REGULAR MEETING OF THE BOARD OF TRUSTEES

January 22nd, 2025

12:00 pm (Noon) - Shoshone Medical Center Classrooms

25 Jacobs Gulch Rd., Kellogg, ID

Our Mission: TO PROVIDE EXCELLENCE IN HEALTHCARE

I. CALL TO ORDER – Andy Helkey, Chair

II. CONSENT AGENDA - **APPROVAL**
   a. Prior Meeting Minutes – December Finance and Regular Board Meeting – PG 1
   b. Chief Executive Officer Report – PG 4
   c. Quality Report – PG 5
   d. Risk Report – PG 6

III. STAFFING
   a. Credentialing Update – applications in process
      i. Wesley D. Wylie MD – Locum Hospitalist thru CompHealth
      ii. Farah E. Vega MD – Contracted Hospitalist

IV. CHIEF FINANCIAL OFFICER'S REPORT – Donja Erdman – PG 7
   a. Pages under Financial Report
      i. November 2024 Financials – **APPROVAL**
      ii. December 2024 Financials – **APPROVAL**
      iii. Incentive Bonus 2024 – **APPROVAL**
      iv. Retirement Match – **APPROVAL**
      v. Heritage Imaging Echo Contract – **APPROVAL**
      vi. MIEC Renewal, Auto Insurance Renewal – **APPROVAL**

V. CHIEF MEDICAL OFFICER'S REPORT – Dr. Jessica Harnisch-Boyd

VI. CHIEF NURSING OFFICER'S REPORT – Karen Overholtzer, RN

VII. OLD BUSINESS
   a. Consent Agenda
   b. Medical Staff Planning Committee

VIII. NEW BUSINESS
   a. Dr. Dale Ross, Emergency department medical director agreement – **APPROVAL** – PG 41
   b. 2025-2027 Strategic Plan – **APPROVAL** – PG 43

IX. BOARD SECRETARY REPORT – Frank Smith

X. COMMITTEE MEETINGS
   a. Executive - (Chairman, Vice-Chair, Treasurer
   b. Finance - (Wendt, Brooks)
   c. Interdisciplinary/Quality - (Brooks, Cobb, Roberts) – 1/16
   d. Building & Grounds – (Cobb, Smith, Brooks)
   e. Credentialing – (Dahlberg, Smith)
   f. Compliance – (Helkey)
   g. Recruitment – (Cobb, Wendt, Brooks)
   h. SMC Foundation – (Smith)

XI. EDUCATION
   a. IHA Hospitals 101 – A guide book to Idaho's Community Hospitals 2025 Edition (in appendix)
   b. Northwest Hospital Alliance Symposium February 7-8

XII. OTHER BUSINESS

   a. May 26th Finance Committee falls on Memorial Day – Approve moving to Tuesday May 27th - **APPROVAL**

XIII. PUBLIC COMMENT

XIV. ADJOURN

Shoshone
MEDICAL CENTER

West Shoshone Hospital District #1
Board of Trustees Meeting

JANUARY 2025

BOARD OF TRUSTEES
FINANCE COMMITTEE MEETING

December 16, 2024

SMC Administration Conference Room
Paul Lewis, Chief Executive Officer and Donja Erdman, Chief Financial Officer - Reporting
7 A. M.

Trustees Present: Frank Smith, Nathan Wendt, Carol Roberts, and Andy Helkey
Guests: Paul Lewis, CEO and Donja Erdman, CFO

The meeting was called to order at 7:06am.

REVIEW OF FINANCIALS:

Preliminary Financial statements for the month of November 2024 were reviewed.

AGENDA ITEMS:

- Kelly Casey of Yellowstone was on Teams to review the malpractice, Cyber, D&O/EPL, Crime and Fiduciary policy renewals for approval.
- 2024 Incentive Goals were reviewed.
- Operating and Capital Budgets for FY2025 were reviewed for approval.
- Lab analyzer request for capital was for approval.
- Employee PTO Policy changes were reviewed for approval.

OTHER BUSINESS –
Discussion on adding sexual misconduct to the insurance. After receiving the premium amount decided against adding it. Discussed claims made versus per occurrence on our malpractice insurance.

No further business, meeting adjourned at 8:03 a.m.

West Shoshone Hospital District #1
Regular Board Meeting
December 18, 2024

In attendance:	**Guests in attendance:**
Andy Helkey, Chair Rick Brooks, Trustee Carol Roberts, Trustee Frank Smith, Treasurer Called in: Nathan Wendt, Trustee	Paul Lewis, CEO Donja Erdman, CFO Joseph Schoeny, Quality Director Mirna Pleines, Risk Manager Susan Berry, Board Clerk Called in: Dr. Jessica Harnisch-Boyd, CMO

I. CALL TO ORDER

Time:	5:15 pm
Place:	Shoshone Medical Center
Presiding:	Andy Helkey, Board Chairman
Recording:	Susan Berry, Board Clerk

I. CONSENT AGENDA

MOTION – To approve the Consent Agenda – (Brooks/Roberts) – unanimously approved

a. Prior Meeting Minutes – November Finance and Regular Board Meeting; November 25 Special Board Meeting – PG 1
b. Chief Nursing Officer's Report – PG 7
c. Quality Report – PG 10
d. Risk Report – PG 11

II. STAFFING

a. Credentialing Update – applications in process
    i. Wesley D. Wylie MD – Locum Hospitalist thru CompHealth
    ii. Farah E. Vega MD – Contracted Hospitalist

III. CHIEF FINANCIAL OFFICER'S REPORT – Donja Erdman – PG 24

a. Pages under Financial Report
    i. **MOTION** – To approve Yellowstone Insurance Renewal – (Roberts/Smith) – unanimously approved
    ii. **MOTION** – To approve FY25 Operating & Capital Budgets - (Wendt/Brooks) – unanimously approved
    iii. **MOTION** – To approve Lab Analyzer – (Roberts/Smith) – unanimously approved
    iv. **MOTION** – To approve Employee PTO Policy - (Brooks/Roberts) – unanimously approved

IV. OLD BUSINESS

a. Consent Agenda – comments from the Board is that is was good to go through each line item to allow for comments/questions.
b. Medical Staff Planning Committee – Paul to schedule a meeting with the Recruitment Committee Board members.

V. NEW BUSINESS

a. 2024 -2025 Strategic Plan Reviews – PG 65
    i. Paul gave a "year in review" recap that included the success of the Cerner Implementation, MRI Project, Fiscal Year End was positive to budget, paid off the Hospital's mortgage, were recognized for two awards (Top 100, Patient Experience), had success with Physician recruitment, Dr. Harnisch-Boyd mentoring residents and the Specialty Clinic in Smelterville now has 6 providers to serve the needs of the Silver Valley.
    ii. Paul's comments for upcoming 2025 is to continue to improve our connection with the community through four Learning Lunches as well as continuing to grow our Senior and Kid's Health Fairs.
b. Dr. Harnisch-Boyd gave a report regarding recruitment of a Kootenai Hospitalist with interest in working at SMC and building a pipeline for future recruits through the Nampa/Boice resident program.

VI. BOARD SECRETARY REPORT – Frank Smith

VII. COMMITTEE MEETINGS

a. Executive - (Chairman, Vice-Chair, Treasurer
b. Finance - (Wendt, Brooks)
c. Interdisciplinary/Quality - (Brooks, Cobb, Roberts) – 12/19; 1/16
d. Building & Grounds – (Cobb, Smith, Brooks)
e. Credentialing – (Dahlberg, Smith)
f. Compliance – (Helkey) – 12/10
g. Recruitment – (Cobb, Wendt, Brooks)
h. SMC Foundation – (Smith)

VIII. EDUCATION

a. Northwest Hospital Alliance Symposium
    i. February 7-8 at the CDA resort. It will be similar to prior years with board education Friday afternoon, dinner Friday night with keynote speaker and educational sessions Saturday morning.

IX. OTHER BUSINESS

X. PUBLIC COMMENT

XI. **MOTION** – TO ADJOURN –(Roberts/Brooks) – unanimously approved

Meeting Adjourned at 5:34 pm

The next board meeting will be JANUARY 22, 2025 LUNCH MEETING 12:15pm at Shoshone Medical Center in the Cafeteria

January 2025

Strategic Plan

During this month's board meeting we will have the opportunity to review the draft 2025-2027 strategic plan for Shoshone Medical Center. We reviewed all the internal and community input received and I believe the final draft captures the key strategic goals to be addressed over the next three years. Some of the goals are continuing from our prior plan and we will also have some areas of new opportunity. I look forward to our discussion and appreciate you direction and vision for Shoshone Medical Center.

Facility Development

The x-ray replacement project is underway and on schedule. The new x-ray unit will be delivered and installed the week of January 20th. Training for our radiology technologists will be completed the following week and the new room will be ready for patient care by January 31st. With the purchase of a new portable x-ray machine, we were able to donate our current unit to North Idaho College for use in their Radiography Technology program.

Staff Recruitment/Retention

We recently welcomed three new leaders to our team. Lance Bishop is our new Information Technology Manager, Emma Marlow has rejoined SMC as the Rehabilitation Services Manager and Danielle Davenport was hired as our new Clinic Manager. Since we have several new managers we are developing a new leader orientation program to provide education and help facilitate strong working relationships with leaders, staff and physicians.

Paul Lewis, CEO

Shoshone MEDICAL CENTER

Joseph Schoeny, RN, BSN, MHA, Quality Director

January 2025

Quality project focus

- Falls
  - Don't fall December
    - **Zero Patient Falls!**
  - 11 YTD (through end of December) compared to 20 YTD same time frame last year
  - Next year the fall rate goal will be set based on the average fall rate in the US which is between 3 -5 falls per 1,000 patient days

Internal Audits

- We completed an internal audit for registration
  - Specifically for signed consents in various areas of the Medical Center
    - Results demonstrated high compliance with signed consents
      - Will continue to monitor

Daily Huddles

- Progressing in ED and In-Patient
  - Our frontline colleagues are contributing excellent opportunities for improvement during our huddles
    - These opportunities are making their way up the help chain and being addressed

Customer service

- **All Press Ganey (HCAHP) surveys had a top box score of 100% in December**

DNV

- Continue to have monthly meetings with Non-Conformity (NC) owners
  - 5 areas are categorized as done (DNV classified conformities)

Opportunities

- We have 4 opportunity areas of non-conformities
  - Medication management is a priority and we are actively addressing it
- We received 2 surveys in December and are actively seeking ways to increase our response rate

Mirna Pleines - Risk, Privacy, Compliance

DECEMBER 2024

Complaint/Grievances/Compliments

- 1 Complaint

Privacy/Compliance

HIPAA:

- 3 (non-reportable events)

Compliance Audit:

- Ancillary: 2 audited / 2 out of compliance
- Radiology: 2 audited / 0 out of compliance
- Swing Bed: 2 audited / 1 out of compliance
- ED: 6 audited / 4 out of compliance

Trending Occurrences:

- Registration: 6
- AMA: 4
- LWBS: 7

High Risk:

- Falls: 1
- Medication: 1

Compliance Activities:

Seven Elements of an Effective Compliance Program

1. **Standards of Conduct (Code)/Policies and Procedures**
   - Ongoing through PolicyTech
2. **Governance and Oversight**
   - 2024 First Quarter Compliance Committee meeting scheduled 3/11/2025
3. **Education and Training**
   - Training on Patient Consents
4. **Develop Effective Lines of Communication**
   - Compliance line posted around facility and intranet.
     - No anonymous reports received in December.
5. **Internal Auditing and Monitoring**
   - Multiple audits this quarter listed in the Compliance Activity Report
6. **Enforcement and Discipline**
   - 4 Corrective Actions Issued for Policy Violations.
7. **Prompt Response to Detected Offenses**
   - All reported violations are promptly investigated.

FINANCE COMMITTEE AGENDA
January 17, 2025 7 am
Shoshone Medical Center – Administration Conference Room

Agenda

1. Call to Order
2. November 2024 Financials – Approval
3. December 2024 Financials - Approval
4. Incentive Bonus 2024 - Approval
5. Retirement Match – Approval
6. Heritage Imaging Echo Contract – Approval
7. Dr. Ross Medical Director Agreement – Approval
8. MIEC Renewal, Auto Insurance Renewal – Approval
9. Finance Committee – May 2025 – Tuesday 27th?
10. Questions
11. Adjourn

SMC Finance Committee

Microsoft Teams Need help?
Join the meeting now
Meeting ID: 256 267 666 986
Passcode: sZ3vz2MC

Dial in by phone
+1 323-457-8090,,33667488# United States, Los Angeles
Find a local number
Phone conference ID: 336 674 88#
For organizers: Meeting options | Reset dial-in PIN

SHOSHONE MEDICAL CENTER
CFO SUMMARY REPORT
NOVEMBER 2024 FINANCIAL OPERATIONS

STATISTICS

- Acute Care admissions were 14 compared to budget at 22. Acute Care days were 39 compared to 68 budgeted. Average Length of Stay for the month was 3.00 and 3.22 budget. Year to date length of stay is 3.18 which is under 4.0 requirement.
- Swing Bed Admissions were 11 compared to 8 budgeted. Swing Bed Days were 109 actual compared to 92 budgeted. The average length of stay was 8.38 compared to 11.32 budget.
- Observation Hours are 353 actual compared to 565 budget.
- Ancillary was 1658 actual compared to 2267 budgeted.
- Emergency Visits are 439 compared to the budget at 453.
- Scopes are 21 actual compared to 18 budgeted.
- Clinic visits were 587 actual compared to 575 budgeted.
- Behavioral Health had 219 visits compared to 324 budgeted. This includes the new counselor and one counselor on family leave.

REVENUE

- Gross revenues of $2,783,657 actual compared to $2,828,947 budgeted for a variance of $-45,291.
- Net Patient revenues of $1,065,269 actual compared to $1,469,291 budgeted for a variance of $-404,021. This includes an allowance for the increase in accounts receivable.

OTHER OPERATING REVENUE

- Ad Valorem Taxes accrued – $103,000 actual compared to $51,532 budget, December 2023 was not accrued so it was added this month.
- Other Operating Revenue $106,665 actual compared to $78,666 budget. 340B revenue was $86,205 which is much improved since we got our HIN number for Walmart.
-

DEDUCTIONS FROM REVENUE

- Deductions from revenue, which includes bad debt, were $1,718,388compared to the budget of $1,359,657 and the prior year of $633,531. The increase is an allowance for the increase in accounts receivable.

EXPENSES

- Salaries and Wages were over budget by $68,665 due to some managers working overtime, additional staff for centralized scheduling and new NP, counselor and payout of accrued vacation for several long term staff members.
- Benefits are over budget by $37,431 additional funds for retirement match.
- Professional Fees were over budget by $44,770 due to locum physicians in the ER and Hospitalist.
- Purchased Services were under budget by $67,011 due to correction of collection payments from August moved to correct account and transition to Cerner.
- Supplies costs were under budget by $-16,547 due lower volumes.
- Utilities expenses are over budget by $1,993.
- Repair and Maintenance are under budget by $-2,575.
- Insurance expenses are under the budget of $-4,895.
- Depreciation expense is over budget by $19,846 due to the Cerner implementation.
- Interest expense is over budget by $3,551.
- Other Expenses are over budget by $3,479 due to employee recognition expenses.

OTHER

- Net loss for the month was $-347,603 compared to the forecasted net gain of $27,666 and the prior year net gain of $511,690.
- Non-Operating Income is interest income from LGIP.
-

SIGNIFICANT BALANCE SHEET CHANGES

- Gross A/R increased $657,380. AR days are 125.3 Gross and 114.2 Net due to Cerner implementation.
- Bad Debt Expense is year to date is $2,000,608 and budget $1,355,652. Recovery of bad debt is $212,670 compared to budget of $200,000. Financial assistance is $223,534 year to date.

Shoshone Medical Center
Balance Sheet
For the Period Ending November 30, 2024

	Current Month Nov 24	Prior Month Oct 24	Audited Nov 23	Audited Nov 22
Assets				
Current Assets				
Cash & Cash Equivalents	10,003,453	10,043,745	13,255,710	11,771,003
Patient Receivables	12,314,500	11,657,120	5,442,563	5,027,623
Allowance for Uncollectibles	(6,783,291)	(6,168,741)	(3,068,469)	(2,662,842)
Net Patient Receivables	5,531,208	5,488,379	2,374,094	2,364,781
Ad Valorem Taxes Receivable	560,154	488,347	649,844	620,402
Inventories	276,931	307,589	293,532	286,052
Prepaid and Other Assets	329,115	315,492	428,845	266,854
Other Receivables	699,354	652,589	776,933	1,041,322
Total Other Assets	1,865,553	1,764,017	2,149,154	2,214,629
Total Current Assets	17,400,215	17,296,141	17,778,958	16,350,413
CASH - US BANK	-	-	258,218	255,921
INVESTMENT - YELLOWSTONE	101,439	101,439	104,923	108,673
PREPAYMENT PENALTY FEES	-	-	53,797	86,076
RIGHT-TO-USE-ASSET - CERNER	3,699,738	3,718,488		
INVESTMENT - BANKCDA - MTG RESERVE	82,709	82,666	827,668	1,319,923
Property & Equipment				
Land	1,097,368	1,097,368	1,097,368	1,097,368
Land Improvements	1,416,812	1,416,812	1,416,812	1,416,812
Buildings & Buildings Service Equipment	14,336,627	14,336,627	14,336,627	14,291,929
Fixed Equipment	3,196,553	3,196,553	3,177,809	3,177,809
Major Moveable Equipment	8,728,253	8,729,278	7,322,981	7,050,348
Total Cost	28,775,613	28,776,638	27,351,597	27,034,266
Accumulated Depreciation				
Land Improvements	(1,182,014)	(1,178,639)	(1,139,222)	(1,092,128)
Buildings and Buildings Service Equipment	(10,182,331)	(10,148,803)	(9,765,971)	(9,314,340)
Fixed Equipment	(3,096,943)	(3,094,486)	(3,067,650)	(3,040,904)
Major Moveable Equipment	(7,151,910)	(7,077,989)	(6,524,696)	(6,214,114)
Total Accumulated Depreciation	(21,613,198)	(21,499,917)	(20,497,540)	(19,661,486)
Construction in Progress	24,645	19,438	7,818	214,594
Net Property and Equipment	7,187,060	7,296,159	6,861,874	7,587,374
Total Assets	**28,471,161**	**28,494,892**	**25,885,438**	**25,708,379**

Shoshone Medical Center
Balance Sheet
For the Period Ending November 30, 2024

	Current Month Nov 24	Prior Month Oct 24	Audited Nov 23	Audited Nov 22
Liabilities				
Current Liabilities				
Accounts Payable	511,053	369,247	496,119	808,544
Accrued Payroll & Related Liabilties	334,881	292,027	273,618	250,225
Accrued Vacation	601,010	575,563	490,137	448,480
Other Accrued Liabilities	746,891	580,964	210,002	456,839
Current Portion LT Debt	301,720	72,507	1,232,872	1,198,511
Total Current Liabilities	2,495,555	1,890,310	2,702,747	3,162,599
Long-Term Debt, Net of Current	3,229,021	3,510,395	947,795	2,180,667
Total Current Liabilities	5,724,576	5,400,704	3,650,543	5,343,266
Fund Balance, Beginning of Period	22,234,896	22,234,896	20,365,113	18,135,080
Excess of Revenue Over Expenses	511,690	859,293	1,869,782	2,230,033
Fund Balance, End of Period	22,746,585	23,094,188	22,234,896	20,365,113
Total Liabilities and Fund Balance	**28,471,161**	**28,494,892**	**25,885,438**	**25,708,379**

Shoshone Medical Center
Statement of Operations
For the Period Ending November 30, 2024

