EASTERN PLUMAS HEALTH CARE DISTRICT
REGULAR MEETING OF THE BOARD OF DIRECTORS
Thursday, December 5, 2013
10:00 A.M.
EPHC Education Center, Portola, CA

Agenda

REASONABLE ACCOMMODATIONS: In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting please contact the Clerk of the Board at (530) 832-6564. Notification 72 hours prior to the meeting will enable the Eastern Plumas Health Care to make reasonable arrangements to ensure accessibility.

	Presenter(s)	I/D/A	Page(s)
1. Call to Order	Gail McGrath	A	
2. Roll Call	Gail McGrath	I	
3. Consent Calendar	Gail McGrath	A	
(A) Agenda			1-2
(B) Meeting Minutes of 10.23.2013	Special Planning Committee		3
(C) Meeting Minutes of 10.22.2013	Special Finance Committee		4
(D) Meeting Minutes of 10.24.2013	Regular Board Meeting		5-9
4. Board Chair Comments	Gail McGrath	I/D	
5. Board Comments	Board Members	I	
6. Public Comment	Members of the Public	I	
7. Auxiliary Report	Katie Tanner	I/D	
8. Committee Reports	Board Members	I/D	
• Standing Finance Committee	Skutt/ McBride		
9. Director of Nursing Report	Linda Jameson	I/D	
10. Clinic Report	Bryan Gregory	I/D	
11. Board Vacancy	Gail McGrath	I/D/A	10

12. Recommendation for Approval of Policies and Privilege Cards — I/D/A

- Cardiology Privilege Card
- HIM Policy and Procedure Binder
- Security Management Program
- PH051 Beyond Use Dating of Pharmaceuticals
- PH052 First Dose Review
- Revision: Acute Unit Patient Acuity Tool

13. Chief Financial Officer Report — Jeri Nelson — I/D

- October/November Financials — 11-21
- Other

14. Declaration of Surplus Property — Tom Hayes — I/D/A

- 2001 Ford Ambulance

15. Chief Executive Officer Report — Tom Hayes — I/D

- DHCS certification surveys update-SNF/ACUTE
- Employee satisfaction survey plan
- Update on boiler repairs
- Guide to Common ACA Questions — 22-25
- Other

16. Closed Session — Gail McGrath — I/D/A

I. Closed Session, pursuant to Health and Safety Code 32155, to review reports on Quality Assurance.

II. Closed Session, pursuant to Government Code Section 54957 to consider the following privileges and appointments to the medical staff:

A. Recommendation for Two Year Active Privileges
- Barnett J. Grier, Jr., MD (Internal Medicine)

B. Recommendation for Two Year Courtesy Privileges
- Alma C. Blanco-Reyes, DDS (Dentistry)

17. Open Session Report of Actions Taken in Closed Session — Gail McGrath — I

18. Adjournment — Gail McGrath — A

EASTERN PLUMAS HEALTH CARE DISTRICT
SPECIAL MEETING OF THE STANDING PLANNING COMMITTEE
OF THE BOARD OF DIRECTORS
Wednesday, October 23, 2013, 2:00 P.M.
EPHC Administrative Conference Room

Minutes

1. **Call to Order:** The meeting was called to order at 2:05 pm by Chairman McGrath.

2. **Roll Call:**
   Present: Gail McGrath, Larry Fites. Tom Hayes, CEO and Tiffany Williams, Administrative Assistant.

3. **Approval of agenda:** The agenda was approved as submitted.

4. **Board Comments**: None.

5. **Public Comments**: None.

6. Boiler replacement next steps : Mr. Fites stated that our boilers are on borrowed time and it is imperative we make the necessary changes. Aspen Architects will be drafting a specific feasibility plan to replace boilers taking into account our Master Facilities Plan.

7. Leadership meeting discussion: There was discussion regarding holding off on any specific financing proposals regarding the Master Plan, which was suggested by the Advisory Council. The proposed Master Plan provides a road map when any improvements are necessary.

8. **Other**: None.

9. **Adjournment: Chairman McGrath** adjourned the meeting at 3:05 p.m.

_____ _____

Approved by **Date**

EASTERN PLUMAS HEALTH CARE DISTRICT
SPECIAL MEETING OF THE STANDING FINANCE COMMITTEE
OF THE BOARD OF DIRECTORS
Tuesday, October 22, 2013
9:00 A.M.
EPHC's Administrative Conference Room

Minutes

1. **Call to Order:** The meeting was called to order at 9:05am by Jay Skutt

2. **Roll Call:**
   Present: Jay Skutt and Janie McBride. Staff: Tom Hayes, Jeri Nelson, and Tiffany Williams.

3. **Approval of Agenda:** The agenda was approved as submitted.

4. **Board Comments:** None.

5. **Public Comments:** None.

6. **CFO Report**
   - **September 2013 Financials:** Ms. Nelson reported September was a low revenue month. Patient revenue was below budget by 13% for the month. Salaries were over budget and $21,000 of the supply variance was due to the flu vaccine. She stated that we received $9,000 for the CARE grant and $14,400 from the Auxiliary for the Portola SNF bath tub. There was discussion regarding Managed MediCal as well as Insurance Exchange.
   - Ms. Nelson reported that Healthland has delayed Centrique for 1 year. They will certify the Classic version for meaningful use stage 2.

Adjournment: Mr. Skutt adjourned the meeting at 10:35am.

_____ _____
Approved by **Date**

EASTERN PLUMAS HEALTH CARE DISTRICT
REGULAR MEETING OF THE BOARD OF DIRECTORS
Thursday, October 24, 2013
10:00 A.M.
EPHC Education Center, Portola, CA
Minutes

1. Call to Order.
The meeting was called to order at 10:00 am by Gail McGrath

2. Roll Call.
Present: Gail McGrath, Larry Fites, Janie McBride, Jay Skutt, and Lucie Kreth
Absent: Larry Fites and Lucie Kreth
Staff: Tom Hayes, CEO, Dr. Eric Bugna, Chief of Staff, and Tiffany Williams, Administrative Assistant.
Visitors: Approximately 6 visitors were present at the start of the meeting

3. Consent Calendar.
Mr. Skutt made a motion to approve the consent calendar as submitted. A second was made by Ms. McBride. None opposed, the motion was approved.

4. Board Chair Comments.
Ms. McGrath stated that there will be no Board meetings in November and that the Regular and Organizational Board meetings are scheduled for December 5, 2013 due to the Holidays.

5. Board Comments.
None.

6. Public Comment.
None.

7. Auxiliary Report
Ms. Tanner reported that Nifty Thrifty grossed $117,184 in September with a net profit of $13,669. She stated that the Nifty Thrifty would be having their annual half off sale in November and that Ms. McBride will be the Co-Manager of Nifty Thrifty beginning in January 2014.

Ms. Kreth and Mr. Fites arrived.

8. Committee Reports
- **Finance Committee**

Mr. Skutt stated that the Finance Committee met and reviewed the September Financials. Total revenue is down. Patient revenue was below budget by 13% for the month. Salaries were over budget and $21,000 of the supply variance was due to the flu vaccine. There was discussion regarding Managed MediCal as well as Insurance Exchange. Ms. Nelson is getting staff trained to help get patients enrolled in the different plans.

• **Quality Committee**
Ms. McGrath stated that the State is requiring much more. The Quality Data was reviewed and processes are in place to correct deficiencies. Ms. Valladon will give a more detailed report during the Quality Report.

• **Planning Committee**
Mr. Fites reported that the Planning Committee met yesterday. He stated that our boilers are on borrowed time and it is imperative we make the necessary changes. Aspen Architects will be drafting a specific feasibility plan to replace boilers taking into account our Master Facilities Plan. He also reported that Aspen Architects have completed the proposed Master Plan. Mr. Fites stated that it is prudent to hold off on any specific financing proposals regarding the Master Plan, which was suggested by the Advisory Council. The proposed Master Plan provides a road map when any improvements are necessary.

9. Chief of Staff
Dr. Bugna reported we are looking for another Internal Medicine provider, otherwise things seem to be going well at the Clinic.

10. Director of Nursing Report
Linda Jameson, RN, DON reported that they are making dramatic improvements in the quality indicators including First Dose Review which is at 100% compliance. She stated that she is focusing on communication and has implemented a communication book, holding monthly department meetings, as well as Nurse Council Meetings. Staffing is key and at this time she has no vacant positions. She also stated that she we have a strong, dedicated, professional staff. Billing is great; she stated she has never seen quicker billing.

Mr. Hayes stated that Ms. Jameson is providing key leadership that was needed and has done a stellar job.

11. Clinic Report
Chelsea Hart, Interim Clinic Manager reported that the leadership transition has been positive. Staff is bringing solutions and creating a more positive staff environment. She stated that they have implemented providers' schedules three months in advance with a goal of six months out. Staff is being cross trained and reallocated. Other activities include:

- Expanding Tele-oncology program meeting to increase the utilization and also building a relationship with Tahoe Forest for continuing education for physicians.
- Assessing needs for specialties. Dermatology is currently available two day per month and we have the need for four.
- Urologist will be starting in January.
- Recruiting Internal Medicine as well as a Family Nurse Practitioner.

Mr. Hayes stated that Ms. Hart has done a great job making decisions and making changes.

12. Quality Report

Kathy Valladon, RN reported that the number of patient satisfaction surveys for Acute has increased and provider and overall satisfaction have improved. They are currently being handed out to the patient on the day of discharge and we are talking to the patient and family. Ms. McBride would like to see the potential number of surveys added to the report.
Ms. Valladon reviewed all of the quality indicators and corrective action plans for deficient items. !00% of all ER, Acute and Surgery charts are being reviewed for compliance for the Plan of Correction indicators.

13. Recommendation for Approval of Privilege Cards and Policies

Ms. McGrath stated that she and Ms. McBride reviewed the following policies;

- Fire Watch Policy
- ED Standing Orders
- AD083 Wireless Device Policy
- IT10 Use of Personal
- IT11 IT Data Center Security
- IT12 Email Encryption
- Storage of Biohazard Waste HK106
- MRSA/MRDO Surveillance Program IC5012
- Internal Medicine Privilege Care Update

Ms. McGrath made a motion to accept the policies listed above. A second was provided by Mr. Fites. None opposed, the motion was approved.

14. CFO Report

- **September Financials**

Ms. Nelson is absent. The financial report was provided under the Finance Committee Report.

