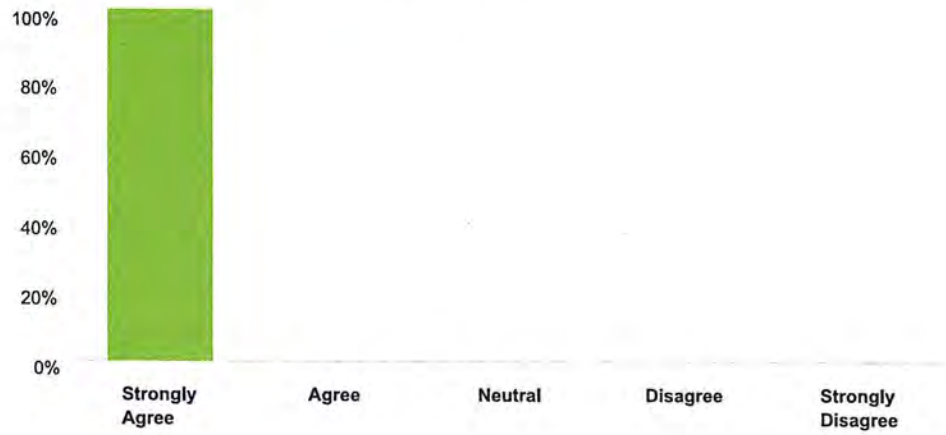
	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied	Total
Time spent on the topics	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1
Materials provided	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1
Information covered	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1

#	Comments (please specify):	Date
	There are no responses.	

09

Q6 The format and content of the CONSENT AND REPORT agenda packet documents were sufficient enough to support decision making.

Answered: 1 Skipped: 0



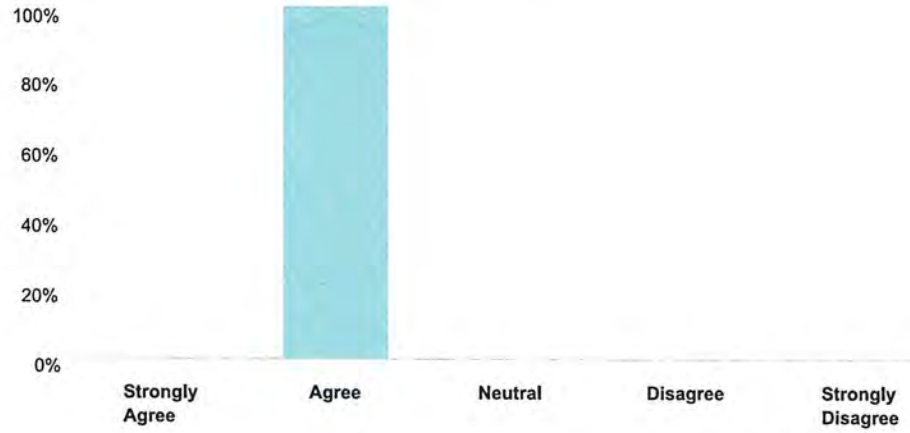
Answer Choices	Responses	
Strongly Agree	100.00%	1
Agree	0.00%	0
Neutral	0.00%	0
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Total		1

#	Comments (please specify):	Date
	There are no responses.	

6

Q7 The EMERGING HEALTHCARE ISSUES presentation format supported active board involvement in the discussion.

Answered: 1 Skipped: 0

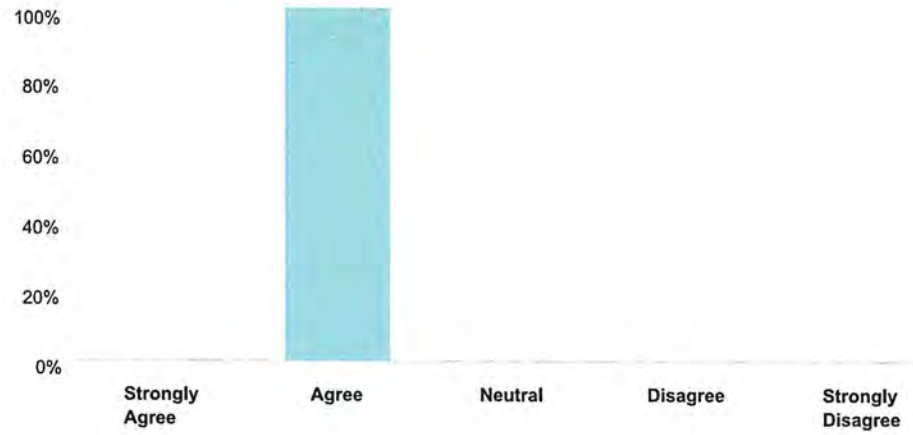


Answer Choices	Responses	
Strongly Agree	0.00%	0
Agree	100.00%	1
Neutral	0.00%	0
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Total		1

#	Comments (please specify):	Date
	There are no responses.	

Q8 Information presented during the meeting was sufficient to enable decision making.

