Harlan County Health System

Hospital | Heartland Family Medicine
717 N. Brown | 906 7th Street
PO Box 836 | PO Box 665
Alma, NE 68920
www.harlancountyhealth.com

Board of Trustees Orientation Manual

2024

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Congratulations on your appointment to the Harlan County Health System Board. We have prepared this orientation packet for you. Thank you for accepting the challenge and responsibility of this board. I appreciate your commitment to our patients, hospital, and the community.

The orientation packet contains the HCHS Bylaws, the GPHA Contract, financials, our most recent audit, the past year's board minutes, important contact information, and a number of articles. While the articles and documents in the orientation packet center around the role of the board, you will note that some of the information will not apply to our hospital. At some point I would like to visit with each you in person to answer any questions you have.

The next regular board meeting is on February 17 at 4:30 pm in the HCHS conference room. I look forward to what the hospital can accomplish with you on the board. Thanks for your commitment to the hospital.

Sincerely,

Stacy Neubauer

Stacy Neubauer, RN, MHA
Chief Executive Officer
Harlan County Health System
PO Box 836 | Alma, NE 68920

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Board of Trustees Orientation Manual

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COPY

RESTATED BYLAWS

OF THE

BOARD OF TRUSTEES

OF

HARLAN COUNTY HEALTH SYSTEM

ALMA, NEBRASKA

Harlan County Health System

As amended 2014

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ARTICLE I. ORGANIZATION AND PURPOSE

Harlan County Health System ("HCHS") is established under Nebraska Revised Statutes Chapter 23, Article 35 *et seq.*, as amended from time to time. Its purpose is to establish and maintain medical facilities for use in providing care to the sick and injured, principally those who are residents of Harlan County, Nebraska and surrounding communities; and to carry on other health care activities deemed appropriate by the Board of Trustees and as permitted by Nebraska law. For purposes of these Bylaws, all references to HCHS shall be deemed to include all medical facilities owned and operated by HCHS.

ARTICLE II. BOARD OF TRUSTEES

Section 1. Composition. HCHS's governing body is a Board of Trustees (the "Board" or "Board of Trustees") which is appointed by the Harlan County Board of Commissioners (the "County Board"). There shall be seven (7) members of the Board of Trustees unless and until said number is otherwise fixed by the County Board. Trustees satisfying the criteria set forth in Article II, Section 2 shall be appointed by the County Board and shall serve staggered six (6) year terms. Trustees shall hold their respective offices until removal or resignation in accordance with these Bylaws or until their successors are duly appointed and qualified.

Section 2. Qualifications. Each Trustee appointed by the County Board shall have the following qualifications:

a. Be a resident of Harlan County, Nebraska, with reasonable efforts made to ensure representation from residents within and outside the corporate limits of the city where the Health System is located.

b. Not be excluded from participation in any federally funded health care program or listed on any federal exclusionary database. All prospective Trustees shall first be checked among the federal exclusionary databases prior to being appointed by the County Board.

The County Board shall consult with the current Board of Trustees regarding the qualifications and skills of potential appointees prior to appointing new Trustees. The Board of Trustees shall reflect a broad representation of Harlan County, and members of the Board of Trustees shall be appointed for their ability to effectively participate in fulfilling the responsibilities of governing HCHS. Within ten (10) days after appointment, each Trustee shall qualify for office by taking the oath of county officers as set forth in Neb. Rev. Stat. § 11-101. The furnishing of a bond shall not be required unless explicitly required by the County Board upon appointment of a Trustee.

Section 3. Powers. The Board of Trustees shall have all powers provided by Nebraska law to boards of county hospitals. Without limiting the foregoing statement, the Board:

a. May purchase or lease a site for the hospital and other facilities and provide and equip such buildings as necessary to fulfill HCHS's mission.

b. May accept property by gift, devise, bequest, or otherwise, and may execute and carry out such conditions connected to the receipt of any gift, devise, or bequest as deemed appropriate by the Board.

c. May sell, lease, exchange, encumber, or otherwise dispose of the HCHS facilities or any other property under the control of the Board upon a concurring vote of a majority of the Trustees; provided, however, that if such sale, lease, exchange, encumbrance, or disposal is of all or substantially all of the HCHS property, said sale, lease, exchange, encumbrance, or disposal must also be approved by the County Board.

d. May borrow money on an unsecured basis or secured by HCHS's facilities and revenues of those facilities for the purposes of initially financing or refinancing the construction, improvement, maintenance, or replacement of facilities or equipping the facilities and acquiring other property or for any other purpose deemed appropriate by the Board. Any issuance of revenue bonds for which the revenue of the facility or facilities has been pledged shall be subject to the prior approval of the County Board.

e. Shall have the exclusive control of the expenditures of all money collected to the credit of HCHS.

f. Shall have exclusive control over any and all improvements or additions to the HCHS facilities and equipment, including the authority to contract for such improvements, additions, equipment, and other property; provided, however, that if any such improvement or addition to the facility or facilities costs more than fifty percent (50%) of the current replacement cost of such existing facility or facilities, the improvement or addition must first be approved by the County Board. Prior approval of the County Board is not required to purchase or contract for equipment.

g. Shall have exclusive control, supervision, care, and custody of the grounds, rooms, buildings, and other property purchased, constructed, leased, or set apart for the HCHS purposes.

h. Shall have the power to pay all current bills and claims due and owing by HCHS, and shall have the authority to pay the salaries of all employees of HCHS.

i. Shall have the power to expend operating funds for recruitment and the reimbursement of the reasonable expenses of persons interviewed or retained for employment or for medical staff appointment.

j. Upon approval of the County Board, establish and fund a retirement plan for the benefit of its full-time employees; such plan shall be funded by any actuarially recognized method approved by the County Board.

k. May authorize the delivery of any additional health care service, ambulance service, assisted or independent living service, or other ancillary service deemed in the Board of Trustee's opinion to be necessary for the betterment of the health status of the residents of Harlan County.

l. May control, own, and operate clinics and health care facilities both within and outside Harlan County.

m. May enter into contractual joint ventures with other governmental hospitals and health care organizations and nonprofit hospitals and health care organizations when doing so provides a tangible benefit to the residents of Harlan County.

n. May obtain legal and other professional services as necessary.

o. Is granted all other powers and duties necessary for the management, control, and government of the HCHS facilities, including but not limited to, any applicable powers and duties granted boards under other provisions of Nebraska law relating to nonprofit corporations, except as those provisions may otherwise conflict with Neb. Rev. Stat. §§ 23-3501 *et seq.*

Section 4. Duties. The Board of Trustees shall have the following duties:

a. Meet at least once per month and keep a complete record of all of its proceedings in accordance with Nebraska public meeting and open records laws.

b. Adopt bylaws and rules for its own guidance and for the government of the facility and establish and monitor policies deemed necessary and appropriate for the operation, conduct, administration, and management of HCHS.

c. Employ or contract for an administrator as chief executive officer of the facility, fix the administrator's compensation, and review the administrator's job performance on an annual basis.

d. Adopt and approve medical staff bylaws that govern the HCHS medical staff, approve the appointment of a qualified medical staff, and oversee the quality of medical care and services provided at the HCHS facilities.

e. Manage and control HCHS's funds in accordance with guidelines established for political subdivisions by the Nebraska Investment Council under Neb. Rev. Stat. § 72-1259 and invest funds in such investments as are permitted for counties in the State of Nebraska.

f. Fix the price to be charged to patients admitted to HCHS for care and treatment.

g. Establish charity care policies for free treatment or financial assistance for care provided by HCHS.

h. Procure and pay premiums on any and all insurance policies required for the prudent management of HCHS, including, but not limited to, general liability, professional malpractice liability, workers' compensation, vehicle liability, and directors and officers liability.

i. On or before July 15 of each year file with the County Board an annual report of HCHS and a statement of all receipts and expenditures made during the prior fiscal year and certify the amount necessary, if any, to maintain and improve HCHS for the ensuing year.

j. Develop and oversee implementation of annual operating budgets pursuant to the Nebraska County Budget Act, to the extent applicable.

k. Generally oversee the management, direction, and long-range planning of HCHS.

l. Notify the Nebraska Department of Health and Human Services Division of Regulation & Licensure (the "Department") in writing within five (5) business days of the occurrence of a vacancy in the Administrator position, identifying the individual responsible for such duties during the interim, and notify the Department in writing within five (5) business days of filling the position, identifying the new Administrator by name and the effective date of his or her position.

m. Require and approve a quality assurance plan providing for specific review and evaluation activities to assess, preserve, and improve the overall quality and efficiency of patient care at HCHS and in related programs of patient care. The Board shall receive and review a report of quality assurance/performance improvement activities and medical staff and utilization review committee reports on a regular basis.

n. Conduct such other activities and take such other action as the Board of Trustees shall deem necessary and proper to carry out its responsibilities, as permitted by law.

The Administrator and his/her assistants may assist the members of the Board of Trustees in carrying out the foregoing duties.

Section 5. Removal and Vacancy.

a. A Trustee may be removed from office by the County Board at any time with or without cause.

b. When a Trustee is absent from three (3) consecutive Board meetings, either regular or special, without being excused by the remaining Trustees, his or her office shall become vacant.

c. A vacancy shall occur when a Trustee resigns or is removed as set forth above. Resignation shall be effective upon tendering a written resignation to the Board of Trustees with a copy to the County Board. A vacancy shall also occur when a

Trustee is ineligible to continue by virtue of a change in residency or ability to satisfy necessary qualifications or upon a change in laws relating to eligibility to serve as a Trustee.

d. All vacancies on the Board of Trustees shall be filled by the County Board. The person appointed to fill such a vacancy shall hold office for the unexpired term of the Trustee he or she is replacing.

Section 6. Compensation and Mileage. The salaries (if any) of Trustees shall be set by the County Board. If the County Board establishes such a salary, the salary shall be not less than one hundred dollars per year, but not more than one hundred dollars per meeting and shall not exceed one thousand two hundred dollars per year. Trustees shall also be reimbursed for necessary mileage at the statutory rate (Neb. Rev. Stat. § 81-1176) while on business of HCHS. Subject to prior Board approval or established Board policy, necessary expenses of Trustees, while on the business of HCHS, may be paid to the extent permitted by the Local Government Miscellaneous Expenditure Act (Neb. Rev. Stat. §§ 13-2201 *et seq.*) as amended from time to time.

Section 7. Officers. The officers of the Board of Trustees shall be a Chairperson, a Secretary, and a Treasurer, elected from among the Trustees. The Trustees may, if desired, elect one member Vice-Chairperson, to assume the authority and duties of the Chairperson in his or her absence. Officers must be members of the Board of Trustees. The Board shall elect the officers at its regular annual meeting in January. The officers shall take office immediately upon being elected and shall serve until the following annual meeting or until their successors have been duly elected and take office. The Trustees may, at any meeting called for the specific purpose, remove from any office, the person so designated to hold that office. Any vacancy in any office by death, resignation, removal or otherwise, shall be filled for the unexpired portion of the term by the Board at its next regular meeting. The duties and authority of the officers shall be as follows:

a. Chairperson. The Chairperson shall preside at all meetings of the Board, approve the agenda for each meeting, call special meetings as he or she deems necessary, oversee the operations of the Board, execute documents on behalf of HCHS when approved by the Board, and have such other duties and authority as normally pertain to the office or as provided by the Board or these Restated Bylaws.

b. Secretary. The Secretary shall keep a complete record of the proceedings of all meetings and actions of the Board, produce such records when called upon to do so at any meeting of the Board, file with the County Board such reports and statements as are required by law, execute documents and instruments on behalf of HCHS when approved by the Board, assume the duties of the Chairperson in his or her absence in the event there is no Vice Chairperson, and have such duties and authority as normally pertain to the office or as are assigned by the Chairperson, the Board, or these Restated Bylaws.

c. Treasurer. The Treasurer shall receive and pay out all money under the control of the Board as approved by it, report such receipts and expenditures to the Board of Trustees and the County Board as required under these Bylaws, and have such other duties and authority as normally pertain to the office or as are assigned by the Chairperson, the Board, or these Restated Bylaws.

The Administrator shall serve as chief executive officer, and the Administrator and his or her assistants may assist the other officers, identified above, in carrying out the foregoing duties.

Section 8. Regular Meetings/Annual Meeting. The annual meeting of the Board of Trustees shall occur at the beginning of the regular meeting in January of each year. Regular meetings of the Board of Trustees shall be held at a time each month to be determined by the Chairperson, at HCHS. Any business pertaining to HCHS may be placed on the agenda, considered, and acted upon at any regular meeting of the Board of Trustees, subject to the rules set forth below regarding the amendment of agendas under Nebraska open meetings laws.

Section 9. Special Meetings. Special meetings may be called by the Chairperson when he or she deems it necessary, or when no fewer than three (3) Trustees or a majority of the County Board requests such a meeting by delivering such a request to the Chairperson in writing. Special meetings may be of an emergent nature. Special meetings of an emergent nature may be held by electronic or telecommunications equipment or in person.

Section 10. Agenda. The agenda at meetings of the Board of Trustees shall be as follows:

a. Regular Meetings.

(1) Call to order.

(2) Presentation and approval of minutes of last regular meeting.

(3) Presentation of annual or monthly financial reports.

(4) Transaction of other business that may properly be brought before the meeting.

(5) Election of Officers at the annual meeting.

(6) Adjournment.

b. Special Meetings

(1) Call to order.

(2) Reading of official call for meeting.

(3) Transaction of business for which meeting is called.

(4) Adjournment.

Section 11. Meeting Notices.

a. Regular/Special Notice. No notice of regular meetings need be given to the Trustees. Trustees shall receive notice of non-emergent special meetings within the timeline for notice provided to the public as set forth herein. Notice of all regular and special meetings shall be given to the public no less than two (2) days prior to the date of the meeting, except in the case of a special meeting of an emergent nature. Notice shall be deemed given to the Trustee when hand delivered personally to the Trustee, mailed electronically, or when delivered or mailed, postage pre-paid, to the Trustee's designated address. The notice shall specify the time, date, and place of the meeting, and shall contain the agenda or contain a statement that the agenda shall be readily available for public inspection at the Administrator's office during normal business hours.

b. Emergency Meetings. Emergency meetings may be conducted without standard notice when emergent circumstances make standard notice unfeasible. In the case of a special meeting for which reasonable advance public notice is unable to be given due to the exigent nature of the matter, each Trustee shall receive at least twelve (12) hours actual notice of the meeting via electronic mail, in writing, or verbally. When it is necessary to hold a special meeting of an emergent nature without reasonable advance public notice, the nature of the emergency shall be stated in the minutes and any formal action taken in such meeting shall pertain only to the emergency.

c. Media. The Administrator shall maintain a list of the news media requesting notification of meetings, and shall make reasonable efforts to provide advance notification to them of the time and place of each meeting and the subjects to be discussed at the meeting, regardless of whether the meeting is regular, special, or an emergency.

d. Attendance. Trustees may participate in a regular or special meeting of the Board through the use of any means of communication by which all Trustees participating (as well as the public in attendance at the public meeting) may simultaneously hear each other during the meeting. A Trustee participating in a meeting by this means is deemed to be present in person at the meeting. However, telephonic or other attendance pursuant to this subsection shall not be used as a means of avoiding any obligation of the Board pursuant to the Open Meetings Act. Attendance at a meeting by a Trustee, for any purpose other than objecting to lack of proper notice, shall constitute a waiver of notice as to that Trustee.

Section 12. Quorum/Voting. A majority of Trustees shall constitute a quorum for the transacting of business at a meeting of the Board. Unless otherwise stated in these Bylaws or in the law, the affirmative vote of a majority of Trustees in attendance at any meeting at which a quorum is present shall be required for any Board action.

Section 13. Public Meeting Requirements. It is the policy of HCHS that the formation of public policy is public business and may not be conducted in secret. All meetings of the Board of Trustees shall conform to the Open Meetings Act of the state of Nebraska, Neb. Rev. Stat. §84-1408 et seq., as amended from time to time. Subject to such amendments, this shall mean that:

a. All regular, special, and emergency meetings of the Board of Trustees, formal or informal, for the purposes of briefing, discussion of public business, formation of tentative policy, or taking any action of the Board, shall be open to the public, except as provided below in subsections (b) and (c) or as otherwise provided by law.

b. Closed sessions may be called by the affirmative vote of a majority of the Trustees if a closed session is clearly necessary for (i) the protection of the public interest or (ii) the prevention of needless injury to the reputation of an individual, provided such individual has not requested a public meeting.

c. Closed sessions may also be called by the affirmative vote of a majority of the Trustees for strategy sessions with respect to collective bargaining, real estate purchases, pending litigation, or litigation which is imminent as evidenced by communication of a claim or threat of litigation to or by the public body; investigative proceedings regarding allegations of criminal misconduct; evaluation of the job performance of a person; or for peer review activities, professional review activities, review and discussion of medical staff investigations and disciplinary actions, and any strategy session concerning transactional negotiations with any referral source that is required by federal law to be conducted at arms' length.

d. The subject matter of and the reason for the closed session shall be stated in the motion to close. The vote to hold a closed session shall be taken in open session. The vote of each Trustee on the question of holding a closed session, the reason for the closed session, and the time when the closed session commenced and concluded shall be recorded in the minutes. The Administrator shall have authority to attend closed sessions of the Board, unless a conflict of interest is identified, in which case the Administrator shall leave the room. The Board shall restrict its consideration of matters during the closed portions of the meeting to only those purposes set forth in the minutes as the reason for the closed session. The meeting shall be reconvened in open session before any formal action is taken. Formal action does not include negotiating guidance given by the Board to legal counsel or other negotiators in closed sessions authorized by law.

e. Any Trustee may challenge the continuation of the closed session if he or she determines that it has exceeded the reasons stated for the closed session or contends that the closed session is improper. Such challenge may be overruled by a majority vote of the Trustees. The challenge and its disposition shall be recorded in the minutes.

f. Notice of Board meetings shall be given in accordance with Section 10 of this Article and to the general public by posting a copy of the notice in a conspicuous place in the lobby of HCHS and by posting written notice in at least three (3) public

places at least twenty-four (24) hours prior to the meeting; provided, however, if providing such notice is untenable, emergency meetings may take place without such notice so long as the provisions of the law and these Restated Bylaws related to emergency meetings are followed.

g. Agenda items shall be sufficiently detailed in the notice to give the public reasonable advance information about specific proposals, projects, and other issues which are known to be subject to consideration at the meeting. Except for the agenda of an emergency meeting, the meeting agenda shall not be altered later than twenty-four (24) hours before the scheduled commencement of the meeting. The Board shall have the right to modify the agenda at the public meeting to include items of an emergency nature only.

h. The public shall have the right to attend, speak at, record, and/or broadcast meetings of the Board, subject to reasonable rules and regulations established by the Board regarding the conduct of persons attending, speaking at, videotaping, televising, photographing, broadcasting, or recording its meetings. No individual shall be required to identify himself or herself as a condition for admission to the meeting, but the Board may require any member of the public addressing the Board to identify himself or herself.

i. At least one copy of all reproducible written material to be discussed will be available at the meeting for examination and copying by members of the public.

j. At least one current copy of the Open Meetings Act, Neb. Rev. Stat. § 84-1408 through -1414, shall be posted in the meeting room at a location accessible to the members of the public. At the beginning of each meeting, the public shall be informed about the location of the posted information.

k. Any action taken on any question or motion duly moved and seconded shall be by roll call vote of the Board in open session, and the record shall state how each Trustee voted or the Trustee's abstention or absence noted.

l. Minutes of all meetings showing the time, place, members present and absent, and the substance of all matters discussed shall be maintained. The minutes of all meetings and evidence and documentation received or disclosed in open session shall be public records and open to public inspection during normal business hours at the office of the Administrator of HCHS. Minutes of regular and special meetings shall be written and available for inspection within ten (10) working days or prior to the next convened meeting, whichever occurs earlier. Minutes of emergency meetings must specify the nature of the emergency and any formal action taken at the meeting and shall be made available to the public no later than the end of the next regular business day following the emergency meeting.

Section 14. Committees. The Board may establish such committees as the Board shall deem advisable for the study of issues of concern to the Board, and for the recommendation of action to the Board. Committees may be of standing or limited duration, shall include no more than two (2) Board members (or no more than one (1)

Board member if the Board consists of three rather than five members), and may include one or more medical, professional, or administrative staff members as deemed appropriate. Committee actions shall be advisory recommendations only, and shall not be binding or official action of HCHS or the Board.

ARTICLE III. MEDICAL STAFF

Section 1. Appointment and Bylaws. The Board of Trustees shall appoint a Medical Staff comprised of physicians and other practitioners who are authorized by law and by the Board to exercise clinical privileges and render patient care services at the Hospital. The Board shall approve, on the recommendation of the Medical Staff, separate Medical Staff Bylaws which shall outline the nature and purposes of the Medical Staff; the qualifications for membership; the responsibilities of individual Medical Staff members; the procedures and criteria for appointment, reappointment, limitation, and termination of membership or privileges; the organization and operation of the Medical Staff; the qualifications and procedures for approval of other professionals, if any, who may render patient care services in the Hospital other than as Medical Staff members or employees; the procedures for review and amendment of such Bylaws; and such other matters as may be deemed appropriate for such Bylaws. The Board may delegate to the Medical Staff specific responsibilities for quality assurance and peer review within the Hospital, subject always to the ultimate authority of the Board of Trustees.

Section 2. Communications. The Board shall maintain regular and systematic communications with the Medical Staff. The Administrator shall serve as liaison between the Medical Staff and the Board of Trustees, and shall maintain regular contact with both the President of the Medical Staff and the Chairperson of the Board of Trustees. In addition, the Board Chairperson may attend Medical Staff meetings and/or the President of the Medical Staff may attend Board meetings.

ARTICLE IV. ADMINISTRATION

The Board of Trustees shall select and employ a Health System Administrator who shall be its direct executive representative in the management of HCHS. The Administrator shall have authority and responsibility for the administration of HCHS in all its activities and departments, subject only to such policies as may be adopted and such orders as may be issued by the Board of Trustees. The Administrator shall act as the duly authorized representative of the Board of Trustees in all matters, except as otherwise directed by the Board. The Administrator shall be the chief executive officer and shall:

a. Maintain a record of, and carry out, all policies established by the Board of Trustees.

b. Oversee the selection, employment, supervision, promotion, demotion, discharge and compensation of employees of HCHS.

c. Develop and maintain personnel policies, and practices for HCHS with the advice and consent of the Board of Trustees.

d. Prepare an annual budget showing the expected receipts and expenditures.

e. See that all physical properties of HCHS are maintained in a good state of repair and operating condition.

f. Supervise all business affairs of HCHS and oversee the collection and expenditure of Health System funds. Funds shall be deposited in financial institution(s) approved by the Board, except that the Administrator may maintain cash on hand in an amount approved by the Board from time to time.

g. Purchase such equipment, supplies and services as may be necessary for the operation of HCHS facilities and programs, provided that Board approval shall be obtained for any purchases which are not within the current budget approved by the Board.

h. Submit to the Board regular reports on all aspects of Health System operations, in such forms as the Board shall require.

i. Serve as liaison between the Board of Trustees and the Medical Staff.

j. Attend meetings of the Board of Trustees and represent the Board of Trustees at meetings of the Medical Staff.

k. Establish schedules of charges for services and supplies provided by HCHS facilities and programs, subject to the approval of the Board.

l. Enroll and reenroll the HCHS's facilities and services in the Medicare and Medicaid programs, to make changes or updates to HCHS's facilities and services status in such programs, to commit HCHS to fully abide by the statutes, regulations, and program instructions applicable to such programs, to communicate with such programs on behalf of HCHS, to execute and deliver cost reports and other required reports related to such programs, and to execute and deliver all documents associated with the foregoing authority.

m. Take such other actions as are assigned by the Board or are otherwise in the best interests of HCHS, and consistent with the laws and Board policies governing operation of HCHS.

n. No assignment, referral, or delegation of authority by the Board of Trustees to the HCHS Administrator, the Medical Staff, or anyone else shall preclude the Board of Trustees from exercising the authority required to meet its responsibility for the conduct of HCHS. The Board of Trustees shall retain the right to rescind any such delegation.

ARTICLE V. CONFLICTS OF INTEREST

Section 1. Policy and Definition. HCHS officials, including members of the Board of Trustees, the Administrator, and employees or Medical Staff members with authority to direct any portion of the business of HCHS, shall strictly refrain from any action which causes, or gives the appearance of causing, a conflict of interest or which may create or give the appearance of creating an improper personal benefit to such individual. All such individuals, as well as the members of their immediate families (parent, spouse, child residing in the same household, or other dependents for federal income tax purposes), and any businesses with which they are associated (as a partner, limited liability company member, director, or officer, or in which the official or a member of the official's immediate family holds more than One Thousand Dollars ($1000) of privately held stock, holds more than a five percent (5%) equity interest in a privately held corporation, or holds more than Ten Thousand Dollars ($10,000) of public traded stock or a ten percent (10%) equity interest in a publicly held corporation), shall be deemed to be "officials" of HCHS for purposes of the rules regarding conflicts of interest.

Section 2. Items of Value. No HCHS official as previously defined, shall accept a gift, loan, contribution, or other item of value from any individual or entity, if offered or accepted in exchange for any actual, implied, or perceived promise that the receipt of such item may influence the official in the performance of his or her duties on behalf of HCHS, or if the circumstances could reasonably create the appearance of such promise or such result. The only exception shall be token items of nominal value which are clearly intended solely as expressions of friendship or appreciation.

Section 3. Use of Position. No HCHS official shall use the official's position or any confidential information received through the holding of that position to obtain financial gain, or use personnel, resources, property, or funds of HCHS for personal financial gain.

Section 4. Contracts. No HCHS official shall have any interest in any contract or business transaction, oral or written, formal or informal, in which HCHS is a party, or receive any fee or commission as the result of any such contract or transaction, unless each of the following steps is followed:

a. The official makes a declaration on the record to the Board of Trustees regarding the nature and extent of his or her interest prior to official consideration of, or execution of, the contract or transaction;

b. The official does not directly influence, approve, or vote on the matter of granting the contract or executing the transaction, except that if the number of Board members declaring an interest in the contract or transaction would prevent the Board from securing a quorum on the issue, then all members may vote on the matter;

c. The official does not act for the Board or HCHS as to inspection of performance under the contract or transaction in which he or she has an interest; and

d. Such contract or transaction is subject to any applicable competitive bidding requirements, and is determined to be fair and reasonable by the Board of Trustees.

Section 5. Records. The Secretary of the Board, with the assistance of the Administrator, shall maintain separately from other HCHS records a ledger regarding each contract or transaction described in Section 4, for five years following the date of the affected official's last day in office, including the names of the contracting parties, the nature of the interest of the official, the date that the contract or transaction was approved, the amount of the contract or transaction, and the basic terms of the contract or transaction. Such information shall be compiled no later than ten (10) days after the contract or transaction has been executed, and such ledger shall be available for public inspection at HCHS during normal working hours. For purposes of this Section and Section 4, the following contracts or transactions shall not be covered:

a. The receiving of deposits, cashing of checks, and buying and selling of warrants and bonds of indebtedness of HCHS by a financial institution.

b. Contracts or transactions involving $100 or less, provided that no contract or transaction shall be divided into multiple contracts or transactions for the purpose of falling below $100.

ARTICLE VI. INDEMNIFICATION AND INSURANCE

Section 1. Covered Individuals. For purposes of this Article, the term "covered individuals" shall include all members of the Board of Trustees, the Administrator, all employees of HCHS, and all HCHS volunteers, when providing services for HCHS; and shall include Medical Staff members and other independent professionals when performing peer review, utilization review, credentialing, quality assurance, and other medical staff organizational functions for HCHS by delegation of authority from the Board of Trustees. The term "covered individuals" expressly excludes, without limitation, Medical Staff members and other health care professionals who are not HCHS employees, when rendering patient care.

Section 2. Defense and Indemnity. HCHS shall defend, hold harmless, and indemnify covered individuals against any and all claims and demands, whether groundless or otherwise, arising out of an alleged act or omission occurring within the scope of their employment or duties, to the fullest extent permitted by Nebraska law. The provisions of this section shall continue to apply to covered individuals and their heirs and representatives after the covered individual ceases to be a covered individual, as to all acts and omissions occurring prior to the date of such cessation.

Section 3. Insurance. The Board of Trustees may authorize the purchase of any and all insurance which the Board deems proper to protect and preserve the assets of HCHS, including without limitation any insurance for HCHS and for covered individuals against any or all expense and liability within HCHS's duty to defend, hold harmless, and indemnify as described above.

ARTICLE VII. AMENDMENTS

These Bylaws may be amended by the affirmative vote of a majority of the members of the Board of Trustees, at any regular or special meeting of the Board, provided each member of the Board shall have received written notice of the proposed amendment no less than ten (10) days prior to the meeting at which the amendment is made. Amendments to the proposed amendments may be offered and adopted at such meeting without additional prior notice, upon the unanimous approval of the Board members present and voting.

ARTICLE VIII. EFFECTIVENESS

If any provision of Nebraska law is amended in such a manner as to render any portion of these Bylaws inconsistent with Nebraska law, then such portion of these Bylaws shall, to the extent necessary, be deemed to be automatically reformed to conform to Nebraska law. In all other respects, these Bylaws shall remain in full force and effect, and unchanged. These Bylaws shall become effective when duly adopted by the Board of Trustees, and shall replace and revoke all prior Bylaws of the Board of Trustees.

Duly adopted on this 16th day of September, 2014.

Bruce Lewis
CHAIRPERSON, BOARD OF TRUSTEES

Susan K. Foster
SECRETARY, BOARD OF TRUSTEES

ADMINISTRATOR/CHIEF EXECUTIVE OFFICER

RESTATED BYLAWS

OF THE

BOARD OF TRUSTEES

OF

HARLAN COUNTY HEALTH SYSTEM

ALMA, NEBRASKA

As amended 2014

DOCS/454873.8

Harlan County Health System

717 North Brown
P.O. Box 836
Alma, NE 68920-0836
phone (308) 928-2151
fax (308) 928-2774
www.harlancountyhealth.com

Job Description: Individual Hospital Board of Trustees Board Member

General Expectations of a board member:
Prospective and incumbent board members should commit themselves with regard to the following:

- Know the organization's mission, purposes, goals, policies, programs, services, history, strengths, and needs.
- Perform the duties of board membership responsibly and conform to the level of competence expected from board members as outlined in the duties of care, loyalty, and obedience.
- Prepare for the policy discussions and decision making required for governance excellence within the organization.
- Serve in leadership positions and undertake special assignments willingly and enthusiastically.
- Suggest possible nominees to the board who are individuals of achievement and distinction and who can make significant contributions to the work of the board and the organization's progress.
- Avoid prejudiced judgments on the basis of information received from individuals and urge those with grievances to follow established policies and procedures through their supervisors (all matters of potential significance should be called to the attention of the CEO and the board's elected leader as appropriate).
- Avoid asking for special favors of the staff, including special requests for extensive information, without prior consultation with the CEO, board, or appropriate committee chairperson.
- Know the difference between the board's role of governance and the role of the CEO in operations of the health system.
- Counsel the CEO as appropriate and support him or her through difficult relationships with groups or individuals.
- Consider giving an annual gift according to personal means.
- Assist the development committees or affiliated foundation and staff by implementing fundraising strategies through personal influence with others (e.g., corporations, individuals, and foundations).
- Participate annually in educational opportunities to remain current on changing trends and issues affecting governance.

Meetings
Board meetings are the center of governance. The way they are planned and conducted, in addition to the dynamics that emerge in them significantly influence the quality of governance. Therefore, individual board members are expected to:

- Prepare for board and committee meetings, including appropriate organizational activities.
- Participate in board and committee meetings with forethought, courtesy, critical thinking and analysis, and attention to results.
- Ask timely and substantive questions at board and committee meetings consistent with the board member's conscience and convictions, while at the same time supporting the majority decision on issues decided by the board.
- Be aware of the rules and laws that govern the conduction of open meetings in the State of Nebraska.

Duties:

The Fundamental Duty of Oversight

The board is the party responsible for the organization. The board must supervise and direct its own officers and govern the organization's efforts in carrying out its mission. The duties of care, loyalty, and obedience describe the manner in which the directors are required to carry out their fundamental duty of oversight.

Duty of Care

Duty of Care requires board members to have knowledge of all reasonably available and pertinent information before taking action. The board member must act in good faith, with the care of an ordinarily prudent businessperson in similar circumstances, and in a manner he or she reasonably believes to be in the best interest of the organization.

Duty of Loyalty

Duty of Loyalty requires board members to candidly discharge their duties in a manner designed to benefit only the hospital or health system, not the individual interests of the board member. It incorporates the duty to disclose situations that may present a potential for conflict with the organization's mission, as well as a duty to avoid competition with the organization.

Duty of Obedience

Duty of Obedience requires board members to ensure that the organization's decisions and activities adhere to its fundamental corporate purpose and charitable mission, as stated in its bylaws.

