EASTERN PLUMAS HEALTH CARE DISTRICT
REGULAR MEETING OF THE BOARD OF DIRECTORS
Thursday, March 26, 2015
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			1-3
(B) Meeting Minutes of 2.26.15 Regular Board Meeting			4-7
(C) Meeting Minutes of 2.26.15 Standing Finance Committee			8
(D) Meeting Minutes of 3.2.15 Standing Planning Committee			9
4. Board Chair Comments	Gail McGrath	I/D/A	
• Board Job Description Approval			10-15
• Board Self Evaluation			
• CEO Evaluation			
5. Board Comments	Board Members	I	
6. Public Comment	Members of the Public	I	
7. Auxiliary Report	Katie Tanner	I/D	
8. Quality Assurance	Shawn Rohan	I/D	
9. Chief of Staff Report	Eric Bugna, MD	I/D	
10. Committee Reports	Board Members	I/D	
• Finance Committee			
• Planning Committee			

11. Chief Nursing Officer Report	Kathy Cocking	I/D	
12. Director of Clinics Report	Bryan Gregory	I/D	
13. Recommendation for Approval of Policies		I/D/A	
• Administration			
• Materials Management			
• Central Supply			
• Perioperative (PACU)			
• Surgery			
• Ambulance			
• Emergency Vaccine Mgmt Plan			
• Care of Dementia Patient			
• Engineering Respirator Requirements			
• Processing Instruments for Autoclave Sterilization			
• Proper Packaging for Medical Instruments			
• Lockout/Blockout Operational Procedures			
14. Chief Financial Officer Report	Jeri Nelson	I/D	
• February Financials			16-26
15. Chief Executive Officer Report	Tom Hayes	I/D	
• Optima Rebate			27-28
• Rural Hospital Article			29-33
• DP/SNF Claw Back Update			
• 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 54956.9(d) (2), Conference with Legal Counsel, Significant exposure litigation, 1 case.

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

a. Recommendation for One Year Provisional Privileges

- **Dr. Ben Hunt, Surgery, Provisional**

b. Recommendation for Two Year Courtesy Privileges

- **Dr. Peter Taylor, OB/GYN, Courtesy**
- **Dr. Leon Jackson, Radiology, Courtesy**

17. Open Session Report of Actions Taken in Closed Session	Gail McGrath	I
18. Adjournment	Gail McGrath	A

EASTERN PLUMAS HEALTH CARE DISTRICT
REGULAR MEETING OF THE BOARD OF DIRECTORS
Thursday, February 26, 2015
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: Dr. Paul Swanson, Janie McBride, Gail McGrath, Lucie Kreth and Jay Skutt.
Staff: Tom Hayes, CEO, Jeri Nelson, CFO, Eric Bugna MD (arrived late), and Alanna Wilson, Administrative Assistant.
Visitors: Approximately 2 visitors were present at the start of the meeting

3. Consent Calendar.
Mr. Skutt motioned to approve the consent calendar with the following changes:

- Dr. Skutt should read Mr. Skutt.(pg. 4)
- In the previous meeting there was a discussion regarding data security so the minutes were changed to "Mr. Boyd gave a report on data security stating that EPHC is very diligent in protecting patient data. "

A second was made by Ms. McBride. None opposed, the motion was approved.

4. Board Chair Comments.
None

5. Board Comments.
Mr. Skutt gave a report on the P.C.S.D.A. meeting he recently attended.

6. Public Comment.
None

7. Auxiliary Report
Elaine White reported that the Nifty Thrifty grossed $8,189.00 for the month of January. They had 908.5 volunteer hours and 9.2 hours in the lobby. The Nifty Thrifty was closed for two weeks in the month of January for cleaning.

8. Chief of Staff Report
Dr. Bugna reported the clinic is running well. They are preparing for the new EMR system and the ICD-10 implementation.

9. Committee Reports

- **Finance Committee**
  Dr. Swanson reported that the month of January had a small net loss. Contractuals are up due to managed MediCal payments. He discussed the upcoming transition to ICD-10. Ms. Nelson will give further detail in her report.

- Mr. Hayes reported on Q/A indicators. There will be new indicators showing up on future reports. A brief discussion regarding the online ranking of SNF units, hospital compare.

10. Director Of Nursing Report:

Ms. Jameson announced she will be leaving the organization March 6th. The Board Members discussed how much Ms. Jameson's hard work and dedication will be missed. Mr. Hayes noted that Ms. Jameson has been preparing well for her departure.

11. Clinic Report: Mr. Gregory reported the following:

- Mr. Gregory will be leaving Doctor's XL and will become an employee of EPHC beginning March 1st.
- Overall the clinics did well in January. Graeagle clinic had 470 visits this month.
- Mr. Gregory reported that the Pain Management program has gone very well. The providers are happy with the program and are getting positive results.
- Dr. Mustafa is now seeing Dermatology patients full days every Wednesday.
- Mr. Gregory reported that our first Diabetic Retinopathy clinic is happening today in Loyalton. Portola will have one on Saturday. He noted that Linda Satchwell has done a great job organizing this clinic.
- Mr. Gregory reported that we are moving forward with the Rural Health Application for site 2.

12. Recommendation for Approval of Policies:

- Infection Control
- Employee Health

After a brief discussion Ms. McGrath motioned to approve the policies. A second was made by Dr. Swanson. None opposed, the motion was approved.

13. CFO Report:

- Ms. Nelson reported that the organization was on track for the month of January. Revenue and Expenses looked good however; we are struggling with reimbursements from Managed MediCal.
- Ms. Nelson discussed the Capital Budget. We are on track this year and have taken out a $200,000.00 loan for equipment required for Centrique conversion.
- A brief discussion was had regarding scope replacement and being proactive on cleaning.
- Ms. Nelson reported that ICD 10 is set to start October 1st.
- Ms. Nelson noted that effects caused by the February storm were handled well by all employees involved.

14. CEO Report: Mr. Hayes reported the following:

Mr. Hayes reported that the planning committee will meet next week to discuss the Boiler replacement. OSHPD is suggesting the Biomass Boiler could be used as a secondary

source. Architects Nate Morgan and David Hitchcock along with Jonathan Kusel will attend. The planning committee will also discuss potential expansion of ER rooms.

- Mr. Hayes gave an update on the EPHC Project List.
- There was a brief discussion about the closing of the Skilled Nursing Facility in Quincy and the possible influx of patients to EPHC facilities.
- Mr. Hayes reported that the CLIA inspection went well. The exit interview went well and we will receive a positive report from the state.
- Mr. Hayes stated we are looking to hire an interim DON to replace Linda Jameson which will give us time to find a permanent replacement.
- Mr. Hayes also reported that he will be attending the upcoming CHA Legislative Day where he intends to discuss the Claw back and MediCal Managed Care. He also reported that we are bidding out our work comp program.

15. Closed Session.

Ms. McGrath announced the Board would move into closed session at 11:37 a.m.; pursuant to Health and Safety Code 32155 and Government Code Section 54957.

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

The Board returned at approximately 12:15 pm and announced

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

II. With respect to Government Code Section 54957 to consider the following privileges and appointments to the medical staff.

a. Approval of One Year Provisional Privileges
b. Dr. Syed Mustafa-Provisional-Internal Medicine

b. Approval of Two Year Courtesy Privileges

- **Dr. Wendy Flappan-Phy. Med. And Rehabilitation**
- **Dr. Paul Swanson-Emergency Medicine**
- **Dr. Robert Leckie-Radiology**

III. Adjournment. Ms. Mc Grath subsequently adjourned the meeting at 12:17 p.m.

_____ _____

Approval Date

EASTERN PLUMAS HEALTH CARE DISTRICT
SPECIAL MEETING OF THE STANDING FINANCE COMMITTEE
OF THE BOARD OF DIRECTORS
Thursday February 26, 2015
8:30 A.M.
EPHC's Administrative Conference Room

Minutes

1. **Call to Order:** The meeting was called to order at 8:33 am by Dr. Paul Swanson
2. **Roll Call:**
   Present: Paul Swanson, M.D., Janie McBride
   Staff: Tom Hayes, CEO, Jeri Nelson, CFO, Linda Jameson DON, Alanna Wilson, Administrative Assistant
   Guest: None
3. **Approval of Agenda:** The agenda was approved as submitted.

4. **Board Comments:** None

5. **Public Comments:** None

6. **CFO Report**
   Ms. Nelson reported that January was a decent month and we are on budget except for contracted adjustments. Getting payments from managed plans continues to be a struggle. There was a brief discussion regarding the way managed MediCal pays. Ms. Nelson also reviewed year to date department profitability as well as capital equipment.
   Ms. Nelson gave a brief report of the CHA Rural Health symposium she attended as well as the upcoming ICD-10 implementation. Training for physicians and coders is critical. Ms. Nelson will be using a SCHP grant for this training.

7. **Adjournment:** The meeting was adjourned at 9:42 a.m.

_____ _____
Approval Date

EASTERN PLUMAS HEALTH CARE DISTRICT
SPECIAL MEETING OF THE PLANNING COMMITTEE
OF THE BOARD OF DIRECTORS
Wednesday, October 15, 2014, 2:00 P.M.
EPHC Administrative Conference Room

Minutes

1. **Call to Order:** The meeting was called to order at 2:06 pm by Chairman McGrath.