Answered: 1 Skipped: 0

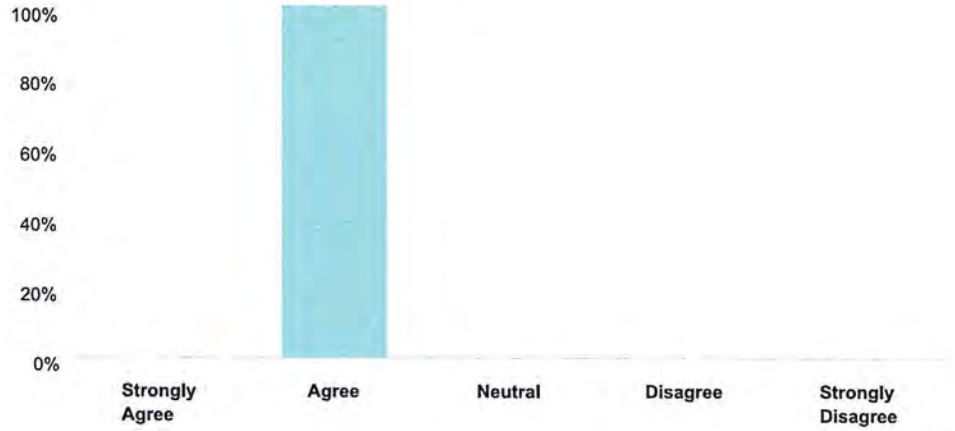


Answer Choices	Responses	
Strongly Agree	0.00%	0
Agree	100.00%	1
Neutral	0.00%	0
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Total		1

#	Comments (please specify):	Date
	There are no responses.	

Q9 This most recent board meeting met our goal regarding the amount of time spent in discussion vs. reporting: 80% discussion vs 20% reporting.

Answered: 1 Skipped: 0



Answer Choices	Responses	
Strongly Agree	0.00%	0
Agree	100.00%	1
Neutral	0.00%	0
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Total		1

#	Comments (please specify):	Date
	There are no responses.	

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Q10 Please indicate additional topics for future EMERGING HEALTHCARE ISSUES.

Answered: 0 Skipped: 1

#	Responses	Date
	There are no responses.	

Q11 Additional comments concerning the meeting:

Answered: 0 Skipped: 1

#	Responses	Date
	There are no responses.	

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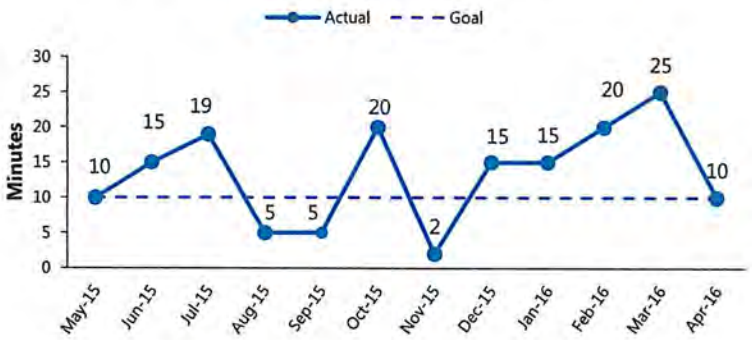
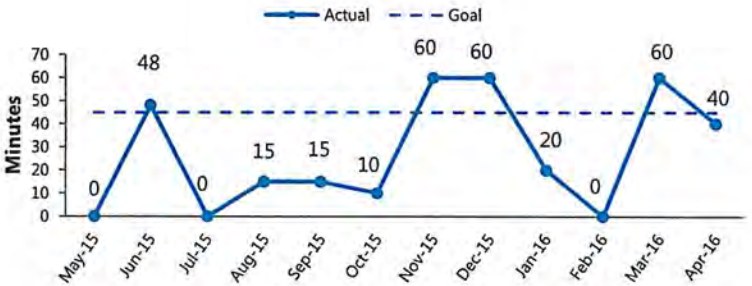
Board Meeting Dashboard

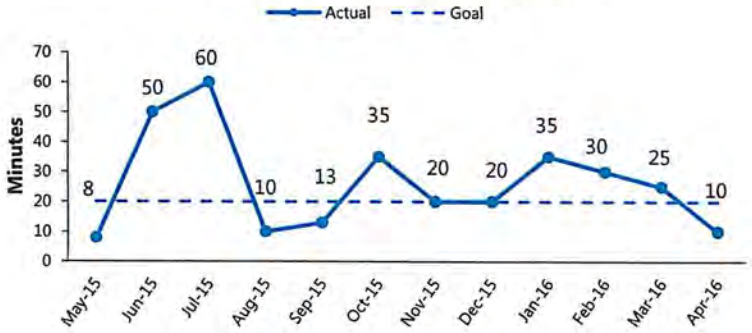
Time spent on financials



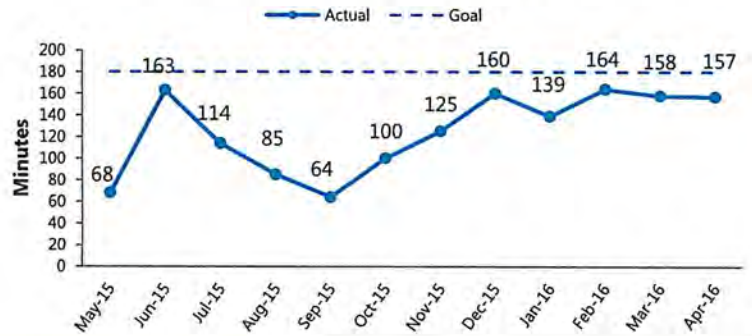
Time spent on emerging health care issues