15. CEO Report

- **2013/2014 Operations Plan:** Mr. Hayes reported that he has finalized the 2013/2014 Operations Plan. A copy was provided.
- **DHCS certification surveys update-SNF/Acute:** Mr. Hayes reported that we are waiting for a re-survey for both Acute and Skilled Nursing Facilities and we expect they will be here in the next few weeks.
- **Employee Satisfaction Survey Plan:** Mr. Hayes reported within the next few months he will be setting up department meetings to discuss specific actions to be taken.
- **Benefit change for PTO and Extended sick leave:** Mr. Hayes stated that there is a need to revise the PTO and Extended benefit policies, which will include reducing the PTO cap from 400 to 350. Extended is for long term sick leave which most hospitals do not offer. At the first of the year we are going to reduce the extended cap from 480 to 280 and extend the qualifying days from 7 to 21.
- **Leadership Meeting Update:** Provided under the Planning Committee report.

- **Other:** Mr. Hayes reported that the incident over the weekend was very traumatic for staff on duty**.** It was a volatile situation and we were lucky the sheriff deputy got here quickly. We are currently reviewing our security plan and plan to install panic buttons. We have temporarily hired security for the night shift. Dr. Moses suggested providing training on how to diffuse and handle these types of situations. We will be having a debriefing meeting on Monday for Management.

  Caroline Carter, Portola Reporter asked Mr. Hayes if there was anything he would like to say regarding the negative comments being made regarding the officer involved. Mr. Hayes stated that we are thankful that he was here, the situation got out of control very quickly and we were very fortunate for his assistance. He also stated that the patient was free to leave the facility at any time.

16. Closed Session.

Ms. McGrath announced the Board would move into closed session at 12:00 pm., pursuant to Health and Safety Code 32155 and Government Code Section 54957.

17. Open Session Report of Actions Taken in Closed Session.

The Board returned at approximately 12:15 pm and announced the following:

I. Health and Safety Code 32155, to review reports on Quality Assurance.
No reportable action.

II. **Government Code Section 54957, to consider the following appointments to the medical staff**:

Dr. Bugna stated that the MEC reviewed the privileges and background including claims history of Lovsho Phen MD, and Christine Laueunesse MD. The MEC is recommending all of the physicians for privileges to the Board.

Dr. Bugna stated that the IDPC reviewed the privileges and background including claims history of Mary Morrison, FNP, Michael Brooks, DPM and Richard Nielsen, DPM. Dr. Bugna reported that the recommendations from the IDPC were accepted by MEC. The MEC is recommending the FNP and two DPMs for Two Year Courtesy Privileges to the Board for Approval.

Dr. Bugna also stated that MEC reviewed the Updated Schedule 1 from Clinicians Telemedicine Group and Virtual Radiology. The MEC is recommending the approval of the updated schedule 1 from both Clinicians Telemedicine Group and Virtual Radiology.

The Board reviewed each Medical Staff file as submitted including but not limited to: privileges, background, malpractice claims information, peer reviews and AMA/Education.

Ms. McBride motioned to approve the following privileges and appointments to the medical staff as submitted.

a. Recommendation for Two Year Active Privileges
- Lovsho Phen, MD (Internal Medicine)

b. Recommendation for One Year Provisional Privileges
- Christine Lajeunesse, MD (Urology)

c. Recommendation for Two Year Courtesy Privileges
- Michael Brooks, DPM (Podiatry)
- Mary Morrison, FNP (Allied Health-FNP)
- Richard Nielsen, DPM (Podiatry)

d. Schedule 1 Updates
- Virtual Radiology
- Clinicians Telemedicine

A second was provided by Mr. Skutt. None opposed, the motion approved.

The Board returned to Open Session at approximately 12:25 pm

18. Adjournment. Ms. McGrath subsequently adjourned the meeting at 12:25 p.m.

_____ _____
Approval Date

NOTICE OF VACANCY

POSTED: 12/6/2013

THIS NOTICE IS TO ANNOUNCE THAT A VACANCY EXISTS ON THE BOARD OF DIRECTORS OF THE

EASTERN PLUMAS HEALTH CARE DISTRICT.

THE DIRECTORS OF THE EASTERN PLUMAS HEALTH CARE DISTRICT INTENDS TO FILL THE VACANCY BY APPOINTMENT, BUT RESERVES THE RIGHT TO FILL IT BY CALLING AN ELECTION.

THE PERSON APPOINTED TO FILL THE VACANCY SHALL SERVE ON THE BOARD UNTIL THE NEXT UNIFORM DISTRICT ELECTION.

THE APPOINTMENT CAN BE MADE ON 12/21/2013 OR THEREAFTER.

THE APPOINTMENT WILL BE MADE ACCORDING TO THE FOLLOWING PROCESS:

- Persons interested in being appointed to fill the vacancy are requested to mail, via certified mail, return receipt requested, email (expect an email reply confirming receipt or call to inquire), or hand-deliver a letter of interest and brief resume to:

  Clerk of the Board
  Eastern Plumas Health Care District
  500 First Avenue
  Portola, CA 96122
  (530) 832-6564
  twilliams@ephc.org

- Deadline for receipt of the letter of interest and resume is 5:00 p.m. December 23, 2013.

- The Board will review the Letters of Interest and Qualifications and interview interested persons at a Special Meeting of the Board of Directors on Monday, January 6, 2014 at 10am at the above address. Persons interested in being appointed to fill a vacancy should plan to attend this meeting. Appointment to be made at same meeting.

EASTERN PLUMAS HEALTH CARE DISTRICT

MEMORANDUM

Date: November 12, 2013

To: Board of Directors

From: Jeri Nelson, Chief Financial Officer

Subject: **Summary of Financial Results – October 2013**

Table 1. Consolidated Financial Results – October 2013

	Actual	Budget	Variance
Total Revenue	**$2,933,350**	**$3,358,498**	**$(425,148)**
Contractual Adjustments	$1,220,817	$1,517,036	$(296,219
Bad Debt/Admin Adjustments	$208,642	$169,503	$39,139
Net Revenue	**$1,503,891**	**$1,671,960**	**$(168,069)**
Total Expenses	**$1,754,935**	**$1,721,261**	**$33,674**
Operating Income (Loss)	$(251,044)	$(49,301)	$(201,743)
Non-Operating Income(Expense)	$51,198	$75,333	$(24,135)
Net Income (Loss)	**$(199,846)**	**$26,032**	**$(225,878)**

Table 2. Consolidated Financial Results – Four Months Ended October 2013

	Actual	Budget	Variance
Total Revenue	**$12,340,464**	**$13,724,949**	**$(1,384,485)**
Contractual Adjustments	$5,337,020	$6,228,649	$(891,629)
Bad Debt/Admin Adjustments	$652,335	$691,470	$(39,135)
Net Revenue	**$6,351,109**	**$6,804,830**	**$(453,721)**
Total Expenses	**$6,809,619**	**$6,857,217**	**$(47,598)**
Operating Income (Loss)	$(458,510)	$(52,387)	$(406,123)
Non-Operating Income (Expense)	$216,957	$301,333	$(84,376)
Net Income (Loss)	**$(241,553)**	**$248,946**	**$(490,499)**

Late September, the Centers for Medicare and Medicaid Services (CMS) issued a two-midnight benchmark and a 96 hour certification requirement for inpatient admissions, both applicable to Critical Access Hospitals. In October, we had very light utilization of hospital inpatient services, no Swing days for the second consecutive month, and our transfers were up. Health care reform is aimed at keeping patients in an observation status, therefore lowering costs of reimbursement, increasing patient co-pays, increasing collection efforts, and ultimately increasing bad debt. I hope going forward we can and do admit patients to our hospital that are appropriate for the care we can provide. We will work with our health care representatives to educate CMS on the drawbacks of the reforms to our community.

EASTERN PLUMAS HEALTH CARE
STATEMENT OF REVENUE & EXPENSE
FOR THE MONTH ENDED
OCTOBER 31, 2013

DESCRIPTION	CURRENT PERIOD			YEAR TO DATE			ANNUAL
	ACTUAL	BUDGET	VARIANCE	ACTUAL	BUDGET	VARIANCE	BUDGET
OPERATING REVENUE							
INPATIENT ROUTINE	98,388	186,550	(88,162)	602,494	738,109	(135,615)	2,186,989
INPATIENT ANCILLARY	72,764	218,608	(145,844)	561,748	865,228	(303,480)	2,563,180
TOTAL INPATIENT	171,152	405,158	(234,006)	1,164,242	1,603,337	(439,095)	4,750,169
SWING ROUTINE	-	66,038	(66,038)	12,000	260,115	(248,115)	776,000
SWING ANCILLARY	-	41,684	(41,684)	16,426	164,197	(147,771)	489,835
TOTAL SWING BED	-	107,722	(107,722)	28,426	424,313	(395,887)	1,265,835
SKILLED NURSING ROUTINE	481,600	520,607	(39,007)	1,922,550	2,065,871	(143,321)	6,132,000
SKILLED NURSING ANCILLARY	76,491	73,485	3,006	353,190	291,619	61,571	865,566
TOTAL SKILLED NURSING	558,091	594,092	(36,001)	2,275,740	2,357,490	(81,750)	6,997,566
OUTPATIENT SERVICES	2,202,743	2,246,410	(43,667)	8,841,620	9,319,344	(477,724)	25,953,805
TOTAL PATIENT REVENUES	2,931,986	3,353,382	(421,396)	12,310,028	13,704,484	(1,394,456)	38,967,375
OTHER OPERATING REVENUE	1,364	5,116	(3,752)	30,436	20,465	9,971	61,396
TOTAL REVENUE	2,933,350	3,358,498	(425,148)	12,340,464	13,724,949	(1,384,485)	39,028,771
DEDUCTIONS FROM REVENUE							
BAD DEBT/ADMINISTRATIVE ADJ'S	208,642	169,503	39,139	652,335	691,470	(39,135)	1,950,550
CONTRACTUAL ADJUSTMENTS	1,220,817	1,517,036	(296,219)	5,337,020	6,228,649	(891,629)	17,440,309
TOTAL DEDUCTIONS	1,429,458	1,686,538	(257,080)	5,989,355	6,920,119	(930,764)	19,390,859
NET REVENUE	1,503,891	1,671,960	(168,069)	6,351,109	6,804,830	(453,721)	19,637,912
OPERATING EXPENSES							
SALARIES	799,777	768,370	31,407	3,106,385	3,063,520	42,865	9,050,380
BENEFITS	213,432	223,883	(10,451)	842,300	894,418	(52,118)	2,668,005
SUPPLIES	114,747	141,217	(26,470)	560,874	567,868	(6,994)	1,700,608
PROFESSIONAL FEES	245,036	243,946	1,090	965,730	976,619	(10,889)	2,788,765
REPAIRS & MAINTENANCE	42,551	48,052	(5,501)	151,243	192,209	(40,966)	576,628
PURCHASED SERVICES	127,861	70,893	56,968	364,246	285,350	78,896	865,194
UTILITIES/TELEPHONE	51,641	58,028	(6,387)	184,719	210,373	(25,654)	715,360
INSURANCE	31,804	32,996	(1,192)	127,217	132,112	(4,895)	396,464
RENT/LEASE EXPENSE	22,940	16,618	6,322	60,151	66,470	(6,319)	199,411
DEPRECIATION/AMORTIZATION	72,484	75,742	(3,258)	289,999	302,967	(12,968)	908,899
INTEREST EXPENSE	21,881	20,948	933	90,143	83,791	6,352	251,373
OTHER EXPENSES	10,780	20,570	(9,790)	66,611	81,518	(14,907)	244,488
TOTAL EXPENSES	1,754,935	1,721,261	33,674	6,809,619	6,857,217	(47,598)	20,365,575
OPERATING INCOME (LOSS)	(251,044)	(49,301)	(201,743)	(458,510)	(52,387)	(406,123)	(727,663)
MISCELLANEOUS	3,403	2,625	778	11,710	10,500	1,210	31,500
CONTRIBUTIONS	5,000	25,000	(20,000)	28,400	100,000	(71,600)	300,000
PROPERTY TAX REVENUE	42,795	47,708	(4,913)	176,847	190,833	(13,986)	572,500
NON-OPERATING INCOME (EXPENSE)	51,198	75,333	(24,135)	216,957	301,333	(84,376)	904,000
NET INCOME (LOSS)	(199,846)	26,032	(225,878)	(241,553)	248,946	(490,499)	176,337

