Board of Commissioners Meeting – Agenda
Public Hospital District No. 4, King County
Snoqualmie Valley Hospital
Thursday, May 26, 2022 – 6:30pm
Zoom Link by request
Call In: 253-215-8782 **Meeting ID**: 821 9057 9664 **Passcode**: 083106

1. **6:30pm – CALL TO ORDER**

2. **6:32pm – APPROVAL OF THE BOARD MEETING AGENDA – *(Vote)***

3. **6:35pm – BUSINESS FROM THE AUDIENCE**
   a. Public Comment (please limit comments to 3 minutes)

4. **6:40pm – CONSENT AGENDA – *(Vote)***

5. **6:45pm – COMMITTEE REPORTS –** *(Information/Discussion/Vote)*
   a. **6:45pm – 2021 Financial Audit Review – Moss Adams**
   b. **7:00pm – Finance Committee** – CFO Ritter - Commissioners Speikers/Hauglie
   c. **7:10pm – Approval of Warrants** [April, 2022] – ***(Vote)***
   d. **7:15pm – Facilities Committee** – COO Denton - Commissioners Carter/Norris
   e. **7:20pm – Medical Committee** – CMO Thompson – Commissioners Norris/Herron

6. **7:30pm – COMMUNICATIONS –** *(Information/Discussion)*
   a. **7:30pm – Kevin Hauglie, President**
   b. **7:35pm – Skip Houser, General Legal Counsel**
      1) **RCW 70.170.060 – Charity Care** – *(Information/Discussion)*
      2) **OPMA** – New Meeting Requirements beginning June 1, 2022 – *(Information/Discussion)*
      3) **King County COVID-19 Updates** – *(Information/Discussion)*
   c. **7:45pm – CEO Report – CEO Jensen** – *(Information/Discussion)*
   d. **7:55pm – Strategic Plan Dashboard – CEO Jensen** *(Information/Discussion)*
   e. **8:05pm – EPIC Status Report – CFO Ritter** – *(Information/ Discussion)*

7. **8:15pm – NEW BUSINESS –** *(Information/Discussion/Vote)*
   a. **8:15pm – CAH Annual Report –** *(Information)*
   b. **8:20pm – Collaborative – Savings and Benefits –** *(Information)*

8. **8:20pm – GOOD OF THE ORDER/COMMISSIONER COMMENT**

9. **8:25pm – EXECUTIVE SESSION –** *(Discussion)*
   Executive Session is convened to discuss the following topic, as permitted by the cited sections of the Revised Code of Washington (RCW 42.30.110)
   (i) To discuss with legal counsel representing the agency matters relating to agency enforcement actions, or to discuss with legal counsel representing the agency litigation or potential litigation to which the agency, the governing body, or a member acting in an official capacity is, or is likely to become, a party, when public knowledge regarding the discussion is likely to result in an adverse legal or financial consequence to the agency.

10. 8:35pm – ADJOURNMENT

Upcoming Meetings:

- Facilities Committee Meeting – Tuesday, June 14, 2022 @11:30am ***(updated date)***
- Finance Committee Meeting – Tuesday, June 17, 2022 @1:00pm ***(updated date)***
- Medical Committee Meeting – Tuesday, June 14, 2022 @3:00pm ***(updated date)***
- Regular Work Study Session – Thursday, June 23, 2022 @4:30pm
- Regular Board of Commissioners Meeting – Thursday, June 23, 2022 @6:30pm

Consent Agenda

Public Hospital District No. 4, King County
Snoqualmie Valley Hospital
Thursday, May 26, 2022

1. **Regular Work Study Minutes** – April 26, 2022

2. **Regular Board of Commissioner Minutes** – April 26, 2022

3. **Physician Credentialing** (April 2022)**:**

Transition from Provisional to Active:
Erika Schroeder, MD – Emergency Medicine
Peter Toth, MD – Emergency Medicine

Transition from Provisional to Telemedicine:
Elmira Basaly, MD – IM Telehospitalist
Sulakshna Dhamija, MD – FP Telehospitalist
Nikolay Kolev, MD – IM Telehospitalist
Thomas Lee, MD – IM Telehospitalist
Gavind Niamatali, MD – IM Telehospitalist

Transition from Provisional to Affiliate:
Debby Martin, ARNP – FP Hospitalist
Tammy Moore, DNP – Family Practice
Tahana Salvadalena, ARNP – Family Practice

Renewal to Telemedicine:
David Atkins, MD – Teleradiology
Ben Babusis, MD – Teleradiology
Alan Chan, MD – Teleradiology
Germaine Johnson, MD – Teradiology

4. **Authorization:** Verbal authorization from Commissioners for CEO to sign all documents electronically on their behalf which were approved during the business meetings

MOSSADAMS

Independent Auditor's Report to the Finance Committee

Mathew Stopa, Senior Manager

MOSSADAMS

Board Communications

Auditor’s Report

- Unmodified Opinion:
  - Financial statements are fairly presented in accordance with generally accepted accounting principles

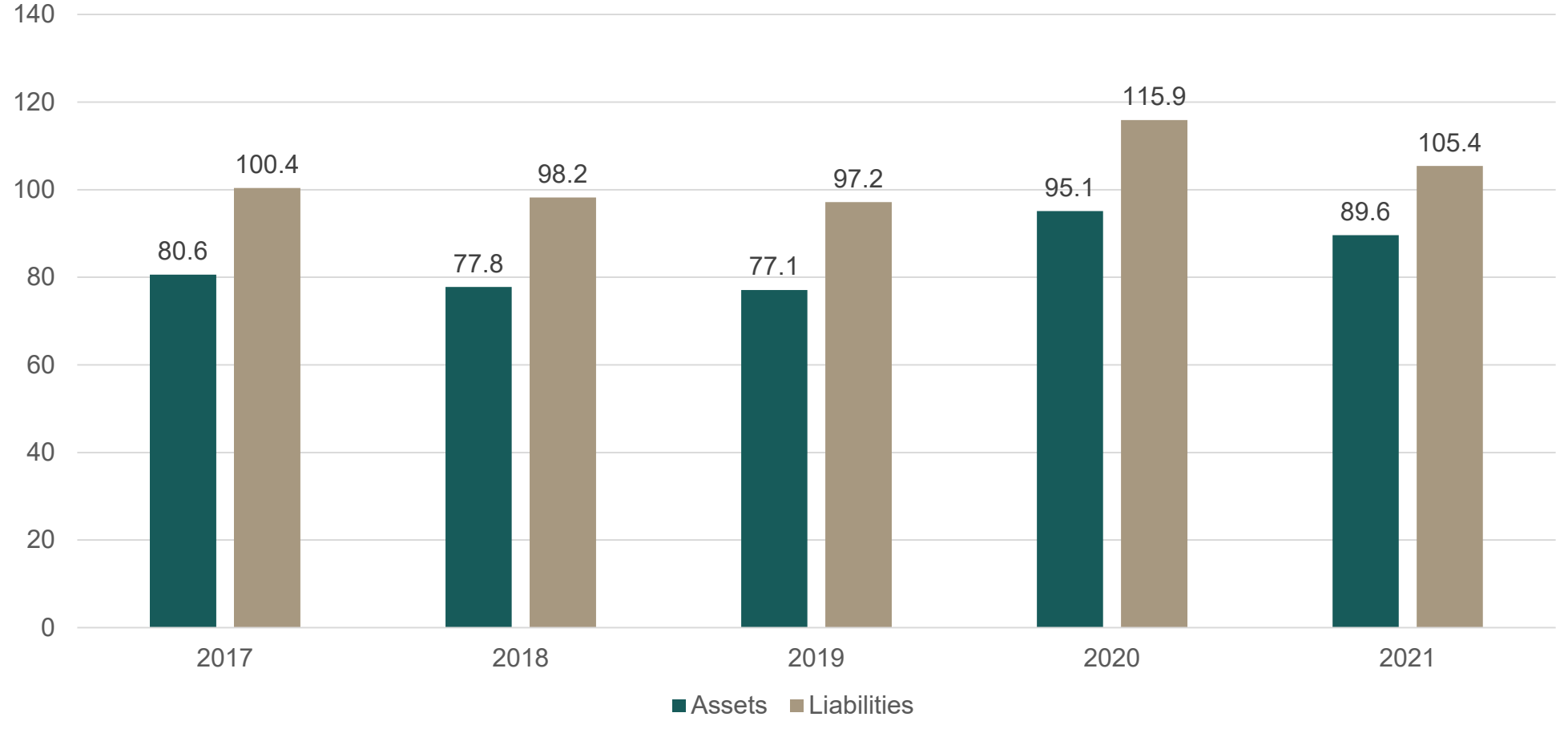
Important Board Communications

- No issues discussed prior to our retention as auditors
- No disagreements with management
- No corrected/uncorrected adjustments
- No internal control deficiencies
- Accounting estimates are reasonable

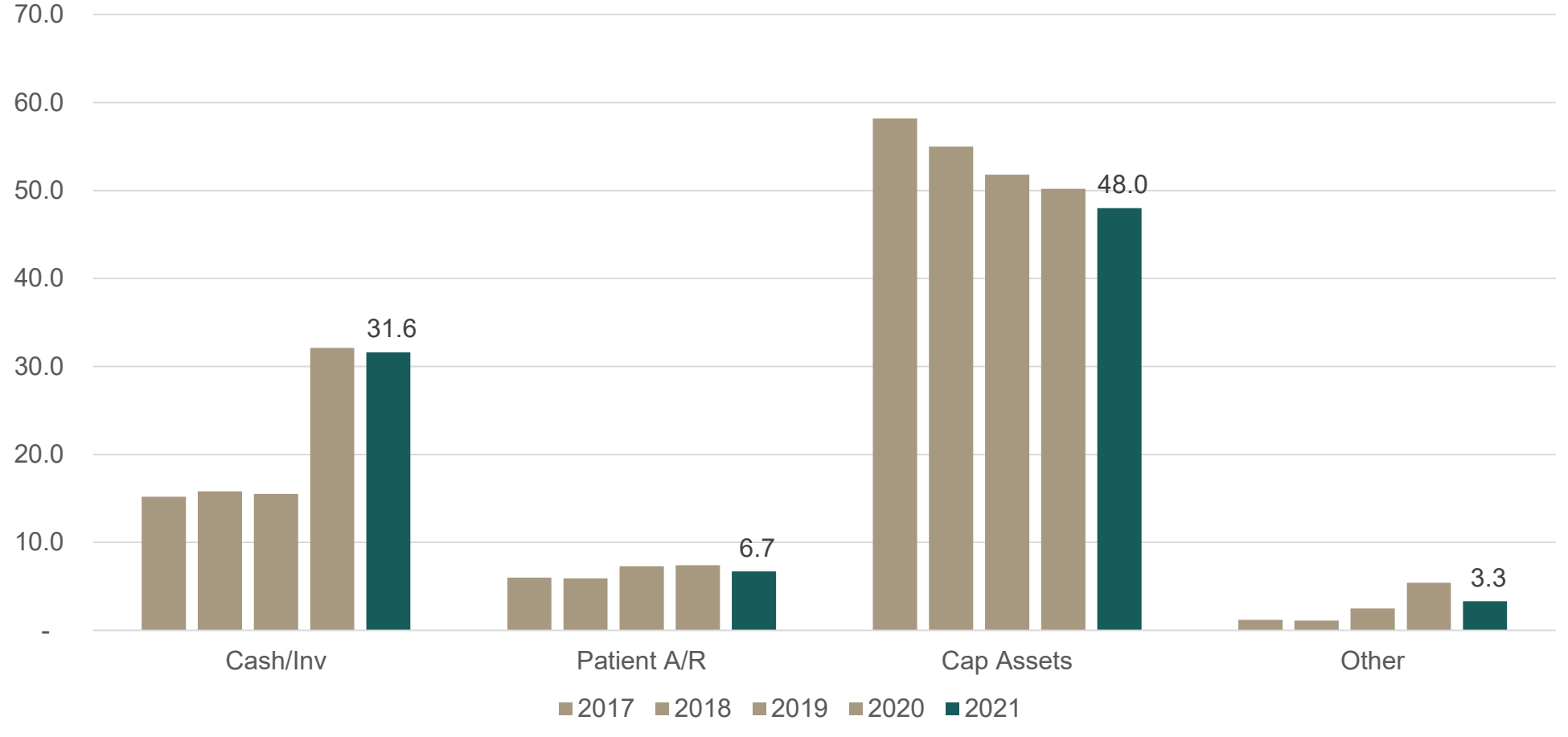
MOSSADAMS

Financial Statement Trends

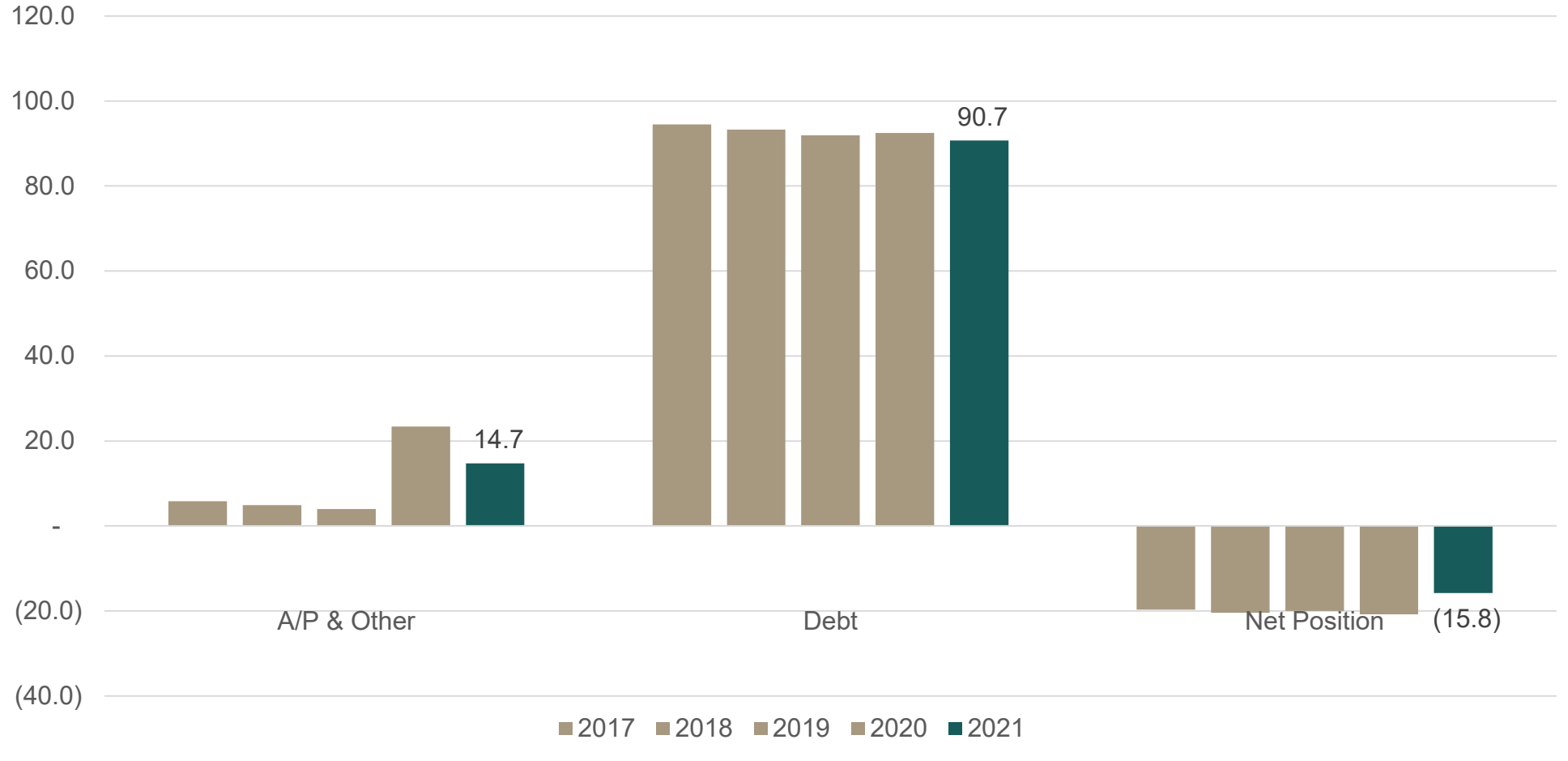
Total Assets and Deferred Outflows of Resources and Total Liabilities
(in millions)



Asset and Deferred Outflows Composition (in Millions)

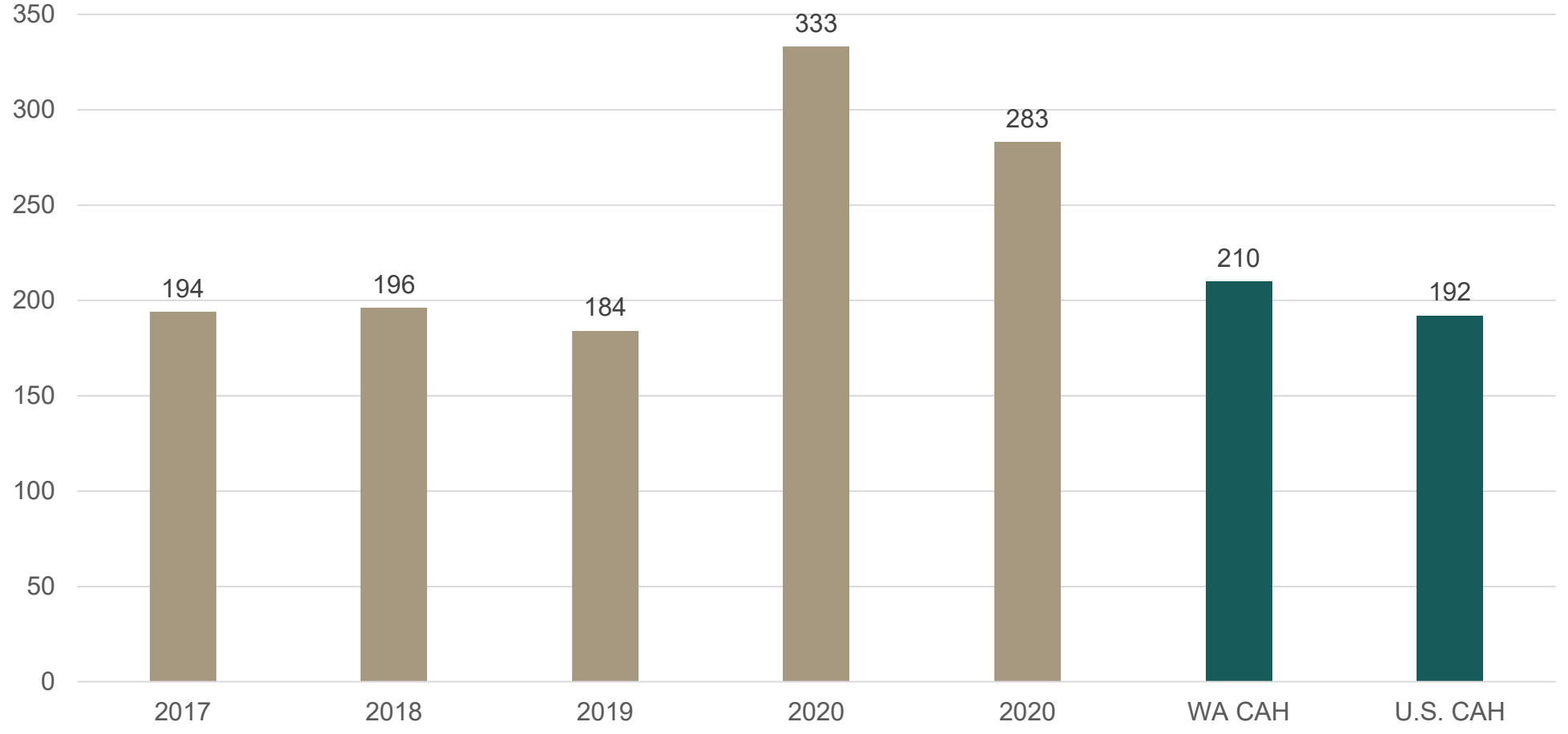


Liabilities and Net Position (in millions)



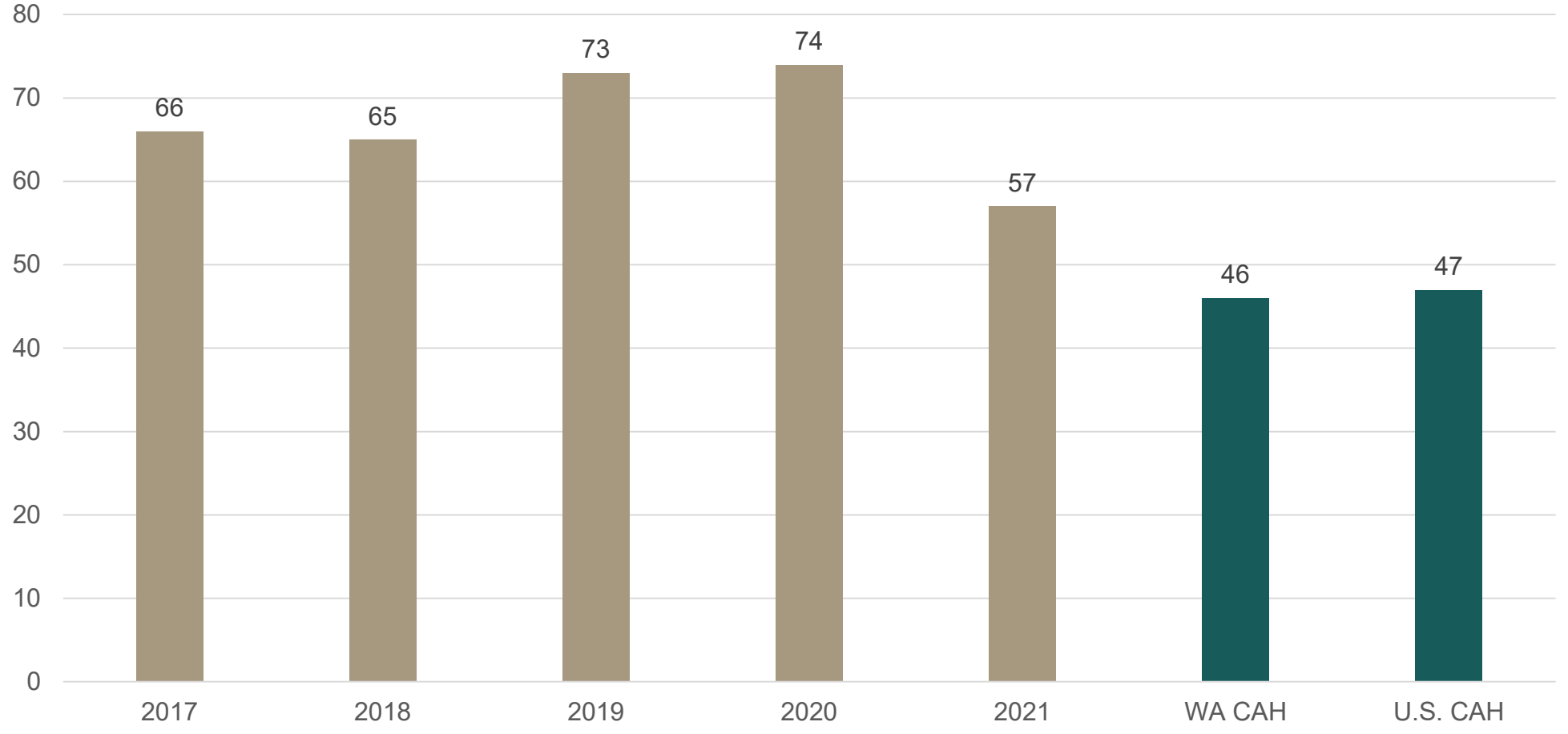
Days Cash and Investments

(with Comparisons to 2020 Critical Access Hospitals (CAH))



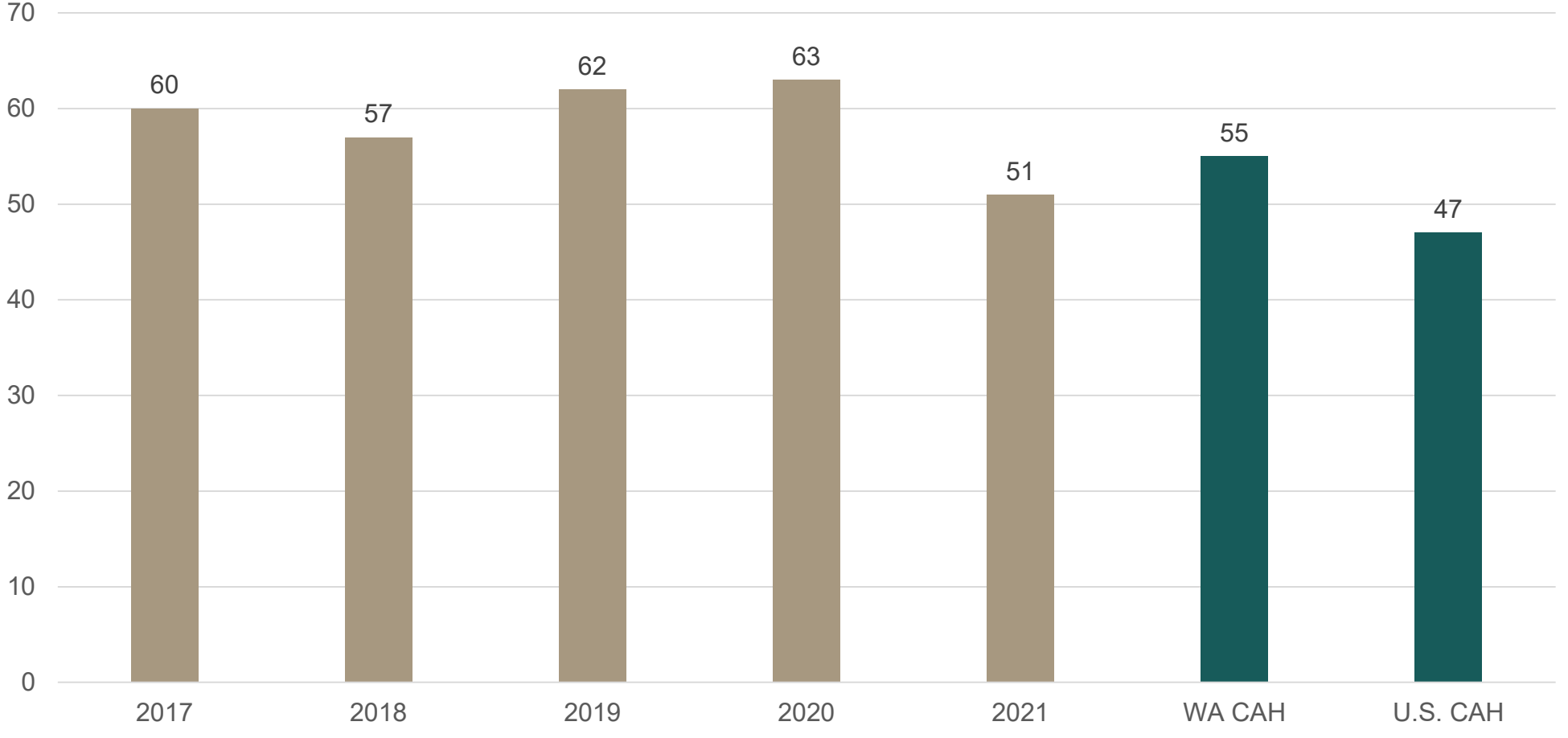
Days Net Revenue in Accounts Receivable

(with Comparisons to 2020 Critical Access Hospitals (CAH))