Time spent on CEO report

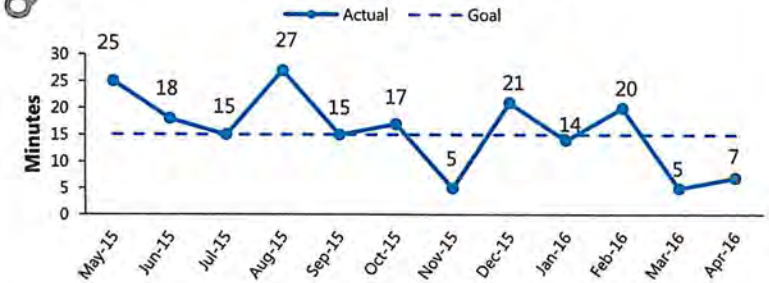


Total meeting time

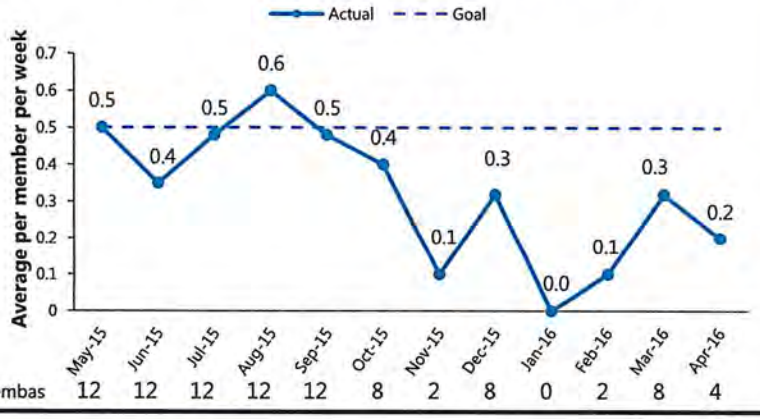


Quality

Time spent on quality (without patient story)



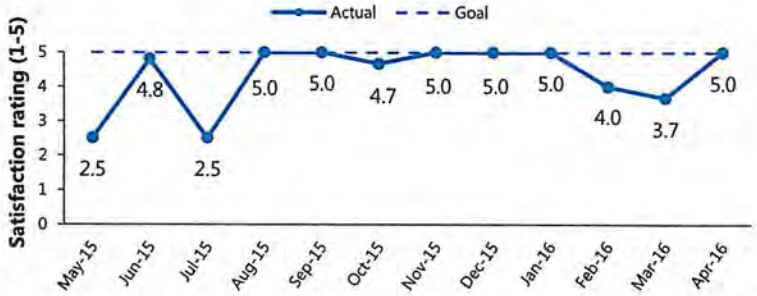
Gemba walks by Board members



Last updated 05/12/2016

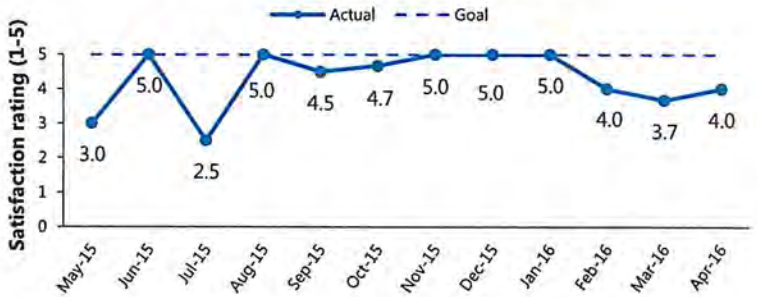
Board Meeting Dashboard

Satisfaction with time spent on emerging health care issues



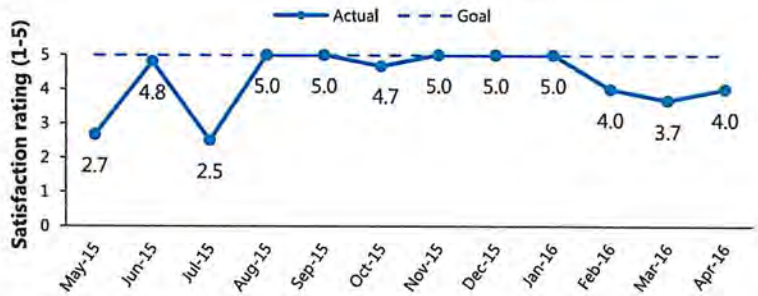
responses	4	5	2	2	2	3	3	2	2	1	3	1

Satisfaction with materials provided for emerging health care issues



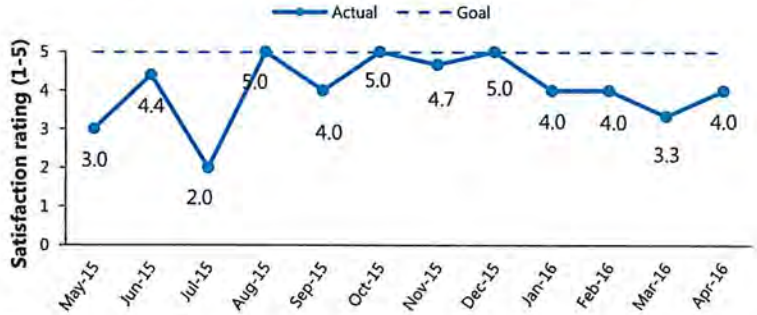
responses	3	5	2	2	2	3	3	2	2	1	3	1

Satisfaction with information covered for emerging health care



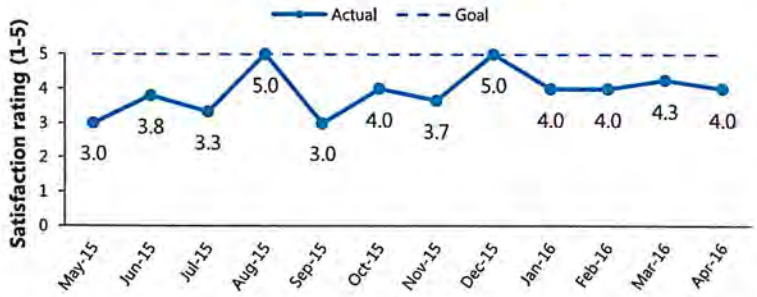
responses	3	5	2	2	2	3	3	2	2	1	3	1

Emerging health care issues presentation format promotes board involvement in discussion



responses	2	5	2	2	2	3	3	2	2	1	3	1

Belief that board met goal of 80% discussion, 20% reporting



responses	4	4	3	2	2	3	3	2	2	2	4	1

Last updated 05/12/2016

May 26, 2016, Board Packet Clippings/Information

Daily Record, 5/11/16

Hospital board reaches out to public

Matthew Altman

Contributed column

The Board of Commissioners for Kittitas County Hospital District 1 has been working for the last several months to improve transparency and communication with regard to board operations.