2. **Roll Call:**
Present: Gail McGrath, Jay Skutt. Tom Hayes, CEO, Alanna Wilson, Administrative Assistant, Jack Bridge, Stan Peiler, Jonathan Kusel, Nathan Morgan, and Dave Hitchcock.
Absent: Jay Skutt

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

4. **Board Comments**: None.

5. **Public Comments**: None.

6. **CEO Reports** :
   - **Boiler replacement.** A brief discussion was had regarding the Biomass boiler. The discussion included the estimated cost of the Biomass boiler, fuel supply, and OSHPD regulation. During the discussion it was noted that EPHC would still need to replace the existing boiler with a primary and secondary boiler system. A biomass boiler could only serve as a redundant boiler and there would be no sense in investing in this system. At this time, all present felt that the organization needs to focus on replacing the current system. Jonathan Kusel left at approximately 2:30 pm.
   - **Other.** Mr. Hayes discussed the possibility of expanding the ER, allowing more rooms for patients. While the architects are here today they will review possible options. Mr. Hayes also provided a brief update regarding the Nurse Call System.

7. **Adjournment: Chairman McGrath** adjourned the meeting at 3:04 p.m.

_____ _____

Approved by **Date**

EASTERN PLUMAS HEALTH CARE
JOB DESCRIPTION

Position Title **EPHC Board of Trustees – Individual Board Member**

Department: EPHC Board of Trustees

I. THE FUNDAMENTAL DUTY OF OVERSIGHT

In a single phrase, the role of the Board is to be the keeper of Governance Integrity. Under the laws of most states, the board of directors of a non-profit organization is the party responsible for the organization. The board must supervise and direct its own officers and govern the organization's efforts in carrying out its mission. The duties of care, loyalty, and obedience describe the manner in which the directors are required to carry out their fundamental duty of oversight.

Duty of Care

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

Duty of Loyalty

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

Duty of Obedience

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

Each board member is also entrusted with individual responsibilities as a part of his or her board membership. The obligations of board service are considerable; they extend well beyond the basic expectations of attending meetings or participating in hospital events. Individual board members are expected to meet higher standards of personal conduct on behalf of the organization than what is usually expected of other types of community volunteers.

Yet, despite all of these "special" responsibilities, board members as individuals have no special privileges, prerogatives, or authority. They must meet in formal Board Meetings to negotiate and make corporate decisions.

A clear statement of individual board member responsibilities adapted to the organization's needs and circumstances can:

- Help with the process of recruiting new board members by clarifying expectations before candidates accept nomination.
- Provide criteria by which the committee responsible for identifying and recruiting prospective nominees can review the performance of incumbents who are eligible for reelection or reappointment.

II. GENERAL EXPECTATIONS

Prospective and incumbent board members should commit themselves with regards to the following:

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

III. RESPONSIBILITIES

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

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

- Review and approve overall financial policies and plans for the organization.
- Receive and review financial reports to assess actual performance compared to projections.
- Ensure that the financial, capital, and strategic plans are aligned.
- Approve operating and capital budgets annually.
- Select an auditor for the annual financial audit.

2. Quality Oversight
The board has the responsibility to oversee the quality of all services provided by all individuals who perform their duties in this facility or under this board's sponsorship. To do this, the board must:

- Make quality of care and patient safety top priorities for the organization and take corrective action as necessary.
- Approve and oversee quality improvement initiatives recommended by senior management and the medical staff.
- Review and carefully discuss quality reports that provide comparative statistical and review measurable policy targets to ensure continual improvement in quality performance.
- Carefully review recommendations of the medical staff regarding new physicians who wish to practice in the organization and approve these recommendations if appropriate.
- Reappoint individuals to the medical staff after evaluation of their performance since their last appointment.
- Receive and discuss data about the medical staff to assure that future staffing will be adequate.
- Receive and discuss malpractice data.

3. Setting Strategic Direction/Mission Oversight
The board has the responsibility to recommend the future direction that the organization will take to meet the community's health needs. To fulfill this responsibility, the board must:

- Establish policy guidelines and criteria for implementing the mission statement.
- Review the mission statements of any subsidiary units to ensure that they are consistent with the overall mission.
- Monitor programs and activities of the hospital and any subsidiary units (Auxiliary, Foundation).
- Periodically review, discuss, and amend the mission statement if necessary to clarify board responsibilities.
- Review and approve a comprehensive strategic plan.
- Ensure that the organization's strategic plan is consistent with the mission.

- Regularly review progress toward meeting goals in the strategic plan to assure that the board is fulfilling its mission.
- Periodically review, discuss, and amend the strategic plan to ensure its relevance to the mission.

4. Self-Assessment & Development

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

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

5. Management Oversight

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

- Support and assist the CEO to help achieve the organization's mission.
- Communicate regularly with the CEO regarding goals, expectations, and concerns.
- Periodically survey CEO employment arrangements at comparable organizations to ensure the reasonableness and competitiveness of his or her compensation package.
- Periodically review management succession plans to ensure leadership continuity.
- Evaluate the performance of the CEO annually and establish specific performance policies that provide the CEO with a clear understanding of board expectations, and update these policies based on changing conditions.

6. Advocacy

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

- Review a periodic community health needs assessment to understand the health issues of the communities served.
- Set goals for the organization around the issue of public advocacy.

IV. MEETINGS

The board only exists, in both a legal and functional sense, when it meets. Consequently, the board meetings are the center of governance. The way they are planned and conducted-in addition to the dynamics that emerge in them-significantly influence the quality of governance. Therefore, individual board members are expected to:

- Prepare for board and committee meetings.
- Participate in board and committee meetings with forethought, courtesy, critical thinking and analyses, and attention to results.

- Ask timely and substantive questions at board and committee meetings consistent with the board member's conscience and conviction while at the same time supporting the majority decision on issues decided by the board.
- Maintain confidentiality of the board's closed sessions, and speak for the board or organization only when authorized to do so.
- Suggest agenda items periodically for board and committee meetings to ensure that significant, policy-related matters are addressed.

V. BOARD

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

- Conform to legal conflict-of-interest policies that include guidelines for the resolution of existing or apparent conflicts of interest.
- Periodically review the board's own structure to assess appropriateness of size, diversity, committees, tenure, and turnover of officers and chairpersons.
- Ensure that each board member understands and agrees to maintain confidentiality with regard to information discussed by the board and its committees.
- Ensure that each board member understands and agrees to maintain confidentiality with regard to information discussed by the board and its committees.
- Maintain efficient and timely communication with any subsidiary boards.
- Adopt, amend, and, if necessary, repeal the articles and bylaws of the organization.
- Maintain an up-to-date board policy manual

VI. CONFLICT OF INTEREST

Conflict of interest, confidentiality, disclosure-these concepts figure prominently in the understanding of governance responsibilities. They do not tell a board, or an individual director, how to govern; rather, they imply a code of conduct and ethical behavior. In order to prevent using the power, position, or information derived from their situations to influence organizational activities and decisions, individual board members must:

- Serve the organization as a whole rather than any special interest group or constituency. The board members' first obligation is to recognize that he or she represents only organization's best interests.
- Disclose any possible conflicts to the board in a timely fashion.
- Maintain independence and objectivity and act with a sense of fairness, ethics, and personal integrity, even though you may not be required to do so by law, regulation, or custom.
- Never offer or accept favors or gifts to or from anyone who does business with the organization.

Passed, approved and adopted by the Board of Directors of Eastern Plumas Health Care District, Plumas County, California at a meeting held on the _____of _____, 20_____, and witnessed by the following:

_____	_____
Chairman	**Secretary**

EASTERN PLUMAS HEALTH CARE DISTRICT

MEMORANDUM

Date: March 16, 2015

To: Board of Directors

From: Jeri Nelson, Chief Financial Officer

Subject: **Summary of Financial Results – February 2015**

Table 1. Consolidated Financial Results – February 2015

	Actual	Budget	Variance
Total Revenue	**$2,823,772**	**$2,926,598**	**$(102,826)**
Contractual Adjustments	$1,029,508	$1,098,497	$(68,989)
Bad Debt/Admin Adjustments	$167,415	$143,071	$24,344
Net Revenue	**$1,626,850**	**$1,685,030**	**$(58,180)**
Total Expenses	**$1,759,430**	**$1,745,707**	**$13,723**
Operating Income (Loss)	$(132,580)	$(60,677)	$(71,903)
Non-Operating Income(Expense)	$47,239	$147,654	$(100,415)
Net Income (Loss)	**$(85,341)**	**$86,977**	**$(172,318)**

Table 2. Consolidated Financial Results – Eight Months Ended February 2015

	Actual	Budget	Variance
Total Revenue	**$25,291,396**	**$25,254,104**	**$37,292**
Contractual Adjustments	$10,243,361	$9,470,209	$773,152
Bad Debt/Admin Adjustments	$893,036	$1,235,095	$(342,059)
Net Revenue	**$14,154,999**	**$14,548,800**	**$(393,801)**
Total Expenses	**$14,446,849**	**$14,684,635**	**$(237,786)**
Operating Income (Loss)	$(291,850)	$(135,834)	$(156,016)
Non-Operating Income (Expense)	$453,082	$531,230	$(78,148)
Net Income (Loss)	**$161,232**	**$395,396**	**$(234,164)**

We experienced a downturn in volumes across all service areas. Net revenue for the month was in line with budget at 57.5% and expenses were slightly over budget. Iôll do a second interim rate reconciliation for Medicare in March which should increase net revenue for inpatient services. On the Balance Sheet, Accounts Receivable Other is mostly due from Medi-Cal for prior years RHC reconciliations and 13/14 AB915 Outpatient Settlement. We concluded our copier replacement for all sites which is the increase to equipment. We are participating in an Intergovernmental Grant Transfer (IGT) for the 13/14 fiscal yearsô inpatient services which required us to pay to the Department of Health Care Services $88,793. This is offset in our Fund Balance account on the Balance sheet.