Each board member is also entrusted with individual responsibilities as a part of his or her board membership. The obligations of board service are considerable; they extend well beyond the basic expectations of attending meetings or participating in hospital events. Individual board members are expected to meet higher standards of personal conduct on behalf of the organization than what is usually expected of other types of community volunteers.
Yet, despite all of these "special" responsibilities, board members as individuals have no special privileges, prerogatives, or authority to act on behalf of the organization. They must meet in formal sessions to negotiate and make corporate decisions.

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Description of Responsibilities:
Harlan County Health System Board of Trustees

Core Responsibilities
The hospital governing board must fulfill certain fundamental or core responsibilities in overseeing the efforts of the organization. These responsibilities cluster around six major areas:

1. Financial Oversight
2. Quality Oversight
3. Setting Strategic Direction/Mission Oversight
4. Self-Assessment & Development
5. Management Oversight
6. Advocacy

The board fulfills these responsibilities by adopting specific outcome targets against which to measure the organization's performance. To accomplish this, the board must:

- Establish policy guidelines and criteria for implementing the mission statement.
- Evaluate proposals brought to the board to ensure that they are consistent with the mission statement.
- Monitor programs and activities of the hospital and any subsidiary units to ensure mission consistency.
- Periodically review, discuss, and amend the mission statement if necessary to clarify board responsibilities.

Financial Oversight
The board has responsibility for the financial soundness of the organization. To accomplish this, the board must:

- Review and approve overall financial policies and plans for the organization.
- Receive and review financial reports to assess actual performance compared to projections.
- Review and adopt ethical financial policies and guidelines.
- Review major capital plans proposed for the organization and any subsidiaries.
- Ensure that the financial, capital, and strategic plans are aligned.

Quality Oversight
The board has the responsibility to assess the quality of all services provided by individuals who perform their duties in the facilities under the board's sponsorship. To do this, the board should:

- Make quality of care and patient safety top priorities for the organization.
- Review, approve and oversee quality improvement initiatives recommended by senior management and the medical staff

- Review and carefully discuss quality reports that provide comparative statistical data, and set measurable policy targets to ensure continual improvement in quality performance.
- Review recommendations of the medical staff regarding new physicians who wish to practice in the organization and approve these recommendations if appropriate.
- Reappoint individuals to medical staff using comparative outcome data to evaluate how they have performed since their last appointment.
- Appoint physicians to governing body committees and seek physician participation in the governance process to assist the board in its patient quality assessment responsibilities.
- Regularly receive and discuss malpractice data reflecting the organization's experience and the experience of individual physicians who have been appointed to the medical staff.
- Regularly receive and discuss data about medical staff to assure that future staffing will be adequate in terms of ages, numbers, specialties, and other demographic characteristics.
- Monitor programs and services to ensure that they comply with policies and standards relating to quality.
- Take corrective action to improve quality performance when appropriate and/ or necessary.

Setting Strategic Direction/Mission Oversight

The board has the responsibility to recommend the future direction that the organization will take to meet the community's health needs. To fulfill this responsibility, the board must:

- Review and approve a comprehensive strategic plan and supportive policy statements.
- Ensure that the organization's strategic plan is consistent with the mission.
- Regularly review progress toward meeting goals in the strategic plan to assure that the board is fulfilling its mission.
- Periodically review, discuss, and amend the strategic plan to ensure its relevance to the mission.

Self-Assessment & Development

The board must assume responsibility for itself; its own effective and efficient performance. To discharge its stewardship responsibilities to its "owners," the board must:

- Participate annually in a formal board evaluation process.
- Maintain and update policy statements regarding roles, responsibilities, duties, and job descriptions for the board itself and its members, officers, and committees.
- Participate both as a board and as individuals in orientation programs and continuing education programs.

Management Oversight

The board is the final authority regarding oversight of management performance by the CEO and support staff. To exercise this authority, the board must:

- Support and assist the CEO to help achieve the organization's mission.
- Communicate regularly with the CEO regarding goals, expectations, and concerns.

- Evaluate the performance of the CEO annually using goals and objectives agreed upon with him or her at the beginning of the evaluation cycle.
- Periodically survey CEO employment arrangements at comparable organizations to ensure the reasonableness and competitiveness of his or her compensation package.
- Periodically review management succession plans to ensure leadership continuity.
- Establish specific performance policies that provide the CEO with a clear understanding of board expectations, and update these policies based on changing conditions.

Advocacy

The board needs to focus on advocacy and lobbying around public policy issues. In order to take an activist role, the board must:

- Conduct a periodic community health needs assessment to understand the health issues of the communities served.
- Set goals for the organization around the issue of public advocacy.
- Establish a policy regarding the board's role in fund development and philanthropy efforts.

Board Governance

Finally, the board is responsible for managing its own governance affairs in an efficient and effective way. To fulfill this responsibility, the board must:

- Maintain written conflict-of-interest policies that include guidelines for the resolution of existing or apparent conflicts of interest.
- Periodically review the board's own structure to assess appropriateness of size, diversity, committees, tenure, and turnover of officers and chairpersons.
- Ensure that each board member understands and agrees to maintain confidentiality with regard to information discussed by the board and its committees.
- Adopt, amend, and, if necessary, repeal the bylaws of the organization.

Harlan

MANAGEMENT AGREEMENT

THIS AGREEMENT, made and entered into this 1st day of January, 2014, by and between the Board of Trustees of the Harlan County Health System, of Alma, Nebraska 68920, hereinafter called "HOSPITAL" and the GREAT PLAINS HEALTH ALLIANCE, INC., a non-profit corporation duly incorporated under the laws of the State of Kansas with Central Office and post office address in the City of Phillipsburg, Kansas 67661 hereinafter called "GREAT PLAINS".

WHEREAS, the Harlan County Health System is a duly organized hospital operating in accordance with the laws of the State of Nebraska, and

WHEREAS, said Board of Trustees is desirous of contracting with Great Plains Health Alliance, Inc., for management of the hospital through its method of shared core services which include Administration, Finance and Reimbursement, Health Information Management, Education, Quality Improvement and Risk Management supervision. The day-by-day supervision of the Hospital will be provided by a qualified person employed by the Hospital who will serve as Hospital Administrator. Great Plains shall be responsible for the oversight of the Hospital Administrator. Routine visits will be made to the Hospital by the administrative staff of Great Plains, and from the other shared services as necessary.

THEREFORE, the undersigned Harlan County Health System Board of Trustees, by the duly constituted officers, does hereby contract with Great Plains Health Alliance, Inc., for the following operating fees:

1. Beginning the effective date hereof, the hospital shall pay to Great Plains as a basic management fee, the annual sum of seventy seven Thousand One Hundred Sixteen Dollars ($77,116.00) payable in twelve (12) monthly installments. This fee covers the services of Administration, Finance and Reimbursement, Health Information Management, Education, Quality Improvement and Risk Management. It also includes all guidance for updating and monitoring the charge master of the hospital, and access to Great Plains purchasing contracts. Beginning January 1, 2015 and each subsequent year thereafter, the management fee will be increased four percent (4%).

2. Great Plains agrees to make available, upon written request to the Secretary of Health and Human Services or upon request to the Comptroller General of the United States or any of their duly authorized representatives, the contract, books, documents and records necessary to certify the nature and extent of management costs. These records will be available up to four years following the termination of said management agreement.

3. Great Plains shall assist the Hospital in all contracts and purchases as may be needed for maintenance and operation of the Hospital, including, but not limited to, the following areas:

- Drugs and Medical Supplies
- Operational Supplies
- Repairs and Maintenance
- Capital Equipment
- Employee Benefits

Bids shall be requested when required by law.

The access to the Great Plains purchasing contracts shall be included in the basic management fee.

4. Notwithstanding any other provision of the Management Agreement, the Hospital and its employees, as a condition precedent to management by Great Plains, shall participate in the Great Plains Health Alliance, Inc. Compliance Program, Code of Conduct and related policies. The Hospital shall have adopted such Compliance Program, Code of Conduct and related policies, including any amendments thereto as may be necessary in the judgment of Great Plains. Notice of any such amendments shall be promptly provided to the Hospital by Great Plains. Upon termination of this Agreement for any reason, the Hospital's participation in the Great Plains Health Alliance, Inc. Compliance Program shall automatically cease as of the date of termination.

5. The Great Plains administrative staff shall operate the hospital under generally accepted administrative standards and in accordance with the polices of Great Plains. The Great Plains administrative staff will meet as requested with the Hospital Board of Trustees, and will operate the hospital under the policies established by this Board with the understanding, however, that the policies cannot alter the operational plan of Great Plains.

6. From time to time, GPHA will develop new services which are not a part of this contract. For those new services for which there will be a charge, the Board of Trustees will be advised and shall determine whether to purchase these services, at a charge in addition to this contract.

7. Nothing in this Agreement shall be deemed to limit the exclusive control of the expenditures of all funds or the supervision, care, and custody of the buildings and other assets of the Hospital by the Harlan County Hospital Board of Trustees. All of the assets of the Hospital, including funds received, are and shall remain the sole and exclusive property of the Hospital, subject to the control of the Harlan County Hospital Board of Trustees. All debts of the Hospital and all accounts payable are and shall remain the sole and exclusive obligations of the Hospital. Great Plains does not undertake to pay any such obligations.

8. Great Plains shall supervise and direct the operation of a suitable hospital accounting system including assistance with the preparation of the annual budget conforming to appropriate governmental regulations which set out major departmental and operating objectives, anticipated revenue, expenses, cash flow and capital expenditures and shall cause the budget to be presented to Hospital prior to the commencement of each fiscal year for its acceptance, rejection or modification. At an appropriate time before the financial budget is presented for adoption, Great Plains shall make recommendations to the Hospital regarding the pay scales of employees and the number of employee positions throughout the Hospital. Upon adoption or any modification of the budget by Hospital, it shall serve as a guide for the operation of the Hospital during the ensuing year.

9. All medical and professional matters shall be the responsibility of Hospital and the Medical Staff of the Hospital. Great Plains shall, however, consult with Hospital and make appropriate recommendations concerning such matters.

10. Great Plains shall use its best efforts to assure that the quality of administrative practices and procedures meet the standards as set by the appropriate licensing agencies, and shall encourage and assist the Medical Staff to ensure that medical practices and procedures meet such standards.

11. This instrument embodies the whole agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained herein; and this contract shall supersede all previous communications, representations and agreements, either verbal or written, between the parties hereto.

12. Nothing in this Agreement shall create any membership, partnership, or joint venture relationship between the Hospital and Great Plains. It is expressly acknowledged by both parties that Great Plains is an independent contractor and that nothing contained herein is intended nor shall be construed to create an employer-employee relationship between Great Plains and the Hospital, or between the Hospital and any employee of Great Plains.

13. This Management Agreement shall take effect on January 1, 2014, and shall remain in effect for one year, and will automatically renew from year to year unless cancelled by either party. During the terms of this Agreement, either party may terminate and cancel this Agreement by giving the other party ninety (90) days notice in writing of its intention to do so, which notice shall be given by certified mail addressed directly to the other party at its usual address.

14. The above Management Agreement shall be executed in four (4) copies.

IN WITNESS WHEREOF both parties hereto have set their hands and seals of the day and year first above written.

GREAT PLAINS HEALTH ALLIANCE

President & CEO

HARLAN COUNTY HEALTH SYSTEM

Chairman, Board of Trustees

ATTEST:

Asst. Secretary

Secretary, Board of Trustees

ELECTRONIC FILE

Harlan County Health System

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
JANUARY 16, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, January 16, 2023 at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Mary Jo Christensen requested a motion to call the meeting to order. At 4:30pm motion was made by Bash and seconded by Howsden. A Roll Call was held: Howsden, Brandon, Long, Bash, Frasier, Christensen.

Additional Attendees: Stacy Neubauer, RN, CEO; Sheri Trahern, CFO; Les Lacy, Regional VP of GPHA; April Einspahr, Recorder; Tonda Ross, BSRT(R)(M)(CT), Director of Radiology; Amy Bunch, BSRT(R)(M)(CT)(QM)(BD), Radiology Tech

II. Capital Equipment Request: 3D Mammography
Motion made by Dr. Long to approve the purchase of 3D Mammography. Seconded by Bash. Discussion was held regarding possible funding sources, the standard of care in this region of Nebraska and in Critical Access Hospitals, and the possibility of offering biopsies.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

Tonda Ross and Amy Bunch left the meeting at 5:12pm.

III. Election of Officers

a. Election of Chairman of the Board: CEO Stacy Neubauer opened the floor for nominations for Chairman of the Board. Doris Brandon nominated Mary Jo Christensen for Chairman. Bash motioned that nominations cease for Chairman of the Board.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Abstain

b. Election of Secretary: Chairman opened the floor for nominations for Secretary. Lisa Howsden nominated Doris Brandon for Secretary. Dr. Long motioned that nominations cease for Secretary of the Board.
A Roll Call Vote was held.

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Abstain	Y	Y	Y	Y

c. Election of Treasurer: Chairman opened the floor for nominations for Treasurer. Lisa Howsden nominated Dusty Frasier for Treasurer. Brandon motioned that nominations cease for Treasurer of the Board.
A Roll Call Vote was held.

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Abstain	Y

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IV. Approval of Consent Agenda

Agenda items include Capital Request for 3D Mammography, Election of Officers, Minutes of Board Meeting held December 19, 2022, Check Run and Credit Card Summary, and Annual Peer Review, Infection Control, Antimicrobial, PI, Patient Safety, Quality and HCAHPS Reviews, and Annual Risk Evaluation and Annual HIPAA Education. Credentialing recommendations were reviewed in coordination with the Medical Staff. New Appointments: Appointments: Um, Andrea, MD (Bryan Teledigm /Bryan Heart Vascular Surgery, Lincoln NE); Jain, Anuj, MD (Bryan Teledigm/Bryan Heart, Lincoln NE); Anchan, Rajeev, MD (Bryan Teledigm/ Bryan Heart, Lincoln NE); Meier, Isaac, MD (Bryan Teledigm/ Bryan Heart, Lincoln NE); Kapalis, Matthew, DO (Bryan Teledigm/Bryan Heart, Lincoln NE); Katta, Natraj, MD (Bryan Teledigm/ Bryan Heart, Lincoln NE); Pacini, Ross, MD (Bryan Teledigm/ Bryan Heart, Lincoln NE); Goettsch, Matthew MD (Bryan Teledigm/ BryanHeart Vascular Surgery, Lincoln NE); Reappointments: Cantral, David, MD (Platte Valley Medical Clinic, Kearney NE); McManaman, Meredith, PA-C (Bryan Teledigm/ Dermatology Associates, Lincoln NE); Perrelli, Kara, MD (Real Radiology LLC, Omaha NE); Stone, Shawn, MD (Real Radiology LLC, Omaha NE); Conner, Timothy, MD (Real Radiology LLC, Omaha NE); Smith, Stanley, MD (Real Radiology LLC, Omaha NE); Henley, David, MD (Real Radiology LLC, Omaha NE). Motion entered by Frasier and seconded by Howsden to approve the Consent Agenda.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

V. Discussion Items

A. Old Business

B. New Business

1. Administrative Report: Stacy Neubauer reported that December financials are unaudited and will be presented at a later date. Current open positions are CFP, Night RN, Lab Manager and Physician. Stacy negotiated contracts with a PRN Physician Assistant and PRN APRN. Holistic Pain Management will hold their first clinic on February 7. Stacy and Sheri reviewed the Cash Flow Projection. Stacy reviewed new services that will be sought in 2023. Jeff Bash requested an analysis of Senior Life Solutions income from Sheri Trahern.
2. CMO Report: Dr. Finkner: Dr. Finkner was unable to attend.
3. GPHA Report: Les Lacy presented a brief Corporate Compliance education.

VI. Public Comments: None

VI. Executive Session: At 6:05PM Chairman requested a motion to go into Executive Session for the purpose of Risk Management and Incentive Compensation Plan. Motion made by Bash and seconded by Brandon.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

VII. Open Session: At 6:20PM motion was made by Bash and seconded by Brandon to go into Open Session.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

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VIII. Motion made by Bash and seconded by Brandon to approve the quarterly incentive compensation for CEO.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

IX. Adjourn: Being that no further business needed to be discussed, at 6:22PM a motion was made by Bash to adjourn the regular meeting of the board of trustees of the Harlan County Health System. Seconded by Brandon.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

Recorded by April Einspahr

Doris Brandon

Doris Brandon, Secretary of the Board

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
February 20, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, February 20, 2023 at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Mary Jo Christensen requested a motion to call the meeting to order. At 4:30pm motion was made by Long and seconded by Bash. A Roll Call was held: Howsden (via Zoom), Brandon, Long, Bash, Frasier, Christensen. Additional Attendees: Stacy Neubauer, RN, CEO; Sheri Trahern, CFO; Les Lacy, Regional VP of GPHA; April Einspahr, Recorder; Marisa Gulizia, Therapy; Taylor Molzahn, Director of Foundation and Marketing; and Cheryl Saathoff, Controller

II. Presentation: Marisa Gulizia presented her vision for expansion of the Therapy Department, as well as the addition of a community wellness location. The department currently utilizes 1,100 square feet and could utilize up to 6,000 square feet. *Marisa Gulizia and Taylor Molzahn left the meeting at 5:23PM.*

III. Approval of Consent Agenda
Agenda items include Minutes of Board Meeting held January 16, 2023 and Check Run and Credit Card Summary. Credentialing recommendations were reviewed in coordination with the Medical Staff. New Appointments: Appointments: K. Fisher, CRNA
Reappointments: M. Baker, MD (Bryan Heart); A. Benner, MD (Plains Radiology); J. Finkner, MD (Heartland Family Medicine); R. Heyd, MD (Plains Radiology); C. Balwanz, MD (Bryan Heart)
Motion entered by Frasier and seconded by Brandon to approve the Consent Agenda.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

IV. Discussion Items
A. Old Business: None
B. New Business
1. Financials: Cheryl Saathoff presented statistics. Sheri Trahern presented monthly financials, Key Indicators and Cash Flow reports. Motion made by Frasier and seconded by Bash to approve the financial reports as presented.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

2. Discussion/Possible Action to Release Collateral held for Clinic Loan: Motion made by Long to release the collateral held for the clinic loan. Seconded by Frasier. See Resolution 2023 – 1.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

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1. Discussion/Possible Action regarding RHC License for Oxford: Motion made by Long to authorize Stacy Neubauer, Chief Executive Officer of Harlan County Health System, and/or Mary Jo Christensen, Chairperson of the Board representing Harlan County Health System Board of Trustees, to close the Rural Health Clinic in Oxford, Nebraska. Seconded by Brandon. See Resolution 2023 – 2.

   A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

2. Administrative Report: Stacy Neubauer noted we have hired a permanent CFO. Kayla Rhynalds will start March 20. Holistic Pain Management pushed their start date to March due to credentialing. Dr. Finkner, along with Stacy, is hosting a social for Dr. Harms in the near future.
3. CMO Report: Dr. Finkner reported he has not received any further follow up from an Ophthalmologist. The Allergist at KRMC is interested in having a satellite clinic in Alma utilizing one of our own mid-level providers.
4. GPHA Report: Les Lacy distributed printed material regarding Corporate Compliance, Nurse staffing, and insurance companies. In addition, he noted GPHA will start a Med Staff Bylaws project. And finally, Bev Whitsmol has been assigned to provide help with our financials if assistance is needed.

V. Public Comments: None

VI. Executive Session: At 6:30PM Chairman requested a motion to go into Executive Session for the purpose of Risk Management. Motion made by Brandon and seconded by Bash.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

VII. Open Session: At 6:45PM motion was made by Brandon and seconded by Bash to go into Open Session.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

VIII. Adjourn: Being that no further business needed to be discussed, at 6:46pm a motion was made by Brandon to adjourn the regular meeting of the board of trustees of the Harlan County Health System. Seconded by Bash.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

Recorded by April Einspahr

MAR 2 0 2023

Doris Brandon

Doris Brandon, Secretary of the Board

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
March 20, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, March 20, 2023 at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Mary Jo Christensen requested a motion to call the meeting to order. At 4:30pm motion was made by Bash and seconded by Long. A Roll Call was held: Howsden, Brandon, Long, Bash, Frasier, Christensen.

Additional Attendees: Stacy Neubauer, RN, CEO; Sheri Trahern, Consultant; Kayla Rhynalds, CFO; Cheryl Saathoff, Controller; Les Lacy, Regional VP of GPHA; April Einspahr, Recorder

II. Approval of Consent Agenda
Agenda items include Minutes of Board Meeting held February 20, 2023 and Check Register, Credit Card Summary, Annual Critical Access Hospital Program Review, and Annual Rural Health Clinic Program Review. There were no credentialing recommendations to review.
Motion entered by Howsden and seconded by Brandon to approve the Consent Agenda without the Chemo Room presentation.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

III. Discussion Items
A. Old Business: None
B. New Business
1. Introduction of Kayla Rhynalds, CFO
2. Financials: Cheryl Saathoff presented statistics. Sheri Trahern presented monthly financials, Key Indicators and Cash Flow reports. Motion made by Brandon and seconded by Howsden to approve the financial reports as presented.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

3. Administrative Report: Stacy Neubauer noted a new regulation goes into effect in November that would require an equipment upgrade if we want to continue to mix chemo. Upon much consideration, the hospital does not believe purchasing new equipment would be the most fiduciarily responsible decision. At this time, we will purchase an isolator so we can continue to mix antibiotics. The cost is estimated to be $37,000.
Stacy sent physician recruitment information to the residency program in Lincoln, and they will pass it on to all programs. She is canceling the Medicus physician recruitment agreement as of April 4, 2023.
An employee engagement survey was sent to all staff with 53 respondents. The Admin Council will digest this information and develop a plan of action as needed.

4. CMO Report: Dr. Finkner reported he is still pursuing Ophthalmology and an Allergist. Dr. Finkner hosted the MD we've been recruiting for dinner in Kearney, and all conversations were positive. At this time, we believe he will still consider Harlan County when deciding.

5. GPHA Report: Les Lacy presented an in-depth review and education of Corporate Compliance.

IV. Public Comments: None

VI. Adjourn: Being that no further business needed to be discussed, at 6:00pm a motion was made by Bash to adjourn the regular meeting of the board of trustees of the Harlan County Health System. Seconded by Howsden.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Christensen
Y	Y	Y	Y	Y	Y

Recorded by April Einspahr

Doris Brandon

Doris Brandon, Secretary of the Board

BOARD OF TRUSTEES REGULAR MEETING MINUTES:
April 24, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, April 24, 2023 at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Mary Jo Christensen requested a motion to call the meeting to order. At 4:30pm motion was made by Long and seconded by Brandon. A Roll Call was held: Howsden, Brandon, Long, Bash, Frasier, Christensen.

Additional Attendees: Stacy Neubauer, RN-MHA, CEO; Kayla Rhynalds, CFO; Cheryl Saathoff, Controller; Les Lacy, Regional VP of GPHA; April Einspahr, Recorder

II. Approval of Consent Agenda
Agenda items include Minutes of Board Meeting held March 20, 2023 and Check Register, Credit Card Summary, QI/Med Staff/Core Measures, and Patient Experience Report. Credentialing and Privileging packets were reviewed in conjunction with the Medical Staff. Motion entered by Howsden and seconded by Bash to approve the Consent Agenda. A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

III. Discussion Items
A. Old Business: None
B. New Business
1. Resolution 2023 – 3.
Motion made by Long and seconded by Bash to add Kayla Rhynalds as a signer on financial accounts at all associated banks. A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

2. Financials: Cheryl Saathoff presented statistics. Kayla Rhynalds presented monthly financials and Key Indicators. Motion made by Bash and seconded by Long to approve the financial reports as presented. Rhynalds noted no Medicare estimate was made for March, and the Financial Audit is wrapping up.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

3. Administrative Report: Stacy Neubauer reported the clinic will undergo a Mock Survey on May 19. We have hired a clinic LPN, night Patient Care Tech, an RN for CardioPulmonary and Nuc Med, a PRN Lab Tech, and another RN. An internship program has been established, and the first student will be Carlee Stuhmer. We are pursuing ophthalmology. The proforma for a mental health program out of the RHC looks favorable. We believe Children's will be open to having a satellite clinic with us in the Fall. We continue to create a proforma for Chronic Care Management. We are looking for an allergist. Dr. Shoppe is interested in working at HCHS. We terminated our contract with Medicus and hired Jackson to recruit a physician. Stacy and Marisa attended the County Supervisor's meeting to discuss the future possibility of a Wellness Center. We recently completed an Employee Engagement Survey and received many positive responses. We will discuss opportunities at two Employee Forums this week.

4. CMO Report: Dr. Finkner reported Dr. Wilkinson is interested in making HCHS his home base with clinics to Oxford, Beaver City and surrounding areas. He would like to do surgeries, including total knees, in Alma. In addition, Dr. Clinch has once again indicated he would like to establish an ophthalmology clinic for cataracts.

5. GPHA Report: Les Lacy gave a GPHA report reviewing County Health Rankings and Roadmaps, password manager usage, nursing CE availabilities, using the right tools to accomplish you job, and research and education development.

IV. Public Comments: None

VI. Executive Session: At 5:46PM Chairman requested a motion to go into Executive Session for the purpose of discussing an Incentive Compensation Plan. Motion made by Bash and seconded by Brandon.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

VII. Open Session: At 5:54PM a motion was made by Brandon and seconded by Bash to go into Open Session.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

VIII. Motion made by Brandon and seconded by Bash to approve the quarterly incentive compensation for CEO.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

IX. Adjourn: Being that no further business needed to be discussed, at 5:55PM a motion was made by Howsden to adjourn the regular meeting of the board of trustees of the Harlan County Health System. Seconded by Bash.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

Recorded by April Einspahr

Doris Brandon

Doris Brandon, Secretary of the Board

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
May 15, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, May 15, 2023 at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Mary Jo Christensen requested a motion to call the meeting to order. At 4:30pm motion was made by Howsden and seconded by Brandon. A Roll Call was held: Howsden, Brandon, Long, Bash (absent at time of roll call), Frasier, Jensen, Christensen.

Additional Attendees: Stacy Neubauer, RN-MHA, CEO; Kayla Rhynalds, CFO; Cheryl Saathoff, Controller; Les Lacy, Regional VP of GPHA; April Einspahr, Recorder

II. Approval of Consent Agenda
Agenda items include Minutes of Board Meeting held April 24, 2023 and Check Register and Credit Card Summary. Credentialing and Privileging packets were reviewed in conjunction with the Medical Staff. Motion entered by Frasier and seconded by Howsden to approve the Consent Agenda.

Agenda. A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

III. Discussion Items
A. Old Business: None
B. New Business
1. Financials and Statistics: Cheryl Saathoff presented statistics. Kayla Rhynalds presented monthly financials and Key Indicators. Jeff Bash joined the meeting at 4:40pm. Motion made by Bash and seconded by Long to approve the financial reports as presented. It was noted that three outpatient physicians were out during the month of April. In addition, a Medicare estimate will be completed next month.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

2. Administrative Report: Stacy Neubauer reported she met with Bryant Klotther of Davis Design to discuss a master facility plan for the campus. They would likely be able to provide a proposal by September. The Bond Interest-Only payment in the amount of $3,510 will be paid. A Special Meeting will be held on June 12 to review the financial audit with Eide Bailly. A new position has been created for an Authorization Specialist, which will likely be fully remote. The therapist and program manager at Senior Life Solutions both resigned. The company will fill in with PRN until those positions are filled. A Physician Recruiter was here last week and reported a very positive experience. An APRN has expressed interest in coming on staff either PT or FT depending on her current non-compete agreement. It was also noted that the housing availability in Harlan County is dire.

3. GPHA Report: Les Lacy reported he is pleased with the CEO. GPHA is undergoing a Med Staff Bylaws project that will begin this week. He reminded the board that GPHA works diligently to provide detailed

research in all areas. They are restarting their RHC webinars. Les spoke briefly about Just Culture. He also discussed compliance issues in healthcare, such as NIST cyber security framework. Finally he noted the importance of cash on-hand in Critical Access Hospitals.

IV. Public Comments: Doris Brandon inquired about the hospital's relationship with the Villa. Brief discussion was held.

VI. Adjourn: Being that no further business needed to be discussed, at 5:40pm a motion was made by Brandon to adjourn the regular meeting of the board of trustees of the Harlan County Health System. Seconded by Howsden.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

Recorded by April Einspahr

Doris Brandon

Doris Brandon, Secretary of the Board

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
June 19, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, June 19, 2023 at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Mary Jo Christensen requested a motion to call the meeting to order. At 4:30pm motion was made by Brandon and seconded by Jensen. A Roll Call was held: Howsden, Brandon, Long, Bash (absent at time of roll call), Frasier, Jensen, Christensen.

Additional Attendees: Stacy Neubauer, RN-MHA, CEO; Kayla Rhynalds, CFO; Cheryl Saathoff, Controller; Les Lacy, Regional VP of GPHA; April Einspahr, Recorder

II. Approval of Consent Agenda
Agenda items include Minutes of Board Meeting held May 15 and June 12, 2023 and Check Register and Credit Card Summary. Credentialing and Privileging packets were reviewed in conjunction with the Medical Staff. *Appointment:* Hilker, Jenna, DNP, APRN (Docs Who Care, Olathe KS); O'Dell, Allison, IMHP (Psychiatric Medical Care, Brentwood TN) *Reappointment:* Wertz, Bradley, CRNA (Holistic Pain Management, Loveland CO); Werth, Jason, CRNA (Holistic Pain Management, Loveland CO); Kreimeyer, Jill, LMHP (Psychiatric Medical Care, Brentwood TN); Bean, Richard, MD (Pacific Companies, Irvine CA/Dallas TX); Albin, Matthias, MD (Heartland Radiology, Grand Island NE); Palmer, Tinna, PLMHP, CMSW (Psychiatric Medical Care, Brentwood TN); Lowe, Scott, MD (Heartland Radiology, Grand Island NE)

Motion entered by Long and seconded by Brandon to approve the Consent Agenda.

Agenda. A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	A	Y	Y	Y

III. Discussion Items
A. Old Business: None
Jeff Bash joined the meeting at 4:35pm.
B. New Business
1. Financials and Statistics: Cheryl Saathoff presented statistics. Kayla Rhynalds presented monthly financials and Key Indicators. Motion made by Frasier and seconded by Howsden to approve the financial reports as presented. Some statistical increases were due to the Pain Management Clinic. Dash Cash on Hand is 138.7.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

2. Administrative Report: Stacy Neubauer reported the Clinic had a mock survey and recommendations have been met. Davis Design (Omaha) will join the next board meeting to discuss creating a Master Facility Plan. Stay reviewed the SMART goals set by the Administration team last October. Open enrollment meetings went very well with employees. We hope to be budget-neutral; however, employees may choose from two plan options this year. NHA and CHI are both creating health insurance

options for Critical Access Hospitals, and we will research those further. We created a job posting for Director of HR and have five candidates interviewing.

3. Chief Medical Officer Report: Dr. Finkner was not available for report.

4. GPHA Report: Les Lacy noted he will provide a CEO Evaluation process and tool. He will gather anonymous comments. He will then meeting with the board to condense the information and present it to Stacy. Les recommends GPHA join with our efforts in the business office. He also presented an article from Beckers Hospital Review regarding advancements in healthcare. Discussion was held regarding Fair Market Value figures for providers and CRNAs. Also of note, Les will be out of office during August, but may be available via phone.

IV. Public Comments

VI. Adjourn: Being that no further business needed to be discussed, at 535pm a motion was made by Howsden to adjourn the regular meeting of the Board of Trustees of Harlan County Health System. Seconded by Long .

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

Recorded by April Einspahr

Doris Brandon

Doris Brandon, Secretary of the Board

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
July 17, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, July 17, 2023 at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Dusty Frasier requested a motion to call the meeting to order. At 4:30 pm motion was made by Bash and seconded by Long. A Roll Call was held: Howsden, Brandon, Long, Bash, Frasier, Jensen, Christensen (not present at time of roll call).

Additional Attendees: Stacy Neubauer, RN-MHA, CEO; Kayla Rhynalds, CFO; Cheryl Saathoff, Controller; Les Lacy, Regional VP of GPHA; April Einspahr, Recorder

II. **Davis Design: Master Facility Assessment:** Bryant Klotther and Erin Dobesh appeared before the Trustees to discuss creating a Master Facility Assessment. The Trustees asked for more options from additional firms.

Bryant Klotther and Erin Dobesh left the meeting at 5:00 pm.
Mary Jo Christensen joined the meeting at 5:10 pm.