All five board members — the three newly elected commissioners and the two returning members — are eager to address issues that arose during the last election. In this brief column, I'm going to talk about actions that we have already taken and efforts that you will see in the coming months.

Perhaps the biggest change we're making is to start video recording our monthly board meetings. Agendas and minutes of the meetings are already posted online, and hard copies are available from the KVH administrative offices. However, we realize that not everyone can attend our meetings, so recording them will allow anyone who is interested to see and hear what transpired. We expect recording to begin at this month's meeting, on May 26. Videos will be posted on the KVH website shortly after each meeting.

Since we're governed by Washington's Open Public Meetings Act, our monthly board meetings are open to the public. In order to encourage more community members to attend, we have adjusted the meeting time to make it more convenient for those with regular working schedules. Our monthly meeting now begins at 5 p.m., with public comment set for 5:30 p.m. Changing the meeting time from 4:30 to 5 p.m., and moving the time for public comment from the beginning of the meeting to 5:30 p.m. will, we hope, allow for more public participation and input.

Another exciting development is that board members will begin holding regular office hours so that KVH employees or members of the public can stop by and talk to us. Elected officials have an obligation to be available and to communicate with their constituents, which is, for example, why state representatives have offices in their home districts.

With regard to Hospital District Commissioners in particular, the Washington State Hospital Association (WSHA) recommends that the Board promote "community centeredness" by "establishing a process for eliciting community input and viewpoints." Having regular office hours will allow us to maintain this kind of relationship with the community. We will be rotating the board members who are there (one or two at a time), the location is the meeting room at Jerrol's and the times will be advertised in the Daily Record and posted on the "Commissioners" page of the KVH website.

This is an informal gathering, so you can come any time during the scheduled hours. For questions about office hours or our monthly meetings, please contact KVH's administrative offices at 509-962-7302.

We have also started to run more community healthcare roundtables. Often these are held at the hospital during the early evening, and participants have a chance to tour the hospital; listen to presentations from commissioners, the CEO, and other members of the senior leadership team; and ask questions or tell us what you want in your community hospital.

We've also begun to take the program on the road, visiting local groups that are interested in learning more about what a public hospital district is and what KVH has to offer. You can sign up to participate in a community healthcare roundtable at www.kvhealthcare.org/ roundtable. In addition to the roundtables, board members are also meeting with community groups to discuss master site facilities planning.

Daily Record, 5/11/16

Finally, commissioners have posted their email addresses on the board's homepage, www. kvhealthcare.org/board-of commissioners . If you have questions for us or concerns that you would like us to be aware of, please email us directly. If we can't answer your question, we'll refer you to someone who can.

The board is aware that we are your elected representatives and that we are the governing body for the public hospital district. Like any other elected officials, we want to keep the lines of communication open. You are both our constituents and our fellow community members. I encourage you to talk to us and attend our regular meetings. Thanks for your interest in the future of KVH.

Matthew Altman is a Kittitas County Hosptial District 1 commissioner.

Samaritan, Confluence affiliation talks still ongoing

By RYAN MINNERLY, Staff Writer | Posted: Monday, May 2, 2016 4:45 pm

MOSES LAKE — Samaritan Healthcare and Confluence Health announced intentions to form an affiliated organization about one year ago. There is still a lot of work to be done, but the vision is getting closer to being realized.

Theresa Sullivan

Samaritan CEO Theresa Sullivan said the two organizations are still working on the formation of a terms sheet for the prospective affiliation, which would essentially lay out the structural makeup of the partnership. Some unexpected events slowed the process, like the resignation of Samaritan's then-CEO Tom Thompson in September 2015. But more than anything, Sullivan said, the process of defining the parameters of the affiliation is one that simply takes time because of its many moving parts.

"We are trying to work through and figure out what meets our critical success factors, our guiding principles, regulatory or legal kinds of issues, what's going to work financially, and then how does it agree with both organizations," Sullivan said. "So we have still been working toward that terms sheet."

As for a timeline for when the partnership may be finalized, Sullivan said that matter is nothing more than educated guesswork. Sullivan said it is possible that there will be more news from the affiliation process in May, but there is no certainty to that estimation.

"I think we are getting close," she said.

Even if the process of developing the final terms sheet is close to its end, though, that doesn't mean the affiliation will be official immediately following. After the structural shape of the partnership is determined, there will still be more plenty more work to be done to hammer out each and every detail before the deal is closed.

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"We are hopeful that if everything goes right, maybe we could see something toward the end of the year (in terms) of a closing of a transaction, but again, there is still a lot of process that has to happen."

Though the process has been long and involved for both organizations, Sullivan said it has been smooth, all things considered — meaning there have been no major controversies to speak of. Both Samaritan and Confluence "have a common goal," she said, so they are working well together.

The goal of the affiliation is to "maintain an integrated regional health care system that delivers high quality, efficient, and cost effective health care for Grant County and the north central Washington region," according to the original announcement from last March.

What does that mean for local residents and their health care?