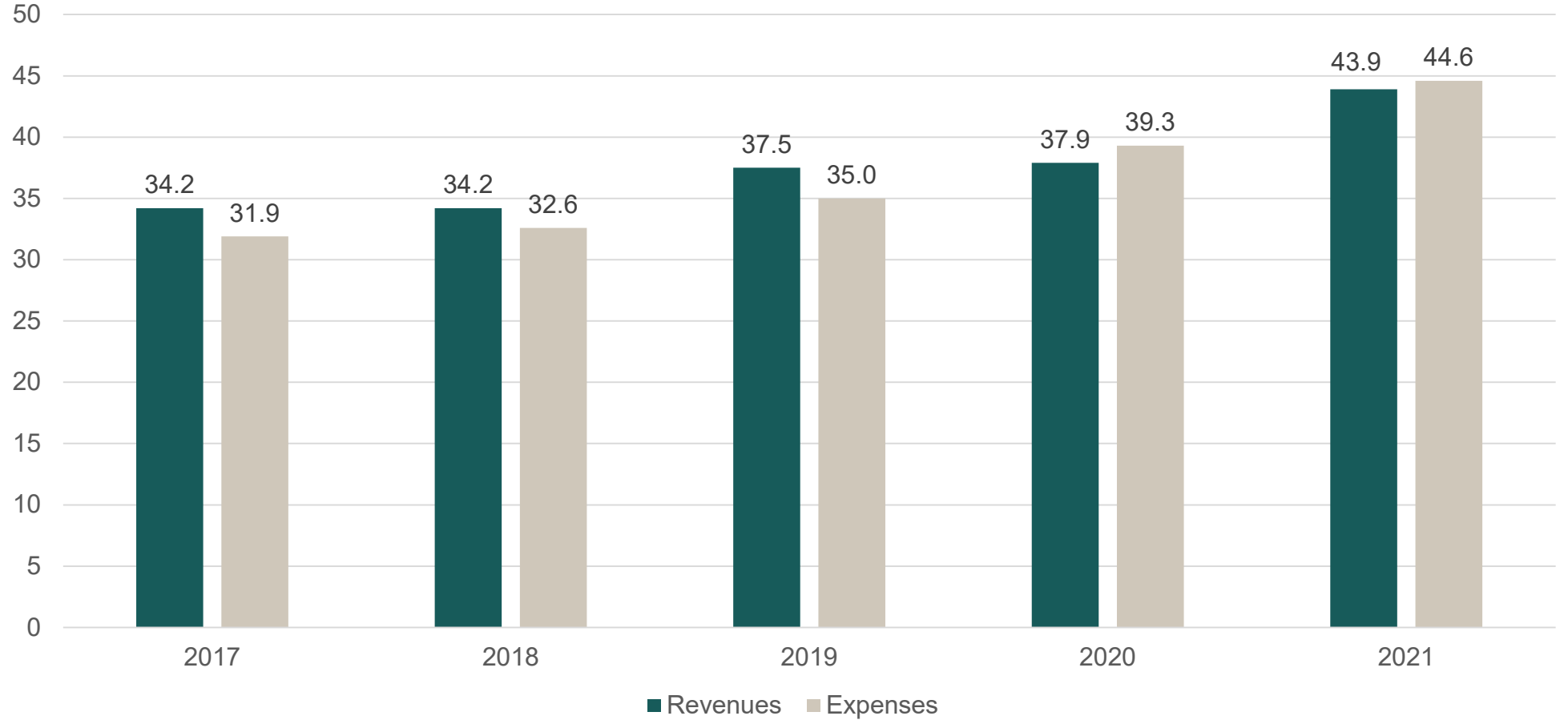


Days Gross Revenue in Accounts Receivable

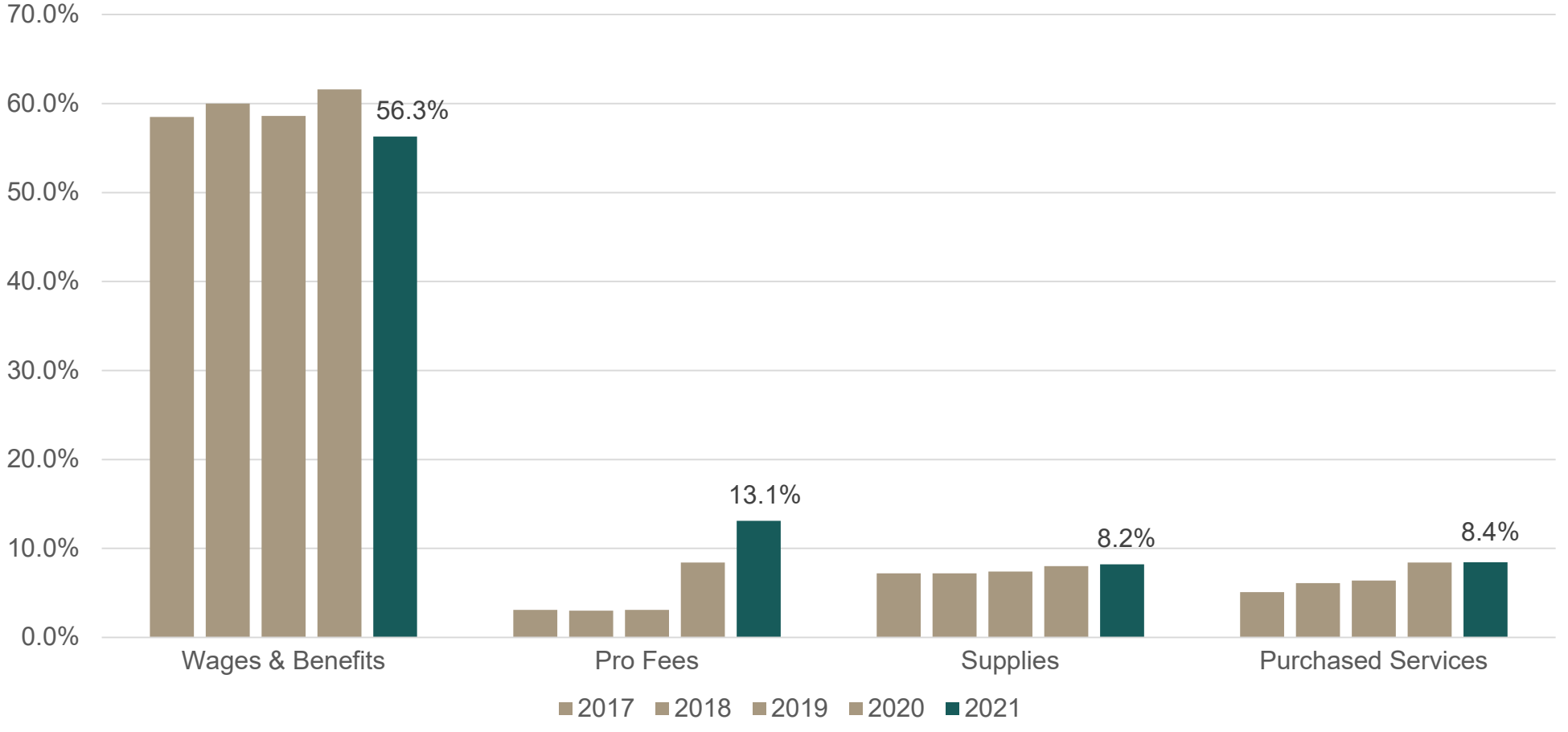
(with Comparisons to 2020 Critical Access Hospitals (CAH))



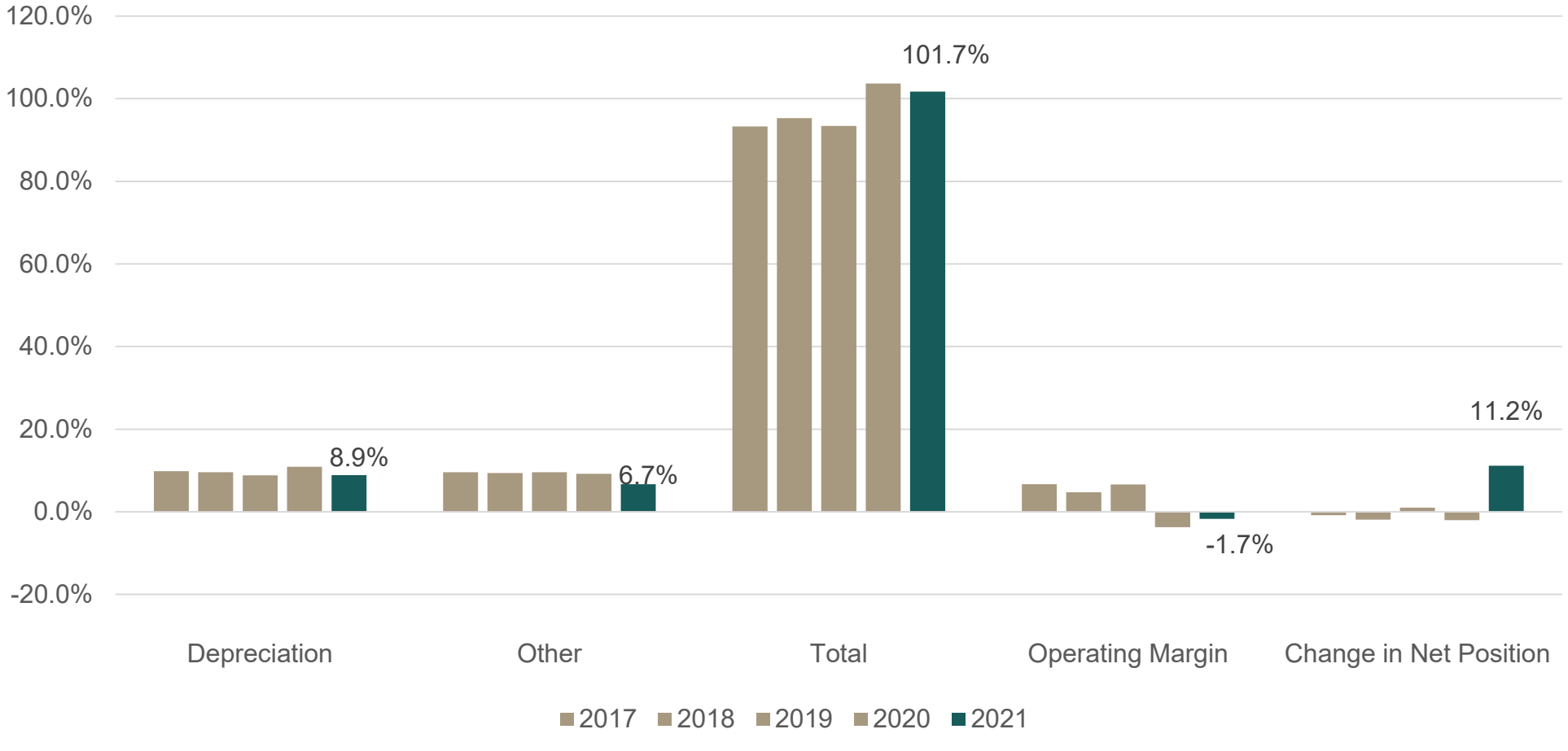
Operating Revenues and Expenses
(in millions)



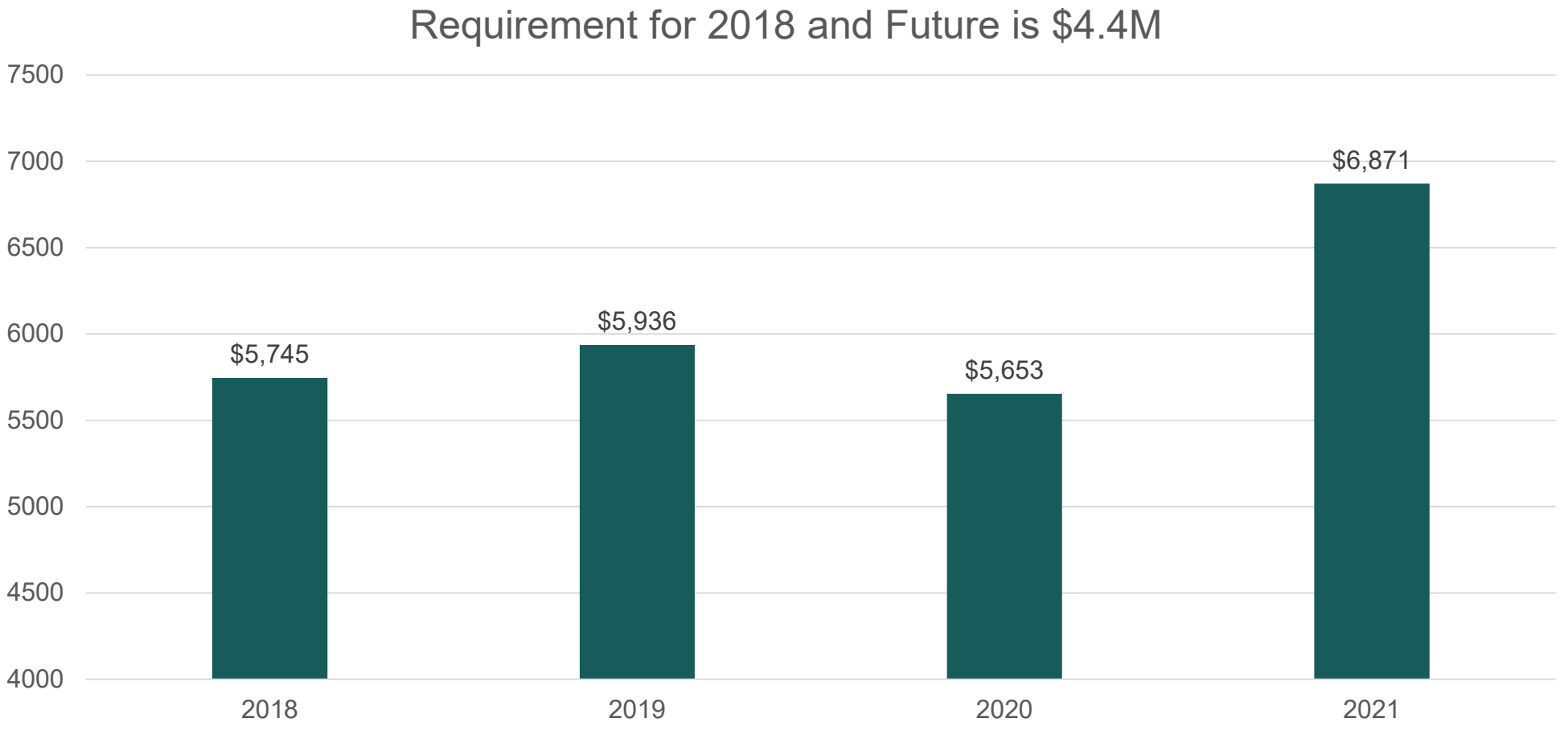
Expenses as a Percentage of Operating Revenue



Expenses as a Percentage of Operating Revenue (continued)



Income Available for Debt Service
(in thousands)



Other Ratio Comparisons

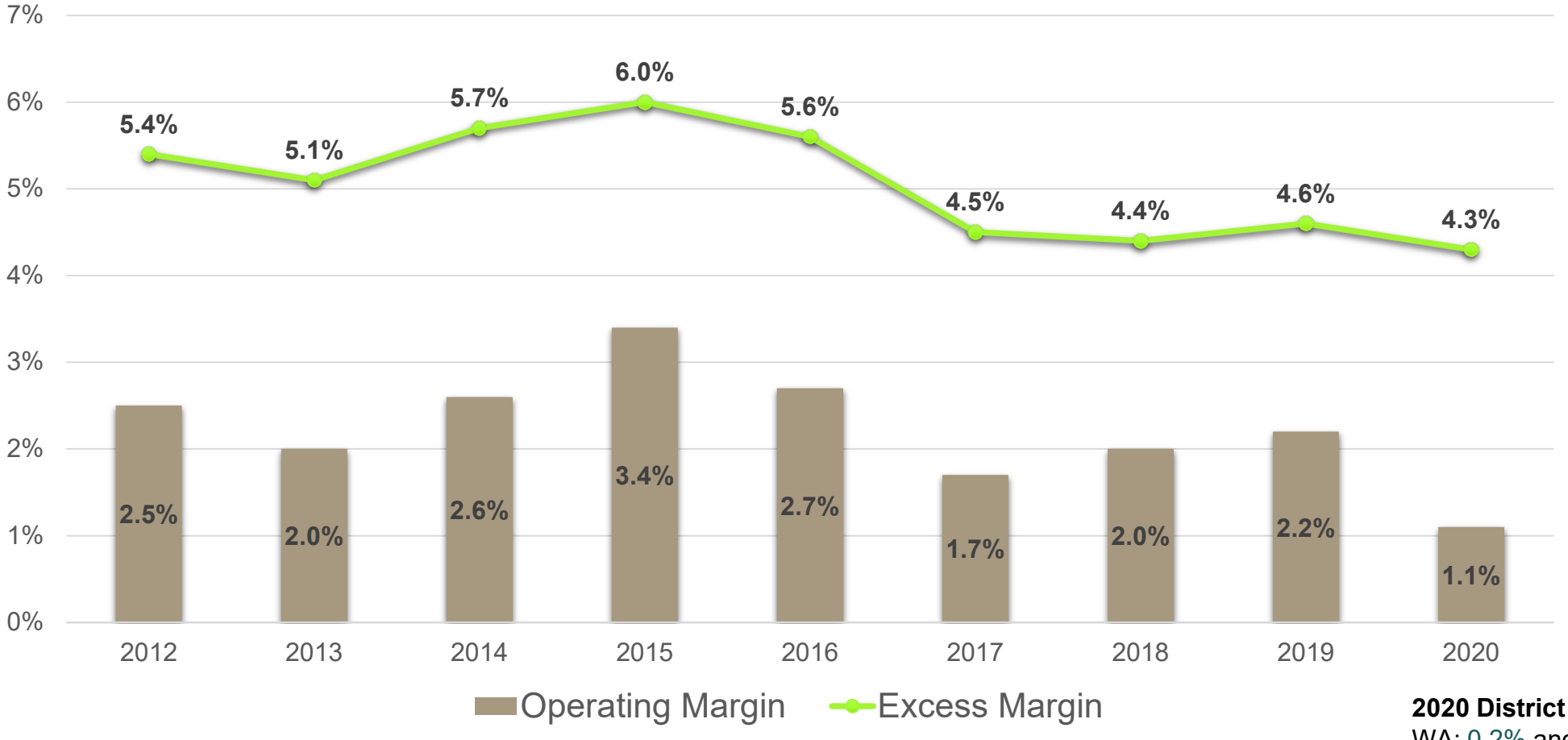
Ratio	SVH	WA	USA
Operating Margin	-1.7%	0.2%	3.6%
Total Margin	11.2%	3.5%	5.4%
Current Ratio	1.9	2.1	1.9
Age of Plant	8.3	13.2	12.3
Debt to Capitalization	118%	40%	31%
Outpatient to Total Revenue	48%	81%	81%

MOSSADAMS

Industry Observations

National Hospital Trends

Operating Margin & Excess Margin as a Percentage of Net Revenue

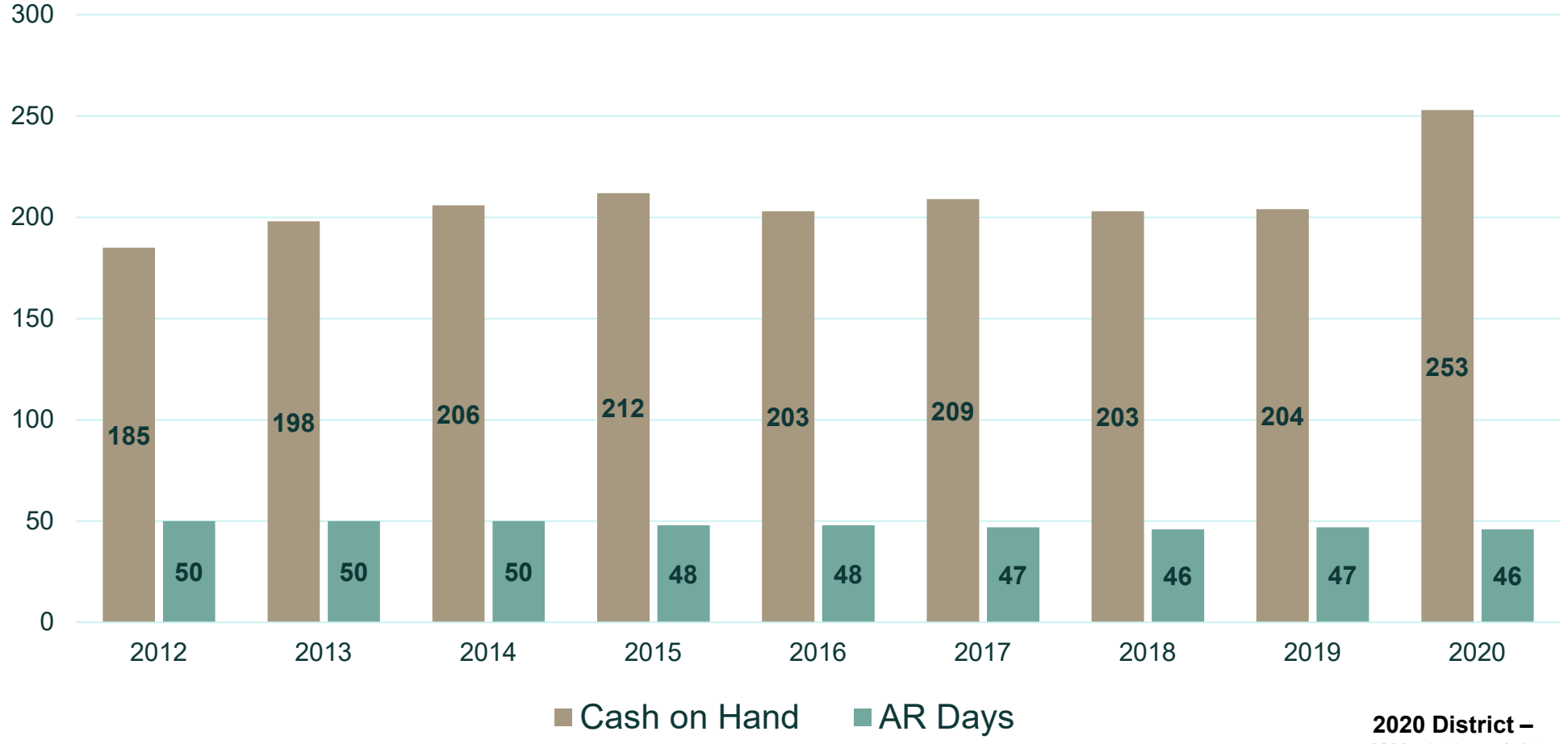


2020 District –
WA: 0.2% and 3.5%
US: 3.6% and 5.4%

Source: Moody's 2020 Medians

National Hospital Trends

Days Cash and Receivables

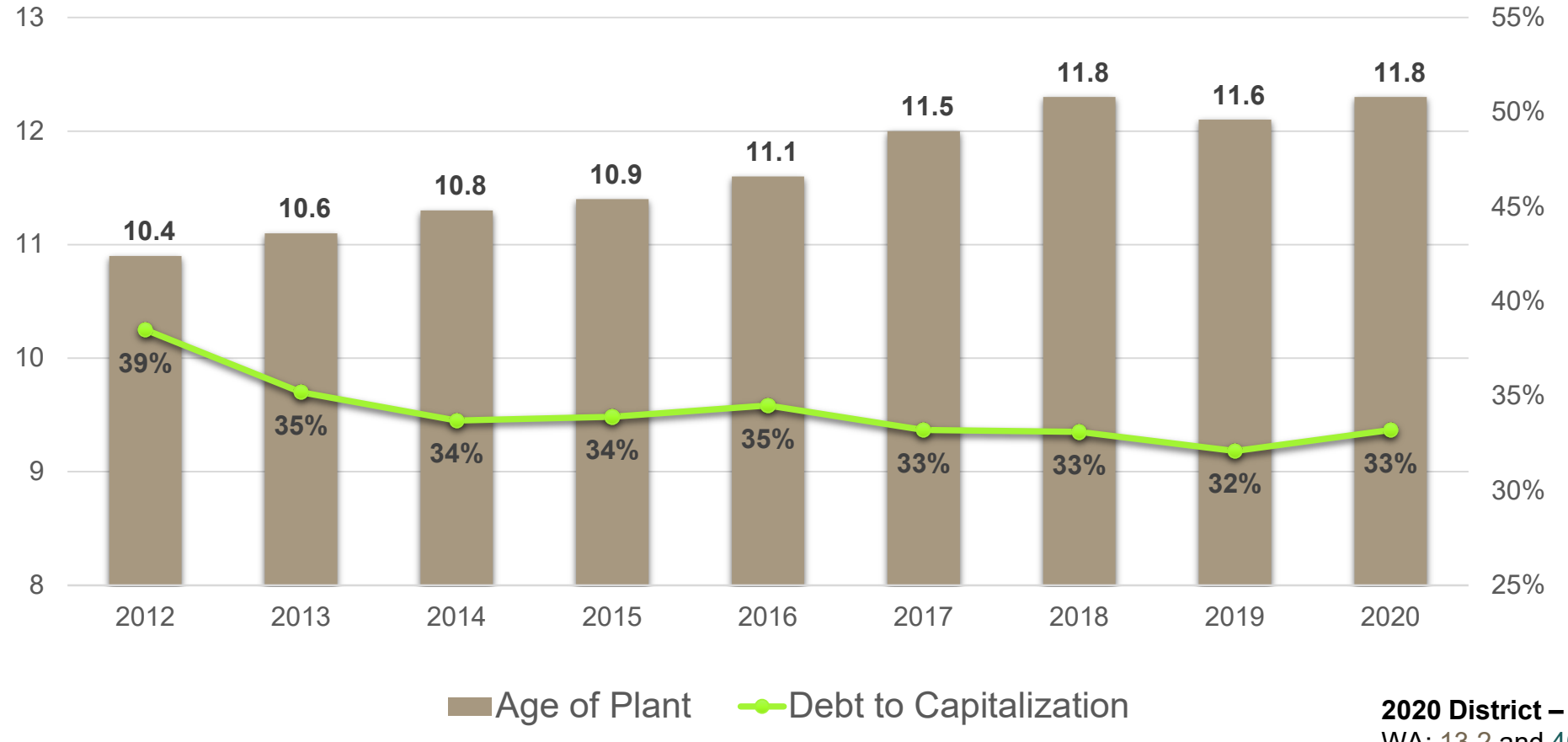


2020 District –
WA: 210 and 46
US: 192 and 47

Source: Moody's 2020 Medians

National Hospital Trends

Age of Plant & Debt to Capitalization

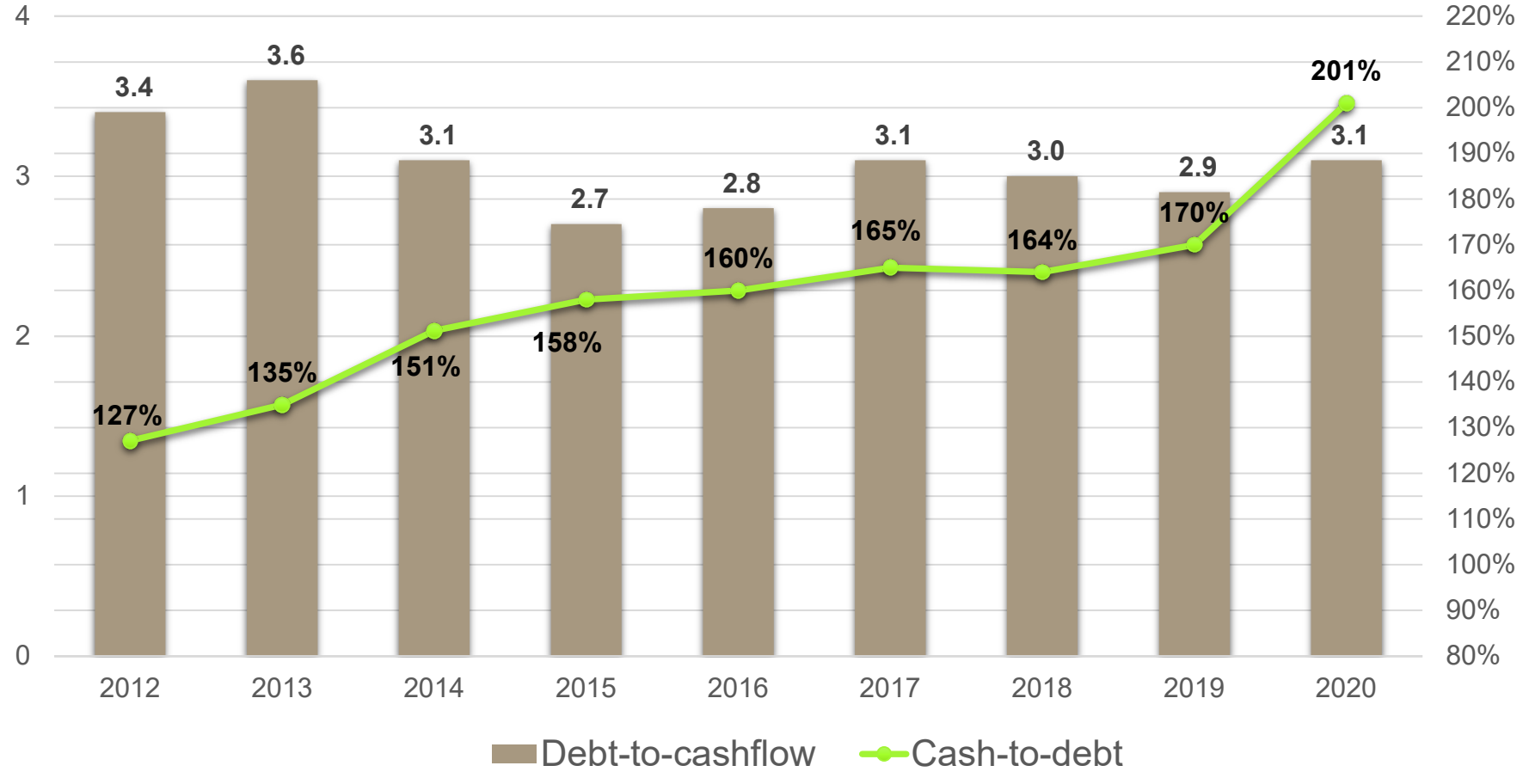


2020 District –
WA: 13.2 and 40%
US: 12.3 and 31%

Source: Moody's 2020 Medians

National Hospital Trends

Debt-to-Cash Flow & Cash-to-Debt



Source: Moody's 2020 Medians

MOSSADAMS

Thank you

Independent Auditor's Report to the Finance Committee

Mathew Stopa, Senior Manager

REPORTS OF INDEPENDENT AUDITORS
AND FINANCIAL STATEMENTS

PUBLIC HOSPITAL DISTRICT NO. 4, KING COUNTY, WASHINGTON

December 31, 2021 and 2020

MOSSADAMS

Table of Contents

MOSSADAMS

Report of Independent Auditors

The Board of Commissioners
Public Hospital District No. 4,
King County, Washington