	CURRENT PERIOD			YEAR TO DATE			ANNUAL
	ACTUAL	BUDGET	VARIANCE	ACTUAL	BUDGET	VARIANCE	BUDGET
STATISTICAL DATA							
ACUTE INPATIENT ADMISSIONS	14	31	(17)	69	123	(54)	365
ACUTE PATIENT DAYS	36	70	(34)	216	277	(61)	821
SKILLED NURSING PATIENT DAYS	1,376	1,488	(112)	5,565	5,904	(339)	17,520
SWING BED DAYS	-	33	(33)	6	130	(124)	388
E.R. VISITS	257	279	(22)	1,286	1,267	19	3,488
CLINIC VISITS	2,195	2,714	(519)	8,410	9,385	(975)	26,802

EASTERN PLUMAS HEALTH CARE
BALANCE SHEET
FOR THE MONTH ENDED
OCTOBER 31, 2013

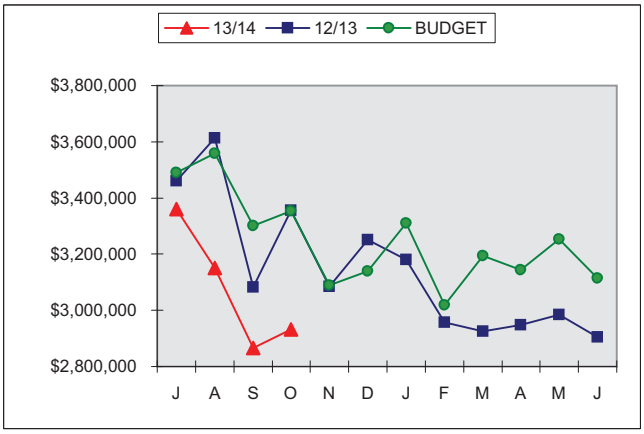
DESCRIPTION	
ASSETS	
CURRENT ASSETS	
CASH	287,094
INVESTMENTS	1,110,187
ACCOUNTS RECEIVABLE NET	2,938,218
ACCOUNTS RECEIVABLE OTHER	621,085
INVENTORY	213,700
PREPAID EXPENSES	112,046
TOTAL CURRENT ASSETS	5,282,330
PROPERTY AND EQUIPMENT	
LAND AND IMPROVEMENTS	934,164
BUILDINGS AND IMPROVEMENTS	10,080,726
EQUIPMENT	10,046,523
IN PROGRESS	175,223
TOTAL PROPERTY AND EQUIPMENT	21,236,637
ACCUMULATED DEPRECIATION	13,486,685
NET PROPERTY AND EQUIPMENT	7,749,952
COSTS OF ISSUANCE NET	12,900
TOTAL	13,045,182
LIABILITIES AND FUND BALANCE	
CURRENT LIABILITIES	
LEASES PAYABLE	68,510
ACCOUNTS PAYABLE	970,326
ACCRUED PAYROLL/RELATED TAXES	934,009
OTHER CURRENT LIABILITIES	369,605
TOTAL CURRENT LIABILITIES	2,342,449
LEASES PAYABLE	308,063
USDA REPAIRS & DEFEASANCE	284,052
CHFFA - EMR & ENDO EQUIP LOAN	33,853
CITY OF PORTOLA- PROPERTY LOAN	348,000
USDA LOANS SNF	3,467,966
USDA LOAN LOYALTON	494,444
USDA LOAN LOYALTON & PORTOLA	73,573
DEFERRED REVENUE	335,339
LTC MEDI-CAL NET	1,557,125
TOTAL LIABILITIES	9,244,865
FUND BALANCE	4,041,870
NET INCOME (LOSS)	-241,553
TOTAL	13,045,182

EASTERN PLUMAS HEALTH CARE
COMPARATIVE BALANCE SHEET
FOR THE MONTHS ENDED

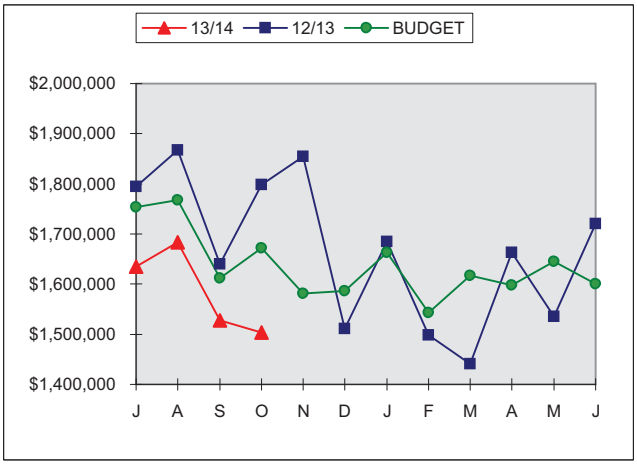
	SEPTEMBER 2013	OCTOBER 2013	CHANGE
ASSETS			
CURRENT ASSETS			
CASH	$ 533,302	$ 287,094	$ (246,208)
LAIF SAVINGS	$ 1,109,513	$ 1,110,187	$ 674
ACCOUNTS RECEIVABLE NET	$ 3,014,105	$ 2,938,218	$ (75,887)
ACCOUNTS RECEIVABLE OTHER	$ 473,185	$ 621,085	$ 147,900
INVENTORY	$ 213,700	$ 213,700	$ -
PREPAID EXPENSES	$ 117,465	$ 112,047	$ (5,418)
TOTAL CURRENT ASSETS	$ 5,461,270	$ 5,282,331	$ (178,939)
PROPERTY AND EQUIPMENT			
LAND AND IMPROVEMENTS	$ 934,164	$ 934,164	$ -
BUILDINGS AND IMPROVEMENTS	$ 10,080,726	$ 10,080,726	$ -
EQUIPMENT	$ 10,046,523	$ 10,046,523	$ -
IN PROGRESS	$ 149,483	$ 175,223	$ 25,740
	$ 21,210,896	$ 21,236,636	$ 25,740
ACCUMULATED DEPRECIATION	$ 13,414,454	$ 13,486,685	$ 72,231
TOTAL PROPERTY AND EQUIPMENT	$ 7,796,442	$ 7,749,951	$ (46,491)
COSTS OF ISSUANCE NET	$ 13,152	$ 12,900	$ (252)
TOTAL	$ 13,270,864	$ 13,045,182	$ (225,682)
LIABILITIES AND FUND BALANCE			
CURRENT LIABILITIES			
LEASES PAYABLE	$ 73,991	$ 68,510	$ (5,481)
ACCOUNTS PAYABLE	$ 872,774	$ 970,326	$ 97,552
ACCRUED PAYROLL/RELATED TAXES	$ 1,014,062	$ 934,009	$ (80,053)
OTHER CURRENT LIABILITIES	$ 368,954	$ 369,605	$ 651
TOTAL CURRENT LIABILITIES	$ 2,329,781	$ 2,342,450	$ 12,669
LEASES PAYABLE	$ 308,063	$ 308,063	$ -
CHFFA LOAN	$ 40,563	$ 33,853	$ (6,710)
CITY OF PORTOLA	$ 348,000	$ 348,000	$ -
USDA LOANS	$ 4,351,830	$ 4,320,035	$ (31,795)
DEFERRED REVENUE	$ 335,339	$ 335,339	$ -
MEDI-CAL LTC	$ 1,557,125	$ 1,557,125	$ -
TOTAL LIABILITIES	$ 9,270,701	$ 9,244,865	$ (25,836)
FUND BALANCE	$ 4,041,870	$ 4,041,870	$ -
NET INCOME (LOSS)	$ (41,707)	$ (241,553)	$ (199,846)
TOTAL	$ 13,270,864	$ 13,045,182	$ (225,682)