EASTERN PLUMAS HEALTH CARE
STATEMENT OF REVENUE & EXPENSE
FOR THE MONTH ENDED
FEBRUARY 28, 2015

	CURRENT PERIOD			YEAR TO DATE			ANNUAL
	ACTUAL	BUDGET	VARIANCE	ACTUAL	BUDGET	VARIANCE	BUDGET
OPERATING REVENUE							
INPATIENT ROUTINE	121450	156775	-35325	1113306	1362122	-248816	2044000
INPATIENT ANCILLARY	104845	144929	-40084	1018959	1259197	-240238	1889551
TOTAL INPATIENT	226295	301703	-75408	2132265	2621319	-489054	3933551
SWING ROUTINE	31748	13530	18218	339748	109519	230229	164000
SWING ANCILLARY	17290	13810	3480	253693	111783	141910	167390
TOTAL SWING BED	49038	27340	21698	593441	221302	372139	331390
SKILLED NURSING ROUTINE	472150	509518	-37368	4127200	4421581	-294381	6643000
SKILLED NURSING ANCILLARY	72596	79024	-6428	612916	687023	-74107	1031720
TOTAL SKILLED NURSING	544746	588542	-43796	4740116	5108604	-368488	7674720
OUTPATIENT SERVICES	2001241	2002851	-1610	17744786	17253586	491200	25683225
TOTAL PATIENT REVENUES	2821319	2920436	-99117	25210607	25204811	5796	37622886
OTHER OPERATING REVENUE	2454	6162	-3708	80789	49293	31496	73940
TOTAL REVENUE	2823772	2926598	-102826	25291396	25254104	37292	37696826
DEDUCTIONS FROM REVENUE							
BAD DEBT/ADMINISTRATIVE ADJ'S	167415	143071	24344	893036	1235095	-342059	1843700
CONTRACTUAL ADJUSTMENTS	1029508	1098497	-68989	10243361	9470209	773152	14125128
TOTAL DEDUCTIONS	1196923	1241568	-44645	11136397	10705304	431093	15968828
NET REVENUE	1626850	1685030	-58180	14154999	14548800	-393801	21727998
OPERATING EXPENSES							
SALARIES	761168	754504	6664	6503904	6563300	-59396	9837081
BENEFITS	231379	237714	-6335	1826770	1965626	-138856	2947482
SUPPLIES	150268	163713	-13445	1117746	1317904	-200158	1971908
PROFESSIONAL FEES	262518	237078	25440	2078485	1984241	94244	2983407
REPAIRS & MAINTENANCE	42614	44006	-1392	356196	352050	4146	528074
PURCHASED SERVICES	102831	94694	8137	868876	759806	109070	1139334
UTILITIES/TELEPHONE	63380	58420	4960	484149	469338	14811	704146
INSURANCE	33763	34975	-1212	261933	279799	-17866	419698
RENT/LEASE EXPENSE	7572	15109	-7537	116991	120875	-3884	181312
DEPRECIATION/AMORTIZATION	67436	76943	-9507	542225	615543	-73318	923314
INTEREST EXPENSE	21909	18115	3794	169162	144919	24243	217379
OTHER EXPENSES	14591	10434	4157	120412	111236	9176	150673
TOTAL EXPENSES	1759430	1745707	13723	14446849	14684635	-237786	22003808
OPERATING INCOME (LOSS)	-132580	-60677	-71903	-291850	-135834	-156016	-275810
MISCELLANEOUS	3572	3083	489	54802	24667	30135	37000
CONTRIBUTIONS	0	100000	-100000	35971	150000	-114029	200000
PROPERTY TAX REVENUE	43667	44570	-903	362309	356563	5746	534845
NON-OPERATING INCOME (EXPENSE)	47239	147654	-100415	453082	531230	-78148	771845
NET INCOME (LOSS)	-85341	86977	-172318	161232	395396	-234164	496035

	CURRENT PERIOD			YEAR TO DATE			ANNUAL
	ACTUAL	BUDGET	VARIANCE	ACTUAL	BUDGET	VARIANCE	BUDGET
STATISTICAL DATA							
ACUTE INPATIENT ADMISSIONS	15	19	-4	135	166	-31	250
ACUTE PATIENT DAYS	44	56	-12	383	486	-103	730
SKILLED NURSING PATIENT DAYS	1349	1456	-107	11764	12636	-872	18980
SWING BED DAYS	12	5	7	166	54	112	82
E.R. VISITS	307	249	58	2541	2308	233	3530
CLINIC VISITS	2200	2150	50	17983	17462	521	26617

EASTERN PLUMAS HEALTH CARE
COMPARATIVE BALANCE SHEET
FOR THE MONTHS ENDED

	JANUARY 2015	FEBRUARY 2015	CHANGE
ASSETS			
CURRENT ASSETS			
CASH	$ 606,909	$ 394,784	$ (212,125)
LAIF SAVINGS	$ 1,113,544	$ 1,113,544	$ -
ACCOUNTS RECEIVABLE NET	$ 3,913,215	$ 3,657,059	$ (256,156)
ACCOUNTS RECEIVABLE OTHER	$ 490,312	$ 845,411	$ 355,099
INVENTORY	$ 237,249	$ 237,249	$ -
PREPAID EXPENSES	$ 87,734	$ 81,951	$ (5,783)
TOTAL CURRENT ASSETS	$ 6,448,963	$ 6,329,998	$ (118,965)
PROPERTY AND EQUIPMENT			
LAND AND IMPROVEMENTS	$ 934,164	$ 934,164	$ -
BUILDINGS AND IMPROVEMENTS	$ 10,147,957	$ 10,147,957	$ -
EQUIPMENT	$ 10,213,880	$ 10,298,113	$ 84,233
IN PROGRESS	$ 366,464	$ 366,464	$ -
	$ 21,662,465	$ 21,746,698	$ 84,233
ACCUMULATED DEPRECIATION	$ 14,377,683	$ 14,445,030	$ 67,347
TOTAL PROPERTY AND EQUIPMENT	$ 7,284,782	$ 7,301,668	$ 16,886
COSTS OF ISSUANCE NET	$ 10,903	$ 10,813	$ (90)
TOTAL	$ 13,744,648	$ 13,642,479	$ (102,169)
LIABILITIES AND FUND BALANCE			
CURRENT LIABILITIES			
LEASES PAYABLE	$ 71,469	$ 48,536	$ (22,933)
ACCOUNTS PAYABLE	$ 1,112,756	$ 1,193,762	$ 81,006
ACCRUED PAYROLL/RELATED TAXES	$ 1,014,602	$ 1,043,172	$ 28,570
OTHER CURRENT LIABILITIES	$ 368,756	$ 368,371	$ (385)
TOTAL CURRENT LIABILITIES	$ 2,567,583	$ 2,653,841	$ 86,258
LEASES PAYABLE	$ 314,738	$ 314,738	$ -
CITY OF PORTOLA	$ 316,159	$ 314,073	$ (2,086)
USDA LOANS	$ 3,781,541	$ 3,769,334	$ (12,207)
DEFERRED REVENUE	$ 167,670	$ 167,670	$ -
MEDI-CAL LTC	$ 1,729,804	$ 1,729,804	$ -
TOTAL LIABILITIES	$ 8,877,495	$ 8,949,460	$ 71,965
FUND BALANCE	$ 4,620,580	$ 4,531,787	$ (88,793)
NET INCOME (LOSS)	$ 246,573	$ 161,232	$ (85,341)
TOTAL	$ 13,744,648	$ 13,642,479	$ (102,169)