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Public Hospital District No. 4, King County, Washington as of and for the years ended December 31, 2021 and 2020, and the related notes to the financial statements, which collectively comprise Public Hospital District No. 4, King County, Washington's financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the financial position of Public Hospital District No. 4, King County, Washington as of December 31, 2021 and 2020, and the changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards (Government Auditing Standards)*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Public Hospital District No. 4, King County, Washington and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Public Hospital District No. 4, King County, Washington's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Public Hospital District No. 4, King County, Washington's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Public Hospital District No. 4, King County, Washington's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 4 through 10 be presented to supplement the financial statements. Such information is the responsibility of management and, although not a part of the financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 20, 2022, on our consideration of Public Hospital District No. 4, King County, Washington's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Public Hospital District No. 4, King County, Washington's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Public Hospital District No. 4, King County, Washington's internal control over financial reporting and compliance.

Moss Adams LLP

Everett, Washington
May 20, 2022

Introduction

Our discussion and analysis provide an overview of the financial position and activities of Public Hospital District No. 4, King County, Washington, doing business as Snoqualmie Valley Hospital and Hospital District No. 4 Clinics (the District). It should be read in conjunction with the financial statements and accompanying notes that follow.

The District completed its sixth year in its new facility in 2021 after relocating in May 2015.

The District implemented an Emergency Department Management Agreement with Overlake Medical Center and contracted with a new ED Physician Group, Puget Sound Physicians, in December of 2020 to improve quality and revenue.

- **ED Management Agreement Effect** The District's partnership with Overlake Medical Center began in the fourth quarter of 2020. The District's 2021 ED gross revenues increased by 2.7 million dollars over 2020 ED revenues, and additional imaging revenues increased by $3,000,000 over 2020. While we did not hit the 2021 budgeted volume target, the District did see 500 more Emergency Room patients in 2021.

- **Executive Team Changes** In December 2020, the District hired a new CEO, Renee Jensen. In March 2021, the District hired a new Chief Medical Officer, Dr. Rachel Thompson, and in July 2021, the District Hired Dr. Tammy Moore as Vice President of Strategic Initiatives. Renee led the executive staff and the District through a six-month strategic planning initiative, and the District began implementing the strategic plan in August 2021. The Strategic Plan focuses on five areas Financial Stewardship, Foundational Elements, Health System of Choice, People, and Community Health Needs.

Operational Highlights

<u>COVID-19 Pandemic Effect 2021</u>

- **COVID-19 Vaccines:** The District established a Drive-Thru Vaccine and Mobile Vaccine department. In May 2021, the District signed a contract with King County Public Health to become a Mass Vaccination site. Reimbursement from King County for the expenses related to the Mass Vaccination will occur in 2022. The District provided 26,178 vaccines in 2021.

- **Paycheck Protection Program (PPP) Loan Forgiveness:** In April 2021, the District received final approval of the PPP Loan forgiveness of $3,965,000.

- **Sleep Lab:** The Sleep Lab clinic did not fully recover from the mandatory shut down of elective procedures in 2020. In April 2021, the District discontinued the Sleep Lab service line.

- **COVID-19 Testing:** The District continued drive-through COVID-19 testing in the community in 2021. The District performed over 10,900 tests in 2021.

Operational Highlights (continued)

- **Coronavirus Aid, Relief, and Economic Security Act (CARES) Funds:**

  - The District received $5,353,000 in CARES funding through the Provider Relief Fund in 2020. The funds were used per HRSA guidelines and expended by June 30, 2021. The District attested for the use of the funds via the HRSA portal in September 2021.

  - The District obtained an $11,028,000 advance from the Centers for Medicare and Medicaid Services (CMS) in April 2020. The District began repayment of the advance in April 2021. Total remuneration is expected by the 29th-month deadline in August 2022.

  - In November and December 2021, The District received an additional total of $650,000 of Phase 4 Provider Relief Funds for Rural Health Incentive and revenue shortfalls in 2020.

Patient Volumes

Patient volumes compared to 2020 actuals are shown below:

Business Line	Patient Volumes Actual January Through December 2021	Patient Volumes Actual January Through December 2020	Percentage Change
Inpatient days	8,520	8,172	4.1%
Emergency room visits	4,243	4,003	5.7%
Outpatient service visits	753	792	-5.2%
Rehab inpatient procedures	29,277	21,907	25.2%
Rehab outpatient procedures	9,024	9,727	-7.8%
Laboratory tests	118,663	44,521	62.5%
Imaging procedures	5,320	4,336	18.5%
Clinic visits	24,258	18,372	24.3%

Inpatient days and inpatient rehab procedures increased due to increased hospitalizations region-wide due to the COVID-19 Pandemic.

Outpatient services decreased due to closure of Sleep Lab Clinic, and shortage of Endoscopy visits versus 2021 projections.

Lab volumes increased due to COVID-19 testing and reference lab services. Imaging and ED visits increased due to the implementation of the Puget Sound Physician as the District's emergency room provider group.

Statement of Revenues, Expenses, and Changes in Net Position

	2021	2020	2019
Net operating revenue	$ 43,885,293	$ 37,876,639	$ 37,473,898
Nonoperating income	10,932,855	6,773,781	3,565,298
	54,818,148	44,650,420	41,039,196
Total operating expenses	44,624,679	39,290,500	35,031,254
Nonoperating expense	5,287,556	6,098,471	5,680,269
	49,912,235	45,388,971	40,711,523
Change in net position	4,905,913	(738,551)	327,673
Net position, beginning of year	(20,783,530)	(20,044,979)	(20,372,652)
Net position, end of year	$ (15,877,617)	$ (20,783,530)	$ (20,044,979)

Comments on Statement of Revenues, Expenses, and Changes in Net Position

Operating Revenue

Operating revenue increased by 16% from 2020 to 2021. The increase was due to increased inpatient census, Emergency Department, Imaging, and lab service line increase.

Operating Expenses

Operating expenses increased by 14% in 2021 compared to 2020. The increase was due to:

- Wage increases of 13%—the result of salary increases for District staff, workforce retention payments, and growth in the total staffing from 300 employees to 320 employees due to extra staff required for COVID-19 Vaccination and testing.

- Professional fees increased by 82%—the result of increased agency services for inpatient coverage and the utilization of the Puget Sound Physician group in the Emergency Department.

- Supplies increased by 19% due to the expense associated with COVID-19 PPE, inflationary pressures, and volume increases in the outpatient units.

- Purchased services expenses were 15% above the prior year due to expanding lab services with Sound Medical Lab volume increases and Revenue Cycle Management expenses related to the rise in net revenues.

Change in Net Position

The net position increase in 2021 was due to higher revenues in Inpatient services, Lab, ED, and Imaging, PPP forgiveness, and recognition of CARES funds.

Balance Sheet

	2021	2020	2019
ASSETS			
Current assets	$ 30,257,837	$ 34,336,813	$ 16,578,299
Capital assets, net	48,001,630	50,159,738	51,807,045
Other noncurrent assets	9,756,558	8,978,977	8,084,923
Total assets	88,016,025	93,475,528	76,470,267
DEFERRED OUTFLOWS OF RESOURCES	1,548,974	1,641,411	635,711
Total assets and deferred outflows of resources	$ 89,564,999	$ 95,116,939	$ 77,105,978
LIABILITIES			
Current liabilities	$ 15,697,764	$ 13,193,637	$ 6,373,084
Noncurrent liabilities	89,744,852	102,706,832	90,777,873
Total liabilities	105,442,616	115,900,469	97,150,957
NET POSITION			
Net investment in capital assets	(774,731)	610,618	2,719,792
Restricted expendable for debt service	9,995,341	9,016,749	8,510,309
Unrestricted	(25,098,227)	(30,410,897)	(31,275,080)
Total net position	(15,877,617)	(20,783,530)	(20,044,979)
Total liabilities and net position	$ 89,564,999	$ 95,116,939	$ 77,105,978

Commentary on Balance Sheet

Current Assets

Current assets decreased due to repayment of the CMS Advance.

Current Liabilities

Current liabilities increased due to the remaining portion of CMS Advance becoming due in 2022.

Long-Term Debt

Long-term debt decreased due to a decrease in the lease liability and payment of Revenue Bonds.

Net Investment in Capital Assets

Net investment in capital assets decreased in 2021 due to accumulated depreciation being higher than the purchase of capital assets in 2021.

Revenue Bond Covenant Compliance

The schedule of revenue bond covenant compliance is shown below. The District complies with all its revenue bond covenants.

SCHEDULE OF BOND COVENANT COMPLIANCE

Coverage Requirement	DECEMBER 2021 Amount
Change in net position	$ 4,905,913
Add	
Interest expense	5,126,107
Depreciation and amortization expense	3,909,193
	9,035,300
Less	
Paycheck Protection Program loan income	(3,965,000)
Taxation for bond principal and interest	(3,105,162)
	(7,070,162)
Available for debt service	$ 6,871,051
Maximum annual debt service	$ 3,675,188
Actual Coverage Ratio	1.87
Coverage Requirement	1.20
Available for debt service required by covenant	$ 4,410,226
Reserve Requirement For the Bonds	
Max annual debt service on all bonds	$ 3,675,188
125% of average annual debt service	4,492,886
10% of proceeds on all bonds	5,007,500
Reserve Requirement	$ 3,675,188
Hospital reserve fund	$ 3,675,188
Liquidity Requirement for the Bonds	
Cash and cash equivalents	$ 16,292,755
Total operating expenses	$ 44,624,679
Less depreciation and amortization expense	3,909,193
	$ 40,715,486
Days cash on hand	146.06
Liquidity Requirement for Bond Covenant	60.00
Cash and cash equivalents required for bond covenants	$ 6,692,957

Contacting the District's Financial Management

This financial report is designed to provide the District's patients, suppliers, taxpayers, and creditors with a general overview of the District's finances and show its accountability for the money it receives. If you have questions about this report or need additional information, contact the District's finance office at Snoqualmie Valley Hospital, 9801 Frontier Avenue SE, Snoqualmie, WA 98065.

Public Hospital District No. 4, King County, Washington
Statements of Net Position

ASSETS AND DEFERRED OUTFLOWS OF RESOURCES

	December 31, 2021	December 31, 2020
CURRENT ASSETS		
Cash and cash equivalents	$ 16,292,755	$ 22,668,120
Short-term investments	4,809,537	-
Assets limited as to use required for current liabilities	2,319,947	2,195,161
Patient accounts receivable, net of allowances for doubtful accounts of $693,440 in 2021 and $895,235 in 2020	6,677,293	7,392,875
Other receivables	60,694	1,411,079
Estimated third-party payor settlements	-	391,000
Inventory	97,611	278,578
Total current assets	30,257,837	34,336,813
ASSETS LIMITED AS TO USE, net of current portion	8,102,735	7,246,674
INTANGIBLE RIGHT TO USE LEASE, net of accumulated amortization	1,653,823	1,732,303
CAPITAL ASSETS		
Land	14,631,178	14,631,178
Construction in progress	59,450	-
Depreciable capital assets, net of accumulated depreciation and amortization	33,311,002	35,528,560
Total capital assets, net of accumulated depreciation and amortization	48,001,630	50,159,738
Total assets	88,016,025	93,475,528
DEFERRED OUTFLOWS OF RESOURCES		
Deferred loss on refunding	1,548,974	1,641,411
Total assets and deferred outflows of resources	$ 89,564,999	$ 95,116,939

LIABILITIES AND NET POSITION

CURRENT LIABILITIES		
Accounts payable	$ 3,040,561	$ 2,012,267
Accrued compensation and related liabilities	2,145,284	1,856,945
Accrued interest payable	399,947	375,161
Estimated third-party payor settlements	65,938	-
Other current liabilities	-	2,370,778
Current portion of lease liability	741,180	594,486
Current portion of advance Medicare payments	7,384,854	4,164,000
Current maturities of long-term debt	1,920,000	1,820,000
Total current liabilities	15,697,764	13,193,637
LEASE LIABILITY, net of current portion	916,269	1,178,793
ADVANCE MEDICARE PAYMENTS, net of current portion	-	6,863,886
PAYCHECK PROTECTION PROGRAM LOAN	-	3,965,000
LONG-TERM DEBT, net of current maturities	88,828,583	90,699,153
Total liabilities	105,442,616	115,900,469
NET POSITION		
Net investment in capital assets	(774,731)	610,618
Restricted expendable for debt service	9,995,341	9,016,749
Unrestricted	(25,098,227)	(30,410,897)
Total net position	(15,877,617)	(20,783,530)
	$ 89,564,999	$ 95,116,939

See accompanying notes.

Public Hospital District No. 4, King County, Washington
Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended December 31, 2021	2020
OPERATING REVENUES		
Net patient service revenue (net of provision for bad debts of $644,213 in 2021 and $513,523 in 2020)	$ 42,416,507	$ 36,640,225
Taxation for operations	1,012,472	580,608
Other	456,314	655,806
Total operating revenues	43,885,293	37,876,639
OPERATING EXPENSES		
Salaries and wages	20,425,025	19,381,198
Employee benefits	4,297,685	3,948,041
Professional fees	5,756,748	3,166,169
Supplies	3,617,141	3,037,649
Repairs and maintenance	341,879	253,800
Utilities	533,873	494,988
Purchased services	3,686,939	3,194,745
Insurance	169,931	169,966
Depreciation and amortization	3,909,193	4,144,885
Other	1,886,265	1,499,059
Total operating expenses	44,624,679	39,290,500
OPERATING LOSS	(739,386)	(1,413,861)
NONOPERATING INCOME (EXPENSE)		
Investment income	1,248	124,608
Taxation for bond principal and interest	3,105,162	3,424,503
Interest expense	(5,126,107)	(5,671,527)
Issuance and financing costs	(161,449)	(426,944)
Paycheck Protection Program loan income	3,965,000	-
Provider Relief Funds and other	3,861,445	3,224,670
Nonoperating income (expense), net	5,645,299	675,310
CHANGE IN NET POSITION	4,905,913	(738,551)
NET POSITION, beginning of year	(20,783,530)	(20,044,979)
NET POSITION, end of year	$ (15,877,617)	$ (20,783,530)

See accompanying notes.

Public Hospital District No. 4, King County, Washington
Statements of Cash Flows

Increase (Decrease) in Cash and Cash Equivalents

	Years Ended December 31, 2021	2020
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from and on behalf of patients	$ 43,589,027	$ 36,434,291
Cash paid to employees	(23,083,986)	(25,186,268)
Cash paid to suppliers	(15,506,354)	(11,203,245)
Cash (paid to) received from advance Medicare payments	(3,643,032)	11,027,886
Other cash receipts	456,314	655,806
Net cash from operating activities	1,811,969	11,728,470
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Cash from tax levies considered a noncapital financing activity	1,012,472	580,608
Cash received from Provider Relief Funds	665,646	5,353,525
Cash received from Paycheck Protection Program Loan	-	3,965,000
Other	825,021	439,100
Net cash from noncapital financing activities	2,503,139	10,338,233
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchase of capital assets	(904,939)	(1,544,591)
Cash from tax levies for general obligation bonds	3,102,224	3,396,725
Proceeds from long-term debt	-	17,456,000
Principal payments on long-term debt	(1,839,583)	(1,580,417)
Interest paid on long-term debt	(5,101,320)	(5,937,393)
Payments for refunding of 2011 LGTO bonds	-	(16,405,844)
Payments on lease liability	(883,496)	(944,933)
Net cash from capital and related financing activities	(5,627,114)	(5,560,453)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of investments	(4,809,537)	-
Investment income	1,248	124,608
Net cash from investing activities	(4,808,289)	124,608
NET CHANGE IN CASH AND CASH EQUIVALENTS	(6,120,295)	16,630,858
CASH AND CASH EQUIVALENTS, beginning of year	32,011,199	15,380,341
CASH AND CASH EQUIVALENTS, end of year	$ 25,890,904	$ 32,011,199
RECONCILIATION OF CASH AND CASH EQUIVALENTS TO STATEMENT OF NET POSITION		
Cash and cash equivalents	$ 16,292,755	$ 22,668,120
Cash and cash equivalents in assets whose use is limited	10,320,988	9,343,079
	$ 26,613,743	$ 32,011,199
NONCASH CAPITAL AND RELATED FINANCING ACTIVITY		
Paycheck Protection Program loan income	$ 3,965,000	$ -

See accompanying notes.

Increase (Decrease) in Cash and Cash Equivalents

	Years Ended December 31, 2021	2020
RECONCILIATION OF OPERATING LOSS TO NET CASH FROM OPERATING ACTIVITIES		
Operating loss	$ (739,386)	$ (1,413,861)
Adjustments to reconcile operating loss to net cash from operating activities		
Revenue from tax levies considered noncapital financing activity	(1,012,472)	(580,608)
Depreciation and amortization	3,186,354	4,144,885
Provision for bad debts	644,213	513,523
Change in assets and liabilities		
Patient accounts receivable	71,369	(593,028)
Other receivables	1,350,385	(1,370,460)
Inventory	180,967	(85,272)
Estimated third-party payor settlements	456,938	(126,429)
Accounts payable	1,028,294	698,403
Accrued compensation and related liabilities	288,339	(486,569)
Advance Medicare payments	(3,643,032)	11,027,886
Net cash from operating activities	$ 1,811,969	$ 11,728,470

Note 1 – Organization

Public Hospital District No. 4, King County, Washington, doing business as Snoqualmie Valley Hospital and as Hospital District No. 4 Clinics (the District), is organized as a municipal corporation under the laws of the state of Washington and operates a licensed 28-bed acute care hospital and primary and specialty care clinics in Eastern King County, Washington. As organized, the District is exempt from payment of federal income tax. The Board of Commissioners consists of five elected community members. The District is not considered to be a component unit of King County.

Note 2 – Summary of Significant Accounting Policies

Accounting standards – The District reports its financial information in a form that complies with the pronouncements of the Governmental Accounting Standards Board (GASB).

Basis of presentation – The accompanying financial statements have been prepared on the accrual basis of accounting using the economic resources measurement focus. Under this method of accounting, revenues are recognized when earned and expenses are recorded when liabilities are incurred without regard to receipt or disbursement of cash.

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

Cash and cash equivalents – Cash and cash equivalents include investments in highly liquid debt instruments with an original maturity date of three months or less, excluding amounts limited as to use by board designation, indenture agreements, or donors.

Assets limited as to use – Periodically, the Board of Commissioners sets aside cash resources for the funding of future capital improvements. In addition, certain funds are restricted by bond indentures to be used solely for debt service or for the funding of future capital projects. These funds are invested in the King County Investment Pool, which is in accordance with state guidelines.

All District investments are carried at market value. Investment income is reported as nonoperating income and expense.

Note 2 – Summary of Significant Accounting Policies (continued)

Patient accounts receivable – Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the District analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the District analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients' balances (which include both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the District records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Capital assets – Land, buildings, and equipment acquisitions are recorded at cost. Improvements and replacements of land, buildings, and equipment are capitalized. The District's capitalization threshold is $5,000 per item and a useful life of at least three years. Maintenance and repairs are expensed. The cost of land, buildings, and equipment sold or retired and the related accumulated depreciation are removed from the accounts, and any resulting gain or loss is recorded.

Depreciation is recorded over the estimated useful life of each class of depreciable asset using the American Hospital Association guidelines and is computed using the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. The estimated useful lives used by the District are as follows:

Buildings and improvements	2 – 40 years
Equipment	3 – 20 years

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

Note 2 – Summary of Significant Accounting Policies (continued)

Net position – Net position of the District is classified into three components. The net investment in capital assets component of net position consists of capital assets, net of accumulated depreciation, reduced by the outstanding balances of related debt that is attributable to the acquisition, construction, or improvement of those assets. The restricted component of net position represents noncapital assets that must be used for a specific purpose. The unrestricted component of net position is the remaining net amount of the assets, deferred outflows of resources, and liabilities that are not included in the determination of net investment in capital assets or the restricted components of net position.

Operating revenues and expenses – The District's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues, such as patient service revenue, result from exchange transactions associated with providing health care services—the District's primary business.

Nonexchange revenues, including taxes, are reported as other operating revenues. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Tax levy income and debt service related to general obligation and revenue bonds and peripheral or incidental transactions, grants, and contributions received for purposes other than capital asset acquisition are reported as nonoperating income or expense.

Net patient service revenue – Patient service revenue is recorded at established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. Preliminary settlements under reimbursement agreements with Medicare and Medicaid are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Reimbursements received from certain third-party payors are subject to audit and retroactive adjustment. Provision for possible adjustment as a result of audits is recorded in the financial statements. When reimbursement settlements are received, or when information becomes available with respect to reimbursement changes, any variations from amounts previously accrued are accounted for in the period in which the settlements are received or the change in information becomes available.

Charity care – The District provides care to indigent patients who meet certain criteria under its charity care policies. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue. Forgone revenue for charity care provided during 2021 and 2020 measured by the District's standard charges was approximately $631,000 and $310,000, respectively.

Federal income taxes – The District, as a political subdivision of the state of Washington, is not subject to federal income taxes under Section 115 of the Internal Revenue Code.

Note 2 – Summary of Significant Accounting Policies (continued)

Subsequent events – Subsequent events are events or transactions that occur after the statement of net position date but before financial statements are issued. The District recognizes in the financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the statement of net position, including the estimates inherent in the process of preparing the financial statements. The District's financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the statement of net position but arose after the statement of net position date and before the financial statements are issued.

The District has evaluated subsequent events through May 20, 2022, which is the date the financial statements are issued.

Note 3 – Net Patient Service Revenue

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

Medicare – The District converted to critical access hospital status under the Medicare program on December 1, 2005, under which inpatient, swing-bed, and outpatient services and hospital-based clinics are reimbursed on a cost basis. Inpatient acute, swing-bed, and outpatient care services rendered to Medicare program beneficiaries are paid on an interim basis at a percentage of billed charges. These interim payments will be subject to final settlement upon submission and audit of the cost report to the Medicare fiscal intermediary. The District's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization.

Net patient service revenue under the Medicare program totaled approximately $29,505,000 and $26,916,000 for 2021 and 2020, respectively. Net unsecured patient accounts receivable due from Medicare at December 31 was $5,367,000 and $4,865,000 in 2021 and 2020, respectively.

Medicaid – As a critical access hospital, the District is reimbursed for inpatient and outpatient services rendered to Medicaid program beneficiaries on a cost reimbursement methodology. Under this methodology, the District is reimbursed at a tentative rate, with final settlement determined after audits by the Medicaid fiscal intermediary of annual cost reports submitted by the District. Long-term care services are paid on a cost reimbursement basis, which may not exceed allocated costs plus state-mandated cost limits. Net patient service revenue under the Medicaid program totaled approximately $4,243,000 and $2,710,000 for 2021 and 2020, respectively. Net unsecured patient accounts receivable due from Medicaid at December 31 were $404,000 and $420,000 in 2021 and 2020, respectively.

The District's estimates of final settlements to or from Medicare and Medicaid for all years through 2021 have been recorded in the accompanying statements of net position. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Differences between the net amounts accrued and subsequent settlements are recorded in operations at the time of settlement. The District's Medicare cost reports have been audited by the Medicare fiscal intermediary through December 31, 2017.

Note 3 – Net Patient Service Revenue (continued)

Other third-party payors – The District has also entered into various payment arrangements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations, which provide for payment or reimbursement at amounts different from published rates. Contractual adjustments represent the difference between published rates for services and amounts paid or reimbursed by these third-party payors.

The following are the components of net patient service revenue for the District for the years ended December 31:

	2021	2020
Gross patient service charges	$ 64,415,313	$ 54,164,685
Adjustments to patient service charges		
Contractual discounts	20,723,715	16,700,895
Provision for bad debts	644,213	513,523
Charity care	630,878	310,042
	21,998,806	17,524,460
Net patient service revenue	$ 42,416,507	$ 36,640,225

Note 4 – Deposits and Investments

The District makes investments in accordance with Washington State law. Eligible investments include obligations secured by the U.S. Treasury, other obligations of the United States or its agencies, certificates of deposit with approved institutions, insured money market funds, commercial paper, registered warrants of local municipalities, the Washington State Local Government Investment Pool, eligible bankers' acceptances, and repurchase agreements (up to 30 days).