EASTERN PLUMAS HEALTH CARE
MONTHLY FINANCIAL GRAPHS
FOR THE YEAR ENDED JUNE 30, 2014

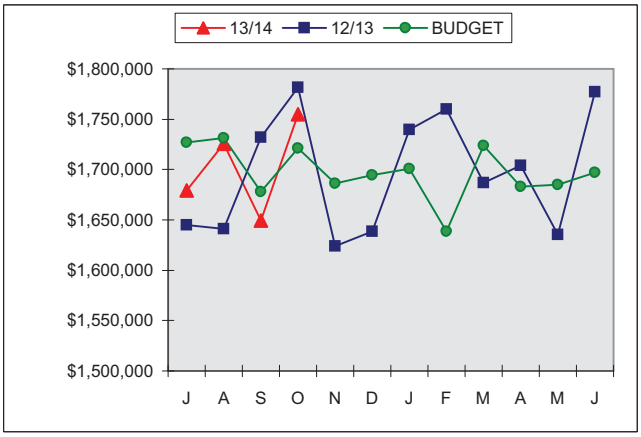
1. GROSS PATIENT REVENUE



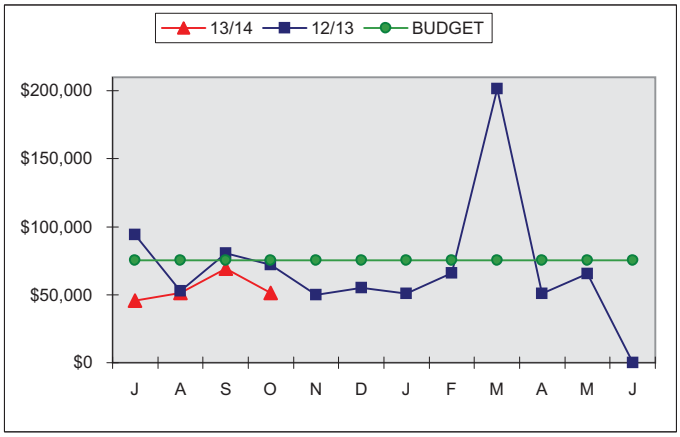
2. ESTIMATED NET REVENUE



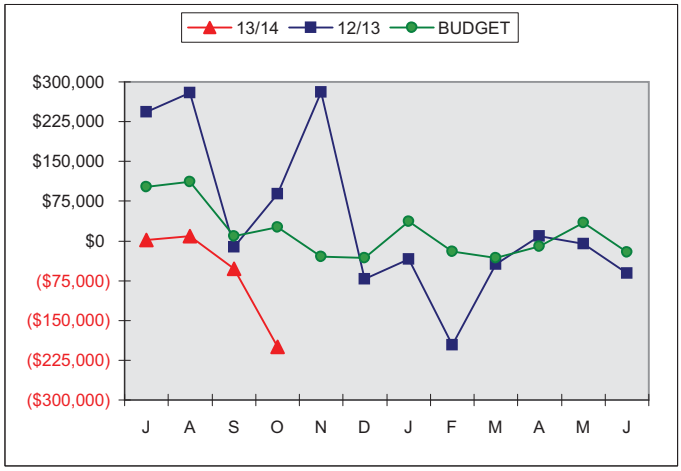
3. OPERATING EXPENSES



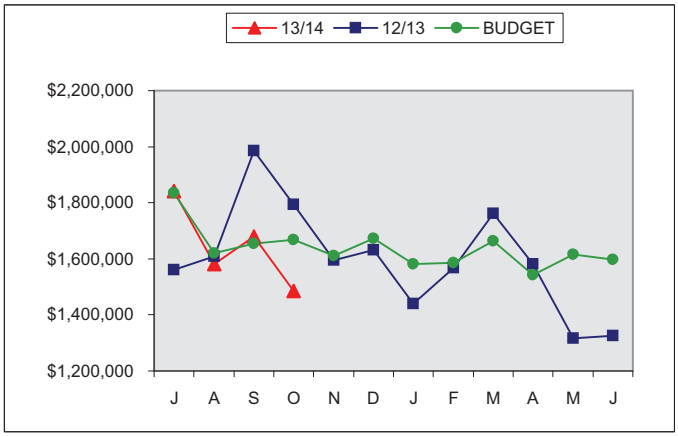
4. NON-OPERATING INCOME



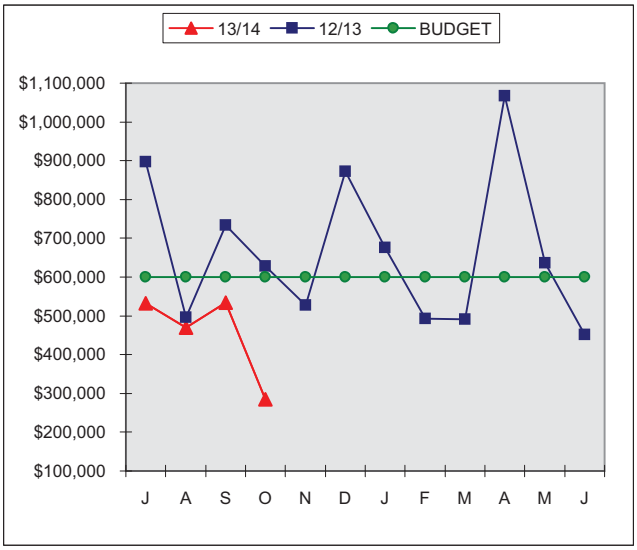
5. NET INCOME (LOSS)