EASTERN PLUMAS HEALTH CARE
BALANCE SHEET
FOR THE MONTH ENDED
FEBRUARY 28, 2015

ASSETS

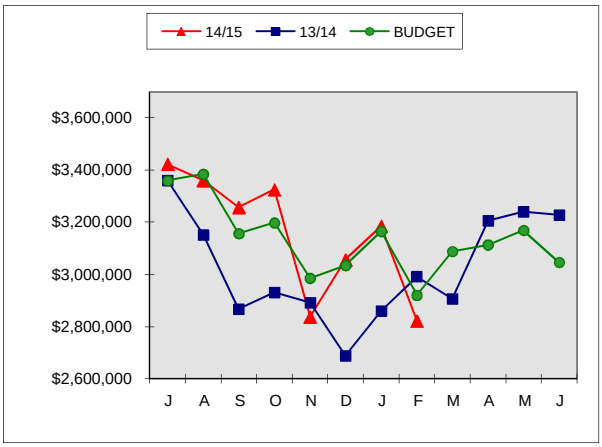
CURRENT ASSETS	
CASH	394,784
INVESTMENTS	1,113,544
ACCOUNTS RECEIVABLE NET	3,657,056
ACCOUNTS RECEIVABLE OTHER	845,411
INVENTORY	237,249
PREPAID EXPENSES	81,951
TOTAL CURRENT ASSETS	6,329,996
PROPERTY AND EQUIPMENT	
LAND AND IMPROVEMENTS	934,164
BUILDINGS AND IMPROVEMENTS	10,147,957
EQUIPMENT	10,298,113
IN PROGRESS	366,464
TOTAL PROPERTY AND EQUIPMENT	21,746,699
ACCUMULATED DEPRECIATION	14,445,030
NET PROPERTY AND EQUIPMENT	7,301,669
COSTS OF ISSUANCE NET	10,813
TOTAL	13,642,479

LIABILITIES AND FUND BALANCE

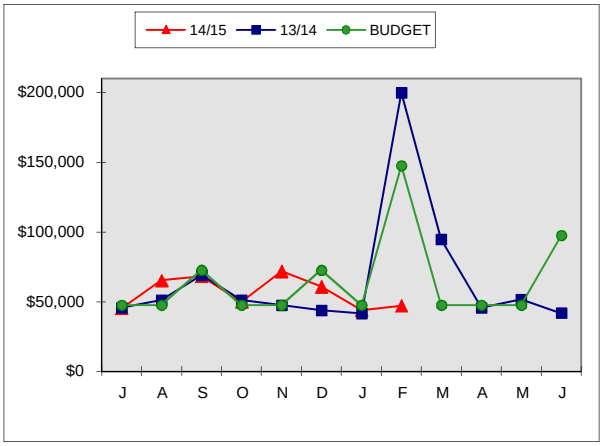
CURRENT LIABILITIES	
LEASES PAYABLE	48,536
ACCOUNTS PAYABLE	1,193,762
ACCRUED PAYROLL/RELATED TAXES	1,043,172
OTHER CURRENT LIABILITIES	368,372
TOTAL CURRENT LIABILITIES	2,653,841
LEASES PAYABLE	314,738
USDA REPAIRS & DEFEASANCE	0
CITY OF PORTOLA- PROPERTY LOAN	314,073
USDA LOANS SNF	3,294,389
PLUMAS BANK LOAN LOYALTON	474,945
USDA LOAN LOYALTON & PORTOLA	0
DEFERRED REVENUE	167,670
LTC MEDI-CAL NET	1,729,804
TOTAL LIABILITIES	8,949,459
FUND BALANCE	4,531,787
NET INCOME (LOSS)	161,232
TOTAL	13,642,479

EASTERN PLUMAS HEALTH CARE
MONTHLY FINANCIAL GRAPHS
FOR THE YEAR ENDED JUNE 30, 2015

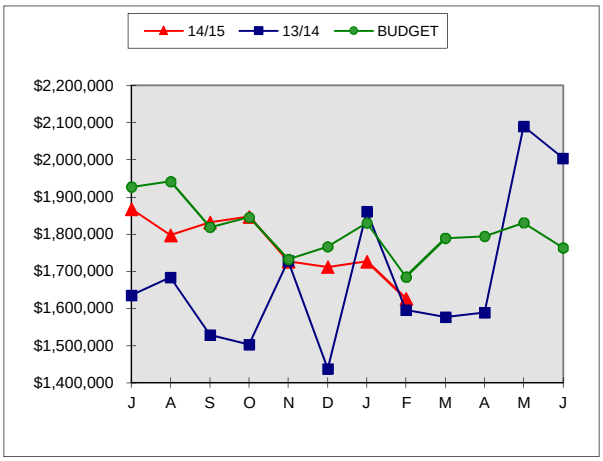
1. GROSS PATIENT REVENUE



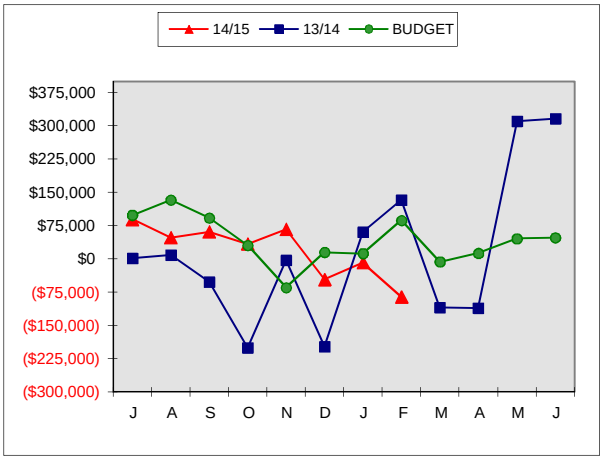
4. NON-OPERATING INCOME



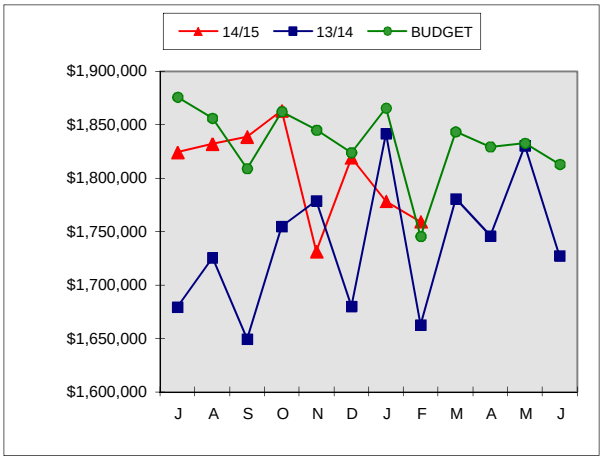
2. ESTIMATED NET REVENUE



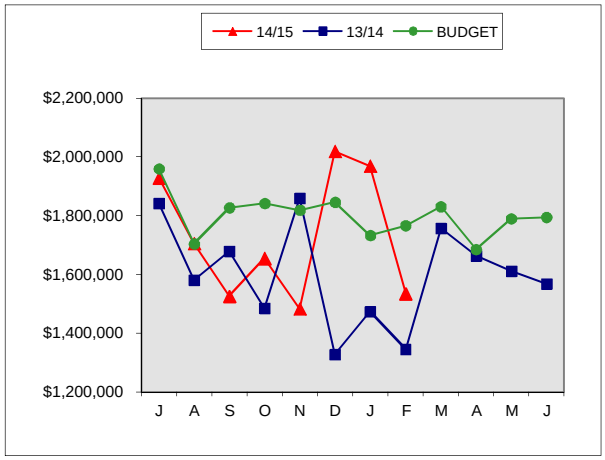
5. NET INCOME (LOSS)