As a political subdivision of the state, the District categorizes deposits and investments to give an indication of the risk assumed at year-end. Category 1 includes deposits and investments that are insured, registered, or held by the District's agent in the District's name. Category 2 includes uninsured and unregistered investments that are held by the broker's or dealer's trust department or agent in the District's name. Category 3 includes uninsured and unregistered deposits and investments for which the securities are held by the broker or dealer, or its trust department or agent, but not in the District's name.

The Revised Code of Washington, Chapter 39, authorizes municipal governments to invest their funds in a variety of investments including federal, state, and local government certificates, notes, or bonds; the Washington State Local Government Investment Pool; savings accounts in qualified public depositories; and certain other investments. All cash and cash equivalents held by the County Treasurer's Office are insured by the State of Washington Public Deposit Protection Commission, as provided by Chapter 39.58 of the Revised Code of Washington. Qualified public depositories pledge securities with this Commission, which are available to insure public deposits within the state of Washington.

Note 4 – Deposits and Investments (continued)

All deposits and investments of the District are categorized as Category 1 and consist of the following at December 31:

	2021	2020
Cash and cash equivalents	$ 16,292,755	$ 22,668,120
Short-term investments		
U.S. government agency obligations	4,809,537	-
Assets whose use is limited		
Board designated		
Investment in King County Investment Pool	426,659	424,404
Taxes receivable	682	682
LTGO Bond Fund		
Investment in King County Investment Pool	6,219,141	5,243,487
Taxes receivable	101,012	98,074
Revenue Bond Fund		
Cash and cash equivalents	3,675,188	3,675,188
	10,422,682	9,441,835
Total deposits and investments	$ 31,524,974	$ 32,109,955

The District participates in the King County Investment Pool (KCIP). The King County Finance and Business Operations Division (FBOD) manages and operates the KCIP. Participation by local governments is voluntary. The investment policies of the KCIP are the responsibility of the FBOD, and any proposed changes are reviewed by King County's Executive Finance Committee. The KCIP is comparable to a Rule 2a-7 money market fund recognized by the Securities and Exchange Commission (17 CFR 270.2a-7). Rule 2a-7 funds are limited to high-quality obligations with limited maximum and average maturities, the effect of which is to minimize both market and credit risk. The objectives of the FBOD's investment practices for the KCIP, in priority order, will be safety, liquidity, and return on investment. Separate financial statements for the KCIP are available from King County. The KCIP is not subject to risk evaluation.

Credit risk – Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The District's investment policy limits the types of securities to those authorized by statute; therefore, credit risk is very limited.

Deposits – All of the District's deposits are either insured or collateralized. The District's insured deposits are covered by the Federal Deposit Insurance Corporation (FDIC). Collateral protection is provided by the Washington Public Deposit Protection Commission (PDPC).

Note 4 – Deposits and Investments (continued)

Custodial credit risk – Custodial credit risk is the risk that, in the event of a failure of the counterparty, the District will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party. The District is not exposed to custodial credit risk.

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of the District's investment in a single issuer. The District is not exposed to concentration of credit risk, because all deposits and investments are insured or collateralized.

Interest rate risk – Interest rate risk is the risk that changes in interest rates of debt instruments will adversely affect the fair value of an investment. The District is not exposed to interest rate risk.

The composition of investments, reported at fair value by investment type at December 31, 2021, and excluding cash and cash equivalents, and assets whose use is limited balances of $26,710,460 is as follows:

Investment Type	Quoted Prices in Active Markets for Identical Assets (Level 1)	Percentage of Totals
U.S. government agency obligations	$ 4,809,537	100%

Note 5 – Property Taxes

The County Treasurer acts as an agent to collect property taxes levied in the county for all taxing authorities. Taxes are levied annually on January 1 on property values listed as of the prior May 31. Assessed values are established by the County Assessor at 100% of the fair market value. A revaluation of all property is required every four years. Taxes are due in two equal installments on April 30 and October 31. Collections are distributed monthly to the District by the County Treasurer. Tax collections for the years ended December 31, 2021 and 2020, were 99.56% and 99.73% of the taxes levied during those respective years.

The District is permitted by law to levy up to $0.75 per $1,000 of assessed valuation for general District purposes. The Washington State constitution and Washington State law, RCW 84.55.010, limit the rate. The District may also levy taxes at a lower rate. Further amounts of tax need to be authorized by the vote of the people.

For 2021 and 2020, the District's regular tax levy was $0.37 per $1,000 on a total assessed valuation of $11,098,518,955 and $10,852,032,197, respectively, for a total regular levy of $4,077,587 and $3,982,030, respectively. A portion of the tax revenue from the regular levy has been pledged toward payments of the limited tax general obligation (LTGO) bonds.

Note 6 – Capital Assets

Capital asset additions, retirements, and balances for the years ended December 31, 2021 and 2020, were as follows:

	Balance, December 31, 2020	Additions	Retirements	Transfers	Balance, December 31, 2021
NONDEPRECIABLE CAPITAL ASSETS					
Land	$ 14,631,178	$ -	$ -	$ -	$ 14,631,178
Construction in progress	-	59,450	-	-	59,450
Total nondepreciable capital assets	14,631,178	59,450	-	-	14,690,628
DEPRECIABLE CAPITAL ASSETS					
Land improvements	11,973,793	-	-	-	11,973,793
Buildings and improvements	32,450,710	538,907	-	-	32,989,617
Equipment	13,528,437	306,582	-	-	13,835,019
LESS ACCUMULATED DEPRECIATION					
Land improvements	(4,331,281)	(722,839)	-	-	(5,054,120)
Buildings and improvements	(10,296,827)	(1,541,851)	-	-	(11,838,678)
Equipment	(7,796,272)	(798,357)	-	-	(8,594,629)
Depreciable capital assets, net	35,528,560	(2,217,558)	-	-	33,311,002
Capital assets, net	$ 50,159,738	$ (2,158,108)	$ -	$ -	$ 48,001,630

	Balance, December 31, 2019	Additions	Retirements	Transfers	Balance, December 31, 2020
NONDEPRECIABLE CAPITAL ASSETS					
Land	$ 14,631,178	$ -	$ -	$ -	$ 14,631,178
Total nondepreciable capital assets	14,631,178	-	-	-	14,631,178
DEPRECIABLE CAPITAL ASSETS					
Land improvements	11,955,883	17,910	-	-	11,973,793
Buildings and improvements	32,029,212	421,498	-	-	32,450,710
Equipment	12,423,254	1,105,183	-	-	13,528,437
LESS ACCUMULATED DEPRECIATION					
Land improvements	(3,587,525)	(743,756)	-	-	(4,331,281)
Buildings and improvements	(8,690,809)	(1,606,018)	-	-	(10,296,827)
Equipment	(6,954,148)	(842,124)	-	-	(7,796,272)
Depreciable capital assets, net	37,175,867	(1,647,307)	-	-	35,528,560
Capital assets, net	$ 51,807,045	$ (1,647,307)	$ -	$ -	$ 50,159,738

Depreciation expense for the years ended December 31, 2021 and 2020, was $3,063,047 and $3,191,898, respectively.

Note 7 – Long-Term Debt and Other Noncurrent Liabilities

Interest rates and maturities of long-term debt at December 31, 2021 and 2020, for the District consisted of the following:

	2021	2020
Limited tax general obligation and refunding bonds, series 2015, 4.25% to 5.00%, due semiannually on June 1 and December 1, maturing in 2038, with annual amounts ranging from $885,000 to $2,880,000, net of unamortized discount of $474,961 and $502,900.	$ 28,905,039	$ 29,737,100
Revenue bonds, series 2015, 5.00% to 6.25%, due semiannually on June 1 and December 1, maturing in 2045, with annual amounts ranging from $930,000 to $3,455,000, net of unamortized discount of $985,777 and $1,026,851.	44,467,544	45,326,053
Limited tax general obligation and refunding bonds, series 2020A and 2020B, 3.25% to 4.12% due semiannually on June 1 and December 1, maturing in 2040, with annual amounts ranging from $105,000 to $4,145,000.	16,410,000	16,490,000
Note payable to Overlake Hospital Medical Center bearing interest of 2.17%. If the terms of the note are met, the note is forgiven in full in December 2023.	966,000	966,000
	90,748,583	92,519,153
Less current portion	(1,920,000)	(1,820,000)
	$ 88,828,583	$ 90,699,153

Under the terms of the revenue and refunding bonds, the District has agreed to maintain certain financial ratios and meet certain covenants. Management is not aware of any violations with its debt covenants.

During 2020, the District issued the 2020 limited tax general obligation and refunding bonds to carry out a tax-exempt refunding of the 2011 limited tax general obligation and refunding bonds. The refunding resulted in the recognition of an accounting loss of $1,045,844, which was deferred and will be amortized over the life of the 2011 bonds, which were set to mature in 2040, and is classified as a deferred outflow of resources on the statement of net position. The refunding decreased the District's aggregate debt service payments by $7,723,000 over the next 20 years and resulted in an economic gain (difference between the present values of the old and new debt service payments) of $5,517,000. Certain conditions were met on September 3, 2021 resulting in a portion of the LTGO bond, a taxable bond, converting to a tax exempt bond with an interest rate of 3.25%.

Note 7 – Long-Term Debt and Other Noncurrent Liabilities (continued)

Changes in the District's long-term liabilities during the years ended December 31, 2021 and 2020, are summarized below:

	Balance, December 31, 2020	Additions	Reductions	Balance, December 31, 2021	Amounts Due Within One Year
Bonds payable					
2020 LTGO bonds	$ 16,490,000	$ -	$ (80,000)	$ 16,410,000	$ 105,000
2015 Revenue bonds	45,326,053	-	(858,509)	44,467,544	930,000
2015 LTGO bonds	29,737,100	-	(832,061)	28,905,039	885,000
Note payable	966,000	-	-	966,000	-
Total noncurrent liabilities	$ 92,519,153	$ -	$ (1,770,570)	$ 90,748,583	$ 1,920,000

	Balance, December 31, 2019	Additions	Reductions	Balance, December 31, 2020	Amounts Due Within One Year
Bonds payable					
2020 LTGO bonds	$ -	$ 16,490,000	$ -	$ 16,490,000	$ 80,000
2015 Revenue bonds	46,095,395	-	(769,342)	45,326,053	880,000
2015 LTGO bonds	30,479,162	-	(742,062)	29,737,100	860,000
2011 LTGO bonds	15,360,000	-	(15,360,000)	-	-
Note payable	-	966,000	-	966,000	-
Total noncurrent liabilities	$ 91,934,557	$ 17,456,000	$ (16,871,404)	$ 92,519,153	$ 1,820,000

Scheduled principal and interest repayments on long-term debt are as follows:

	2015 LTGO Bonds		2015 Revenue Bonds		2020 LTGO Bonds		Note Payable		Total	
	Principal	Interest	Principal	Interest	Principal	Interest	Principal	Interest	Principal	Interest
2022	$ 885,000	$ 1,452,950	$ 930,000	$ 2,741,375	$ 105,000	$ 634,463	$ -	$ -	$ 1,920,000	$ 4,828,788
2023	980,000	1,408,813	980,000	2,694,875	120,000	630,311	966,000	-	3,046,000	4,733,999
2024	980,000	1,362,250	1,025,000	2,645,875	240,000	625,584	-	-	2,245,000	4,633,709
2025	965,000	1,319,513	1,080,000	2,594,625	380,000	616,218	-	-	2,425,000	4,530,356
2026	1,220,000	1,278,500	1,130,000	2,540,625	255,000	601,476	-	-	2,605,000	4,420,601
Amounts due 2027 - 2031	7,725,000	5,372,750	6,710,000	11,649,725	1,975,000	2,824,070	-	-	16,410,000	19,846,545
Amounts due 2032 - 2036	11,045,000	3,127,500	8,945,000	9,420,038	3,430,000	2,333,198	-	-	23,420,000	14,880,736
Amounts due 2037 - 2041	5,580,000	423,000	12,060,000	6,305,313	9,905,000	1,198,878	-	-	27,545,000	7,927,191
Amounts due 2042 - 2045	-	-	12,593,321	2,036,563	-	-	-	-	12,593,321	2,036,563
									92,209,321	$ 67,838,488
Less amount representing unamortized discount									1,460,738	
									$ 90,748,583	

Note 8 – Retirement Plans

Deferred compensation plan – In 2006, the District began offering its employees a deferred compensation plan, the Public Hospital District No. 4, King County, Washington, 457 Plan, created in accordance with Internal Revenue Code (IRC) Section 457. The plan, available to all eligible employees, permits them to defer a portion of their salary until future years. The District makes no contributions to this plan. The deferred compensation is payable to employees upon termination, retirement, death, or unforeseen emergency.

The plan is administered by Nationwide Retirement Plans, and the District has limited administrative involvement and does not perform the investing function for the plan. The District does not hold the assets of the plan in a trustee capacity and does not perform fiduciary accountability for the plan. Therefore, the District employees' deferred compensation plan created in accordance with IRC 457 is not reported on the financial statements of the District. Contributions made by employees to the 457 Plan totaled $132,791 and $183,594 in 2021 and 2020, respectively.

Defined contribution plan – In 2006, the District also began sponsoring a defined contribution plan in accordance with IRC Section 403(b) covering substantially all qualified employees. Plan provisions and contribution requirements are established by the District and may be amended by the District's Board of Commissioners. Active participants meeting hourly and employee contribution criteria receive an employer matching contribution based on a percentage of the employees' base salary, subject to certain limitations. The employer contribution fully vests upon completion of two qualified years or upon the occurrence of death, disability, or attainment of age 65 for qualified employees. Forfeited contributions, if any, are applied against future employer obligations.

The District's liability under the plan, which is also administered by Nationwide Retirement Plans, is limited to its annual contribution. The District's contributions to the employee benefit plan totaled $137,760 and $156,034 in 2021 and 2020, respectively. Contributions made by employees to the benefit plan totaled approximately $861,499 and $901,534 in 2021 and 2020, respectively. For more information on the plans, contact the District's human resources office.

Note 9 – Concentrations of Credit Risk

The District grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors was as follows:

	2021	2020
Medicare	53%	48%
Medicaid	10%	9%
Other commercial	32%	36%
Patient and self-pay	5%	7%
	100%	100%

Note 10 – Commitments and Contingencies

Lease liability – The District leases certain facilities and equipment under lease arrangements. A summary of the principal and interest amounts for the remaining leases are as follows December 31, 2021:

	Principal	Interest
2022	$ 741,180	$ 79,987
2023	544,790	40,441
2024	291,109	17,671
2025	76,640	2,690
2026	3,730	100
	$ 1,657,449	$ 140,889

Intangible right to use lease – The District reported $846,146 and $952,987 as amortization expense on the statements of revenues, expenses, and changes in net position in 2021 and 2020, respectively. Accumulated amortization was $1,869,900 and $1,956,964 in 2021 and 2020, respectively. With the implementation of GASB 87, a lease meeting the criteria of this statement requires the lessee to recognize a lease liability and an intangible right to use asset.

Litigation – The District is involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the District's future financial position or results from operations.

Compliance with laws and regulations – The health care industry is subject to numerous laws and regulations from federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity with respect to investigations and allegations regarding possible violations of these laws and regulations by health care providers, including those related to medical necessity, coding, and billing for services, has increased substantially. Violations of these laws and regulations could result in expulsion from government health care programs, together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the District is in compliance with the fraud and abuse regulations, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Insurance – The District has its professional liability insurance coverage with Physicians Insurance. This policy provides protection on a "claims-made" basis whereby claims filed in the current year are covered by the current policy. If there are occurrences in the current year, they will be covered in the year the claim is filed only if claims-made coverage is obtained in that year or if the District purchases insurance to cover "prior acts." Current coverage with no deductible is for $1,000,000 per occurrence subject to a $5,000,000 annual limit. No liability has been accrued for future claims for acts occurring in the current or prior years. Also, it is possible that claims may exceed coverage obtained in any given year.

Note 11 – COVID-19 Pandemic

Medicare advance payments – The District applied for and received $11,027,886 under the Accelerated Payment Program, administered by the Centers for Medicare and Medicaid Services (CMS). This amount is treated as an advance liability bearing no interest and with a recoupment period that was originally scheduled to begin 120 days following receipt of the accelerated payments. On September 30, 2020, a new funding bill was enacted, which delayed recoupment of such funds. The finalized funding bill gave companies one year before Medicare can claim payments to repay the advance payments. Additionally, the measure lowered the interest rate on outstanding payments after the 29-month period from 10.25% to 4.00%. Recoupment began in April 2021 and the District has 29 months from that point to fully repay the advance if it is not recouped by Medicare. The District has included $7,384,854 and $4,164,000 in current liabilities and $0 and $6,863,886 in long-term liabilities within the statement of net position at December 31, 2021 and 2020, respectively.

Provider relief funding –The District received funds under the Provider Relief Fund, administered by the U.S. Department of Health & Human Services (HHS), under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) of $665,646 and $5,353,525 in 2021 and 2020, respectively. The District recognized $3,036,424 and $2,982,747 of the total received as nonoperating revenue in 2021 and 2020, respectively. The District was required to agree to the terms and conditions associated with the funds. Those terms and conditions include measures to prevent fraud and misuse. Documentation is required to ensure that these funds are to be used for expenses or lost revenue attributable to COVID-19. Also, anti-fraud monitoring and auditing will be done by HHS and the Office of the Inspector General.

Note 12 – Paycheck Protection Program Loan

In April 2020, the District received loan proceeds of $3,965,000 under the Paycheck Protection Program (the PPP Loan). The Paycheck Protection Program (PPP) was established as part of the CARES Act and is administered by the U.S. Small Business Administration (SBA). The PPP Loan to the District was made through Northwest Bank.

The original term of the PPP Loan was two years. The annual interest rate on the PPP Loan was 1.0%. Payments of principal and interest on the loan were deferred for the first six months of the term of the loan, as well as through any loan forgiveness application period. The promissory note evidencing the PPP Loan contained customary events of default relating to, among other things, payment defaults, breach of representations and warranties, or provisions of the promissory note. The occurrence of an event of default could trigger the immediate repayment of all amounts outstanding, collection of all amounts owing from the District, and/or filing suit and obtaining a judgement against the District.

Under the terms of the CARES Act, PPP Loan recipients may apply for and be granted forgiveness for all or a portion of the loans granted under the PPP. In April 2021, the District received notification that the PPP Loan was fully forgiven. Income from extinguishment of debt has been recorded in the statement of revenues, expenses, and changes in net position of the financial statements for the year ended December 31, 2021.

MOSSADAMS

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Board of Commissioners
Public Hospital District No. 4,
King County, Washington

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Public Hospital District No. 4, King County, Washington as of and for the year ended December 31, 2021, and the related notes to the financial statements, which collectively comprise Public Hospital District No. 4, King County, Washington's financial statements, and have issued our report thereon dated May 20, 2022.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Public Hospital District No. 4, King County, Washington's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Public Hospital District No. 4, King County, Washington's internal control. Accordingly, we do not express an opinion on the effectiveness of Public Hospital District No. 4, King County, Washington's internal control.

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

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

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether Public Hospital District No. 4, King County, Washington's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

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

Moss Adams LLP

Everett, Washington
May 20, 2022


MOSSADAMS

MOSSADAMS

Communications with Those Charged with Governance

To the Board of Commissioners of
Public Hospital District No. 4 of King County, Washington

We have audited the financial statements of Public Hospital District No. 4 of King County, Washington (the District) as of and for the year ended December 31, 2021, and have issued our report thereon dated May 20, 2022. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America and *Government Auditing Standards*

As stated in our engagement letter dated November 10, 2021, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* (*Government Auditing Standards*). As part of an audit conducted in accordance with U.S. GAAS and *Government Auditing Standards*, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control over financial reporting. Accordingly, we considered District's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

As a part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we will perform tests of the District's compliance with certain provision of laws, regulations, contracts, and grants. However, the objective of our tests is not to provide an opinion on compliance with such provisions.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in the engagement letter and our planning meeting with you.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the District are described in Note 2 to the financial statements. No new accounting policies were adopted and there were no changes in the application of existing policies during 2021. We noted no transactions entered into by the District during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

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

- Management's estimate of the contractual and bad debt allowances is based on management's estimate of collectability. We evaluated the key factors and assumptions used to develop the contractual and bad debt allowances in determining that they are reasonable.

- Management's estimate of the useful lives of fixed assets is based on the intended use and is within the American Hospital Association or Medicare guidelines, or consultants' estimates. We evaluated the key factors and assumptions used to develop the useful lives of fixed assets in determining that they are reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the amounts due from third parties is determined based on completion of the District's cost report and intermediary reviews thereon. We have reviewed the estimate for consistency with prior years and for reasonableness.

- Management's estimate of the accrued paid leave liability is calculated based on actual unused paid leave hours as of year-end. We reviewed paid leave hours and the related pay rates and determined that the calculation was reasonable.

- The CARES Act Provider Relief Fund nonoperating revenue is estimated based on management's interpretation of the terms and conditions set forth by United States Department of Health and Human Services (HHS). We evaluated the key factors and assumptions used to develop the CARES Act Provider Relief Fund nonoperating revenue in determining that it is reasonable in relation to the financial statements as a whole.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were:

- Disclosure of the net patient service revenue in Note 3 of the financial statements due to third-party payment agreements.

- Disclosure of the uncertainty surrounding the COVID-19 pandemic and the significant estimate associated with the CARES Act Provider Relief Fund nonoperating revenue in Note 11 to the financial statements.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the District's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the District's financial statements.

Disagreements with Management

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

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with auditing standards generally accepted in the United States of America. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. We did not detect any corrected or uncorrected misstatements during our audit procedures.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated May 20, 2022.

Management Consultation with Other Independent Accountants

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

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Board of Commissioners and management of Public Hospital District No. 4 of King County, Washington, and is not intended to be and should not be used by anyone other than these specified parties.

Moss Adams LLP

Everett, Washington
May 20, 2022

Finance Committee – Agenda

Public Hospital District No. 4, King County
Snoqualmie Valley Hospital
Friday, May 20, 2022 – 12:00pm
Via Zoom

COMMITTEE MEMBERS:
David Speikers, Commissioner, Chair of Finance
Kevin Hauglie, Commissioner, President
Patrick Ritter, CFO
Renée Jensen, CEO
Voltaire Tiotuico, Director of Finance
Jamie Palermo, Sr. Executive Assistant

2021 FINANCIAL AUDIT REVIEW – MOSS ADAMS: 12.31.21 Audit Completed. Auditors report is an unmodified opinion. Important board communications are as follows: No issues discussed prior to auditor retention, no disagreements with management, no corrected/uncorrected adjustments, no internal control deficiencies, and accounting estimates are reasonable.

April Income Statement Narrative:
April Operating revenues were **4%** $162,000 above budget due to higher than budgeted Urgent Care Clinic and Endoscopy revenue.

April Operating Expenses were **2%** (82,000) over budget. The two major expense categories over budget were Purchased Services and Other Expenses. The purchase services overages were due to COVID/Lab Testing and Med Surge expenses related to inpatient intake software Other Expenses increased due to B&O taxes, Annual Training/Compliance Software expense and Board Election Expense.

Operating Revenues were more Operating expenses giving an Operating income of **$86,431**

Non-Operating expenses were **$208,299** producing a Net Loss of **$121,868**. The Net Loss was lower than budgeted net loss for April by **$29,000**.

2022 Annual Income
Net Income year to date is **$219,012**. This is **$401,000** better than budget YTD.

Balance Sheet Highlights:

- Overall Assets decreased
    - Greater Allowance because of District Payor Mix
    - Cash increased due to Tax receipts.

- Liabilities Decreased
    - CMS Advance (50% recoupment)

Cash Flow Statement Highlights:

- **Operating Activities Increase of $530,000**
    - April Net Loss and Increase in AR off set by Tax Receipts
- **Investing Activities Increase $18,863**
    - Right to use assets off set expenditures for Epic.
- **Financing Activities Decrease $64,138**
    - Monthly Long Term Debt payments

Total Cash up $484,742

AR Days Goal 55

- 56.8 Days April
    - AR increased by 6 days. This increase was due to a back log of COVID testing charges. Little over 1 million in testing charges.