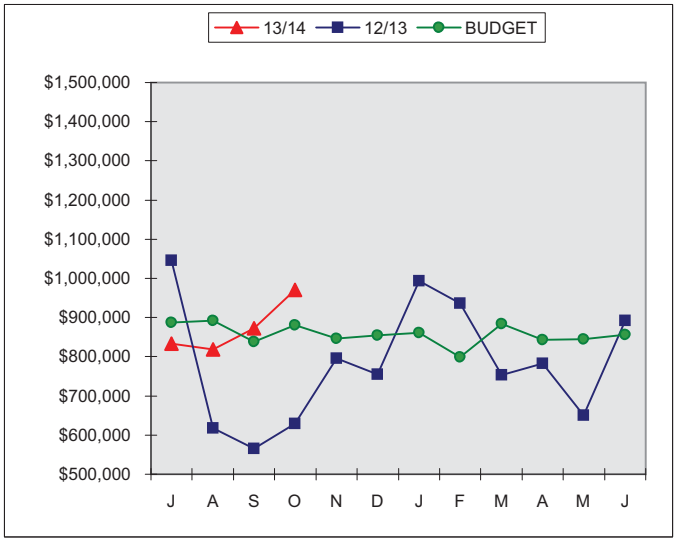
6. CASH RECEIPTS



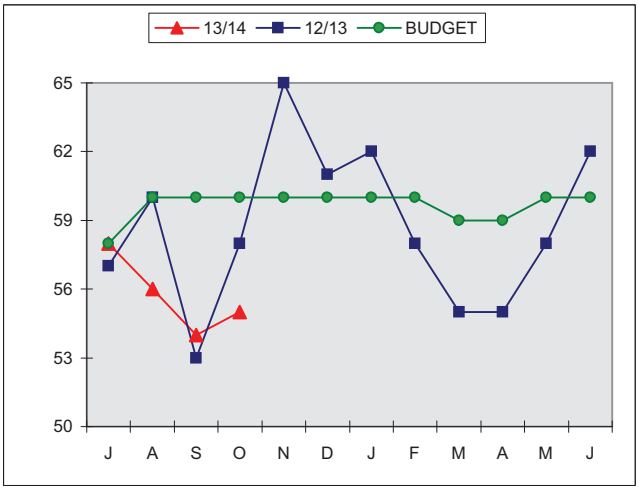
7. OPERATING CASH



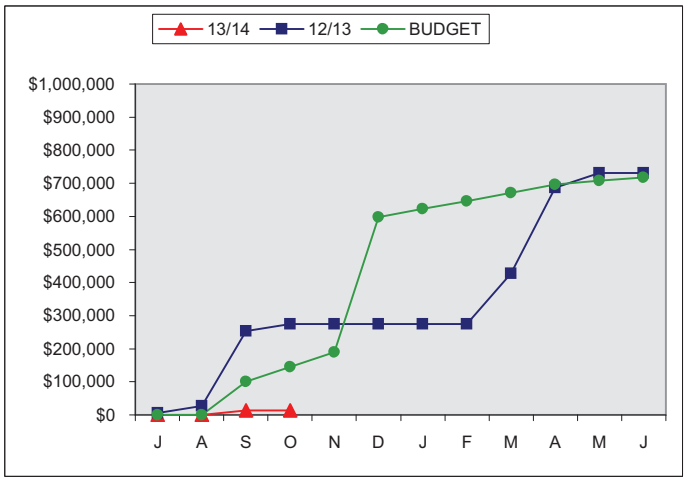
10. ACCOUNTS PAYABLE



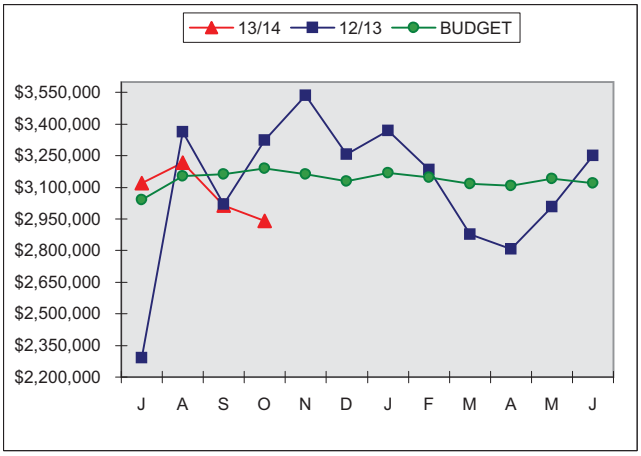
8. ACCOUNTS RECEIVABLE-DAYS



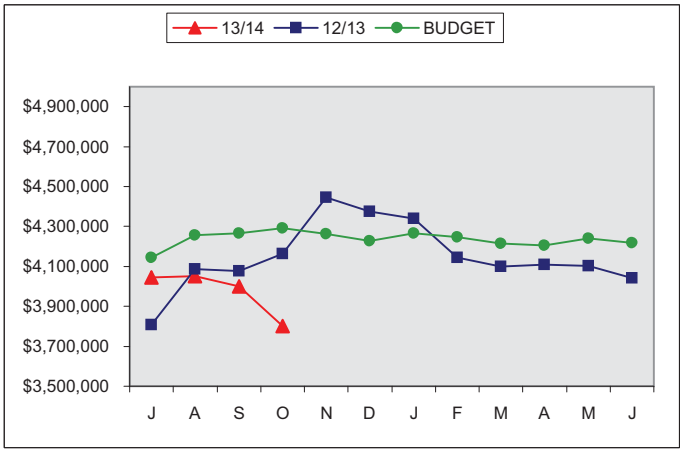
11. CAPITAL EXPENDITURES-YTD



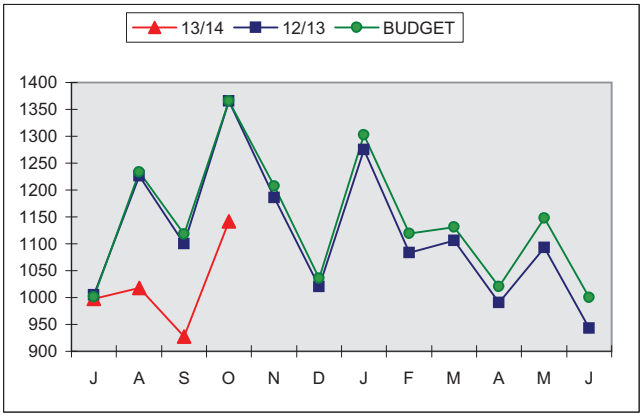
9. ACCOUNTS RECEIVABLE, NET



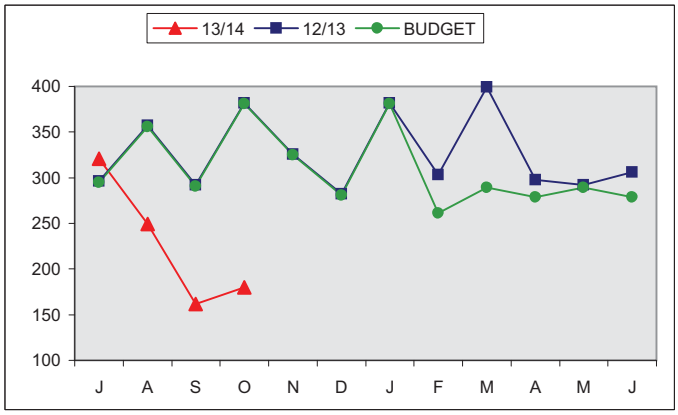
12. FUND BALANCE + NET INCOME (LOSS)