III. **Approval of Consent Agenda**
Agenda items include Minutes of Board Meeting held June 19, 2023, and Check Register and Credit Card Summary. QI, Med Staff and Core Measures quarterly reports, and Patient Experience Report. Credentialing and Privileging packets were reviewed in conjunction with the Medical Staff.
Appointment: Pitsch, Robert, MD (Bryan Heart Vascular Surgery/ Bryan Teledigm, Lincoln NE); Elg, Nathan, DO (Avel eCARE, Sioux Falls SD); Tonsager, Jessica, MD (Avel eCARE, Sioux Falls SD); Christians, Benjamin, DO (Avel eCARE, Sioux Falls SD). *Reappointment:* Ghosh, Meenakshi, MD (Good Samaritan Medical Group, Kearney NE); Borsody, Mark, MD (Teledigm Physician Services, LLC, Lincoln NE). *Resignation:* Tareq Qdaisat, MD (UNMC)
Motion entered by Long and seconded by Brandon to approve the Consent Agenda as presented.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

IV. **Discussion Items**
A. Old Business: None
B. New Business
1. Financials and Statistics: Cheryl Saathoff presented statistics. Kayla Rhynalds presented monthly financials and Key Indicators. Motion made by Bash and seconded by Frasier to approve the financial reports as presented. Days Cash on Hand is 106.87. In June, we made $74,159.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

2. **Administrative Report:** Stacy Neubauer requested the Trustees consider moving the October Board Meeting to October 23, 2023. All were in favor. Meeting will be held October 23. Stacy relayed the Admin Team's desire to have a social event with the Board of Trustees. A Medical Resident was onsite

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2. **Administrative Report:** Stacy Neubauer requested the Trustees consider moving the October Board Meeting to October 23, 2023. All were in favor. Meeting will be held October 23. Stacy relayed the Admin Team's desire to have a social event with the Board of Trustees. A Medical Resident was onsite Friday for an interview. An offer will be made this week. Our new HR Director, Joanna Donohoe will start full-time employment with HCHS on August 1.

3. **Chief Medical Officer Report:** Dr. Finkner reported he would like to see an offer made to Dr. Sethi, with a student loan payment plan contingent on her commitment to HCHS.

4. **GPHA Report:** Les Lacy reported on CMS QAPI programs, CEO evaluation, and several issues reported in Becker's Review. Of note, Les recommended the Trustees move QAPI to the New Business section of the Agenda.

V. **Public Comments**

VI. **Executive Session:** At 6:00 pm Stacy Neubauer requested an Executive Session for the purpose of discussing an Incentive Compensation Plan. Motion made by Bash and seconded by Brandon.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

VI. **Open Session:** At 6:15 pm a motion was made by Brandon and seconded by Bash to go into Open Session.
A Roll Call Vote was held.

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

VII. Motion made by Bash and seconded by Brandon to approve the quarterly incentive compensation for the CEO.
A Roll Call Vote was held.

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

VIII. **Adjourn:** Being that no further business needed to be discussed, at 6:17 pm a motion was made by Bash to adjourn the regular meeting of the Board of Trustees of Harlan County Health System. Seconded by Brandon.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

Recorded by April Einspahr

Mary Jo Christensen

Mary Jo Christensen, Chairman of the Board

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
August 21, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, August 21, 2023, at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted, and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Mary Jo Christensen requested a motion to call the meeting to order. At 4:30 pm motion was made by Bash and seconded by Dr. Long. A Roll Call was held: Howsden (via phone), Brandon (Absent), Long, Bash, Frasier, Jensen, Christensen.

Additional Attendees: Stacy Neubauer, RN-MHA, CEO; Kayla Rhynalds, CFO; Les Lacy, Regional VP of GPHA (via phone); April Einspahr, Recorder; Joanna Donohoe, HR Director. Joanna left the meeting after a brief introduction.

II. **Approval of Consent Agenda**
Agenda items include Minutes of Board Meeting held July 17, 2023, and Check Register and Credit Card Summary. Motion entered by Frasier and seconded by Bash to approve the Consent Agenda as presented.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Absent	Y	Y	Y	Y	Y

III. **Discussion Items**

A. Old Business: None

B. New Business

1. **Financials and Statistics:** Kayla Rhynalds presented monthly statistics, financials and Key Indicators. Motion made by Dr. Long and seconded by Frasier to approve the financial reports as presented. Days Cash on Hand is 106.92. Year to Date Net Income is $1,055,133.

   A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Absent	Y	Y	Y	Y	Y

2. **Administrative Report:** Stacy Neubauer reported we are accepting bids for a Master Facility Plan. We will hold a second leadership retreat in October. A Community Needs Assessment is available currently. Looking ahead, we will be almost 100% staffed by next month. We hired one RN and two LPNs for the night shift. Dr. Clinch has agreed to provide services beginning in January and every other month. We are considering Ortho with Dr. Wilkenson and InReach. Dr. Schoppe is coming to tour the facility this week. We have hired Dr. Dakota Dreher on a PRN basis. As previously discussed, the hospital has been recruiting for a Physician for several years. We currently have one employed physician, Dr. Finkner, who also serves as Chief Medical Officer. We have used recruitment firms, word of mouth, and have joined recruitment residency programs. To date, we have made one offer to a qualified candidate. A second candidate is in the interview process.

3. **Chief Medical Officer Report:** Dr. Finkner reported he would like to meet with Dr. Schoppe. He also noted Dr. Tanveer Sidhu will be onsite on the 28th to tour the community and facility. Dr. Finkner is also

speaking with a local counselor who may work well with the telehealth mental health med management program.

4. **GPHA Report:** Les Lacy reported we should be focusing on the fundamentals of managing the hospital: orientation, education and mission-driven team building. The new normal has become short-term employment rather than searching for a lifetime employer. He reviewed optional benchmarks that are available to us as needed. He reviewed Smishing and cyber security. He recommended password managers. Finally, he reviewed the cost per square foot to build a new facility in various cities in the United States compared to Nebraska.

IV. **Public Comments:** None

V. **Executive Session:** At 5:30 pm Mary Jo requested an Executive Session for the purpose of contract negotiations. Motion made by Bash and seconded by Dr. Long. Lisa Howsden left the meeting.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Absent	Absent	Y	Y	Y	Y	Y

VI. **Open Session:** At 6:00 pm a motion was made by Bash and seconded by Long to go into Open Session.
A Roll Call Vote was held.

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Absent	Absent	Y	Y	Y	Y	Y

VII. **Adjourn:** Being that no further business needed to be discussed, at 6:00 pm a motion was made by Bash to adjourn the regular meeting of the Board of Trustees of Harlan County Health System. Seconded by Dr. Long.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Absent	Absent	Y	Y	Y	Y	Y

Recorded by April Einspahr

Mary Jo Christensen

Mary Jo Christensen, Chair of the Board

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
September 19, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Tuesday, September 19, 2023, at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted, and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Christensen requested a motion to call the meeting to order. At 4:30 pm motion was made by Howsden and seconded by Bash. A Roll Call was held: Howsden, Brandon, Long, Bash, Frasier (absent at time of roll call), Jensen, Christensen.

Additional Attendees: Stacy Neubauer, RN-MHA, CEO; Kayla Rhynalds, CFO; Les Lacy, Regional VP of GPHA; April Einspahr, Recorder.

II. **Approval of Consent Agenda**
Agenda items include Minutes of Board Meeting held August 21, 2023, and Check Register and Credit Card Summary.
Motion entered by Long and seconded by Howsden to approve the Consent Agenda with an amendment to the August 21, 2023 meeting minutes. Minutes will reflect Lisa Howsden left the August meeting at the time of the Executive Session.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Absent	Y	Y

III. **Discussion Items**
A. Old Business: None
Dusty Frasier joined the meeting at 4:45pm.
B. New Business
1. **Financials and Statistics:** Kayla Rhynalds presented statistics, financials and Key Indicators. Motion made by Brandon and seconded by Bash to approve the financial reports as presented.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

2. **Administrative Report:** Stacy Neubauer reported she is working with several organizations who may be able to provide a Master Facility Assessment and Plan. Dr. Schoppe visited HCHS and was impressed with the facility. He is ready and willing to come. We will rent the equipment for the first six months. At that time, the rental fees will go toward the purchase of the equipment. The contract is with legal. The go-live goal in January 2024. The hospital has had communication with Partners PEO regarding a transition to onsite HRIS/Payroll systems. Stacy sent an Employee Engagement Survey update to staff regarding what has been done to improve the three highlighted areas: benefits, culture and communication.

3. **Chief Medical Officer Report:** Dr. Finkner presented an update on surgical services. He is also interested in offering an allergy clinic. We are set to interview a physician candidate next week.
4. **GPHA Report:** Les Lacy reported he researched the OIG website regarding Medicare Advantage plans. He will distribute printed copies of his notes to the board.

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IV. **Public Comments:** None

V. **Executive Session:** At 5:30pm Mary Jo made a motion to enter an Executive Session for the purpose of contract negotiations. Motion seconded by Frasier.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

VI. **Open Session:** At 7:50 pm a motion was made by Bash and seconded by Frasier to go into Open Session.
A Roll Call Vote was held.

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

VII. **Adjourn:** Being that no further business needed to be discussed, at 7:50 pm a motion was made by Bash to adjourn the regular meeting of the Board of Trustees of Harlan County Health System. Seconded by Frasier.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

Recorded by April Einspahr

Doris Brandon

Doris Brandon, Secretary of the Board of Trustees

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
October 23, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Tuesday, October 23, 2023, at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted, and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Christensen requested a motion to call the meeting to order. At 4:30 pm motion was made by Bash and seconded by Brandon. A Roll Call was held: Howsden, Brandon, Long, Bash, Frasier, Jensen, Christensen.

Additional Attendees: Stacy Neubauer, RN-MHA, CEO; Kayla Rhynalds, CFO; Les Lacy, Regional VP of GPHA (via Zoom); April Einspahr, Recorder.

II. **Approval of Consent Agenda**
Agenda items include Minutes of Board Meeting held September 19, 2023, and Check Register and Credit Card Summary. Credentialing and Privileging reports were reviewed in cooperation with the Medical Staff.
Motion entered by Long and seconded by Bash to approve the Consent Agenda as presented.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y via Zoom	Y	Y	Y	Y	Y	Y

III. **Discussion Items**
A. Old Business: None
B. New Business
1. **Quarterly QAPI, Med Staff, Core Measures, HCAHPS:** Stacy Neubauer presented Diane Fegter's report of the Quality Initiatives, Med Staff Reports, Core Measures and HCAHPS. Discussion was held regarding possible quality initiatives for 2024. Motion made by Frasier and seconded by Bash to approve the reports and suggested initiatives as presented.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

2. **Financials and Statistics:** Kayla Rhynalds presented statistics, financials and Key Indicators. Motion made by Brandon and seconded by Bash to approve the financial reports as presented.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

3. **Administrative Report:** Stacy Neubauer reported she would like to have a Master Facility Assessment presentation for the Trustees. Administration held an annual retreat in which they reviewed individual and team Strengths Finder results. They also reviewed stats, goals, financials, and set goals for 2024. They listened to a presentation regarding Emotional Intelligence, started a book study for 2024, and developed goals for quality, finance, marketing, and Ivantage. Stacy also reported as of Sept 2022, the hospital had lost $23,000, and after hiring the Authorization Specialist, as of Sept 2023, we have only lost $162. We are in negotiations for an orthopedic group. Negotiations with an Ophthalmologist are

ongoing. Stacy presented an update regarding Human Resources. A termination letter was sent to Partners effective December 31, 2023. We have a go-live date with an HRIS for January 1, 2024. Unico will be our Broker of Record. Our PTO policy and wages are under review. An employee forum will be held November 16, and the Town Hall meeting will be November 8. Finally, the NHA Caring Kind award was awarded to Haley Booe, who was nominated by several employees.

4. **Chief Medical Officer Report:** Dr. Finkner was not present for the meeting.
5. **GPHA Report:** Les Lacy reported GPHA held a training session regarding physical assessments for adults, CISA cyber defense, long Covid, pharmacy, IT security, HR topics, social determinants of health, the future of AI, a legal EMTALA presentation, and survey issues. All sessions available in person or virtual. The GPHA annual education included med errors, Medicare Advantage, and ICD-11.

IV. **Public Comments:** None

V. **Executive Session:** At 5:25pm Bash made a motion to enter an Executive Session for the purpose of contract negotiations. Motion seconded by Long.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

VI. **Open Session:** At 6:35pm a motion was made by Bash and seconded by Long to go into Open Session.
A Roll Call Vote was held.

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

Motion made by Bash to approve CEO Incentive per contract. Seconded by Long.
A Roll Call Vote was held.

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

VII. **Adjourn:** Being that no further business needed to be discussed, at 6:36pm a motion was made by Brandon to adjourn the regular meeting of the Board of Trustees of Harlan County Health System. Seconded by Bash.

A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Y	Y

Recorded by April Einspahr

Doris Brandon

Doris Brandon, Secretary of the Board of Trustees

Harlan County Health System

Hospital | Heartland Family Medicine
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www.harlancountyhealth.com

BOARD OF TRUSTEES REGULAR MEETING MINUTES:
November 20, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, November 20, 2023, at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted, and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Christensen requested a motion to call the meeting to order. At 4:30 pm motion was made Bash and seconded by Brandon. A Roll Call was held: Howsden, Brandon, Long (Absent), Bash, Frasier, Jensen via Zoom, Christensen.

Additional Attendees: Stacy Neubauer, RN-MHA, CEO; Kayla Rhynalds, CFO; Les Lacy, Regional VP of GPHA (via Zoom); April Einspahr, Recorder.

II. **BWBR Architects Presentation by Scott Kirchner, Principal; Anna Pratt, Project Manager; Lacy Mann, Contracts Specialist:** Scott Kirchner presented a review of BWBR, recent projects, and methodology for creating a Master Facility Assessment and Plan. Joe Beckenhauer, CEO of Beckenhauer Construction was also present for the presentation.

At 4:58pm, all staff and Trustees left the meeting to move vehicles from the West side of the parking lot for air care arrival. The meeting resumed at 5:02pm. Dusty Frasier, Joe Beckenhauer and members of BWBR left the meeting at 5:45pm.

III. **Approval of Consent Agenda**
Agenda items include Minutes of Board Meeting held October 23, 2023, and Check Register and Credit Card Summary. Credentialing and Privileging reports were reviewed in cooperation with the Medical Staff.
Motion entered by Bash and seconded by Howsden to approve the Consent Agenda as presented.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y via Zoom	Y	A	Y	A	Y via Zoom	Y

IV. **Discussion Items**
A. Old Business: None
B. New Business
1. **Bond Payment:** Motion made by Brandon and seconded by Howsden to make an interest-only payment in the amount of $2,925.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y via Zoom	Y	A	Abstain	A	Y via Zoom	Y

2. **Annual Utilization Program Review:** Motion made by Bash and seconded by Brandon to accept the 2024 Utilization Program Review.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y via Zoom	Y	A	Y	A	Y via Zoom	Y

3. **Annual Risk Management/Quality Plan:** Motion made by Bash and seconded by Brandon to accept the 2024 Utilization Program Review.

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A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y via Zoom	Y	A	Y	A	Y via Zoom	Y

4. **Financials and Statistics:** Kayla Rhynalds presented statistics, financials and Key Indicators. Motion made by Brandon and seconded by Bash to approve the financial reports as presented.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y via Zoom	Y	A	Y	A	Y via Zoom	Y

5. **Administrative Report:** Stacy Neubauer requested feedback on BWBR. The cost of the Master Plan is $55,000. The Therapy Department space is not adequate for the patient load. Stacy will temporarily renovate the current ER Waiting Room to create offices for the therapists. The current office will become a private treatment room. The hospital filled the dietary role that has been open for several months. There are 2-3 candidates on deck for the QI position. Stacy reported a change in Cheryl Saathoff's role from Controller to Payroll and Finance Manager. The Ortho contract has been signed and we anticipate making an announcement next week. The surgeon will start with a half day onsite and grow to 2.5 days per month. The surgeon will need to be credentialed prior to starting. Stacy has termed the relationship with Jackson Physician Search; however, when she is ready to being the search again, they have agreed to waive the onboarding fee. The Clinic had a record-breaking day last Monday, with the largest number of patients ever seen in one day. Stacy held employee forums last week and had excellent attendance. Howsden inquired about Dr. Dreher's ability to do procedures. Stacy will ask him if he is interested and report back to the Trustees.

6. **Chief Medical Officer Report:** Dr. Finkner was not present for the meeting.

7. **GPHA Report:** Les Lacy provided education about the New Market Tax Credit. He indicated it has many hoops to jump through but may be worth looking into. He gave remarks about a DON Roundtable in November, including education for QI, IT, health resources, social determinates of health, future of AI in nursing and healthcare, providers and survey preparedness. Next month he will provide a corporate compliance refresher.

V. **Public Comments:** None

VI. **Adjourn:** Being that no further business needed to be discussed, at 6:27pm a motion was made by Bash to adjourn the regular meeting of the Board of Trustees of Harlan County Health System. Seconded by Brandon.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y via Zoom	Y	Y	Y	A	Y	Y via Zoom

Recorded by April Einspahr

Doris Brandon

Doris Brandon, Secretary of the Board of Trustees

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BOARD OF TRUSTEES REGULAR MEETING MINUTES:
December 18, 2023
HCHS Board Room

I. The Harlan County Health System Board of Trustees held their regular meeting Monday, December 18, 2023, at Harlan County Health System in Alma, Nebraska. Being that the meeting was properly publicized to the community, the meeting agenda was properly posted, and the meeting was held in open session in compliance with the Nebraska Open Meetings Act Neb. Rev. Stat. Ch. 84, Act. 14, Chairman Christensen requested a motion to call the meeting to order. At 4:30 pm motion was made Bash and seconded by Brandon. A Roll Call was held: Howsden, Brandon, Long, Bash, Frasier, Jensen (absent), Christensen.

Additional Attendees: Stacy Neubauer, RN-MHA, CEO; Kayla Rhynalds, CFO; Les Lacy, Regional VP of GPHA (via Zoom); April Einspahr, Recorder.

II. **Approval of Consent Agenda**
Agenda items include Minutes of Board Meeting held November 20, 2023, and Check Register and Credit Card Summary, and the Annual Infection Control Plan. Credentialing and Privileging reports were reviewed in cooperation with the Medical Staff.
Motion entered by Brandon and seconded by Frasier to approve the Consent Agenda as presented.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Absent	Y

III. **Discussion Items**
A. Old Business: None
B. New Business
1. **2024 Budget:** Kayla Rhynalds presented the 2024 budget for review and discussion. Motion made by Howsden and seconded by Bash to approve the 2024 Annual Budget. Chairman Christensen asked the Corporate Compliance Officer if it would be appropriate for her to abstain from voting on the budget since salaries are included in the budget. Corporate Compliance Officer Lacy reported no issues with Christensen voting on the budget. He also noted the budget includes a three year capital expense forecast.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Absent	Y

3. **Financials and Statistics:** Kayla Rhynalds presented statistics, financials and Key Indicators. Motion made by Long and seconded by Howsden to approve the financial reports as presented.
A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	A	Absent	Y

4. **Administrative Report:** Stacy Neubauer reviewed the 2024 Strategic Plan document, which will be adjusted as needed. She reported the Woodruff Estate was settled and Harlan County Health System received one fourth of the estate. She noted deep reverence and gratitude for Mr. Woodruff's remarkable generosity. Stacy gave an overview of clinic statistics since two new physicians are now seeing patients in Alma. Trustee Bash inquired about the ability to qualify for a preceptorship program.

seeing patients in Alma. Trustee Bash inquired about the ability to qualify for a preceptorship program. Stacy indicated she has contacted the individual she was referred to and she has an upcoming meeting to discuss bringing nursing students onsite as well.

5. **Chief Medical Officer Report:** Dr. Finkner was not present for the meeting.

6. **GPHA Report:** Les Lacy provided biannual Corporate Compliance education.

IV. **Public Comments:** None

VI. **Adjourn:** Being that no further business needed to be discussed, at 5:31pm a motion was made by Bash to adjourn the regular meeting of the Board of Trustees of Harlan County Health System. Seconded by Brandon. A Roll Call Vote was held:

Howsden	Brandon	Long	Bash	Frasier	Jensen	Christensen
Y	Y	Y	Y	Y	Absent	Y

Recorded by April Einspahr

Doris Brandon

Doris Brandon, Secretary of the Board of Trustees

2024 Budgeted Income Statement
Projected

Patient Revenue	
Inpatient Revenue	968,755.00
Outpatient Revenue	15,238,935.00
Ambulatorty Clinic Revenue	956,000.00
Total Patient Revenue	17,163,690.00
Deductions from Revenue	
Contractual Adjustments	2,062,130.00
Other Discounts	170,900.00
Bad Debts	153,600.00
Total Deductions	2,386,630.00
Net Patient Revenue	14,777,060.00
Other Operating Revenue	1,022,621.00
Total Operating Revenue	15,799,681.00
Operating Expenses	
Salaries & Wages	5,544,628.19
Employee Benefits	1,481,214.83
Contract Labor	150,000.00
Prof Medical Fees & Services	395,600.00
Other Fees & Services	4,096,270.00
Supplies	1,874,958.25
Utilities	208,355.00
Repairs and Maintenance	299,550.00
Insurance	118,750.00
Other Operating Expenses	796,495.00
Deprec & Amort	991,095.00
Interest Expense	55,000.00
Total Operating Expenses	**16,011,916.27**
Net Operating Income	(212,235.27)
Non-Operating Income	235,326.00
Net Income	23,090.73

2024 Budget Balance Sheet
Project

Assets	
Current Assets	
Cash & Cash Equivalents	
TOTAL CASH & EQUIVALENTS	4,021,895.94
TOTAL SHORT TERM INVESTMENTS	696,530.54
TOTAL PATIENT RECEIVABLES	1,478,458.00
TOTAL OTHER RECEIVABLES	68,300.00
TOTAL THIRD PARTY SETTLEMENTS	(100,000.00)
TOTAL INVENTORIES	203,000.00
TOTAL PREPAID EXPENSES	112,000.00
TOTAL CURRENT ASSETS	6,480,184.48
ASSETS LIMTED AS TO USE	653,253.67
LONG TERM INVESTMENTS	-
INVESTMENTS IN OTHER ENTITIES	-
TOTAL PROPERTY, PLANT & EQUIPMENT	16,851,532.00
TOTAL ACCUMLATED DEPRECIATION	(11,059,592.00)
NET PROPERTY, PLANT & EQUIMENT	5,791,940.00
TOTAL ASSETS	12,925,378.15
Liabilities and Fund Balance	
Current Liabilities	
ACCOUNTS PAYABLE	489,000.00
ACCRUED WAGES & PTO	805,000.00
PAYROLL DEDUCTIONS & TAXES	34,450.00
OTHER CURRENT LIABILITIES	341,000.00
TOTAL CURRENT LIABILITIES	1,669,450.00
TOTAL LONG TERM LIABILITIES	830,300.00
TOTAL LIABILITIES	2,499,750.00
Fund Balance	
OPERATING FUND	10,394,694.57
TEMP RESTRICTED FUND BALANCE	7,842.85
PERM RESTRICTED FUND BALANCE	-
NET PROFIT (LOSS)	23,090.73
TOTAL NET ASSETS	10,425,628.15
TOTAL LIABILITIES & NET ASSETS	12,925,378.15

Department:

EQUIPMENT	DEPARTMENTS	QTY	COST	TOTAL
HARLAN COUNTY HEALTH SYSTEM 2024 CAPITAL BUDGET CONSIDERATIONS				
Dexa Machine	X-Ray	1	$ 70,000.00	$ 70,000.00
Oven	Food & Nutrition	1	$ 7,500.00	$ 7,500.00
Nurse Call System	Inpatient	1	$ 61,262.00	$ 61,262.00
Auto-Scrubber	Housekeeping	1	$ 11,000.00	$ 11,000.00
Fluidotherapy	Rehab	1	$ 5,000.00	$ 5,000.00
Shuttle MVP	Therapy	1	$ 6,850.00	$ 6,850.00
SCI Fit Pro1 Upper Body Exerciser	Therapy	1	$ 5,400.00	$ 5,400.00
Clinic Mini Split Thermostat	Clinic - Maintenance	1	$ 5,000.00	$ 5,000.00
Cautery Machine	Surgery	1	$ 17,000.00	$ 17,000.00
Sidewalk Repair	Maintenance	1	$ 20,000.00	$ 20,000.00
Freezer	Food & Nutrition	1	$ 12,000.00	$ 12,000.00
Water and Ice Machine	Nutrician	1	$ 15,000.00	$ 15,000.00
Stryker Cart	Surgery	1	$ 11,000.00	$ 11,000.00
Endo Tower Monitor	Surgery	1	$ 9,000.00	$ 9,000.00
Exam Chairs	Outpatient - Specialty	2	$ 9,500.00	$ 19,000.00
Lab Fridge	Lab	1	$ 10,000.00	$ 10,000.00
Fire Alarm Panel	Maintenance	1	$ 20,000.00	$ 20,000.00
ER COTS ROOM 2 AND 3	EMERGENCY ROOM	2	$ 10,000.00	$ 20,000.00
				$ 285,012.00
HARLAN COUNTY HEALTH SYSTEM 2025 CAPITAL BUDGET CONSIDERATIONS				
Power Injector for CT	CT	1	$ 45,000.00	$ 45,000.00
Kitchen Lights	Nutrician	1	$ 10,000.00	$ 10,000.00
Med Packager	Pharmacy	1	$ 35,000.00	$ 35,000.00
				$ 90,000.00
HARLAN COUNTY HEALTH SYSTEM 2026 CAPITAL BUDGET CONSIDERATIONS				
Equipment for Bariatric Patients	Inpatient	1	$ 10,000.00	$ 10,000.00
Old Clinic Building Roof	Maintenance	1	$ 50,000.00	$ 50,000.00
Equipment	IT	1	$ 15,000.00	$ 15,000.00
				$ 75,000.00
EQUIPMENT TOTAL				**$ 450,012.00**

Harlan County Health System
Financial Statement Highlights
February 2024

Balance Sheet

Harlan County Health System's cash increased by $149,540. The Days Cash on Hand for the checking and Sweep accounts is 102.97. The Days Cash on Hand including Funded Depreciation is 129.967. Net Profit for the year is $675,706. HCHS cashed a CD at FSB and applied to Clinic liability. The February Clinic loan balance is $317,272.06.

Income Statement

Inpatient Revenue for the month of January was over budget ($9K, 12%) and over budget for the year ($79K, 49.3%). The Average Daily Census for the month was 1.069 compared to the 12-month average of 1.284 and 1.097 for the prior year. There were 20 Inpatient days and 11 Swing Bed days for the month. Outpatient revenue is under budget for the month at (-8.9%). RHC volumes decreased slightly for the month to 687 visits, compared to January of 710 visits, which was a volume record.

Contractual Adjustments reflect the monthly estimated allowance for other payors based upon accounts receivable. There was a large adjustment to contractual adjustment due to the number of days in AR for December and January compared to February. Other adjustments reflect accounts that have been written off due to factors other than by contractual agreement. The Other Adjustments category is reflective of actual write-offs (medical necessity, pre-authorizations, etc.). There were no bankruptcy cases. There were no significant adjustments in February.

Bad Debt expense is over budget for the Month of February ($22K).

The up-front collections for January totaled $11,958.36. This includes the hospital, RHC and scheduled procedures.

Other Operating Revenue is significantly over budget for the month and prior year. The 340-B revenue in January was $241,819. We have seen our revenue increase with the switch to Macro Helix in November 2023.

Salaries and Wages are slightly over budget for the month (4.2%). Contract Labor for Inpatient Care is over budget ($20K, 160.3%). This is estimated to improve the over the next couple months.

Professional Medical Fees & Services was under budget for the month (23.9%). This continues to improve month over month.

Other Fees and Services were consistent with the budget for the month.

Supplies are under budget for the month ($55K, 35.2%).

Utilities are under budget for the month (18.6%). Repairs and Maintenance, and Insurance are under budget (53% for the month but over year to date (12%) due to construction of ER Waiting room conversion.

Harlan County Health System
Financial Statement Highlights
February 2024

Other Operating Expenses are over budget for the month $131K, due to the 340-B program expenses, increased patient volumes in Pain Management, and the Master Planning Assessment and Plan process.

Depreciation is slightly under budget (6.4%) for the month.

Net Operating Income is over budget for the month of February. We received $6,204 from HCHS Foundation.

Costs per adjusted patient stay (Inpatient volumes adjusted for Outpatient revenue) have decreased -2.44% relative to 2023. Net Revenue per adjusted patient day has decreased -10.72%.