3. OPERATING EXPENSES

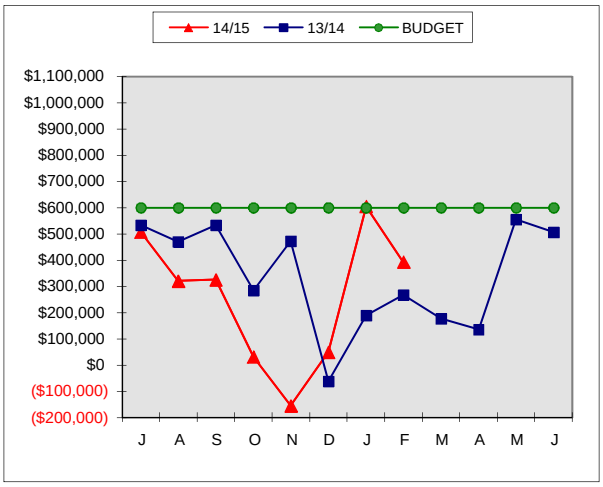


6. CASH RECEIPTS

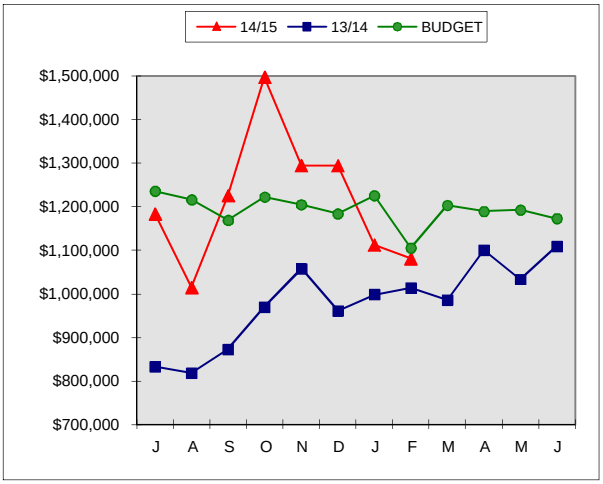


EASTERN PLUMAS HEALTH CARE
MONTHLY FINANCIAL GRAPHS
FOR THE YEAR ENDED JUNE 30, 2015

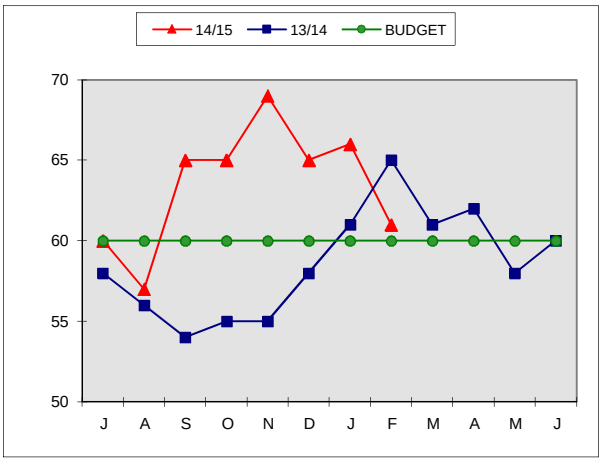
7. OPERATING CASH



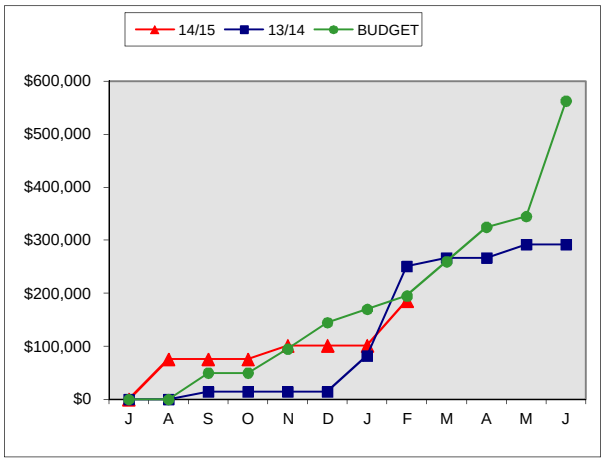
10. ACCOUNTS PAYABLE



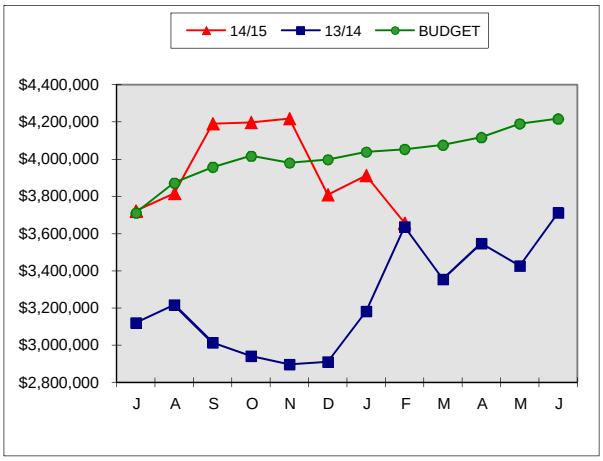
8. ACCOUNTS RECEIVABLE-DAYS



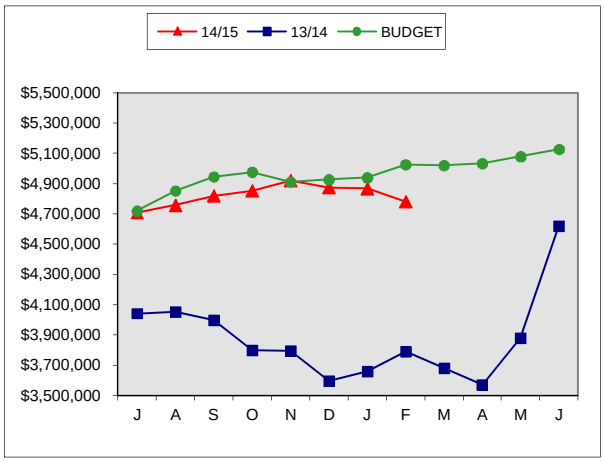
11. CAPITAL EXPENDITURES-YTD



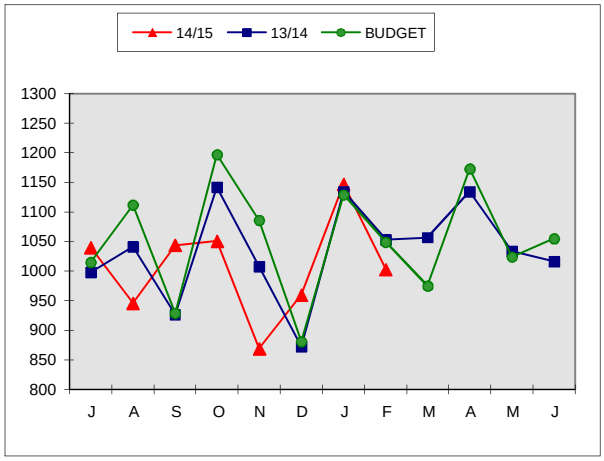
9. ACCOUNTS RECEIVABLE, NET



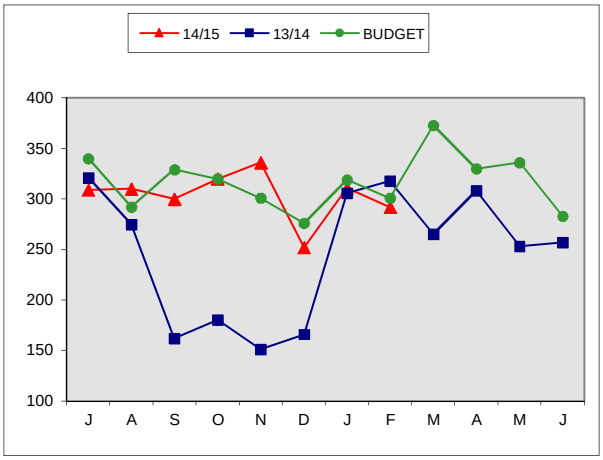
12. FUND BALANCE + NET INCOME (LOSS)