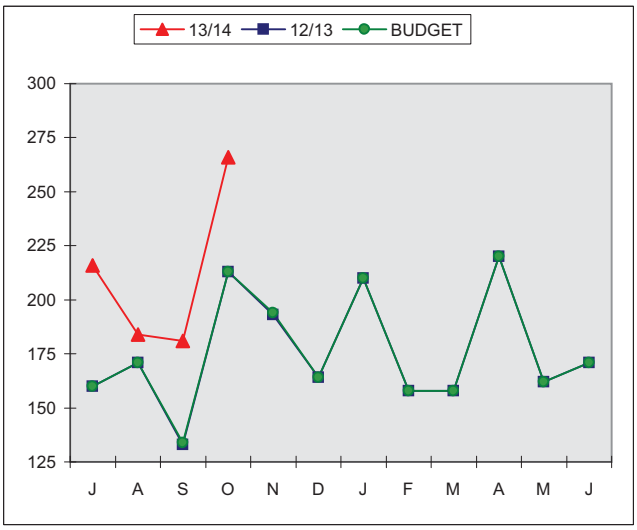
13. PORTOLA MEDICAL CLINIC VISITS



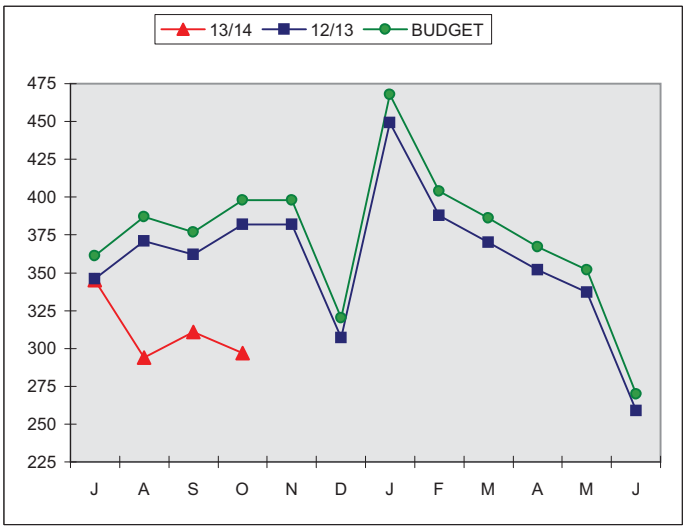
16. LOYALTON MEDICAL CLINIC VISITS



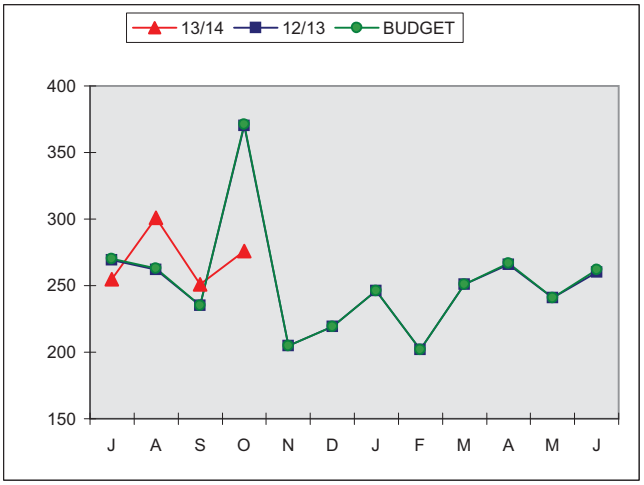
14. PORTOLA DENTAL CLINIC VISITS



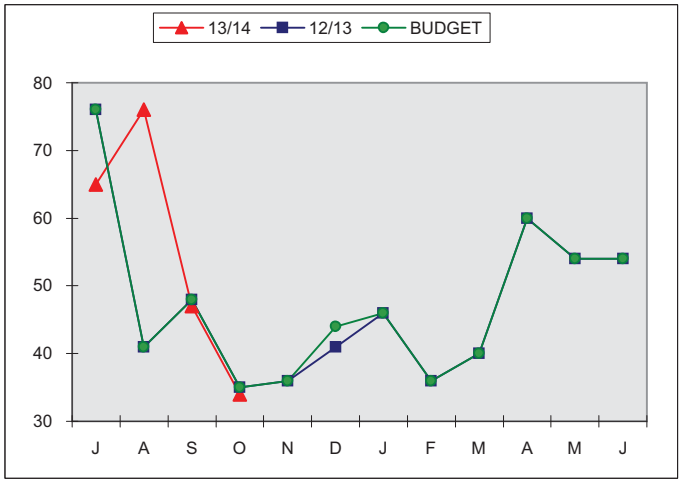
17. INDIAN VALLEY MEDICAL CLINIC VISITS



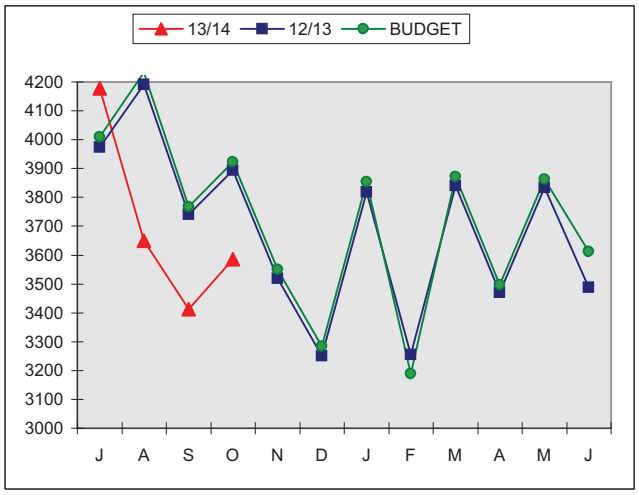
15. GRAEAGLE MEDICAL CLINIC VISITS



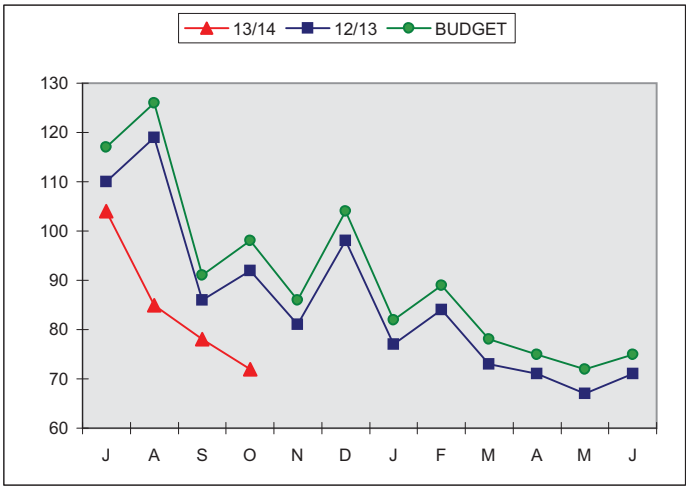
18. PORTOLA ANNEX VISITS



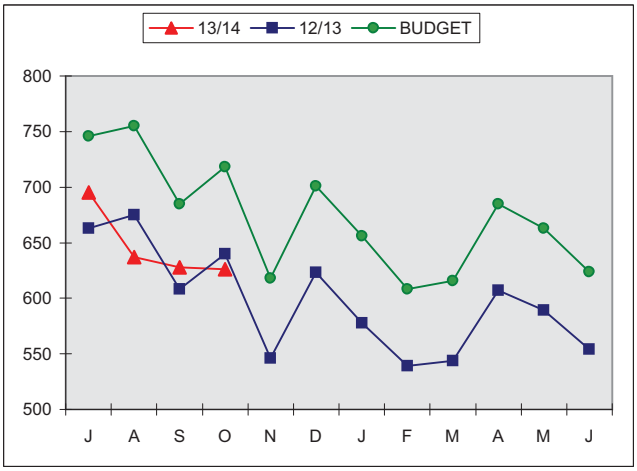
19. LABORATORY PROCEDURES



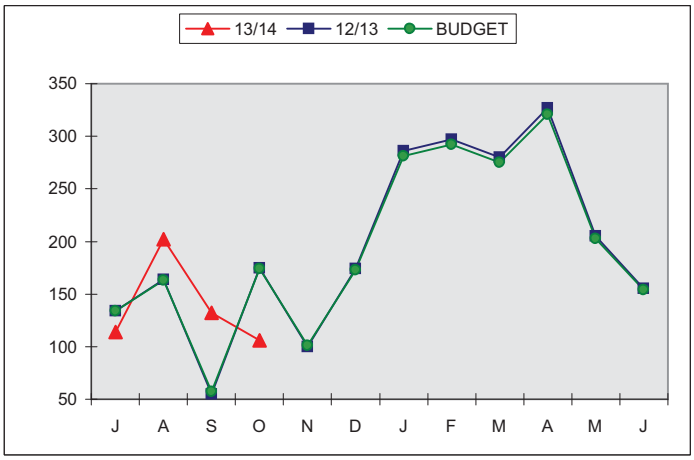
22. AMBULANCE RUNS



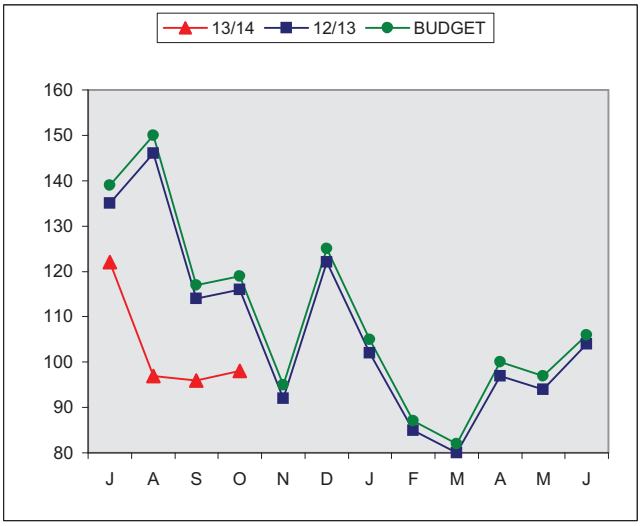
20. RADIOLOGY PROCEDURES



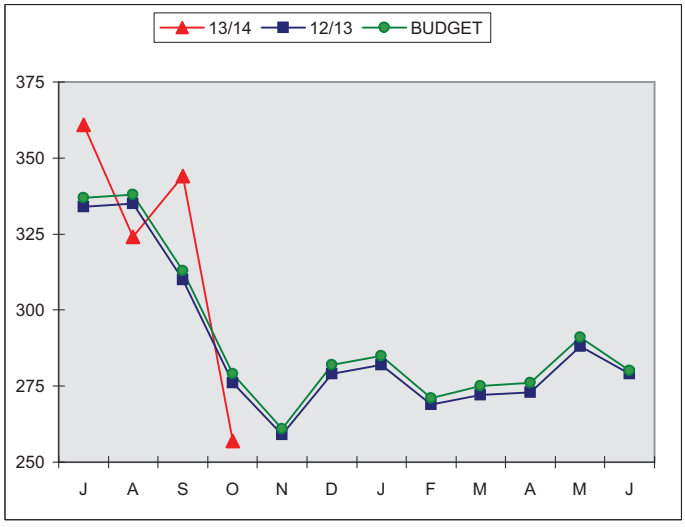
23. RESPIRATORY PROCEDURES



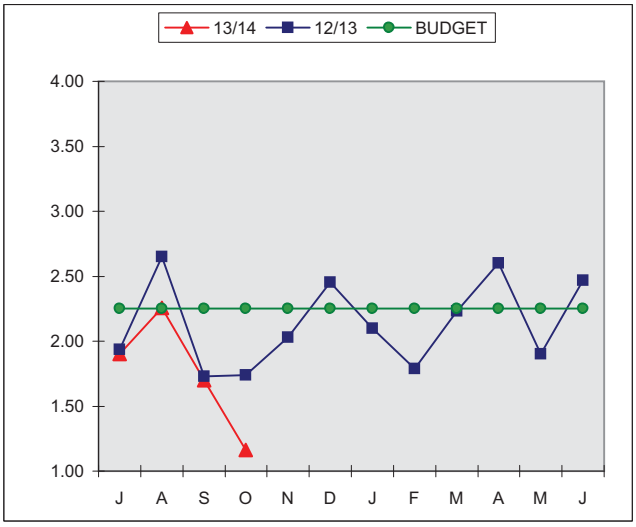
21. ECGS



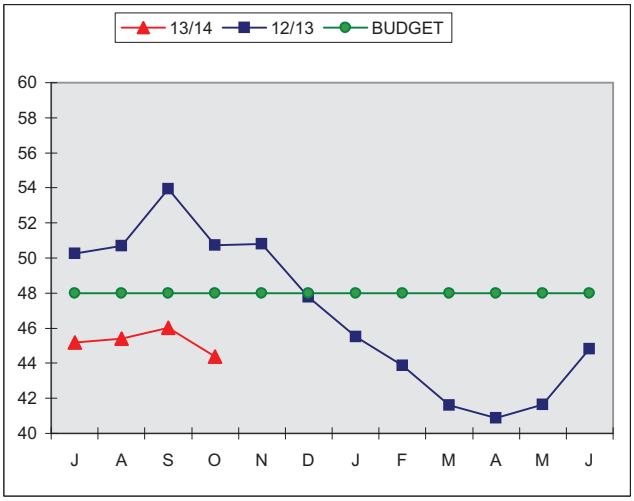
24. EMERGENCY ROOM VISITS



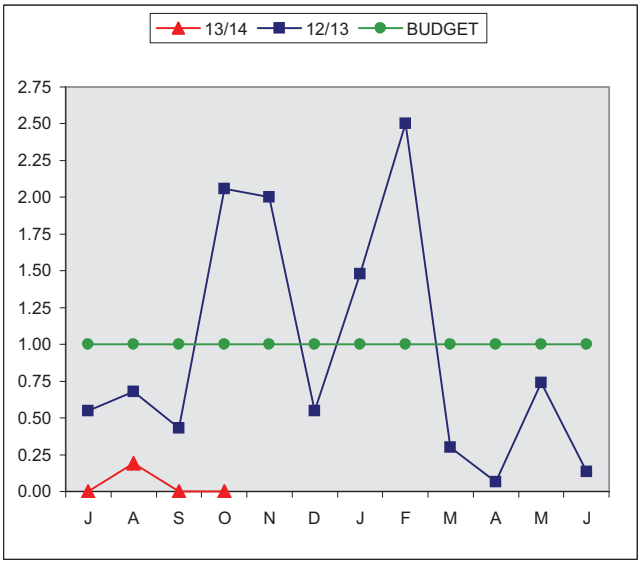
25. AVERAGE DAILY CENSUS - ACUTE



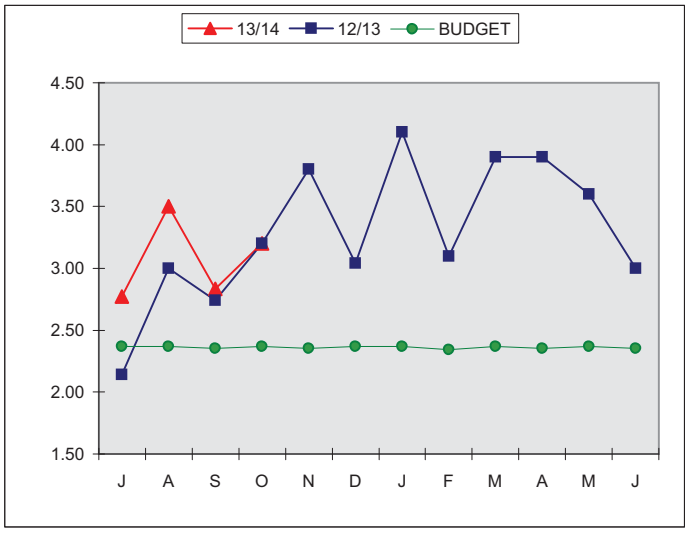
26. AVERAGE DAILY CENSUS - SNF



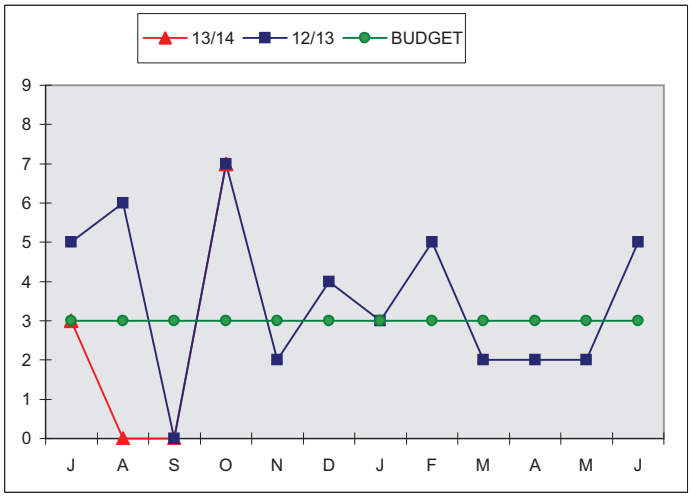
27. AVERAGE DAILY CENSUS-SWING



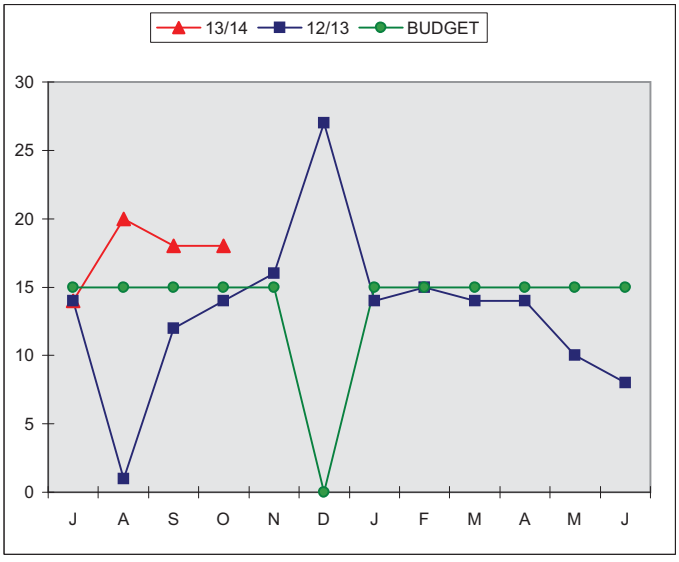
28. AVERAGE LENGTH OF STAY - ACUTE



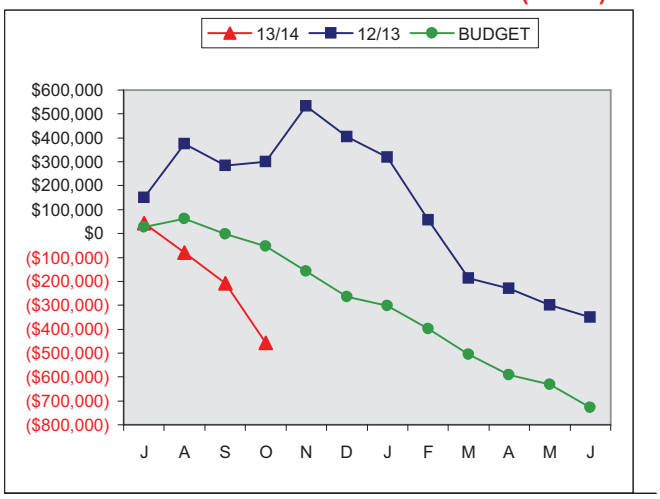
29. SURGERIES - IN & OUTPATIENT



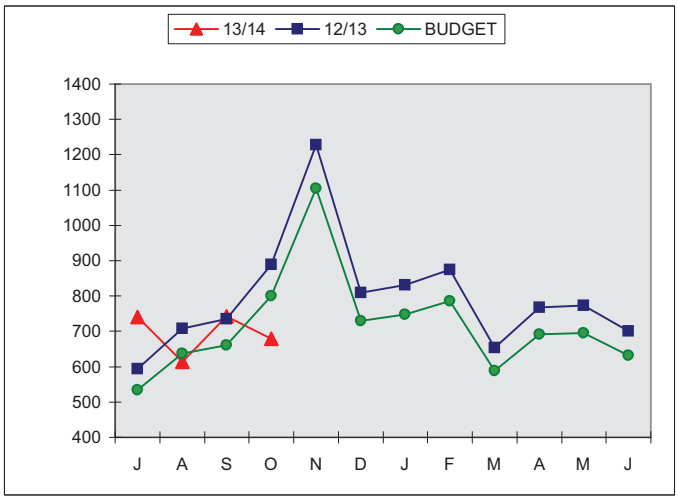
30. ENDOSCOPY PROCEDURES



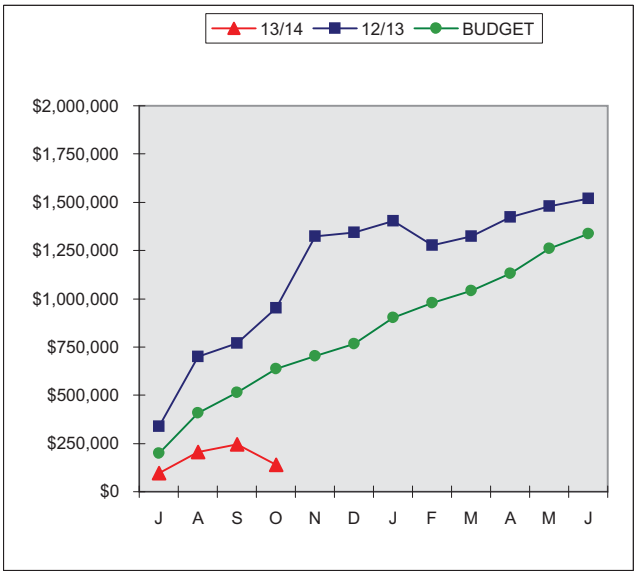
31. YEAR TO DATE OPERATING INCOME(LOSS)



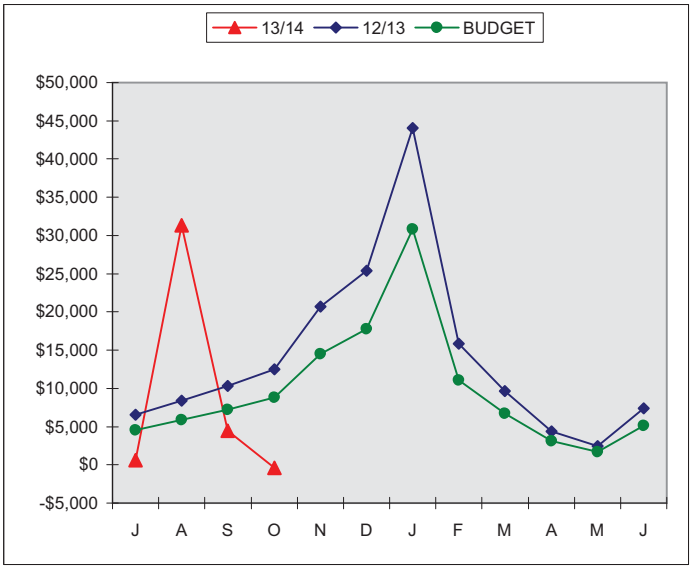
34. OVERTIME HOURS



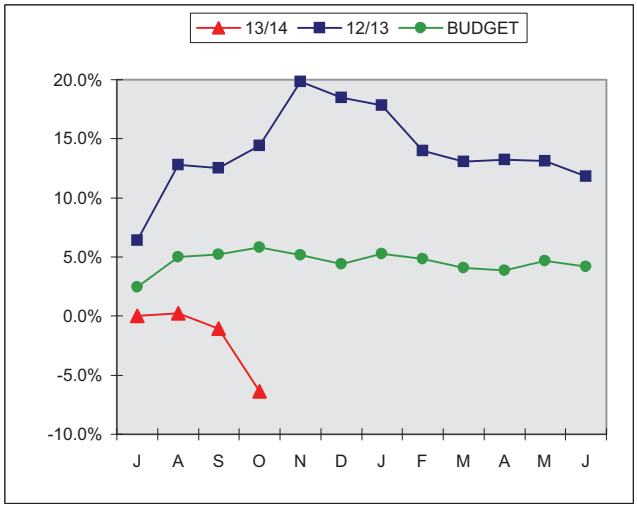
32. EARNINGS BEFORE INTEREST, DEPRECIATION & AMORTIZATI



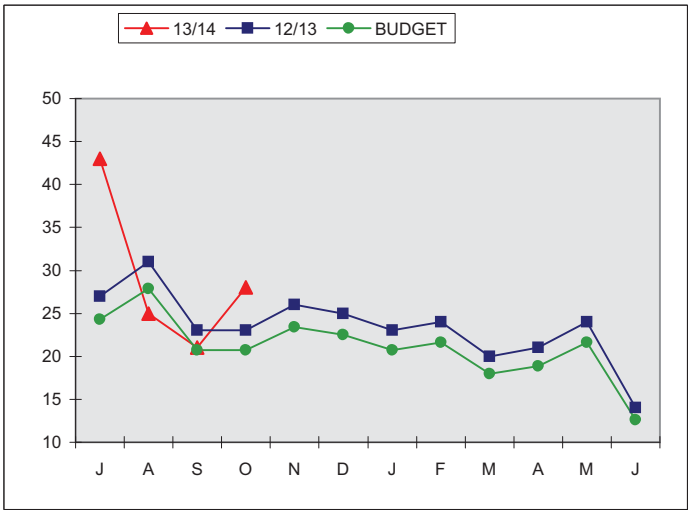
35. DENIALS



34. RETURN ON EQUITY



36. EMERGENCY DEPARTMENT TRANSFERS



EXECUTIVE BRIEFING 3

By *Trustee* staff

A Trustee's Guide to Common ACA Questions

One of the most significant pieces of the Affordable Care Act, the requirement that individuals be insured or pay a tax penalty, takes effect in January. To help people purchase coverage, the Centers for Medicare & Medicaid Services developed online health insurance marketplaces in each state. Open enrollment for 2014 through the marketplaces began on Oct. 1 and runs through March 31, 2014.

Because trustees serve as hospital representatives for their communities, they may be approached with questions or concerns about obtaining coverage under the ACA. Board members can use the following questions and answers as talking points when responding to patients and community members.

HEALTH INSURANCE MARKETPLACES