Bond Covenants: (Snapshot forecast)

- Debt Coverage is 1.85 requirement is 1.20
- Reserve Requirement is at $3,675,188 as required.
- Day's cash above the reserve is 165. The bond requirement is 60

PUBLIC HOSPITAL DISTRICT NO. 4, KING COUNTY

FINANCE COMMITTEE (APRIL 2022)

MAY 20, 2022

Financial Statements

KING COUNTY HOSPITAL DISTRICT # 4
HOSPITAL & CLINICS COMBINED
STATEMENT OF OPERATIONS
ACTUAL vs BUDGET
APRIL 2022

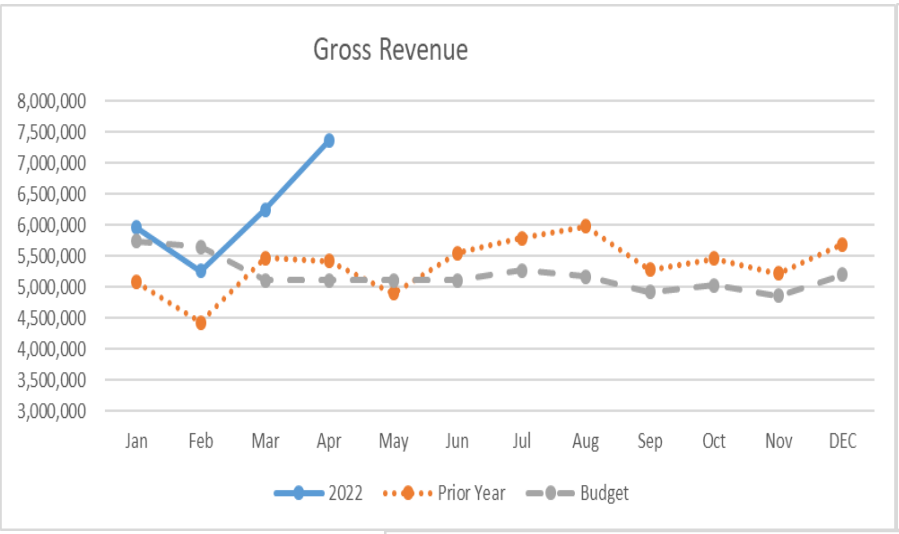
CURRENT MONTH					YEAR TO DATE			
ACTUAL	BUDGET	VARIANCE	% VARIANCE		ACTUAL	BUDGET	VARIANCE	% VARIANCE
$ 3,733,267	$ 3,572,517	$ 160,750	4%	NET PATIENT SERVICE REVENUE	$ 14,916,044	$ 14,713,932	$ 202,112	1%
103,716	96,200	7,516	8%	TAXATION FOR OPERATIONS	402,119	384,797	17,322	5%
30,417	36,733	(6,316)	-17%	OTHER	126,359	146,930	(20,571)	-14%
3,867,400	3,705,450	161,950	4%	TOTAL OPERATING REVENUE	15,444,521	15,245,659	198,862	1%
				OPERATING EXPENSES				
1,672,515	1,671,366	(1,149)	0%	SALARIES	6,871,448	6,681,264	(190,184)	-3%
361,376	367,864	6,488	2%	EMPLOYEE BENEFITS	1,539,733	1,468,752	(70,981)	-5%
414,437	450,556	36,119	8%	PROFESSIONAL FEES	1,600,869	1,802,242	201,373	11%
305,265	325,239	19,974	6%	SUPPLIES	1,271,343	1,300,956	29,613	2%
44,417	34,907	(9,510)	-27%	REPAIRS AND MAINTENANCE	142,951	149,628	6,677	4%
53,915	50,062	(3,853)	-8%	UTILITIES	219,514	200,248	(19,266)	-10%
421,097	359,470	(61,627)	-17%	PURCHASED SERVICES	1,571,911	1,437,880	(134,031)	-9%
17,466	15,218	(2,248)	-15%	INSURANCE	69,718	60,872	(8,846)	-15%
43,389	49,048	5,659	12%	LEASES AND RENTALS	165,836	196,192	30,356	15%
319,784	311,202	(8,582)	-3%	DEPRECIATION	1,280,517	1,244,808	(35,709)	-3%
127,307	63,699	(63,608)	-100%	OTHER	325,495	254,797	(70,698)	-28%
3,780,969	3,698,631	(82,338)	-2%	TOTAL OPERATING EXPENSES	15,059,335	14,797,639	(261,696)	-2%
86,431	6,819	79,612	1168%	OPERATING INCOME	385,186	448,020	(62,834)	-14%
5,005	6,848	(1,843)	-27%	INVESTMENT INCOME, NET OF AMOUNT CAPITALIZ	23,057	27,394	(4,337)	-16%
223,633	253,349	(29,716)	-12%	TAXATION FOR BOND PRINCIPAL & INTEREST	991,067	1,013,396	(22,329)	-2%
(423,494)	(416,847)	(6,647)	-2%	INTEREST EXPENSE, NET OF AMOUNT CAPITALIZED	(1,672,953)	(1,667,390)	(5,563)	0%
(13,454)	(9,096)	(4,358)	-48%	BOND ISSUANCE AND FINANCING COSTS	(40,743)	(36,384)	(4,359)	-12%
-	-	-		NON OPERATING REV - PROVIDER RELIEF FUNDS	-	-	-	
11	8,032	(8,021)	-100%	OTHER NET	533,399	32,129	501,270	1560%
(208,299)	(157,714)	(50,585)	-32%	NON OPERATING, NET	(166,174)	(630,855)	464,681	74%
(121,868)	(150,895)	29,027	-19%	CHANGE IN NET POSITION	219,012	(182,835)	401,847	-220%
$ (121,868)	$ (150,895)	$ 29,027	-19%	NET POSITION	$ 219,012	$ (182,835)	$ 401,847	-220%

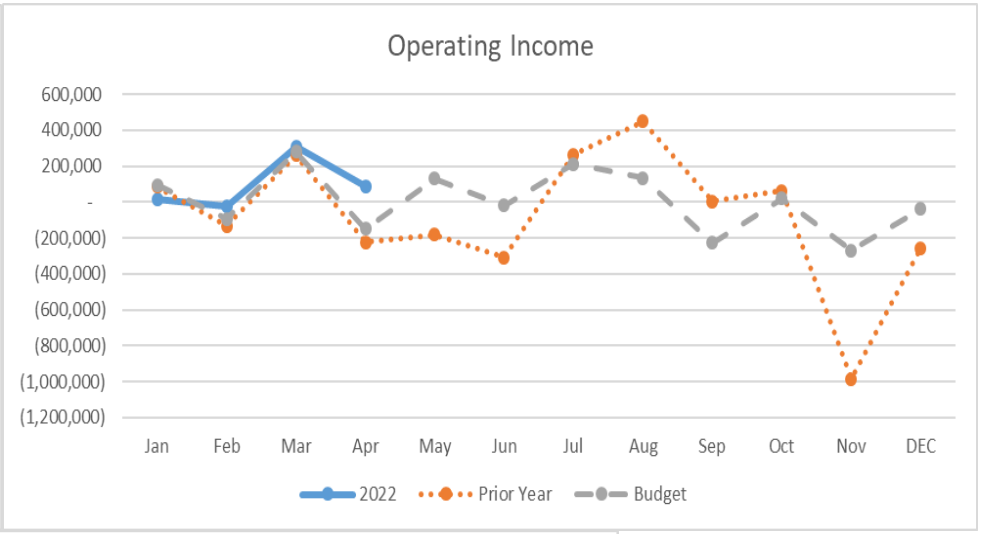
SNOQUALMIE VALLEY HOSPITAL COMBINED BALANCE SHEET	MARCH 2022	APRIL 2022
ASSETS		
CURRENT ASSETS		
UNRESTRICTED CASH	8,905,602	8,553,476
BOARD RESTRICTED FUNDS	4,911,814	4,911,814
CMS ADVANCE PAYMENT	6,007,920	5,163,014
MANDATED RESERVE FUNDS	10,133,066	11,814,840
TOTAL CASH	29,958,401	30,443,143
ACCOUNTS RECEIVABLE	9,762,057	11,199,230
LESS A/R ALLOWANCES	2,928,029	4,072,585
COST REPORTS RECEIVABLE	-	-
EMR MEANINGFUL USE	-	-
TOTAL NET RECEIVABLE	6,834,027	7,126,645
TAXES RECEIVABLE	4,098,011	2,394,906
INVENTORY	153,697	136,677
PREPAID EXPENSES	49,701	109,321
INTANGIBLE ASSETS	2,982,423	2,968,969
OTHER RECEIVABLES	34,769	19,180
TOTAL CURRENT ASSETS	44,111,030	43,198,841
FIXED ASSETS		
LAND AND IMPROVEMENTS	26,604,969	26,604,969
BUILDINGS	33,260,553	33,260,553
EQUIPMENT	9,201,725	9,201,725
INFORMATION SYSTEMS	4,702,979	4,702,979
RIGHT TO USE ASSET	1,459,434	1,394,904
CONSTRUCTION IN PROGRESS	94,989	140,656
LESS: ACCUMULATED DEPRECIATION	26,246,312	26,501,566
NET FIXED ASSETS	49,078,337	48,804,220
TOTAL ASSETS	93,189,367	92,003,061

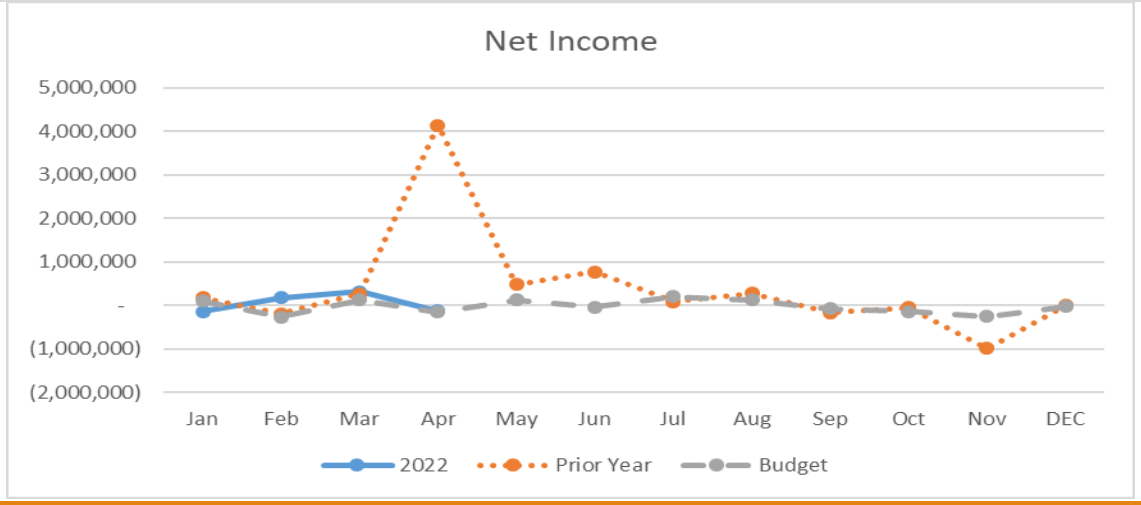
SNOQUALMIE VALLEY HOSPITAL COMBINED BALANCE SHEET	MARCH 2022	APRIL 2022
ASSETS		
CURRENT ASSETS		
UNRESTRICTED CASH	8,905,602	8,553,476
BOARD RESTRICTED FUNDS	4,911,814	4,911,814
CMS ADVANCE PAYMENT	6,007,920	5,163,014
MANDATED RESERVE FUNDS	10,133,066	11,814,840
TOTAL CASH	29,958,401	30,443,143
ACCOUNTS RECEIVABLE	9,762,057	11,199,230
LESS A/R ALLOWANCES	2,928,029	4,072,585
COST REPORTS RECEIVABLE	-	-
EMR MEANINGFUL USE	-	-
TOTAL NET RECEIVABLE	6,834,027	7,126,645
TAXES RECEIVABLE	4,098,011	2,394,906
INVENTORY	153,697	136,677
PREPAID EXPENSES	49,701	109,321
INTANGIBLE ASSETS	2,982,423	2,968,969
OTHER RECEIVABLES	34,769	19,180
TOTAL CURRENT ASSETS	44,111,030	43,198,841
FIXED ASSETS		
LAND AND IMPROVEMENTS	26,604,969	26,604,969
BUILDINGS	33,260,553	33,260,553
EQUIPMENT	9,201,725	9,201,725
INFORMATION SYSTEMS	4,702,979	4,702,979
RIGHT TO USE ASSET	1,459,434	1,394,904
CONSTRUCTION IN PROGRESS	94,989	140,656
LESS: ACCUMULATED DEPRECIATION	26,246,312	26,501,566
NET FIXED ASSETS	49,078,337	48,804,220
TOTAL ASSETS	93,189,367	92,003,061

STATMENT OF CASH FLOWS		
SOURCE AND APPLICATION OF FUNDS	MARCH 2022	APRIL 2022
Net Income	312,357	(121,868)
Add (Deduct) items not affecting cash:		
Depreciation expense	255,254	255,254
(Increase) decrease in accounts receivable	(1,822)	(292,617)
(Increase) decrease in current assets		
Tax Receivable/Other Receivable	179,353	1,718,694
Inventory	25,055	17,020
PrePaid Expenses	19,131	(59,619)
Intangible Assets	9,096	13,454
Increase (decrease) in current liabilities		
Notes and Loans Payable	-	-
Accounts Payable	(476,792)	151,283
Accrued Payroll & Taxes	249,805	(49,300)
Accrued Interest (Bonds)	173,951	173,951
Other Current Liabilities	(2,320)	(2,280)
Deferred Stimulus Funds	(481,361)	(844,906)
Current Long Term Debt	(77,500)	(77,500)
Deferred Tax Revenue	(371,351)	(351,311)
Other (net)	(66)	(237)
Net Cash provided by operating activities	(187,210)	530,017
CASH FLOW FROM INVESTING ACTIVITIES		
Investment in plant and equipment		
Land	-	-
Buildings	-	-
Equipment	-	-
Right to Use Assets	64,530	64,530
Construction in Progress	-	(45,667)
Net cash used for investing activities	64,530	18,863
CASH FLOW FROM FINANCING ACTIVITIES		
Change in long-term liabilities	(63,830)	(64,138)
Increase (decrease) in cash	$ (186,509)	$ 484,742
Beginning Cash Balance	30,144,911	29,958,401
Prior Year Adjust impact		
Ending Cash Balance	29,958,401	30,443,143

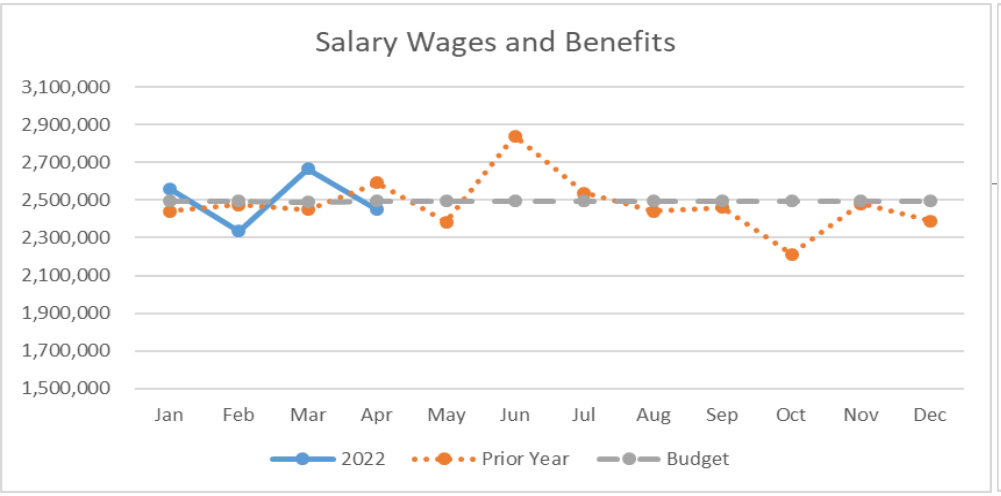
Financial Dashboards (Revenue & Income)

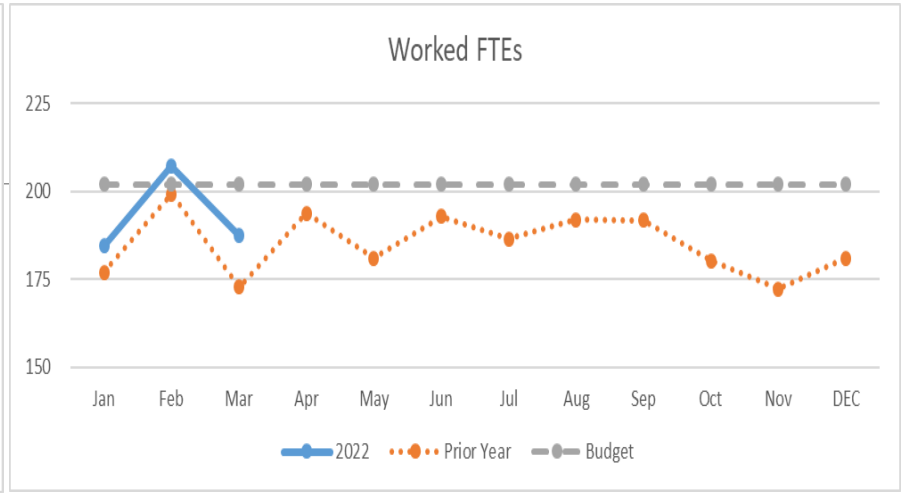


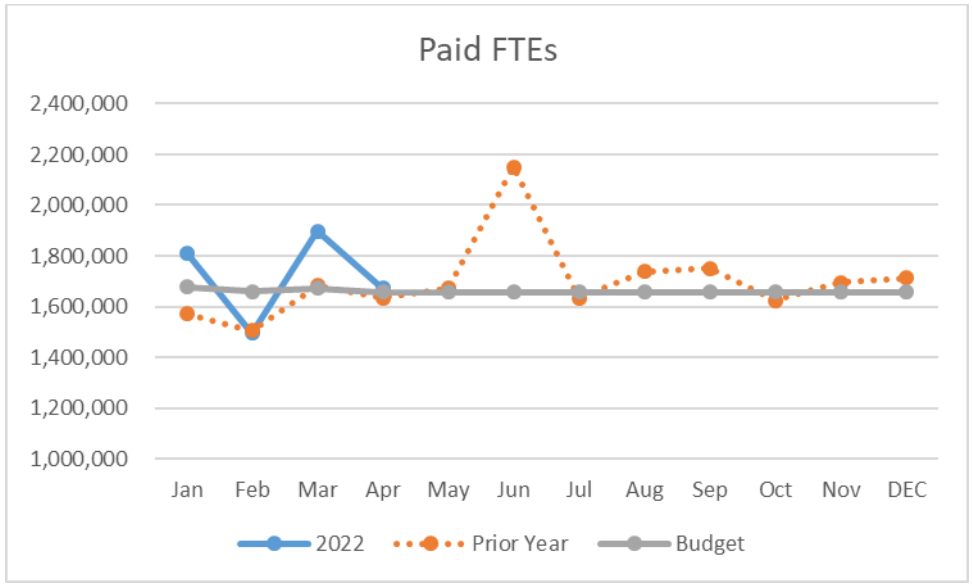


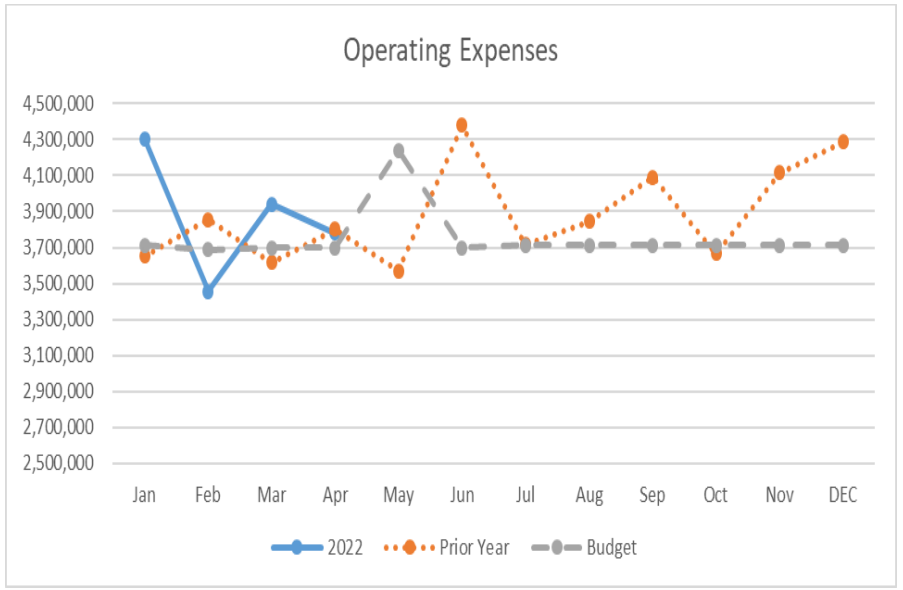


Financial Dashboards (Expenses)

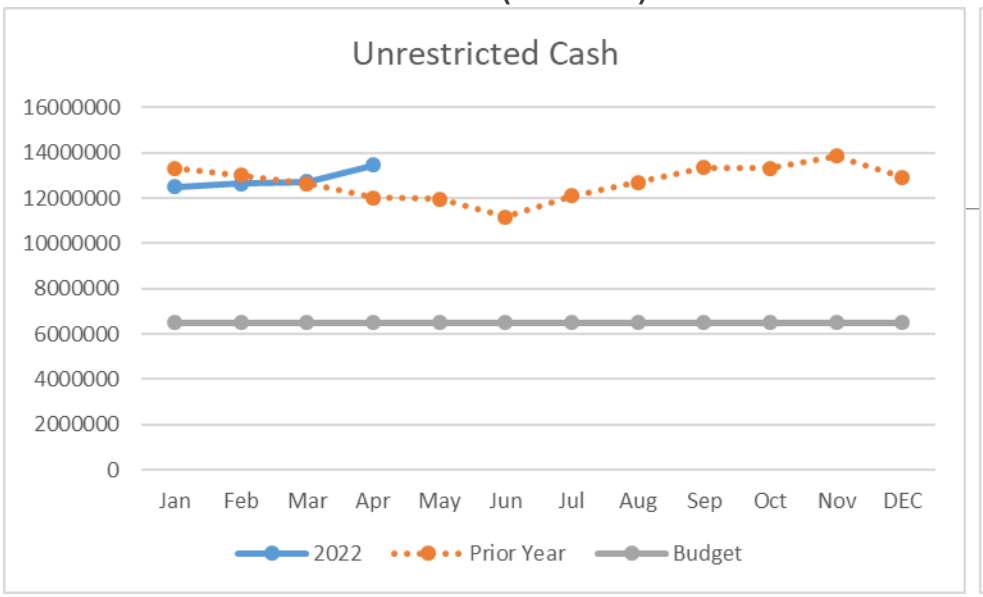


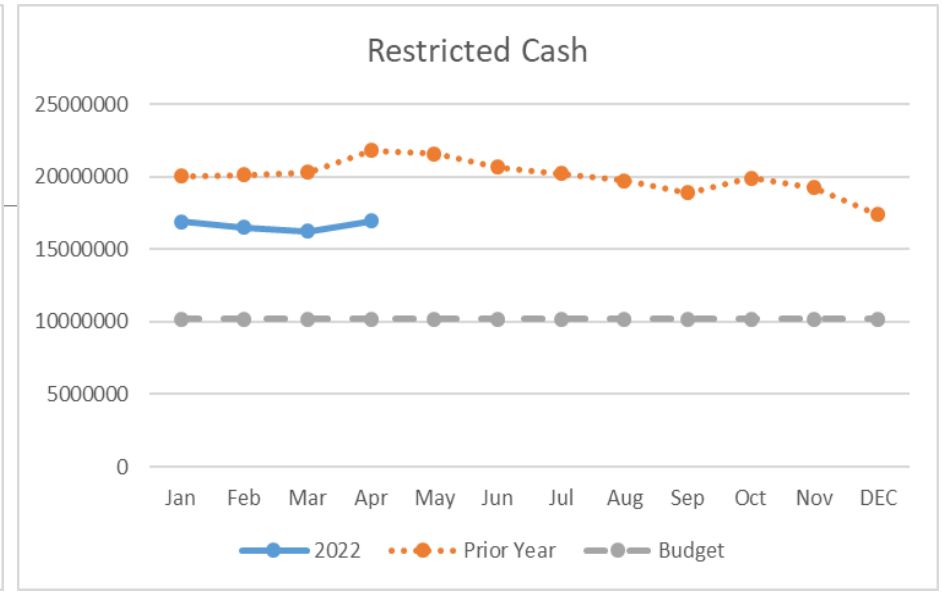


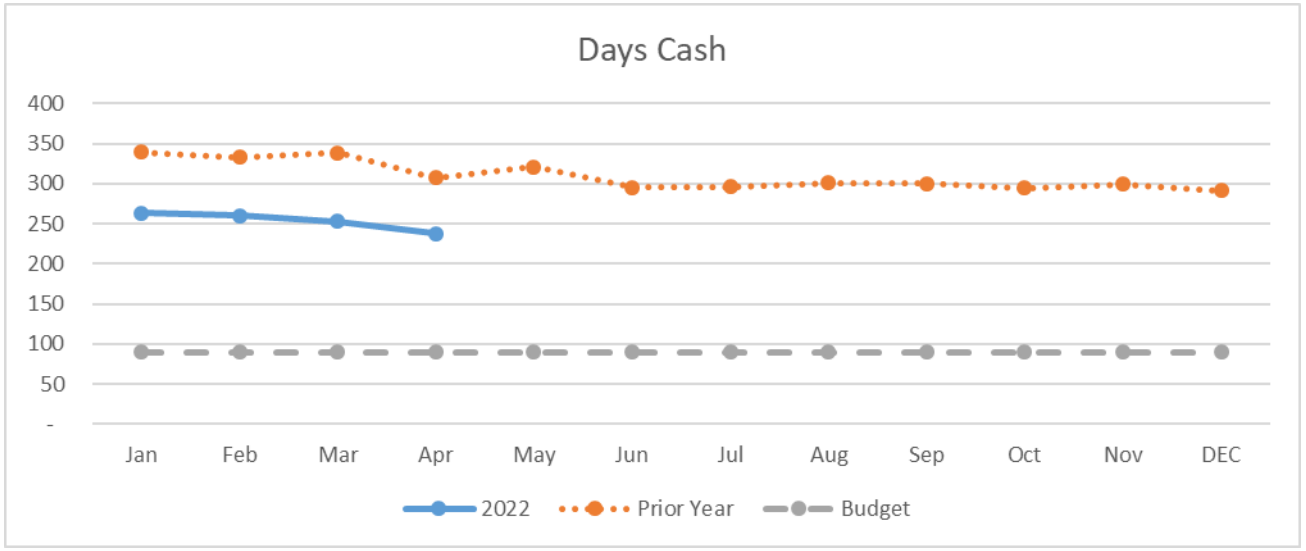




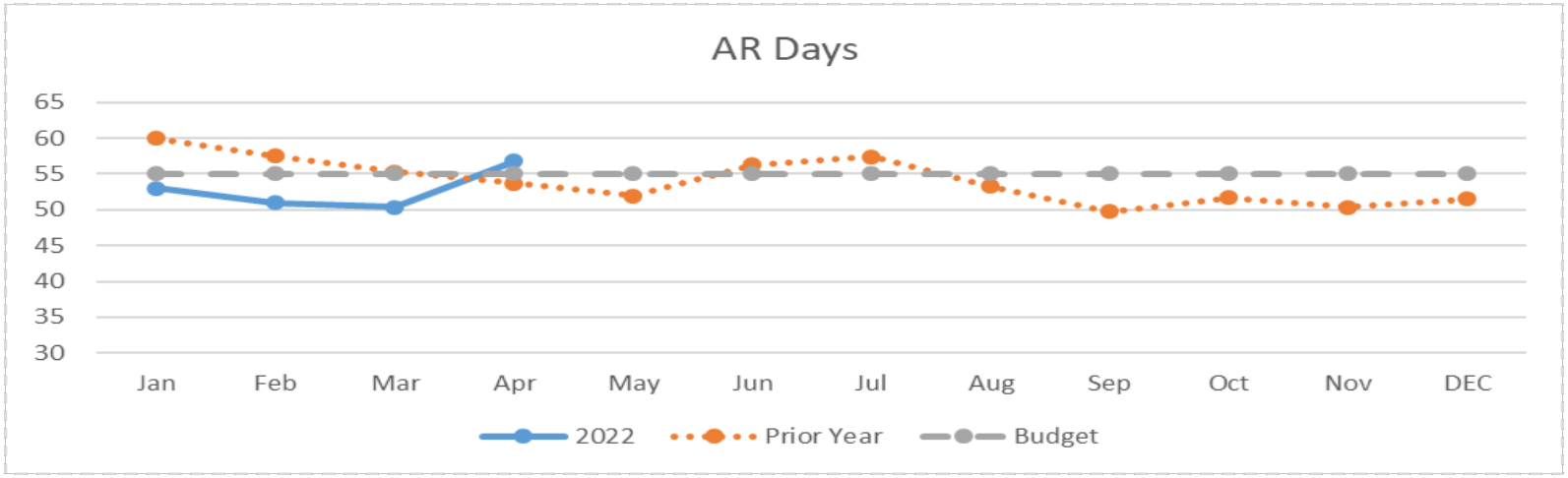
Financial Dashboards (Cash)