Month to Date					Year to Date			
ACTUAL PY Nov 23	ACTUAL Nov 24	BUDGET Nov 24	ACT to BUD Variance		ACTUAL PY Nov 23	ACTUAL Nov 24	BUDGET Nov 24	ACT to BUD Variance
				Revenue				
2,489,603	2,783,657	2,828,947	(45,291)	Gross Patient Revenue	33,855,675	35,964,808	34,418,861	1,545,948
(633,531)	(1,718,388)	(1,359,657)	(358,731)	Deductions From Revenue	(16,287,813)	(18,244,611)	(16,542,492)	(1,702,119)
1,856,073	**1,065,269**	**1,469,291**	**(404,021)**	**Net Patient Service Revenue**	**17,567,862**	**17,720,197**	**17,876,369**	**(156,172)**
138,893	103,000	51,468	51,532	Ad Valorem Taxes - Accrued	742,429	673,326	626,192	47,134
137,312	106,665	78,666	27,999	Other Operating Revenue	1,023,919	911,502	957,099	(45,598)
2,132,277	**1,274,934**	**1,599,424**	**(324,490)**	**Total Operating Revenue**	**19,334,210**	**19,305,025**	**19,459,660**	**(154,635)**
				Expenses				
469,880	729,100	660,435	68,665	Salaries & Wages	7,649,581	8,599,850	8,035,291	564,559
275,012	191,822	154,392	37,431	Benefits	1,963,872	1,932,698	1,878,430	54,268
209,562	262,725	217,954	44,770	Professional Fees	2,383,098	2,886,705	2,651,777	234,929
206,433	124,519	191,530	(67,011)	Purchased Services	2,232,826	1,710,439	2,330,280	(619,841)
262,869	169,924	186,472	(16,547)	Supplies	2,124,238	2,178,373	2,268,737	(90,364)
31,736	31,500	29,508	1,993	Utilities	350,843	380,506	359,011	21,495
7,435	2,053	4,628	(2,575)	Repairs & Maintenance	61,426	87,643	56,309	31,334
15,773	10,671	15,567	(4,895)	Insurance	213,407	128,205	189,394	(61,188)
66,453	114,306	94,837	19,469	Depreciation & Amortization	849,941	1,160,200	1,153,856	6,344
8,548	16,399	12,848	3,551	Interest	114,436	207,877	156,317	51,560
7,426	17,765	14,285	3,479	Other	159,063	150,674	173,806	(23,132)
1,561,127	**1,670,785**	**1,582,455**	**88,330**	**Total Expenses**	**18,102,730**	**19,423,171**	**19,253,207**	**169,964**
571,150	**(395,851)**	**16,969**	**(412,820)**	**Operating Income (Loss)**	**1,231,479**	**(118,145)**	**206,454**	**(324,599)**
73,407	48,248	10,697	37,551	**Non-Operating Income**	638,303	629,835	130,149	499,686
644,558	**(347,603)**	**27,666**	**(375,269)**	**Excess of Revenue Over Expenses**	**1,869,782**	**511,690**	**336,602**	**175,087**

SHOSHONE MEDICAL CENTER
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS
November 30, 2024

CASH FLOWS PROVIDED BY OPERATING ACTIVITIES	November 30, 2024 Month-to-Date	November 30, 2024 Year-to-Date	Prior Year November 30, 2023 Year-to-Date
Receipts:			
All Third Party and Patient Payors	1,022,440	14,463,083	17,558,548
Other Operating/Taxes Receipts	91,093	1,752,097	2,001,295
	1,113,533	16,215,180	19,559,843
Disbursements:			
Employee Expenses	852,622	10,360,412	9,548,403
Operating Expenses	294,390	6,800,585	8,221,357
	1,147,011	17,160,997	17,769,760
Net Cash Provided (Used) by Operating Activities	**(33,478)**	**(945,816)**	**1,790,083**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest/Other/Non-Operating Received	48,248	629,835	638,303
Purchase of LT Investments	-	261,702	1,454
(Disbursements) for Property & Equipment	(5,207)	(1,414,914)	(124,442)
(Payments)/Receipts from Debt Reserve Fund	(43)	744,959	492,255
		-	
Net Cash Provided (Used) in Investing Activities	**42,998**	**221,581**	**1,007,570**
CASH FLOWS FROM FINANCING ACTIVITIES			
Interest (Paid)	(16,399)	(177,601)	(114,436)
(Payments)Financing Fees	-		-
Proceeds from Short-Term Debt	-		-
(Payments) on Short-Term Debt	-		-
Proceeds from Long-Term Debt	-		-
(Payments) on Long-Term Debt	(33,411)	(2,350,420)	(1,198,510)
Net Cash Provided (Used) in Financing Activities	**(49,811)**	**(2,528,021)**	**(1,312,946)**
Net Increase (Decrease) in Cash	**(40,291)**	**(3,252,256)**	**1,484,706**
CASH AND CASH EQUIVALENTS - BEGINNING BALANCE	**10,043,745**	**13,255,710**	**11,771,003**
CASH AND CASH EQUIVALENTS - ENDING BALANCE	**$ 10,003,453**	**$ 10,003,453**	**13,255,710**

SHOSHONE MEDICAL CENTER
FINANCIAL INDICATORS
Saturday, November 30, 2024

MONTH TO EATE					YEAR TO DATE			
ACTUAL PY Nov-23	ACTUAL Nov-24	BUDGET Nov-24	ACT to BUD VARIANCE		ACTUAL PY Nov-23	ACTUAL Nov-24	BUDGET Nov-24	ACT to BUD VARIANCE
1.5	1.3	2.3	(1.0)	Average Daily Census-Hospital Acute	2.3	2.1	2.3	(0.2)
2.8	3.6	3.07	0.6	Average Daily Census-Hospital Swing Bed	3.0	3.4	3.07	0.3
3.83	2.79	3.15	(0.4)	Average Length of Stay-Hospital Acute	3.23	3.47	3.11	0.4
13.83	8.38	11.32	(2.9)	Average Length of Stay-Hospital Swing Bed	11.45	11.84	11.32	0.5
80	70	88	(18)	O/P Visits per Day	90	87	88	(0)
14	14	22	(8)	Acute Admits	255	215	131	84
4	11	8	3	Swing Bed Admits	96	110	50	60
46	39	68	(29)	Acute Days	827	753	827	(74)
83	109	92	17	Swing Bed Days	1,111	1,231	1,121	110
25.4%	61.7%	48.1%	13.7%	Revenue Deductions % GPR	48.1%	61.7%	48.1%	13.7%
1.12	0.00	1.03	(1.0300)	Medicare Case Mix Index	1.03	0.00	1.03	(1.03)
25.3%	68.4%	44.9%	23.5%	Salaries % Net Patient Revenue	43.5%	68.4%	44.9%	23.5%
58.5%	26.3%	23.4%	2.9%	Benefits % of Salaries	25.7%	26.3%	23.4%	2.9%
10.6%	6.1%	6.6%	-0.5%	Supplies % Gross Patient Revenue	6.3%	6.1%	6.6%	-0.5%
14.2%	16.0%	12.7%	3.3%	Supplies % Net Patient Revenue	12.1%	16.0%	12.7%	3.3%
58.0	132.7	50.0	82.7	Gross Days in Accounts Receivable	53.4	125.3	50.0	75.3
45.1	155.8	45.0	110.8	Net Days in Accounts Receivable	43.0	114.2	45.0	69.2
233.0	192.8	160.0	32.8	Days Cash on Hand	242.9	200.5	160.0	40.5
14.6	17.9	30.0	-12.1	Days in Accounts Payable	19.3	18.0	30.0	-12.0
0.74	-5.31	1.25	-6.6	Debt Service Coverage Ratio	2.09	1.81	1.25	0.6
26.8%	-31.0%	1.1%	-32.1%	Operating Margin(Includes Tax Subsidies)	6.4%	-0.6%	1.1%	-1.7%
$719,558	($216,898)	$135,351	($352,249)	EBITDA	$2,834,159	$1,879,766	$135,351	$1,744,415
33.75%	-17.01%	8.46%	-25.47%	EBITDA %	14.66%	9.74%	8.46%	1.27%

SHOSHONE MEDICAL CENTER

Hospital Statistics

November 30, 2024

Month to Date					YTD			
ACTUAL PY 11/30/2023	ACTUAL 11/30/2024	BUDGET 11/30/2024	ACT to BUD Variance		ACTUAL PY 11/30/2023	ACTUAL 11/30/2024	BUDGET 11/30/2024	ACT to BUD Variance
				ACUTE SERVICES				
14	14	22	-8	**ADMIT - ACUTE**	255	215	263	-48
1.53	1.30	2.27	-0.97	Average Daily Census	2.27	2.06	2.27	-0.20
3.83	2.79	3.11	-0.32	Average Length/Stay	3.23	3.47	3.11	1.51
				DISCHARGES				
12	14	22	-8	Total Patients Discharged	256	217	266	-49
46	39	68	-29	**TOTAL DAYS**	827	753	827	-74
				MEDICARE INFO				
9	7	11	-4	Medicare Admissions	132	129	134	-5
30	20	34	-14	Medicare Days	406	432	410	22
7	8	11	-3	Medicare Pt Discharged	126	123	130	-7
4.29	2.50	3.16	-0.66	Average Length of Stay	3.22	3.51	3.15	-3.14
				MEDICAID INFO				
0	2	2	0	Medicaid Admissions	24	13	26	-13
2	3	7	-4	Medicaid Days	82	46	87	-41
1	1	2	-1	Medicaid Pt Discharged	26	10	27	-17
2.00	3.00	3.22	-0.22	Average Length of Stay	3.15	4.60	3.22	1.38
				SWING BED SERVICES				
4	11	8	3	**Total Admissions**	96	110	100	10
2	8	6	2	Medicare Admissions	65	77	69	8
1	0	0	0	Medicaid Admissions	3	5	2	3
1	3	2	1	Other Admissions	28	28	29	-1
83	109	92	17	**Total Days**	1111	1231	1121	110
18	85	56	29	Medicare Days	642	881	681	200
31	0	3	-3	Medicaid Days	64	59	36	23
34	24	33	-9	Other Days	405	291	405	-114
6	13	8	5	Swingbed Pt Discharged	97	104	99	5
2.77	3.63	3.07	0.56	Average Daily Census	3.04	3.37	3.07	0.30
13.83	8.38	11.32	-2.93	Average Length of Stay	11.45	11.84	11.32	0.51
711	**353**	**565**	**-212**	**OBSERVATION HOURS**	**7013**	**6913**	**6875**	**38**

SHOSHONE MEDICAL CENTER

Hospital Statistics

November 30, 2024

Month to Date					YTD			
ACTUAL PY 11/30/2023	ACTUAL 11/30/2024	BUDGET 11/30/2024	ACT to BUD Variance		ACTUAL PY 11/30/2023	ACTUAL 11/30/2024	BUDGET 11/30/2024	ACT to BUD Variance
2028	1658	2267	-609	Ancillary Departments	27309	26388	27579	-1191
357	439	453	-14	Emergency Room	5414	5595	5517	78
7	13	14	-1	Inpatients	159	147	166	-19
350	426	440	-14	Outpatients	5255	5448	5351	97
346	**219**	**324**	**-105**	**BEHAVIORAL HEALTH**	**3954**	**3373**	**3936**	**-563**
86	145	132	13	Outpatients	1557	1816	1605	211
0	0	0	0	Physician Visits	0	0	0	0
86	**145**	**132**	**13**	**TOTAL Wound care**	**1557**	**1816**	**1605**	**211**
				SCOPES				
0	0	0	0	Inpatient	0	0	2	-2
22	21	18	3	Outpatient	394	318	224	94
22	**21**	**19**	**2**	**TOTAL SCOPES**	**394**	**318**	**226**	**92**
				X-RAY				
18	6	12	-6	Inpatient	153	142	147	-5
290	258	357	-99	Outpatient	4275	3928	4347	-419
308	**264**	**369**	**-105**	**TOTAL PROCEDURES**	**4428**	**4070**	**4494**	**-424**
				MAMMOGRAPHY				
0	0	0	0	Inpatient	0	0	0	0
192	144	151	-7	Outpatient	1872	1662	1833	-171
192	**144**	**151**	**-7**	**TOTAL PROCEDURES**	**1872**	**1662**	**1833**	**-171**
				CT SCANS				
5	3	8	-5	Inpatient	93	83	96	-13
193	159	227	-68	Outpatient	2729	2575	2767	-192
198	**162**	**235**	**-73**	**TOTAL CT SCANS**	**2822**	**2658**	**2863**	**-205**
				ULTRASOUNDS				
3	1	3	-2	Inpatient	40	25	40	-15
81	97	93	4	Outpatient	1114	1095	1127	-32
84	**98**	**96**	**2**	**TOTAL ULTRASOUNDS**	**1154**	**1120**	**1167**	**-47**
				MRI				
0	2	2	0	Inpatient	25	25	27	-2

SHOSHONE MEDICAL CENTER

Hospital Statistics

November 30, 2024

Month to Date					YTD			
ACTUAL PY 11/30/2023	ACTUAL 11/30/2024	BUDGET 11/30/2024	ACT to BUD Variance		ACTUAL PY 11/30/2023	ACTUAL 11/30/2024	BUDGET 11/30/2024	ACT to BUD Variance
36	61	49	12	Outpatient	584	625	598	27
36	**63**	**51**	**12**	**TOTAL MRI's**	**609**	**650**	**625**	**25**
23	**18**	**23**	**-5**	**BONE DENSITOMETRY**	**278**	**284**	**278**	**6**
				ECHO'S				
0	0	0	0	Inpatient	9	0	0	0
0	0	0	0	Outpatient	32	0	0	0
0	**0**	**0**	**0**	**TOTAL ECHO'S**	**41**	**0**	**0**	**0**
				LABORATORY				
223	172	382	-210	Inpatient	4478	3580	4642	-1062
3956	3806	4381	-575	Outpatient	52819	48818	53305	-4487
4179	**3978**	**4763**	**-785**	**TOTAL LABORATORY**	**57297**	**52398**	**57947**	**-5549**
				HOLTERS/STRESS TREAMILL				
0	0	0	0	Holters	0	0	0	0
4	0	5	-5	CEM / Zio	58	29	59	-30
0	0	0	0	Stress Treadmill	4	0	0	0
4	**0**	**5**	**-5**	**TOTAL HOLTERS**	**62**	**29**	**59**	**-30**
487	**587**	**575**	**12**	**CLINIC VISITS**	**7409**	**6441**	**7000**	**-559**
				PHARMACY				
3996	3968	6723	-2755	Inpatient	78980	78953	81801	-2848
7332	2072	10714	-8642	Outpatient	126827	157670	130358	27312
11328	**6040**	**17438**	**-11398**	**TOTAL PHARMACY**	**205807**	**236623**	**212159**	**24464**
				RESPIRATORY				
426	16	816	-800	Inpatient	9532	4397	9934	-5537
313	71	306	-235	Outpatient	3725	1886	3722	-1836
739	**87**	**1122**	**-1035**	**TOTAL RESPIRATORY**	**13257**	**6283**	**13656**	**-7373**
				EKG				
0	-1	3	-4	Inpatient	31	26	34	-8
84	84	109	-25	Outpatient	1301	1192	1328	-136
84	**83**	**112**	**-29**	**TOTAL EKG**	**1332**	**1218**	**1362**	**-144**

SHOSHONE MEDICAL CENTER

Hospital Statistics

November 30, 2024

Month to Date					YTD			
ACTUAL PY 11/30/2023	ACTUAL 11/30/2024	BUDGET 11/30/2024	ACT to BUD Variance		ACTUAL PY 11/30/2023	ACTUAL 11/30/2024	BUDGET 11/30/2024	ACT to BUD Variance
				PFT (Included in Resp Total)				
0	0	0	0	Inpatient	0	0	0	0
21	0	15	-15	Outpatient	184	45	178	-133
21	**0**	**15**	**-15**	**TOTAL PFT's**	**184**	**45**	**178**	**-133**
				PHYSICAL THERAPY				
313	161	425	-264	Inpatient	4812	3358	5173	-1815
1396	971	986	-15	Outpatient	17812	13906	12000	1906
53	18	36	-18	Schools	542	355	436	-81
1762	**1150**	**1447**	**-297**	**TOTAL PHYSICAL THERAPY**	**23166**	**17619**	**17609**	**10**
				OCCUPATIONAL THERAPY				
169	162	164	-2	Inpatient	1886	1930	1997	-67
96	53	153	-100	Outpatient	1326	1083	1859	-776
156	69	94	-25	Schools	1248	1242	1140	102
421	**284**	**411**	**-127**	**TOTAL OCCUPATIONAL THERAPY**	**4460**	**4255**	**4996**	**-741**
				SPEECH THERAPY				
55	49	66	-17	Inpatient	725	896	804	92
59	58	54	4	Outpatient	709	752	663	89
0	75	0	75	Schools	0	753	0	753
114	**182**	**121**	**61**	**TOTAL SPEECH THERAPY**	**1434**	**2401**	**1467**	**934**
				CENTRAL SUPPLY				
431	253	696	-443	Inpatients	8195	5987	8470	-2483
2980	2056	3062	-1006	Outpatients	37125	31185	37249	-6064
3411	**2309**	**3758**	**-1449**	**TOTAL CENTRAL SUPPLY**	**45320**	**37172**	**45719**	**-8547**
				DIETARY MEALS				
566	523	610	-87	Patients	7368	7050	7420	-370
0	0	1	-1	Doctors	8	0	9	-9
3	2	12	-10	Meetings	134	68	143	-75
855	760	888	-128	Employees	10760	10154	10805	-651
1424	**1285**	**1510**	**-225**	**TOTAL MEALS**	**18270**	**17272**	**18377**	**-1105**
2027	**2112**	**1946**	**166**	**WELLNESS VISITS**	**23731**	**26239**	**23677**	**2562**

SHOSHONE MEDICAL CENTER
CFO SUMMARY REPORT
DECEMBER 2024 FINANCIAL OPERATIONS

STATISTICS

- Acute Care admissions were 18 compared to budget at 19. Acute Care days were 61 compared to 69 budgeted. Average Length of Stay for the month was 3.00 and 3.22 budget. Year to date length of stay is 3.39 which is under 4.0 requirement.
- Swing Bed Admissions were 4 compared to 10 budgeted. Swing Bed Days were 87 actual compared to 105 budgeted. The average length of stay was 29.00 compared to 11.31 budget.
- Observation Hours are 333 actual compared to 584 budget.
- Ancillary was 1084 actual compared to 2342 budgeted.
- Emergency Visits are 579 compared to the budget at 487.
- Scopes are 0 actual compared to 19 budgeted.
- Clinic visits were 605 actual compared to 620 budgeted.
- Behavioral Health had 225 visits compared to 381 budgeted.

REVENUE

- Gross revenues of $3,038.648 actual compared to $3,248,272 budgeted for a variance of $-209,624. We had lower volumes than expected and price increases did not go into place until 1/1/25.
- Net Patient revenues of $1,165,695 actual compared to $1,592,619 budgeted for a variance of $-426,923. This includes an allowance for the increase in accounts receivable as well as lower total revenue for the month.

OTHER OPERATING REVENUE

- Ad Valorem Taxes accrued – $53,713 actual compared to $54,101 budget.
- Other Operating Revenue $106,013 actual compared to $59,877 budget. 340B revenue was $80,558, budget is lower for 340B due to anticipation of manufacturers to cut the program.
-

DEDUCTIONS FROM REVENUE

- Deductions from revenue, which includes bad debt, were $1,872,953 compared to the budget of $1,655,653. The increase is an allowance for the increase in accounts receivable. I am seeing the paid claims in

Cerner matching the adjustments we made in Medworx which is what we want to see.

EXPENSES

- Salaries and Wages were under budget by $-85,007 use of locums in nursing and lab.
- Benefits are under budget by $-79,684 due to health insurance is paid a month in advance and we were not invoiced by Blue Cross of Idaho until January.
- Professional Fees were under budget of $-14,165 due to additional amounts budgeted for hospitalist that have not been put into place.
- Purchased Services were under budget by $-62,018 due to budget of MRI maintenance contract that is still under warranty for a couple of more months.
- Supplies costs were under budget by $-6,259 due to lower volumes.
- Utilities expenses are under budget by $-6,161 due to milder winter than anticipated.
- Repair and Maintenance are under budget by $-5,015.
- Insurance expenses are under the budget of $-5,667 due to budgeted D&O being higher than actual renewal.
- Depreciation expense is under budget by $19,289 due to the Cerner amortization.
- Interest expense is under budget by $1,138.
- Other Expenses are under budget by $-3,843 due to lack of discretionary spending.

OTHER

- Net loss for the month was $-128,349 compared to the forecast net gain of $18,589.
- Non-Operating Income is interest income from LGIP and rental income.
-

SIGNIFICANT BALANCE SHEET CHANGES

- Gross A/R increased $657,38864,7900. AR days are 134.5 Gross and 76.7 Net due to Cerner implementation. I asked the business office to focus on cleaning up the AR prior to Cerner implementation. I am searching for an outsource company to assist with the backlog in Cerner.

- Bad Debt Expense is $195,963 and budget $168,780. Recovery of bad debt is $12,564 compared to budget of $20,054. Financial assistance is $27,779 and budgeted $22,053.