1 What is a health insurance marketplace?

A health insurance marketplace (also known as an exchange) is a way to shop for and compare plans and to get health coverage questions answered. Individuals, families who don't have coverage or buy their own coverage, and small businesses can shop for coverage in these marketplaces and make side-by-side comparisons of different plans. The marketplaces are not for people who already have such health coverage as Medicare, Medicaid, Children's Health Insurance Program, TRICARE or VA.

The marketplaces also are not for people with employer coverage, except where the employer plan is considered "unaffordable" or "inadequate." A plan is considered affordable if the cost for employee-only coverage doesn't exceed 9.5 percent of a worker's income and adequate if it covers at least 60 percent of an employee's covered medical expenses. (Sources: AARP Health Law Answers: The Health Care Law: More Choices, More Protections at http://healthlawanswers.aarp.org; *Kaiser Health News:* Insuring Your Health, June 4, 2013, at www.kaiserhealthnews.org).

2 What do marketplace plans cover and how do the plans differ?

All plans sold through the marketplaces must cover 10 so-called essential health benefits. They are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

For the most part, the plans differ not in which benefits they cover, but in the proportion of costs that consumers are responsible for paying. There are four basic types of plans: Platinum plans pay 90 percent of the cost of covered medical services, on average, while individuals are responsible for 10 percent; gold plans pay 80 percent; silver plans pay 70 percent; and bronze plans, 60 percent. Premiums will vary based on those percentages, so platinum plans generally will be pricier than bronze ones.

To apply for insurance, go to www.healthcare.gov/marketplace/individual. People who need assistance with this process can use the site's online chat function, call 800-318-2596 or meet in person with trained navigators, certified application counselors or assistance personnel located within their communities. (Health Care.gov; *Kaiser Health News:* Insuring Your Health, July 30, 2013; The Center for Consumer Information & Insurance Oversight at www.cms.gov/cciio)

PURCHASING AND PENALTIES

3 What subsidies are available to help people purchase a plan?

Two types are available: premium subsidies and cost-sharing subsidies.