Kayla Rhynalds, CFO
Cheryl Saathoff, Payroll/Finance Manager

HARLAN COUNTY HEALTH SYSTEM

	STATISTICS	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	TOTAL	AVERAGE	Jan-23
INPATIENT																
ADMITS																
	ACUTE/MEDICAL SURGICAL	6	3	6	4	11	5	7	8	6	10	6	8	80	7	4
	SKILLED/SWING BED	2	3	6	3	4	1	3	4	4	5	6	2	43	4	4
	INTERMEDIATE/HOSPICE	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0
	TOTAL	8	6	12	7	15	6	10	12	10	16	12	10	**124**	**10**	8
DISCHARGES																
	ACUTE/MEDICAL SURGICAL	5	4	6	3	11	5	8	8	6	10	5	9	80	7	5
	SKILLED/SWING BED	2	3	6	2	5	1	3	3	5	3	8	2	43	4	4
	INTERMEDIATE/HOSPICE	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0
	TOTAL	7	7	12	5	16	6	11	11	11	14	13	11	**124**	**10**	9
PATIENT DAYS																
	ACUTE/MEDICAL SURGICAL	20	5	16	10	26	12	19	20	15	24	12	20	199	17	15
	SKILLED/SWING BED	7	23	27	15	10	4	20	30	31	34	54	11	266	22	19
	INTERMEDIATE/HOSPICE	0	0	0	0	0	0	0	0	0	6	0	0	6	1	0
	TOTAL	27	28	43	25	36	16	39	50	46	64	66	31	**471**	**39**	34
AVERAGE DAILY CENSUS PATIENT DAYS																
	ACUTE/MEDICAL SURGICAL	0.645	0.167	0.516	0.333	0.839	0.387	0.633	0.645	0.500	0.774	0.387	0.690	7	0.543	0.484
	SKILLED/SWING BED	0.226	0.767	0.871	0.500	0.323	0.129	0.667	0.968	1.033	1.097	1.742	0.379	9	0.725	0.613
	INTERMEDIATE/HOSPICE	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.194	0.000	0.000	0	0.016	0.000
	TOTAL	0.871	0.933	1.387	0.833	1.161	0.516	1.300	1.613	1.533	2.065	2.129	1.069	**15**	**1.284**	1.097
LENGTH OF STAY																
	ACUTE/MEDICAL SURGICAL	4.0	1.3	2.7	3.3	2.4	2.4	2.4	2.5	2.5	2.4	2.4	2.2	30	3	3.0
	SKILLED/SWING BED	3.5	7.7	4.5	7.5	2.0	4.0	6.7	10.0	6.2	11.3	6.8	5.5	76	6	4.8
	INTERMEDIATE/HOSPICE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-	0	0.0
OUTPATIENT VISITS																
Visits	EMERGENCY ROOM	59	64	92	93	93	79	88	89	58	86	58	53	912	76	63
Visits	TELEHEALTH 71100	12	3	4	2	6	6	1	6	74	2	3	1	120	10	30
	TOTALS	71	67	96	95	99	85	89	95	132	88	61	54	**1,032**	**86**	93
DEPARTMENT USAGE																
Procedures	OBSERVATION HOURS 60140	444	286	228	269	432	254	319	316	344	478	352	247	3,969	331	255
Procedures	ER 62300	39	60	89	101	76	102	76	68	76	72	61	51	871	73	44
Procedures	LAB 70100	1581	1237	1687	1453	1339	1612	1214	1398	1485	1481	1736	1618	17,841	1487	1125
Procedures	RADIOLOGY	342	299	452	370	385	371	337	384	323	358	372	344	4,337	361	232
Procedures	THERAPY	2064	1857	2113	2062	1852	2079	1996	2273	1972	1964	1773	1828	23,833	1986	1480
Procedures	TREATMENT ROOM 77000	53	48	45	25	20	22	14	16	16	15	13	10	297	25	28
Procedures	SPECIALTY CLINIC 77020	185	155	226	255	197	237	201	198	202	115	134	202	2,307	192	168
Procedures	CARDIAC REHAB/PULM 70300 71000	158	130	197	182	136	86	63	96	125	119	137	110	1,539	128	144
Procedures	SURGERY 62100	22	17	22	16	15	32	27	56	29	31	40	28	335	28	8
Procedures	SENIOR LIFE SOLUTIONS 70325	75	91	67	78	71	58	59	75	65	44	42	54	779	65	122
	TOTALS	**4963**	**4180**	**5126**	**4811**	**4523**	**4853**	**4306**	**4880**	**4637**	**4677**	**4660**	**4492**	**56,108**	**4676**	**3606**
CLINIC VISITS																
	RHC - ALMA - Registration Stats	571	511	524	519	589	582	495	672	600	616	710	687	7,076	**590**	342

Fiscal Calendar JANDEC

Harlan County Health System
BALANCE SHEET
For the Period Ending FEB 2024

	FEB 2024	JAN 2024	CHANGE	DEC 2023	YTD CHANGE
ASSETS					
CURRENT ASSETS					
CASH & CASH EQUIVALENTS	4,612,400	4,473,724	138,675	4,435,129	177,270
SHORT TERM INVESTMENTS	1,204,175	1,193,313	10,863	718,410	485,765
PATIENT RECEIVABLES	1,655,936	1,936,811	(280,875)	1,685,402	(29,466)
OTHER RECEIVABLES	234,981	262,489	(27,507)	94,205	140,777
THIRD PARTY SETTLEMENTS	(544,615)	(527,186)	(17,429)	(527,186)	(17,429)
INVENTORIES	209,674	204,917	4,758	192,967	16,707
PREPAID EXPENSES	127,501	120,000	7,501	98,107	29,395
OTHER CURRENT ASSETS	0	0	0	0	0
TOTAL CURRENT ASSETS	7,500,052	7,664,067	(164,015)	6,697,034	803,018
ASSETS LIMITED AS TO USE	611,119	610,899	220	660,452	(49,333)
LONG TERM INVESTMENTS	0	0	0	0	0
INVESTMENTS IN OTHER ENTITIES	0	0	0	0	0
PROPERTY, PLANT, EQUIPMENT	15,763,500	15,757,985	5,515	15,709,265	54,235
ACCUMLATED DEPRECIATION	(9,901,152)	(9,823,837)	(77,315)	(9,743,120)	(158,031)
PROPERTY & EQUIPMENT (net)	5,862,348	5,934,148	(71,800)	5,966,145	(103,797)
TOTAL ASSETS	13,973,519	14,209,114	(235,595)	13,323,631	649,888
LIABILITIES AND FUND BALANCE					
CURRENT LIABILITIES					
ACCOUNTS PAYABLE	325,923	334,902	8,979	363,725	37,802
ACCRUED WAGES & PTO	569,441	542,098	(27,343)	514,063	(55,379)
PAYROLL DEDUCTIONS & TAXES	164,626	178,411	13,785	90,376	(74,250)
OTHER CURRENT LIABILITIES	367,539	362,003	(5,536)	394,253	26,714
TOTAL CURRENT LIABILITIES	1,427,529	1,417,414	(10,115)	1,362,416	(65,113)
TOTAL LONG TERM LIABILITIES	759,164	792,868	33,704	850,087	90,924
TOTAL LIABILITIES	2,186,693	2,210,283	23,589	2,212,504	25,811
FUND BALANCE					
OPERATING FUND	11,094,781	11,094,781	0	11,094,781	0
TEMP RESTRICTED FUND BALANCE	16,339	16,620	281	16,346	7
PERM RESTRICTED FUND BALANCE	0	0	0	0	0
NET PROFIT (LOSS)	675,706	887,430	211,724	0	(675,706)
TOTAL NET ASSETS	11,786,826	11,998,831	212,005	11,111,127	(675,699)
TOTAL LIABILITIES & NET ASSETS	13,973,519	14,209,114	235,595	13,323,631	(649,888)

Fiscal Calendar JANDEC

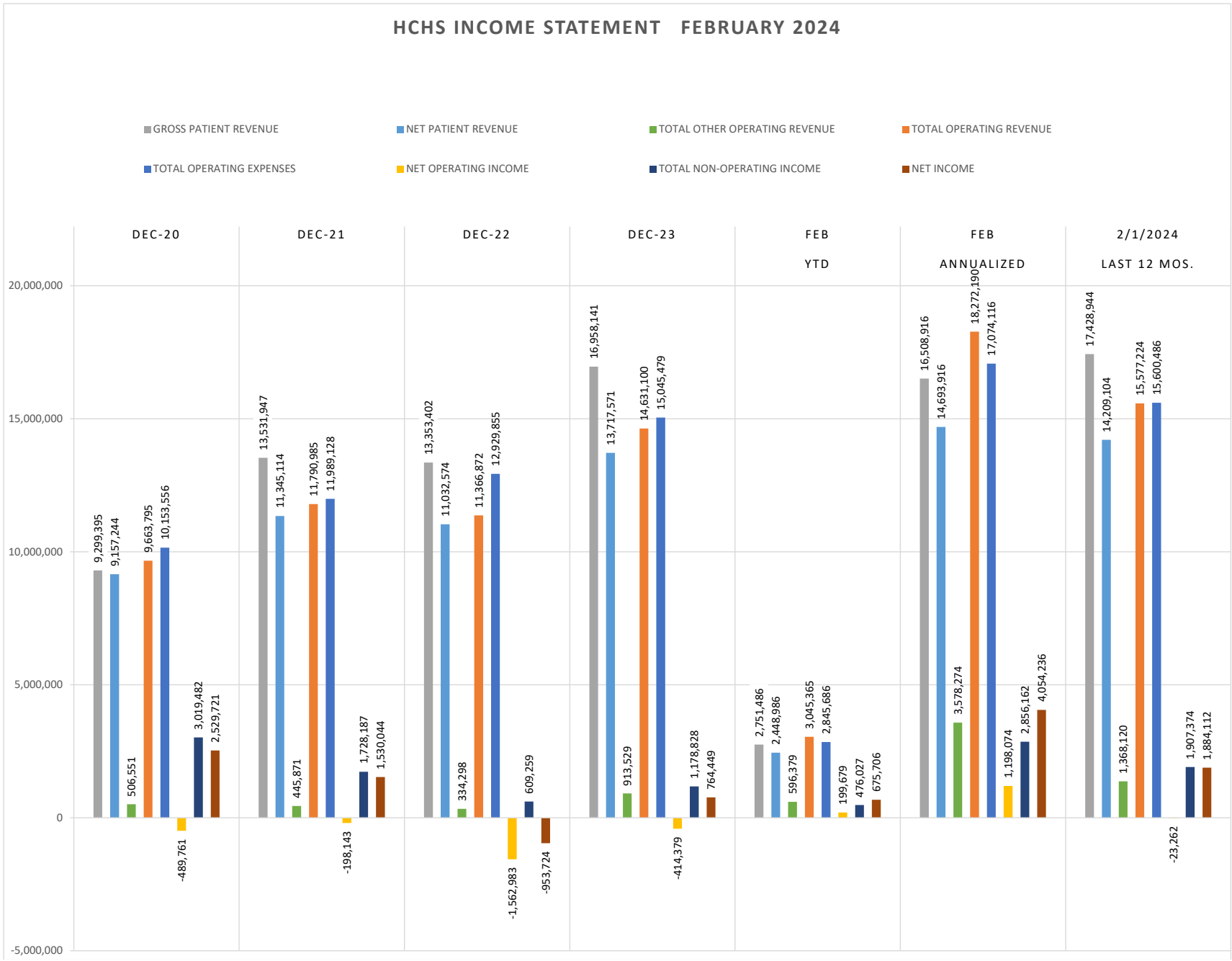
HARLAN COUNTY HEALTH SYSTEM
COMPARITIVE INCOME STATEMENT
FOR THE PERIOD ENDING FEB 2024

	FEB 2024 ACTUAL	FEB 2023 ACTUAL	PRIOR - CUR PERIOD VAR	FEB 2024 YTD ACTUAL	FEB 2023 YTD ACTUAL	PRIOR - ACT YTD VAR	YTD BUDGET	ACT - BUD YTD VAR
PATIENT REVENUE								
INPATIENT REVENUE	90,382	63,248	27,134	241,081	159,930	81,151	161,461	79,620
OUTPATIENT REVENUE	1,117,536	975,725	141,811	2,286,908	1,962,021	324,887	2,453,709	(166,801)
AMBULATORY CLINIC REVENUE	112,385	94,873	17,512	223,497	158,731	64,766	159,334	64,163
TOTAL PATIENT REVENUE	1,320,303	1,133,846	186,457	2,751,486	2,280,682	470,804	2,774,504	(23,019)
DEDUCTIONS FROM REVENUE								
CONTR ADJMTS	356,558	103,298	(253,261)	212,730	305,395	92,665	343,686	(130,956)
OTHER DISCOUNTS	26,369	18,488	(7,881)	43,682	14,186	(29,496)	28,484	15,198
BAD DEBTS	35,009	38,944	3,935	46,088	3,648	(42,440)	25,600	20,488
TOTAL DEDUCTIONS	417,937	160,730	(257,207)	302,500	323,229	20,729	397,770	(95,270)
NET PATIENT REVENUE	902,366	973,116	(70,750)	2,448,986	1,957,453	491,533	2,376,734	72,252
BUILDING & MISC REVENUE	5,731	5,766	(35)	9,768	9,322	447	1,115	8,653
340B PHARMACY	241,819	47,579	194,241	578,886	128,195	450,691	151,667	427,219
INV INCOME-REALIZED	3,842	1,990	1,852	7,726	4,272	3,454	6,236	1,490
TOTAL OTHER OPERATING REVENUE	251,392	55,335	196,057	596,379	141,788	454,591	159,018	437,361
TOTAL OPERATING REVENUE	1,153,758	1,028,451	125,307	3,045,365	2,099,241	946,124	2,535,752	509,613
OPERATING EXPENSES								
SALARIES & WAGES	499,519	366,508	(133,011)	1,000,245	750,205	(250,040)	959,011	41,234
EMPLOYEE BENEFITS	112,359	81,885	(30,475)	233,534	175,620	(57,913)	249,734	(16,200)
CONTRACT LABOR	32,536	49,339	16,803	54,705	86,791	32,086	25,000	29,705
PROF MEDICAL FEES & SERV	25,078	33,014	7,936	60,227	68,904	8,676	65,934	(5,707)
OTHER FEES & SERVICES	352,402	288,836	(63,566)	668,944	561,170	(107,774)	682,710	(13,767)
SUPPLIES	101,504	71,387	(30,118)	239,938	231,641	(8,297)	313,233	(73,295)
UTILITIES	14,888	16,366	1,478	30,172	32,960	2,788	36,585	(6,413)
REPAIRS & MAINTENANCE	9,861	22,885	13,025	56,134	51,310	(4,825)	50,083	6,051
INSURANCE	10,659	11,406	747	20,957	18,769	(2,189)	19,792	1,165
OTHER OPERATING EXP	131,583	43,394	(88,189)	313,127	105,615	(207,513)	134,120	179,007
DEPR & AMORT	77,315	108,666	31,351	158,031	196,925	38,894	165,183	(7,152)
INTEREST EXP	3,982	4,318	337	9,671	8,103	(1,568)	9,167	504
TOTAL OPERATING EXPENSES	1,371,686	1,098,005	(273,681)	2,845,686	2,288,013	(557,673)	2,710,552	135,134
NET OPERATING INCOME	(217,928)	(69,554)	(148,374)	199,679	(188,772)	388,451	(174,800)	374,479
NON-OPERATING INCOME								
ASSETS RELEASED	0	0	0	0	19,375	(19,375)	833	(833)
CONTRIB & GRANTS	6,204	0	6,204	476,027	142,486	333,542	29,287	446,740
COMMUNITY BENEFIT	0	0	0	0	0	0	767	(767)
GAIN/LOSS ON SALE	0	0	0	0	0	0	8,333	(8,333)
TOTAL NON-OPERATING INCOME	6,204	0	6,204	476,027	161,860	314,167	39,220	436,807
NET INCOME	(211,724)	(69,554)	(142,170)	675,706	(26,912)	702,618	(135,580)	811,286

HARLAN COUNTY HEALTH SYSTEM KEY PERFORMANCE INDICATORS	Benchmarks	Benchmark Comparison	YTD Dec 2023	YTD Feb 2024	TREND	
Days in Accounts Receivable (including private paycontract accounts)	53	In Progress	66.25	57.18	↓	downward trend is favorable
Days in Accounts Receivable (excluding private paycontract accounts)	53	POSITIVE	38.11	26.50	↓	downward trend is favorable
Days Cash on Hand (checking funds)	60	POSITIVE	117.33	102.97	↓	upward trend is favorable
Days Cash on Hand including funded depreciation	60	POSITIVE	136.33	129.85	↓	upward trend is favorable
Current Ratio	3.00	POSITIVE	8.05	5.25	↓	upward trend is favorable
Operating Margin	1.61	In Progress	0.00	0.07	↑	upward trend is favorable
Salaries and Contract Labor to Net Patient Revenue	0.45	POSITIVE	0.37	0.43	↑	downward trend is favorable
Medicare Inpatient Payor Mix	0.80	POSITIVE	0.92	0.94	↑	upward trend is favorable
Average Age of Plant (in years)	9.87	In Progress	10.03	10.44	↑	downward trend is favorable
Long Term Debt to Capitalization	0.25	POSITIVE	0.06	0.06	↓	downward trend is favorable
Employee Turnover	0.22	POSITIVE	0.13	-	↓	downward trend is favorable
Cost per adjusted patient day			2,623.58	2,559.55	↓	downward trend is favorable
Gross Revenue per adjusted patient day			3,011.42	2,474.82	↓	upward trend is favorable
Net Revenue per adjusted patient day			2,467.21	2,202.74	↓	upward trend is favorable

STATEMENTS OF CASH FLOWS
FOR THE YEAR ENDING DECEMBER 31, 2023

	MONTHLY ACTUAL Dec-23	MONTHLY ACTUAL Jan-24	MONTHLY ACTUAL Feb-24
NET GAIN (LOSS)	(37,800)	887,430	(211,723)
NON-CASH ITEMS:			
DEPRECIATION	74,101	80,717	77,315
CHANGES IN WORKING CAPITAL:			
PATIENT ACCOUNTS RECEIVABLE	(103,826)	(251,409)	280,875
DUE FROM MEDICARE	270,885	0	17,429
ALL OTHER CURRENT ASSETS	8,752	(202,127)	15,250
ACCTS PAY AND OTHER CURRENT LIAB.	(23,514)	(28,823)	(8,979)
SALARIES AND BENEFITS PAYABLE	(68,403)	116,070	13,558
INTEREST PAYABLE	0	0	0
OTHER INVESTING SOURCES (USES):			
ADDITION TO LIMITED USE ASSETS	(3,006)	49,553	(220)
NET PURCHASES OF FIXED ASSETS	(202,597)	(48,720)	24,822
DECR (INCR) IN RESTR FUNDS/GIFTS/BOT XFERS	1,180,202	274	2,384
OTHER FINANCING SOURCES (USES):			
RETIREMENT OF DEBT	130,003	(89,469)	(61,171)
NET INCREASE (DECREASE) IN CASH	1,224,797	513,496	149,540
BEGINNING CASH	5,107,570	5,153,539	5,667,037
ENDING CASH	5,153,539	5,667,037	5,816,575
NET INCREASE (DECREASE) IN CASH	45,969	513,498	149,538
	825,878	513,498	663,036


HCHS INCOME STATEMENT FEBRUARY 2024
GROSS PATIENT REVENUE
NET PATIENT REVENUE
TOTAL OTHER OPERATING REVENUE
TOTAL OPERATING REVENUE
TOTAL OPERATING EXPENSES
NET OPERATING INCOME
TOTAL NON-OPERATING INCOME
NET INCOME
DEC-20
DEC-21
DEC-22
DEC-23
FEB YTD
FEB ANNUALIZED
2/1/2024 LAST 12 MOS.
20,000,000
15,000,000
10,000,000
5,000,000
0
-5,000,000
9,299,395
9,157,244
506,551
9,663,795
10,153,556
-489,761
3,019,482
2,529,721
13,531,947
11,345,114
445,871
11,790,985
11,989,128
-198,143
1,728,187
1,530,044
13,353,402
11,032,574
334,298
11,366,872
12,929,855
-1,562,983
609,259
-953,724
16,958,141
13,717,571
913,529
14,631,100
15,045,479
-414,379
1,178,828
764,449
2,751,486
2,448,986
596,379
3,045,365
2,845,686
199,679
476,027
675,706
16,508,916
14,693,916
3,578,274
18,272,190
17,074,116
1,198,074
2,856,162
4,054,236
17,428,944
14,209,104
1,368,120
15,577,224
15,600,486
-23,262
1,907,374
1,884,112

Quality Improvement/Risk Management Plan 2024

PURPOSE

The purpose of this plan is to provide a mechanism for assessing, quantifying, and improving the quality of services provided by Harlan County Health System and Heartland Family Medicine.

1. To serve as a systematic and ongoing method of identifying opportunities for improvement in the performance of the Health System, both in terms of quality of care provided, and in fiscal performance.

2. To identify, investigate and evaluate opportunities for improvement in service provided.

3. To assure that professional services are regularly, effectively, and validly evaluated.

4. To assure and improve communication across departments to facilitate the efficient operation of the Health System and the maintenance of high-quality patient care.

5. To institute a plan of implementation for any opportunities for improvement in service identified and to evaluate the effectiveness of the changes.

6. To provide a mechanism for comparison of performance of the Health System against external standards and against similar hospitals' performance.

7. To assure compliance with Medicare Conditions of Participation (COPs) for Critical Access Hospitals (CAHs) regarding Quality Assurance.

8. To assure accuracy in the completion of documentation in the patient medical record.

AUTHORITY

The Harlan County Health System Board of Trustees, having the ultimate responsibility for the quality of patient care and efficient operation of the Health System, authorizes the Administrator of Harlan County Health System to institute a Quality Improvement program involving the Medical Staff as well as the Health System's clinical, administrative, and support departments. The Administrator directs all departments of the Health System and all contracted service providers to participate in the Quality Improvement program.

ORGANIZATION

A chart is attached which delineates lines of responsibility under the Quality Improvement program HCHS Organizational Chart. As indicated on the organizational chart, the Quality Improvement program encompasses all departments of the Health System; all contracted service providers, and includes participation by Good Samaritan Hospital, Kearney, Nebraska d/b/a CHI Health Good Samaritan (Consulting Hospital). Central Nebraska Critical Access Network is the

Critical Access Hospital (CAH) network in which Harlan County Health System is a member. Activities of the Quality Improvement program are coordinated through the Quality Improvement Committee, and organized by the Quality Improvement Coordinator. Much of the quality improvement activity of the Health System will involve cross - departmental work groups, most often organized to work on specific issues or projects. These work groups may be appointed on an ad - hoc basis by the QI Committee, the QI Coordinator, the Administrator, or the Board of Trustees when needed.

The Quality Improvement Committee is comprised of a member of the Medical Staff, the CEO, Director of Nursing, Director of Radiology and the Laboratory Director, the CFO, the Manager of Health Information Management, and the QI Coordinator (if separate from one of the above positions). Other members may be added as deemed appropriate by the QI Committee.

SCOPE

Quality Improvement activities will be integrated and coordinated to evaluate services using an outcomes-based approach whenever possible. A cross-departmental approach will most often be appropriate to accomplish this. Contracted services, especially clinical services will be integrated into the program wherever appropriate. The Medical Staff will participate in the plan as described below.

PROCEDURE

ASSIGNMENT OF RESPONSIBILITY

The Board of Trustees recognizes that the preservation of assets and delivery of quality patient care are their major responsibility. Final authority to establish, maintain, alter, and support an ongoing Quality Improvement Program rests with this body. In addition to the fiduciary responsibility inherent upon the Board of Trustees, there is also a regulatory responsibility to adhere to requirements set forth under the CAH Conditions of Participation. It is intended that this plan fulfill all such regulatory requirements.

The Board of Trustees delegates operational responsibility for the Quality Improvement program to the Health System CEO. In turn, the CEO delegates operational aspects of the program to the Quality Improvement Committee, which acts as the coordinating body for all QI activities in the Health System. The individual designated as the Quality Improvement Coordinator will have organizational and administrative responsibility for the activities of the Quality Improvement Committee. The Quality Committee meets monthly to discuss critical measures that are significantly above or below benchmarks, every department of the hospital reports on their measures quarterly in January, April, July and October.

The Medical Staff will function as a peer review committee, having final authority for evaluation of quality and appropriateness of diagnosis and treatment of patients. As a peer review committee, all records of any review or investigation, including work papers and reports, are protected from discovery under Nebraska law.

DELINEATION OF SCOPE OF ASSESSMENT

All of the following will be considered appropriate subjects for evaluation under the facility wide Quality Improvement program. All subjects will be evaluated against the generally accepted standards of care for a Critical Access Hospital in rural Nebraska. In order to help accomplish this, a benchmarking process described below will be utilized.

1. All inpatient and outpatient medical care provided by personnel employed by or under contract to Harlan County Health System, regardless of where care is provided.

2. Any unusual or undesirable events involving patients, visitors, and / or staff of Harlan County Health System.

3. Any unusual or undesirable events or situations regarding facilities or equipment of the Health System.

4. Routine operations of all departments of Harlan County Health System.

5. Any admission denial notification or notice of quality concern received from the Medicare Quality Improvement Organization (QIO) or Medicare Administrative Contractor (MAC).

6. The overall quality of diagnosis and management reflected by the orders for medical care by the Medical Staff.

7. Issues related to referral or transportation of patients from the hospital under the terms of the Network Participation Agreement in place with Good Samaritan Hospital.

PEER REVIEW

The Medical Staff will implement routine screening criteria to review the quality and appropriateness of diagnosis and management of inpatients and outpatients at Harlan County Health System. Harlan County Health System will work with the Critical Access Hospital Network in conjunction with Good Samaritan Hospital to complete the Peer Review Process. A Copy of the current screening criteria utilized by the Medical Staff are appended to this document titled Internal Peer Review Form. Medical Staff will conduct reviews of an episodic nature, generic quality screen failures, adverse findings of the QIO, requests from other committees, review of benchmarked data from outside sources, requests from the Board of Trustees, and requests from other departments of the Health System.

IDENTIFICATION OF IMPORTANT ASPECTS OF CARE

MEDICAL STAFF

Issues to be reviewed on an ongoing basis, generally during the monthly Medical Staff Meeting or during the specific committee meetings include, but are not limited to the following:

- Medical Staff Credentialing and Privileging

IMPLEMENTATION OF CORRECTIVE ACTION TO RESOLVE PROBLEMS

When a problem or opportunity for improvement is identified through the Quality Improvement process, action must be designed and implemented to assure correction. The action plan needs to be specific to include the following elements:

1. What is the issue involved or the opportunity for improvement?
2. Who or what departments are involved?
3. What is the expected improvement?
4. What is the plan of implementation for the changes?
5. What will our method of evaluating the change be? How often will we follow up?

COMMUNICATION OF RESULTS OF THE QI PLAN

The Quality Improvement Committee will review collected quality monitoring data from studies of outcomes, incidents, patient satisfaction, and benchmarking. The QI Committee will also be available to assist individual departments with evaluation of problems not outlined in this plan. The QI Committee will serve as a coordinating and evaluation committee. The Committee will evaluate the results of the data and draw conclusions. These conclusions, along with samples of data, will be reported to the Board of Trustees on a periodic basis.

The Quality Improvement Committee will perform an evaluation of the Quality Improvement program annually to determine its effectiveness. Revisions will be made as necessary to improve the function of the plan. At least annually, the plan, along with any recommendations for revision, will be submitted to the Board of Trustees for approval.

_____

Chairman Board of Trustees Date

_____

CEO Date

_____

Medical Director Date

Carma Hefner RN 3-18-24

Quality Manager Date

Harlan County Health System

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HARLAN COUNTY HEALTH SYSTEM
2023 ANNUAL CRITICAL ACCESS HOSPITAL PROGRAM EVALUATION

PURPOSE

This annual evaluation is prepared to assess the services provided and gauge their effectiveness at Harlan County Health System, Alma, Nebraska. It is also intended to fulfill the requirements of the Medicare Conditions of Participation for Critical Access Hospitals, Section 485.641(a)(1). The purpose of the evaluation is to determine whether the utilization of services at HCHS was appropriate, whether established policies were followed, and identify where process improvements are indicated.

SERVICE AREA

For the purposes of this evaluation, the service area of Harlan County Health System is defined as all of Harlan County, and parts of Furnas, Phelps, and Franklin Counties in Nebraska. The organization also recognizes that services are provided to residents of Kansas within the counties of northern Phillips and Norton. When considering the adequacy of services, the organization must acknowledge the temporary population created by tourism created by the presence of the Harlan County Reservoir and recreational areas.

PROFESSIONAL SERVICE CONTRACTS

Due to the organization's commitment to meeting the healthcare needs of the consumers served, the organization maintains multiple professional service contracts. The contracts are reviewed annually in an effort to ensure that the services being offered meet the needs of not only the consumers but remain true to the organization's mission and values. During the review process, contracts were reviewed to be current, cost effective, and reflect appropriate relationships. A listing of contracts requiring Business Associate Agreements is maintained and updated annually to remain compliant with state and federal regulations. Business Associate Agreements are put in place with all new vendors/partners that conduct business with HCHS of a nature that requires Business Associate Agreements.

HUMAN RESOURCES

In 2023, the hospital moved our HR back in house by hiring an HR Director.

General Workforce

Currently the organization employs 92 employees whose combined hours equal 72.28 FTEs.

Contract Labor

At the end of 2023 HCHS is utilizing the assistance of one temporary staff member (in nursing) to address a workforce shortage.

Medical Staff Recruitment

Physician recruitment remains an ongoing process at HCHS. In 2023 we did hire a FT MD and a PRN Internal MD. We also have 8 midlevel providers who work FT, PT & PRN.

STATE COP SURVEY

HCHS successfully completed a state survey in May 2022 with zero deficiencies.

ELECTRONIC MEDICAL RECORD (EMR)

On July 1, 2018, HCHS and its affiliated clinics transitioned to Meditech EMR.

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CLINICAL NUTRITION EDUCATIONAL VISITS

Volumes for specific types of outpatient nutritional visits for 2023 consisted of 5 for diabetes, 4 for cardiac rehab nutrition, 3 for weight, 1 for low carb/high protein, 1 for post gallbladder removal.

SERVICES PROVIDED THROUGH SPECIALTY CLINICS

We have added several new clinics in 2022. The table below provides a breakdown of visits per Specialty Clinic.

Clinic	2021	2022	2023
Cardiology	560	534	547
ENT	88	182/27	230
Telemed	7	31	76
Nuc Med	28	24	29
Oncology	108	86	146
Podiatry	161	173	157
Pulmonary	94	135	120
General surgery	71	158	297
GYN	64	46	60
Dermatology	0	21	14
Orthopedic	0	163	226
Urology	0	24	79
Endoscopy	0	69	74
OP/Treatment Rm	1034	679	911

COMMUNITY HEALTH & EDUCATION

HCHS sent out a community survey in 2023 to address community priority areas strategically and collaboratively to improve the health and well-being of the community. Through this survey it was identified that our focus areas should be 1.) Education on services & expanding our current selection, 2.) Wellness (what type of wellness services they would like to see) and 3). Understanding concerns to improve quality of care.

HCHS is working to improve our services that we can offer our community all the time and these areas will remain goals for our facility.

PATIENT GRIEVANCE/CONCERNS

HCHS utilizes a standardized process for completing investigations of customer concerns/grievances and seeks to reach resolution of reported cases. Customers can be patients, family members, providers, or staff members. Once an occurrence has happened or a potential occurrence has been identified, the occurrence should be documented as soon as possible in Action Cue. The occurrence will be assigned to the appropriate director, officer or committee for review and mitigation. Further documenting and follow-up regarding the occurrence will be completed as necessary. Any opportunity for improvement that is identified during the review process will be addressed with an action plan. Additionally, provider-related concerns were referred to Peer Review Committee. For 2023, HCHS had 1 filed grievance related to the care received in the ED.

UTILIZATION REVIEW

Utilization activity is reported at Medical Staff meetings monthly and includes the following information: total number of inpatient hospital admissions, number of admissions by type of service, i.e., medical, surgical, etc., and average length of stay.

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SERVICES RENDERED in 2023 (*Contracted)

- 24/7 Emergency Department: Critical Care with Air/Ground Transport, Outpatient Observation Care, Avel eEmergency*, Teledigm Services
- Inpatient Services: Acute Care, Sub-Acute (Swing Bed) Services, Intermediate (Private Pay) Swing Bed Services, Hospice/Hospice Respite, Teledigm Services*
- Outpatient Services: Cardiology, Podiatry, Orthopedic, Teledigm Services*, General Surgery Consults, Holistic Pain Management*, Urology, ENT, Gynecology, Immunotherapy, General Outpatient Services, Infusions
- Surgical Services: General Surgery, Urology, Orthopedic Surgery
- Ancillary Services: Treadmill Stress Testing, Nuclear Stress Testing, Electrocardiography, 3- 14 Day CAM Patch, Echocardiography, Vascular Ultrasound
- Cardiopulmonary Rehab
- Dietary: Nutritional counseling*
- Laboratory: Diagnostic analysis
- Pharmacy: Emergency, Inpatient, Limited Outpatient
- Radiology: Digital Radiography, CT, MRI, Nuclear Imaging, Bone Density, 3D Mammo, Ultrasound, C-Arm Fluoroscopy
- Rehabilitative Services*: Occupational Therapy, Physical Therapy, Speech Therapy
- Geriatric Phsyc (Senior Life Solutions)*

VOLUME INDICATORS

Measure	2023	2022	2021	2020
Total CAH admits	117	117	174	94
CAH Average Daily Census	1.91	1.66	2.25	1.2
CAH Avg Length of Stay	3.61	5.18	4.79	3.0
Total Observation Admits	159	102	95	42
Inpatient Surgery, Total	N/A	N/A	N/A	N/A
Outpatient Surgery, Total	298		43	9
Swing Bed (SB) Admissions	41	49	70	47
Swing Bed patient days	232	420	556	397
SB average daily census	1.57	1.15	1.52	1.09
Total ER Visits	940	776	788	659
ER Visits/Month	79	64	65 (average)	34-69 54.9
% ER visits transferred	92 10%	73 10%	86 10%	99-6.59 8.25%
CAH Admits From ER, % Total Admits	146 6.5%	112 6.9%	123 15%	62-659 5.17%
Lab	16,746	15,665	17,647	14,353
Radiology	3,885	3,359	2,265	1,767
Ultrasound	149	120	135	129
MRI	152	116	120	105
CT	837	644	677	552
Mammograms	265	256	249	194
Physical Therapy (quantitative units)	20,696	17,306	14,616	13,928
Occupational Therapy (q. units)	2,155	1,857	2,015	1,216
Speech Therapy (quantitative units)	253	172	195	189
Cardio Pulmonary Rehab	1,580	1,250	566	402
Senior Life Solutions	886	2,013	3,382	1,718

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EMPLOYED MEDICAL STAFF

Dr. Michael Finkner assumed the position of Chief Medical Officer in 2020 and continues to serve in this position.

Measure	Facility	Benchmark
% Timely Reappointment	95%	100%
Employed Medical Staff % Board Certified	66%	N/A
% Med Staff Met annual CME Requirement	100%	50%
Attendance: Med Staff Meetings	85%	70%
Comprehensive Bylaws Review	2014 by Baird Holm	N/A

REVIEW OF ACTIVITY AND CLOSED CHARTS

A review of closed charts is accomplished through the Quality Improvement and Peer Review programs. Records that trigger a red flag are subjected to peer review. Through our network agreement with Good Samaritan Health Systems, we can send and receive records for the peer review process. As part of the Quality Improvement program, Active Medical Staff participate quarterly with the Consulting Pathologist in review of Surgical Case and Tissue removed during surgical cases. A total of 39 cases were reviewed in this manner. Review of 9 separate instances of blood transfusions was completed and identified process improvement issues is any, were addressed with an assessment and changes in policy and procedures. No significant morbidity was found because of these services.

Infection Control review undertaken with the medical staff involves a sampling of records of acute or swing bed patients with identified infections. The review involves antibiotic usage and appropriate obtaining of cultures. 0 nosocomial infections were reported in 2023. The annual Hand Hygiene rate of 94% is much higher than the national rate of 70% for healthcare workers.

Antimicrobial Stewardship has met all the CMS requirements. These consisted of appointing by the Hospital Governing Board an antibiotic stewardship champion which leads the committee, establishing a committee of qualified members and monitoring all antibiotic use, appropriateness, and timeliness. This committee meets Quarterly, and reports are given at Quality Meetings, Medical Staff meetings and Hospital Board meetings.

HCHS utilized abstracting tools provided in conjunction with CIMRO of Nebraska, our Medicare QIO, the Medicare Beneficiary Quality Improvement Project (MBQIP) and the Hospital Quality Alliance (HQA). This aids in improving care through information, which is sponsored by the Centers for Medicare and Medicaid services and the American Hospital Association.

HCHS is also part of the Hospital Quality Improvement Contractor Program (HQIC). This HQIC initiative is a new four-year program by the Centers for Medicare and Medicaid Services (CMS). It builds on the achievements of previous CMS hospital-based quality improvement initiatives and the Hospital Improvement Innovation Network (HIIN), with a keen focus to improve patient safety, quality and outcomes in rural, critical access and vulnerable populations. CMS has contracted with TMF Health Quality Institute for this initiative to work with 300 hospitals across the United States.
The initiative's intent is to provide targeted quality improvement assistance to rural and critical access hospitals, as well as hospitals serving vulnerable and underserved populations to achieve measurable outcomes with a focus on patient safety, care transitions and opioids. The initiative also provides support to hospitals during public health emergencies, epidemics, pandemics, and other crises as they arise. The HQIC initiative will focus on three CMS goals, which align with the CMS Rural Health Strategy: Goal 1: Improve behavioral health outcomes, with a focus on decreased opioid misuse Goal 2: Increase patient safety, with a focus on reduction of harm Goal 3: Increase the quality-of-care transitions, with a focus on high utilizers to improve overall utilization.