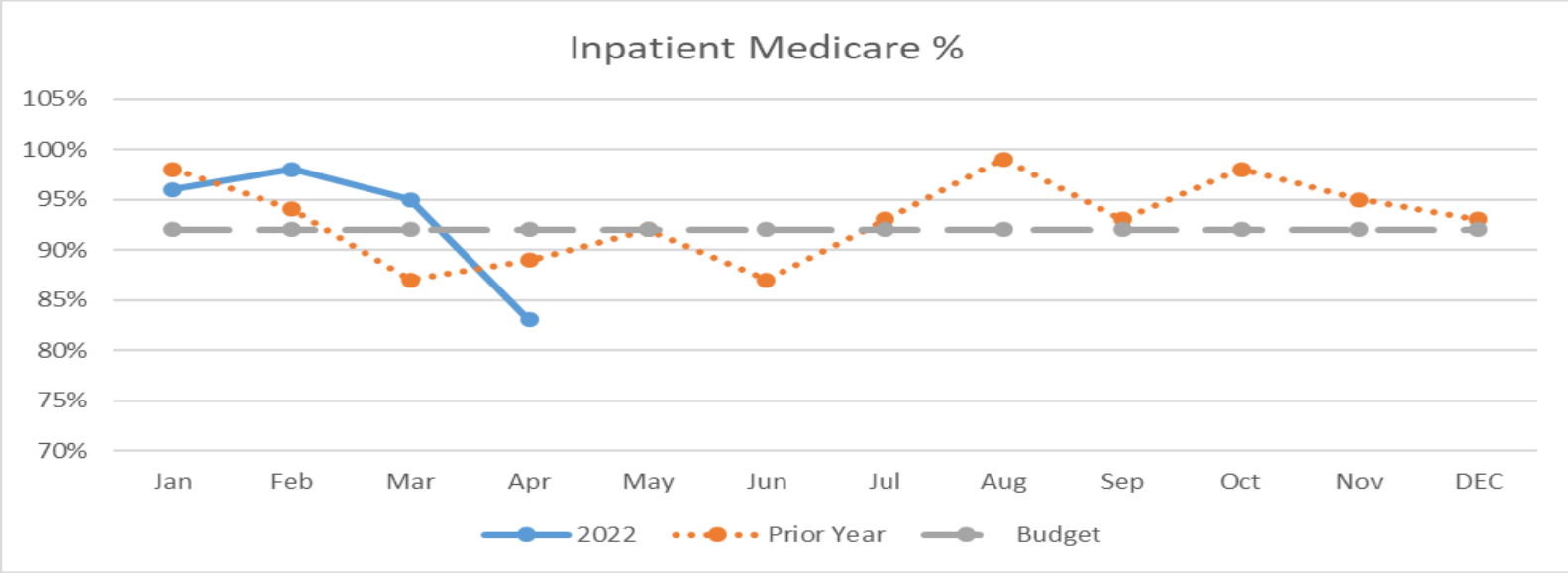




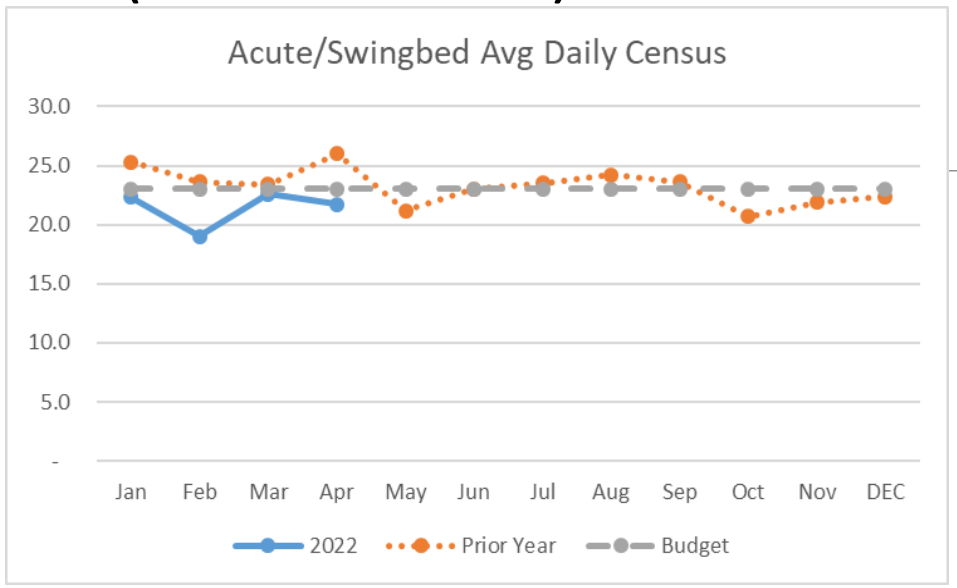


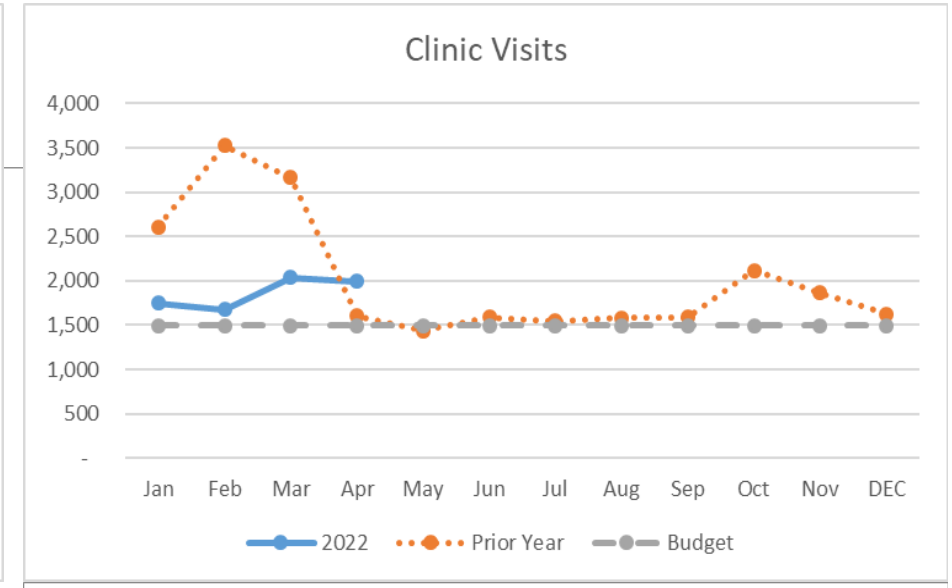
Productivity Dashboards (AR/Payor Mix)

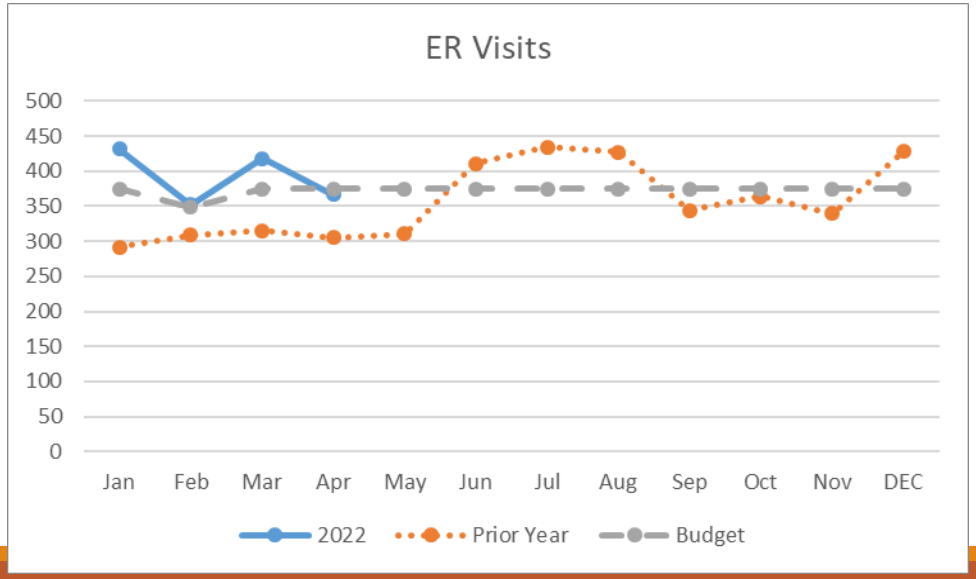


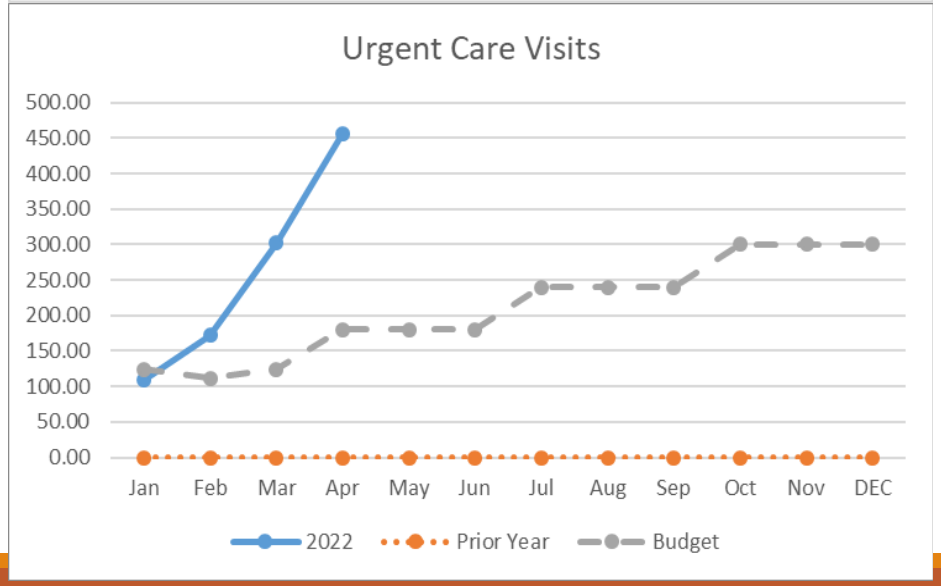


Productivity Dashboards (Census Visits)

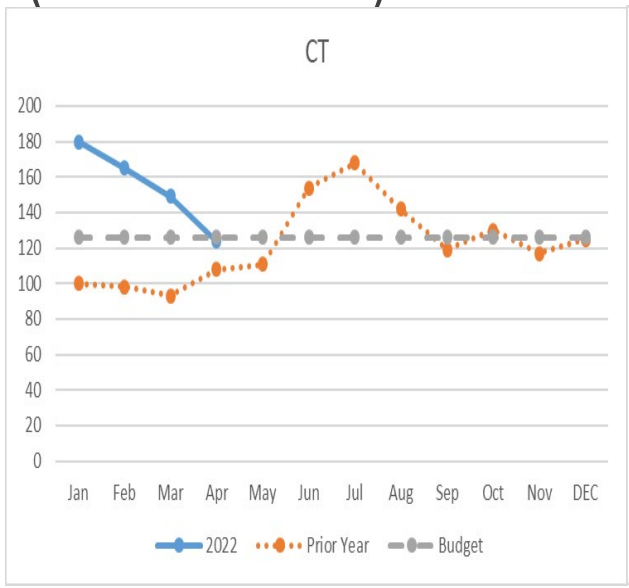


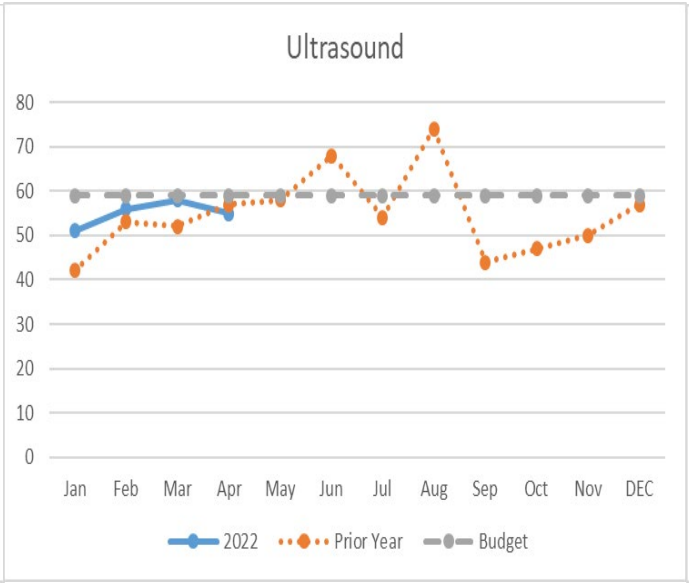


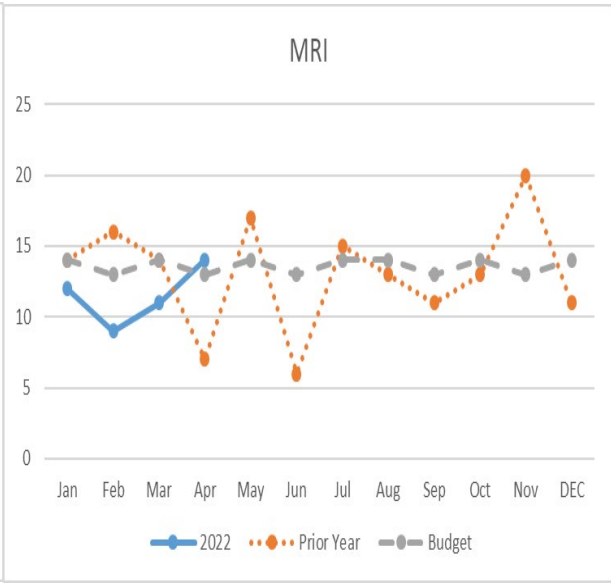


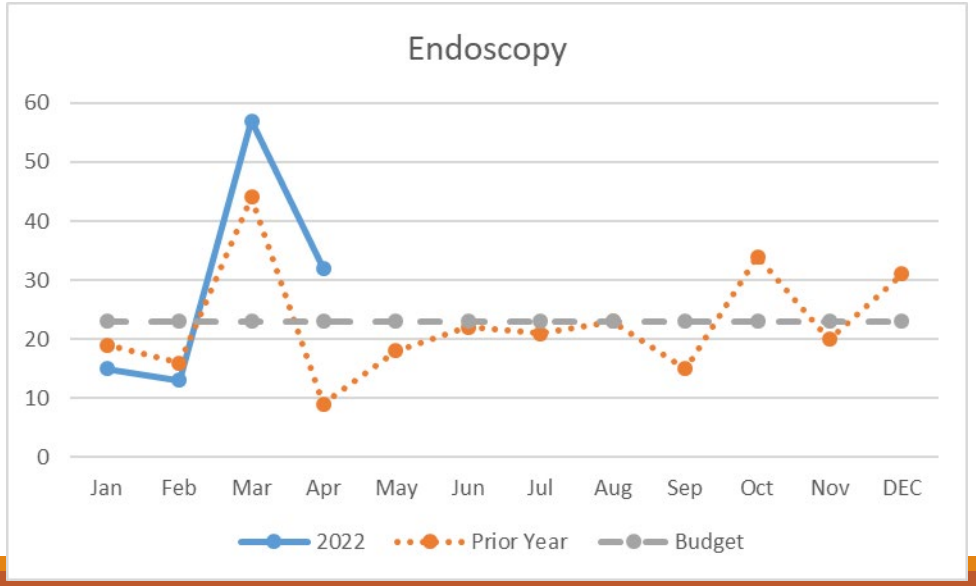


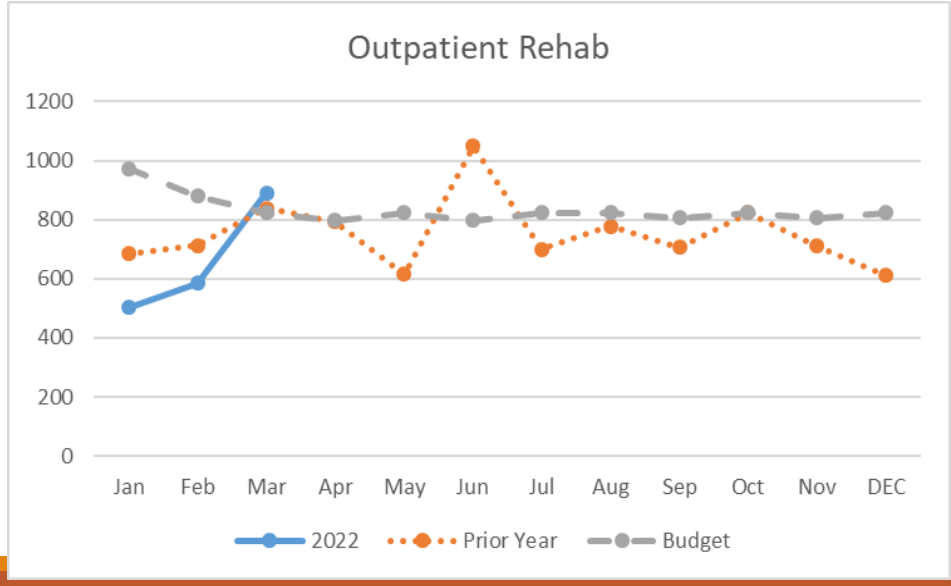
Productivity Dashboards (Procedures)











2021 Cost Report

2021 Cost Report Completed and Filed 05/17/2021

- Owed $65,938 back to Medicare payable on 05/31/2022

PUBLIC HOSPITAL DISTRICT NO. 4, KING COUNTY

Snoqualmie Valley Hospital
9801 Frontier Ave. S.E. Snoqualmie, WA 98065
Phone: 425-831-2300, FAX: 425-831-1994

Cash Disbursements for the period April 1 to April 30, 2022

Northwest Bank Accounts Payable Warrants

$1,653,383.70	Accounts Payable Warrants
	Warrants #78940 - #79228
$1,653,383.70	

Northwest Bank Payroll Warrants & EFT

$1,228.80	Payroll Warrants
1,174,131.01	Hospital & Clinic Payroll Auto Deposits
445,171.73	Hospital & Clinic Payroll Tax
83,628.90	Hospital & Clinic Retirement 457, 403B, & 403B Match Plans
$1,704,160.44	

GRAND TOTAL **$3,357,544.14**

I hereby certify that the described supplies have been received or services rendered in behalf of Public Hospital District No. 4 of King County.

Renee Jensen, Chief Executive Officer

David Speikers, Commissioner, Secretary

I, the undersigned, do hereby certify under penalty of perjury that the materials have been furnished, the services rendered or the labor performed as described herein, and that the claim is a just, due and paid obligation against Public Hospital District #4, King County and that I am authorized to authenticate and certify to said claim.

Carolyn Marks, Assistant Director Finance

I:\Carrie\Board Report & Monthly Reports\BOARD-Cash Disbursements\[BOARD-Cash disbursements 2022.xls]Apr22

Public Hospital District No. 4 King County
Financial Update
Cash Balances
4/30/2022

	Bank/Fund	Cash Balance
Unrestricted		
	Northwest Bank	
	Warrant	$ 612,460.91
	Outstanding Warrants	(550,707.54)
	Payroll	684.63
	Operating	1,874,000.02
	Reconciliating Items	9,665.14
	Lockbox	500,000.00
	Money Market	4,767,068.87
	US Bank Treasury	4,901,254.57
	Banner Bank	
	#4052002599	466,194.72
	#4052002382	348,281.01
	Key Bank	
	#479681237018	109,494.86
	General Fund King Co	
	140040010	86,207.35
	GO Bond Fund King Co	
	140048510	324,915.83
	Petty Cash	300.00
	Total Unrestricted	**13,449,820.37**
Restricted		
	Limited GO Bond Fund-King Co	
	140048400	6,383,018.99
	Reserve Fund-King Co	
	140046010	1,756,633.18
	Reserve 2015 Rev Bond-US Bank	3,675,187.50
	CMS Advance Payment (Money Mkt)	5,163,013.70
		$ 16,977,853.37
	Board Restricted Funds	**$ 102,276.62**
	Total All Accounts	**$ 30,529,950.36**

PUBLIC HOSPITAL DISTRICT NO 4, KING COUNTY

Cash Disbursements for 2022

	Accounts Payable	Payroll and Taxes	Total
January	$ 2,903,911.86	$ 1,721,188.63	$ 4,625,100.49
February	$ 2,156,973.83	$ 1,626,375.80	$ 3,783,349.63
March	$ 2,103,599.41	$ 1,747,960.53	$ 3,851,559.94
April	$ 1,653,383.70	$ 1,704,160.44	$ 3,357,544.14
May			
June			
July			
August			
September			
October			
November			
December			
Total	$ 8,817,868.80	$ 6,799,685.40	$ 15,617,554.20

Cash Disbursements for 2021

	Accounts Payable	Payroll and Taxes	Total	Over(Under) Prior Year Cash
January	$ 1,883,824.00	$ 1,580,891.83	$ 3,464,715.83	$ 1,160,384.66
February	$ 1,882,972.66	$ 1,546,935.95	$ 3,429,908.61	$ 353,441.02
March	$ 1,934,346.63	$ 1,604,040.34	$ 3,538,386.97	$ 313,172.97
April	$ 2,008,435.53	$ 1,652,180.15	$ 3,660,615.68	$ (303,071.54)
May	$ 1,994,858.45	$ 1,624,665.98	$ 3,619,524.43	
June	$ 1,591,743.83	$ 2,036,186.47	$ 3,627,930.30	
July	$ 1,989,070.29	$ 2,489,415.67	$ 4,478,485.96	
August	$ 1,772,231.98	$ 1,671,199.28	$ 3,443,431.26	
September	$ 2,009,446.20	$ 1,761,079.78	$ 3,770,525.98	
October	$ 1,768,485.08	$ 1,602,472.64	$ 3,370,957.72	
November	$ 2,065,508.80	$ 1,630,907.58	$ 3,696,416.38	
December	$ 2,015,112.91	$ 2,377,789.44	$ 4,392,902.35	
Total	$ 22,916,036.36	$ 21,577,765.11	$ 44,493,801.47	$ 1,523,927.11

Cash Receipts for 2022

	Deposits at Banks All accounts	Line of Credit or Bond Fund or Money Market	Total
January	$ 1,769,502.02	$ 1,300,000.00	$ 3,069,502.02
February	$ 3,525,534.39		$ 3,525,534.39
March	$ 3,320,462.41	$ 500,000.00	$ 3,820,462.41
April	$ 2,647,666.68	$ 1,000,000.00	$ 3,647,666.68
May			
June			
July			
August			
September			
October			
November			
December			
			$ -
Total	$ 11,263,165.50	$ 2,800,000.00	$ 14,063,165.50

Cash Receipts for 2021

	Deposits at Banks All accounts	Line of Credit or Bond Fund or Money Market	Total	Over(Under) Prior Year Cash
January	$ 5,433,086.54		$ 5,433,086.54	$ (2,363,584.52)
February	$ 3,271,499.60		$ 3,271,499.60	$ 254,034.79
March	$ 4,291,205.71		$ 4,291,205.71	$ (470,743.30)
April	$ 3,330,161.68		$ 3,330,161.68	$ 317,505.00
May	$ 3,144,291.11		$ 3,144,291.11	
June	$ 3,128,792.15		$ 3,128,792.15	
July	$ 3,504,942.72		$ 3,504,942.72	
August	$ 3,900,834.68		$ 3,900,834.68	
September	$ 3,680,429.86		$ 3,680,429.86	
October	$ 3,058,246.01		$ 3,058,246.01	
November	$ 3,903,031.22		$ 3,903,031.22	
December	$ 4,394,700.98		$ 4,394,700.98	
Total	$ 45,041,222.26	$ -	$ 45,041,222.26	$ (30,978,056.76)

Days AP Payable	19.10

Facilities Committee Meeting – Minutes

Public Hospital District No. 4, King County
Snoqualmie Valley Hospital
Tuesday, May 17, 2022 – 11:30 am
Via Zoom

Committee Members Present:
Commissioner Jen Carter
Commissioner Dariel Norris
Karyn Denton, COO/CNO, Executive Chair
Renee Jensen, CEO
Danny Scott, Director of Facilities
Jamie Palermo, Sr. Executive Assistant

Old Business: None

New Business:

1. **Maintenance Issues:** No major issues. Facilities Team working on exterior cleaning of the building; moss removal, power washing.
   Facility Usage – As of April 2020: Due to COVID-19, all external uses of the community room are cancelled until further notice
2. **Environment of Care:** Staff nominations for the Safety Committee have been finalized and first roll out meeting is scheduled May 18th

Emergency Management: ALNW drill scheduled for September. Involves multiple roles and personnel in the hospital, police and fire support. Commissioner Norris requested the Board be able to attend or view the event. Danny will look into various options.

Fire Safety Management: No report

Hazardous Materials Waste Management: No report

Medical Equipment Management: No report

Physical Plant: No report

Safe Patient Handling: No report. Commissioner Norris asked if Board could have additional training of the activities that are covered in safe patient handling. The Safe Patient Handling Charter has been attached to these minutes for reference.

Safety Management: Safety Committee having first meeting May 18th

Security Management: Danny has finalized new security program and will present details of the changes.

Utilities management: No report

Workplace Harm: No report

East Campus: Staff have returned to office, and increased security rounds have been continued. Commissioner Carter requested an update on plans for East Campus space and possible options for staff offices. COO Denton reported that CEO Jensen and CFO Ritter have been engaged in discussions with another local business as they may have space for lease. More information will be available after their next meeting.

Commissioner Carter asked if there is a timeline as to when to open the hospital back up to public events. It was reported that there is no current plan to do so but staff will continue to provide updates.

Other: No report

Next meeting: June 14, 11:30am – via Zoom

2021-22 Safe Patient Handling Sub-committee Charter

Committee Name	Snoqualmie Valley Hospital District #4 Safety Patient Handling Sub-committee
Overall Purpose/ Strategic Objective	The purpose of the Safe Patient Handling Committee is the development, on-going monitoring and, when needed, revision of the Safe Patient Handling Program at Snoqualmie Valley Hospital. The program is designed to protect healthcare employees and patients from injury during patient transfers, transport, and movement. In doing so, the Committee will follow requirements as outlined in WAC 246-320-221 and 296-17-35203(7).
Committee Membership and Leadership	Committee membership will be composed of: 1. Co-Chair of the Patient Safety Committee 2. Director Facilities/Safety Officer 3. Nursing floor staff member 4. Rehabilitation Services staff member The Co-Chair of the Patient Safety Committee will act as Chair of the sub-committee. The Co-Chair of the Patient Safety Committee and the Safety Officer are permanent members of the sub-committee. The Safe Patient Handling Sub-Committee will maintain a composition of which at least 50% are direct patient care staff, as required by WAC. The QI Director serves as an ad-hoc member of the Committee. As needed, other ad-hoc members will be added to the group for issues requiring special support and/or expertise.
Executive Sponsor	The Committee has direct reporting to the Snoqualmie Valley Hospital QI Committee.
Tasks/ Functions	Ongoing activities include: • Development, monitoring and revision of the Safe Patient Handling Program. The Program must include safe patient handling policy and process review, an annual performance evaluation to assess program effectiveness, utilize hazard assessments, review and update guidelines for safe patient handling when needed, review the safety design of any new construction or remodel, annual skills training and review, and a staff “opt-out” process. • Participation in Root Cause Analysis review of injuries sustained by patients and/or staff. • Other special projects or performance improvement projects needed for continued program success
Meeting Management	**Meeting schedule:** The Safe Patient Handling Committee will meet on a monthly basis. Meetings will be scheduled for no longer than 1 hour. Notices of meeting dates and times will be posted on the Sharepoint Calendar and by e-mail to participants.

2021-22 Safe Patient Handling Sub-committee Charter

Meeting Management (continued)	The meetings for each full year will be set so that scheduling and staffing can accommodate maximum attendance of the staff. Participation by a hospital employee shall be on scheduled work time and compensated at the appropriate rate of pay. Members shall be relieved of all other work duties during meetings. Staff members of the Sub-committee will be paid to attend scheduled meetings as part of their normal work day. It is understood that meeting schedules may require that a staff member attend on his/her scheduled day off. In those cases, the employee will clock in and be paid for their time at the meeting. All attempts will be made for meeting times to be convenient for both day and night shift staff. **Record-keeping/minutes:** • Meeting agendas will be posted to SharePoint, with notices to committee members by email. • The minutes of each meeting will be posted to SharePoint within a week of the meeting with notices to Sub-committee members by email. A master copy of all meeting minutes will be maintained and available for review on SharePoint. **Attendance requirements and participation expectations:** • All members are expected to attend, in person, at least 75 percent of the meetings held each year. Arrangements can be made to allow a designated replacement on a case by case basis. If a member needs to be excused, requests for an excused absence should be communicated to the Chairperson. If the attendance expectation is not met, the permanent members will notify the member's supervisor to determine the status of future participation. • It is the expectation of the Committee that all members will participate actively, including reading required materials in advance of the meeting as assigned, coming prepared to meetings, and engaging in respectful dialogue as professional committee members. **Decision-making process:** • Consensus will be used as the decision-making model. • Should a particular issue need to be voted upon by the committee, the action must be approved by a majority vote of the full committee members present at the meeting.