Shoshone Medical Center
Balance Sheet
For the Period Ending December 31, 2024

	Current Month Dec 24	Prior Month Nov 24	Audited Nov 24	Audited Nov 23
Assets				
Current Assets				
Cash & Cash Equivalents	9,797,368	10,003,453	10,003,453	13,255,710
Patient Receivables	13,179,290	12,314,500	12,314,500	5,442,563
Allowance for Uncollectibles	(7,645,621)	(6,783,291)	(6,783,291)	(3,068,469)
Net Patient Receivables	5,533,669	5,531,208	5,531,208	2,374,094
Ad Valorem Taxes Receivable	597,923	560,154	560,154	649,844
Inventories	277,993	276,931	276,931	293,532
Prepaid and Other Assets	340,680	329,115	329,115	428,845
Other Receivables	694,158	699,354	699,354	776,933
Total Other Assets	1,910,755	1,865,553	1,865,553	2,149,154
Total Current Assets	17,241,792	17,400,215	17,400,215	17,778,958
CASH - US BANK	-	-	-	258,218
INVESTMENT - YELLOWSTONE	96,038	101,439	101,439	104,923
PREPAYMENT PENALTY FEES	-	-	-	53,797
RIGHT-TO-USE-ASSET - CERNER	3,699,738	3,699,738	3,699,738	
INVESTMENT - BANKCDA - MTG RESERVE	82,757	82,709	82,709	827,668
Property & Equipment				
Land	1,097,368	1,097,368	1,097,368	1,097,368
Land Improvements	1,416,812	1,416,812	1,416,812	1,416,812
Buildings & Buildings Service Equipment	14,336,627	14,336,627	14,336,627	14,336,627
Fixed Equipment	3,196,553	3,196,553	3,196,553	3,177,809
Major Moveable Equipment	8,734,816	8,728,253	8,728,253	7,322,981
Total Cost	28,782,175	28,775,613	28,775,613	27,351,597
Accumulated Depreciation				
Land Improvements	(1,185,380)	(1,182,014)	(1,182,014)	(1,139,222)
Buildings and Buildings Service Equipment	(10,215,860)	(10,182,331)	(10,182,331)	(9,765,971)
Fixed Equipment	(3,099,446)	(3,096,943)	(3,096,943)	(3,067,650)
Major Moveable Equipment	(7,229,799)	(7,151,910)	(7,151,910)	(6,524,696)
Total Accumulated Depreciation	(21,730,485)	(21,613,198)	(21,613,198)	(20,497,540)
Construction in Progress	25,203	24,645	24,645	7,818
Net Property and Equipment	7,076,894	7,187,060	7,187,060	6,861,874
Total Assets	**28,197,218**	**28,471,161**	**28,471,161**	**25,885,438**

Shoshone Medical Center
Balance Sheet
For the Period Ending December 31, 2024

	Current Month Dec 24	Prior Month Nov 24	Audited Nov 24	Audited Nov 23
Liabilities				
Current Liabilities				
Accounts Payable	385,901	511,053	511,053	496,119
Accrued Payroll & Related Liabilties	393,737	334,881	334,881	273,618
Accrued Vacation	525,408	601,010	601,010	490,137
Other Accrued Liabilities	767,871	746,891	746,891	210,002
Current Portion LT Debt	301,720	301,720	301,720	1,232,872
Total Current Liabilities	2,374,637	2,495,555	2,495,555	2,702,747
Long-Term Debt, Net of Current	3,204,345	3,229,021	3,229,021	947,795
Total Current Liabilities	5,578,982	5,724,576	5,724,576	3,650,543
Fund Balance, Beginning of Period	22,746,585	22,234,896	22,234,896	20,365,113
Excess of Revenue Over Expenses	(128,349)	511,690	511,690	1,869,782
Fund Balance, End of Period	22,618,236	22,746,585	22,746,585	22,234,896
Total Liabilities and Fund Balance	**28,197,218**	**28,471,161**	**28,471,161**	**25,885,438**

Shoshone Medical Center
Statement of Operations
For the Period Ending December 31, 2024

Month to Date					Year to Date			
ACTUAL PY Dec 23	ACTUAL Dec 24	BUDGET Dec 24	ACT to BUD Variance		ACTUAL PY Dec 23	ACTUAL Dec 24	BUDGET Dec 24	ACT to BUD Variance
				Revenue				
2,732,380	3,038,648	3,248,272	(209,624)	Gross Patient Revenue	2,732,380	3,038,648	3,248,272	(209,624)
(494,830)	(1,872,953)	(1,655,653)	(217,300)	Deductions From Revenue	(494,830)	(1,872,953)	(1,655,653)	(217,300)
2,237,550	**1,165,695**	**1,592,619**	**(426,923)**	**Net Patient Service Revenue**	**2,237,550**	**1,165,695**	**1,592,619**	**(426,923)**
50,224	53,713	54,101	(388)	Ad Valorem Taxes - Accrued	50,224	53,713	54,101	(388)
56,423	102,013	59,877	42,136	Other Operating Revenue	56,423	102,013	59,877	42,136
2,344,197	**1,321,422**	**1,706,597**	**(385,175)**	**Total Operating Revenue**	**2,344,197**	**1,321,422**	**1,706,597**	**(385,175)**
				Expenses				
641,792	686,377	771,383	(85,007)	Salaries & Wages	641,792	686,377	771,383	(85,007)
105,349	127,508	207,192	(79,684)	Benefits	105,349	127,508	207,192	(79,684)
238,577	214,834	228,999	(14,165)	Professional Fees	238,577	214,834	228,999	(14,165)
109,095	99,611	161,629	(62,018)	Purchased Services	109,095	99,611	161,629	(62,018)
157,950	180,466	186,725	(6,259)	Supplies	157,950	180,466	186,725	(6,259)
37,777	30,698	36,859	(6,161)	Utilities	37,777	30,698	36,859	(6,161)
7,016	834	5,848	(5,015)	Repairs & Maintenance	7,016	834	5,848	(5,015)
13,949	10,671	16,338	(5,667)	Insurance	13,949	10,671	16,338	(5,667)
65,239	117,287	97,999	19,289	Depreciation & Amortization	65,239	117,287	97,999	19,289
7,709	13,144	14,282	(1,138)	Interest	7,709	13,144	14,282	(1,138)
8,253	11,093	14,936	(3,843)	Other	8,253	11,093	14,936	(3,843)
1,392,706	**1,492,523**	**1,742,191**	**(249,668)**	**Total Expenses**	**1,392,706**	**1,492,523**	**1,742,191**	**(249,668)**
951,491	**(171,101)**	**(35,594)**	**(135,507)**	**Operating Income (Loss)**	**951,491**	**(171,101)**	**(35,594)**	**(135,507)**
61,194	42,752	54,183	(11,431)	**Non-Operating Income**	61,194	42,752	54,183	(11,431)
1,012,686	**(128,349)**	**18,589**	**(146,939)**	**Excess of Revenue Over Expenses**	**1,012,686**	**(128,349)**	**18,589**	**(146,939)**

SHOSHONE MEDICAL CENTER
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS
December 31, 2024

	December 31, 2024 Month-to-Date	December 31, 2024 Year-to-Date	Prior Year December 31, 2023 Year-to-Date
CASH FLOWS PROVIDED BY OPERATING ACTIVITIES			
Receipts:			
All Third Party and Patient Payors	1,163,235	1,163,235	1,388,120
Other Operating/Taxes Receipts	123,153	123,153	84,069
	1,286,388	1,286,388	1,472,189
Disbursements:			
Employee Expenses	830,630	830,630	699,516
Operating Expenses	665,006	665,006	521,524
	1,495,637	1,495,637	1,221,040
Net Cash Provided (Used) by Operating Activities	**(209,249)**	**(209,249)**	**251,149**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest/Other/Non-Operating Received	42,752	42,752	61,194
Purchase of LT Investments	5,401	5,401	(208)
(Disbursements) for Property & Equipment	(7,121)	(7,121)	(60,758)
(Payments)/Receipts from Debt Reserve Fund	(48)	(48)	(599)
		-	
Net Cash Provided (Used) in Investing Activities	**40,984**	**40,984**	**(371)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Interest (Paid)	(13,144)	(13,144)	(7,709)
(Payments)Financing Fees	-	-	-
Proceeds from Short-Term Debt	-	-	-
(Payments) on Short-Term Debt	-	-	-
Proceeds from Long-Term Debt	-	-	-
(Payments) on Long-Term Debt	(24,676)	(24,676)	(604,474)
Net Cash Provided (Used) in Financing Activities	**(37,820)**	**(37,820)**	**(612,182)**
Net Increase (Decrease) in Cash	**(206,085)**	**(206,085)**	**(361,404)**
CASH AND CASH EQUIVALENTS - BEGINNING BALANCE	**10,003,453**	**10,003,453**	**13,255,710**
CASH AND CASH EQUIVALENTS - ENDING BALANCE	**$ 9,797,368**	**$ 9,797,368**	**12,894,306**

SHOSHONE MEDICAL CENTER
FINANCIAL INDICATORS
Tuesday, December 31, 2024

MONTH TO EATE					YEAR TO DATE			
ACTUAL PY Dec-23	ACTUAL Dec-24	BUDGET Dec-24	ACT to BUD VARIANCE		ACTUAL PY Dec-23	ACTUAL Dec-24	BUDGET Dec-24	ACT to BUD VARIANCE
2.3	1.3	2.2	(0.9)	Average Daily Census-Hospital Acute	4.3	2.3	2.2	0.1
3.8	3.6	3.38	0.3	Average Daily Census-Hospital Swing Bed	3.8	3.8	3.38	0.4
3.43	2.79	3.67	(0.9)	Average Length of Stay-Hospital Acute	3.94	3.43	3.67	(0.2)
13.11	8.38	11.31	(2.9)	Average Length of Stay-Hospital Swing Bed	8.36	13.11	11.31	1.8
80	70	76	(6)	O/P Visits per Day	85	80	76	5
21	14	19	(5)	Acute Admits	38	21	19	2
10	11	10	1	Swing Bed Admits	12	10	10	0
72	39	69	(30)	Acute Days	134	72	69	3
118	109	105	4	Swing Bed Days	117	118	105	13
18.1%	61.6%	48.1%	13.6%	Revenue Deductions % GPR	18.1%	61.6%	48.1%	13.6%
1.06	0.00	1.03	(1.0300)	Medicare Case Mix Index	1.03	1.06	1.03	0.03
28.7%	58.9%	44.9%	13.9%	Salaries % Net Patient Revenue	28.7%	58.9%	44.9%	13.9%
16.4%	18.6%	23.4%	-4.8%	Benefits % of Salaries	16.4%	18.6%	23.4%	-4.8%
5.8%	5.9%	6.6%	-0.7%	Supplies % Gross Patient Revenue	5.8%	5.9%	6.6%	-0.7%
7.1%	15.5%	12.7%	2.8%	Supplies % Net Patient Revenue	7.1%	15.5%	12.7%	2.8%
58.0	130.1	50.0	80.1	Gross Days in Accounts Receivable	53.4	134.5	50.0	84.5
45.1	155.8	45.0	110.8	Net Days in Accounts Receivable	43.0	76.7	45.0	31.7
233.0	188.8	160.0	28.8	Days Cash on Hand	242.9	228.8	160.0	68.8
14.6	24.8	30.0	-5.2	Days in Accounts Payable	19.3	27.7	30.0	-2.3
0.74	0.06	1.25	-1.2	Debt Service Coverage Ratio	2.09	0.02	1.25	-1.2
40.6%	-12.9%	1.1%	-14.0%	Operating Margin(Includes Tax Subsidies)	40.6%	-12.9%	1.1%	-14.0%
$1,085,633	$2,082	$135,351	($133,269)	EBITDA	$1,085,633	$2,082	$135,351	($133,269)
46.31%	0.16%	8.46%	-8.30%	EBITDA %	46.31%	0.16%	8.46%	-8.30%

SHOSHONE MEDICAL CENTER
FINANCIAL INDICATORS
Tuesday, December 31, 2024

MONTH TO EATE					YEAR TO DATE			
ACTUAL PY Dec-23	ACTUAL Dec-24	BUDGET Dec-24	ACT to BUD VARIANCE		ACTUAL PY Dec-23	ACTUAL Dec-24	BUDGET Dec-24	ACT to BUD VARIANCE
2.3	1.3	2.2	(0.9)	Average Daily Census-Hospital Acute	4.3	2.3	2.2	0.1
3.8	3.6	3.38	0.3	Average Daily Census-Hospital Swing Bed	3.8	3.8	3.38	0.4
3.43	2.79	3.67	(0.9)	Average Length of Stay-Hospital Acute	3.94	3.43	3.67	(0.2)
13.11	8.38	11.31	(2.9)	Average Length of Stay-Hospital Swing Bed	8.36	13.11	11.31	1.8
80	70	76	(6)	O/P Visits per Day	85	80	76	5
21	14	19	(5)	Acute Admits	38	21	19	2
10	11	10	1	Swing Bed Admits	12	10	10	0
72	39	69	(30)	Acute Days	134	72	69	3
118	109	105	4	Swing Bed Days	117	118	105	13
18.1%	61.6%	51.0%	10.7%	Revenue Deductions % GPR	18.1%	61.6%	51.0%	10.7%
1.06	0.00	1.03	(1.0300)	Medicare Case Mix Index	1.03	1.06	1.03	0.03
28.7%	58.9%	48.4%	10.4%	Salaries % Net Patient Revenue	28.7%	58.9%	48.4%	10.4%
16.4%	18.6%	26.9%	-8.3%	Benefits % of Salaries	16.4%	18.6%	26.9%	-8.3%
5.8%	5.9%	5.7%	0.2%	Supplies % Gross Patient Revenue	5.8%	5.9%	5.7%	0.2%
7.1%	15.5%	11.7%	3.8%	Supplies % Net Patient Revenue	7.1%	15.5%	11.7%	3.8%
58.0	130.1	50.0	80.1	Gross Days in Accounts Receivable	53.4	134.5	50.0	84.5
45.1	155.8	45.0	110.8	Net Days in Accounts Receivable	43.0	76.7	45.0	31.7
233.0	188.8	160.0	28.8	Days Cash on Hand	242.9	228.8	160.0	68.8
14.6	24.8	30.0	-5.2	Days in Accounts Payable	19.3	27.7	30.0	-2.3
0.74	0.06	1.25	-1.2	Debt Service Coverage Ratio	2.09	0.02	1.25	-1.2
40.6%	-12.9%	-2.1%	-10.9%	Operating Margin(Includes Tax Subsidies)	40.6%	-12.9%	-2.1%	-10.9%
$1,085,633	$2,082	$130,871	($128,789)	EBITDA	$1,085,633	$2,082	$130,871	($128,789)
46.31%	0.16%	7.67%	-7.51%	EBITDA %	46.31%	0.16%	7.67%	-7.51%

SHOSHONE MEDICAL CENTER

Hospital Statistics

December 31, 2024

Month to Date					YTD			
ACTUAL PY 12/31/2023	ACTUAL 12/31/2024	BUDGET 12/31/2024	ACT to BUD Variance		ACTUAL PY 12/31/2023	ACTUAL 12/31/2024	BUDGET 12/31/2024	ACT to BUD Variance
				ACUTE SERVICES				
21	18	19	-1	**ADMIT - ACUTE**	21	18	19	-1
2.32	1.97	2.23	-0.26	Average Daily Census	2.32	1.97	2.23	-0.26
3.43	3.39	3.67	-0.28	Average Length/Stay	3.43	3.39	3.67	9.56
				DISCHARGES				
21	18	19	-1	Total Patients Discharged	21	18	19	-1
72	61	69	-8	**TOTAL DAYS**	72	61	69	-8
				MEDICARE INFO				
12	8	11	-3	Medicare Admissions	12	8	11	-3
48	26	38	-12	Medicare Days	48	26	38	-12
6	8	10	-2	Medicare Pt Discharged	6	8	10	-2
8.00	3.25	3.73	-0.48	Average Length of Stay	8.00	3.25	3.73	5.43
				MEDICAID INFO				
2	3	1	2	Medicaid Admissions	2	3	1	2
9	12	5	7	Medicaid Days	9	12	5	7
0	3	1	2	Medicaid Pt Discharged	0	3	1	2
0.00	4.00	5.40	-1.40	Average Length of Stay	0.00	4.00	5.40	-1.40
				SWING BED SERVICES				
10	4	10	-6	**Total Admissions**	10	4	10	-6
7	2	6	-4	Medicare Admissions	7	2	6	-4
0	0	1	-1	Medicaid Admissions	0	0	1	-1
3	2	3	-1	Other Admissions	3	2	3	-1
118	87	105	-18	**Total Days**	118	87	105	-18
57	41	72	-31	Medicare Days	57	41	72	-31
31	0	6	-6	Medicaid Days	31	0	6	-6
30	46	27	20	Other Days	30	46	27	20
9	3	9	-6	Swingbed Pt Discharged	9	3	9	-6
3.81	2.81	3.38	-0.57	Average Daily Census	3.81	2.81	3.38	-0.57
13.11	29.00	11.31	17.69	Average Length of Stay	13.11	29.00	11.31	17.69
1003	**333**	**584**	**-251**	**OBSERVATION HOURS**	**1003**	**333**	**584**	**-251**

SHOSHONE MEDICAL CENTER

Hospital Statistics

December 31, 2024

Month to Date					YTD			
ACTUAL PY 12/31/2023	ACTUAL 12/31/2024	BUDGET 12/31/2024	ACT to BUD Variance		ACTUAL PY 12/31/2023	ACTUAL 12/31/2024	BUDGET 12/31/2024	ACT to BUD Variance
2070	1084	2342	-1258	Ancillary Departments	2070	1084	2342	-1258
425	579	487	92	Emergency Room	425	579	487	92
13	14	13	1	Inpatients	13	14	13	1
412	565	474	91	Outpatients	412	565	474	91
256	**225**	**381**	**-156**	**BEHAVIORAL HEALTH**	**256**	**225**	**381**	**-156**
110	134	147	-13	Outpatients	110	134	147	-13
0	0	0	0	Physician Visits	0	0	0	0
110	**134**	**147**	**-13**	**TOTAL Wound care**	**110**	**134**	**147**	**-13**
				SCOPES				
0	0	0	0	Inpatient	0	0	0	0
23	0	19	-19	Outpatient	23	0	19	-19
23	**0**	**20**	**-20**	**TOTAL SCOPES**	**23**	**0**	**20**	**-20**
				X-RAY				
10	8	14	-6	Inpatient	10	8	14	-6
338	344	353	-9	Outpatient	338	344	353	-9
348	**352**	**366**	**-14**	**TOTAL PROCEDURES**	**348**	**352**	**366**	**-14**
				MAMMOGRAPHY				
0	0	0	0	Inpatient	0	0	0	0
182	182	156	26	Outpatient	182	182	156	26
182	**182**	**156**	**26**	**TOTAL PROCEDURES**	**182**	**182**	**156**	**26**
				CT SCANS				
14	4	8	-4	Inpatient	14	4	8	-4
209	192	240	-48	Outpatient	209	192	240	-48
223	**196**	**247**	**-51**	**TOTAL CT SCANS**	**223**	**196**	**247**	**-51**
				ULTRASOUNDS				
0	0	3	-3	Inpatient	0	0	3	-3
79	85	110	-25	Outpatient	79	85	110	-25
79	**85**	**114**	**-29**	**TOTAL ULTRASOUNDS**	**79**	**85**	**114**	**-29**
				MRI				
1	0	2	-2	Inpatient	1	0	2	-2

SHOSHONE MEDICAL CENTER

Hospital Statistics

December 31, 2024

Month to Date					YTD			
ACTUAL PY 12/31/2023	ACTUAL 12/31/2024	BUDGET 12/31/2024	ACT to BUD Variance		ACTUAL PY 12/31/2023	ACTUAL 12/31/2024	BUDGET 12/31/2024	ACT to BUD Variance
42	44	55	-11	Outpatient	42	44	55	-11
43	**44**	**57**	**-13**	**TOTAL MRI's**	**43**	**44**	**57**	**-13**
18	**28**	**25**	**3**	**BONE DENSITOMETRY**	**18**	**28**	**25**	**3**
				ECHO'S				
0	0	0	0	Inpatient	0	0	0	0
0	0	0	0	Outpatient	0	0	0	0
0	**0**	**0**	**0**	**TOTAL ECHO'S**	**0**	**0**	**0**	**0**
				LABORATORY				
344	370	394	-24	Inpatient	344	370	394	-24
4372	3883	4527	-644	Outpatient	4372	3883	4527	-644
4716	**4253**	**4922**	**-669**	**TOTAL LABORATORY**	**4716**	**4253**	**4922**	**-669**
				HOLTERS/STRESS TREAMILL				
0	0	0	0	Holters	0	0	0	0
8	0	5	-5	CEM / Zio	8	0	5	-5
0	0	0	0	Stress Treadmill	0	0	0	0
8	**0**	**5**	**-5**	**TOTAL HOLTERS**	**8**	**0**	**5**	**-5**
495	**605**	**620**	**-15**	**CLINIC VISITS**	**495**	**605**	**620**	**-15**
				PHARMACY				
4911	4364	7955	-3591	Inpatient	4911	4364	7955	-3591
7553	1954	17643	-15689	Outpatient	7553	1954	17643	-15689
12464	**6318**	**25599**	**-19281**	**TOTAL PHARMACY**	**12464**	**6318**	**25599**	**-19281**
				RESPIRATORY				
1178	41	844	-803	Inpatient	1178	41	844	-803
367	52	316	-264	Outpatient	367	52	316	-264
1545	**93**	**1160**	**-1067**	**TOTAL RESPIRATORY**	**1545**	**93**	**1160**	**-1067**
				EKG				
0	1	3	-2	Inpatient	0	1	3	-2
108	111	113	-2	Outpatient	108	111	113	-2
108	**112**	**116**	**-4**	**TOTAL EKG**	**108**	**112**	**116**	**-4**