Harlan County Health System

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This HQIC program is supported by the American Hospital Association and the Nebraska Hospital Association. It provides an opportunity for HCHS to network with other Nebraska Hospitals and compare data collected with other hospitals from within the state.

Measure	# Cases
CAH Mortality rate, Inpatient	5
CAH readmit within 30 days	4
CAH nosocomial infections	2
Mortality, ER	5
Employed Mid-level ER case review by phys.	57
External Peer Review Sent in 2022	59
CRNA internal peer review	24
ED assessment & Transfer	92

OVERVIEW OF EVALUATON PROCESS

Quality Improvement Plan

The Harlan County Health System Quality Improvement Plan was reviewed and revised by the QI Committee in November 2023 for the upcoming year. The Board of Trustees approved the revised QI Plan.

Medication Administration

Medication bar-coding and scanning at the patient's bedside before medications are delivered is being utilized at HCHS. Meditech Pharmacy and Medication Administration Check and Avera ePharmacy are being utilized to assist with the patient safety efforts.

Medical Staff Peer Review Plan

Medical Staff conducts chart reviews of an episodic nature, generic quality screen failures, adverse findings of the QIO, requests from other committees, review of benchmarked data from outside sources, requests from the Board of Trustees, and requests from other departments of the Health System.

Network CAH Quality Improvement Plan

Our network agreement remains with Good Samaritan Health Systems in Kearney, NE.

Medical Staff Credentialing Plan

The use of an outside Credentials Verification Organization (CVO) to collect and verify primary source confirmation of references and other data associated with medical staff credentials actions has continued to work well during 2023. This collection and verification of information has been coupled with a locally generated summary for each new or renewal application, as well as an institution specific review of clinical privileges for appropriateness.

HEALTHCARE POLICIES

Critical Access Hospital Policy Review Committee

Policies and Procedures are reviewed and approved annually by utilizing an online process.

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SUMMARY

As has been the case since 1998, it is the opinion of the Board of Trustees, Administration, and "key" consulting staff members that the Critical Access Hospital model of service provision and reimbursement works well for this institution. The building renovation and expansion project that was completed in February 2009 would not be possible in the absence of the CAH reimbursement model. The financial viability of the Health System has stabilized since receiving CAH certification in 1999. However, decreases in reimbursement and additional regulatory burdens such as sequestration, Outpatient Physician Supervision and the 96-hour rule, along with meaningful use of electronic medical records are making it much more difficult for a small organization to remain viable in an area like Harlan County that depends on the local health system for medical care.

It is in the opinion of the review members that Harlan County Health System is in overall compliance with regulatory requirements of federal and state programs.

Doris Brandon — 3/18/2024
Doris Brandon, Secretary, Board of Trustees — Date

12 mar 2024
J. Michael Finkner, Chief Medical Director — Date

3/12/2024
Stacy Neubauer, Chief Executive Officer — Date

3/12/2024
Jess Stemper, Physician Assistant — Date

3/12/2024
Karen Wright, Director of Nursing Services — Date

Harlan County Health System

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HEARTLAND FAMILY MEDICINE
(D.B.A. HARLAN COUNTY HEALTH SYSTEM)
2023 ANNUAL RHC PROGRAM EVALUATION

As a condition of participation in the Rural Health Clinic Program, an annual evaluation of the clinic's total operation has been performed. The evaluation must include a review of the clinic's utilization, policies, and procedures and clinic records. The purpose of the evaluation is to:

1) Determine if the utilization of services is appropriate.
2) Determine if policies and procedures are being followed.
3) Recommend any necessary changes.

In consideration of the regulations, the annual evaluation committee was formed to evaluate the total rural health clinic program. This report reflects the findings of the annual evaluation committee.

The clinic is located in Harlan County, Nebraska which had been designated as a State Primary Medical Care Shortage Area. The Rural Health Clinic Alma is owned by Harlan County Health System, Alma, Nebraska: Harlan County Health System, 717 N Brown, P.O. Box 836, Alma, NE 68920-0836.

The operation of the clinic is under the supervision of the CEO of Harlan County Health System.

VISITS

The total number of visits in 2023 was: 6,699. This includes nurse and nursing home visits.

CLINICAL

The Rural Health Clinic is under the medical direction of John M Finkner, MD, and has a medical staff that meets the requirements outlined "the Code of Federal Regulations; Public Health", 491.8:

1. One or more physicians
2. One or more physician assistant or nurse practitioners
3. Ancillary personnel supervised by the professional staff.
4. Staff shall be sufficient to provide the services essential to the operation of the clinic.
5. A physician, nurse practitioner, or physician assistant is available to provide patient care services at all times the clinic operates.
6. A nurse practitioner or physician assistant is available to provide patient care services at least 50% of the time the clinic is in operation.

During 2023, the clinic operated with the following employed providers:

- John M. Finkner, M.D
- Jessica Stemper PA-C
- Jennifer Taylor PA-C
- Connie Lans PA-C
- Rebecca Kahrs APRN
- Dakota Dreher, MD (Added Nov. 2023)
- Linda Mazour, MD (Added Dec. 2023)

The Clinic is under the medical direction of John M. Finkner, M.D. In addition to the employed medical staff, PRN providers are utilized to meet the needs of the patients and RHC requirements. Heartland Family Medicine Alma Clinic d.b.a. Harlan County Health System provides basic primary care. The clinic added Mental Health Telehealth services in October with Clinton Webb, APRN.

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Heartland Family Medicine began operation from the new clinic in May 2019. That address is 906 7th street, PO Box 665, Alma, NE 68920. The hours for HFM are Monday 8:00am – 12:00pm and 1:00pm to 7:00pm, Tuesday through Friday 8:00am – 12:00pm and 1:00pm to 5:00pm.

Conclusion

The annual Evaluation Committee's conclusion is that Heartland Family Medicine, Alma Clinic d.b.a. Harlan County Health System is providing services appropriately and is following established policies and procedures.

John M. Finkner, MD — Date 11-2024

Jennifer Taylor, PA-C — Date 3/6/24

Shannon Lynch, Director of RHC — Date 3/6/24

Stacy Neubauer, CEO — Date 3/12/2024

Outside Community Member — Date 3/12/24

****

Approved at Medical Staff Meeting:

John M. Finkner, MD — Date

****

Approved at HCHS Board of Trustees Meeting:

Mary J Christensen, Chairman — Date 3-18-24

Harlan County Health System
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Alma, NE 68920

	NAME	POSITION	PHONE & EMAIL
1	Lisa Howsden	Member	308-991-7330 howsden@atcjet.net 1425 Lock St, Rep City, NE 68971
2	Deb Jensen	Member	(308) 920-0451 Djensen4@yahoo.com
3	Dr. Jim Long	Member	308-928-2525 jnjlong@frontiernet.net 907 Main, Alma, NE
4	Doris Brandon	Secretary	308-920-0898 Dorisb55@yahoo.com PO Box 64, Alma, NE 68920
5	Jeff Bash	Interim Member	308-991-0903 Jbash5477@gmail.com PO Box 408 Orleans, NE
6	Mary Jo Christensen	Chair	308-920-1073 christensenmaryjo@frontier.com 70742 Killdeer, Alma, NE 68920
7	Dusty Frasier	Member	(308) 440-6680 dfrasierpt@gmail.com 12167 US Hwy 136, Republican City, NE 68971

Harlan County Health System

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Medical Staff

J. Michael Finkner, M.D., Chief Medical Officer

Linda Mazour, M.D.

Dakota Dreher, M.D.

Jennifer Taylor, PA-C

Jessica Stemper, PA-C

Connie Lans, PA-C

Rebecca Kahrs, APRN

PRN Medical Staff

David Blauvelt, PA-C, PRN

Jenna Matlock, PA-C, PRN

Molly Oertwig, APRN FNP-C, PRN

Paige Pauley, PA-C, PRN

Ryan Lieske, PA-C, PRN

Sarah Shurigar-Meyer, LICSW, PRN

Taylor Wright, APRN, FNP-C, PRN

Harlan County Health System

STRATEGIC PLAN 2024

2024 Board of Trustees

CHAIR
Mary Jo Christensen, LPN
Alma, NE

TREASURER
Dusty Frasier, PT
Republican, NE

SECRETARY
Doris Brandon
Alma, NE

MEMBER
James Long, MD
Alma, NE

MEMBER
Lisa Howsden
Republican City, NE

MEMBER
Deb Jensen
Alma, NE

MEMBER
Jeff Bash
Orleans, NE

Introduction

As has been the case since 1998, it is the opinion of the Board of Trustees, Administration, and key staff members that the Critical Access Hospital model of service provision and reimbursement works well for Harlan County Health System. The building renovation and expansion project that was completed in February 2009 would not be possible in the absence of the CAH reimbursement model.

The financial viability of the Health System has stabilized since receiving CAH certification in 1999. However, decreases in reimbursement and additional regulatory burdens such as sequestration, Outpatient Physician Supervision and the 96-hour rule, along with meaningful use of electronic medical records are making it much more difficult for a small organization to remain viable in an area like Harlan County that depends on the local health system for medical care.

As such, the Administrative Counsel set forth a process to develop an Annual Strategic Plan. In late 2022, the team developed its first Annual Strategic Plan, and in October 2023, they did the same process at a Leadership Development Retreat in Alma, Nebraska. The following outlines the ideas and goals developed for 2024.

STACY NEUBAUER, RN-MHA
Chief Executive Officer

KAYLA RHYNALDS, CHFP, FHFMA
Chief Financial Officer

APRIL EINSPAHR, SHRM-CP
Director of Support Services, Executive Assistant

DANIELLE LANDEN, RN
Director of Clinical & Professional Services

HALEY BOOE, RN
Director of Perioperative & Outpatient Services

JOANNA DONOHOE, SHRM-CP
Director of Human Resources

KAREN WRIGHT, RN
Director of Nursing

SHANNON LYNCH, RN
Director of Rural Health Clinic

TAYLOR MOLZAHN
Director of Foundation and Marketing

TONDA ROSS,
Director of Radiology

It is the mission of Harlan County Health System to provide the safest, highest quality care, and the best experience possible for our communities. We accomplish this by focusing on the following measures:

FINANCE

Harlan County Health System will develop an annual budget, maintain expenses while meeting a reasonable rate of growth, and regularly re-evaluate service lines for viability.

GROWTH

HCHS Directors and Officers will set a personal goal to be accomplished within 3-24 months. The Business Development Team will develop growth plans for each line of business, and Directors and Officers will develop and execute budgeted statistics for all areas.

MARKETING

Harlan County Health System will develop an annual marketing plan with targeted community participation and promotion. We will actively seek donors and evaluate all social media outlets for viability.

PATIENT EXPERIENCE

Harlan County Health System will meet or exceed Nebraska benchmarks for patient satisfaction. We will focus on lowering noise levels, increasing the number of HCAHPS surveys that are delivered, sharing results with Medial Staff quarterly, and creating a discharge team.

PEOPLE

Harlan County Health System is committed to providing excellent pay and benefits to staff. As such, we will complete a benefit review, develop an online enrollment process, implement Med Trainer, and evaluate the recruitment and orientation processes.

QUALITY

Harlan County Health System will develop an annual budget, maintain expenses while meeting a reasonable rate of growth, and regularly re-evaluate service lines for viability.

RURAL HEALTH CLINIC

Two new Physicians have been secured as on 2023. As such, we will monitor growth in the Rural Health Clinic to ensure viability. We will evaluate the Provider Scorecards and will evaluate RVU contracts for providers.

Marketing

2024 Goals/Objectives:

1. Increase community presence - Every employee chooses 1-2 events throughout the year to participate in and continue doing so as long as they're an employee of HCHS.
2. Increase Instagram Followers by 10%
3. Double Tik Tok Followers
4. Improve community participation in hospital sponsored events
5. Maintain 2-3 Tik Tok videos a month
6. 1-2 meaningful testimonials a month
7. Weekly post on LinkedIn Page

2024 Slogan

"Grow With Us"

- Include images of staff, our facility, providers, etc.
- Use #GrowWithUs in most of our advertising
- Utilize various taglines that include words: grow, growth, growing, etc. and have those words bolded.

Examples:

2024 Events

HCHS Sponsored Events:

- Women's Night Out
- Dueling Pianos (Foundation)
- Golf Tournament (Foundation)
- 4th of July Road Race
- Harvest Snack Bags
- Community Lab Fair
- Pool Day in Alma
- Back to School Event
- Mammos & Margs
- Town Halls x2
- Speed & Agility Camp (PT)
- Senior Career Day
- Flu Shot Clinic
- Suicide Awareness Walk
- School Physicals @ Schools
- Grain Giving
- Popcorn & Movie Sponsor @Theatre
- Monthly Wellness Challenges
- Quarterly 'give back' days

Community Events:

- Chamber Easter Egg Hunt
- 4th of July Parade
- Harlan County Fair
- Stamford Pork Days
- Oxford Turkey Days
- Applefest
- Chamber Santa Day
- Pburg Rodeo Parade

School Events (Alma & SV):

- 1 Football Game
- 1 Softball Game
- 1 Volleyball Game
- 1 Girls/Boys Bball Game
- 1 Wrestling Meet

2024 Social Media Content

- Staff Anniversaries & Birthdays each month
- Wellness challenges
- videos/Tik Toks
- Giveaways
- Funny Memes
- Staff experiences
- Meaningful testimonials w/ pics
- Incorporate "grow with us" slogan weekly
- Interactive questions
- Motivation Mondays
- Awareness's
- Events
- Provider spotlights/"get to know us"
- Services

Foundation Board

CHAIR
Shannon Lynch, RN
Alma, NE

Vice Chair
Annette Lowe
Alma, NE

SECRETARY
Candi Randall
Naponee, NE

Director/Treasurer
Taylor Molzahn
Alma, NE

MEMBER
Samantha Stuhmer
Alma, NE

MEMBER
Sandi Guthrie
Alma, NE

MEMBER
Gwen Westerbeck
Alma, NE

MEMBER
Brittany Reeg
Alma, NE

MEMBER
Darrel Westerbeck
Alma, NE

Leave A Legacy Campaign

Leaving a legacy to the Harlan County Health System Foundation is a profound investment in the well-being of our community. By contributing to this vital institution, you are ensuring that future generations in our small, close-knit community have access to quality healthcare.

Rural health is the backbone of a thriving community, and the Harlan County Health System Foundation plays a pivotal role in maintaining and enhancing the health and vitality of our residents. In leaving a legacy to the foundation, you are not only supporting the present but also shaping the future of healthcare in Harlan County. Your generosity echoes through time, leaving an indelible mark on the health and well-being of our community, and for that, we express our deepest gratitude. Together, we are building a healthier, stronger, and more resilient future for Harlan County, where every individual can thrive and live their best life.

Ways to Grow:

- Hosting informational meetings to talk about the current growth and the projected future of HCHS. Include handouts with the "Leave A Legacy" information on it and explain the importance of community support in order to continue providing care for our community.
- Partner with more local attorneys to help advocate for our Foundation.
- Provide naming opportunities for significantly large donations.
- "Grain Giving" - Annual opportunity where we essentially recruit area farmers to donate bushels. We can partner with the local CO-OP and provide signage there and along the highway of the clinic that lists the grain donors each year. Break it down by different levels based on how much they've donated.
- Host a donor appreciation dinner each year for those who've donated in the past year and/or invite them to our annual staff appreciation dinner.
- Host a large gala every few years that recognizes donors, past & current employees, includes history of our organization, entertainment, and possible silent auction.

Master Facility Plan

Purpose:

Establishes a framework for orderly growth and development of capital improvements on campus. It should be responsive to an institution's current and projected needs and sufficiently flexible to accommodate changes that can be expected to occur.

Growth Opportunity:

- Provides current Foundation donors and potential donors with a visualization of our future intentions. Having this could strike interest for new and hopefully larger donations because of what this could mean for our community if we were to move forward with the plan.
- Could increase our market share, especially if we were to include a wellness center, because it could bring more individuals from surrounding communities.
- This would also be an excellent recruitment piece as well because it shows growth and opportunity in our community.

Business Development

Team Members:

STACY NEUBAUER, RN-MHA
Chief Executive Officer

TAYLOR MOLZAHN
Director of Foundation and Marketing

DANIELLE LANDEN, RN
Director of Clinical & Professional Services

KAYLA RHYNALDS, CHFP, FHFMA
Chief Financial Officer

SHANNON LYNCH, RN
Director of Rural Health Clinic

HALEY BOOE, RN
Director of Perioperative & Outpatient Services

MARISA GULIZIA, DPT
Director of Physical Therapy

Current Initiatives:

- Orthopedics w/ InReach
- Ophthalmology - Launching 2024 w/ Dr. Clinch
- Allergy Clinic - SynAllergy
- Searching for Mental Health Counselor
- 2024 Master Facility Assessment
- Looking into Pediatrics w/ Children's

ROLES AND RESPONSIBILITIES OF NONPROFIT BOARDS

1. **Determine the organization's mission, vision, values and purpose.** A statement of mission and purposes should articulate the organization's goals, means and primary constituents served. It is the board's responsibility to create the mission statement and review it periodically for accuracy and validity. Each individual board member should fully understand and support it.
2. **Select the chief executive.** Boards must reach consensus on the executive's job description and undertake a careful search to find the most qualified individual for the position.
3. **Support the chief executive and review her performance.** The board should ensure that the executive has the moral and professional support he or she needs to further the goals of the organization. The executive, in partnership with the entire board, should decide upon a periodic evaluation of the executive's performance.
4. **Ensure effective organizational planning.** As stewards of the organization, a board sets the overall direction and establishes general priorities. It must actively participate with the staff in a strategic planning process and assist in implementing the plan's goals.
5. **Ensure adequate resources/raise money.** One of the board's foremost responsibilities is to provide adequate resources for the organization to fulfill its mission. The board should work in partnership with the executive and development staff, if any, to raise funds from the 'community'.
6. **Ensure effective fiduciary oversight.** The board, in order to remain accountable to its donors, the public, and to safeguard its tax-exempt status, must assist in developing the annual budget and ensuring that proper financial controls are in place.
7. **Determine, monitor, and strengthen the organization's programs and services.** The board (in conjunction with the staff) determines which programs are the most consistent with a organization's mission and monitors their effectiveness.
8. **Enhance the organization's public standing.** An organization's primary link to the community, including constituents, the public, and the media, is the board. Clearly articulating the organization's mission, accomplishments, and goals to the public, as well as garnering support from important members of the community, are important elements of a comprehensive public relations strategy.
9. **Ensure legal and ethical integrity and maintain accountability.** The board is ultimately responsible for ensuring adherence to legal standards and ethical norms. Solid personnel policies, grievance procedures, and a clear delegation to the executive of hiring and managing employees will help ensure proper decorum in this area. The board must establish pertinent policies, and adhere to provisions of the organization's articles and bylaws.
10. **Recruit and orient new board members and assess board performance.** All boards have a responsibility to articulate and make known their needs in terms of member experience, skills, and many other considerations that define a "balanced" board composition. The Board must also orient new members to their responsibilities and the organization's history, needs, and challenges. By evaluating its performance in fulfilling its responsibilities, the board can recognize its achievements and reach consensus on which areas need to be improved.

TIPS FOR BECOMING A BETTER BOARD MEMBER

1. **Journals**: subscribe to *Modern Health Care* and *Trustee* magazines. These are great sources for industry news and effective governance. (see resources)

2. **Education**: attend at least one extramural health care and governance educational seminar every other year. (see resources for options).

3. **Financial statements**: if you don't already possess the ability, develop the skill to read and interpret financial statements immediately.

4. **Medical staff and physician groups:** take time to meet with several representatives to better understand these groups aspirations, challenges, and their perspective on health care and of the organization's strengths and weaknesses.

5. **Directors and Officers (D & O) liability insurance coverage and indemnification**: check on the limits and key provisions of your hospital's policy. Request that your hospital's counsel make a presentation on the topic at an upcoming board meeting.

6. **Apprenticeship**: if you are a new board member, expect to serve an apprenticeship with a journeyman board member. It takes the most able and committed person with no health care experience at least a year to get up to speed (that is, understanding the health care industry, your local market, your organization, challenges and opportunities).

7. **Stakeholders**: your overarching and fundamental obligation as a board member is to protect and advance the interest of stakeholders. Issues, policies and decisions should be viewed through their eyes.

8. **Governance responsibilities and roles**: Do everything you can to help your board stay on track, avoiding issues and tasks that are irrelevant, inconsequential, or better handled by others.

9. **Vision**: become fixated on your organization's vision. Everything you do should be directed toward fulfilling it.

10. **Governance not management**: Whenever a board slips into the role of management (meddling) both the quality of governance and management declines.

11. **Information**: the quality of governance can never exceed the quality of information your board receives. Constantly assess it in terms of: timeliness, accuracy, potential bias, what has been left out and unsaid, unstated assumptions, the frame of reference of whoever compiled it.

12. **Preparation**: Prior to board and committee meetings carefully read agenda materials, proposals and recommendations up for discussion and vote.

13. **Participate**: it is impossible to contribute unless you do.

12. **Question and challenge**: One of the most important functions of a board is to serve as a source of checks and balances, particularly when significant issues are being discussed.

13. **Tenacity**: Be tenacious in exploring an issue when your gut tells you that all is not right.

14. **Big issues should have time to match**: It is far easier to deal with simple and inconsequential matters: the routine often drives the non-routine. When a decision has significant consequences and is risky, demand that the board have the patience to deliberate it properly.

15. **Vote your conscience**: be willing to express a dissenting opinion and to vote no. Share your rationale and be sure it is reflected in the notes.

16. **Don't talk too much**: The best boards are characterized by relatively even participation across all members.

17. **Don't show off**: leave your ego at the boardroom door.

18. **Effective and efficient meetings**: the board chair has a particularly important role in facilitating effective and efficient meetings. Learn how to do this well (see resources).

19. **Never take action alone**: your board exists and can only act as a group. When a board meeting is over, your authority evaporates like a referee's at the end of a game. As an individual outside the board room, don't ever make demands of management, make promises to medical staff or employees or meddle in operations.

20. **Do not compromise your ethics and values**: Never do or say anything in the board room that you wouldn't want to read about on the front page of your local newspaper the next morning.

21. **Support your board's decisions and policies** (even if you voted against the decision): To govern well, your board must speak as a single voice. If you are continually unable to join in the chorus after having sung your song, consider resigning.

22. **Express your concerns**: if you have concerns about what your board is doing or how it is going about it, express them. First talk to the board chair, if that doesn't work, request that the matter appear on the agenda.

23. **Never perform nongovernance work for your organization** (even on a nonpaid basis): For example, if you are an information consultant, let someone on staff prepare the RFP for the new computer system. Regardless of the contribution you might make, doing so will jeopardize your objectivity as a board member and blur the line between governance and management.

24. **Keep a professional distance** from second and third-line executives, management staff, and employees. It is essential to scrupulously avoid even the appearance of providing others an opportunity to do an end run around the CEO.

25. **Be aware of conflicts of interest**: As an engaged and successful member of the community you will have conflicts of interest; they're unavoidable. Disclose any personal and professional conflicts on an annual basis, as well as report significant conflicts, as they arise. If others, or you, consider the conflict to be material, extricate yourself from all involvement in the matter-leave the room and do not discuss the issue with management or your board colleagues.

26. **Confidentiality:** keep sensitive information within the board room setting and don't discuss these issues with friends, associates or family members. You will rarely get into trouble (or compromise your board or organization) by saying too little.

27. **If you don't have something good to say, don't say anything at all**. Airing negative opinions outside the boardroom about any aspect of the organization reduces your ability to be effective.

28. **Consider appearances**: be careful about how you interact with the competition, for example, don't be a regular golf partner with a competitive CEO, avoid being a patient at a rival facility, etc.

29. **Get to know your fellow board members**, including the CEO. Good relationships are a powerful elixirs that facilitate how, and how well, a board does its work.

30. **If you are a CEO or board chair**, take each member of the board out to dinner at least once a year.

31. **Do a personal accounting of your board membership**. What are you giving and getting back? Is there rough parity between the two? Relative parity assures continued motivation and energy for your board work.

32. **Self examination**: once a year, engage in a careful, thoughtful, and critical self-examination of your role as a member of the board. Key questions are noted below.

- How am I performing? How can I perform better?
- How much of a contribution have I made over the last year? What specific things could I do to make a greater contribution?
- What are some of the things I do in meetings that impede board performance?
- What are some things that I refrain from doing, but shouldn't?
- Do I have the time and energy to be an engaged and active member of this board?
- Do I still enjoy being a member of this board?

35. **Know your limits**: when you realize that you do not have the time, energy, or commitment to serve on this board, or have had too many instances where you find it difficult (or impossible) to support its policies and decisions-*resign*. Do so gracefully and with style, but do it.

BoardroomBasics

Knowledge Resources for Health Care Governance Effectiveness

Overview of Board Roles and Responsibilities

INSIDE

KNOWLEDGEPOINTS

- Key functions of a highly successful board of trustees
- Practices to improve a board's visionary thinking
- The importance of determining eligibility requirements and developing board member job descriptions

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Overview

The world of health care is a complex and ever-changing environment. To ensure that high quality care is provided to consumers, and to effectively lead organizations to be successful in the coming years, a knowledgeable and loyal governing board is an absolute requirement. This *Boardroom Basics* is designed to educate trustees on the their basic roles and responsibilities as board members of health care organizations.

Major Board Functions

Board members must clearly understand the difference between "governance" and "management." The governing body is responsible for ensuring the mission and vision of the organization, in addition to being legally responsible for the operation of the organization. The governing board must see the "big picture," and work with all of the information available to it in order to lead the organization forward in carrying out its mission and vision.

Management is responsible for the day-to-day tasks of running the hospital. The board delegates the day-to-day management to the chief executive officer (CEO). The CEO and the senior management team is guided, but not directed, by the governing board. They lead the hospital's staff in carrying out the mission and vision that has been developed and approved by the governing board.

The roles and responsibilities of the governing board involves everything from ensuring the cost-effective utilization of resources to determining the organization's mission, and establishing a long-range strategic plan to help attain that mission. Although the responsibilities are many and varied, there are six major areas of responsibility that all governing boards have:

1. Hiring and retaining an effective CEO;
2. Mission development and long-range planning;
3. Ensuring high quality care;
4. Oversight of medical staff credentialing;
5. Financial oversight; and
6. Board education and development, including self-evaluation.

Hiring and retaining an effective CEO — One of the most important jobs of the governing board is selecting and retaining an effective CEO. The CEO is the link between the day-to-day operations of the organization and the board. He/she is responsible for leading the organization to carry out the vision developed with the governing board. Each board is unique, and there is no single right way to identify precisely which responsibilities lie with the board, and which lie with the CEO. Therefore, it is imperative that the CEO and the governing board work cooperatively to identify respective roles and relationships. Continuing review and evaluation of the CEO by the board is then necessary to ensure that the responsibilities are being appropriately carried out.

Several issues and options that boards may wish to consider to help build strong relations between the board and the CEO of the organization are listed below:

- Understand that the selection of the CEO is a major responsibility, in that the CEO will significantly shape the future of the organization;
- Create an employment contract for the CEO which identifies terms of employment, job duties, compensation and benefits, and renewal and termination agreements;
- Use incentive compensation targeted to achievement of strategic objectives as a way to motivate, challenge and reward the CEO;
- Have realistic expectations of the CEO;
- Clarify performance expectations for the CEO in writing, identify measurable goals and evaluation guidelines, and then conduct annual reviews of the CEO's performance;
- If problems are identified, be sure that they are communicated to the CEO in a timely manner, and then allow the CEO sufficient time to correct the problems which are under his/her control;
- Recognize that the board shares ownership and bears overall responsibility for the successful management of the hospital. By approving a plan or recommendation made by the management, the board is approving the work to be done, and bears responsibility for its successful completion and outcomes;
- Support the CEO through the many difficult challenges that he/she will face; and
- Ensure that the CEO is feeling challenged and satisfied with the work.

One of the most important jobs that a governing board has is that of selection and retention of an effective CEO. The CEO is the link between the day-to-day operations of the organization, and the governing board.

Mission development and long-range planning — The responsibility and authority for determining the organization's mission, the statement that defines what the organization is and why it exists, lies with the governing board. The board is also responsible for working with senior management to develop the goals, objectives and policies that grow out of, and are measured against, the mission statement. The long-range strategic plan should be created using the mission statement as its guide, and should identify major goals and strategies to achieve these goals. The plan should be reviewed regularly to assess its ability to meet and further the mission of the organization.

Ensuring high quality care — The board is ultimately responsible for ensuring that high quality care is consistently and effectively delivered to patients. The governing board is responsible for ensuring that the staff has the support and resources necessary to enable them to fulfill their roles. The board is also responsible for reviewing the quality of medical care delivered in the hospital through the quality assurance program.

Oversight of medical staff credentialing — A major function of the hospital governing board is the establishment and use of effective policies and procedures for appointment (and reappointment) of physicians to the medical staff. The board itself is not actually responsible for the collection and validation of information used to evaluate potential medical staff. However, the board must be familiar with the criteria for medical staff appointments and reappointments in order to ensure that the hospital is following the appropriate procedures in evaluation of potential applicants.

Trustees must ensure that the hospital has a credentialing process that considers the following essential pieces of information:

- A valid license in all states that apply;
- Evidence of completed training, including an undergraduate degree, completion of a medical school education, and residency, fellowship, or other training if so claimed;
- No disciplinary actions by previous hospitals, professional societies, or specialty boards that have not been satisfactorily explained;
- Good standing at current hospitals;
- Current and adequate malpractice insurance;

- Valid board certifications, if claimed or required by the organization;
- Satisfactory recommendations regarding professional performance;
- Clinical skills, ethical character, ability to work well with others;
- Statement of health, including any histories of substance abuse or chronic illness;
- Malpractice claims history; and
- Privileges granted at other hospitals and evidence of special training and experience, especially in conducting high-risk or unusual procedures.

Trustees must be comfortable in an environment of ambiguity. They must hold fast to commitment to their community, while recognizing their institutional loyalty.[3]

Financial oversight — A hospital board's responsibilities in financial oversight are critical, as payment sources and systems are constantly changing and becoming more and more complex.

Boards have the broad responsibility of protecting the limited resources of both the organization and the community. In addition, the board must ensure the cost-effective utilization of resources and the establishment of both long-range and short-range financial plans. The board should periodically review financial reports, ensure that adequate capital is available for the organization's investment strategies, and actively participate in and encourage regular philanthropic efforts.

Board education and development, including self-evaluation — Governing boards should continually strive to understand the hospital's programs, services and needs, and the impacts of environmental trends on the hospital's long-term direction. Performance measures should be established, and the board should conduct an annual self-evaluation. Learning boards plan and manage by continuously learning about themselves and their changing environment. Continuing education is a necessity to keep leadership current on key issues, and to perpetuate high quality care. Governing board members must engage in continuous governance improvement, enhance the quality of board thinking, and make a firm commitment to improvement. In addition, board members must develop a high level of understanding, not only of the hospital and the health care field, but of the areas most critical to organizational effectiveness and performance, in order to make fast and informed decisions when the need arises.

A Visionary Board

Today's high-performance board must embrace new ideas, and new ways of thinking, and must be prepared to change with the times. A forward thinking and visionary board must not resist change; they must embrace it.

Identified below are ten key factors that contribute to being a visionary board:[1]

Board Structure

- Utilize highly-focused committees and task forces
- Create streamlined boards capable of making timely, informed decisions
- Provide strategic guidance, and hold management accountable for day-to-day leadership

Communication

- Expect strategy-oriented reports
- Discussion is driven by strategic challenges and opportunities
- Should be brief, clear and concise; written at a high level that facilitates understanding and action
- Use to enhance leadership understanding and decision making
- Use to establish a foundation for dialogue, teamwork and consensus building

The governing board must see the big picture, and work with all of the information available to lead the organization in a positive direction.