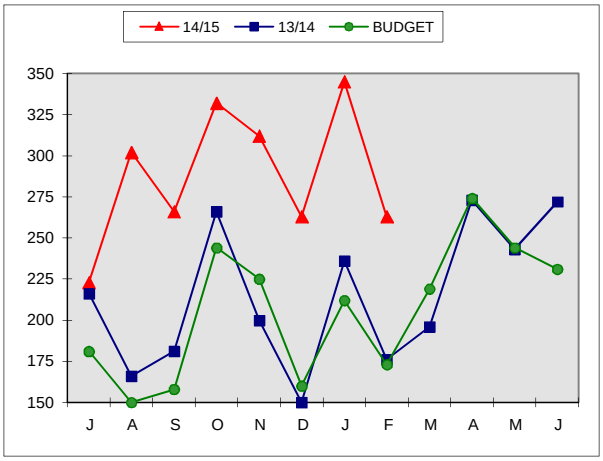
13. PORTOLA MEDICAL CLINIC VISITS



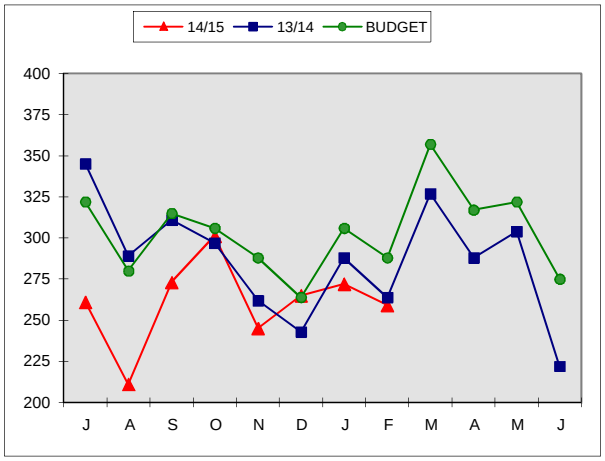
16. LOYALTON MEDICAL CLINIC VISITS



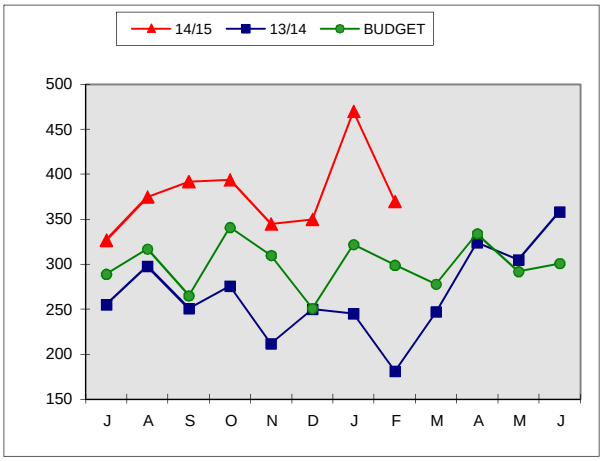
14. PORTOLA DENTAL CLINIC VISITS



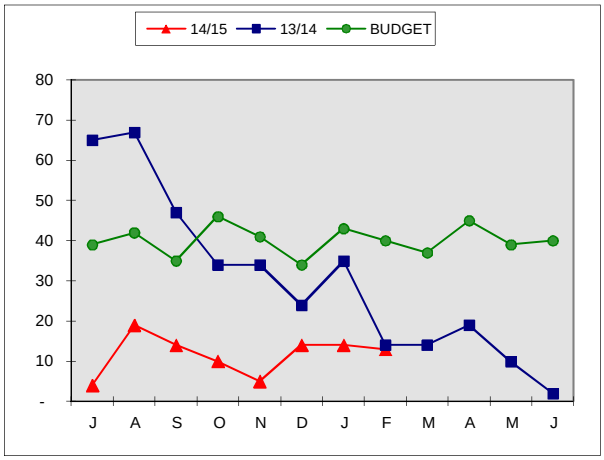
17. INDIAN VALLEY MEDICAL CLINIC VISITS



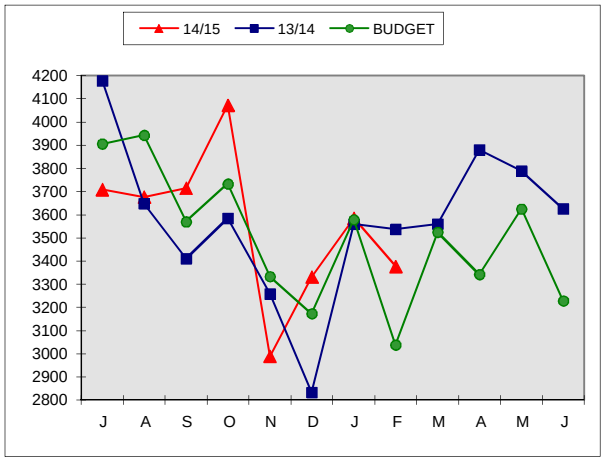
15. GRAEAGLE MEDICAL CLINIC VISITS



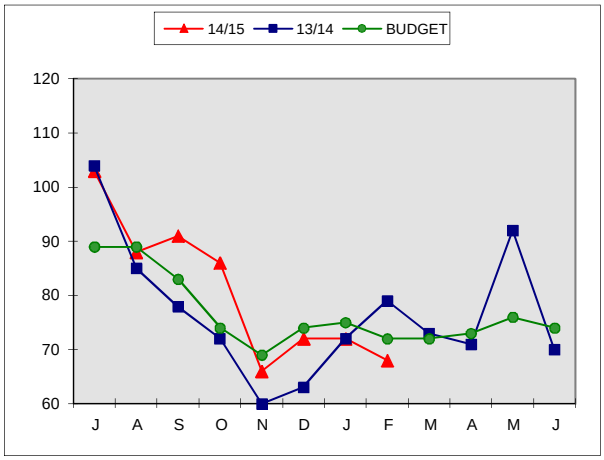
18. PORTOLA ANNEX VISITS



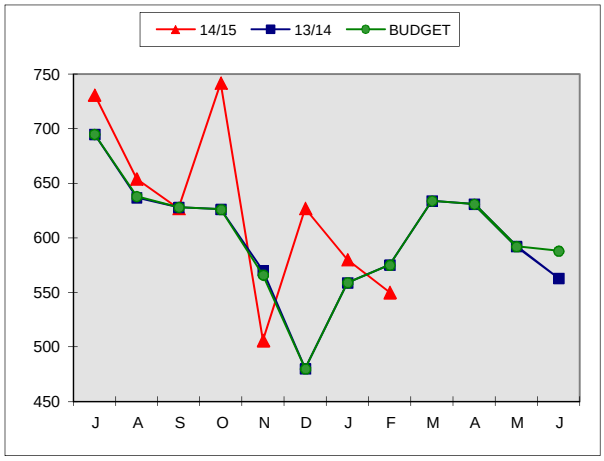
19. LABORATORY PROCEDURES



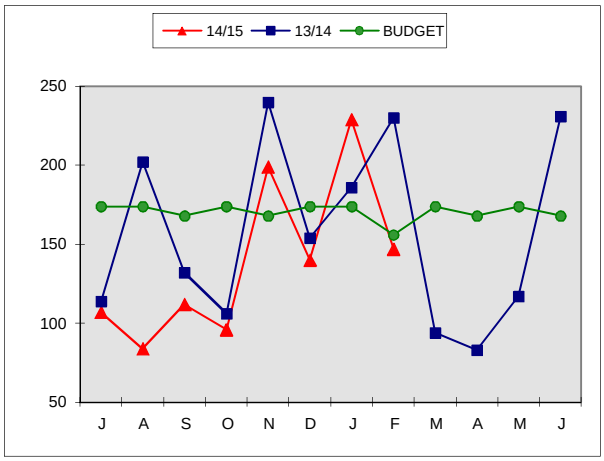
22. AMBULANCE RUNS



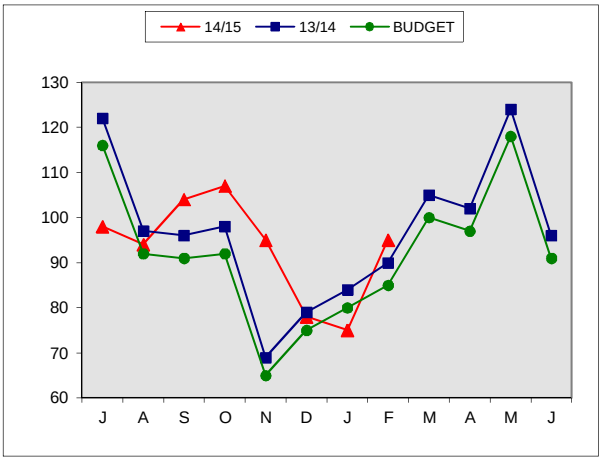
20. RADIOLOGY PROCEDURES



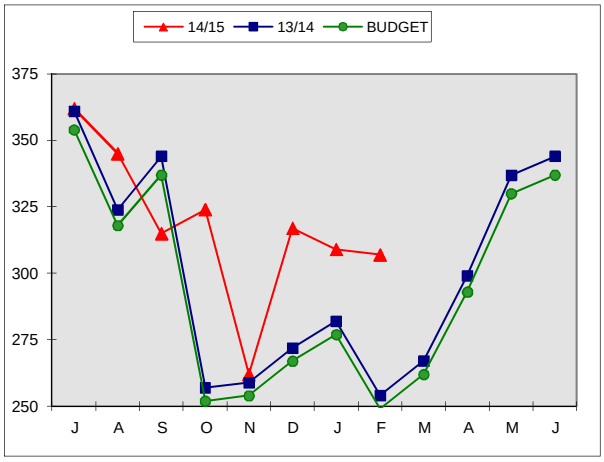
23. RESPIRATORY PROCEDURES



21. ECGS

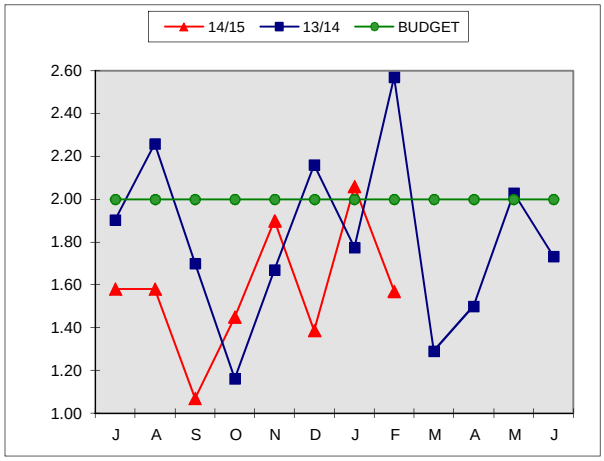


24. EMERGENCY ROOM VISITS

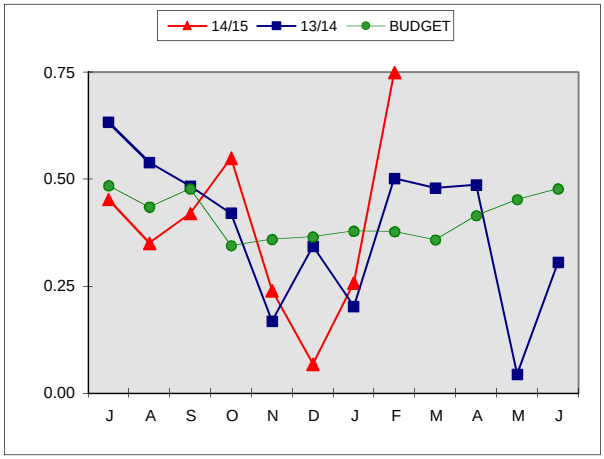


EASTERN PLUMAS HEALTH CARE
MONTHLY FINANCIAL GRAPHS
FOR THE YEAR ENDED JUNE 30, 2015

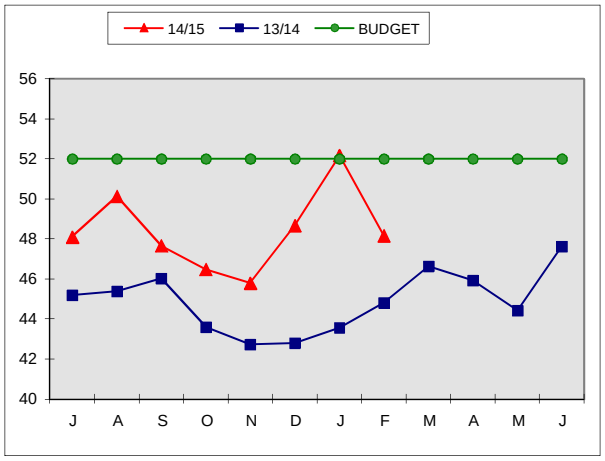
25. AVERAGE DAILY CENSUS - ACUTE



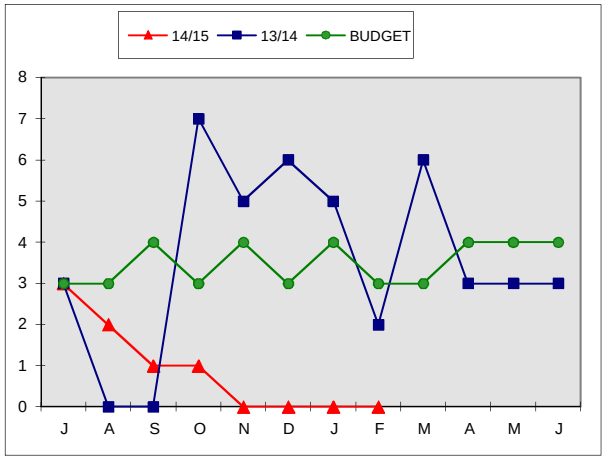
28. AVERAGE DAILY CENSUS - OBSERVATION



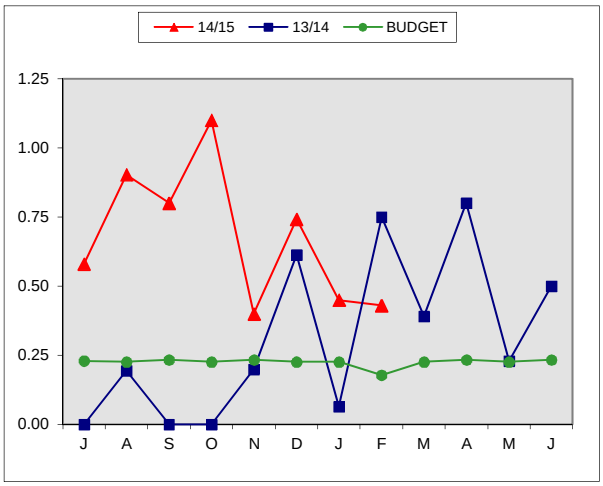