SHOSHONE MEDICAL CENTER

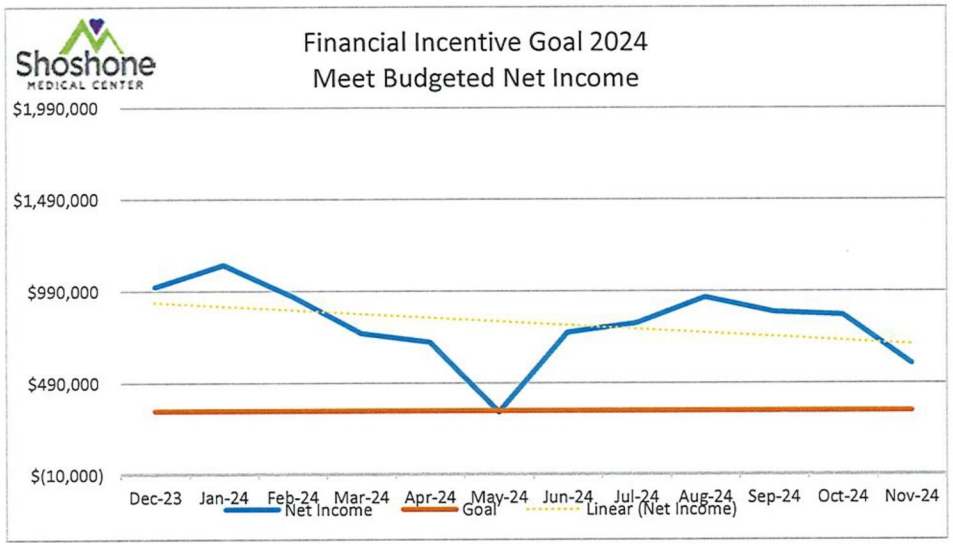
Hospital Statistics

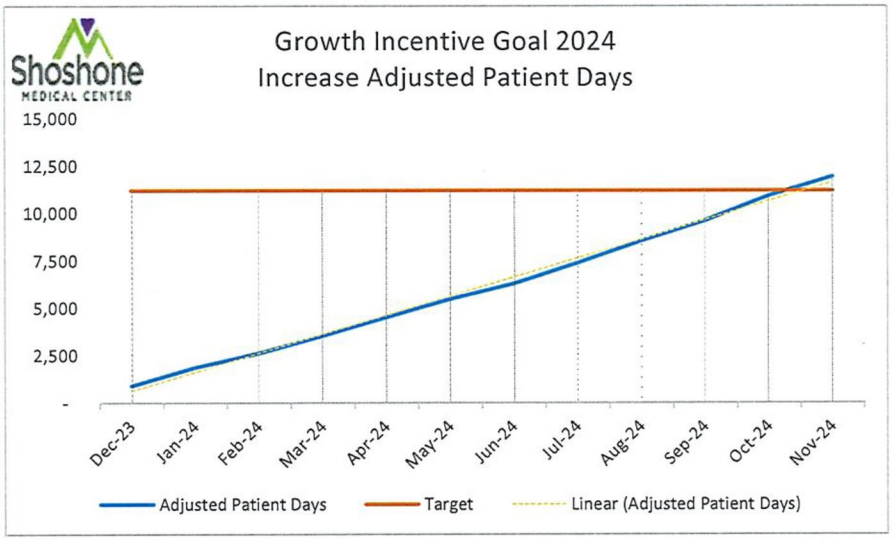
December 31, 2024

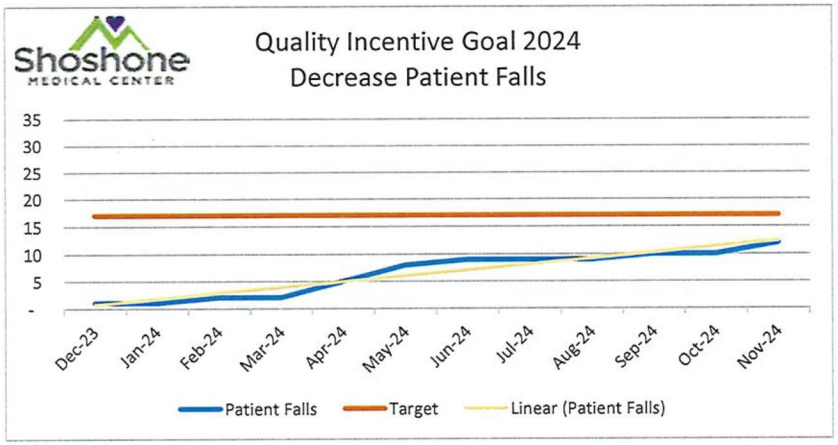
Month to Date					YTD			
ACTUAL PY 12/31/2023	ACTUAL 12/31/2024	BUDGET 12/31/2024	ACT to BUD Variance		ACTUAL PY 12/31/2023	ACTUAL 12/31/2024	BUDGET 12/31/2024	ACT to BUD Variance
				PFT (Included in Resp Total)				
0	0	0	0	Inpatient	0	0	0	0
17	0	15	-15	Outpatient	17	0	15	-15
17	**0**	**15**	**-15**	**TOTAL PFT's**	**17**	**0**	**15**	**-15**
				PHYSICAL THERAPY				
427	195	329	-134	Inpatient	427	195	329	-134
1129	670	1019	-349	Outpatient	1129	670	1019	-349
49	25	37	-12	Schools	49	25	37	-12
1605	**890**	**1385**	**-495**	**TOTAL PHYSICAL THERAPY**	**1605**	**890**	**1385**	**-495**
				OCCUPATIONAL THERAPY				
238	137	170	-33	Inpatient	238	137	170	-33
83	49	114	-65	Outpatient	83	49	114	-65
136	59	119	-60	Schools	136	59	119	-60
457	**245**	**402**	**-157**	**TOTAL OCCUPATIONAL THERAPY**	**457**	**245**	**402**	**-157**
				SPEECH THERAPY				
75	45	77	-32	Inpatient	75	45	77	-32
37	48	62	-14	Outpatient	37	48	62	-14
0	58	58	0	Schools	0	58	58	0
112	**151**	**197**	**-46**	**TOTAL SPEECH THERAPY**	**112**	**151**	**197**	**-46**
				CENTRAL SUPPLY				
722	350	719	-369	Inpatients	722	350	719	-369
2854	1863	3164	-1301	Outpatients	2854	1863	3164	-1301
3576	**2213**	**3883**	**-1670**	**TOTAL CENTRAL SUPPLY**	**3576**	**2213**	**3883**	**-1670**
				DIETARY MEALS				
705	506	610	-104	Patients	705	506	610	-104
0	0	0	0	Doctors	0	0	0	0
3	22	7	15	Meetings	3	22	7	15
854	679	911	-232	Employees	854	679	911	-232
1562	**1207**	**1528**	**-321**	**TOTAL MEALS**	**1562**	**1207**	**1528**	**-321**
2166	**2233**	**2314**	**-81**	**WELLNESS VISITS**	**2166**	**2233**	**2314**	**-81**

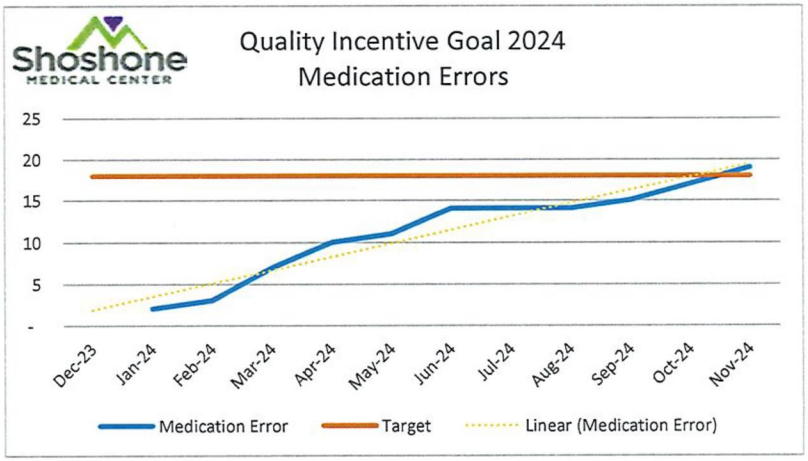
2024 Incentive Pay Goals

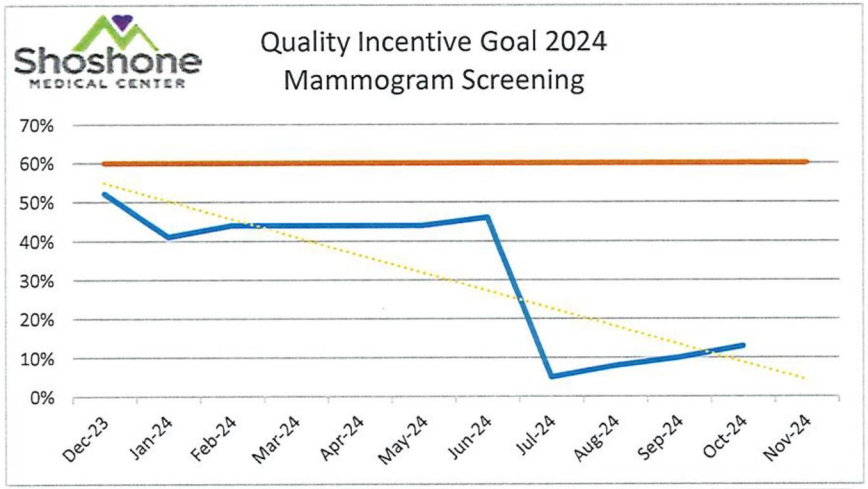
	Nov-24
Meet or Exceed Budgeted Net Income	🟢
Increase Adjusted Patient Days	🟢
Decrease Patient Falls	🟢
Medication Errors	🔴
Mammogram Screening	🔴
CAHPS Percentile Rank	🔴
Clinic Patient Satisfaction	🟢
% met of goals (Quarterly)	🟢
Overall	🟢

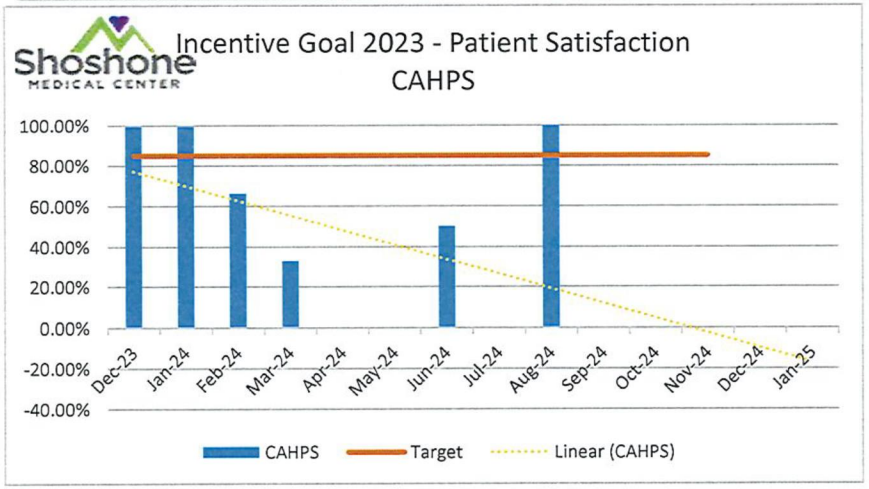

Financial Incentive Goal 2024
Meet Budgeted Net Income
$1,990,000
$1,490,000
$990,000
$490,000
$(10,000)
Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24
Net Income
Goal
Linear (Net Income)

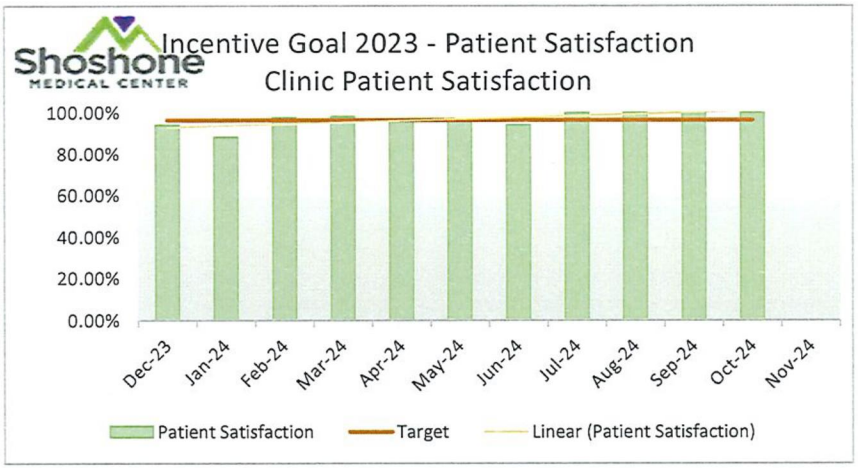

Growth Incentive Goal 2024
Increase Adjusted Patient Days
15,000
12,500
10,000
7,500
5,000
2,500
-
Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24
Adjusted Patient Days
Target
Linear (Adjusted Patient Days)


Quality Incentive Goal 2024
Decrease Patient Falls
35
30
25
20
15
10
5
-
Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24
Patient Falls
Target
Linear (Patient Falls)


Quality Incentive Goal 2024
Medication Errors
25
20
15
10
5
-
Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24
Medication Error
Target
Linear (Medication Error)


Shoshone
MEDICAL CENTER
Quality Incentive Goal 2024
Mammogram Screening
70%
60%
50%
40%
30%
20%
10%
0%
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24


Shoshone
MEDICAL CENTER
Incentive Goal 2023 - Patient Satisfaction
CAHPS
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
-20.00%
-40.00%
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
CAHPS
Target
Linear (CAHPS)


Shoshone
MEDICAL CENTER
Incentive Goal 2023 - Patient Satisfaction
Clinic Patient Satisfaction
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Patient Satisfaction
Target
Linear (Patient Satisfaction)

SHOSHONE MEDICAL CENTER
2024 Incentive Pay Goals

						$ 1,400	$ 2,800	$ 350	10%
Category	**Weight**	**Metric**		**Baseline**	**Goal**	**Manager**	**Director**	**Staff**	**Admin**
Financial	Trigger	Meet or Exceed Budgeted Net Income	2024 Budget	$ 336,602	>$336,602				
Growth	33.33%	Increase Adjusted Patient Days - 3%	2023 Final	10,841	11,166	$ 466.62	$ 933.24	$ 116.66	3.33%
Safety/Quality	11.11%	Decrease patient falls	2023 Actual	23	17	$ 155.54	$ 311.08	$ 38.89	1.11%
Safety/Quality	11.11%	Clinic Mammogram Screening	2023 Actual	48%	60%	$ 155.54	$ 311.08	$ 38.89	1.11%
Safety/Quality	11.11%	Medication Errors	2023 Actual	18	18	$ 155.54	$ 311.08	$ 38.89	1.11%
Patient Satisfaction	16.6%	CAHPS Percentile Rank	2023 Actual	80.00%	85.00%	$ 232.40	$ 464.80	$ 58.10	1.66%
Patient Satisfaction	16.7%	Clinic Patient Satisfaction	2023 Actual	96.38%	96.38%	$ 233.80	$ 467.60	$ 58.45	1.67%
Total	100.0%					$ 1,399.44	$ 2,798.88	$ 349.88	10.00%
						24	3	84	

Program Requirements:
Must have worked 520 hours to be eligible
Must be employed at the time of payment

Potential to Earn	$ 33,586.56	$ 8,396.64	$ 29,389.92	$ 64,839.42
Additional to Earn	$ 33,586.56	$ 8,396.64	$ 29,389.92	$ 64,839.42
Total	$ 67,173.12	$ 16,793.28	$ 58,779.84	$ 129,678.84

$ 103,743.08

Additional Incentive Bonus - Leadership

							$ 700	$ 1,400	$ 2,800	5%
Coordinator/Manager/Director		**Measure**	**Goal**	**Manager**	**Coordinator**	**Director**	**Coordinator**	**Manager**	**Director**	**Admin**
Financial		Review Department Report and send to Donja by the 10th of the following month	11/12	X		X		$ 280.00	$ 560.00	1%
Growth		Submit Productivity numbers by Thursday following pay period end	11/12	X		X		$ 280.00	$ 560.00	1%
Safety/Quality		Submit PI project data by the 5th of the following month	0.92%	X		X		$ 280.00	$ 560.00	1%
Safety/Quality		Huddle Attendence (representative from dept), exceptions only if every person in your department is not working (1 person dept)	90%	X	X	X	$ 350.00	$ 280.00	$ 560.00	1%
		Complete Learning Journeys timely for direct reports redistribution $ between other categories	100%	X	X	X	$ -			
		Quarterly Manager Meeting Attendance	3/4	X	X	X	$ 350.00	$ 280.00	$ 560.00	1%
Engagement		Gallup Action Plan - created and worked, updated quarterly redistribute $ between other categories	100%	X	X	X	$ -			
		Total					$ 700.00	$ 1,400.00	$ 2,800.00	5%

SHOSHONE MEDICAL CENTER
FY 2024 INCENTIVE GOALS RESULTS

	Growth	Quality	Quality	Quality	Patient Satisfaction	Patient Satisfaction	
	Adjusted Patient Days	Patient Falls	Med Errors	Mammo Screening	CAHPS	Clinic	
	33.3%	11.11%	11.11%	11.11%	16.70%	16.70%	100%
	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	
Staff	$ 116.66	$ 38.89	$ -	$ -	$ -	$ 58.45	$ 214.00
Manager Target	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96
Coordinator Target	$ 233.31	$ 77.77	$ -	$ -	$ -	$ 116.90	$ 427.98
Director Target	$ 933.24	$ 311.08	$ -	$ -	$ -	$ 467.60	$ 1,711.92
Administration Target	3.33%	1.11%	0.00%	0.00%	0.00%	1.67%	6.11%

	Good	Good	Failed	Failed	Failed	Good	Total		
Staff	$ 116.66	$ 38.89	$ -	$ -	$ -	$ 58.45	$ 214.00	97	$ 20,758.00
Admin	$ 233.31	$ 77.77	$ -	$ -	$ -	$ 116.90	$ 427.98		$ 427.98
Business Office Director	$ 933.24	$ 311.08	$ -	$ -	$ -	$ 467.60	$ 1,711.92		$ 1,711.92
Dietary Coordinator	$ 233.31	$ 77.77	$ -	$ -	$ -	$ 116.90	$ 427.98		$ 427.98
Emergency Department	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
EVS Coordinator	$ 233.31	$ 77.77	$ -	$ -	$ -	$ 116.90	$ 427.98		$ 427.98
Facilities Coordinator	$ 233.31	$ 77.77	$ -	$ -	$ -	$ 116.90	$ 427.98		$ 427.98
Facilities Director	$ 933.24	$ 311.08	$ -	$ -	$ -	$ 467.60	$ 1,711.92		$ 1,711.92
Fiscal	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
HIM	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
Human Resources	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
Information Services									$ -
Laboratory									$ -
Medical/Surgical	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
Outpatient Services	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
Patient Access	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
Quality	$ 933.24	$ 311.08	$ -	$ -	$ -	$ 467.60	$ 1,711.92		$ 1,711.92
Pharmacy	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
Purchasing	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
Radiology	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
Respiratory	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
Risk	$ 933.24	$ 311.08	$ -	$ -	$ -	$ 467.60	$ 1,711.92		$ 1,711.92
Social Services	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
SMC Family Medicine	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96		$ 855.96
NP	$ 466.62	$ 155.54	$ -	$ -	$ -	$ 233.80	$ 855.96	3	$ 2,567.88
Fitness Center - Coordinator	$ 233.31	$ 77.77	$ -	$ -	$ -	$ 116.90	$ 427.98		$ 427.98
Total	$ 10,965.57	$ 3,655.19	$ -	$ -	$ -	$ 5,494.30	$ 20,115.06		$ 42,584.98

Admin	3.33%	1.11%	0.00%	0.00%	0.00%	1.67%	6.11%
Total	$ 74,887.67	$ -					

	2020	2021	2022	2023	2024
Manager	$ 26,833.39	$ 22,673.70	$ 14,229.60	$ 13,289.92	$ 10,271.52
Director	$ 9,156.10	$ 13,313.19	$ 3,557.40	$ 3,127.04	$ 6,847.68
Staff	$ 25,129.62	$ 23,933.16	$ 16,897.84	$ 16,416.96	$ 20,758.00
Coordinator	$ 1,953.73	$ 1,259.65	$ 1,778.70	$ 1,563.52	$ 2,139.90
Admin	$ 45,269.09	$ 44,414.25	$ 31,913.03	$ 34,809.63	$ 32,302.69
NP	$ 336.90	$ 1,259.65	$ 1,778.70	$ 1,563.52	$ 2,567.88
Total	$ 108,678.83	$ 106,853.60	$ 70,155.27	$ 70,770.59	$ 74,887.67