CEO Evaluation

- Provide comprehensive, clear criteria
- Create mutual board/CEO agreement on scope and purpose, and tie together with compensation
- Identify specific performance goals related to strategic success

Board Self-Assessment

- Identify continuing quality initiatives by which to measure board performance
- Establish the self-assessment as an annual process
- Use the self-assessment as a means to identify improvement opportunities
- Utilize the assessment to identify education, recruitment and process needs

Membership and Selection

- Utilize a job description and board member "profile"
- Match individual members with organizational strategic needs
- Ensure that the membership is diverse, and has a variety of well-qualified and dedicated individuals
- Key factors in board member selection should be diversity, depth, commitment, involvement and dedication

Leadership and Effectiveness

- Boards should be professional and team-oriented
- Trustees should reinforce each others' competencies and areas of expertise
- Develop a strong understanding of health care issues, challenges, and impacts

Medical Staff Alignment

- Board members must understand medical staff issues and concerns
- Physician and medical staff viewpoints should be communicated to the board through the medical staff executive committee, advisory committees, medical staff surveys and other meaningful ways
- A regular assessment of medical staff attitudes and needs should be conducted

Education and Development

- A thorough and ongoing orientation for new trustees should be established
- Peer-to-peer counseling and assistance should be used for new or "struggling" board members
- A written policy and budget for board education should be established
- Board education should be tied to strategic and organizational challenges
- Board education should be included as a part of every board meeting

Strategic Decision Making

- Agendas should match strategic issues and priorities
- Meetings should be well-organized and tightly structured
- Discussion and planning should be focused on ensuring the future success of the organization

Performance Measurement

- Visual tools should be utilized to compare past, present and future performance (graphs, charts, etc.)
- Performance should be measured against goals, and performance gaps should be identified
- Performance measurements should invite discussion and create educational opportunities

Eligibility Criteria

In order for the board to ensure access to the critical skills and capabilities required to provide effective and informed leadership, trustees must meet specific criteria, and the board as a whole must be a functional and team-oriented unit, with varying strengths and areas of expertise.

The criteria for potential board members should be developed and documented in the form of a trustee job description. Duties and responsibilities should be identified, and qualification requirements and preferred qualities should be included. Trustee job descriptions do not have to be lengthy and detailed, but rather should be an overview of skills and expertise that the nominating committee can use as a guide when recruiting new trustees.

Bibliography

[1] The Walker Company; Shining Light on Your Board's Passage to the Future, AHA and Ernst & Young LLP

[2] "The Nonprofit Board Book," Independent Community Consultants

[3] *"Wanted: A Few Good Trustees," Trustee, March 1995*

Effective governance: the roles and responsibilities of board members

DON L. ARNWINE

Don L. Arnwine

Running a health care organization is a team sport. It is very important that all members of the team—whether on the medical staff, in management, or on the board—understand the role of governance and what constitutes effective governance. Many misunderstandings about the roles of boards exist. Many people think that board members are paid, for example, which is not true.

My interest in the subject of governance began when I became chief executive officer (CEO) of an organization that was to establish a major health care and medical educational program in West Virginia. Five organizations merged to create the new organization; 5 boards also merged to create 1 board of 56 members. Two years after the merger, we created a governance committee to study the subject, and that's when my interest in governance began. While CEO of the Voluntary Hospitals of America, which grew from 30 to 850 hospitals during my tenure, I had the opportunity to visit with many boards. More recently, I have given 15 to 20 board retreats annually and have been an advisor to the Governance Institute. If I were allowed to focus on only one subject during the rest of my career, it would be governance.

Governance is fundamental. I have seen good boards become bad boards and bad boards become good boards. I have seen organizations fail because of problems at the governance level. Ineffective governance compromises the ability of the management to succeed. Effective governance, in contrast, greatly assists the organization. Effective governance has the following characteristics: it is efficient, allows a respectful conflict of ideas, is simple, is focused, is integrated and synergistic, has good outcomes, preserves community assets, and leads to enjoyment and personal reward for the individual board members.

In the sections that follow, I review the roles and responsibilities of boards, factors that increase board effectiveness, and the evolution of governance.

ROLES OF BOARDS

Boards have 3 primary roles: to establish policies, to make significant and strategic decisions, and to oversee the organization's activity.

Policy making

Effective execution of policy is necessary to fulfill the other 2 roles. Policies define focus and differentiate responsibilities among the board, the management, and the medical staff. Well-written policies lead to more efficient board functioning. Instead of having the same matter or very similar matters on the agenda repeatedly, the board can develop a policy that covers the issue and leave implementation of the policy to management. Boards have approximately 24 hours together each year, spread over regular meetings. It is essential to use that time wisely.

At the same time, board-level policies should be reviewed regularly. At Baylor Medical Center at Irving, where I chair the board of trustees, we asked a staff member to review past board minutes and extract all policies. We then refined and consolidated them. The board now reviews policies annually to see if they are still needed.

Decision making

Decision making involves making choices about the organization's vision, mission, and strategies. Boards make decisions about issues that are strategic and significant, such as whether to enter an affiliation agreement with another organization. As decision makers, boards can also delegate nongovernance types of decisions to others—and would be wise to do so.

Oversight

Oversight is an important function, but boards must remember that the organization is theirs to oversee, not to manage. Some boards cross the line and try to involve themselves in management. Nevertheless, in the oversight role, the board is legally responsible for everything that happens within the hospital, whether in the emergency department, a clinic, or a nursing unit. In the area of quality, for example, the board's oversight role may include setting the tone by stating that the organization is committed to quality; establishing policies related to quality, such as credentialing; ensuring that mechanisms are in place, such as committees, to establish a plan for quality; and monitoring implementation of the plan.

Board committees play an important role in the governance process. It is useful to periodically review the structure and func-

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tions of the committees and to ensure that everyone knows what to expect from them.

RESPONSIBILITIES OF BOARDS

Boards have numerous responsibilities: they oversee management, finances, and quality; set strategic direction; build community relationships; establish ethical standards, values, and compliance; and select a CEO and monitor his or her progress. I believe that the 2 most important tasks are selecting the CEO and establishing the direction of an organization. Although the management team develops the strategic plan, it is the board's responsibility to accept or modify the strategic plan and to set the direction. The board considers elements in the environment—such as growing competition and changing patterns of care—and develops a vision, a mission, strategic thrusts, goals, and tactics that respond to the environment, all the while showing the organization's values.

Financial oversight is a familiar job that boards usually do well. Boards ensure the use of financial controls; ensure that funds are prudently invested, considering cash management, banking, and contracting parameters; and establish policies related to budgets. Their goal is to protect the community's assets. Oversight of the quality area often involves utilization and risk management in addition to continuous quality improvement.

Attention to community relationships is a responsibility unique to not-for-profit institutions. Inasmuch as board members have contact with the community, they can be sensitive to the expectations and needs of its citizens and bring that knowledge to the board room. The focus is on all those the organization serves: consumers, businesses, elected representatives, payors, and collaborators. Boards are paying more attention to the quality of life in their communities. At Baylor Medical Center at Irving, for example, the board has adopted a community action plan developed by the management team.

The ethical standards of the organization are determined by the behavior of the board. Through its ongoing actions, the board decides what behavior will and will not be tolerated. These actions supersede ethical statements—however important such statements are—in showing an organization's true values. In recent years, compliance issues have risen to board-level responsibility as well, particularly as the media have reported people being sent to jail and organizations and individuals being fined millions of dollars for breaches in government regulations. Compliance is probably the only new issue that has been added to board responsibilities over the past 10 years.

When reviewing these responsibilities, it is important to note that the board as a whole, and not any individual member, has the authority. Further, the board exists only when it is in session. The committee is an appendage of the board, and the board can delegate certain tasks to a committee or an individual, but otherwise an individual board member has no prerogative. Thus, it would be inappropriate for a board member to walk in to a manager's office and ask to review the books or demand certain changes. Such actions, in fact, can cause much disruption. The CEO is the full-time agent of the board and is the only person directly accountable to the board.

THE "WHEEL OF GOVERNANCE": 3 INGREDIENTS FOR AN EFFECTIVE BOARD

The wheel of effective governance has 3 spokes: behavior, structure, and expectations. If one of these spokes breaks down, the board will have a flat tire, and the faulty governance process can compromise the organization's ability to move forward.

Behavior

Appropriate board behavior can be defined as functioning in accord with the board's roles and responsibilities. Thus, board members should know the difference between governance and management, see service as a responsibility of citizenship, and find enjoyment in such service. Appropriate behavior also has key characteristics, the first of which is respect—for the organization, the management, the clinicians, the employees, and other members of the board. Respect is basic, but it doesn't always exist. I've seen many boards whose members were antagonistic towards large segments of the medical staff, for example. Such behavior is distracting and counterproductive.

Respect leads to 2 additional behavioral characteristics that are needed: openness in the board discussions and confidentiality. The two go hand in hand. Last year, when I was asked to consult with a CEO and chairman of the board to improve the climate of the board and eliminate the cliques that seemed to be forming, I discovered that the problems had arisen because of breaches in confidentiality. Some board members were speaking casually about board activities among people at their churches or at parties; others felt they couldn't be open because of this breach. The more sensitive the issue under discussion, the more important confidentiality becomes. As one board chairman used to say, "What you hear here or see here or do here, when you leave here let it stay here."

Conflicts of interest also fall in the category of behavior. Some people believe that a potential conflict of interest precludes service on the board. Based on such a view, some hospital boards do not include physicians, claiming that they could have a conflict. I disagree with this view. An attorney friend of mine told me that there's no evil in conflict of interest; the evil lies in the hiding thereof. All boards need to have a policy about conflict of interest. Usually this policy requires all members to disclose potential conflicts and to abstain from voting on such matters.

Another behavioral element is distinguishing between the important and the unimportant. The board has limited time. If it spends hours and hours on trivial matters, it won't be able to address significant and strategic matters.

Finally, the board needs to work for consensus. In not-for-profit organizations, members don't "vote their shares," with one individual being able to carry the day. Instead, boards work by reaching a common understanding of the issues, dealing with the options, choosing one, and unanimously supporting the decision even if an individual initially voted against it. Unity on the final decision is essential; if it does not exist, some people will take advantage of the discord and create problems. Team players are needed, people who join the board because they support the organization's mission and values. Board members do not participate to implement individual agendas but to help the organization effectively meet its responsibility in the community. The

Table 1. Desired characteristics of board members

I. Knowledge
- Understands and subscribes to the organization's mission and values
- Understands the economics of health care and the plan and budgets required to achieve the organization's mission
- Knows the organization's current financial position
- Understands community demographics and needs
- Knows how to build partnerships with other community groups
- Understands the complexity of the organization's challenges
- Has a grasp of medical information, technology, trends, and consequences
- Knows the difference between governance and management
- Knows how to be a "team player": when to listen and when to speak up
- Sees social/volunteer service as a responsibility of citizenship
- Understands real estate, physical facilities, and land development

II. Skills
- Can work to build consensus
- Can work with and be supportive of administrative and clinical staff
- Is adept at strategic and financial planning
- Has strong communication skills
- Can deal with diverse groups and ideas in a constructive way
- Can interpret financial information
- Has experience in a field or endeavor that contributes to the disciplines that affect the organization, i.e., insurance/managed care, medicine, law, finance/banking, real estate, marketing, information technology, public policy, corporate management, etc.
- Knows how to differentiate the important from the unimportant

III. Attitudes and personal characteristics
- Feels that collaboration is necessary for success
- Possesses openness and honesty
- Subscribes to and practices a high moral standard
- Is optimistic but realistic
- Values personal growth and learning, particularly covering matters confronting the board and the organization
- Sees self as a servant leader
- Accepts that the board has the authority and that individual board members have none (unless delegated by the board)
- Is personally challenged by what is best for the organization and the community
- Can be decisive and comfortable with large-scale decisions
- Accepts that change is our constant companion

"goodwill quotient" is exceedingly important, and these behavioral aspects will contribute significantly to that.

Structure

Boards may not pay much attention to structure, thinking that it is covered in the bylaws and requires no further comment. Nevertheless, problems often arise from structure rather than behavior. For example, I've encountered several boards in which the chairman had served for ≥30 years, and members were discontented and ready for someone new. Many board bylaws do not address tenure. Whether the term limit is 2 or 3 years or something different, it is helpful if everyone knows what to expect. Dissatisfied members know that they will be able to vote for someone else, and volunteers may be more willing to take on the role of chairman if they know it is for a designated period. Other issues may concern the frequency of meetings or the size of the board.

I believe strongly in agenda creation and management. Since the board's deliberations are determined by the agenda, that one

Table 2. A sample board service commitment letter*

I, _____, recognizing the important responsibility I am undertaking in serving as a member of the board of trustees of this organization, hereby pledge to carry out in a trustworthy and diligent manner the duties and obligations in my role as a board member.

The organization will be governed by individuals selected for their experiences and personal attributes. No individual will be selected because of his or her membership in or representation of any particular constituency. Once selected, each individual shall be required to fulfill his/her fiduciary duty with care and loyalty in the best interest of the system and the people it serves. The following characteristics will be utilized in selecting people to serve.

My role: I acknowledge that my primary roles as a board member are 1) to contribute to defining the organization's mission and governing the fulfillment of that mission, and 2) to carry out the functions of the office of board member as stated in the bylaws.

My role as a board member will focus on the development of policies that govern the implementation of institutional plans and purposes. This role is separate and distinct from the role of the chief executive officer, who determines the means of implementation.

My commitment: I will exercise the duties and responsibilities of this office with integrity, collegiality, and care.

Pledge
- To establish as a high priority my attendance at all meetings of the board and committees on which I serve.
- To be prepared to discuss the issues and business addressed at scheduled meetings, having read the agenda and all background material relevant to the topics at hand.
- To maintain the confidentiality of what is said or seen at board or board committee meetings.
- To work with and respect the opinions of my peers who serve on this board.
- To always act for the good of the community and the organization.
- To represent the organization in a positive and supportive manner at all times and in all places.
- To observe the parliamentary procedures and display courteous conduct in all board and committee meetings.
- To refrain from intruding on administrative issues that are the responsibility of management, except to monitor the results and prohibit methods that conflict with board policy.
- To avoid conflicts of interest between my position as a board member and my personal life. If such a conflict does arise, I will declare that conflict before the board and refrain from voting on matters in which I have conflict.
- To support in a positive manner all actions taken by the board of trustees even when I am in a minority position on such actions.
- To agree to serve on at least one committee or task force and participate in the accomplishment of its objectives.
- To participate in the annual strategic planning retreat, board self-evaluation programs, and board development workshops, seminars, and other educational events that enhance my skills as a board member.

If, for any reason, I find myself unable to carry out the above duties as best I can, I agree to resign my position as a board member.

*Modified from Gillis J. *1995 Board Member Manual.* Gaithersburg, Md: Aspen Publishers, 1994.

document relates closely to the board's effectiveness. The agenda can be organized into 3 categories: items for information, items for action, and items for strategic discussion. This agenda organization helps members know what is expected of them and eliminates worry, for example, about having to vote on an item that is just for information. If executive committees and task forces are appropriately established and charged, the board can trust their efforts and avoid recreating what happened at a committee meeting. Committee suggestions and other smaller, noncontroversial action items can be grouped into a "consent agenda," requiring only one motion and one vote. Background information on items in the consent agenda can be provided in the board book sent out before the meeting. Use of a consent agenda saves time and allows the board to focus on the most significant issues.

Structure also includes the nomination of new members. At Baylor Medical Center at Irving, we keep a matrix that indicates current members' skills in 8 essential areas. If attrition occurs, we look at the matrix and determine which skills are needed most. While the list of desired characteristics of board members developed by the Governance Institute is long *(Table 1)*, it is understood that every board member will not have all the attributes. The average hospital board—now 12 members—is smaller than it used to be and includes physicians (both internal and external to the community).

Expectations

The final spoke consists of expectations or, more specifically, board members' knowledge of what is expected of them and what they can expect from others. One of the best ways to clarify expectations is to have new members sign a letter that outlines those expectations *(Table 2)*. Such a document also makes it easier to remove a board member if, for example, his or her attendance has been poor. It also serves to clarify the requirements of board membership when approaching a potential volunteer.

In return for their service, board members should expect respect, a proper orientation, proper flow of communications, advanced preparation for board discussions, judicious use of their time, educational opportunities, and the opportunity to contribute. In addition, boards should be able to expect "no surprises." Boards will be comfortable with the CEO if they feel that he or she is being open with them. More than anything else, surprises damage the board's comfort level; members worry that other important matters are not being communicated. Finally, the board member can expect to participate in a board that is well led, informed, experienced in proper board function, well sized, properly motivated, consistent, a unit, and respectful of management and professionals.

THE EVOLUTION OF GOVERNANCE

The focus of governance has evolved. When hospitals were being built after World War II, roles focused on stewardship, civic duty, and fundraising. Today, the focus is on management oversight, financial management, and community response. The focus of the future is on strategic performance. The board needs to ensure that it has the right expertise around the table to deal with critical issues of the time. Today, for example, boards may need expertise in information technology, just as in an earlier era they needed expertise in architecture and construction. Other critical issues to be addressed by boards today include declining reimbursements, physician relationships, consumer and community relationships, and philanthropy.

If boards understand their roles and responsibilities, have a proper structure including well-chosen members, exhibit appropriate behaviors, and know what is expected of them, they can live up to the challenges of the future and keep health care organizations on track for the good of the community.

https://www.healthstream.com/resources/blog/blog/2019/02/04/10-healthcare-trends-to-watch-in-2019

10 Healthcare Trends to Watch in 2019

February 04, 2019

This post is taken from an article by Robin L. Rose, MBA VP, Healthcare Resource Group, HealthStream, where she looks ahead at the coming year, with an eye to big picture trends that could have a significant impact on how we provide and experience care.

Nothing in Healthcare Should Be Taken for Granted

The healthcare industry as we have known it is disappearing. A multitude of factors such as ever increasing prices, growing numbers of seniors, serious provider shortages, and a lack of affordability, even for many with good insurance, are driving change. New technologies, such as artificial intelligence, are slowly infiltrating the industry. Disrupters like Amazon are seeing opportunity amidst the turbulence, and usage and practice patterns are changing dramatically as the industry attempts to move from fee-for-service to value-based care. Although change always takes a bit longer than we think or expect, it is inevitable in this case. When we look back in 10 years, healthcare practice and delivery may be unrecognizable from what we experience today. The following are ten of the trends driving this transformation.

1. Amazon is becoming a major disrupter in many areas of healthcare.
2. Healthcare costs are becoming scarier than the illness itself.
3. We need to prepare for new health risks.
4. Artificial Intelligence (AI) is dramatically changing healthcare.
5. We are finally addressing population health.
6. CMS is changing course.

https://www.healthstream.com/resources/blog/blog/2019/02/04/10-healthcare-trends-to-watch-in-2019

7. We need more joy in the work of healthcare.

8. The nursing shortage is getting worse.

9. Physicians are in short supply too.

10. Digital healthcare organizations are emerging.

https://blog.definitivehc.com/top-8-healthcare-trends-2019

TOP 8 HEALTHCARE TRENDS IN 2019

MARCH 19, 2019 BY TORY WALDRON

Recently, our CEO, Jason Krantz, hosted a webinar: 8 Healthcare Trends that Will Impact your Sales in 2019.

We were excited to have over a thousand attendees participate in a live Q&A and survey, which asked "Which trends covered today are the most important to you?" In this survey, consolidation won by a landslide:

1. Consolidation – 288 votes
2. Consumerism – 164 votes
3. Telehealth – 158 votes
4. AI & Machine Learning – 128 votes

https://blog.definitivehc.com/top-8-healthcare-trends-2019

5. Staffing Shortages – 127 votes
6. Cybersecurity – 108 votes
7. Ancillary Technology – 108 votes
8. Wearables – 61 votes

Did you miss the webinar? Here is a recap, in order of our viewers' preferences:

1. Industry consolidation & new entrants

The healthcare industry is consolidating rapidly as it moves toward value-based care. In 2018, Definitive Healthcare tracked an astounding 803 mergers and acquisitions (M&As) and 858 affiliation and partnership announcements, which means that consolidations were taking place almost every single business day of the year.

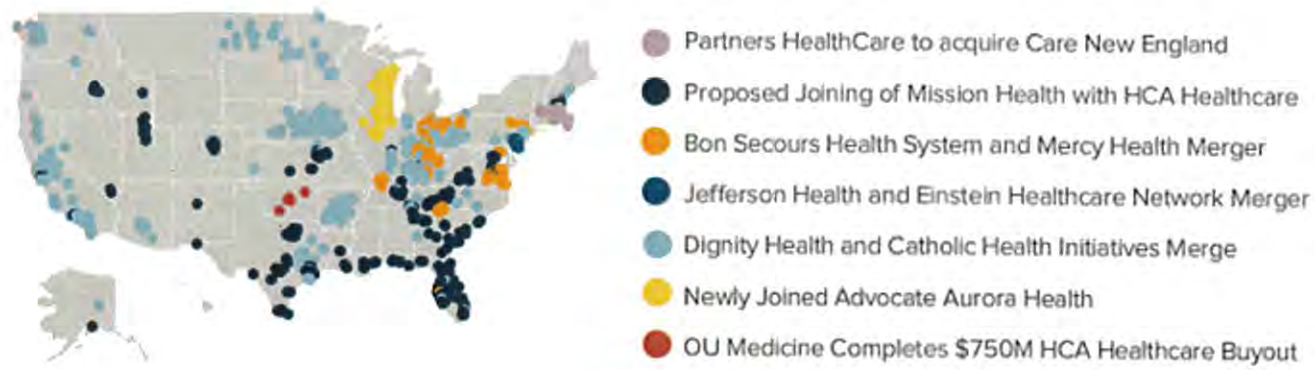

Fig 1: 2018 M&A data from Definitive Healthcare's platform

There are conflicting views on what all of this means. Some see the consolidation trend as a movement toward lower costs and better care, as smaller hospitals become affiliated with bigger healthcare systems and better technologies, but others are concerned about the growing power of healthcare industry giants. Either way, this trend is here to stay – and is even slated to accelerate over the next few years.

2. Consumerism

The healthcare consumer today is frugal, technology savvy, and seeking convenience:

- **Cost**: 65 percent of commercial insurance respondents selected cost as a top factor when choosing where to seek care.
- **Technology-driven**: Patients are increasingly looking at online reviews, transparent pricing, and satisfaction ratings for local providers to determine where they will go to get their treatments.
- **Convenience:** McKinsey's surveys show the growing proliferation of post-acute environments, like retail clinics. In fact, over the past four years, consumers who report using retail clinics has climbed from 9 percent to 24 percent in younger generations.

Personalization is becoming very important – there's no longer a "one-size-fits-all" care model in place, and we see this in the reduction of the number of people that see a primary care provider. Younger generations may be content to simply visit a nearby urgent care clinic to receive treatment.

3. Telehealth

According to Definitive Healthcare's 2017 Inpatient Telemedicine Study, over 70 percent of consumers would rather use video than visit their primary care provider in person. Telehealth is already growing fast, accounting for almost $22B in 2017, and it is expected to reach $93.45B by 2026.

4. AI & machine learning

Artificial Intelligence is the most talked about technology since the cloud, and for a good reason. There is an explosion of data in our society with 2.5 quintillion bytes of data generated each day. Hospitals, in particular, have more data than they know what to do with. The first wave of technology adoption in hospitals has been focused on collecting process, patient, financial, and organizational data, but now there is an increasing need to move toward understanding and utilizing this data to decrease costs and improve care. Many hospitals are starting to turn toward artificial intelligence to solve this problem.

5. Staffing shortages

There are two reasons behind the recent healthcare staffing shortage – a shifting workforce and shifting patient demographics. Approximately 55 percent of all

registered nurses are 50 years old or older, and 52 percent of the active physician workforce is 55 or older.

With an aging population, we need more care than ever, but there are fewer nurses and physicians available. On top of this, regulations are changing. For example, in 2018, Massachusetts had a ballot question that would have required an increase in the nurse-to-patient ratio. Although this particular question did not pass, other states may place similar votes on the ballot to increase the mandated ratio of nurses to patients – making this issue even more prominent.

6. Cybersecurity

An increase in mergers and acquisitions have created new vulnerabilities in information sharing. In 2018 alone, we saw many data breaches that exploited healthcare records; eight of those breaches exposed over 500,000 healthcare records, and three of those breaches revealed over a million. These attacks are high-profile and often highly-targeted, with the majority being financially motivated. Healthcare is already high stakes with personal, sensitive data – and will continue to be a main target for attacks in the coming years.

7. Optimization & Ancillary Technology

Currently, the healthcare technology install base is varied. There are many different vendors targeting different areas of the market, and this creates a lot of barriers to interoperability. If you look at the vendor market share for outpatient EHR systems, you can see that there are over 18 different vendors across the space.

https://blog.definitivehc.com/top-8-healthcare-trends-2019

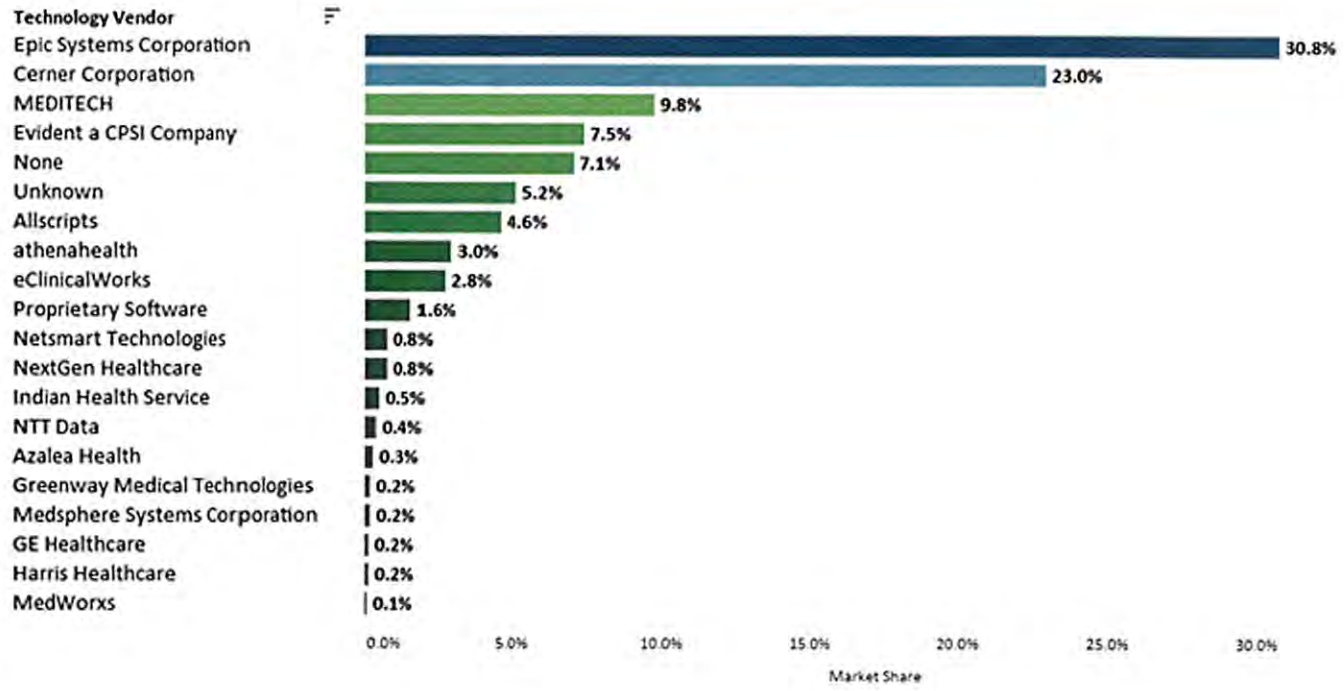

Fig 2: Vendor market share of outpatient EHR technologies from the Definitive Healthcare platform, accessed March 2019

Clearly, the healthcare technology space is crowded and complicated. Information systems need to be able to send a patient's medical information back and forth in a coordinated manner - within and across organizational boundaries - in order to access and exchange data sets. In 2019, there will be a greater shift toward semantic operability, which allows information management systems to interpret and derive insights from the shared data.

8. Wearables

The wearable and remote patient monitoring market has just started to take off; the Apple watch can now detect irregular heart rhythms and diabetics can monitor their blood sugar levels with digital glucose monitors.

This trend is still in its early stages, with only 1,800 hospitals using mobile applications (less than 25 percent of all U.S. hospitals), according to Definitive

https://blog.definitivehc.com/top-8-healthcare-trends-2019

Healthcare's data. But, the wearable market is projected to reach $12.1B by 2021 and the remote monitoring market is projected to grow to $31.3B by 2023 – almost double where it is today.

Small Rural Hospital and Clinic Finance 101

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PURPOSE

This manual was developed for use by state Medicare Rural Hospital Flexibility (Flex) Program personnel as well as staff and boards of critical access hospitals (CAHs), small rural prospective payment system (PPS) hospitals and provider based rural health clinics (RHC). The content is designed to be as non-technical as possible and to provide answers to frequently asked questions regarding CAH, PPS and RHC finance and financial performance.

GOVERNMENT INSURANCE PROGRAMS

What is Medicare?

The Medicare program, an amendment to Social Security legislation known as Title XVIII, provides medical coverage to all Americans 65 years of age and older. The bill was signed into law by President Lyndon B. Johnson in 1965 and took effect in 1966. The enactment of the Medicare program was significant because it was the beginning of the federal government's role as a major financer of health care. Medicare is health insurance for people 65 or older, people under 65 with certain disabilities and people of any age with End-Stage Renal Disease. Medicare is funded by both Social Security payroll taxes and insurance premiums, with coverage categories divided into "Parts." Medicare Part A is the hospital insurance portion of the program and includes acute hospital inpatient care and inpatient skilled nursing care. Medicare Part B is the medical insurance component and includes coverage for doctor visits and outpatient care. Medicare Part C, known as Medicare Advantage, covers both Part A and Part B options. And, Medicare Part D is the prescription drug coverage component of the program, which went into effect on January 1, 2006.

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home health care
- Most people do not have to pay a premium for Medicare Part A because they, or a spouse, paid Medicare taxes while working in the United States. If they do not automatically get premium-free Part A, they may still be able to enroll and pay a premium.

Medicare Part B (Medical Insurance)

- Helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment and home health care
- Helps cover some preventive services
- Most people pay up to the standard monthly Medicare Part B premium
- Some Medicare recipients buy coverage that fills gaps in Medicare coverage, such as Medicare Supplemental Insurance (Medigap)

Medicare Part C (also known as Medicare Advantage)

- Offers health plan options run by Medicare-approved private insurance companies. Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B
- Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D)
- Some Medicare Advantage Plans may include additional benefits for an additional cost

Medicare Part D (Medicare Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs
- Run by Medicare-approved private insurance companies
- Costs and benefits vary by plan

What is Medicaid?

Medicaid is health coverage available to people and families who have limited income and resources. It is funded both by the federal government and state governments but is managed at the state level. The program was enacted in 1965 as Title XIX of the Social Security Act. The funding of Medicaid is a major component of state spending, on average comprising 25 percent of the total state budget. Nationally, 60 percent of Medicaid spending goes toward acute care services and over a third goes toward long-term care services.

Medicaid recipients who are disabled or elderly may also receive coverage for services such as nursing home care or home and community-based services. Depending on the state's rules, individuals may also be asked to pay a small part of the cost (copayment) for some medical services. If an

individual qualifies for both Medicare and Medicaid, most of their health care costs will be covered, including prescription drug coverage.

Frequently, nursing home residents run out of financial resources during their stay, at which point they become eligible for Medicaid coverage. States attempt to control the costs by ensuring that those receiving Medicaid benefits are truly eligible and at times adopt payment methodologies of the Medicare program. Because Medicaid programs are managed at the state level, there is state-to-state variation in eligibility requirements, coverage and reimbursement.

Medicaid reimbursement, in general, is lower than both Medicare and private insurance reimbursement. Thus, the proportion of Medicaid business for any health care organization is particularly relevant to its financial performance. Moreover, because Medicaid programs place stress on state budgets, state regulators often carry out cost containment measures to reduce Medicaid spending. State cost containment activities include the reduction of payments to providers, reduction in covered services and reduced pharmacy benefits. As of April 2014, 13 states receive cost-based reimbursement for inpatient services. In addition, as of July 2016, 16 states receive cost-based reimbursement for outpatient service. For information on state-specific Medicaid reimbursement rates for CAHs, please visit: https://www.ruralhealthinfo.org/topics/critical-access-hospitals#medicaid.

What is Children's Health Insurance Program (CHIP)?

The Children's Health Insurance Program (CHIP) provides access to low cost health insurance coverage for children in families who earn too much to qualify for Medicaid but not enough to be able to buy private health insurance. These families are eligible for free or low-cost health insurance that pays for doctor and dental visits as well as prescription drugs, hospitalizations and more.

GOVERNMENT HEALTH CARE REIMBURSEMENT

What is the prospective payment system?