With dialogue still ongoing between Samaritan and Confluence and the partnership's parameters not yet defined, it's hard to say. But Sullivan said there are a few target areas, without specifics, within which residents can expect to see improvements if and when the affiliation becomes official.

The first is enhanced collaboration between health care providers in the area. Sullivan said currently, many health care organizations operate on different information systems, preventing smooth transfer of patient records between providers. Even at Samaritan, the hospital recently switched to the EPIC electronic health record, while the clinic is not yet on the same system. One goal of the affiliation process is to put health care providers in the area on the same page so they can seamlessly transfer information to better serve patients.

"Right now, when you look at something like information systems, you have providers on different systems. We (Samaritan and Confluence) could have a common system with EPIC," Sullivan said. "That's a big deal for patients as they are moving from clinics, hospitals. Why don't you have my record if I was seen in the clinic? Why don't you know that?"

Continuity of health care is a major selling point for the partnership. Sullivan said aligning the services offered by both organizations will also benefit local residents seeking care.

"Health care is changing and we really need to be coordinating care across," she said. "So if somebody goes to the hospital for care, how is that information coming back to make sure that their provider in the clinic has that information?"

Of course, improving local access to care is at the center of the prospective partnerships. But in order to do so and to expand services offered in the area, more doctors will be needed. Fortunately, Sullivan said they expect to see improvements in the recruitment of physicians and other providers once the affiliation takes place.

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"It's easier to do that when you are able to do that together," she said. "And that will help us — when you talk about growing services, a lot of times in order to grow or expand services, you have to be able to recruit doctors or other health care providers. I think we can improve doing that together."

Although the current condition of the local health care system is apparently stable, Sullivan said the affiliation is expected to ensure stability for years to come. While both organizations are healthy today, she said a partnership between the two can contribute to maintaining that stability.

"With health care reform and the way that health care is changing, we want to look to the future while we are healthy and we want to be able to retain that local health care control as much as we can," Sullivan said. "Partnering with a partner like Confluence really makes a lot of sense in doing that proactively, rather than going, 'OK, we thought we were doing good and we were, but now we are not anymore.'"

Put it all together and the vision is really to make Moses Lake "more of a hub for health care services." Being situated an hour and a half from any other care, Sullivan said a Samaritan-Confluence can push Moses Lake toward being the area's epicenter of health care.

"I think there is more that can be offered here," she said. "To me, what a service to the community if it can all work out."

Ryan Minnerly can be reached via email at countygvt@columbiabasinherald.com.

One step closer: Samaritan approves structure of potential Confluence affiliation

By RYAN MINNERLY, Staff Writer | Posted: Thursday, May 12, 2016 9:00 am

MOSES LAKE — Samaritan Healthcare and Confluence Health took a substantive step forward in the process of forming an affiliated health care organization in Moses Lake Tuesday.

Sullivan

The Board of Commissioners of Grant County Public Hospital District No. 1, which owns and operates Samaritan as a government entity, signed a memorandum of understanding (MOU) Tuesday afternoon that outlines the basic structural, governance and financial terms of Samaritan's potential affiliation with Confluence Health.

The signing of the memorandum does not make the affiliation official yet, but representatives from both organizations recognized the move as a step forward in the process of developing a partnership.

The hospital district's Board of Commissioners convened for a special meeting at Samaritan. The commissioners were joined by legal counsel and Confluence representatives to explain the basic parameters of the MOU to a crowd of about 20 meeting attendees.

Confluence's Board of Directors was scheduled to hold a meeting Tuesday evening to consider approving the memorandum of understanding. Confluence CEO Peter Rutherford said he anticipated the Confluence board would join Samaritan in approving the memorandum.

The next step in the process is developing definitive legal agreements for the potential Samaritan-Confluence affiliation — basically, agreeing on the details of the partnership. The MOU outlines what the basic structure and governance of an affiliated organization would look like, but the definitive agreements will fill in all the blanks. According to information released by both Samaritan and Confluence, that process is expected to take several months.

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Howard Thomas, joint counsel for both Samaritan and Confluence, explained that the memorandum of understanding accepted Tuesday lays out a structure in which Samaritan integrates with Confluence's Grant County operations.

If the affiliation is eventually finalized, Grant County Public Hospital District No. 1 will lease all of its real estate assets, including Samaritan and its clinics, to a new company that will be created as a division of Confluence. All of Samaritan's current employees will be transferred to that new company with the same salaries and principally the same benefits, Thomas said, except for physicians. Samaritan's current physicians will transfer to the Wenatchee Valley Medical Group, which Thomas said is a "professional corporation that houses all of the physicians within Confluence."

Brad Berg, an attorney for Foster Pepper that is serving as legal counsel for Samaritan, explained that the established affiliation structure is just another way for the hospital district to provide health care services to its residents. Currently, the district owns and operates Samaritan, but if the affiliation takes place, it will lease its facilities to Confluence and monitor the lease to assure services continue to be provided locally.

"What that really represents, if it were to go forward, is a decision by the board to change the manner in which it wants to assure that health care services are provided to the residents of the district," Berg said.

"As a result, the role of the board will shift from being involved directly in the operation, to monitoring the terms of the lease and the other agreements to assure that health care services continue to be provided to district residents."

Thomas said as for governance, Grant County will be "well represented" in the Confluence structure. The district commissioners will appoint two individuals to serve on Confluence Health's Board of Directors, which already has two Grant County residents.

"Part of the idea here was to really make sure that the commission is still fully involved in Confluence and have a voice at Confluence as the organization continues to grow," Thomas said.