GL 2241 Accrued Incentive	$ 94,815.14
2024 Incentive	$ 74,887.67
2024 Manager Incentive	$ 44,406.84
Total Incentive	$ 119,294.51

SHOSHONE MEDICAL CENTER
457 MATCH FY2024

Employee	ID	Amount	Total Wages	7% Match	SMC Match Amount
		$4,290.80	$58,949.56	$4,126.47	$4,126.47
		$13,213.53	$94,382.29	$6,606.76	$6,606.76
		$3,407.24	$48,674.93	$3,407.25	$3,407.24
		$110.14	$1,573.50	$110.15	$110.14
		$1,710.91	$24,441.61	$1,710.91	$1,710.91
		$14.25	$814.37	$57.01	$14.25
		$3,632.76	$53,958.02	$3,777.06	$3,632.76
		$4,436.93	$63,384.84	$4,436.94	$4,436.93
		$4,068.84	$58,126.20	$4,068.83	$4,068.83
		$9,599.81	$137,140.03	$9,599.80	$9,599.80
		$3,283.30	$46,933.12	$3,285.32	$3,283.30
		$16,171.04	$83,702.47	$5,859.17	$5,859.17
		$607.68	$10,841.51	$758.91	$607.68
		$2,920.63	$41,723.52	$2,920.65	$2,920.63
		$159.02	$28,793.89	$2,015.57	$159.02
		$4,060.76	$58,010.99	$4,060.77	$4,060.76
		$1,457.76	$32,481.94	$2,273.74	$1,457.76
		$27,507.33	$99,439.69	$6,960.78	$6,960.78
		$1,627.57	$68,562.88	$4,799.40	$1,627.57
		$5,076.39	$72,520.03	$5,076.40	$5,076.39
		$4,024.00	$57,485.72	$4,024.00	$4,024.00
		$243.48	$41,027.21	$2,871.90	$243.48
		$30,500.00	$182,880.21	$12,801.61	$12,801.61
		$23,757.22	$118,786.01	$8,315.02	$8,315.02
		$2,555.11	$36,501.67	$2,555.12	$2,555.11
		$2,198.35	$46,542.17	$3,257.95	$2,198.35
		$5,178.54	$73,979.23	$5,178.55	$5,178.54
		$5,019.48	$72,092.12	$5,046.45	$5,019.48
		$10,804.38	$95,767.78	$6,703.74	$6,703.74
		$28,174.33	$70,755.15	$4,952.86	$4,952.86
		$2,933.15	$41,902.11	$2,933.15	$2,933.15
		$2,272.47	$32,463.81	$2,272.47	$2,272.47
		$535.91	$7,655.77	$535.90	$535.90
		$21,691.45	$103,292.64	$7,230.48	$7,230.48
		$5,408.93	$77,270.16	$5,408.91	$5,408.91
		$3,307.47	$47,903.64	$3,353.25	$3,307.47
		$4,117.71	$51,471.15	$3,602.98	$3,602.98
		$23,000.00	$145,830.53	$10,208.14	$10,208.14
		$17,979.42	$224,741.60	$15,731.91	$15,731.91
		$2,614.47	$37,349.80	$2,614.49	$2,614.47
		$3,165.40	$45,219.94	$3,165.40	$3,165.40
		$4,300.26	$21,501.31	$1,505.09	$1,505.09
		$8,780.81	$109,759.92	$7,683.19	$7,683.19
		$1,138.44	$40,613.48	$2,842.94	$1,138.44
		$3,081.61	$44,022.91	$3,081.60	$3,081.60
		$12,933.28	$117,575.57	$8,230.29	$8,230.29
		$205.22	$32,192.16	$2,253.45	$205.22
		$6,760.40	$95,198.26	$6,663.88	$6,663.88
		$459.21	$45,923.59	$3,214.65	$459.21
		$1,468.12	$48,937.94	$3,425.66	$1,468.12
		$5,654.27	$80,775.39	$5,654.28	$5,654.27

SHOSHONE MEDICAL CENTER
457 MATCH FY2024

Employee	ID	Amount	Total Wages	7% Match	SMC Match Amount
		$847.58	$42,379.06	$2,966.53	$847.58
		$405.57	$5,793.92	$405.57	$405.57
		$3,449.32	$49,276.25	$3,449.34	$3,449.32
		$9,389.66	$136,343.94	$9,544.08	$9,389.66
		$30,500.00	$51,788.51	$3,625.20	$3,625.20
		$13,414.81	$72,077.18	$5,045.40	$5,045.40
		$1,753.73	$87,686.01	$6,138.02	$1,753.73
		$3,726.49	$113,284.03	$7,929.88	$3,726.49
		$5,102.96	$71,785.09	$5,024.96	$5,024.96
		$3,494.89	$50,033.83	$3,502.37	$3,494.89
		$161.39	$24,040.73	$1,682.85	$161.39
		$399.90	$21,676.35	$1,517.34	$399.90
		$2,472.29	$50,344.40	$3,524.11	$2,472.29
		$1,893.53	$41,573.67	$2,910.16	$1,893.53
		$2,583.08	$36,901.30	$2,583.09	$2,583.08
		$7,750.45	$110,720.83	$7,750.46	$7,750.45
		$8,483.47	$121,192.90	$8,483.50	$8,483.47
		$13,094.37	$119,039.79	$8,332.79	$8,332.79
		$6,460.32	$92,290.00	$6,460.30	$6,460.30
		$3,030.76	$46,405.82	$3,248.41	$3,030.76
		$182.87	$16,874.05	$1,181.18	$182.87
		$1,604.73	$51,905.68	$3,633.40	$1,604.73
		$2,604.33	$47,832.34	$3,348.26	$2,604.33
		$8,455.45	$70,462.23	$4,932.36	$4,932.36
		$6,852.15	$98,474.18	$6,893.19	$6,852.15
		$16,371.80	$158,536.16	$11,097.53	$11,097.53
		$15,917.20	$159,171.78	$11,142.02	$11,142.02
		$1,375.73	$64,983.35	$4,548.83	$1,375.73
		$613.57	$33,461.12	$2,342.28	$613.57
		$9,873.81	$98,737.77	$6,911.64	$6,911.64
Totals		$533,885.79	$5,476,946.61	$383,386.25	$340,467.62
GL 2240					$304,679.47
Accrual Needed					$35,788.15

Shoshone
MEDICAL CENTER

Service Agreement Summary

Contractor:	Heritage Imaging
Contract Description:	Provide imaging personnel and equipment to perform echocardiography studies
Place of Service:	Shoshone Medical Center Hospital
Agreement type:	Professional services agreement
Scope of Services:	Echocardiography studies to be provided 1-2 days every two weeks
Contract Term:	Thirty-six months initial term, one-year subsequent renewal terms. Termination by either party with 90-day notice
Service Fee:	$1,300/day of service plus $225-$250 per scan after four scan minimum
Estimated annual cost:	$33,800 - $78,000 (dependent on frequency of service and volume of studies)
Effective date:	February 1, 2025

Therapeutics Committee; (iii) Medical Executive Committee; (iv) Interdisciplinary Committee; and (v) other meetings as needed.

(d) Assist Hospital administration to seek to maintain the Department provider schedule to ensure continuous coverage (24 hours per day, seven days per week, 365 weeks per year).

(e) Assist and participate in new provider recruitment and in ongoing competency and performance reviews of current providers.

(f) Review, approve and develop as needed, all policies for Emergency Services in coordination with Department Manager and Hospital administration

(g) Provide assistance and direction as needed by Hospital or Department staff related to Emergency Services and the Department.

(h) Meet at least quarterly with the Department Manager and Hospital Administration to review and discuss Emergency Services and Department operations.

(i) Provide a monthly written report to be used as documentation and support for services provided in this Agreement.

(j) Monitor the ongoing training and education requirements of Department providers.

(k) Coordinate with community-based EMS entities and medical directors to review and enhance continuity of care in the community.

(l) Support Department and organizational regulatory compliance and strategic initiatives.

(m) Assist Hospital in establishing, reviewing, and updating appropriate policies and procedures relevant to the Department as necessary to improve patient care and maintain efficient and effective Hospital operations.

(n) Participate in Hospital's regular quality improvement activities relating to the Department.

(o) Participate in Hospital's credentialing, peer review, and related activities relevant to the Department.

(p) Participate in medical staff conferences, teaching programs, and other pertinent activities relating to the Department.

(q) Furnish appropriate clinical instruction, training and information to the Hospital personnel and staff relevant to the Department.

Shoshone
MEDICAL CENTER

Physician Contract Summary

Physician Name:	Dale Ross, MD
Position Description:	Emergency Department Medical Director
Place of Service:	Shoshone Medical Center Hospital
Agreement type:	Addendum to independent contractor professional services agreement
Clinical Responsibilities:	Provide medical directorship services for emergency department
Contract Term:	One year term with automatic renewal for subsequent one-year terms Termination by either party with 30-day notice
Compensation:	$135/hour, maximum of 12 hours/month
Estimated annual cost:	$19,440
Effective date:	January 25, 2024

Responsibilities:

(a) Perform such duties as are commonly performed by or required of a medical director of an emergency department and coordinate with Hospital administration to seek to ensure Hospital's compliance with all licensure, accreditation, and payer standards relevant to the Department.

(b) Work with Department physicians and personnel to engage in performance improvement programs and serve as the physician leader in departmental quality, patient experience and safety initiatives.

(c) Participate in meetings associated with the performance and quality of Department services, including but not limited to (i) Emergency Department Committee; (ii) Pharmacy and

SHOSHONE MEDICAL CENTER
Insurance Coverage

Broker	Insurance Company	Insurance	Renewal Date	2025 Renewal		2024 Renewal		2023 Renewal Amount		2022 Renewal Amount	2021 Renewal Amount
Gallagher	MIEC	Professional Liability	2/1/2025	$ 23,792.00	0%	$ 23,887.00	16%	$ 20,542.00	####	$ 41,687.16	$ 33,541.72
Gallagher	Selective	Commercial Property	7/1/2024		-100%	$ 46,592.00	18%	$ 39,506.00	20%	$ 33,050.00	$ 28,146.00
Gallagher	Selective	Flood	7/1/2024		-100%	$ 510.00	-91%	$ 5,651.00	40%	$ 4,041.00	$ 3,946.00
Gallagher	National Casualty Company	Commercial Auto	2/4/2025		-100%	$ 4,212.00	2%	$ 4,137.00	7%	$ 3,882.00	$ 3,776.00
Gallagher	WCF	Workers Compensation	7/1/2024		-100%	$ 48,183.00	-21%	$ 61,210.00	####	$ 95,928.00	$ 78,264.00

SHOSHONE MEDICAL CENTER
STRATEGIC PLAN 2025-2027
For Plan Year 2025

TABLE OF CONTENTS

OUR MISSION

To provide excellence in healthcare.

OUR VISION

To provide valley-wide healthcare that assures the provision of quality services.

OUR COMMITMENT

- To assure that quality healthcare services are provided locally.
- To assure continual improvement of the effectiveness of the Quality Management System.
- To comply with all rules, regulations and guidelines.
- To provide for the integration of services with regional healthcare systems.
- To focus on a culture of safety and fiscal responsibility throughout the organization.
- To provide resources for facilitating wellness awareness and promoting community health education.
- To integrate services with physicians and other community healthcare providers.

STRATEGIC GOALS AND OBJECTIVES FOR 2025

1. **Evaluate expanding services and access to address the healthcare needs of local communities**
   - 1.1. Perform surgery service line feasibility study
     - 1.1.1. Based on study findings, develop strategy for program development and implementation
   - 1.2. Evaluate growth of outpatient services: cardiac and pulmonary rehabilitation; chemotherapy; pain management
     - 1.2.1. Implement services that address healthcare needs of local communities
   - 1.3. Improve access to healthcare services
     - 1.3.1. Evaluate and adopt solutions to expand community access to primary care (urgent care, walk-in care, established care, etc.)
     - 1.3.2. Expand telemedicine services
     - 1.3.3. Evaluate patient transportation program to reduce travel barriers to healthcare services

2. **Evaluate and implement quality of care and patient safety goals**
   - 2.1. Identify key quality metrics that will ensure continuous quality improvement and use benchmark data to monitor improvement
   - 2.2. Implement a board-sponsored quality/safety committee to adopt best practices, drive organization-wide quality and measure performance
   - 2.3. Standardize patient experience surveys across all service lines. Implement action plans based on patient experience feedback

3. **Develop recruitment and retention plan to increase engagement and growth opportunities for staff members, practitioners and physicians**

   3.1. Expand leadership training and education program and provide additional resources/opportunities for professional development and growth within SMC

   3.2. Implement a formal recruitment process to help support selection of most qualified candidates

   3.3. Adopt a formal medical staff recruitment and development plan to align with provided services

   3.4. Expand the new employee orientation program to provide additional support and training for new staff members

4. **Sustain financial stability and performance**

   4.1. Achieve annual budgeted performance

   4.2. Provide and train leaders to use benchmark information to monitor financial performance

   4.3. Develop an annual community report to provide education on service delivery of Shoshone Medical Center

5. **Invest in facilities and resources to improve the care of our local communities**

   5.1. Complete master asset and facilities plans and implement key findings

   5.2. Improve efficiency and quality of care through the evaluation and adoption of supportive technologies (AI, telehealth, patient portal, etc.)

   5.3. Invest in services that will assist with the security and integrity of electronic and digital information and systems

6. **Connect with our patients and community**

   6.1. Implement a formal communication plan that informs our patients and local communities of available programs and services

   6.2. Expand multiple marketing channels (print, digital, face-to-face) to share key communications about services, accomplishments and health information

      6.2.1. Use surveys and other community-based data to monitor effectiveness of marketing and communications program

APPENDIX

- Marketing Recap
- Thank Yous
- Employee Recognition
- Events
- February Event Calendar
- Education
  - Speaker Brad Nieder
  - IHA Hospitals 101 Guide Book

MARKETING RECAP
For DECEMBER 2024

HIGHLIGHTED DEPARTMENTS:

Post Acute Rehab

- Dedicated Lobby Presentation
- Facebook Posts

COMMUNITY EVENTS

- N/A

SPECIAL EVENTS

- MEC Dinner (12/5)
- Employee Christmas Party & Lunch (12/12)

ADDITIONAL MARKETING

SMC Facebook

- 12/3 SMC Calendars Available
- 12/6 Post Acute Rehabilitation Services
- 12/9 New SMC Foundation FB Page
- 12/18 New Portable X-Ray Machine
- 12/20 Happy Holidays w/SMC Staff photos
- 12/22 Happy Holidays w/Clinic Provider photos
- 12/24 Merry Christmas
- 12/31 Happy New Year

Fitness Center Facebook

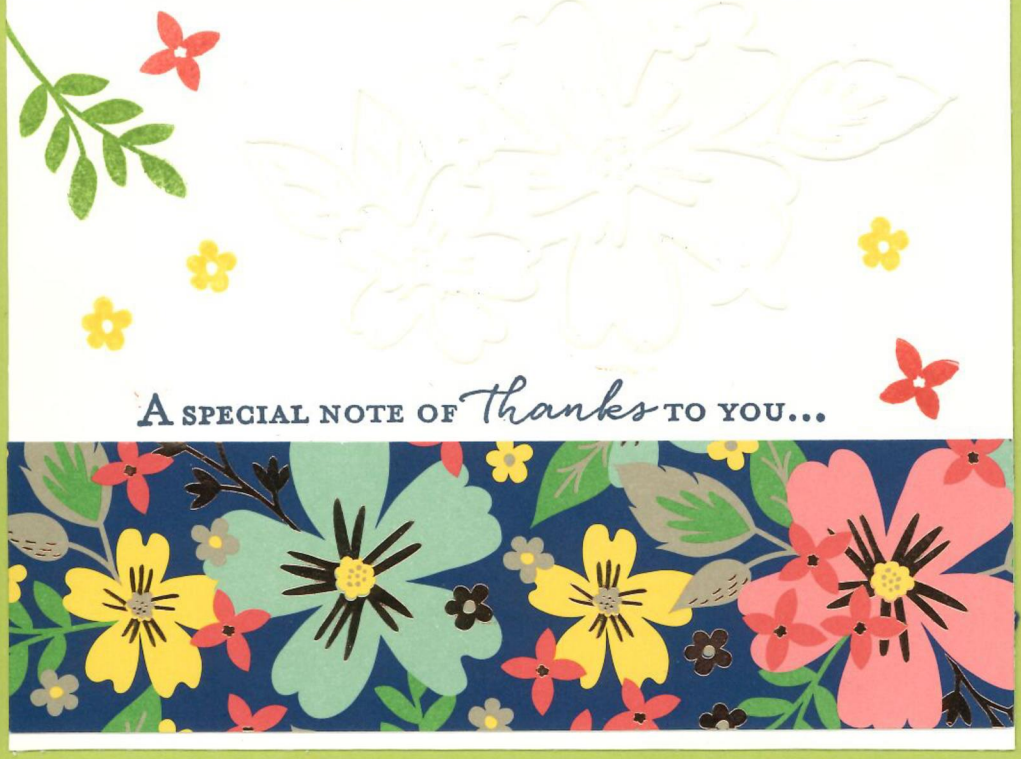
- 12/2 Fitness Center Membership & Classes
- 12/4 High Intensity Training
- 12/19 Happy Holidays w/Gym Holiday Hours
- 12/22 Personal Trainer Sessions w/Belden Lindsey
- 12/24 Happy Holidays w/Gym Holiday Hours
- 12/31 Happy New Year

Daktronic (Electronic) Sign:

- Accepting New Patients
- Same Day Appointments
- Happy Holidays

UPCOMING EVENTS

- February 7-8 Annual NWHA Symposium at CDA Resort
- February 7 – Speaker Dr. Ralph Neider on Healthy Living | Noon | SMC or Virtual
- February 12 – SMC Heart Health Learning Lunch | Noon | Pinehurst COC



Thank you so much for the flowers. I am forever grateful for my SMC family.

YOU COULD NOT BE MORE
THOUGHTFUL
~~AND~~ I COULD NOT BE MORE
Thankful

From,
Alicia
Mitchell

DECEMBER GOLD STARS

Employee Nominated:  Edwina Cunningham

Edwina volunteered to work all day on Thanksgiving, so the rest of us admitters could have the day off to spend with our families. This was very kind and selfless of her. Thank you Edwina, you rock!

Employee Nominated:  Jessica Grimmett

Jessica came to the ER and saw it was busy. She stayed for a couple of hours and helped with patient care. ER staff stated they appreciated her help in the ED. Jessica did not have to stay and help but choose to.

Employee Nominated:  Randi Avina

ED staff stated "Randii was a great help in the ED and did a good job. She passed medications, did vitals, and discharged patients." Thank you Randii.

Employee Nominated:  Robin Schremser

The Ed staff stated they really appreciated Robin's help in the ED this weekend. "Robin checked on the ED, figured out how to solve the issues, came and was responsive to the ED. She called in staff and came and passed medications in the ED."

Employee Nominated:  Alicia Mitchell

Alicia allowed many patients to be registered ahead of her when the lobby was overwhelmed, she waited over 30 minutes before being registered. Admitting staff greatly appreciates her dedication to patient care, as well as her patience and grace with us.

Employee Nominated:  Aaron Brownfield

The Medical Unit had a 100% compliance rate with the MOON form signed and scanned into the medical record for the month of November. The Medical Unit had a 100% sign and scan rate of Swingbed choice forms. Aaron was responsible for ensuring these documents were scanned into Cerner in a timely manner.

Employee Nominated:  Tristan Hagaman

Tristan is a wonderful team player and when she is working medical she always takes time to check on the ED staff multiple times during her shift and is always willing to help the ED staff when it is busy.

Employee Nominated:  Donna Dunn

For all the work done on flu vaccination and the documentation of employee vaccinations. Thank you. You have made a safer world.

Employee Nominated:  Chris Hartwig

Former patient mentioned Chris by name as someone who "was very happy to help me and went out of his way to make sure my room was clean."

Employee Nominated:  Samantha Smith

Patient said that "Sam was awesome, great sparkling personality and and always making me smile." I was almost sad to leave because everyone took such good care of me.

Employee Nominated:  Crystal Smith

Crystal worked all day Wednesday in outpatient before her scheduled nightshift in the ER. We had a busy night in the ER and Crystal worked extremely hard all night without having much of an opportunity to take a break and she did it with a smile on her face. Then, due to a call off on dayshift, Crystal was willing to stay over her shift until 8:30 in the morning to help cover dayshift. I don't know many people with such dedication to caring for our community as Crystal has consistently demonstrated since I first began working with her.

Employee Nominated:  Amy Paul

Amy did a fantastic job with year end inventory.

Employee Nominated:  Kathy Tweedy

Kathy has been a rock star with post Cerner implementation. She handles it calming but firmly. She doesn't get defeated and continues to work the AR everyday.

Employee Nominated:  Stacie Gilmore

Stacie has been a rock star for Patient Access. She takes on new challenges with enthusiasm and works incredibly hard.