In 1983, the payment methodology for inpatient acute hospital care (Medicare Part A) changed from cost-based reimbursement to a prospective payment system (PPS). In this new payment system, all the various clinical diagnoses were classified into groups called Diagnosis Related Groups

(DRGs). With the establishment of DRG categories, of which there were more than 500, hospitals were paid a fixed amount to treat each patient based on age, sex, International Classification of Diseases (ICD) diagnoses, procedures, discharge status and the presence of comorbidities or complications. Subsequently in 2007, Medicare updated this methodology to Medicare Severity-Diagnosis Related Groups (MS-DRG) of which there are approximately 1,000 categories. Upon admission, each patient is assigned a MS-DRG based on his or her primary diagnosis, for example, pneumonia. The hospital is then paid a specific dollar amount for that pneumonia patient based on the MS-DRG code assigned. Some patients need more anticipated services to treat their specific ailment(s), while other cases require fewer services. Regardless, the hospital is still paid the same amount for that MS-DRG code. Naturally, some diagnoses, and their corresponding MS-DRGs, have very high levels of complexity and thus are more costly to treat. For example, a heart transplant is vastly more complicated and requires more resources than a normal newborn birth. Consequently, MS-DRG reimbursement for heart transplants is higher than for the normal newborn MS-DRG.

Base MS-DRG rates can be adjusted for several reasons, including a hospital's location. Just as the cost of living in the United States varies by location, the cost of providing health care varies by location as well. A heart transplant performed in San Francisco, California, would likely cost more than one performed in Omaha, Nebraska, due to wage differences, supply costs differences, etc. The MS-DRG system adjusts for this by varying MS-DRG payments according to market forces across the country.

Inherent in the MS-DRG reimbursement system is the incentive for hospitals to treat and discharge patients as quickly as possible. Because this reimbursement program pays hospitals on a per-patient basis, there is a financial incentive for hospitals to treat as many patients as possible, as efficiently as possible. By discharging patients in a timely manner, it frees more bed space which can be used to treat more incoming patients. Additionally, the reduced number of days spent in the hospital for a given patient reduces the required resources and associated costs of caring for that patient. In this way, for any MS-DRG, a shorter length of stay can be more profitable for the hospital than a longer length of stay. However, it is important to note that Medicare has implemented some reductions in payment under the MS-DRG methodology when the Medicare beneficiary is discharged before the Medicare average length of stay with a discharge to a

covered skilled nursing stay in a nursing home or to a home health agency. Because of this direct impact on profitability, the Average Length of Stay metric is used by hospitals to assess the efficiency of their organization.

Outpatient services are reimbursed prospectively under one of three methodologies. The first methodology is the Clinical Lab Fee Schedule. This fee schedule applies to outpatient lab services rendered by prospective payment hospitals. The second methodology is the Medicare Physician Fee Schedule which provides for the payment methodology for outpatient therapies (i.e., Physical Therapy, Occupational Therapy and Speech Therapy). Under these methodologies, the payment is based on a fee schedule that is assigned according to the Current Procedural Terminology (CPT) codes reported for the services. The final methodology is the Ambulatory Payment Classification (APC) methodology. Initially implemented by CMS in 2000, this methodology provides for payments of services by grouping a CPT code or group of CPT codes into an APC classification. Each APC classification then has a payment level assigned. This methodology provides for significant bundling of services.

What is the Medicare Swing Bed program?

As discussed earlier, hospitals are reimbursed on a MS-DRG basis for inpatient acute care. Often, patients who require acute inpatient services require inpatient rehabilitative aftercare or skilled nursing care. MS-DRG acute payment rates are set based upon the resources required to treat the acute condition only and not those expended on the subsequent rehabilitation. Therefore, the Medicare program created a separate reimbursement system to compensate providers for the extended care service they provide. The amount of extended care required by patients for any condition is highly variable because of differences in age, overall health and other factors that determine the speed of recovery. Due to this length of stay variation, hospitals receive reimbursement based on the overall assessed condition of the patient, the amount of which is determined by the assigned Resource Utilization Group (RUG).

The RUG system classifies patients into one of 66 RUG levels, based on the expected amount of provider resources to be expended. RUG payments are larger for most severe conditions that require a great deal of attention and service. In cases in which extended care is required, PPS hospitals receive two payments for a patient: MS-DRG payment for the treatment of the acute

condition and the RUG payment for care offered to patients after the acute treatment.

The Medicare swing bed program allows hospitals with 100 beds or fewer to provide both acute care treatment and skilled nursing treatment to patients without having to physically move the patient to another bed. The hospital receives both forms of reimbursement described above, simply by discharging patients from acute care beds and admitting them to skilled nursing beds when the patient meets the coverage guidelines for skilled care. The skilled nursing bed is sometimes referred to as a swing bed because the hospital swings a bed from an acute care designation to a skilled nursing designation. Patients must be in the medically necessary acute care bed for at least 72 hours before they can be discharged to a swing bed unless a waiver has been granted by CMS to the provider as a participant in special Medicare programs (i.e., Tracks 1+ and 3 accountable care organizations (ACO)).

What is CAH cost-based reimbursement?

During the 1980s and 1990s, almost 400 hospitals closed across the US because of financial losses from the PPS system. In 1997, the Balanced Budget Act created the Medicare Rural Hospital Flexibility (Flex) Program and CAH provider type. Medicare pays for the same services from CAHs as for other acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests and post-acute skilled nursing days). However, CAH payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients.

CAHs receive cost-based reimbursement for inpatient and outpatient services provided to Medicare patients (and Medicaid patients depending on the policy of the state in which they are located). Cost based reimbursement provides significant financial advantage to CAHs by allowing them to get paid at 101 percent of costs on all of their hospital Medicare revenue. The cost of treating Medicare patients is estimated using cost accounting data from Medicare cost reports.

What is CAH Medicare ambulance reimbursement?

Under Medicare ambulance reimbursement, if a CAH, or an entity that is owned and operated by the CAH, is the only provider or supplier of ambulance service located within a 35-mile drive of that CAH, the CAH, or

the CAH-owned and operated entity, is paid 101 percent of the reasonable costs of the CAH or entity in furnishing ambulance services. Additionally, if there is no other provider or supplier of ambulance services within a 35-mile drive of the CAH but there is a CAH-owned and operated entity furnishing ambulance services that is more than a 35-mile drive from the CAH, that CAH-owned and operated entity can be paid 101 percent of reasonable costs for its ambulance services as long as it is the closest provider or supplier of ambulance services to the CAH.

What are allowable costs for 101 percent cost-based reimbursement from Medicare?

Medicare pays CAHs for most inpatient, outpatient and swing bed services to Medicare beneficiaries on the basis of reasonable cost. Reasonable cost is the cost that was incurred to provide a medical service, to the extent the cost is necessary to efficiently deliver that service. Expenses must be prudent and reasonable as well as related to patient care. For a condensed list of allowable vs. non-allowable expenses, please refer to Table A below.

Table A. Allowable Costs in CAH

Type of Expense	Allowable or Not Allowable
Public education	Allowable
Employee recruitment	Allowable
Taxes based on income	Not Allowable
Sales tax	Allowable
Property taxes	Allowable
Entertainment	Not Allowable
Civic organizations	Allowable
Legal fees	Depends on activity
Collection agency fees	Allowable
Political/lobbying costs	Not Allowable

What is the difference between PPS and cost-based reimbursement?

PPS is a system where payment levels are set ahead of time or prospectively before health care services are delivered, as opposed to after the diagnosis

and treatment. Because rates are set prior to services, each service has a pre-determined rate associated with it. These rates are based on estimates of the resources that must be expended for any particular service (i.e., physician time and effort, supplies, etc.). In this way, this reimbursement system attempts to appropriately match payments to the acuity of patient illnesses. For example, hospitals are paid a fixed amount for performing a hip replacement and a different fixed amount for treating a patient with heart failure. This type of reimbursement methodology controls for costs because providers are paid a fixed rate per service, regardless of the costs they incur.

What is Optional (Method II) Billing?

A CAH may elect the Optional (Method II) Payment Method under which it bills the fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) for both facility services and professional services to its outpatients on a single claim. Eligible medical professionals affiliated with CAHs can elect the Optional (Method II) Payment Method whereby the CAH bills on behalf of these professionals for their outpatient services. These services include when a CAH physician reassigns outpatient billing services to the CAH, for example, in pathology, radiology, emergency room, outpatient surgery and outpatient clinics. This payment does not include services provided at a rural health clinic and only applies to the CAH outpatient services.

It is important to note that Optional (Method II) Payment Method billing is setting-specific, not provider-specific. If a provider works in an RHC, they cannot use Optional (Method II) Payment Method for those clinic services. However, if that same provider also provides outpatient services in the CAH, that provider could use Optional (Method II) Payment Method for those outpatient CAH services under the Optional (Method II) Payment Method based on the sum of:

- For facility services: 101 percent of reasonable costs, after applicable deductions, regardless of whether the physician or practitioner has reassigned his or her billing rights to the CAH; and
- For physician professional services: 115 percent of the allowable amount, after applicable deductibles and coinsurance, under the Medicare Physician Fee Schedule. Payment for non-physician practitioner services is 115 percent of the amount that otherwise

would be paid for the practitioner's professional services under the Medicare Physician Fee Schedule.

Physicians reassign their billing to the hospital and the hospital must do the billing. All providers of the CAH do not need to use Optional (Method II) Payment Method but can individually elect to do so. Overall, it is beneficial for the CAH to elect the Optional (Method II) Payment Method, as it results in higher reimbursement. However, software and other system limitations can make it difficult to impossible to implement this methodology.

In the past, if a CAH chose to be paid under the Optional (Method II) Payment Method, it was required to make that election on an annual basis. However, in the Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS) Final Rule, CMS changed the regulations for the optional method election. Effective for cost reporting periods beginning on or after October 1, 2010:

- If a CAH elects the optional method in its most recent cost reporting period beginning before October 1, 2010, that election remains in place until the CAH submits a termination request to its FI/MAC. CAHs will no longer be required to make an annual election. However, the CAH must continue to submit 855R forms for any newly hired/contracted practitioners.
- If a CAH chooses to make a change or terminate its optional method election, the CAH will need to notify its FI/MAC in writing at least 30 days prior to the start of the next cost reporting period

What is a Medicare Administrative Contractor (MAC)?

Section 911 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) established Medicare Contracting Reform (MCR). This statute required the Department of Health and Human Services (HHS) to replace Medicare's 48 carriers and fiscal intermediaries who process Medicare Part A and B Fee-for-Service claims with the new MAC authority. The primary reasons for instituting this change were to increase the contractor's efficiency in the receipt, processing and payment of Fee-For-Service claims. For more information on the MACs, please visit: https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html.

If CAHs are reimbursed at 101 percent, why might they not make a profit?

Some CAH expenses, such as recruiting and bad debts, are not included in the cost-based reimbursement formula. In addition, a 2 percent sequestration reduction applies to Medicare's portion of the reimbursement after deductibles and coinsurance has been calculated. Therefore, CAHs earn less than 101 percent of cost for care of their Medicare patients. Consequently, profitability of CAHs is dependent on private insurance business, for both inpatient and, increasingly, outpatient services. Private insurance payors do not reimburse CAHs on a cost basis, but rather follow a PPS system or reimburse on a percent of charges. In fact, the profitability of commercial business is enhanced because of the cost-based reimbursement received for Medicare/Medicaid revenue.

Suppose a CAH administrator decides to purchase and install a CT scanner for $1 million and assume 40 percent of patient care at the CAH in the CT department is Medicare revenue. The CAH will receive $400,000 in cost reimbursement over the useful life of the scanner ($1 million * 40 percent = $400,000) from Medicare for their portion of this scanner used to serve patients. This reduces the hospital's remaining costs for the CT scanner to $600,000. The use of the scanner from other patients would need to be available in order to offset the remaining costs based on overall demand.

It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers. When performing financial assessments of CAHs, it is essential to evaluate both the proportion of private insurance business as well as the rates negotiated with the private payor.

What is a hospital cost report?

The Medicare Cost Report is a financial document filed annually by all Medicare providers participating in the program, including: hospitals, skilled nursing facilities, home health agencies, RHCs, federally qualified health centers (FQHC), hospice, renal dialysis and home office. The Medicare Cost Report is submitted annually to CMS for settlement of costs relating to health care services rendered to Medicare beneficiaries. The Medicare Cost Report records: each institution's total costs and charges associated with providing services to all patients; the portion of those costs and charges allocated to Medicare patients; and the Medicare payments received.

The Medicare Cost Report must be filed with the FI/MAC within five months of fiscal year end of the CAH to achieve settlement of costs for health care services. Final settlement will equal the total reimbursable costs incurred by or on behalf of the CAH for furnishing covered care to the CAH's Medicare enrollees (less applicable deductible and coinsurance). Throughout the course of the year, the hospital receives interim payments from Medicare for its services. These payments are based on historical costs as claims are processed. At the end of the hospital's fiscal year, if the final settlement determination is greater than payments already made to the CAH through interim settlement, an underpayment will be declared, and CMS will make a lump-sum payment to the CAH. Conversely, if the final settlement determination is less than the total payment made, the CAH has been overpaid and CMS must recover the overpayment. This is like the filing of individual taxes each year, where a person will either owe money or be paid a refund from the state or federal government, based on estimated tax payments from the previous year. The above payment methodology illustrates the importance of up-to-date charges, billing and coding methodologies, and cost reporting strategies for the hospital to ensure accuracy and maximize allowable payment.

If a CAH or PPS hospital has an RHC attached, how do they bill for those services and file their expenses?

The primary benefit of RHC status is enhanced reimbursement from Medicare and Medicaid. Medicare reimburses RHCs based on allowable and reasonable costs. There are two types of RHCs: independent RHCs and provider based RHCs. Provider based RHCs work as a department of another provider, such as a CAH, providing health care services to the same population. Independent RHCs, on the other hand, are not affiliated with other providers. There can be significant reimbursement implications associated with each type of designation; for example, independent RHCs are subject to a payment cap, whereas provider based RHCs are not subject to a payment cap if the parent entity is a hospital with fewer than 50 available acute care beds (not licensed beds). Provider based RHCs are reported on the main provider's cost report as a department of that provider. As a result, overhead is allocated to the RHC through the step-down overhead allocation process in the same manner that impacts all of the provider's patient care service departments. Throughout the year, the RHC receives interim per visit payments based on past Medicare cost reports or

other relevant information provided to CMS. At the end of the fiscal year, Medicare calculates the actual payments to be made to the RHC per the Medicare Cost Report. These payments are compared to the actual payments previously made to the RHC to determine if a payable is due to, or a receivable due from, the RHC.

CAH FINANCES

What are the most important CAH financial indicators?

Financial indicators closely aligned with financial strength can be used to determine the financial status of a CAH. Financial indicators, often ratios, combine line items from the balance sheet, statement of operations and/or statement of cash flows in a meaningful way to help interpret strengths or weaknesses in operations or financing activities. Examining these ratios over time can help determine an organization's future trajectory or momentum.

In June 2012, a group of CAH financial experts met in Minneapolis, Minnesota at a CAH Financial Leadership Summit. Of the many identified financial ratios proven useful for assessing organizations financial conditions, the Summit participants identified the 10 most important indicators for evaluating CAH financial performance. Table B displays each of these 10 indicators with the 2016 CAH US medians as listed in the *CAH Financial Indicators Report: Summary of 2016 Medians by State* updated by the Flex Monitoring Team in April 2018. Each indicator also notes if favorable values are trending above or below the median.

Table B. CAH Financial Indicator Medians, 2016

CAH Financial Indicator	2016 US Median	Favorable Trending
Days in Accounts Receivable	51.34	Down
Days Cash on Hand	77.72	Up
Total Margin	2.74%	Up
Operating Margin	0.93%	Up
Debt Service Coverage	3.35	Up
Salaries to Net Patient Revenue	44.90%	Down
Medicare Inpatient Payer Mix*	72.70%	Down
Average Age of Plant (years)	10.48	Down
Long Term Debt to Capitalization	27.20%	Down

*Summit participants agreed Overall Payor Mix was a more comprehensive indicator of financial performance than Medicare Inpatient Payor Mix alone.
Source: Flex Monitoring Team CAH Financial Indicators Reports Primer and Calculator Resources, Template for Presentation of CAHFIR Data, April 2018.

A definition, formula and benchmarks for each of the 10 most important indicators of CAH financial performance is provided below. Each indicator also includes an example data table, which is meant to be used as a reference when calculating these ratios for a specific CAH. Sample data corresponds with the financial statements in the Appendix, including a balance sheet, statement of operations and statement of cash flows. Many of the line items on the financial statements have a letter designation under the column titled "Row". These letters are referenced in the descriptions of the indicator calculations.

Days in Net Accounts Receivable

Days in Net Accounts Receivable measures the number of days it takes an organization to collect its payments.

How values are calculated:

- Net Accounts Receivable: [Row B] – [Row C]
- Net Patient Revenue: [Row Q]
- Days in Net Accounts Receivable: ([Row B] - [Row C]) ÷ ([Row Q] ÷ 365)

Example data:

	2015	2016	2017
Net Accounts Receivable	771,000	802,000	778,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Days in Net Accounts Receivable	**54.17**	**54.92**	**52.70**

High values reflect a long collection period and indicate problems in the organization's business office with regards to billing or collecting payments. The ability to collect payments for services is increasingly difficult, but extremely important. Improvement in days in accounts receivable can mean hundreds of thousands of dollars in improvement in cash on hand. Common problems include out of date chargemasters, poor registration processes and bad communication. Days in Accounts Receivable is a good measure of how the billing process is working and its efficiency, but it does not indicate the overall financial strength of the hospital. Favorable values are **below** the median and the 2016 CAH US Median = **51.34 days**. Reductions to accounts receivable will improve cash on hand.

Days in Gross Accounts Receivable

Days in Gross Accounts Receivable tests the net days in accounts receivable with a goal of being the same amount of time as net days in accounts receivable.

How values are calculated:

- Gross Accounts Receivable: [Row B]
- Gross Revenue: [Row P]
- Days in Gross Accounts Receivable: [Row B] ÷ ([Row P] ÷ 365)

Example data:

	2015	2016	2017
Gross Accounts Receivable	1,001,000	1,012,000	993,000
Gross Revenue	6,395,000	6,460,000	6,503,000
Days in Gross Accounts Receivable	**57.13**	**57.18**	**55.74**

Days in Gross Accounts Receivable is important to track and compare to net accounts receivable to assess the revenue cycle performance. Gross and net days are close in value in highly functioning business offices. Gross accounts receivable does not include any accounting adjustments which makes it a good measure of overall performance when compared to net days in accounts receivable. For example, if gross days are higher than net days,

the organization's allowances (i.e., write offs) may require further analysis. Favorable values are **below** the median and the 2016 CAH US Median = **58.91 days**.

Days Cash on Hand

Days Cash on Hand measures the number of days an organization could operate if no additional cash was collected or received. This reflects the organization's safety net relative to the size of the hospital's expenses.

How values are calculated:

- Cash and Temporary Investments: [Row A]
- Total Expenses: [Row X]
- Depreciation and Amortization: [Row U]
- Provision for Doubtful Accounts/Bad Debt: [Row W]
- Days Cash on Hand: [Row A] ÷ (([Row X] - [Row U] - [Row W]) ÷ 365)

Note: Provision for Doubtful Accounts/Bad Debt is only included in this equation if classified as an operating expense on the Income Statement.

Example data:

	2015	2016	2017
Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
Total Expenses	5,688,000	5,747,000	5,817,000
Depreciation and Amortization	229,000	218,000	211,000
Bad Debt	102,000	107,000	126,000
Days Cash on Hand	**76.31**	**86.17**	**121.96**

Lending organizations view this ratio as critical in the assessment of a project's feasibility, as it represents the amount of dollars readily available to meet short term obligations and make debt payments, should an organization experience short term financial distress. Favorable values are **above** the median and the 2016 CAH US Median = **77.72 days**.

Total Margin

Total Margin measures the control of expenses relative to revenues.

How values are calculated:

- Change in Net Assets: [Row Z]
- Total Revenue: [Row S]
- Total Margin: [Row Z] ÷ [Row S]

Example data:

	2015	2016	2017
Change in Net Assets	64,000	87,000	159,000
Total Revenue	5,752,000	5,834,000	5,976,000
Total Margin	**1.11%**	**1.49%**	**2.66%**

Total Margin indicates the organization's overall profit. It is important to note that organizations need at least a small measure of profit to reinvest in their facilities, staff and infrastructure. Consistently negative total margins may eventually lead to hospital closure. While Total Margin is a good indicator of financial strength, it is important to look at operating margin as well. An organization might have a high Total Margin ratio if, for example, it is the recipient of non-operating sources of revenue, such as a county subsidy to provide quality health care to indigent residents. Margin driven by supplemental funding sources may be at risk with more pressure on local and county governmental budgets, for example. Favorable values are **above** the median and the 2016 CAH US Median = **2.74 percent**.

Operating Margin

Operating Margin measures the control of operating expenses relative to operating revenues related to patient care. Operating expenses are all expenses incurred from the hospital in delivering services. Examples are salaries and benefits, purchased services, depreciation and amortization, supplies, interest expense, professional fees and bad debt expense.

How values are calculated:

- Net Operating Income: [Row R] – [Row X]
- Total Operating Income: [Row R]
- Operating Margin: ([Row R] – [Row X]) ÷ [Row R]

Example data:

	2015	2016	2017
Net Operating Income	-7,000	10,000	63,000
Total Operating Income	5,681,000	5,757,000	5,880,000
Operating Margin	**-0.12%**	**0.17%**	**1.07%**

This measure reflects the overall performance on the CAH's core business: providing patient care. It is important to note that it takes into account the deductions from revenue, such as contractual allowances, bad debt and charity care. Favorable values are **above** the median and the 2016 CAH US Median = **0.93 percent**.

Debt Service Coverage Ratio

Debt Service Coverage Ratio measures the ability to pay obligations related to long-term debt.

How values are calculated:

- Change in Net Assets: [Row Z]
- Interest: [Row V]
- Depreciation and Amortization: [Row U]
- Repayment of Debt (Principal Payments): [Row AA]
- Interest Paid on Long Term Debt (Interest Payments): [Row BB]
- Debt Service Coverage Ratio: ([Row Z] + [Row V] + [Row U]) ÷ ([Row AA] + [Row BB])

Example data:

	2015	2016	2017
Change in Net Assets	64,000	87,000	159,000
Interest	28,000	17,000	13,000
Depreciation and Amortization	229,000	218,000	211,000
Principal Payments	169,000	145,000	90,000
Interest Payments	28,000	17,000	10,000
Debt Service Coverage Ratio	**1.63**	**1.99**	**3.83**

The measure reflects the availability of capital after debt obligations have been satisfied. The debt service coverage represents a key ratio in determining the ability of an organization to take on additional debt, whether for information technology (IT), equipment or a building project. The higher the value of the debt service coverage ratio, the greater the cushion to repay outstanding debt or take on additional obligations. Favorable values are **above** the median and the 2016 CAH US Median = **3.35**.

Salaries to Net Patient Revenue

Salaries to Net Patient Revenue measures labor costs relative to the generation of operating revenue from patient care.

How values are calculated:

- Salaries: [Row T]
- Net Patient Revenue: [Row Q]
- Salaries to Net Patient Revenue: [Row T] ÷ [Row Q]

Example data:

	2015	2016	2017
Salaries	2,895,000	2,908,000	2,958,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Salaries to Net Patient Revenue	**55.73%**	**54.56%**	**54.90%**

Salaries are a major part of the expense structure and require close management. Reviewing the costs can help a CAH assess its staffing efficiency. Overstaffing can reduce overall hospital profitability. Closely monitoring salaries to net patient revenue and improving efficiencies can improve financial performance. Favorable values are **below** the median and the 2016 CAH US Median = **44.90 percent**.

Payer Mix Percentage

Payer Mix Percentage is the proportion of patients represented by each payer type. As displayed below, inpatient and outpatient payer mix are calculated differently.

Inpatient Payer Mix measures the percentage of total inpatient days that are provided to patients of each payer type. The 2016 CAH US Median for Medicare inpatient payer mix was **72.70 percent**. Favorable values are **below** the median.

$$\frac{\text{Inpatient Days for Payer}}{\text{Total Inpatient Days} - \text{Nursery Bed Days} - \text{Nursing Facility Swing Days}}$$

Outpatient Payer Mix measures the percentage of total outpatient charges that are for patients of each payer type.

$$\frac{\text{Outpatient Charges for Payer}}{\text{Total Outpatient Charges}}$$

Payer mix percentages are particularly important in estimating provider revenue because the final reimbursement amount for any patient ultimately depends on the payment source. For CAHs, reimbursement for Medicare is

101 percent of costs. Real costs for Medicare patients are already below 100 percent since some costs, such as physician recruiting, are not reimbursed by Medicare (see Table A - "Allowable Costs in CAH"). The only alternative source of profits is providing services to privately insured patients. It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers.

Average Age of Plant

Average Age of Plant measures the average age in years of the buildings and equipment of an organization.

How values are calculated:

- Accumulated Depreciation: [Row E]
- Depreciation and Amortization: [Row U]
- Salaries to Net Patient Revenue: [Row E] ÷ [Row U]

Example data:

	2015	2016	2017
Accumulated Depreciation	1,874,000	1,755,000	1,896,000
Depreciation Expense	229,000	218,000	211,000
Average Age of Plant	**8.18**	**8.05**	**8.99**

CAHs often fail to improve or rebuild their facilities. The status of newer facilities has been shown to have a positive effect on financial performance and on the recruitment and retention of physicians and staff. Average age of plant is a good indicator of distress with older hospitals having greater problems. Lower, decreasing values indicate a newer facility or more frequent reinvestments in buildings or equipment over time. Favorable values are **below** the median and the 2016 CAH US Median = **10.48 years**.

Long Term Debt to Capitalization

Long Term Debt to Capitalization measures the percentage of net assets (or equity) that is debt.

How values are calculated:

- Long Term Debt, Net of Current Portion: [Row K]
- Net Assets - Accumulated Earnings (Deficit): [Row M]
- Long Term Debt to Capitalization: [Row K] ÷ ([Row K] + [Row M])

Example data:

	2015	2016	2017
Long Term Debt	186,000	183,000	178,000
Net Assets	1,835,000	2,173,000	2,694,000
Long Term Debt to Capitalization	**9.20%**	**7.77%**	**6.20%**

This ratio measures the amount of capital that is financed with debt, which is important to lenders for long term viability. Higher values signify a riskier situation and indicate that a hospital may have a harder time sustaining debt payments in the future and/or getting financing from lenders. Favorable values are **below** the median and the 2016 CAH US Median = **27.20 percent**.

Is there a model for predicting CAH financial distress?

The Financial Distress Index was developed by researchers from the North Carolina Rural Health Research and Policy Analysis Center at University of North Carolina at Chapel Hill. A well-functioning prediction model, such as this, can be used as an early warning system to identify hospitals at increased risk of facing financial distress. State Flex Programs, CAH CEOs and boards reviewing the model could identify areas of particular distress and develop strategies, or interventions, to improve financial performance. To view more information about the prediction of financial distress among rural hospitals, please visit: https://www.ruralhealthresearch.org/publications/998.

Today's characteristics (recent financial performance and measures of a market in which a hospital operates) are used to assign CAHs to one of four risk levels that predict whether a CAH will be in financial distress two years later. Many financial performance and market characteristics were considered for inclusion. The final model was selected due to its ability to predict performance in a straightforward manner. Variables used in the model are noted below in Tables C, D, E and F.

The model separates hospitals into risk of financial distress categories. Financial distress events include:

- Unprofitability
- Equity decline
- Insolvency
- Closure

Accurate assignment of hospitals to categories that reflect low, mid-low, mid-high and high risk of financial distress can provide an effective early warning system to CAHs, allowing CAH Administrators and state Medicare Flex Program Coordinators to target efforts to those at higher risk.

Table C. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Financial Performance

Variable	Description
Profitability	Total margin; two-year change in total margin
Reinvestment	Retained earnings as a percent of total assets
Benchmark performance	Percent of benchmarks met over two years

Table D. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Government Reimbursement

Variable	Description
Medicare	CAH status
Medicaid	Medicaid to Medicare fee index

Table E. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Hospital Characteristics

Variable	Description
Ownership	Government/not-for-profit, for-profit
Size	Net patient revenue (millions)

Table F. Descriptive Measures of Variables Included in Prediction of Financial Distress among Rural Hospitals, Market Characteristics

Variable	Description
Competition	Log of miles to nearest hospital more than 100 beds; market share (<25%)
Economic Condition	Log of poverty rate in the market area
Market Size	Log of population in the market area

Where can I find information about the financial performance of CAHs in my state?

The Flex Monitoring Team has created a login protected online tool called the *Critical Access Hospital Measurement and Performance Assessment System* (CAHMPAS). CAHMPAS is available to CAH executives, state Flex Programs

and federal staff to explore the financial, quality and community-benefit performance of CAHs. CAHMPAS provides graphs and data, which allows comparison of CAH performance for various measures across user-defined groups: by location, net patient revenue or other factors. CAHMPAS includes a variety of metrics and allows CAHs to compare their financial performance to peer facilities. For more information visit: http://www.flexmonitoring.org/cahmpas/.

The Flex Monitoring Team has also released primers, a presentation template and a calculator spreadsheet to support communication of the CAH financial data. The primer documents explain the measure calculations and offer insights regarding the roles each measure plays in assessing a hospital's financial health. The presentation temple is an editable PowerPoint file for CAHs to use in presenting their own CAH financial data to others. The calculator spreadsheet is an Excel file that enables CAHs to verify the Flex Monitoring Team's calculations and calculate more recent financial indicators using data on hand. For more information visit: http://www.flexmonitoring.org/publications/cahfir-resources/.

IMPROVING CAH FINANCIAL PERFORMANCE

What interventions can CAHs use to improve their financial performance?

The 2012 CAH Financial Leadership Summit identified several important financial interventions that historically have been associated with improved financial performance. They include:

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Lean process improvement training
- Financial education for CAH department managers
- Financial education for CAH boards
- Pooling Small Rural Hospital Improvement Program (SHIP) dollars
- Developing chief financial officer (CFO) networks
- Benchmarking financial indicators

A subsequent CAH Financial Leadership Summit was held in 2016 to build upon the knowledge gained from the 2012 Summit. The resulting report, *2016 Financial Leadership Summit Report: Strategies for Rural Hospitals Transitioning to Value-based Purchasing and Population Health,* is designed to help rural hospital leaders meet existing challenges by describing market forces impacting rural hospitals and providing key operational strategies that providers may deploy to overcome these challenges and be successful in alternative payment models. The report highlights success stories and lessons learned that were shared by the panelists during the summit. To view the Summit findings and recommendations, please visit: https://www.ruralcenter.org/resource-library/2016-financial-leadership-summit-report-strategies-for-rural-hospitals.

Why is a review of the cost report important?

A review of the cost report can be completed by an outside party to look for common errors in preparation. Because it drives Medicare payments, errors on the cost report directly affect the bottom line, sometimes as much as hundreds of thousands of dollars. Errors include incorrect allocations of expenses and inaccurate statistics, for example. Most cost reports are outsourced but understanding direct and indirect costs and how cost reports work is a critical input to making sound decisions for chief executive officers (CEOs), chief financial officers (CFOs) and board members.

What is a chargemaster and how often should it be reviewed?

The Charge Description Master (CDM) is primarily a list of services and procedures, room accommodations, supplies, drugs/biologics and/or radiopharmaceuticals that may be billed to a patient registered as an inpatient or outpatient on a claim. It is integral to the CAH's revenue cycle and provides many of the necessary data elements for compliant claims submission for reimbursement. It is recommended to have an outside source perform a comprehensive chargemaster and revenue cycle review annually. Ongoing education is also crucial to having business office staff remain current with information necessary to appropriately bill for services rendered. Code changes and description changes must be communicated to the departments who will be generating the charges and may need to be altered or added to the system. Similarly, charge tickets may need to be updated. Billing and coding workshops are available in many locations throughout the country.

What are strategic, financial and operational assessments?

Strategic, financial and operational assessments provide a broad-based analysis of hospital performance and help identify specific opportunities for CAH improvement. These studies provide an objective review of the areas where many CAHs need help, including:

- Matching services to community needs
- Staffing to benchmarks
- Clinic management
- Medical staff planning
- Organizational culture

Assessments are recommended periodically to determine areas of focus for follow-up improvement work.

What is revenue cycle management?

Revenue cycle management is a means to improve hospital revenue and reimbursement by streamlining workflow, processes and education throughout all financial components of the hospital. A holistic revenue cycle management includes a multi-disciplinary approach focusing on culture change with comprehensive, dramatic and permanent results. Specific areas of focus may include:

- Comprehensive chargemaster and revenue cycle review
- Business office and patient financial services review
- Development of training protocols for revenue capture
- Implementation of an effective revenue control process
- Pricing analysis
- Recovery audit contractor (RAC) preparedness and revenue cycle process improvement
- Revenue process capture audits

These assessments should result in identifying opportunities for improvement and specific, actionable recommendations.

Why are physician practice management assessments useful?

As more and more physicians align and become employees of CAHs, it is critically important to contract with physicians and operate clinics according to best practices. A practice management assessment looks at physician and mid-level provider productivity, scheduling, staffing, billing and collection

practices. These assessments should result in specific recommendations and action plans that have the potential to bring in additional revenue and improve clinic efficiency.

What is Lean and how can it impact CAH finances?