There are checks and balances built into the MOU, too. For instance, if Confluence wanted to eliminate a service currently offered in Moses Lake — which, Thomas said, is "not even remotely part of the discussion" – but if that were the case, the hospital district's Board of Commissioners would have to approve. Likewise, Confluence will get the final say on expansion or addition of services since it will be providing the capital for such ventures after the affiliation takes place.

The memorandum of understanding indicates that the hospital district will lease its facilities to the new Confluence division in Moses Lake for 30 years, with two 10-year options to extend the lease. This provides a long enough time period for true integration to occur, Thomas said.

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Collectively, the two organizations really have an opportunity to improve and expand health care provisions locally, Thomas said.

"Together, you really have a nice footprint geography-wise and also a good complement of services with a lot of multi-specialty physician groups combining with a hospital system," he said. "From there, you can have cradle-to-grave care, if you will, that covers all aspects, and that's the kind of integration that policy makers are looking for as we try to improve quality and value."

That's what the affiliation is all about, Sullivan said — improving local access to high-value, high-quality care in Moses Lake and north central Washington.

"It's easy and needed to look at all of our agreements and the details of what the transaction is, but I think … at the forefront is, what does it mean for our community and what does it mean to the people of the district that we serve?" Sullivan said. "The goal of the whole thing is really to improve those services and really to grow Moses Lake as a (health care) hub."

Berg reiterated Tuesday that the approval of the memorandum of understanding marks a step toward the affiliation, but in no way is it a finalization of a partnership. He said the MOU is the beginning of the process, as it is "an expression of intent by both the district and Confluence to explore affiliation, and it identifies a structure." Neither organization is legally bound to affiliate at this point.

Confluence CEO Rutherford was among those on hand Tuesday at Samaritan. He said the potential affiliation is exciting for local residents.

"I think this is a great thing for the Moses Lake community and it's a great thing for north central Washington," Rutherford said. "I think it sets us up in a way to … lead locally what health care is going to look like for the next several decades in this community. We won't be answering to decision makers outside this region."

"Our goal is to be able to provide as much locally led care as possible in a long-term, viable manner so patients do not have to travel."

Sullivan echoed similar sentiments. She said what is most exciting is the opportunity to expand and improve health care locally so people in the area don't have to seek care outside of the region.

"I'm pretty passionate about the idea of growing services in Moses Lake," Sullivan said. "To me, this is the only way that we are going to be able to really effectively grow service in Moses Lake."

"This is a tremendous opportunity to enhance our existing services and improve access to care, which the people of our community deserve."

Samaritan Healthcare commissioners Julie Weisenburg, Dale Paris, Alan White, and Joseph Akers voted to approve the affiliation MOU. Commissioner Tom Frick abstained.

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May 3, 2016

YAKIMA, Wash. -- Yakima Regional Medical and Cardiac Center and Toppenish Community Hospital are in the process of being sold, a move that has triggered a lawsuit from one of the region's largest charitable foundations.

Yakima Valley Community Foundation is suing the hospitals' owner, alleging it has started a process of selling the hospitals without the foundation's participation, in violation of a long-standing contract.

The foundation has a legal say in the sale under an agreement forged in 2003 when the hospitals were sold by a nonprofit system to a for-profit company.

On March 16, for-profit Community Health Systems, which owns both Regional and Toppenish Community Hospital, notified the foundation of a "preliminary, nonbinding letter of intent" to sell the two facilities with the name of a potential buyer, according to court documents.

Late last week, the foundation filed suit in Yakima County Superior Court arguing that the notification was inadequate and rushed. Under the 2003 agreement, the foundation has the right of first refusal in the event the hospitals were ever sold — meaning the foundation would have an opportunity to match a potential buyer's price and buy the hospitals instead.

The foundation's lawsuit does not identify the potential buyer.

"Our goal here isn't to block them from doing anything," foundation CEO and president Linda Moore said Friday. "Our goal is to have a robust, thoughtful process of selecting the best choice for Yakima that involves the community and the advisory committees that were set up for those two hospitals."

Not even hospital staff or the boards of trustees at Regional or Toppenish were aware of the potential sale — which is "highly offensive," Moore said.

Bertha Ortega, chair of the board of directors at Toppenish, said she got a call on Saturday afternoon from the board's main contact with Tennessee-based CHS.

She said she was told "that there is a process that the hospitals are being sold, but (they) could provide very little information to me at this time."

"I was a little taken aback," she said.

Regional CEO Bryan Braegger and interim Toppenish CEO Christopher Mendoza sent an internal memo to hospital staff on Sunday, which said that due to a confidentiality agreement, the only information they can provide is that they've "been involved in strategic discussions about a potential sale of the hospitals."

The potential sale was meant to remain confidential, the letter says, but "has been made public by the Yakima Valley Community Foundation as a result of a lawsuit."

As to the buyer's identity and what the future holds for staff and patients, "We commit to sharing all of that information with you — in a very transparent way — as soon as we can," the letter says.

Regional administrators said in an email that they were surprised to learn of the foundation's lawsuit, as the discussions surrounding the sale had so far been "cordial and productive."

They want to assure everyone "that we are committed to the best possible future for the hospitals," the email said.

Regional is licensed for 214 beds, making it the second-largest hospital in the county, after Yakima Valley Memorial Hospital. Toppenish has 63 licensed beds.

The foundation's connection to the hospitals dates to its inception in 2003 when Florida-based Health Management Associates bought Regional and Toppenish from Providence Health System.

As part of the sale negotiations, HMA gave $5.9 million to start the foundation and agreed to contribute $1 million a year for the next 10 years.

In the same negotiations, the new foundation was granted the right of first refusal. The agreement is highly unusual and aims to guarantee certain protections when a nonprofit hospital becomes for-profit.