Employee Nominated:  Bryan Humphrey

Bryan has been the glue holding the rehab department together. He did a great job as super user for Cerner. He is dedicated to the front desk even through challenging times.

Employee Nominated:  Liz Zaborski

Liz has done a great job reconciling the general ledger.

Employee Nominated:  Susan Berry

Susan is the party queen. From Dana and John retirement party to MEC dinner to Employee Christmas party. She organizes all these events and comes up with way to make them fun and exciting.

Employee Nominated:  Kelli Kenser

She was amazing to remember our brand new process of OBS exclusion time and called back after she left to tell me the times she had seen the patient for the OBS exclusion to be entered. THANK YOU for following the new process!!

Employee Nominated:  Brent Poland

Brent was the top medication scanner for the month of November! THANK YOU for embracing change and being a leader!

Employee Nominated:  Kenda Morgan

Verified the correct process for Medicare Advantage Coverage. Worked hard to reach out to 4 different agencies to get their responses. THANK YOU Kenda for being so dedicated to getting the correct process to work here for our PTs!

Employee Nominated:  Karen Overholtzer

Worked over the weekend in the ED to cover for Holidays for staff. THANK YOU for being willing to come in and work when needed.

Employee Nominated:  Aaron Brownfield

For helping so much with making a CERNER book that helps keep all the new data together and updating it regularly. Plus all the calls you made this last week to get coverage for the unit!

Employee Nominated:  Tiffney Hojem

I usually have the door to my office opened and have had the privilege of hearing Tiff interact with our customers while she brings them back. She is incredibly thoughtful, kind and caring in her interactions and you can tell she makes our customers feel very at ease. Her interactions with her patients is a great example of someone who provides excellence in healthcare!

Employee Nominated:  Ryan Mann

Ryan has done an outstanding job recruiting and hiring several positions over the past few months

Shoshone MEDICAL CENTER

Staff Christmas Party & Lunch

Thursday, December 12th
11:30am in the Cafeteria

Present Pong

- *Please purchase at a small local business if possible*
- *Cost around $15*
- *Please ensure it is work appropriate (no alcohol please)*
- *To participate, bring your gift to **Purchasing on the 11th***

Dessert will be a Potluck

- *Please bring your dessert to the party!*

December Secret Santa!

If you'd like to participate:

- *December 2nd – Deadline to respond to Susan Berry*
- *December 3rd - We'll email you your Secret Staff Member*
- *December 9th – Bring (2) $10 Gifts to Purchasing*
- *Gifts will be distributed each week by our **Grinchy Santa!***
- *December 20th – Secret Santas Revealed!*

February 2025

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
26	27	28	29	30	31	1 **American Heart Month**
2	3	4	5	6	**Wear Red Day** 7 ***Annual NWHA Symposium*** Dr. Brad Nieder Presentation on Healthy Living NOON in SMC Cafteria & Virtural	8
9	10	11	12 **Learning Lunch NOON** SMC Community Outreach Center Pinehurst	13	14	15
16	17	18	19 **Foundation Meeting** Noon Classrooms 1 & 2	20 **IDC Meeting** 1pm - 2pm Classrooms 1 & 2	21	22
23	24 **Finance Committee Meeting** 7am SMC Admin Conference Room	25	26 **Board Meeting** 5:15pm SMC Classroom 1	27	28	1
2	3	**SMC Employee Wellness Screening in February**				

Brad Nieder, MD

The Healthy Humorist®

DOCTOR
SPEAKER
COMEDIAN

BIOGRAPHY

"The Healthy Humorist®"—Brad Nieder, MD, CSP*—is a doctor, funny speaker and clean comedian. Described as "Jerry Seinfeld with an 'M.D.,'" Dr. Brad was infected with the comedy bug while watching Johnny Carson's "Tonight Show" monologues from the foot of his parents' bed. When he got older and stayed up a bit later he discovered David Letterman's "Late Night" antics. He taped and memorized George Carlin's HBO specials. He wrote funny articles for his Denver high school newspaper. He was a founding member of an improvisational troupe (The SImps) while an undergraduate student at Stanford University. And he performed standup comedy at comedy clubs throughout Denver while he was in medical school at the University of Colorado.

After completing his internship and getting his medical license, Dr. Brad began delivering his unique brand of healthcare humor around the country to corporate audiences, convention crowds and conference attendees. Physicians, nurses, bankers, teachers—indeed people from all industries—have benefited from his medical humor.

Dr. Brad earned the CSP* designation in 2011 and is now 15 years into his career as a professional speaker. He has not been published in the "New England Journal of Medicine." (But he has co-authored the book "Humor Me," and he has a great CD ("A House Call in San Francisco") and DVD ("The Healthy Humorist in Orlando: Laughter is the Best Medicine").) He's not a celebrity speaker. He hasn't been on "The Tonight Show." He's not an Amazon best-selling author. (Aren't those claims usually just a scam anyway?) He's simply one of the best funny speakers and clean comedians in the meetings industry today.

Dr. Brad lives in Colorado with his lovely wife and three wonderful kids. He tries to practice the "healthy" part of what he preaches by running and swimming in the Colorado sunshine. He also loves to ski and fly-fish in the Rocky Mountains. He loves to travel, too, though, mainly to indulge in "The Healthy Humorist's Unhealthy Eating Adventure Across America" (THHUEAAA) in which he consumes such unhealthy fare as Italian beef in Chicago, BBQ in Austin and ice cream in Columbus. (Yes, he agrees it's weird that central Ohio has such an abundance of great frozen treats!)

"a HUGE hit!"
—Sr. Manager of Professional Relations, Philips

"brilliant performance"
— Project Manager, Kaiser Permanente

"one of the best keynotes ever."
—Manager of Education Programs, American Health Care Association

"simply the best."
—Director of Meetings and Publications, American Medical Technologists

"Dr. Brad was phenomenal!"
—Regional VP of Operations, Health Inventures

CLIENTS INCLUDE

AAPC · AMGEN · ashp · Banner Health · BlueCross BlueShield · Centura Health · COPIC · Health ONE · The New England Journal of Medicine · Kaiser Permanente · Tyson

CSP = Certified Speaking Professional (an earned designation from the Global Speakers Federation that essentially means Dr. Brad has been doing a great job on stage for a long time for many audiences!)

Idaho Hospital Association

HOSPITALS 101

A guide to Idaho's Community Hospitals

2025 edition

Dear Idaho Legislators,

On behalf of Idaho's 51 hospitals and nearly 35,000 dedicated healthcare workers represented by the Idaho Hospital Association (IHA), we extend our heartfelt thanks for your service to the people of Idaho.

As members of a citizen Legislature, you face the challenging task of navigating a vast array of issues, particularly when considering the financial, legal, and policy implications of the hundreds of bills presented each year. We hope that you will view the IHA, along with this document, as a valuable resource to help guide your decision-making process.

The *Hospitals 101* guide was created to provide you with essential information to better understand the complexities of healthcare legislation and support you in addressing these critical issues with your constituents. This guide will help provide detailed background information on things like payment methodologies and serve as a quick reference to the many acronyms and processes that are an intrinsic part of healthcare.

As one of the fastest growing states in the country, the health of our economy and our citizens depends on a robust healthcare infrastructure that ensures access to high-quality care for all. We stand ready to serve as your partner and resource in this important work for all Idahoans.

Please don't hesitate to reach out with any questions or concerns. Best wishes for a productive and successful session!

Warm regards,

Brian Whitlock
President / CEO

Toni Lawson
Vice President

Brian Whitlock
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Table of Contents

Idaho Hospital Association

Idaho's Community Hospitals
SNAPSHOT

20,682
Births

610,368
Emergency Visits

149,379
Inpatient Admissions

5.8 mil
Outpatient Encounters

34,957
hospital employees

direct contribution to Idaho's GSP
$6.21 bil.

* Based on 2023 Data

*** most recent 10-yr data available**

24 / 7 / 365 --- that's how Idaho's emergency departments run. When your loved one is having chest pain or has been in an accident, healthcare workers are ready to answer the call. But the ED isn't always the best or least costly place for care. Idaho's hospitals have worked for years helping Idahoans get the right care at the right time in the right place. Preventive care, community outreach and education, and a commitment to primary care all help guide patients to get their care in the best setting. This means, while our population has skyrocketed, the number of ED visits has remained disproportionately low.

The Unique Role of Hospitals

Idaho's hospitals play a vital role in meeting the healthcare needs of their communities. They provide a wide range of acute care and diagnostic services, supporting public health needs, providing access to primary care, and offering countless other community services to promote the health and well-being of the community.

While some hospital services are also delivered by other healthcare providers, three things make the role of the hospital unique:

- **24/7 Access to Care**: Hospitals are committed to providing healthcare services, including specialized resources, 24/7, 365 days a year. Always there, ready to care is more than a tagline. It's what drives our healthcare workers to make sure our doors are open for everyone in times of need.
- **The Safety-Net Role**: Being ready to care for any patient who seeks emergency care, regardless of one's ability to pay, is a cornerstone practice at Idaho's acute care hospitals.
- **Disaster Readiness & Response**: Ensuring that staff and facilities are prepared to care for victims of large-scale accidents or attacks, natural disasters, and epidemics is built into Idaho's hospital operations.

These critical roles – collectively known as the "standby" role – while often taken for granted, represent an essential component of our nation's health and public safety infrastructure. The standby role of hospitals is not explicitly funded; instead, the funding is built into a hospital's overall cost structure. Hospital staff train and prepare for a variety of situations and work in partnership with state and local officials to be ready when critical events happen.

For many rural Idaho communities, local hospitals are vital to the support of emergency services, access to pharmacies, and are key in addressing mental health crises.

Idaho Hospital Association Members

IHA represents 51 hospitals throughout the state. A majority of our members, 39, are full-service, community hospitals that provide 24/7 care in their communities. In addition to the hospital, some of our members manage nursing homes, clinics, and rural health centers. IHA also represents five behavioral health, two long-term acute care, three rehabilitation, and one veterans hospital. Hospital designations include:

Critical Access Hospitals (CAH): This designation is given to certain rural hospitals by the federal government. Implemented in 1997, this designation is intended to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. As of July 1, 2022, CAHs are reimbursed 99% of Medicare rates on allowable costs. Twenty-seven of Idaho's community hospitals have the CAH designation. The primary requirements to maintain CAH status are:

- providing 24/7 emergency care services;
- having 25 or fewer acute care inpatient beds;
- being located more than 35 miles from another hospital (exceptions may apply); and,
- maintaining an annual average length of stay of 96 hours or less for acute care patients.

Prospective Payment Systems (PPS): Another federal designation, PPS refers to the method of Medicare reimbursement where payments are made based on a predetermined, fixed amount for services. The payment amount for a particular service is derived based on classification systems; DRGs (diagnosis-related group) for inpatient care and APCs (ambulatory payment classifications) for outpatient care. Overall, reimbursements to PPS hospitals from Medicare do not cover the actual cost of providing the care. There are 13 full-service PPS hospitals in our membership and an additional 11 that are state, federal, mental health, rehabilitation, or long-term acute care.

Rural Emergency Hospital (REH): The REH designation was created by Congress in 2021 to help rural hospitals avoid closure and to improve access to healthcare in rural areas. REHs provide emergency services and certain outpatient services to patients who typically stay less than 24 hours. No Idaho hospitals have yet converted to this new designation, but there are Idaho communities that have difficulties sustaining their Critical Access Hospital that are actively evaluating this opportunity.

IHA Member Hospitals

Hospital Ownership

The following definitions provide clarification on the various types of hospitals that exist in Idaho. All Idaho hospitals are defined and licensed under sections 39-1301 through 39-1314 of Idaho Code.

Non-Profit or Not-for-Profit Hospitals

A not-for-profit hospital is an organization that can demonstrate that no part of its net earnings is given to a shareholder or individual. The term non-profit does not mean that the hospital does not make a margin. Instead, "profits" of the hospital are returned to the control of the hospital for operations rather than to shareholders. A not-for-profit hospital is exempt from most federal and state taxes due to its charitable status, but is not exempt from employment taxes (e.g., Social Security and Medicare taxes). Hospital-owned properties may or may not be exempt from local property tax based on how the property is being used. Idaho has 22 not-for-profit hospitals.

County Hospitals

Counties are authorized to establish and maintain county hospitals and nursing homes. (IC 31-3601 et seq.) Currently, nine Idaho counties own hospital facilities. Idaho Code allows a county commission to appoint a county hospital board, "charged with the care, custody, upkeep, management and operation of all property belonging to the county" (IC 31-3607) which is responsible for conducting, operating and maintaining a county hospital. (IC 31-3601). Basically, county hospital boards are established as a separate public entity to operate and manage the county's hospital assets. The commissioners appoint board members, approve the hospital's budget on an annual basis and one commissioner sits as a member of the hospital's board. A county hospital board is a taxing unit under Idaho law and may levy taxes to support the hospital's operations, although most in Idaho do not.

IHA Members by Ownership

22	Not-for-Profit
9	County
11	Investor Owned
6	District
2	State
1	Federal

Hospital Districts

Idaho currently has six district hospitals charged by Idaho Code with ensuring the "betterment and protection of the public health and care of the sick and afflicted." Hospital districts are established through a process of approval that includes a vote of county commissioners, then approval by a majority of voters in the proposed district. (IC 39-1318 et seq.). Hospital districts may cover more than one county but must be approved by the county commissions of each county. Hospital district boards are made up of seven elected trustees who can appoint up to two additional members if needed. The board members are elected to six-year terms and annual audits are published for the public. Although a hospital district is a separate public entity and has the ability to levy and collect property taxes, these are limited to .06% (less in some circumstances) of market value on taxable property within the district. Any additional levies must be approved by two-thirds of electors.

Private or Investor-Owned Hospitals

The profit or loss of the hospital is a direct profit or loss for the shareholders (owners) of the hospital. These facilities may be publicly traded or privately owned. In the IHA membership, twelve hospitals are investor-owned. These hospitals pay taxes on hospital property and purchases. Specialty hospitals are often private or investor-owned and are licensed facilities that provide a limited service for one of the following types of care: surgical; long-term acute care; psychiatric; or rehabilitative.

State and Federal Hospitals

The Department of Health and Welfare operates Idaho's two state hospitals while the federal government operates Idaho's Veterans Administration Hospital.

System Hospitals

These are hospitals that may be managed or owned by a corporate entity. A hospital system may have a collection of all the hospitals previously described such as for-profit, not-for-profit, specialty or critical access. Additionally, a hospital system may also own or operate other service lines, like outpatient treatment centers or primary care practices.


HOSPITAL OWNERSHIP
County
Not-For-Profit
Federal
District
Investor Owned
State
Boundary Community Hospital
Bonner General Health
Rehabilitation Hospital of the Northwest
Kootenai Health
Shoshone Medical Center
Northern Idaho Advanced Care Hospital
Benewah Community Hospital
Gritman Medical Center
Clearwater Valley Health
Idaho State Hospital North
St. Joseph RMC
St. Mary's Health
Syringa Hospital & Clinics
Lifeways Hospital
VA Medical Center
St. Luke's Nampa Medical Center
Intermountain Hospital
St. Luke's Rehabilitation
St. Luke's Meridian Medical Center
St. Alphonsus RMC
St. Alphonsus Medical Center Nampa
St. Alphonsus Regional Rehabilitation Hospital
St. Luke's Boise Medical Center
Cottonwood Creek Behavioral Hospital
Vibra Hospital of Boise
Steele Memorial Medical Center
St. Luke's McCall Medical Center
Cascade Medical Center
Weiser Memorial Hospital
Madison Memorial Hospital
Teton Valley Health Care
Lost Rivers Medical Center
Eastern Idaho RMC
Idaho Falls Community Hospital
Valor Health
St. Luke's Wood River Medical Center
Bingham Memorial Hospital
Idaho State Hospital South
North Canyon Medical Center
West Valley Medical Center
Power County Hospital
Portneuf Medical Center
St. Luke's Elmore Medical Center
St. Luke's Jerome Medical Center
Caribou Medical Center
Minidoka Memorial Hospital
St. Luke's Magic Valley Medical Center
Bear Lake Memorial Hospital
Cassia Regional Hospital
Nell J. Redfield Memorial Hospital
Franklin County Medical Center

Hospital Governance

The world of healthcare is complex and constantly changing. To ensure the needs of each community are considered and high-quality care is provided, a knowledgeable, committed hospital board is vital. Every hospital has some level of community governance, whether it be through an advisory board, elected trustees, community volunteers or a mix of elected officials and volunteers. The role of hospital board members is to provide governance and leadership to all activities of the hospital. Members are typically a collection of physicians and community leaders skilled in finance, business, fundraising, investment, planning and law, using their knowledge to help the hospital achieve strategic goals.

The roles and responsibilities of the governing board involve everything from ensuring the cost-effective utilization of resources to determining the organization's mission and establishing a long-range strategic plan. Although the responsibilities vary, the primary duties of hospital governing boards include:

- Hiring and retaining an effective CEO
- Developing mission, programmatic and financial strategic planning
- Monitoring and ensuring quality care
- Safeguarding the financial health and viability of the hospital
- Overseeing medical staff credentialing

Trustees are responsible for performing these activities within all applicable licensure standards, relevant laws, and governmental regulations.

Hospital Operations

At its core, every hospital strives to provide quality healthcare for their communities. They are always there, ready to care. To make that clear and concise goal a reality, hospitals, even Idaho's small rural facilities, are multifaceted entities, providing a wide range of services through highly educated and skilled employees and partners. These myriad services are paid by both the direct recipients of care as well as third-party payers – insurance companies, Medicare, Medicaid, Workers Comp, Tri-Care, or the Veterans Administration. Each of these organizations negotiates a unique contractual arrangement or fee schedule with hospitals. That complexity is compounded by an intense level of data reporting, the need to operate a financially viable business that is open 24/7, 365 days a year, and recruiting and retaining highly skilled employees. Simply put, hospitals are unlike any other organization, and running a hospital at the executive and board levels requires a significant amount of knowledge, experience, and understanding of the intricate world of healthcare finance.

At the most fundamental level, hospitals measure their fiscal health by their ability to remain viable and provide services to patients in their communities. A more accounting-based measure is the use of the operating margin. The operating margin is the difference between net operating revenues and the hospital's operating expenses.

As discussed in other sections, hospitals incur costs in providing healthcare services, some of which are not paid. This can occur for various reasons, and some are out of the hospital's control (e.g., fixed reimbursement by governmental payers that pay less than costs or emergency care for the uninsured). Regardless of the cause, these situations present a challenge to a hospital's fiscal health.

Hospitals with positive operating margins can enhance their benefits to the community and charitable care programs as well as invest in technology and capital improvements. Without modern technology and facilities accommodating newer medical procedures, hospitals have difficulty recruiting and retaining physicians, including specialists who have certain expectations to meet the needs of their patients. Positive margins also allow hospitals to weather economic downturns through the use of reserves, much like the state does with its Rainy Day Fund.

Average Operating Margin for IHA Member Hospitals (Hospital Operations)	
FFY 2021	0.97%
Average Operating Margin for IHA Member Hospitals (Hospital Operations)	
FFY 2022	(2.92%)

A hospital's operating margin is calculated by subtracting expenses from revenues. In normal times, the average margin for Idaho's hospitals barely kept pace with inflation. In fact, for Federal Fiscal Year (FFY) 2022, 24 of 27 rural Idaho hospitals ended their year with a negative operating margin. Overall, 76% of Idaho's hospitals had a negative operating margin.

During FFY 2022, Idaho's hospitals had some of their worst financial quarters in decades. Workforce shortages, skyrocketing labor costs, and uncontrolled increases in pharmaceuticals and other supplies – compounded by fixed reimbursement rates from government and commercial payers – created a massive and unsustainable swing in operating margins for hospitals.

Because of the nature of governmental reimbursement and uncompensated care, our hospitals must rely on other sources of revenue to achieve modest margins (especially by normal business standards). Consider, for example, a somewhat comparatively regulated and vital public entity like Idaho Power. In its 2023 annual report, Idaho Power had a net income of approximately 14.8%.

The long-term effects on operating margins caused by less-than-cost governmental reimbursements have yet to be adequately addressed and continue to worsen. It is critical that we resolve issues like compensation for the care delivered, reducing burdensome and duplicative reporting, creating a healthcare system where care coordination improves the care for the patient and reduces waste, and addressing the needs of the uninsured and underinsured so they are able to get appropriate care in the right setting before problems become severe.

Ensuring our community hospitals remain viable and accessible throughout Idaho is critical to sustaining rural communities and allowing Idahoans to find quality healthcare close to home. The most basic and efficient way hospitals can stabilize their financial footing is to have reserves. Regardless of their organizational structure

(not-for-profit, county, district, or investor-owned), hospitals are allowed and expected to keep an appropriate level of reserves. The minimum amount of reserves is expected, by industry standards, to be 90 days of operating cash on hand. For many Idaho hospitals, this is a number that has been difficult to attain and sustain, even before the workforce shortages.