Lean focuses on increasing efficiency and eliminating waste. This creates greater value for customers and uses fewer resources. In the health care setting, Lean processes can result in substantial cost savings, fewer delays and increased patient and staff satisfaction. Lean education, Lean networks and shared Lean expertise have all been successfully used by individual CAHs and networks of rural hospitals.

Why is education on finances important for CAH department managers and board members?

Financial education for CAH department managers can enhance budgeting, planning and financial skills in department heads, whose background may be clinical rather than business or administrative. CAH Board members similarly lack basic CAH financial knowledge. Financial education for CAH Boards provides a fundamental grounding on cost-based reimbursement and CAH financial strategies. Hospital financial management is complex and rural hospital boards need a basic understanding of CAH finances to provide needed oversight. This type of education has been done successfully with rural hospitals using both on-site workshops and web-based presentations, which are often stored and accessible online.

Why is collaboration important for improving finances in CAHs?

Two minds are better than one. Collaboration allows CAH staff to share ideas, lessons learned, best practices and funds with one another. Many state Flex Programs have provided support to develop CFO networks. CFO networks have proven to be a popular method of education, peer learning and peer support. In more than a dozen states, rural hospital CFOs meet periodically, either in person or virtually, to discuss common issues, gain new skills and share experiences and techniques.

Benchmarking financial outcomes among groups of hospitals is a common means of measuring performance and comparing results. By collaboratively comparing results, CAHs identify areas of strength and weakness and measure progress toward strategic goals. This collective benchmarking also

provides an opportunity for the hospitals to share common issues, best practices and lessons learned. The University of North Carolina-Chapel Hill's distribution of annually updated financial indicator data through CAHMPAS is a useful source for benchmarking, but other information sources are also available.

Aside from the value of bringing collective minds together, using various funding sources to achieve an end goal can be strategic. Pooling SHIP dollars among a group of CAHs has provided an effective means of providing financial or Lean education to hospital staff and boards. Economies of scale, shared expertise, access to speakers and resources, peer learning and support have all been reported as benefits of pooling resources.

ADDITIONAL PERFORMANCE INDICATORS AND STRATEGIES

CAH Finance Summit

In May 2018, a group of financial experts met in Minneapolis, Minnesota at a CAH Finance Summit. This summit produced additional indicators to be monitored and strategies to be implemented to assist CAHs in achieving operational and financial success.

Market Indicators

Understanding an organization's market share is vital in developing and updating strategic and marketing plans. Ultimately, a higher market share will be desirable and necessary to allow for operational and financial success. The challenge for providers is obtaining the market share data for their organization as this is based on claims data, typically unavailable publicly and varies by region. Organizations that are looking to obtain market share data will need to explore available sources in their market area. This may include proprietary sources, state hospital associations, state governmental agencies and marketing firms that specialize in the health care industry.

The level of detail available in market share data will drive the amount of analysis to be performed and the nature of the strategies that may be developed. In addition to understanding the overall market share, the ability to understand the nature of services, demographics and unique patients associated with outmigration can assist the organization in developing network, service and/or demographic marketing strategies. Organizations

may find it necessary to employ a skilled health care data analyst or share the employment of a health care data analyst with other CAHs.

Over time, understanding potential patient attribution under a population health reimbursement model is crucial to be the dominate provider of primary health care services. This can be a difficult indicator to obtain for an entity that is not currently in or exploring to be in a population health model. However, for those in a population health model, this information can be a good indicator of the level of primary care being provided as well as brand loyalty for patients in a specific financial class.

Financial Performance and Conditions (liquidity)

The summit identified the Current Ratio as an additional important indicator of liquidity.

Current Ratio measures the number of times short-term obligations can be paid using short-term assets.

How values are calculated:

- Current Assets: [Row D]
- Current Liabilities: [Row J]
- Current Ratio: [Row D] ÷ [Row J]

Example data:

	2015	2016	2017
Current Assets	2,121,000	2,332,000	2,859,000
Current Liabilities	889,000	833,000	803,000
Current Ratio	**2.39**	**2.80**	**3.56**

This ratio measures the amount of current assets that are available to pay off current liabilities. Lower values signify a riskier situation and indicate that a hospital may have a harder time sustaining payment on current liabilities in the future. Favorable values are **above** the median and the 2016 CAH US Median = **2.48**.

CAHs that are looking to maximize their financial performance must ensure they are leveraging the reimbursement and other advantages that are available to rural providers. This includes working with their cost report preparer to ensure the organization has elected the cost reporting strategies that are most beneficial to the organization. They should also work with its licensure and reimbursement specialists to ensure that they are utilizing the most beneficial licensure status for the individual services being offered. This

includes the review of overhead allocation methodologies and the utilization of rural health clinic, provider- based clinic, visit nurse and other reimbursement/licensure opportunities.

High performing providers are also implementing revenue cycle committees to identify and address opportunities to improve the overall reimbursement for services being rendered. This includes the development of standardized processes, charge capture teams and denial management programs as well as assigning and holding individuals accountable for their roles in the revenue cycle process. This includes holding patient care staff accountable in addition to the traditional assignment of business office and health information management accountability.

The ability to obtain timely reports from a management reporting system is crucial in being able to identify potential areas of concern early in the process. The availability of adequate management reporting is a product of system capabilities and the skill set of those responsible for managing the systems.

The provision of education to department heads as it relates to organizational finances and reimbursement is important in all CAHs. Many CAH leaders struggle with organization finances due the lack of education they have been provided in both their formal education as well as education provided in the provider setting. Health care finances are complicated and a failure to understand the financial ramifications of decisions can lead individuals to make decisions without the proper information. Sources for financial education to department heads can be the internal finance department, state hospital associations and trustee seminars.

Operational Efficiency

Improving the efficiency and effectiveness of resource utilization is key in improving the operational and financial performance of the organization. The use of Lean process improvement and other improvement methodologies, as well as benchmarking, can provide for improvement in processes and total resource consumption. The use of Lean concepts is utilized by some CAHs, but many others could benefit from its use.

The use of staffing and other cost benchmarks is a challenge for most CAHs. This is usually due to the lack of access to the desired information for comparison purposes. This is not data that is publicly reported or otherwise available. Therefore, CAHs typically need to look to external proprietary

products and/or utilize internally developed benchmarks based on past performance. However, some states have gathered groups of providers to share their staffing and cost information to develop averages and benchmarks. This can be coordinated through a State Office of Rural Health, State Hospital Association or another similar group.

Once benchmarking data is available, the organization must create a methodology to gather and report this information to organizational leadership on a timely basis. This reporting may be performed utilizing current systems or may require the use of business intelligence software and reporting systems. While once cost prohibitive, the cost of business intelligence software to gather and generate desired reports has become affordable for even the smallest of organizations.

The cost of and scarcity of some professional services and acceptance of remote technologies has led to the increased utilization of telemedicine services. These services can allow a CAH to provide much needed services in the rural setting at a much more affordable cost. In addition, more payors are allowing payment for these services. Currently, one of the biggest hurdles for providing telemedicine services is the low-level reimbursement for the service. In 2018, Medicare provides $25.76 in reimbursement for the originating site. This includes the CAH and rural health clinic. Many organizations are advocating for higher reimbursement for these services at the state and federal level.

Workforce

The adequacy and education of the rural workforce of a CAH has been a challenge for years. It is becoming more difficult due to the continued reported shortages of health care providers and the increased complexity of the health care environment.

While health care workforce adequacy is a national issue and one that will most likely not be solved for some time, CAHs need to develop strategies at the local level to address the challenges today. This includes understanding the local workforce, educating and identifying potential future employees, and understanding staff satisfaction. Organizations may need to work with national, state and local government entities to obtain information regarding the make-up of health care professionals at the national, state and local areas. This may include current data as well projected data to assist in identifying current and future shortage areas. This workforce data can be

used to develop local education programs to educate individuals in middle school and high school on the background and availability of future employment positions in information technology, clinical services, emergency department, emergency medical services, community paramedic, etc. Many schools provide health career courses in high school to introduce opportunities and to provide for job shadowing. The ability to generate interest by local students can help in the recruitment process as the organization provides encouragement and, potentially, financial support during their obtaining of the necessary education and licensure. Workforce analysis may also involve developing strategies to support unpaid family care-givers that are vital to the health care system.

Once staff have been employed, the next challenge is retaining them. Encouraging staff engagement and the provision of staff satisfaction tools can assist organizations to identify the overall health of their workforce pool and also areas of risk that must be addressed to improve overall satisfaction and performance.

Education of the workforce, boards, community members, other stakeholders and legislators on the transition from volume to value is also important. This transition from volume to value is a foreign concept to many as it is no longer business as usual. The transition will require many individuals to rethink past strategies as they work to create new strategies to manage and succeed in this transition. Organizations will struggle if some leaders are developing strategies based on volume while others are pursuing strategies based on value without understanding the process of transition that is occurring.

Care Management

Understanding care management can be key in maintaining and/or increasing market share and part of understanding the transition from volume to value. The first step in implementing successful care management programs is to understand the transition from volume to value. As organizations continue to move forward in the transition, the importance of care management will increase. This is due to the fact that the reimbursement under a value methodology will focus more on earlier interventions and less on the provision of high dollar back end services.

The transition to value-based strategies will result in some providers obtaining Patient Centered Medical Home (PCMH) certification and/or to join

accountable care organizations. Both models will encourage a focus on care management. Medicare and many other payors have developed payment methodologies for these services. This includes annual wellness visits, chronic care management and transitional care management. Annual wellness visits are covered by Medicare and provide for an annual visit to address and plan for a patient's health care for the next year. This includes the provision of other preventive, screening and educational services designed to address, prevent and/or to provide early detection of potential issues that can decrease the quality of life for the patient and drive up the overall cost of health care. Many of these services are provided at little or no cost to the beneficiary.

Chronic Care Management services are covered by Medicare and many other providers. Among the requirements for coverage are the existence of 2 or more chronic conditions. Unaddressed, these chronic conditions can lead to a decrease in the quality of life for the patient and higher long-term costs. Chronic Care Management allows for coverage and payment for monthly follow-up with the patient without a face-to-face visit to discuss adherence to care plans, upcoming appointments, challenges in affording necessary medications, etc. In addition to the potential improvement in health outcomes, these visits are often very popular with the patients as they appreciate the ongoing connection with their care providers.

Transitional Care Management is the management of a patient for the 30 days after discharge from an inpatient stay. Medicare and many other providers provide coverage and payment for this service. The focus of this service it to assist the patient with the transition from the inpatient setting to the home without a readmission to the hospital. This includes making sure all discharge orders are understood and being followed. Some organizations have seen a significant reduction in readmissions once a Transitional Care Management program has been implemented.

The implementation of these programs requires the development of care plans for patients and follow-up by the provider and patient. The ongoing communication between the provider and the patient can often be the encouragement to engage the patient. The success with improved patients' lives can be the encouragement providers need to engage in these programs. Full implementation of care management services can be a differentiator in the market as they have the potential to increase patient and provider engagement and improve overall satisfaction by the patient. In

addition, these services can increase other ancillary services that are often provided by the rural provider while decreasing the higher cost services that may have to be provided in larger organizations and with greater cost. In time, this can help lead to increased market share.

Quality Performance

Monitoring reported quality performance is increasing over time as the information is becoming more readily available to the public. Medicare's Hospital Compare is one example of publicly available data that patients and families are using to make comparisons and choices about health care. Information on individual hospitals can be found at: https://www.medicare.gov/hospitalcompare/search.html. Information on physicians can be found at: https://www.medicare.gov/physiciancompare/. While there are ongoing questions as to the validity of the data and potential challenges of reporting results for providers with smaller volumes, this information is being used by current and potential patients and must be monitored. Over time, it is anticipated that more quality data will be made available to the public. CAHs should develop a process for the long-term monitoring of these programs and strategies for improving any areas of concern that are noted in the reporting.

Increasingly, organizations are transitioning current compensation models with physicians towards a model that provides financial rewards for quality activities and performance with less focus on overall production. The transition is a balancing act as there is still a need for productivity but must include reportable quality results. The transition may take time, but it is expected that the portion of compensation for quality activities and performance will continue to increase. At the same time, organizations will be developing internal strategies to track the activities and performance.

Community Health

The ability to measure the health of a community is crucial in determining the overall success of health care providers efforts. This can be a challenge as much of the information on the factors of success are not being measured. The ability to track social determinants of health and county health rankings are key. Health care providers must strive to identify and measure social determinants of health. This can include:

- Availability of affordable housing and food

- Access to transportation
- Access to health care and community-based resources
- Accessibility and quality of education and job training
- Literacy rates
- Public safety

While facilities may not be able to track data for each determinant, organizations should start with the data that is available and continue to work with external organizations to develop strategies for capturing the necessary data to monitor these statistics. In addition, organizations should be working with their state and county to ensure adequate data and reporting exist on county health. Facilities can monitor trends and their rankings to help determine the level of success for the program as well as areas of opportunity for improvement.

Since the cost of care is an integral part of compensation under the value methodology, providers also need to address Hierarchical Condition Category (HCC) reporting. HCC reporting is based on ICD-10 coding and provides for a methodology to assess the level of medical risk for a patient. The resulting HCC risk score is utilized to determine the expected cost of a patient and to compare the difference in costs between providers for a normalized population. CAHs are at higher risk of under reporting their HCC risk since much of their reimbursement has not been reimbursed based on the completeness of coding since entering the CAH program. Strategies for increasing the accuracy of HCC reporting include initial assessment of coding as well as the development of strategies to improve provider documentation and health information management coding based on the results of the assessment.

For many years, the trend in physician contracts has been to increase the amount of compensation that is based on production. Frequently, these contracts have been successful in increasing the productivity of the physicians. However, under population health concepts there needs to be a balance between production and population health activities that may not be reflective of volumes. This has led to a transition in contracting models to reduce the emphasis on production with an increase in population health and other quality initiatives. While it may be difficult to obtain statistics regarding contract structure for all providers in their community, facilities can gather and track internal information to determine the percentage of contract with

their primary care providers that include incentives for population health activities.

The reported costs of health care typically only include the direct costs associated with the services. This would include insurance premiums, copays, coinsurance, deductibles, medications, etc. However, it rarely tracks the full cost. This would include time, travel, lost wages, etc. Understanding the full cost of care to the patient is critical in managing costs as well as promoting access to care in the long run. Health care providers should be working with local and state resources to develop strategies to capture and monitor these costs over time.

Overarching Strategies

To be successful, providers need to understand their data. For some this will require organizations to develop new strategies to create or obtain the necessary data for analysis. Once the data is obtained, it needs to be converted into quality information that can be used to create actionable strategies. As previously noted, this will require some organizations to add health care data analysts. Once actionable strategies have been identified, responsibility and accountability will need to be assigned in the organization.

Many of the challenges in rural health care are caused by inadequate or inappropriate rural policies established by Congress, CMS and state agencies. There is an ongoing need for advocacy for the establishment of rural health care policies that take into account the unique situations in the rural setting. This advocacy should come from more than just the rural providers, but should include rural patients, business leaders and other stakeholders. Congressional and other state and local leaders need to hear from their constituents regarding the need for workable rural health care policies. Successful discussions will include proposed solutions in addition to the addressing of current problems and challenges with current policies.

HOW ARE SMALL RURAL PPS HOSPITALS REIMBURSED?

Small rural PPS hospitals have many of the same major issues and concerns with a few very specific differences. While they are typically in areas with a larger population base, they are not reimbursed based on cost from Medicare and may be in closer proximity to competitors.

PPS FINANCES

What are the most important financial indicators?

In general, the most important financial indicators for the small rural PPS hospital are the same as those that are important for CAHs. The biggest differences are the strategies employed to impact the indicators and improve performance. While there are CAH US Median's available for these indicators, there is not a central resource for this information for small rural PPS providers. The calculations for these indicators remain the same as previously indicated.

Days in Net Accounts Receivable

The same common issues as found in CAHs will result in poor reported performance in the PPS provider. This includes out of date chargemasters, poor registration processes and bad communication. Lower levels that are stable or declining are favorable.

Days in Gross Accounts Receivable

Low numbers in this category can be an indicator of a highly functioning business office. Again, lower levels that are stable or declining are favorable.

Days Cash on Hand

As a safety net calculation, this indicator is used by lending organizations as a reflection of the amount of dollars that are readily available to meet short term expectations. As such, higher levels or levels that are trending upward are favorable.

Total Margin

The indicator performance in a given year, as well as the trend over time, is important to track as a measure of overall profitability. Ongoing poor performance in this area can have significant impact on other indicators and eventually lead to closure. Higher levels or levels that are trending upward are favorable.

Operating Margin

As a measure of operating expenses in comparison to operating revenues, this indicator of how well an organization is operating in its core business

area. As is the case in Total Margin, higher levels or levels that are increasing over time are favorable.

Debt Service Coverage Ratio

As previously noted, this ratio measures the ability of an organization to pay obligations related to long-term debt. A favorable value is one that is above the median and/or is trending upward.

Salaries to Net Patient Revenue

Just like in a CAH, the major expense in a PPS hospital is related to salaries. Profitability of the organization can often be impacted by overstaffing. A lower value and/or one that is declining is favorable.

Payor Mix Percentage

While Medicare does reimburse PPS hospitals under a different reimbursement methodology, the importance of this indicator remains. This is due to the fact that the profitability of Medicare revenue is still usually the lowest amongst payers in the PPS setting. The ability to generate higher long-term profitability is dependent on a higher percentage of non-Medicare payers. A lower and/or declining value for this indicator is favorable.

Average Age of Plant

As is the case in the CAH, the successful PPS hospital needs to continue its reinvestment in buildings and equipment to attract and retain physicians and staff as well as to keep up with the needs of the patient. Favorable values in this indicator are lower.

Long Term Debt to Capitalization

As a measure that indicates the amount of capital that is financed with debt, higher numbers will be an indication of higher risk for lenders. A lower number is an indication of less risk of sustaining debt payments and may improve the ability for an organization to acquire additional debt.

IMPROVING PPS FINANCIAL PERFORMANCE

What interventions can PPSs use to improve their financial performance?

Many of the same interventions that are effective for the CAH to improve their financial performance can be effective in improving the performance for the PPS hospital. However, the specifics for each intervention may be different. They include:

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Lean process improvement training
- Financial education for PPS department managers
- Financial education for PPS boards
- Pooling Small Rural Hospital Improvement Program (SHIP) dollars
- Developing chief financial officer (CFO) networks
- Benchmarking financial indicators

Unless otherwise indicated below, the interventions in these areas are essentially similar to those in the PPS.

Why is a review of the cost report important?

While the PPS hospital is not reimbursed based on cost for the majority of its services, there are some areas where Medicare may reimburse for some costs through the cost report. The cost associated with Medicare bad debt can be a major area of opportunity during the review of the Medicare Cost Report. Reportable Medicare bad debt occurs when the Medicare beneficiary fails to pay the hospital for the applicable deductible and coinsurance that is applied on inpatient, swing bed, nursing home, distinct part unit and rural health clinic services. In addition, the bad debt related to outpatient services reimbursed under the outpatient perspective payment system are eligible. To be eligible, the facility must be able to demonstrate the amounts were uncollectible after following the normal collection processes for the organization. Unfortunately, many providers fail to properly capture all of this reimbursement opportunity. Other items related to the wage index, rural

health clinics and disproportionate share may be identified during such a review.

Revenue Cycle Management for the PPS Hospital

The focus of revenue cycle management in the PPS hospital is essentially the same as in a CAH. However, the importance of development of training protocols for revenue capture and revenue process capture audits is usually higher for the PPS hospital. Unlike the CAH, Medicare reimburses the PPS hospital based on revenue capture and coding versus cost, as identified in the Medicare Cost Report. Failure to properly capture and code services in the PPS hospital will impact reimbursement from both non-Medicare payors and Medicare.

Physician Practice Management Assessments

The potential benefits of physician practice management assessments may be greater in a PPS hospital than in the CAH. In a PPS hospital, one would expect to see a lower number of rural health clinics (RHC) in relation to provider based or free-standing clinics. In addition, for those PPS hospitals with more than 50 beds, the provider based RHC would be limited to the cost per visit limit. Due to these differences, a larger portion of any cost savings due to improved efficiencies and/or cost reductions, etc., will have a greater potential of improving the financial performance of the PPS organization.

How can Lean impact PPS finances?

Whereas a portion of any cost savings identified in the CAH are shared with Medicare, cost savings identified in the PPS hospital frequently allow for a 100% impact to the operating and total margin. This is due to the nature of the PPS reimbursement methodology. For this reason, the PPS hospital may be able to use Lean to find smaller cost savings that have a larger net financial impact than would be available under the CAH methodology.

Education on finances for PPS department managers and Board members?

PPS department managers can also enhance their budgeting, planning and financial skills with the proper financial education. PPS Board members will also usually benefit. Unlike the financial education provided to CAH leaders,

the education to PPS leaders should focus on prospective payment methodologies and strategies.

THE PROVIDER BASED RHC IN THE CAH OR PPS HOSPITAL SETTING

The challenges facing provider-based clinics that are part of a CAH or PPS hospital are unique to their licensure status. The nature of the enhanced reimbursement from Medicare and Medicaid, completion of a Medicare Cost Report, potential payment caps and application of productivity standards can provide for opportunities and risks not seen in other provider types.

While the provider based RHC does file a Medicare Cost Report, this information is imbedded into its main provider's cost report and financial statements. Therefore, financial indicators relating to just the RHC are not available for the RHC in the same manner as the CAH. However, that does not preclude the RHC from monitoring specific indicators and initiating interventions to improve financial performance.

The importance and impact of RHCs on hospital finances has continued to grow. Historically, the RHC program has provided for a methodology for RHCs in certain areas with Health Professional Shortage Area (HPSA) designation to receive cost-based reimbursement for professional services. This cost-based reimbursement methodology provides for a significant improvement in reimbursement by Medicare for these professional services. While this has been a popular reimbursement model since its inception in 1977, it has become more popular in recent years due to the growth in the number of rural hospitals employing physicians and the size of the clinics has grown.

Currently, approximately 20% of national health care expenditures occur in the clinic setting. However, this is expected to continue to grow as health care continues its movement from the inpatient hospital setting to the outpatient hospital setting as well as the move from the outpatient hospital to the clinic setting. Advances in technology, introduction of population health reimbursement methodologies and expansion of reimbursement for care coordination services is expected to be a driver in continued growth for clinic-based services. The RHC reimbursement methodology allows the hospital-based clinic to provide these services in a manner that still provides for the enhanced reimbursement levels typically required in the rural setting.

Without this reimbursement methodology, many providers would find it financially impossible to provide clinic-based services.

RHC FINANCES

What are the important RHC financial indicators?

As was previously noted, the Medicare Cost Report and financial statements do not provide for the same type of financial indicators as are available for the CAH. However, some indicators do exist that can be beneficial to RHC leadership.

Days in Accounts Receivable (Gross and Net)

While most of the financial indicators identified for CAHs and PPS cannot be calculated separately for the RHC, the gross and net days in accounts receivable is typically an indicator that can be separately calculated for the RHC. As such, this is a good indicator for monitoring the health of the revenue cycle in the RHC. Higher days in accounts receivable can be an indication of chargemaster, coding, charge capture and communication issues. A lower value is favorable.

Cost per Visit

The Medicare Cost Report calculates an average cost per visit for services in the RHC. In 2014, this average cost was $176. While a higher cost per visit does provide for a higher level of reimbursement from Medicare and potentially Medicaid, it does make services rendered to non-Medicare patients less profitable. A lower cost per visit is favorable over the long run as it allows the facility to improve its financial performance for services rendered to non-Medicare payers.

Medicare Payer Mix

As is the case in the CAH and PPS hospital, a lower Medicare payer mix over time can assist the organization in improving financial performance. However, increasing the non-Medicare payer mix should not come from decreasing Medicare volumes, but rather from increasing the non-Medicare volume. At the same time, the organization needs to be managing its average cost per visit to allow for profitability from the services rendered to the non-Medicare patient.

Visits per Physician/Nurse Practitioner/Physician Assistant

The number of visits by provider is important for two reasons. First, is the application of productivity standard by Medicare on the Medicare Cost Report? If the providers as a whole are producing at a level below this standard, Medicare will calculate the cost per visit with the calculated standard number of visits. This has the effect of reducing the calculated cost per visit and subsequent payment to the RHC. Second, a higher number of visits is an indicator of greater productivity and should reduce the calculated cost per visit over time. A lower cost per visit allows the RHC to improve its profitability with non-Medicare payors. A higher number of visits per provider is a favorable indicator.

Percentage of Nurse Practitioner/Physician Assistant FTEs to Total Provider FTEs

RHCs are required to have a minimum amount of coverage by a nurse practitioner or physician assistant. However, the percentage of the total provider FTEs that are nurse practitioners and/or physician assistants varies significantly. Some RHCs will just staff the minimum requirement of nurse practitioner or physician assistant while others will rely much heavier on these non-physician practitioners. The potential benefits of utilizing a higher percentage of these practitioners is the lower cost associated with these professionals as well as the lower productivity standard that is applied to each non-physician practitioner. A higher percentage of these non-physician practitioners is favorable as it can be an indicator of the ability to control cost and manage the productivity standards that can ultimately impact Medicare reimbursement.

Staffing Cost per Provider FTE

Compensation for practitioners can vary significantly between RHCs. While there may be significant variations by region, large variations can also exist between neighboring RHCs. For this reason, in addition to being able to manage the mix of overall practitioners in the RHC, the RHC needs to be able to manage the cost of each FTE. Facilities can calculate per FTE staffing costs for physicians, nurse practitioners and physician assistants. A lower staffing cost per provider FTE is favorable as it may be an indication of RHCs ability to control the cost per visit and improve the profitability of non-Medicare and non-Medicaid volumes.

Average Charge per Billable Visit

While managing the number of visits is important, the average charge per visit is equally important. While Medicare and Medicaid reimburse based on a cost per visit methodology, 20% of the reimbursement from Medicare is based on the charge submitted. In addition, this indicator may provide insight into the adequacy of pricing for other payers as well as the appropriateness of the coding and documentation processes. A higher average charge per billable visit may indicate that the provider has appropriately priced the services being rendered and/or that the RHC and its staff are appropriately documenting, coding and capturing all reportable services. A lower average charge per billable visit may be an indication that pricing is below average for the services rendered, that there is opportunity to improve documentation, coding and charge capture or that the RHC is seeing less complex patients. A higher average charge per billable visit is typically favorable.

IMPROVING RHC FINANCIAL PERFORMANCE

What interventions can RHCs use to improve their financial performance?

Many of the same interventions that are effective for the CAH and PPS hospital to improve their financial performance can be effective in improving the performance for the RHC. However, the specifics for each intervention may be different. They include:

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Lean process improvement training
- Developing chief financial officer (CFO) networks
- Benchmarking operational indicators

Unless otherwise indicated below, the interventions in these areas are essentially similar to those in the PPS.

Why is a review of the cost report important?

For the RHC, a cost report review can identify opportunities for the RHC to develop strategies to improve financial performance. Average RHC visits by discipline, limitations of reimbursement due to the application of productivity standards, the impact of lower charges on coinsurance reimbursement, payer mix, cost per visit, etc., are examples of information the RHC may be able to pull from their Medicare Cost Report. The information identified in these areas may lead the provider to consider additional work in the area of operational assessment, revenue cycle management, physician practice management assessment and lean process development.

The Chargemaster in the RHC

The CDM in the RHC is most times less complex than that of the CAH or PPS hospital. However, that does not diminish the importance of ongoing monitoring and maintenance of the chargemaster. The main focus for ongoing monitoring is to ensure annual updates to CPT codes are implemented, new CPT codes related to new physicians in different specialties are added and that pricing is properly established. Any changes that are implemented should include an update to the forms used by the clinic providers to complete the procedures and diagnosis for process payment.

Revenue Cycle Management

In the RHC, the focus of revenue cycle management involves coding assessments, training for revenue capture, revenue process charge capture audits and review of upfront collection efforts. Failure to properly capture and code services in the RHC can significantly impact reimbursement from non-Medicare payors.

Physician Practice Management Assessments

The potential benefits of physician practice management assessments in the RCH cannot be overstated. In the RHC these assessments can include reviews of physician contracts, development of compensation strategies, review of scheduling protocols, process flow assessments and staffing reviews. These assessments can result in increased efficiencies, decreased costs and/or improved patient access.

How can Lean impact RHC finances?

When included as part of the physician practice management assessment, Lean can help improve process flows while also reducing costs. For those RHCs that are subject to the cost per visit limits and are over these limits, any savings in cost over the limits will be reflected in the operating margin and total margin. For those RHCs already below the limits, a large portion of the savings will usually still end up as improvements in the operating margin and total margin.

APPENDIX

Example - Balance Sheet

[Row]		2015	2016	2017
	ASSETS			
	Current Assets:			
A	Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
B	Patient Accounts Receivable, Gross	1,001,000	1,012,000	993,000
C	Less: Provision for Doubtful Accounts	-230,000	-210,000	-215,000
	Other Accounts Receivable	-	24,000	24,000
	Supplies	162,000	169,000	169,000
	Other Current Assets	68,000	57,000	57,000
D	Total Current Assets	2,121,000	2,332,000	2,859,000
	Property, Plant & Equipment:	2,663,000	2,612,000	2,712,000
E	Less: Accumulated Depreciation	-1,874,000	-1,755,000	-1,896,000
	Net Fixed Assets	789,000	857,000	816,000
F	TOTAL ASSETS	2,910,000	3,189,000	3,675,000
	LIABILITIES & NET ASSETS			
	Current Liabilities:			
G	Current Portion of Long Term Debt	144,000	89,000	49,000
H	Accounts Payable & Accrued Liabilities	115,000	148,000	158,000
	Estimated Amounts Due to Third Party	260,000	226,000	226,000
I	Other Current Liabilities	370,000	370,000	370,000
J	Total Current Liabilities	889,000	833,000	803,000
K	Long Term Debt, Net of Current Portion	186,000	183,000	178,000
L	TOTAL LIABILITIES	1,075,000	1,016,000	981,000
	NET ASSETS			
M	Accumulated Earnings (Deficit)	1,835,000	2,173,000	2,694,000
	TOTAL LIABILITIES & NET ASSETS	2,910,000	3,189,000	3,675,000

Example - Statement of Operations

[Row]		2015	2016	2017
	REVENUE			
N	Total Inpatient Revenue	2,402,000	2,445,000	2,471,000
O	Total Outpatient Revenue	3,993,000	4,015,000	4,032,000
P	Total Gross Revenue	6,395,000	6,460,000	6,503,000
	Less: Contractual Allowances	-1,200,000	-1,130,000	-1,115,000
Q	Net Patient Revenue	5,195,000	5,330,000	5,388,000
	Other Operating Revenue	486,000	427,000	492,000
R	Total Operating Revenue	5,681,000	5,757,000	5,880,000
	Gain (Loss) on PP&E Disposal	-2,000	-3,000	-
	Contributions/Grants	65,000	69,000	77,000
	Investment Income	8,000	11,000	19,000
S	Total Revenue	5,752,000	5,834,000	5,976,000
	EXPENSES			
T	Salaries	2,895,000	2,908,000	2,958,000
	Benefits, Supplies & Other	2,434,000	2,497,000	2,509,000
U	Depreciation & Amortization	229,000	218,000	211,000
V	Interest	28,000	17,000	13,000
W	Provision for Doubtful Accounts/Bad Debt	102,000	107,000	126,000
X	Total Expenses	5,688,000	5,747,000	5,817,000
Y	EXCESS OF REVENUES OVER EXPENSES	64,000	87,000	159,000
	Restricted Contributions	-	-	-
Z	CHANGE IN NET ASSETS	64,000	87,000	159,000

Example - Statement of Cash Flows

[Row]		2015	2016	2017
	CASH FLOWS FROM OPERATING ACTIVITIES			
	Change in Net Assets	522,000	547,000	542,000
	Adjustments to reconcile change in net cash provided by operating activities:	246,000	459,000	-210,000
	Purchase of Other Assets	-3,000	-6,000	-
	Other Current Liabilities	34,000	-	-
	Net Cash Provided by Operating Activities	799,000	1,000,000	332,000
	CASH FLOWS FROM FINANCING ACTIVITIES			
AA	Repayment of Debt	-169,000	-145,000	-90,000
	Purchase of PP&E	-63,000	-189,000	-100,000
BB	Interest Paid on Long Term Debt	-28,000	-17,000	-10,000
	Gifts to Purchase Capital Assets	46,000	-	-
	Net Cash Used by Investing Activities	-214,000	-351,000	-200,000
	CASH FLOWS FROM INVESTING ACTIVITIES			
	Interest and Dividends on Investments	8,000	11,000	19,000
	Net Cash Used by Investing Activities	8,000	11,000	19,000
	NET INCREASE (DECREASE) IN CASH	593,000	660,000	151,000
	CASH, BEGINNING OF YEAR	527,000	1,120,000	1,178,000
	CASH, END OF YEAR	1,120,000	1,780,000	1,931,000