26. AVERAGE DAILY CENSUS - SNF



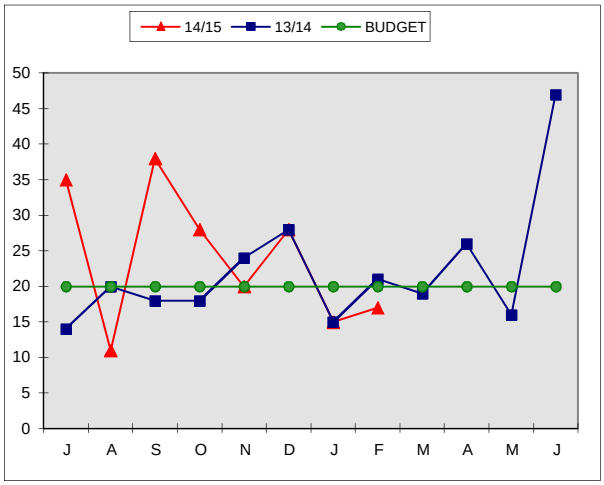
29. SURGERIES - IN & OUTPATIENT



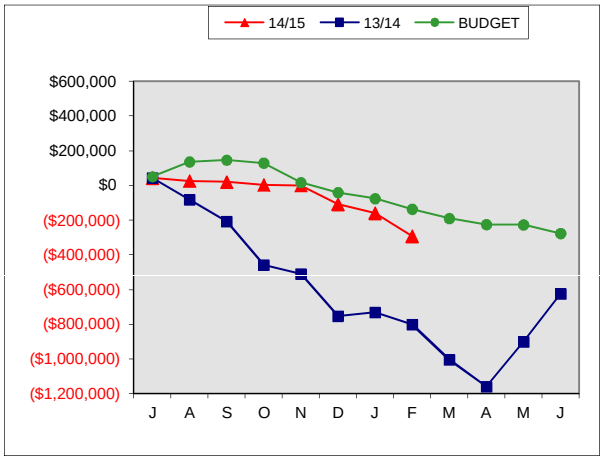
27. AVERAGE DAILY CENSUS-SWING



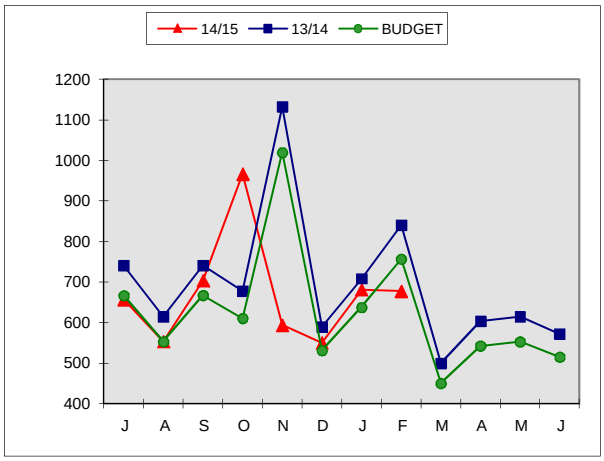
30. ENDOSCOPY PROCEDURES



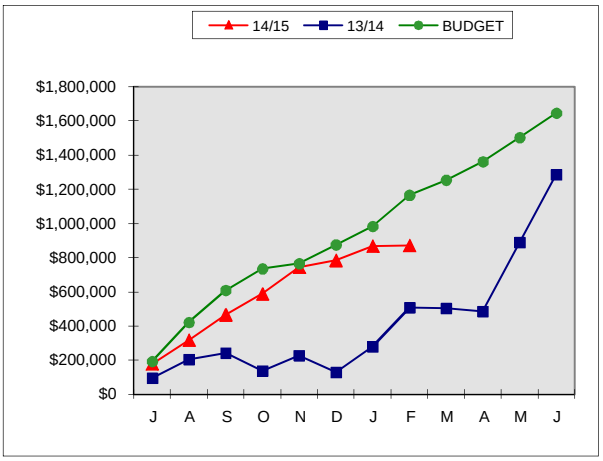
31. YEAR TO DATE OPERATING INCOME (LOSS)



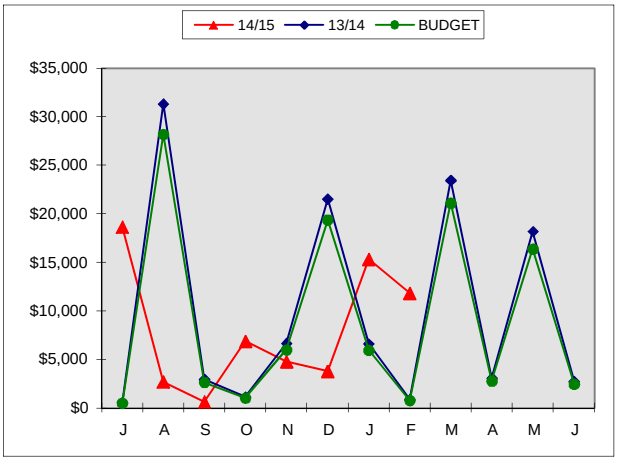
34. OVERTIME HOURS



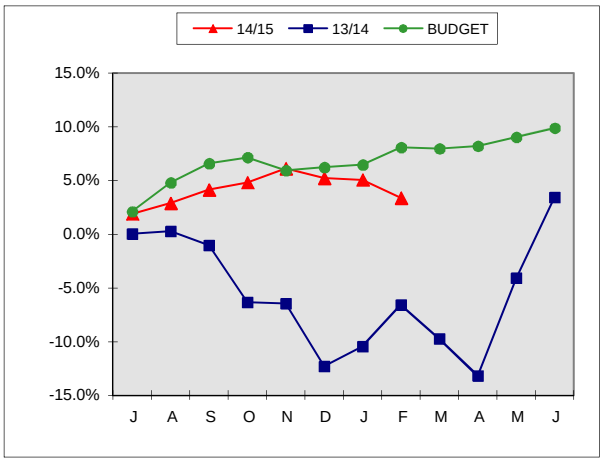
32. EARNINGS BEFORE INTEREST, DEPRECIATION & AMORTIZATION



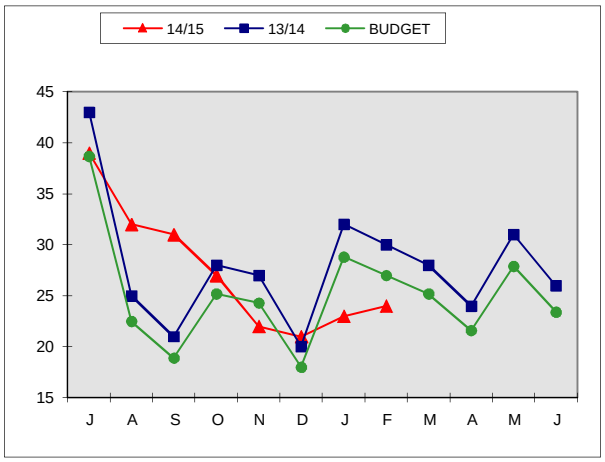
35. DENIALS



34. RETURN ON EQUITY



36. EMERGENCY DEPARTMENT TRANSFERS



OPTIMA
HEALTHCARE INSURANCE SERVICES

March 13, 2015

Thomas Hayes
Chief Executive Officer
Eastern Plumas Health Care
500 First Avenue
Portola, CA 96122

RE: California Healthcare Insurance Company, Inc.,
A Risk Retention Group (CHI) – Premium Rebate

Dear Tom:

In support of CHI and Optima's core purpose to "make a positive difference in health care", management and the Board of Directors are pleased to announce the 8th consecutive year of the distribution of premium rebates to the owners of CHI!