Reserves are necessary to provide resources in times of economic stress or for providing necessary equipment to keep services and providers in the community. Reserves are also essential to establish a hospital's fiscal health when borrowing to replace antiquated buildings or equipment. As a key indicator of fiscal health and viability, reserves are required by financial institutions as a condition for capital lending. Reserves impact the cost of borrowing, and a violation of this requirement can result in the lender demanding immediate repayment or an increased interest rate on the debt.

Patient Billing and Payment

Chances are good that if you get a call from a constituent about healthcare, a confusing bill is likely at the center of it. At the end of the day, one of the most talked about issues is the hospital or provider bill. Billing and payment of claims for members of health plans (private or governmental) is determined by contract terms or by federal and state law. The degree to which hospitals and other providers can negotiate reimbursement from non-governmental insurance varies considerably. As referenced earlier, there are a host of different plan types, provider networks, and reimbursement methodologies.

The healthcare delivery system is a combination of complex organizations doing multi-faceted work designed to get people to a healthy state from countless ailments at varying levels of severity – working to save lives in the process. Throughout this process a bill must be created that goes through numerous iterations beginning with the patient's first steps of care. With so many different fingerprints on a given person's care – including labs, x-rays, rehabilitation, anesthesia, doctors, specialists, and hospitals as well as those determining necessity of care, payment and coverage – the resulting documents can often be overwhelming and confusing. Hospitals have staff available to work with patients throughout the financial process.

Insured patients typically receive two types of documents. Statements – generally received after services are provided but before the insurance company is billed – outline the charges for each service received. These charges are not at the rates agreed upon with the insurance company, which generally means they are not the actual cost that will be incurred by the patient, similar to the way that the sticker price of a new car is rarely what the buyer pays.

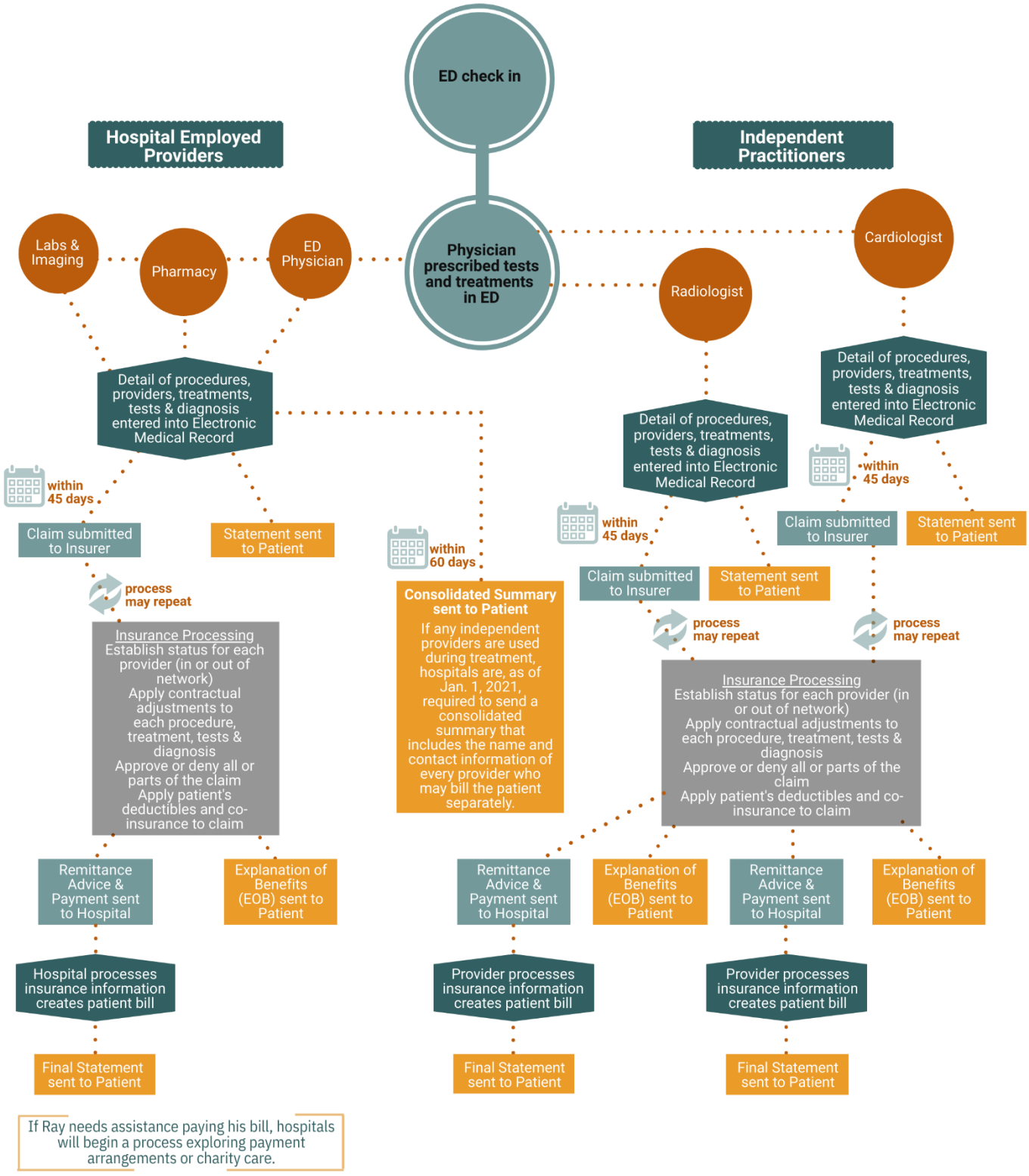
The second item is the hospital bill which is received after the insurance company has reviewed the detailed information they were sent. The bill lists the charges as well as the adjustments reflecting the difference between the charges and the amount the insurance company has negotiated for the services. This is known as a contractual adjustment. That is followed by the amount that will be paid on the patient's behalf by the insurance company which depends on the plan, the provider's network status with the insurance company, and the insured's status with their deductible and/or out-of-pocket costs. Any residual amount left after considering these adjustments would typically be the amount owed by the patient. These amounts may comprise a combination of deductible, co-insurance, co-payments and non-covered charges as determined by the patient's insurance plan.

While hospitals and providers can provide estimates to patients based on the care they expect to receive and what their insurer's contractual amount is, it's important to note it isn't a complete picture of the patient's out-of-pocket costs. Until the insurance process is completed, hospitals don't know how much deductible is yet to be fulfilled by the patient. Additionally, situations that end up needing more complex or different care and treatment than originally anticipated will change the patient's final bill.

No two cases are exactly alike but the following is an example of a simplified billing process a patient might experience after care in the local emergency department. As you can see, even "simplified" is anything but simple.

Ray's Hospital Billing Story

a 50-year-old who experienced severe chest pain and headed to a local Emergency Department with his employer-sponsored insurance coverage.



Healthcare Payers

Healthcare is a unique industry where the consumer (i.e. the patient) does not usually carry all of the financial burden for the services they receive. Insurance and government payers are a significant part of the financial equation. These "third party payers" heavily direct the cost of healthcare as well as acceptable or allowable processes and treatments.

Price Makers & Price Takers

Even though you see the logo of your community hospital on it, the hospital isn't the primary driver that determined what would be on your bill. Hospitals, in economic terms, are mostly price takers – just like you are at the grocery store. When you need eggs, you either buy them at the stated price or not. You don't call over a manager to negotiate a different price. You take the price that is set…or you don't have scrambled eggs for breakfast.

The difference is that a plate of scrambled eggs is a want, but healthcare is a need.

So, who are the key price makers that influence rates and have pricing power?

Pharmaceutical companies ~ With little or no competition for many drugs, pharmaceutical manufacturers are price makers, setting the cost for expensive but necessary infusions, drugs, and other treatments.

Insurers ~ Those that cover our patients – whether it's Medicare, private insurance, or Worker's Compensation – set the prices hospitals and providers are reimbursed.

Workforce ~ Idaho competes regionally and sometimes nationally for key employees like nurses, doctors, specialists, and therapists. Compensation offered by neighboring states directly impacts what we have to pay to keep quality employees, and high demand and lower supply means higher costs.

The impact of these three significant price makers is what drives the bottom line of healthcare costs.

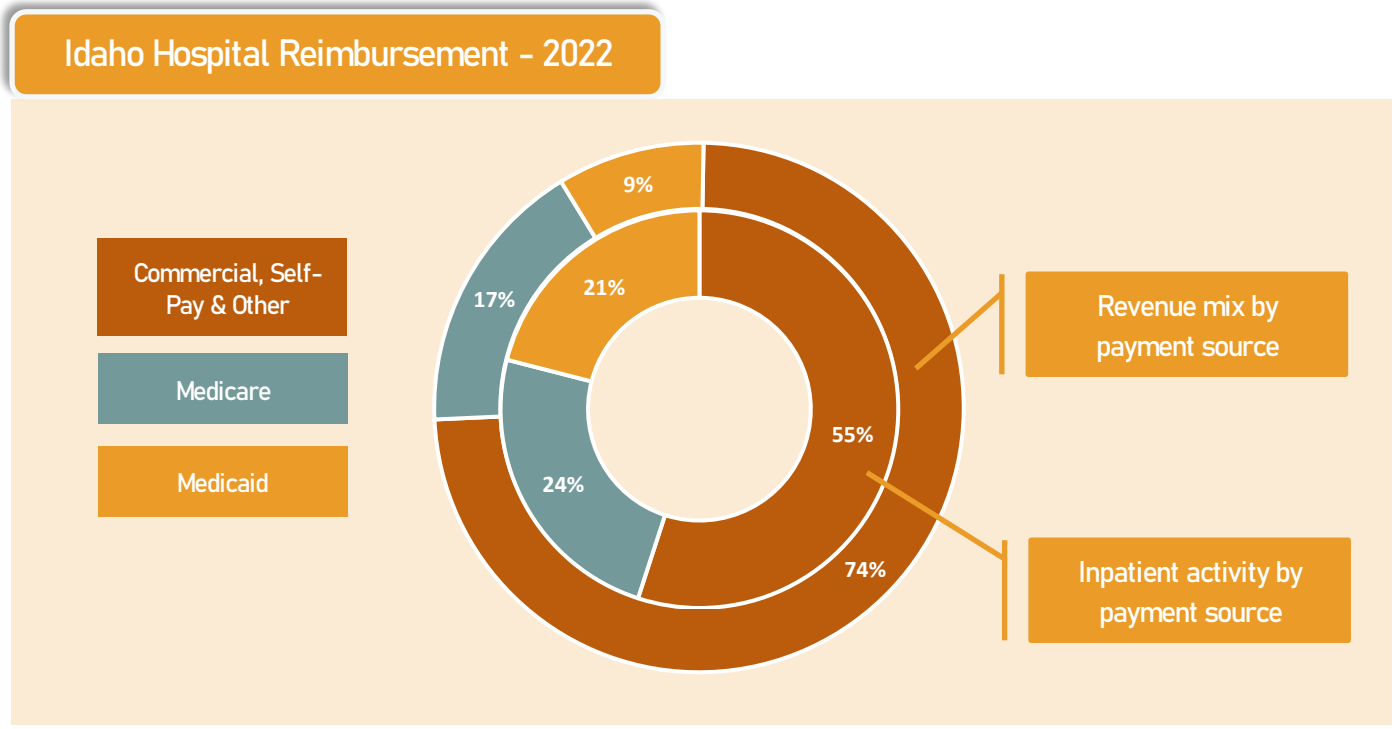
Federal law requires each hospital to charge the same prices to all patients. This list of prices, along with the associated medical codes, is the hospital's chargemaster. While charges are the same regardless of the patient being served, the hospital receives different payment amounts (reimbursement) depending on the payer source. Hospitals negotiate payments for billed charges with some payers and receive predetermined amounts from others. In Idaho, payers fall into three categories:

Private Insurers (commercial, Medicare-advantage (MA), and employer-based) pay rates that are negotiated between the payer and the hospital through contracts, thus creating a network of providers offering health services to patients who are insured by a particular health plan.

Government payers pay the lowest rates which often do not cover the actual cost of the service. Types of government payers include, but are not limited to, Medicare, Medicaid, the U.S. Department of Veterans Affairs, Department of Defense, and state correctional agencies.

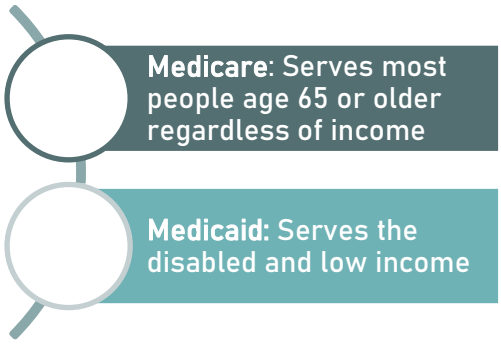
Uninsured or underinsured patients have either no insurance coverage or plans with large deductibles or limited coverage. They can also be considered "self-pay".

The chart below depicts how the largest payers (commercial, Medicare, and Medicaid) impact hospitals reimbursement in Idaho in contrast to the rate their enrollees access inpatient services.



Governmental Payers

For hospitals, or any other provider, to receive payments from Medicare or Medicaid, they must first go through a rigorous certification process and adhere to the Conditions of Participation (CoPs).



Hospitals are also classified into one of three hospital types for payment: Prospective Payment System (PPS), Critical Access Hospital (CAH), or Rural Emergency Hospital (REH). Payments are further classified by service type: inpatient hospitalizations and outpatient procedures, diagnostics, or treatments. Each type of payment has its own reimbursement methodology and those differ between the types of hospital (PPS / CAH / REH).

Like commercial insurance, hospitals and other healthcare providers are paid by Medicare and Medicaid only after services are provided to the beneficiary.

Medicare

Established in 1965, Medicare is available to most people beginning at age 65 and to those with end stage renal (kidney) disease or total disability. Medicare is funded by a combination of contributions made by employers and their employees while the employee is working, premiums paid by Medicare participants, and federal funds. In May 2024, 390,132 Idahoans (or 19% of Idaho's population) were covered by Medicare. This is a six-percent increase from 2022.

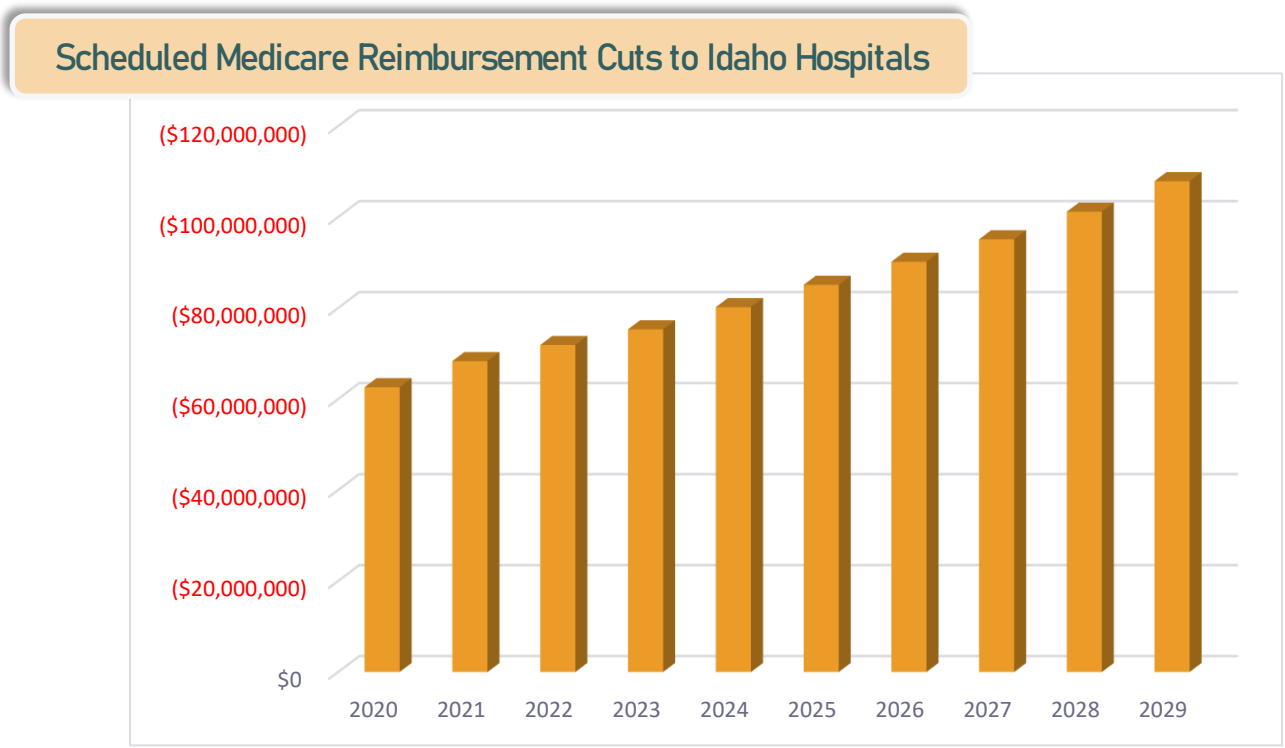
Medicare is made up of:

- Part A, which covers hospital benefits
- Part B, which covers outpatient and physician services
- Part C, an option to receive Part A, B and sometimes D benefits through private insurance plans known as "Medicare Advantage" plans. These plans can include enhanced benefits at additional costs (i.e. vision or lower co-pays)
- Part D, Medicare's prescription drug plan

Medicare is overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS) and is administered through contractors known as Medicare Administrative Contractors (MACs). Idaho's MAC is Noridian Healthcare Solutions.

Medicare payments vary among geographic regions to reflect local wage rates (aka the Wage Index). Idaho hospitals are reimbursed at lower rates than neighboring states like Washington and Oregon. Our state's lower Wage Index negatively impacts hospitals' ability to recruit much needed employees as we are not reimbursed as high as our regional counterparts.

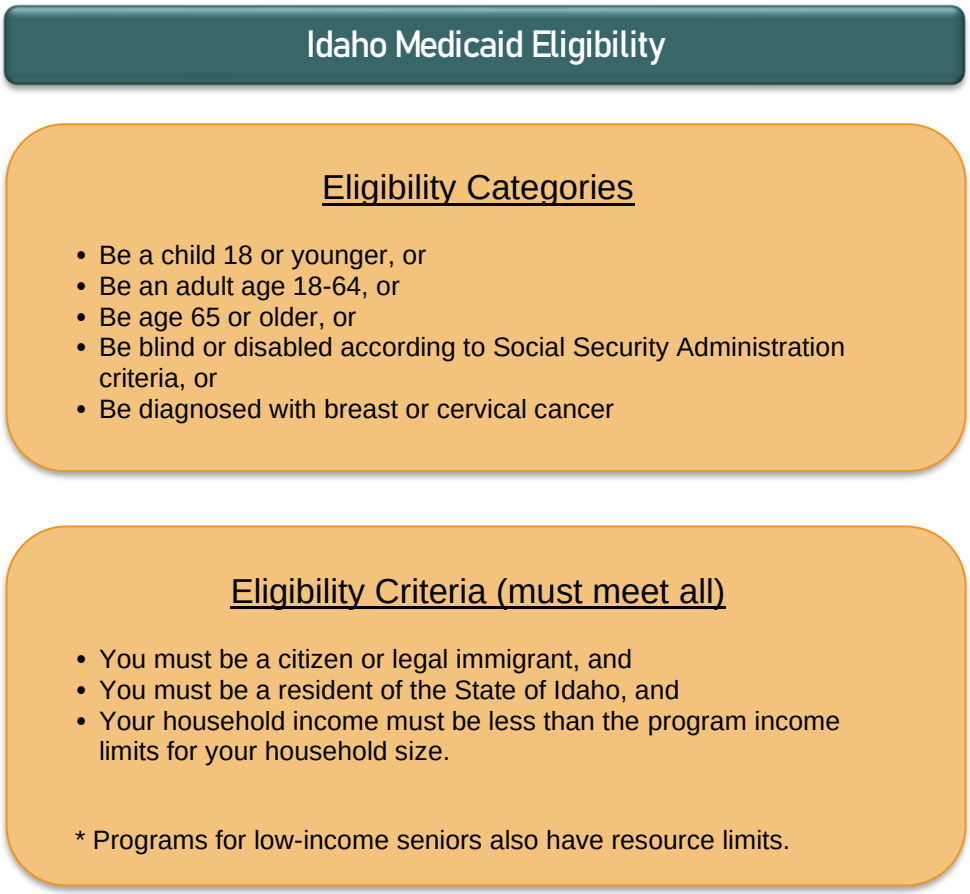
Overall, Medicare pays less than cost to most hospitals and this trend is scheduled to become exacerbated. Since 2010, Idaho hospitals have had Medicare reimbursements cut by over $995 million. An additional $634 million in cuts are scheduled from 2023-2029. Some of these cuts come from the Affordable Care Act and were designed to offset the cost of paying for coverage of the uninsured through Medicaid expansion. These cuts to Idaho hospitals began in 2010 and have happened regardless of Idaho delaying expansion of Medicaid until 2020.