(That right was not activated when HMA was bought by CHS in 2014 because that was a company-wide buyout, not a sale of the individual hospitals.)

CHS' notification in March that it was invoking the right of first refusal was insufficient, the foundation's complaint says, because rather than a detailed description of the potential sale, it was a "nonbinding, preliminary letter of intent."

By invoking the right too early, CHS started the clock on the foundation without them having adequate data to make a decision, said foundation attorney Paul Lawrence of the Seattle-based Pacifica Law Group.

"We believe the right is activated when there is a binding, firm, contractual commitment that specifies the essential elements of a potential sale, and we don't believe that what has been provided to us to date qualifies as an appropriate trigger," he said. "Part of the problem here is, we don't know what agreement we're trying to match, so to speak."

In addition to needing more information, Moore said the foundation should have the ability to "assign" its right of first refusal to another entity — like a nonprofit health care system — which could then buy the hospitals.

And Moore wants more time to consider options. The complaint says the foundation's request for an extension was rejected, with the hospital owners telling the foundation to exercise its right by last Friday or lose it.

"They're saying to the foundation, 'You've got 30 days to make up your mind about a multimillion-dollar acquisition that is a hospital, and you can't partner with anybody to get it done,'" she said. "What kind of right is that? Not much of one."

In the lawsuit, the foundation says the hospital owners told them their right of first refusal cannot be assigned to another entity, but the foundation argues that nothing in their right prohibits such an assignment.

The foundation also asks the court to rule that HMA/CHS have violated both the agreement with the foundation and state law by not providing adequate charity care.

A separate class action has been progressing against Regional and its owners since 2013, alleging the hospital actively discouraged poor people from seeking care and did not meet the state Charity Care Act requirements. A judge in that case ruled in December that the hospital indeed violated the law.

Who they are

CHS is one of the largest for-profit hospital chains in the country, operating 160 hospitals across 22 states.

Last summer, the company announced that it would spin off about 40 of its rural hospitals, primarily in areas where they were the sole acute-care provider, into a new company still under the CHS umbrella.

That spin-off was just completed late last month, but neither Yakima Regional nor Toppenish was included in the creation of the new Quorum Health Corporation, according to the company's website. The closest Quorum hospital is in Springfield, Ore.

Before CHS bought HMA in 2013, its letter of intent to the state Department of Health allocated a price of $177 million to the purchase of Yakima Regional, but because that price was wrapped into the total nationwide buyout of HMA, the figure may not have any bearing on the actual worth of the hospital, Moore said.

In 2003, when HMA first bought Regional and Toppenish from the Sisters of Providence, Moore said the company paid only about $81 million.

She would not disclose who CHS has named as the potential buyer, nor the proposed price of the two hospitals.

Besides the short timeline given for the foundation's decision, Moore said they're greatly concerned by the seeming lack of research done by the potential buyer.

According to the right of first refusal, she said, "They're supposed to give us a fully signed agreement that everybody has looked; they've done their due diligence," looked at all the records, any pending lawsuits, contracts with the doctors, and so forth. "In this circumstance, the buyer hadn't done any of that due diligence."

If the potential buyer had done it, all that information would have been available to the foundation, allowing them to make an informed decision.

Without that information, Lawrence said, it's like agreeing to buy a house at a certain price without knowing whether it needs a new roof.

Community accountability

What the foundation would like to see, Moore said, is a process like what Yakima Valley Memorial Hospital undertook when it began seeking a partner.

"It took them three years to get to the agreement," looking at lines of business and the cultural fit, she said. And they kept the community informed along the way.

The foundation doesn't want to buy a hospital. But she said there are many high-quality nonprofit hospital operators, and there are ways to get the right kind of capital for nonprofit operations, "if you had the right kind of commitment and vision and operational excellence."

"We don't have to take poor medical care from a for-profit operator, or nothing," she said. "I think people have been very disappointed with CHS and HMA's contributions."

In Toppenish, Ortega said they have actually enjoyed good communication with CHS, with the parent company listening to the board's input on a CEO replacement and other matters. CHS has also invested "considerable capital" in the hospital, she said, including new machines and updates to the building.

"I want to be an optimist in how I have dealt with them. They've been very responsive," she said.

But she has no sense of what the company might do next.

"I'm still digesting the information from Saturday," she said. "Like, 'Oh, OK, what's really going on?'"

Given the high need within the Yakima and Toppenish communities, local health care leaders are very concerned about who might buy the hospitals.

Yakima Valley Farm Workers Clinic CEO Carlos Olivares had heard the hospitals were in the process of being sold, and says he's glad the foundation is going to court over it.

"The sad part about this is that the system that comes squeezes the assets out of our community, creates a disastrous situation, then simply passes the ball to the next guy, who's going to again squeeze the last drop that's there and pretty soon, we will have nothing," he said. "And the community is the one that loses."

From his perspective, neither CHS nor HMA fulfilled their commitments to the community. He cited the recent dismantling of Regional's cardiology group as an example of their owners' lack of investment.

"It sounds like an episode from 'Game of Thrones,' when they come in and destroy a town and then they leave," Olivares said. "It's outrageous."

Olivares said it would make sense for Providence to come back to Yakima, given its aggressive growth in Walla Walla and Tri-Cities.

"From my perspective, this would be a no-brainer for them because I think they know the community; I think they would do well; and frankly, they owe us this," he said. "They took off in a big rush and gave it to a company that clearly didn't do what they expected it to do."

Across town, Memorial CEO Russ Myers said that the hospital will continue to focus on patient care. And if there is a sale, he said, Memorial hopes to coordinate care with the new owner when it's necessary to serve patients.