Medical Committee – Minutes

Public Hospital District No. 4, King County
Snoqualmie Valley Hospital
Tuesday, May 17, 2022 – 3:00pm
[Via Zoom]

PARTICIPANTS: **Dariel Norris** – Commissioner; **Emma Herron** – Commissioner; **Dr. Rachel Thompson** – CMO; **Renée Jensen** – CEO

COMMUNITY

COVID

- Vaccine and testing are both at 50 or under, administrations per day.
- Discussion regarding combining the testing and vaccinations sites in June dependent on FEMA contract extension.

HOSPITAL

System Wide

- Strategic goals are now included on the Daily Pulse display.
- ED dashboard in final phase of creation.

Inpatient/Swing ***(Average Daily Census)***

2022 Budget (pts/day)	April 2022 (pts/day)	April 2022 YTD (pts/day)
23	22.0	21.73

Emergency ***(Average Daily Visit Volumes)***

2022 Budget (visits/Day)	April 2022 (visits/day)	April 2022 YTD (visits/day)
13	12.23	13

Endoscopy ***(Monthly Visit Volumes)***

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
10	11	45	25								

2021 Monthly Average: 17.9

HOSPITAL AND RIDGE CLINICS

Monthly Visit Volumes

2022	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Visits	1642	1501	1732	1537								
Average per Day	53	54	55	51								

2021 Average (Apr-Dec): 162 visits per month, 62.9 visits per day

Urgent Care Volumes

2022	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Visits	109	172	302	456								
Average per Day	6	6	10	15								

Updates

- Provider searches ongoing for new PCP and Behavioral Therapist.
- Looking into opportunities with podiatry and dermatology.

MEDICAL STAFF – MEC and Med Committee Recommendations:

Transition from Provisional to Active:
Erika Schroeder, MD – Emergency Medicine
Peter Toth, MD – Emergency Medicine

Transition from Provisional to Telemedicine:
Elmira Basaly, MD – IM Telehospitalist
Sulakshna Dhamija, MD – FP Telehospitalist
Nikolay Kolev, MD – IM Telehospitalist
Thomas Lee, MD – IM Telehospitalist
Gavind Niamatali, MD – IM Telehospitalist

Transition from Provisional to Affiliate:
Debby Martin, ARNP – FP Hospitalist
Tammy Moore, DNP – Family Practice
Tahana Salvadalena, ARNP – Family Practice

Renewal to Telemedicine:
David Atkins, MD – Teleradiology
Ben Babusis, MD – Teleradiology
Alan Chan, MD – Teleradiology
Germaine Johnson, MD – Teradiology

NEXT MEETING: Tuesday, June 14, 2022 – 3:00pm

RCW 70.170.060

Charity care—Prohibited and required hospital practices and policies—Rules—Notice of charity care availability—Department to monitor and report.

*** CHANGE IN 2022 *** (SEE **1616-S.SL**) ***

(1) No hospital or its medical staff shall adopt or maintain admission practices or policies which result in:

(a) A significant reduction in the proportion of patients who have no third-party coverage and who are unable to pay for hospital services;

(b) A significant reduction in the proportion of individuals admitted for inpatient hospital services for which payment is, or is likely to be, less than the anticipated charges for or costs of such services; or

(c) The refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital.

(2) No hospital shall adopt or maintain practices or policies which would deny access to emergency care based on ability to pay. No hospital which maintains an emergency department shall transfer a patient with an emergency medical condition or who is in active labor unless the transfer is performed at the request of the patient or is due to the limited medical resources of the transferring hospital. Hospitals must follow reasonable procedures in making transfers to other hospitals including confirmation of acceptance of the transfer by the receiving hospital.

(3) The department shall develop definitions by rule, as appropriate, for subsection (1) of this section and, with reference to federal requirements, subsection (2) of this section. The department shall monitor hospital compliance with subsections (1) and (2) of this section. The department shall report individual instances of possible noncompliance to the state attorney general or the appropriate federal agency.

(4) The department shall establish and maintain by rule, consistent with the definition of charity care in RCW **70.170.020**, the following:

(a) Uniform procedures, data requirements, and criteria for identifying patients receiving charity care;

(b) A definition of residual bad debt including reasonable and uniform standards for collection procedures to be used in efforts to collect the unpaid portions of hospital charges that are the patient's responsibility.

(5) For the purpose of providing charity care, each hospital shall develop, implement, and maintain a charity care policy which, consistent with subsection (1) of this section, shall enable people below the federal poverty level access to appropriate hospital-based medical services, and a sliding fee schedule for determination of discounts from charges for persons who qualify for such discounts by January 1, 1990. The department shall develop specific guidelines to assist hospitals in setting sliding fee schedules required by this section. All persons with family income below one hundred percent of the federal poverty standard shall be deemed charity care patients for the full amount of hospital charges, except to the extent the patient has third-party coverage for those charges.

(6) Each hospital shall post and prominently display notice of charity care availability. Notice must be posted in all languages spoken by more than ten percent of the population of the hospital service area. Notice must be displayed in at least the following locations:

(a) Areas where patients are admitted or registered;

(b) Emergency departments, if any; and

(c) Financial service or billing areas where accessible to patients.

(7) Current versions of the hospital's charity care policy, a plain language summary of the hospital's charity care policy, and the hospital's charity care application form must be available on the hospital's website. The summary and application form must be available in all languages spoken by more than ten percent of the population of the hospital service area.

(8)(a) All hospital billing statements and other written communications concerning billing or collection of a hospital bill by a hospital must include the following or a substantially similar statement prominently displayed

on the first page of the statement in both English and the second most spoken language in the hospital's service area:

You may qualify for free care or a discount on your hospital bill, whether or not you have insurance. Please contact our financial assistance office at [website] and [phone number].

(b) Nothing in (a) of this subsection requires any hospital to alter any preprinted hospital billing statements existing as of October 1, 2018.

(9) Hospital obligations under federal and state laws to provide meaningful access for limited English proficiency and non-English-speaking patients apply to information regarding billing and charity care. Hospitals shall develop standardized training programs on the hospital's charity care policy and use of interpreter services, and provide regular training for appropriate staff, including the relevant and appropriate staff who perform functions relating to registration, admissions, or billing.

(10) Each hospital shall make every reasonable effort to determine:

(a) The existence or nonexistence of private or public sponsorship which might cover in full or part the charges for care rendered by the hospital to a patient;

(b) The annual family income of the patient as classified under federal poverty income guidelines as of the time the health care services were provided, or at the time of application for charity care if the application is made within two years of the time of service, the patient has been making good faith efforts towards payment of health care services rendered, and the patient demonstrates eligibility for charity care; and

(c) The eligibility of the patient for charity care as defined in this chapter and in accordance with hospital policy. An initial determination of sponsorship status shall precede collection efforts directed at the patient.

(11) At the hospital's discretion, a hospital may consider applications for charity care at any time, including any time there is a change in a patient's financial circumstances.

(12) The department shall monitor the distribution of charity care among hospitals, with reference to factors such as relative need for charity care in hospital service areas and trends in private and public health coverage. The department shall prepare reports that identify any problems in distribution which are in contradiction of the intent of this chapter. The report shall include an assessment of the effects of the provisions of this chapter on access to hospital and health care services, as well as an evaluation of the contribution of all purchasers of care to hospital charity care.

(13) The department shall issue a report on the subjects addressed in this section at least annually, with the first report due on July 1, 1990.

[2018 c 263 § 2; 1998 c 245 § 118; 1989 1st ex.s. c 9 § 506.]

NOTES:

Effective date—2018 c 263: See note following RCW **70.170.020.**

MRSC
Empowering local governments

HB 1329: Answers to Your OPMA Questions

May 19, 2022 by Steve Gross
Category: Open Public Meetings Act, New Legislation and Regulations

The best laid schemes o' mice an' men
Gang aft a-gley
Robert Burns

As we've all seen over the last few years, no matter how well we've planned, something always comes along to make us question what we think we know. Currently, local government agencies are balancing the existing emergency rules under Proclamation 20-28.15 and Proclamation 20-28.14 — which expire June 1 — with the statutory provisions of chapter 42.30 RCW (the Open Public Meetings Act or OPMA) as modified by the Washington State Legislature in ESHB 1329.

MRSC's Managing Attorney Flannary Collins summarized ESHB 1329's changes to the OPMA in The OPMA Gets an Update from the Legislature. Go re-read that blog. I'll wait.

Welcome back! In this blog update we summarize some of your questions on what the new law means. A reminder that, as we noted in OPMA/PRA Emergency Proclamation Will Expire June 1, the emergency restrictions on public meetings **will expire** at 12:01 AM on June 1, 2022.

Does ESHB 1329 allow an agency to hold fully remote meetings absent an emergency?

No. Section 5 of ESHB 1329 clearly says an agency can hold a fully remote meeting only "after the declaration of an emergency by a local or state government or agency." In order to do so, the agency must determine "that it cannot hold a meeting of the governing body with members or public attendance in person with reasonable safety because of the emergency."

While the current OPMA-specific emergency proclamation will end on June 1, the governor's general declaration of emergency (Proclamation 20-05) is still in effect. This may provide a legal basis for local counties, cities, towns, and special purpose districts to continue to operate their meetings fully remotely. There may also be local declarations of emergency that are still in effect. At least one city (Port Angeles) is considering a rule that ties restrictions on meetings to the county's COVID-19 tracker. Check with your attorney to see if those declarations provide a sufficient basis to restrict access to meetings.

Can a member of the public be excluded from the in-person component of a meeting?

Yes, but only if the agency determines there are reasonable safety risks because of the emergency. The agency can "[h]old a meeting of the governing body at which the physical attendance by some or all members of the public is limited."

Can we require people to provide their identifying information in order to provide public comment?

Yes, but...

An agency can *request* that a speaker identify themselves to provide public comment but probably should not *forbid* them from speaking if they decline. Board meetings are a limited public forum, and MRSC has previously said that absent some other statutory requirement to hold a public hearing, the OPMA did not require a governing body to take comment at all. Since it chose to do so, a governing body could place content-neutral restrictions on participation. Some examples of these restrictions include identifying the speaker, limiting comments to items on the meeting agenda, and limiting the time per speaker.

ESHB 1329 does not change this analysis. It adds the requirement to the OPMA that an agency take comment at or before every regular meeting at which the board will take final action. But we believe the character of the meeting is still a limited public forum. The bill does not require that you allow verbal public comment during the meeting. It allows you to limit comments to written comments and to set a deadline by which they must be submitted. The bill also contains language making it clear that:

> Nothing in this section diminishes the authority of governing bodies to deal with interruptions under RCW 42.30.050, limits the ability of the governing body to put limitations on the time available for public comment *or on how public comment is accepted*, or requires a governing body to accept public comment that renders orderly conduct of the meeting unfeasible.

(Emphasis mine.)

From a policy perspective, many of us at MRSC have been discussing the sign-in requirement with agencies for several years. We've heard agencies express their concerns about publicizing speakers' home addresses during a televised meeting, and about having those addresses become part of the public record because they are on a sign-in sheet.

We think there is a tension between the agency's statutory right to control public comment and a person's constitutional right to petition the government for redress. We suggest agencies look at the reason they want speakers to provide their name or address and see if they really need to keep that information. That is why we suggest that you can request identification but probably should not require it.

What is a "regular meeting" for purposes of the new public comment requirement?

ESHB 1329 did not change the requirement in RCW 42.30.070 that agencies adopt a schedule of regular meetings. While there is no specific definition of "regular meeting," a conservative interpretation of the statute is that any meeting that is on the adopted schedule is a "regular meeting." It does not matter if you call the meeting a "business meeting" or a "study session," if the meeting is on a schedule that is adopted by ordinance or resolution then it is a regular meeting.

However, not all regular meetings are subject to the public comment requirement – only those "at which final action is taken." (See the next question.)

What is "final action" for purposes of the new public comment requirement?

ESHB 1329 did not change the definition of "final action" in RCW 42.30.020(4).

> "Final action" means a collective positive or negative decision, or an actual vote by a majority of the members of a governing body when sitting as a body or entity, upon a motion, proposal, resolution, order, or ordinance.

If a new matter is added to a regular meeting agenda during the meeting, does the agency have to wait until the next regular meeting to take final action on that matter (to allow for public comment)?

No. The new language in the statute says that the agency

> ...shall provide an opportunity at or before every regular meeting at which final action is taken for public comment. The public comment required under this section may be taken orally at a public meeting, or by providing an opportunity for written testimony to be submitted before or at the meeting....

While the stated intent of ESHB 1329 is to increase transparency and public participation, and the bill *encourages* the use of technology to provide greater opportunities for public comment, the plain language of the statute only *requires* public comment before certain types of meetings, specifically meetings at which final action is taken. It does *not* require an agency to link the public comment with specific agenda items or to delay final action on a specific matter until it has received public comment on that matter.

If we've already held a public hearing on a matter but the governing body has not taken final action, do we still have to allow public comment on that matter?

No. The langauge requires public comment at or *before* every meeting at which final action is taken. It does not require public comment on every agenda item being considered at that meeting. Agencies can note on the agenda when comment will not be taken on a specific item because the hearing on that item has been closed. Presiding officers can also note this at the beginning of the public comment period.

Is the requirement to post agendas online (and the exceptions to that requirement) the same for regular and special meetings?

No. RCW 42.30.077 (regular meeting agendas), as amended by ESHB 1329, requires a special purpose district, city, or town post regular meeting agendas on their or another agency's website unless the agency can show that it:

a. Has an aggregate valuation of the property subject to taxation by the district, city, or town of less than $400,000,000, as placed on the last completed and balanced tax rolls of the county preceding the date of the most recent tax levy;

b. Has a population within its jurisdiction of under 3,000 persons; *and*

c. Provides confirmation to the state auditor at the time it files its annual reports under RCW 43.09.230 that the cost of posting notices on a website of its own, a shared website, or on the website 8 of the county in which the largest portion of the district's, city's, or town's population resides, would exceed one-tenth of one percent of the district's, city's, or town's budget.

Special meeting agendas are controlled by RCW 42.30.080 (which was otherwise amended by ESHB 1329). That statute still says that notices of a special meeting are not required to be posted online if "it employs no full-time equivalent employees, or does not employ personnel whose duty, as defined by a job description or existing contract, is to maintain or update the website."

The legislative history of ESHB 1329 does not provide any insight as to why these two requirements are now different. You should discuss with your agency attorney whether it makes sense for your agency to follow the more restrictive of the two requirements. It seems that if your agency qualifies for the exception to post regular meetings it would also meet the requirement for special meetings.

Do the amendments to RCW 42.30.090 in section 11 of ESHB 1329 mean that we must publish an order or notice of adjournment every time we conclude a meeting?

No. MRSC asked Ann Macfarlane, a noted parliamentarian and co-founder of Jurassic Parliament, and she told us:

The customary language used in Robert's Rules of Order is to conclude the meeting by adjourning it. This means "this meeting is ended." This may occur in three instances:

a. If the members move to adjourn by majority vote (non-debatable motion)

b. If the scheduled business has come to an end, in which case the chair may say, "There being no further business, this meeting is adjourned." No motion required.

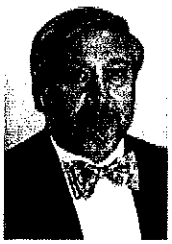
c. If a riot breaks out and there is danger to safety, the chair may adjourn the meeting unilaterally.

However, Robert's Rules also uses the phrase "to adjourn the meeting" to refer to a situation where the meeting is not yet concluded, so it is "adjourned to another time." This is unfortunate. I wish that they had adopted the phrase "continue the meeting" for this situation.

MRSC believes that the term "adjournment" in the OPMA refers to rescheduling a regular or special meeting (e.g., because there isn't quorum) and that no notice has to be posted when a regular or special meeting just comes to an end. We agree with Ann that agencies can continue to say, "This meeting is adjourned" when the agency has concluded the business on the agenda.

For more information on this and other OPMA issues, see our Open Public Meetings Act topic page.

MRSC is a private nonprofit organization serving local governments in Washington State. Eligible government agencies in Washington State may use our free, one-on-one Ask MRSC service to get answers to legal, policy, or financial questions.



About Steve Gross

Steve Gross joined MRSC as a Legal Consultant in January 2020.

Steve has worked in municipal law and government for over 20 years as an Assistant City Attorney for Lynnwood, Seattle, Tacoma, and Auburn, and as the City Attorney for Port Townsend and Auburn. He also has been a legal policy advisor for the Pierce County Council and has worked in contract administration.

VIEW ALL POSTS BY STEVE GROSS ▸

Follow us:

Snoqualmie Valley HEALTH

Chief Executive Officer Report
May 19th, 2022

Happy Mother's Day to all of the hard working Mom's on the SVH Team!

"There is no way to be a perfect mother and a million ways to be a good one"
-Jill Churchill

Foundational Elements

Building essential infrastructure to support a healthy future.

Objective: Successful migration to Epic system & Go-live by Dec. 31st, 2022.

On target – Go live for September 19th, 2022 @ 45%

- **EPIC Implementation** – See attached progress report & dashboard. This is an internal document that gives the team a high level view of challenge areas, areas of focus and areas that might be at risk.
- **Employee Safety Committee** – With Danny Scott, Facilities Director, joining us we have the perfect opportunity to reinvent and relaunch our employee safety committee. Danny did a great job getting representation from all areas of the organization. The purpose of this committee is to ensure that frontline staff have a voice and active role in helping to ensure a safe work environment. The first meeting was a huge success; rumor has it that it was the best meeting Dr. Thompson has attended at SVH! Well done Danny!
- **Off campus work space** – We continue to investigate options for a professional work space for the HR and finance team members that are currently working at East Campus. We are looking for something that is more accessible for a diverse workforce, professional in appearance, and easier to access in the winter months. Currently there is one business in town that has some available space that may work well for us at an affordable price. More details to come as our options become available.
- **Strategic Planning** – The strategic plan is a living document that we utilize all year however, each year before budget season we review the plan at all levels to remove work that is complete or no longer relevant, add additional items that have risen to the top of importance and evaluate our overall direction. We will begin this series of meetings soon, including the board of commissioners. Other groups that will have concentrated time with the plan will be the Leadership/management team, the operational leaders, and the medical staff. Each group will have education combined with input and plan building time over the summer. The goal will be to have a budget impact and capital budget planning completed to complement the budgeting cycle.
- **WSHA Education –** CEO Jensen attending the WSHA leadership summit with several of the board members both in person and virtually. The conference topics were very relevant and the option to attend virtually was a great new addition to the educational offerings.
- **HIM Transition –** This month our HIM team transitioned to employment with HRG. HRG is a large company with expertise in this area. The transition will provide the team with additional tools, technology, and education which SVH could not provide to a small team. This transition will improve charge capture, increase our ability to support new and growing services, and lower our overall cost.
- **Medical Records –** Based on overwhelming feedback from our community we transitioned our medical records function to ScanStat a large company that specializes in fulfilling medical record requests. This

Renée K. Jensen, Chief Executive Officer
9801 Frontier Avenue SE, Snoqualmie, WA 98065 • Ph. (425) 831-2362 | Fax:(425) 831-3412
Owned and Operated by King County Public Hospital District No. 4

transition will improve turnaround times for record requests and provide better document management processes.

Health System of Choice

Develop a brand of the future and define the "New SVH".

Objective: Maintain a composite clinic score of overall patient satisfaction of 4.0 or greater.

On target - Composite clinic score of overall patient satisfaction = 4.74

- **The Ridge Urgent Care –** The Snoqualmie Valley Chamber hosted an official ribbon cutting for the Ridge Urgent Care. It was well attended by local officials and very much appreciated that the community recognizes the challenges we faced opening the clinic in the middle of COVID challenges.
- **Survey vitals –** In January we changed our patient satisfaction platform to Survey Vitals to improve data, survey format and ability to collect more data. Survey Vitals is so successful that it is being acquired by a new company. This will require us to change platforms again this year and establish new baselines. We do not have a lot of information on the impacts of this change yet but we will keep the board up to date as it may require changing or adjusting a metric on the board strategic plan dashboard.
- **Hospital Lobby –** improving physical spaces to enhance the patient experience is a large part of the strategic plan. Have you seen the hospital lobby recently? The furniture is decluttered and reduced to appear more like a lobby than a waiting room, the piano has a new more prominent location near the fireplace, and Trail Youth Coffee is settled into their new space offering pastries in addition to morning coffee!
- **Community and Outreach Meetings (Sherry Jennings) –**
    - City of Snoqualmie Economic Development Commission meeting.
    - King County Office of Emergency Management Summer Hazards Conference.
    - King County PIO Skills Training with Seattle PD and Seattle Fire (On-Scene Media Relations)
    - A Supportive Community for All meeting with all agencies present.
    - State of the Cities Meeting hosted by SnoValley Chamber.
    - Snoqualmie Valley Human Services Coalition Meeting.
    - Community relations with Eastside Fire & Rescue Battalion Chief.
    - Community relations with Snoqualmie Ridge ROA Communications Director to discuss opportunities for visibility and partnership.
    - Healthy Communities Coalition meeting.
    - Parent Education Alignment meetings.
    - SnoValley Chamber Meeting
    - Fall City Association Meeting/presented hospital update
    - SVGA Meeting

Internal to Support Strategic Plan

- Working with Clinics on SVH Wellness Program launch (Community Health Needs)
- Designing materials with PT/Outpatient team for Parkinson's Program to promote this service to community (Community Health Needs)
- Working with team on NEO Refresh (People)
- Working on Snoqualmie Valley Health messaging, collateral (Health System of Choice)

Internal/External to encourage engagement

- SVH Team participated in North Bend Beautification Day 4/22.
- Encompass's Inspire Breakfast with Amy Johnson 4/26
- Coordinated and Celebrated Snoqualmie Ridge Urgent Care Ribbon Cutting with Team and SnoValley Chamber 5/4
- Launched and helped coordinate National Hospital Week at SVH (5/ 9-13)

People

Recruit and retain the highest caliber SVH team to successfully execute the vision of the "New SVH".
Objective: 4th Quarter open positons will be decreased by 25% to an average of 45 or less.
At target – Open positions reduced from 60 in January to 45 in March and holding steady at 45 in April.

- **Diversity, Equity & Inclusion –** The WSHA sponsored DEI training is now complete. We are continuing the conversation with our leaders and staff and exploring more ways to incorporate DEI into our work.
- **New Leaders – This month we have welcomed** Kathy Smith-Brown, RN ED Manager, and Kelly Miller, Laboratory Manager to our team. Both are doing a great job getting up to speed and jumping right in to help their teams.
- **Executive Team Training –** The executive team participated in an in depth leadership analysis called Personalysis. Following the assessment each team member met with a coach and discussed how to best use their leadership profile to improve professional performance. The final step of this education concluded with a team meeting and deep diving into each team members profile as well as the compounded team profile. This work is extremely important in improving team performance and leadership skills for the executive team. The work was so valuable that we plan to continue using it going forward and offering the training to the Director team next.
- **Hospital/Nurses Week –** Our HR team with the support of Sherry Jennings did a fantastic job celebrating our staff and making hospital week fun for all. Complete with food, balloons, games, ice cream and coffee (not all in the same day of course)! Thank you to everyone for recognizing our hardworking staff.

Community Health Needs

Develop our programs and infrastructure to meet and support the needs of our community.
Objective: Increase annual visits in the rural health clinics by 3% over prior year (2022 target = 17,583).
On target – Total RHC clinic visits YTD are at 7451

- **COVID Vaccines & Testing –** Still seeing a steady volume in both areas, especially as positive rates climb these past couple of weeks. We will plan to discontinue drive through COVID vaccines in June and staff the testing center based on volumes and demand. Testing will likely be moved to the current vaccination area. Temporary testing area is TBD on next phase of use.
- **Provider Recruitment –** We are currently advertising and accepting resumes for a primary care provider to join our team as well as an additional behavioral therapist. Exploring the possibility of specialty support in podiatry and dermatology; more to come as these conversations mature.

- **Urgent Care –** The daily volumes in urgent care continue to be strong and out performing our original proforma. Community feedback is positive and well received. We have implemented our COVID Rx program in the urgent care which is contributing to our volumes. Patients are able to go to the urgent care without appointment, be tested, evaluated and if appropriate receive medication at the time of visit. To date the highest single day in the Urgent Care was April 18th, with 26 patients.
- **Community Health Needs Assessment –** We are in the final data gathering stages of our CHNA. It will be fresh and ready for our strategic planning sessions this summer. HealthFacilities Planning is completing this work via a grant awarded to SVH through the Department of Health.
- **City of Snoqualmie –** CEO Jensen had a very productive meeting with Mayor Kathrine Ross to discuss hospital and city priorities; look for areas of alignment and continue to build upon the existing positive and collaborative relationship between SVH & the City.

Financial Stewardship

Ensuring we have comfortable financial resources to support our ability to provide excellent care and service to our community.

Objective: Positive .5% profit margin. (2022 Budget est = $236,628 net income target)

On target – YTD is $219,012

- **See finance summary prepared by CFO Ritter for more details on financial performance.**
- **Sound Medical Laboratories (SML)** – The transition of SML business is complete and we are no longer functioning as a testing site for their samples. The transition went well with no outstanding issues. We are closely monitoring the outpatient revenue impacts of this transition.
- **FEMA Contracts –** We are still unsure about the extension of our FEMA contracts for vaccination and testing. It does appear with the current COVID spike and the release of the new pediatric boosters that there is a possibility that the contracts could be extended. We are planning to discontinue our drive through vaccination program and reduce our testing program if these funds are not extended through the next quarter.