The distribution of this premium rebate brings the total rebates over the past eight years (since 2007) to over $22 million. Cumulatively, including premium holidays, distributions to CHI owners since the inception of the company are over $28.5 million.

CHI was formed over 25 years ago to enable hospitals to gain control of their professional liability needs through a stable, financially strong alternative to a traditional insurance company. The loyalty and dedication of the CHI owners contribute greatly to the success of the organization. Distributing a premium rebate is another way to demonstrate that CHI is different from the traditional insurance market, and that by aligning the incentives of the insurance company and the insurance buyer, superior results can be achieved.

I am very pleased to report that 2014 was another very good year for CHI and Optima. Significant factors relating to CHI's positive financial results include an increase in brokerage commission income, a reduction in the reinsurance treaty rate, positive budget variances in operating expenses and a year-end actuarial reserve study that required a development reserve takedown.

Although claims results were not stellar two years ago in 2012, better than expected claims results over the past several years have demonstrated the commitment of CHI and its owners to quality health care and management of risk. The historical claims results are reflected in the year-end actuarial reserve study, which required a development reserve takedown. The takedown triggered a recommendation by Optima management to the Board of Directors for the declaration of a premium rebate totaling $6 million.

The Board approved the recommendation at their February 20, 2015 meeting. The 2014 premium rebate will be paid in two installments. The first installment of $4 million is included in the enclosed check along with $1 million from the second installment of the 2013 premium rebate. The total distribution in 2015 is $5 million, representing the largest distribution in company history!

Assuming the Board reaffirms the 2014 premium rebate at the February 2016 Board meeting, the remaining $2 million installment will be paid to qualified policyholders of record as of December 31, 2015 and distributed in the spring of 2016.

Historically, CHI premium rebates have been allocated to each owner using a combination of each owner's pro rata contribution to the overall company profit and each owner's relative size. In 2013, a new component to the distribution was added to reward loyalty and longevity.

The profit component of the allocation is each individual owner's pro rata contribution to the overall CHI profit for the most recent three years (2011-2013 for the 2014 rebate). The size component of the allocation is based on each owner's relative size; defined as each owner's pro rata annual direct written premium. The size component was changed this year, as in the past it was based on relative occupied bed equivalents (OBEs) and the first million dollars of manual premium (excluding the SIR credit) as a percentage of the total. The loyalty and longevity component of the allocation is each individual owner's pro rata number of years as a CHI qualified policyholder (owner), capped at 20% of annual direct written premium.

Now for the most important part – enclosed is Eastern Plumas' check for $49,721! This check represents 0% profit; 26% size; and 74% longevity. Congratulations and thank you for your loyalty, support and ownership.

Sincerely,

Diane Abbett
President
California Healthcare Insurance Company, Inc.,
A Risk Retention Group

DA:js
Enclosure

cc: Jeri Nelson
Linda Jameson
Robin Mitchell/Bonnie Garcia

Rural hospitals, beset by financial problems, struggle to survive

By Guy Gugliotta March 15 at 5:21 PM

MOUNT VERNON, Tex. — Despite residents' concerns and a continuing need for services, the 25-bed hospital that served this small East Texas town for more than 25 years closed its doors at the end of 2014, joining the ranks of dozens of other small rural hospitals that have been unable to weather the punishment of a changing national health-care environment.

For the high percentages of elderly and uninsured patients who live in rural areas, closures mean longer trips for treatment and uncertainty during times of crisis. "I came to the emergency room when I had panic attacks," said George Taylor, 60, a retired federal government employee. "It was very soothing and the staff was great. I can't imagine Mount Vernon without a hospital."

The Kansas-based National Rural Health Association, which represents about 2,000 small hospitals across the country and other rural care providers, says that 48 rural hospitals have closed since 2010, the majority in Southern states, and 283 others are in trouble. In Texas alone, 10 have closed.

[*FDA warns about medical scopes after 'superbug' hits California hospital*]

"If there was one particular policy causing the trouble, it would be easy to understand," said Mark Holmes, a health economist at the University of North

Carolina. "But there are a lot of things going on."

Experts and practitioners cite declining federal reimbursements for hospitals under the Affordable Care Act as the principal reasons for the recent closures. Besides cutting back on Medicare, the law reduced payments to hospitals for the uninsured, a decision based on the assumption that states would expand their Medicaid programs. However, almost two dozen states have refused to do so. In addition, additional Medicare cuts caused by a budget disagreement in Congress have hurt hospitals' bottom lines.

But rural hospitals also suffer from multiple endemic disadvantages that drive down profit margins and make it virtually impossible to achieve economies of scale.

These include declining populations; disproportionate numbers of elderly and uninsured patients; the frequent need to pay doctors better than top dollar to get them to work in the hinterlands; the cost of expensive equipment that is necessary but frequently underused; the inability to provide lucrative specialty services and treatments; and an emphasis on emergency and urgent care, chronic money-losers.

[*The most important question every doctor should ask their patient*]

Rural health-care experts say that unless the problems of rural hospitals are addressed by state and federal officials, there could be a repeat of the widespread closings that followed an overhaul of the Medicare payment system 30 years ago. That 1983 change, called the prospective payment system, established fixed reimbursements for care instead of payments based on a hospital's reported costs. It rewarded large, efficient providers, but 440 small hospitals closed before the

system was adjusted in 1997 to help them. Those adjustments created the designation of critical-access hospitals for some small, isolated facilities, and exempted them from the fixed-payment system.

"And now, beginning in 2010, we've had another series of cuts that are all combining to create another expansion of closures just like we saw in the '90s," said Brock Slabach, senior vice president of the Rural Health Association. "We don't want to wake up with another disaster."

In Mount Vernon, a town of 2,678 people nestled in grassland and dairy country about two hours east of Dallas, family practitioner Jean Latortue has taken out a lease on the now-vacant hospital building to convert it into an outpatient and urgent care clinic at his own expense. Reopening may be a risky move, he acknowledged, but the need is there.

"The community went into panic mode," he said. "I figured I had to step up."

The nonprofit ETMC Regional Healthcare System, based in Tyler, Tex., closed the Mount Vernon hospital and two others of its then-12 rural hospital affiliates because it could no longer sustain operating losses that had persisted for five years.

[*U.S. Hospitals: Where a blood test can cost $10 or $10,000*]

Perry Henderson, senior vice president of affiliate hospitals for ETMC, and other experts cite three reasons for the rash of closures nationally.

Sequestration, the across-the-board federal budget cut that arose out of the legislative impasse between the Obama administration and congressional

Republicans, has resulted in a 2 percent reduction in Medicare reimbursements since 2013.

"If Medicare is 50 percent of your revenue and you lose two points," North Carolina's Holmes said, "it can be a killer."

Rural hospitals took a second hit from the health law's reductions in special Medicaid payments to hospitals with large numbers of indigent and uninsured patients. Federal officials made the cuts assuming that most states would embrace the Medicaid expansion envisioned in the law, thus sharply reducing their number of uninsured. But 23 states, including Texas, have declined to do so.

Another issue is the deductibles charged by some of the new insurance plans created under the health law. In many cases, they "are running between $2,500 and $5,000," and people can't pay them, said Maggie Elehwany, chief lobbyist for the Rural Health Association.

Latortue, who came to Mount Vernon as an ETMC hospital doctor in 2008, appears undaunted by the challenges of reinventing the hospital, which was treating an average of eight inpatients a week when it closed. Still, he said, "I'm very busy, and patients need to be seen — we'll be all right."

At the new clinic, he intends to provide outpatient services, including lab work, and emergency care, stabilizing patients until they can be transferred to the Titus Regional Medical Center in Mount Pleasant, 16 miles away, or to a smaller facility in Winfield, eight miles away. He also plans a wellness clinic to treat obesity and will offer Botox and laser cosmetic services. A cardiologist and a gastroenterologist will make weekly visits, and he is also looking for an Ob-Gyn.

Still, none of this will replace the hospital, and his patients know it. "I live right behind the building," said Mary Hunter, a fit grandmother of 73. "I've had very good health until my blood pressure spiked last week," she said. "We retired in 2006 and moved here, partly because of the hospital. And now it's gone."

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Related: Rural hospitals get billions in extra Medicare funds