"Health care is a partnership between your community and the health care organization. That's our belief," he said.

However, he said, "Given the licenses that exist and how the state allocates beds, I can tell you that Memorial as it's currently structured cannot take care of this community alone."

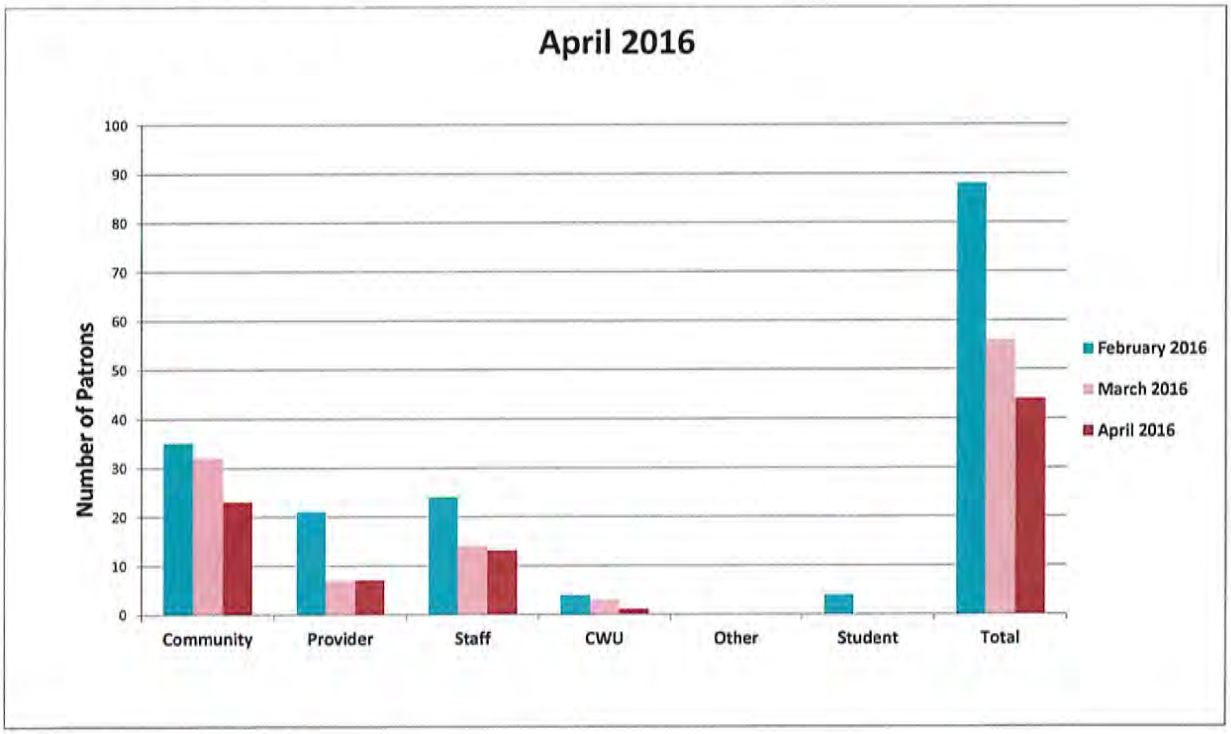
Kittitas Valley Healthcare
Community Health Library
Monthly Patron Statistics

	January			February			March		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Community		21			35			32	
Provider		18			21			7	
Staff		12			24			14	
CWU		0			4			3	
Other		0			0			0	
Student		3			4			0	
Total		54	0		88	0		56	0

	April			May			June		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Community	33	23		20			26		
Provider	48	7		26			30		
Staff	41	13		21			16		
CWU	2	1		1			1		
Other	0	0		2			1		
Student	0	0		2			0		
Total	124	44	0	72	0	0	74	0	0

	July			August			September		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Community	34			32			32		
Provider	24			22			12		
Staff	19			25			19		
CWU	2			0			1		
Other	0			0			0		
Student	0			0			0		
Total	79	0	0	79	0	0	64	0	0

	October			November			December		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Community	23			16					
Provider	20			21					
Staff	12			26					
CWU	0			3					
Other	0			0					
Student	0			1					
Total	55	0	0	67			0	0	0



Community Health Library Databases - Number of Searches

Database Name		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL
UpToDate	2015	1063	1165	1407	1112	1154	1742	1288	1655	1814	1654	2025	1772	17851
	2016	1451	1810	1706	1202									6169
ClinicalKey	2015	156	110	163	217	263	99	186	68	79	207	140	132	1820
	2016	442	167	174	108									891
ClinicalKey for Nurses	2015	----------										48	85	133
	2016	255	61	69	34									419
EBSCO Consumer Health Complete	2015	18	73	31	38	2	16	27	13	8	3	3	8	240
	2016	1	3	33	4									41
ProQuest	2015	14	54	0	0	2	17	12	2	2	2	3	0	105
	2016	13	7	0	4									24
Patron Services														
Articles & Newsletters Sent to Patrons & Providers	2015	8	36	10	28	4	15	6	2	64	48	71	43	287
	2016	42	117	50	52									261
Books Checked Out	2015	47	38	36	30	7	21	20	39	12	27	9	7	293
	2016	27	34	12	19									92
Inter-library Loan	2015								2			1		3
	2016	3	5	1	0									9

n/a = not available

Monthly Book Circulation

	2014	2015	2016
Jan	21	47	27
Feb	50	38	34
Mar	18	36	12
Apr	31	30	19
May	13	7	
June	39	21	
July	32	20	
Aug	20	39	
Sept	17	12	
Oct	17	27	
Nov	19	9	
Dec	40	7	
YTD Total	317	293