Premium subsidies: Individuals and families with incomes up to 400 percent of the federal poverty level ($45,960 for an individual and $94,200 for a family of four in 2013) may be eligible for federal tax credits

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IMAGES FROM SHUTTERSTOCK

to help pay premiums. These subsidies may be used to purchase any plan. The subsidies come in the form of premium tax credits. If they qualify, people can opt to receive the tax credits in advance, and the marketplace will send the money directly to the insurer every month. This subsidy will reduce how much people owe up front. Individuals also can choose to receive their credit when they file their taxes the following year.

Cost-sharing subsidies: Cost-sharing subsidies can substantially reduce the deductibles, co-payments, coinsurance and total out-of-pocket spending limits for people with incomes up to 250 percent of the FPL ($58,875 for a family of four in 2013). Cost-sharing reductions will be applied automatically for people who qualify based on their income, but only if they buy a silver-level plan. These subsidies essentially increase the insurance company's share of covered benefits, resulting in reduced out-of-pocket spending for lower-income people.

A family of four whose income is between 100 and 150 percent of the FPL ($23,550 to $35,325) will be responsible for paying 6 percent of covered expenses out-of-pocket compared with the 30 percent that a family not getting subsidized coverage would owe in a silver plan. A family with an income between 150 and 200 percent of the FPL ($35,325 to $47,100) will be responsible for 13 percent of expenses, and one with an income between 200 and 250 percent of the FPL will be responsible for 27 percent ($47,100 to $58,875). In addition, people who earn 250 percent of the FPL or less will also have their maximum out-of-pocket spending capped at lower levels than will be the case for others who buy plans on the exchange. In 2014, the out-of-pocket limits for most plans will be $6,350 for an individual and $12,700 for a family. But people who qualify for cost-sharing subsidies will see their maximum out-of-pocket spending capped at $2,250 or $4,500 for single or family coverage, respectively, if their incomes are less than 200 percent of the FPL, and $5,200 or $10,400 if their incomes are between 200 and 250 percent of FPL. People should keep in mind, though, the cost-sharing subsidies apply to in-network expenses only. (*Kaiser Health News:* Insuring Your Health, July 9, July 30 and Aug. 27, 2013)

4 What are the penalties for not having insurance and how are they collected?

If an individual doesn't have health coverage that meets the minimum requirements, he or she may have to pay a penalty. When filing 2014 taxes in 2015, people must indicate on their returns if they have health insurance coverage and, if not, pay a fine. The individual penalty is the greater of $95 or 1 percent of income, rising to the greater of $695 or 2.5 percent of income, in 2016.

The Congressional Budget Office estimates that less than 2 percent of Americans who don't have health insurance will pay a penalty. Certain people may not have to pay a fine, including: those for whom the premiums are more than 8 percent of their income; those with income so low they don't have to file taxes; those living in the United States illegally (undocumented immigrants); those who have a gap in coverage of three months or less; those who are exempt because of their religious beliefs; American Indians and Alaska Natives; Americans living abroad for at least one year; those who have experienced a hardship (considered on a case-by-case basis); and those in prison. Individuals must apply for waivers through their health insurance marketplace. (*Kaiser Health News:* Capsules August 2013; AARP Health Law Answers: FAQs — Health Law Basics)

5 What options are available to low-income people who live in a state that is not expanding Medicaid?

Even if the state is not expanding Medicaid, an individual should still apply for coverage to see if he or she qualifies. An individual's medical needs or unique circumstances might mean he or she qualifies.

If someone doesn't qualify for Medicaid under a state's current rules, one of two situations applies.

If the individual's income is more than about $11,500 a year as a single person (about $23,500 for a family of four, or 100 percent of the FPL), he or she will be able to buy health insurance in the marketplace and get lower costs based on household size and income.

If the individual makes less than the FPL, he or she will still be able to get insurance in the marketplace, but won't be able to get lower costs based on income. If the individual does not purchase coverage, he or she is eligible for an exemption from the tax penalty, available when applying for coverage in the marketplace.

Finally, the health care law has expanded funding to community health centers, which provide primary care for millions of Americans. These centers provide services either for free or on a sliding scale based on the individual's income. (HealthCare.gov)

THE CONGRESSIONAL BUDGET OFFICE ESTIMATES THAT LESS THAN 2 PERCENT OF AMERICANS WHO DON'T HAVE HEALTH INSURANCE WILL PAY A PENALTY.

EMPLOYERS AND EMPLOYEES

6 If employers stop offering coverage and employees purchase insurance on or off the exchanges, can they still make pre-tax contributions to health savings accounts?

Yes. People are able to make pre-tax contributions as long as they buy a policy that meets federal standards for plans that can be linked to health savings accounts. This means a high-deductible policy. In 2013, HSA-qualified plans must have a deductible of at least $1,250 for individual coverage and $2,500 for a family plan, among other requirements.

The amount that individuals and their employers can contribute to the accounts is limited to $3,250 and $6,450 for individual and family coverage, respectively. (The IRS makes cost-of-living adjustments to these and other limits annually.) Even if a person's employer no longer offers health insurance in 2014, the money in the HSA is available to use for medical expenses. (*Kaiser Health News:* Insuring Your Health, April 2, 2013)

7 Can an individual who works for a company that provides insurance drop that coverage and buy it through the marketplace instead?

Most people in 2014 will be able to choose to buy a health plan through the marketplace, and individuals whose income is less than 400 percent of the FPL may be eligible for a subsidy. This can make buying a policy through the marketplace an attractive option. However, individuals aren't eligible for a subsidized marketplace plan unless their job-based coverage is considered unaffordable or inadequate. (*Kaiser Health News:* Insuring Your Health, April 2, 2013)

8 Are employers required to provide health insurance?

The health care law puts in place protections for employer-sponsored coverage. Beginning in 2015, large employers, those with more than 50 full-time employees, must either provide coverage that is both adequate and affordable for their full-time workers, or pay a penalty if their workers buy health insurance through the marketplace with a subsidy. Large employers are required to offer coverage to dependents (not including spouses), but there is no requirement that they help to subsidize that coverage. So the test for "affordable" coverage is based on premiums for employee-only coverage, not the cost of a family plan.

Employers with 50 or fewer full-time employees are not required to offer health coverage. These individuals are eligible to buy coverage through an insurance marketplace. Employers who wish to provide coverage can use the Small Business Health Options Program, or SHOP. SHOP enables side-by-side coverage and cost comparisons, and tax credits are available for coverage bought through a SHOP for small businesses with up to 25 employees and average wages of $50,000 or less. All plans offer the same essential health benefits. The tax credits cover up to one-half of the employer contribution (35 percent for nonprofits) to-

Free Preventive Services

All marketplace plans and many other plans must cover the following list of preventive services without charging a co-payment or coinsurance. This applies only when these services are delivered by a network provider.

- abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
- alcohol misuse screening and counseling
- aspirin use to prevent cardiovascular disease for men and women of certain ages
- blood pressure screening for all adults
- cholesterol screening for adults of certain ages or at higher risk
- colorectal cancer screening for adults older than 50
- depression screening for adults
- diabetes (type 2) screening for adults with high blood pressure
- diet counseling for adults at higher risk for chronic disease
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- immunization vaccines for adults. Doses, recommended ages and recommended populations vary: hepatitis A; hepatitis B; herpes zoster; human papillomavirus; influenza (flu shot); measles, mumps, rubella; meningococcal; pneumococcal; tetanus, diphtheria, pertussis; varicella
- obesity screening and counseling for all adults
- sexually transmitted infection prevention counseling for adults at higher risk
- syphilis screening for all adults at higher risk
- tobacco use screening for all adults and cessation interventions for tobacco users

Source: HealthCare.gov

ward premiums. Beginning in 2016, the SHOP will be extended to cover small businesses with up to 100 employees. (AARP Health Law Answers: FAQs — Health Law Basics, What the Health Care Law Means for Small Businesses, What the Health Care Law Means for Employees of Small Businesses)

9 What coverage for children is available through the marketplace?

All marketplace health plans must cover a standard list of preventive screenings, immunizations, supplements and medications for children without charging a co-payment or coinsurance, even if the yearly deductible hasn't been met. The ACA also requires that individual and small-group health plans sold through health insurance marketplaces cover pediatric dental services. Specific coverage requirements will be determined by each state within federally set guidelines. Under the health care law, pediatric dental health coverage sold on the exchanges cannot have annual or lifetime limits on coverage.

The health law also allows parents to keep their children on their health insurance policy until they are age 26, even if the children don't live with their parents, aren't in school or are married. (HealthCare.gov; *Kaiser Health News:* Insuring Your Health, Jan. 14, 2013; AARP: What the Health Care Law Means for Young Adults, August 2013, at www.aarp.org)

10 What is a grandfathered plan and what rules does it have to follow?

Most health insurance plans that existed on March 23, 2010, are eligible for grandfathered status and, therefore, do not have to meet all the requirements of the health care law. But if an insurer or employer makes significant changes to a plan's benefits or how much members pay through premiums, co-pays or deductibles, then the plan loses that status. Government regulations spell out how much plans can change the amount paid by workers or employers before losing their status. Both individual plans and group plans can be grandfathered.

A grandfathered plan has to follow some of the same rules as other plans under the ACA. For example, the plans cannot impose lifetime limits on how much health care coverage people may receive, and they must offer dependent coverage for young adults until age 26 (although until 2014, a grandfathered group plan does not have to offer such coverage if a young adult is eligible for coverage elsewhere). A plan also cannot retroactively cancel coverage because of a mistake made when the individual applied for it, a practice known as a rescission.

However, there are many rules grandfathered plans do not have to follow. For example, they are not required to provide preventive care without cost-sharing. In addition, they do not have to offer the package of essential health benefits that individual and small group plans must offer beginning in 2014. Furthermore, grandfathered individual plans still can impose annual dollar limits, such as capping key benefits at $750,000 in a given year. Grandfathered individual policies also can still lock out children younger than 19 if they have a pre-existing condition. (*Kaiser Health News:* FAQ — Grandfathered Health Plans, Aug. 28, 2013) T

Essential Health Benefits

All private health insurance plans offered in the marketplace will offer the same set of essential health benefits. These include at least the following items and services:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- prescription drugs
- rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills)
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including dental and vision

Source: HealthCare.gov

Learn More

More assistance is available to hospitals and systems on the American Hospital Association's Get Enrolled website, www.aha.org/getenrolled. It provides the latest news from the Centers for Medicare & Medicaid Services, national resources and state-specific information about insurance commissioners, marketplaces and Medicaid and CHIP enrollment.

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