Upcoming Events –

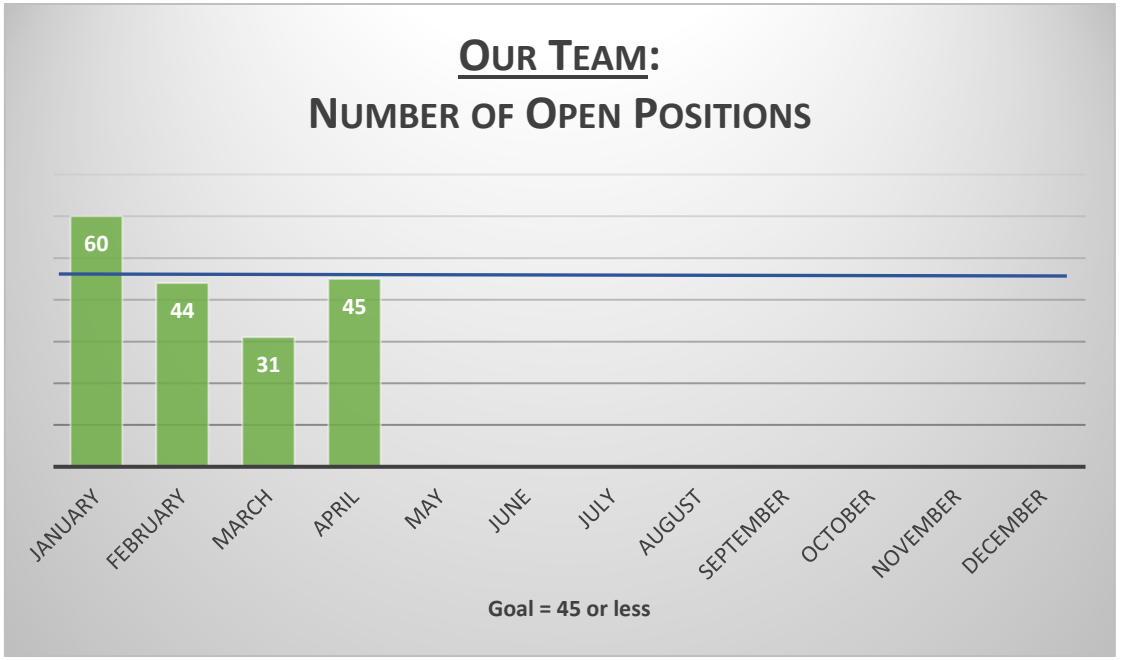
- SVH Board Strategic Planning Retreat – TBD Full day before September
- WSHA Rural Advocacy Days | September 18-21 | Washington D.C.
- WSHA Annual Meeting – In Person or Virtual
    - Sunday, October 16 – Tuesday, October 18
    - Hyatt Regency Lake Washington | Renton, WA
    - Registration opens late summer

Respectfully Submitted, Renée K. Jensen

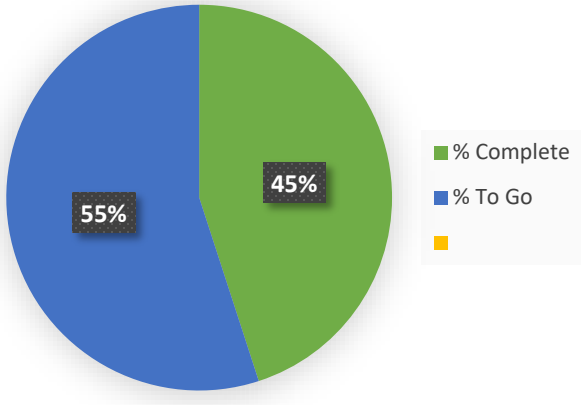
2022 Strategic Plan Dashboard

Financial Target:
.5% Profit Margin

Our Team:
Number of Open Positions

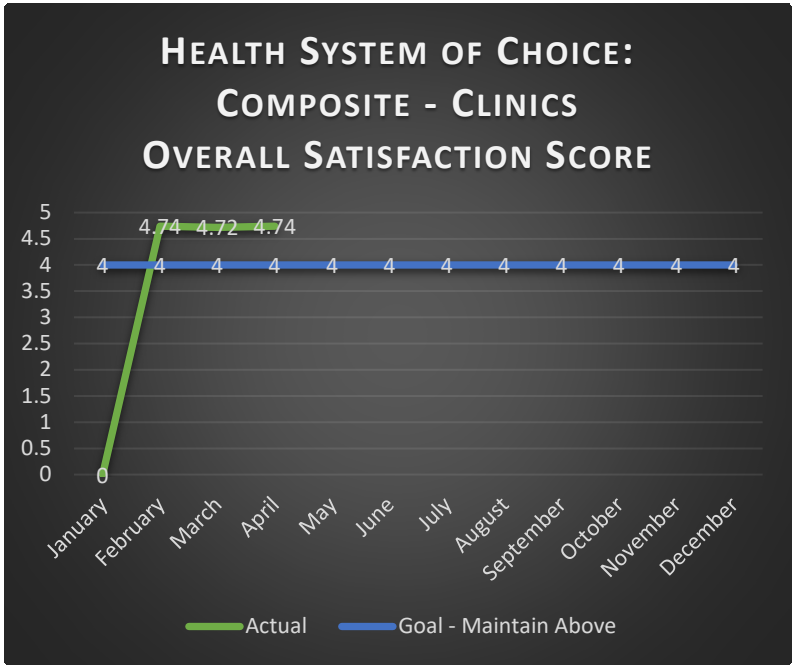


Foundational Element:
EPIC Conversion

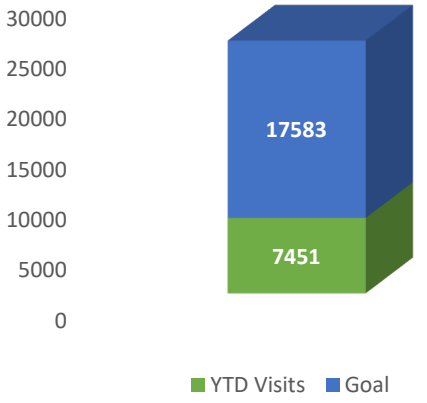


Goal = 100%

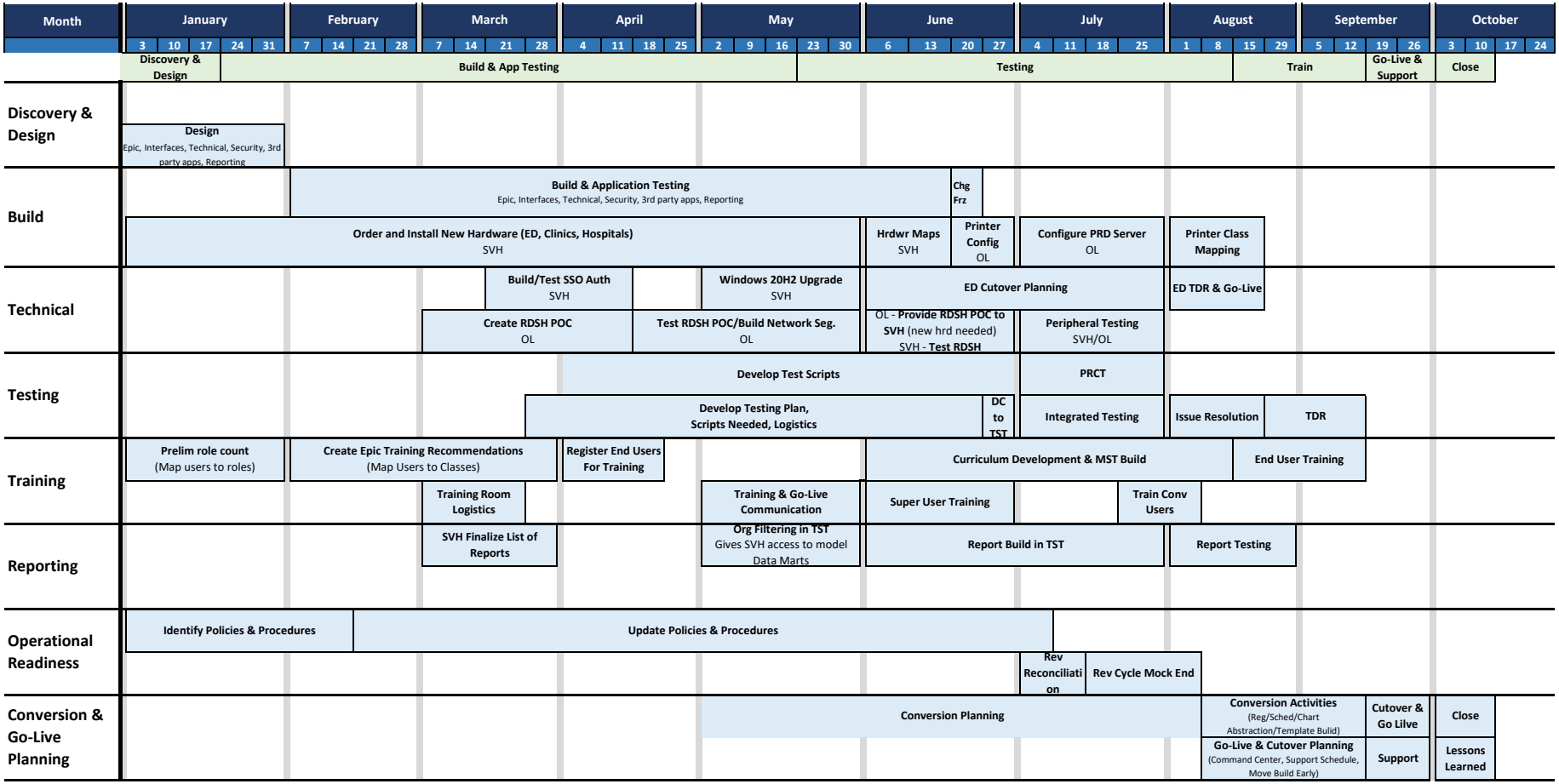
Health System of Choice:
Composite - Clinics
Overall Satisfaction Score



Community Health Needs:
Total # of Clinic Visits



Last updated: May 16, 2022


Month
January
February
March
April
May
June
July
August
September
October
3 10 17 24 31 7 14 21 28 7 14 21 28 4 11 18 25 2 9 16 23 30 6 13 20 27 4 11 18 25 1 8 15 29 5 12 19 26 3 10 17 24
Discovery & Design
Build & App Testing
Testing
Train
Go-Live & Support
Close
Discovery & Design
Design
Epic, Interfaces, Technical, Security, 3rd party apps, Reporting
Build
Build & Application Testing
Epic, Interfaces, Technical, Security, 3rd party apps, Reporting
Chg Frz
Order and Install New Hardware (ED, Clinics, Hospitals)
SVH
Hrdwr Maps
SVH
Printer Config
OL
Configure PRD Server
OL
Printer Class Mapping
Technical
Build/Test SSO Auth
SVH
Windows 20H2 Upgrade
SVH
ED Cutover Planning
ED TDR & Go-Live
Create RDSH POC
OL
Test RDSH POC/Build Network Seg.
OL
OL - Provide RDSH POC to SVH (new hrd needed)
SVH - Test RDSH
Peripheral Testing
SVH/OL
Testing
Develop Test Scripts
PRCT
Develop Testing Plan, Scripts Needed, Logistics
DC to TST
Integrated Testing
Issue Resolution
TDR
Training
Prelim role count
(Map users to roles)
Create Epic Training Recommendations
(Map Users to Classes)
Register End Users For Training
Curriculum Development & MST Build
End User Training
Training Room Logistics
Training & Go-Live Communication
Super User Training
Train Conv Users
Reporting
SVH Finalize List of Reports
Org Filtering in TST
Gives SVH access to model Data Marts
Report Build in TST
Report Testing
Operational Readiness
Identify Policies & Procedures
Update Policies & Procedures
Rev Reconciliation
Rev Cycle Mock End
Conversion & Go-Live Planning
Conversion Planning
Conversion Activities
(Reg/Sched/Chart Abstraction/Template Build)
Cutover & Go Lilve
Close
Go-Live & Cutover Planning
(Command Center, Support Schedule, Move Build Early)
Support
Lessons Learned

2021 Critical Access Hospital Program Evaluation

March, 2022

Interval of Reporting Period and Process:

The Critical Access Hospital Program Evaluation encompasses review of 2021 operations compared to 2020 and/or 2019 where applicable. It is constructed in the first quarter of the following year as a responsibility of the CEO though contributions come from many sources in the organization. Comparisons to the prior year or to the plans for the year are incorporated when applicable. The majority of these data items are being monitored on a monthly and a year to date basis over the course of the year.

Overview of Patient Care Services:

Provided on-site:

- Acute and Observation admissions of low to moderate complexity and severity of illness
- Swing bed admissions of low to high complexity and severity of illness
- Emergency department services including Cardiac Level 2, Stroke Level 3, and Trauma Level 5
- Rehab therapy inpatient and outpatient: Physical, Occupational, Speech, and Recreational
- Imaging services: CT, MRI, Ultrasound, DEXA
- Laboratory services: chemistry, hematology, urinalysis, banked blood distribution, coagulation studies, molecular diagnostics
- Endoscopy services: EGD, Colonoscopy and associated endoscopic interventions
- Outpatient infusions/wound care/catheter care
- Rural Health Clinic and Specialty Clinic care
- Dietician services

Provided on-site through contract arrangement:

- Echo/Stress test, Modified Barium Swallows
- PICC line and mid-line placements
- Sleep studies
- TeleStroke Neurologist video consultation service

Provided off-site through contract arrangement:

- Reference lab services including ABO/Cross-matching and microbiology
- Anatomic pathology

Provided off-site through coordination at time of service:

- Interventional Radiology procedures
- Transfer to higher level of care or access to specialty care consultations
- Dental and Optometric care for Swing Bed patients

Patient Care Services Utilization:

Service Volume Indicator	2021	2020	% Change 2020 to 2021	2019	2018
Inpatient Acute Admissions	52	38	37%	47	42
Inpatient Acute Patient Days	271	120	126%	138	151
Inpatient Acute Average LOS (days)	5.2	3.2	65%	2.9	3.6
Inpatient Swing Bed Admissions	256	267	-4%	266	260
Inpatient Swing Bed Patient Days	8,249	8,267	-18%	8,143	8,211
Inpatient Swing Bed Average LOS (days)	32.2	31.0	1.3%	30.6	31.6
Emergency Department Visits	4,243	3,200	33%	3,960	3,818
% Admitted to SVH	2.0	1.2% 16% gen'l adm	67%	1.4% 22% gen'l adm	1.3%
% Discharged Home	87%	90.5%	-3.5%	90%	89%
% Transferred out, non-psych	9%	7.5% 84% gen'l adm	1.5%	6.3% 78% gen'l adm	6.9%
% Admitted to psychiatric facility	.8%	0.3%	.5%	0.6%	
Departed Against Medical Advice	1.02%	0.5%	.7%	1.7%	
Total ED wRVU	22,070	14,626	51%	17,483	16,632
Endoscopy Procedures	272	133	105%	340	318
Outpatient Rehab Procedures	9,024	8,068	12%	10,206	7,633
Lab Tests	118,663	103,486	15%	53,952	41,523
Medical Imaging Exams	5,320	4,048	31%	4,678	4,032
Clinic Visits	24,258	18,170	34	19,458	18,052
Infusion and Wound Encounters	556	483	15%	720	761

Average total inpatient occupancy was 93% in 2021 compared to 92% in 2020. Several times during 2021 the inpatient census exceeded 25 patients per day consistent with the bed count waiver provided by the Department of Health while under federal and state emergency conditions declaration.

Our Emergency Department increased by 1043 visits in 2021. This had direct impact on the volume of acute inpatient admissions which had 151 more patient days in 2021 over prior year.

Endoscopy utilization increased with the full year availability. There were 139 more Endoscopy procedures in 2021 than in 2020.

Clinic volumes increased in 2021 by 4500 visits over 2020. Dr. Chan and Karen Lajambe retired and we brought on board two new DNPs to replace them. We also added a new pediatrician and added two Physician Assistants in anticipation of the Urgent Care opening.

Laboratory volumes continued to climb with our Drive-through services due to the Delta Variant. The remainder and larger segment of growth in laboratory volumes was from local clinic referrals which continued to climb over the course of 2021 as new clinic sites transitioned to using our reference lab services.

Staffing:

The following departments were staffed 24 hours a day, 7 days a week:

- MedSurg inpatient unit
- Emergency Department
- Laboratory
- X-ray and CT (transitioned from on-site 5 nights and call coverage on 2 nights to fully on-site staff 7 nights each week in Q4)
- Security
- Pharmacy (staffed by Cardinal remote pharmacy services 6pm-9am M-F, 12p-9am Sa-Su)

Call schedules were maintained in the following departments to provide for staff responses on an as needed basis during night time hours:

- X-ray and CT (Q1-3 as above)
- Facilities Maintenance
- Housekeeping
- Hospitalists
- IT/Informatics
- Pharmacy (for physical response to extract medications from pharmacy if not stocked in automatic dispensing unit)
- Clinic providers

After hours pharmacy services are provided via a contracted provider for tele-pharmacy. Also, all professional radiology services are provided via a contracted provider for tele-radiology providing physician reading, telephone consultation, and reporting for all medical imaging exams 24/7.

Quality Improvement:

Quality Improvement was transformed in 2021 to create a more holistic approach focusing on connections to the strategic plan. Quality improvement projects were renovated to be more actionable with an expectation of accountability to demonstrate continuous improvement. Developing, implementation and monitoring quality is an organizational team approach. Quality improvement projects are determined through ongoing process, procedure, performance and risk management. The Quality Committee tracks, reviews and confirms progress in quality improvement projects to the quality and safety of patient care and the safety of the workforce. Benchmarking of measured outcomes and processes is performed in collaboration with the Rural Health Collaborative, WSHA Partnership for Patients, DOHG Trauma Quality reporting, Eastside Healthcare Network UW Harborview stroke program partners CQI activities, Overlake Hospital STEMI collaboration performance analysis, and national benchmarking on HAI via NHSN reporting.

Record Reviews and Audits:

All ED and Med Surg and clinic transfers to higher level of care are reviewed for appropriateness of transfer, for correct and timely communication of necessary information, and completeness of documentation. The review of indications for transfer in 2021 has confirmed the expanded hours of on-site CT/Xray tech availability. The need for increased access to cardiology consultative services remain included in affiliation discussions.

Peer Reviews for 2021 followed the process outlined in Lucidoc for RHC Clinic Documentation Peer Reviews. 5 notes monthly or 15 quarterly were randomly assigned to clinic providers by the Clinical Practice Director. Auditing provider-answered questionnaires regarding their peer's quality of clinical documentation, utilization of evidence based medical decision making, and if a clear follow-up plan was documented. Peer Review Surveys are located in Survey Monkey. Clinical Practice Director shares documentation feedback with providers.

Internal auditing completed in 2021 is as follows:

- All Rapid Response and Code Blues
- All unanticipated patient deaths
- All patient or family complaints regarding care

MedSurg:

- Bar Code Scanning for Med Admin reviewed in report format monthly
- ED to Admission to ensure patients in ED that are admitted to M/S do so with timely orders and timely transfer from ED to MedSurg within 45 minutes of decision to admit. All admissions are reviewed and scored.

Emergency Department:

- Restraint documentation: Audits revealed sections to not be intuitive to complete and did not clearly delineate RN vs Tech documentation responsibilities; a revision project was initiated and implemented.
- All traumas are reviewed for correct activations and length of stay
- All transfers to higher level of care are reviewed alongside the chart records from the receiving hospital following completion of definitive care. Reviews are performed by the nurse manager and the medical director and the treating ED physician.

Infection Prevention:

All positive cultures are reviewed and assessed for current and or new interventions.

- Patients with suspected or confirmed MDROs are monitored daily and placed on isolation
- All patients placed on isolation are reviewed every other day for appropriateness
- Chart review and mini RCA's are completed on all HAI C.diff infections and for all HAI CAUTIs

- All inpatients with urinary catheters:
    - Are assessed for appropriate nursing based protocols
    - Urinary catheter days was 1196 and all appropriate orders had nurse driven protocols in place
    - CAUTIs: 9 with a CAUTI rate of 7.53
- Chart audits were started in December of 2021 and will continue through 2022, including:
    - I&Os
    - Urinary catheter bag emptying
    - Peri care
    - Urinary catheter tube cleaning
- Patient surveillance was started in November of 2021 and will continue through 2022, conducted randomly twice a week, including:
    - Review patient's PICC/central line dressings
    - Proper placement of tubing and urinary catheters bags
- Equipment Surveillance
    - Monitor cleanliness of DM3 machines used for patient vital signs
    - Monitor cleanliness of accu check devices

All Records:

- Average time Admission to chart completion for Clinic Providers: 483.5 hours (20.14 days)—this metric is not at target due to non-compliance with charting protocols by members of medical staff. Process improvement is underway.

New Programs Developed and/or Implemented in 2021:

- Hospital Medicine program
- Nocturnist program
- Transitional Care program
- MedSurg Daily Huddles
- Quality Program
- Event Reporting and Reviewing (SZTF)
- Provider Socials
- Behavioral Health Team

Patient Satisfaction:

	Overall Rating: 2021	Overall Rating: 2020
Inpatient	78.85%	74.4%
Emergency Department	89.64%	82.25%
Clinics	88.8%	89.8%
Outpatient Services	89.5%	92.28%

Overall pleased with preservation of patient satisfaction in general considering the dramatic changes, limitations, restrictions, and new safety procedures associated with the pandemic to include prohibition of visitors, car visits, telemedicine imperfections, etc.

Review of Goals Established at the conclusion of 2021 for 2022:

- **Satisfaction**: Measures the overall experience of customers across the organization in our major service areas – **Achieved**: Patient Satisfaction "Overall" score > 80% for at least 3 of 4 service areas (Inpt, ED, Outpt, Clinics)
    - ED = 90%
    - OP = 89%
    - Clinics = 89%
    - Medical Top Box = 72%
- **Population Health**: Measures our ability to shift to value based service and delivery models. In addition to successful participation in a new model of care, this will also be a predictor of our ability to financially perform in a value based model going forward – **Achieved**: Annual Wellness Visits > 15% for NWMHP ACO or > 30% for Eastside Health Network
    - 31% completed in the Eastside Health Network
- **Safety**: Are we supporting an environment of safety, by encouraging reporting while reducing potential harmful events to our patients – **NOT Achieved**: Severity > D safety events < 15% of total events
    - December 2021 = 11%
    - 2021 annual average = 16%
- **Financial Accountability:** Are we being good stewards of our resources and ensuring we are getting paid for the work we dare doing – **Achieved**: Preventable Payment Denials < 5%
    - 2021 Annual Average = 0.4%

Goals and Plans Established at the conclusion of 2021 for 2022:

- See Strategic Plan for Goals and Progress

Financial Performance of 2020:

	2021	2020	2019	2018
Change in Net Position	$4,555,061 (un-audited)	$509,019 (un-audited)	$ 360,595	$ (651,327)
Charity Care	$832,733	$1,103,109	$ 884,873	$ 592,414

Prepared by:

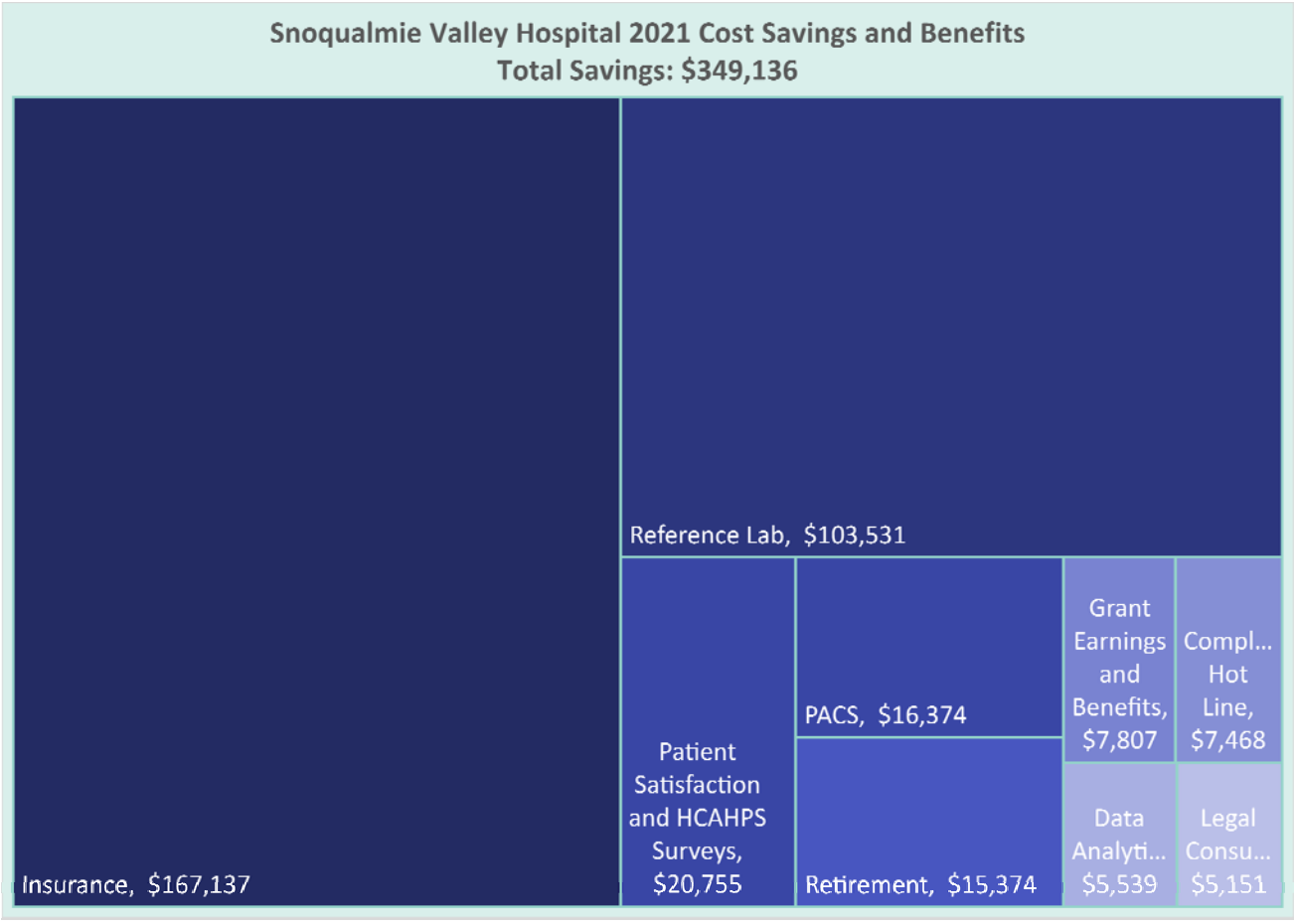
Renée K. Jensen, FACHE
Chief Executive Officer

2021 Savings and Benefits by Category

Hospital Dues	Snoqualmie
Class A Dues	$ 27,000.00
Class B Dues	$ -
Total Investment	**$ 27,000.00**

Contract Utilization Savings	Snoqualmie
Compliance Hot Line	$ 7,468
Data Analytics	$ 5,539
Grant Earnings and Benefits	$ 7,807
Insurance	$ 167,137
Legal Consult.	$ 5,151
PACS	$ 16,374
Patient Satisfaction and HCAHPS Surveys	$ 20,755
Price Transparency and Revenue Cycle Management	$ -
Recruitment	$ -
Reference Lab	$ 103,531
Retirement	$ 15,374
Transitional Care Consulting	$ -
TOTAL SAVINGS	**$ 349,136.00**
NET SAVINGS	**$ 322,136.00**

ROI by Year	Snoqualmie
ROI 2021	**12.9**
ROI 2020	11.6
ROI 2019	4.2
ROI 2018 (Class A Dues Only)	5.7
ROI 2017 (Class A Dues Only)	7.2
ROI 2016 (Class A Dues Only)	3.0
ROI 2015 (Class A Dues Only)	8.2



2021 Savings and Benefits by Category

Hospital Dues		Total
Class A Dues	$	405,000.00
Class B Dues	$	96,000.00
Total Investment	**$**	**501,000.00**

Contract Utilization Savings		Total
Compliance Hot Line	$	82,148
Data Analytics	$	72,007
Grant Earnings and Benefits	$	125,738
Insurance	$	2,966,961
Legal Consult.	$	77,261
PACS	$	32,922
Patient Satisfaction and HCAHPS Surveys	$	71,049
Price Transparency and Revenue Cycle Management	$	228,109
Recruitment	$	654
Reference Lab	$	475,357
Retirement	$	155,681
Transitional Care Consulting	$	186,000
TOTAL SAVINGS	**$**	**4,473,887.15**
NET SAVINGS	**$**	**3,972,887.15**

ROI by Year	Average ROI
ROI 2021	**8.8:1**
ROI 2020	5.5:1
ROI 2019	3.6:1
ROI 2018 (Class A Dues Only)	6.3:1
ROI 2017 (Class A Dues Only)	8.2:1
ROI 2016 (Class A Dues Only)	9.9:1
ROI 2015 (Class A Dues Only)	5.0:1