Medicaid ~ Eligibility and Coverage

Established in 1965, Medicaid is available to the lowest-income individuals, pregnant women, and the aged, blind, or disabled. Jointly funded by the federal and state governments, the program is operated by the states and overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS). Idaho's Medicaid program is administered by the Department of Health and Welfare in accordance with a contract between CMS and the State of Idaho known as the State Plan.

Although the federal government sets minimum standards, Idaho, as well as all other states, has some level of flexibility in designing the eligibility and services that can be provided through the Medicaid program. States can elect to cover people at higher income levels and define additional eligible populations. Eligibility for Medicaid is assessed both by category and criteria as can be seen in the following chart.

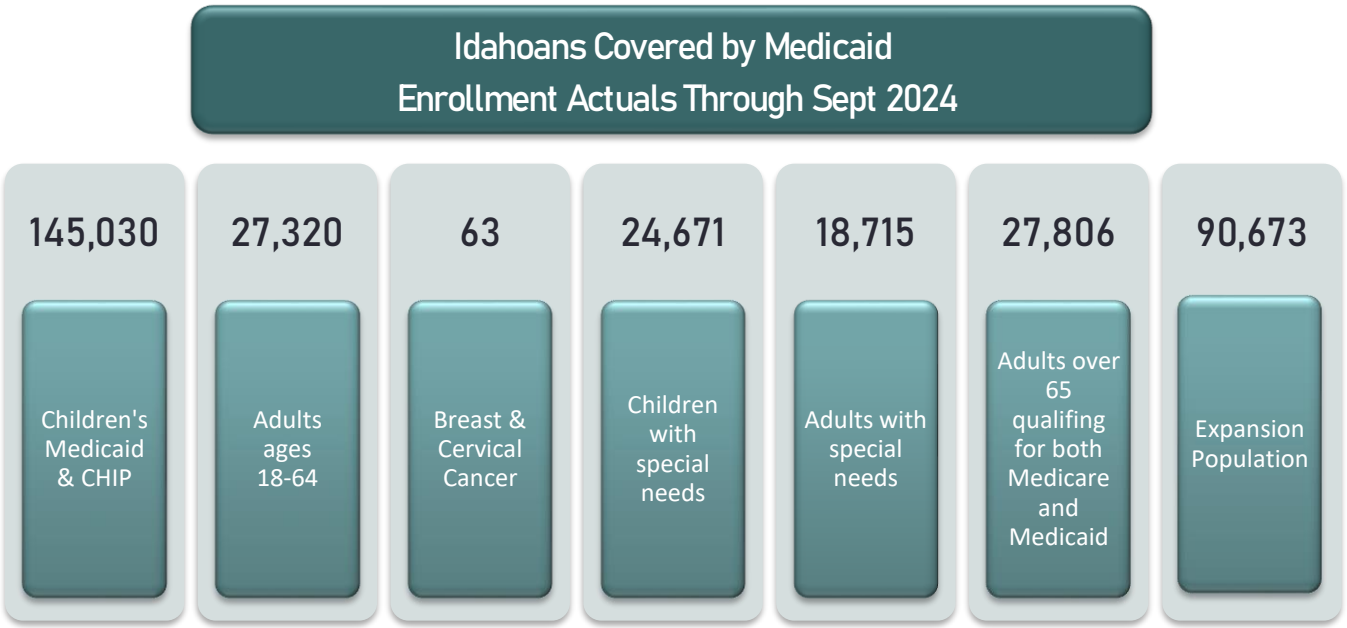


Medicaid programs are available for different populations including children, expectant mothers, adults, and seniors. Each program has its own income criteria based on the size of the household. For low-income seniors who are also on Medicare, sometimes referred to as “Dual Eligibles”, there are also thresholds for their resources. The income limits are a factor of the federal poverty level (FPL).

Medicaid Maximum Monthly Income Limits – Effective Jan. 2024

This chart does not apply to disabled adults or children, women with breast or cervical cancer, or those who are eligible for dual coverage under Medicare and Medicaid

Household size	Monthly Income for Coverage of Child Under 19	Pregnant ~ Monthly Income for Adult Coverage *(unborn child counts as part of household)*	Adult
1			$1,732
2	$3,237	$2,351	$2,351
3	$4,089	$2,970	$2,970
4	$4,940	$3,588	$3,588
5	$5,792	$4,207	$4,207
Each additional	+ $852	+ $619	+ $619



Data provided by Idaho Department of Health and Welfare

Medicaid Funding

Idaho's Medicaid administration is highly efficient, with nearly 97 cents of every dollar being spent to provide healthcare services. Even with that efficiency, providers are not reimbursed for the actual cost of providing the care.

Federal law dictates that Medicaid cannot pay more than what Medicare would have paid for the same service. Where Medicare has fee schedules, for example outpatient radiology and lab services, the fee schedule has been deemed by CMS to be the "allowable cost" for Medicaid reimbursement. However, those fee schedule rates are often lower than the hospitals' actual costs. Overall, when you factor in all Medicaid payments as well as supplemental payments, hospitals report receiving between 90% – 93% of the cost to provide care.

Idaho Medicaid currently pays under a cost-based, fee-for-service design; however, under legislative direction, the Department of Health and Welfare is working with providers to move toward a value-based reimbursement system. The foundations for this evolution are the State Health Innovation Plan (SHIP) and the development of Patient-Centered Medical Homes (PCMH) across the state.

Medicaid is jointly funded by the federal and state governments. In the existing Medicaid program, the federal government provides about two-thirds of the funding while Idaho pays the remaining portion. For the expanded Medicaid program, Congress has statutorily set the split at 90% federal funds and 10% state funds.

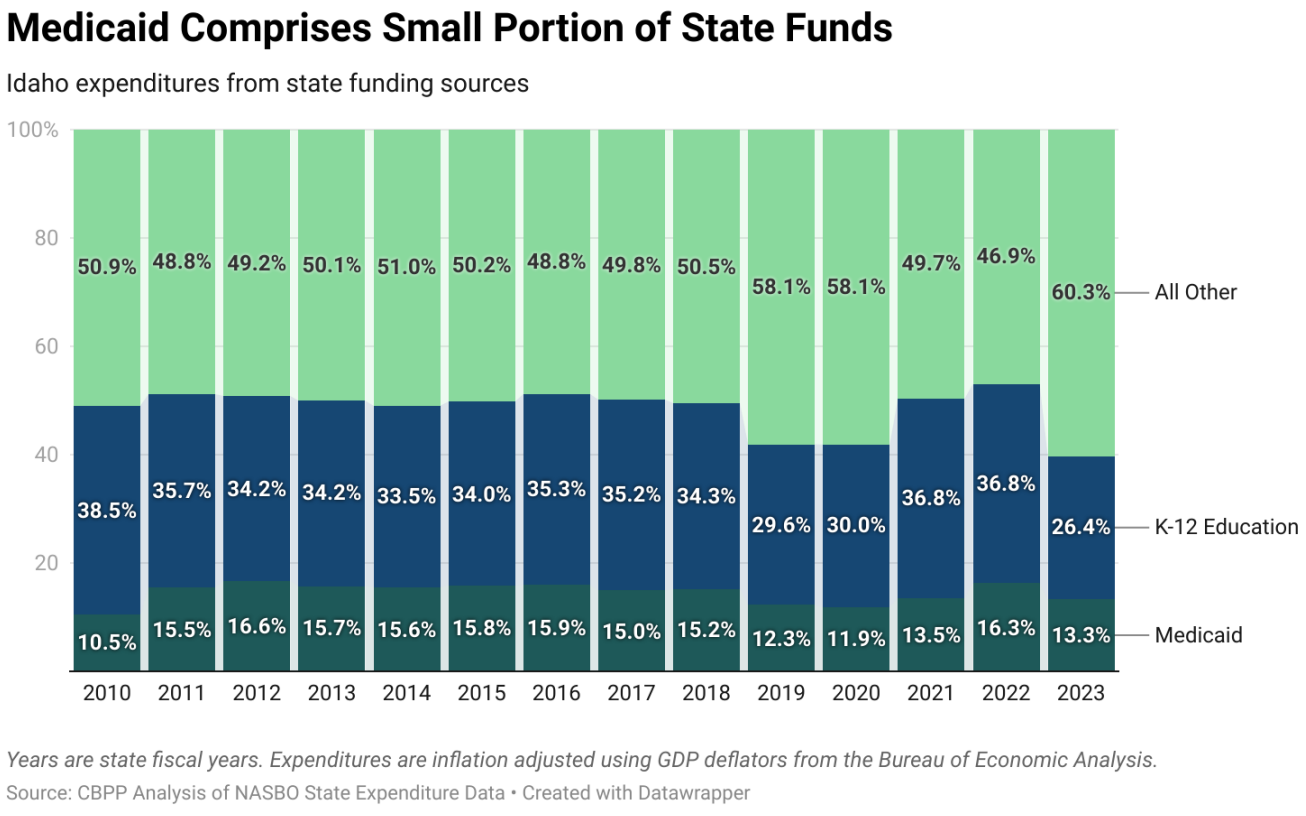
Although the Medicaid expansion program exceeded its projected costs in the first year, it was still a windfall to the state and local communities, contributing heavily to an almost two-billion-dollar surplus. In addition to savings to local and state government programs, Medicaid expansion allowed for budget reductions for the Department of Correction, Division of Behavioral Health, State Catastrophic Fund and a shift for Public Health costs to counties that no longer had to pay for County Indigent Programs. Medicaid expansion generated additional economic activity throughout the state and put money back into the state and local coffers, supporting tax rebates and record investments in schools, infrastructure, and workforce development. While Medicaid expansion enrollment fluctuates monthly, providing healthcare coverage for 81,553 Idahoans (November 2024) allowed many of those enrollees to stay in the workforce.

Federal Share – The federal share (often referred to as the match) is called the Federal Medical Assistance Percentage (FMAP) and the exact amount is determined annually by the Centers for Medicare and Medicaid Services (CMS) based on each state's per capita income; the lower the per-capita income, the higher the FMAP. Simply stated –

the more Idahoans earn, the more responsibility we have for the cost of Medicaid. As one of the states with the largest growth in per capita income, federal participation in Idaho's traditional FMAP has decreased to 66.91% (IDHW projection) for Federal Fiscal Year 2025.

Some Medicaid programs, such as the Children's Health Insurance Program (CHIP), Tribal Healthcare, as well as Idaho's expanded Medicaid program have enhanced match rates that are statutorily set by Congress. The Medicaid expansion program is set at a 90/10 match rate regardless of economic indicators. That rate cannot change without a specific act of Congress.

State Share – The state share for Medicaid is funded through the Idaho Legislature's annual appropriation process. Even with the addition of Medicaid expansion, the percentage of the entire state general fund allocated for Medicaid costs has stayed relatively stable, averaging less than 15% of the total general fund budget since 2010.



Years are state fiscal years. Expenditures are inflation adjusted using GDP deflators from the Bureau of Economic Analysis.

Source: CBPP Analysis of NASBO State Expenditure Data • Created with Datawrapper

Supplemental Payments

Because hospitals do not receive sufficient payment to cover the costs of serving Medicaid, Medicare, and uninsured patients, some hospitals are eligible for special supplemental payments through the Medicaid Disproportionate Share Hospital Program (DSH), Medicare DSH Program, or Medicaid Upper Payment Limit Program (UPL). The Disproportionate Share Hospital (DSH) program is a state Medicaid payment program that allocates an annual federal DSH allotment. The Medicaid DSH Program provides hospitals financial assistance toward the cost of care for the uninsured and any remaining uncompensated Medicaid costs (after UPL payments are considered).

Medicaid DSH and Upper Payment Limit (UPL) Hospital Programs

Generally, to qualify for a DSH payment in Idaho, a hospital must meet the federal criteria of having at least a one-percent Medicaid utilization rate and have an ongoing capability to do non-emergent delivery of newborns. Once eligible for DSH, the amount of DSH funds paid to a hospital depends on the burden of uncompensated Medicaid and uninsured care relative to other eligible hospitals. It is also dependent on the amount of federal funding made available to the state in the annual DSH allotment. In 2022, the federal DSH allotment for Idaho was $7.9 million (down from $21.2 million in 2021). The reason for the significant decline was the change in Medicaid reimbursement methodology which caused the UPL to increase and the available DSH allotment to decrease. Idaho is categorized as a "low DSH state" as the state's Medicaid DSH payments account for less than 1% of all Medicaid spending. State Medicaid DSH payments that are above the 3% threshold are considered "high DSH states". In some of these states, DSH payments can account for nearly 17% of total Medicaid spending.

Certain hospitals qualify for supplemental payments to help subsidize regular Medicaid payments that are less than the federally regulated UPL (Upper Payment Limit). These payments are calculated and paid at the end of the year and are in addition to regular Medicaid payments. The UPL is a federally required calculation that the state Medicaid program must present to CMS annually. Federal regulation requires that Medicaid cannot pay hospitals more than Medicare would have paid, had Medicare been responsible to pay for hospital services. Once the state proves to CMS' satisfaction that Medicaid paid out less than the federal UPL ceiling, the state is allowed to disperse federal supplemental payments to providers to reach that UPL ceiling through an approved payment methodology.

The state must provide matching funds for both the annual federal DSH allotment and UPL payments. The state's share is based on the state's FMAP rate. In Idaho, hospitals provide the state matching funds via hospital provider assessments on private hospitals or intergovernmental fund transfers from non-state government-owned facilities. By calculating the DSH payments after the UPL distributions have occurred, the state Medicaid program ensures that there is no "double dipping" from these two supplemental payment programs.

It is important to note that despite these supplemental payments, hospitals still are not paid adequately to provide care to the Medicare and Medicaid populations. Further, DSH funding has been cut significantly beginning in 2021 as part of the Affordable Care Act. Moreover, with the CMS approval of Idaho's application to adjust the payment methodology for the Upper Payment Limit, it is likely the DSH payments will disappear altogether.

2022 Hospital Tax Increase

In the 2022 Session, the Idaho Legislature amended the Hospital Assessment Statute to allow for a new calculation methodology that would increase the Federal supplemental payment to hospitals that helps offset losses incurred from lower state Medicaid reimbursement rates. The new methodology was approved by CMS in December 2022. This amendment allows the state to tax hospitals up to 30% of that total payment to offset other non-hospital Medicaid expenses, including home and community-based services (HCBS) to allow developmentally disabled adults to stay in their homes and communities. However, the state match required to draw down this federal payment is still provided by hospitals themselves, not the General Fund.

Workers' Compensation

In Idaho, state law requires that any employer with three or more regular employees have workers' compensation coverage for disability, rehabilitation and medical care for a worker that is injured on the job. Idaho law allows employers to require injured employees with a non-emergent condition to obtain treatment from designated providers as long as the employer has followed state law regarding notice of the providers. Insurance companies authorized to write workers' compensation insurance in Idaho are required to abide by the rates set by the National Council on Compensation Insurance (NCCI).

While Workers' Compensation is highly regulated by state law, the coverage for disability, rehabilitation and medical services is typically provided by property and casualty insurance companies or self-insured employers. Coverage of an injured worker's care may be contingent on both the employee and the employer following the rules promulgated by the Idaho Industrial Commission which publishes a fee schedule that sets the rates for hospital and physician payments. Inpatient payments depend on the patient's diagnosis and treatment, much like Medicare rates.

Private Health Insurance Coverage

Health insurance plans are regulated by both state and federal law. The 2010 Patient Protection and Affordable Care Act (ACA) made sweeping changes to the health insurance industry and imposed a number of requirements intended to control cost and expand the availability and quality of health insurance to consumers.

Regardless of the ACA, an insurance company in the United States must be licensed by the state in which it issues coverage. It is possible for an insurer to issue coverage in one state that covers members that live in another. The Idaho Department of Insurance is responsible for licensing companies to transact business in Idaho and for ensuring that those companies remain solvent and comply with all the requirements of Idaho laws and regulations. Currently, eight companies are authorized by the Idaho Department of Insurance to offer individual market health benefit products in Idaho.

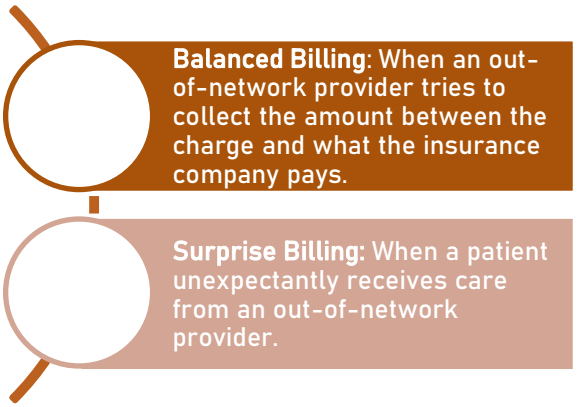
The majority of health insurance offered in the United States today is considered "managed care." The term managed care generally means a system for financing and, sometimes delivery, of healthcare that is intended to control cost, utilization and quality of care. For plans licensed in Idaho, there are a number of state regulations that address the way they can do business, including the time within which the plan must pay claims, late payment interest and rules related to authorizations for services and appeals. There are many types of managed care plans although the distinction between types has become more and more blurred over the past few years. All tend to share common characteristics to varying degrees, including:

- Networks of contracted providers that agree to accept reduced rates for services in exchange for an expected higher volume of patients or the ability to have coverage for patients in some plans.
- Requirements for prior authorization of many services.
- Tiered cost share amounts for prescription drugs.
- Scrutiny of medical necessity of care.
- Payment policies that may dictate the setting or other prerequisites for coverage of some services.
- Variability in the patient's share of cost for healthcare services, such as:
    - Is the provider in the plan's network? Some plans may have no benefits for providers not in the network. When covered, cost share amounts are typically higher for lower tier or out-of-network providers.
    - What type of service is being provided? Regardless of network participation, state and federal law require that emergency care be covered. The ACA requires that specified preventive care be covered in full when provided by in-network providers.

In recent years, the trend has been toward significantly increasing patient cost share amounts for both in- and out-of-network care to the point that the financial responsibility has become unaffordable for many patients and contributes to higher hospital bad debt.

For providers in a network, the patient can be billed only for the patient's cost share amount (copayments, coinsurance and deductibles) and for services not covered by the plan, regardless of the "allowed amount" determined by the insurer (which should be consistent with the provider's contract rate). The provider is often required to obtain the patient's consent prior to rendering non-covered services in order to bill for them.

When a provider is not in the plan's network, of course, there is no contract to dictate the amount that the plan must pay or the amount that can be billed to the patient. Many insurers will set the allowed amount at what they consider to be a "reasonable" fee for the service(s) received when making payment. This will leave the patient with a greater liability to the provider than if an in-network provider was used. Additionally, the plan can, and often does, assess significantly higher deductibles and co-insurance amounts when out-of-network providers are used.



However, federal law prohibits the increasing of co-insurance and deductible amounts when accessing emergency services in out-of-network hospitals.

"Balanced billing" occurs when an out-of-network provider bills the patient for the amount between the charge and the insurer's allowed rate.

On Dec. 27, 2020, the No Surprises Act was signed into federal law, addressing surprise medical billing. In part, this law, much of which went into effect on January 1, 2022:

- Protects patients from receiving surprise medical bills resulting from gaps in coverage for emergency services and certain services provided by out-of-network clinicians at in-network facilities, including by air ambulances.
- Holds patients liable only for their in-network cost-sharing amount, while giving providers and insurers an opportunity to negotiate reimbursement.
- Allows providers and insurers to access an independent dispute resolution process in the event disputes arise around reimbursement. The legislation does not set a benchmark reimbursement amount.
- Requires both providers and health plans to assist patients in accessing healthcare cost information.

In addition to the federal No Surprises Act, Idaho passed the Idaho Patient Care Act creating mandates for hospitals and healthcare providers regarding the patient billing process and medical debt collections.

Types of Plans

The major differences between the most common types of plans are:

Preferred Provider Organization (PPO) plans do not require separate licenses in most states although the insurers that use PPOs for their benefit plans must meet licensure requirements. Typically plan rules are not as stringent for PPOs as for HMO plans and out-of-network care is usually, but not always, covered.

Health Maintenance Organizations (HMO) are separately licensed and generally have higher financial reserve requirements than other plans. HMOs often have closed provider networks which means that, except for emergency care, services are covered only when rendered by providers within the HMO network. HMOs may also require that a covered person have a primary care provider coordinate their care.

High Deductible Health Plans (HDP or HDHP) combine a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) with medical coverage that has higher deductibles than traditional insurance plans. The HSA or HRA may be funded by either employer or employee contributions or both and are designed to encourage patients to be better consumers of care.

Medicare Advantage Plans (MA) are plans offered by private insurance companies that follow Medicare rules.

Your Health Idaho - Health Insurance Exchange

As a requirement of the ACA, most U.S. citizens and legal residents were required to have health insurance beginning in 2014, although there is no longer a financial penalty for individuals who do not carry insurance. In Idaho, residents can purchase insurance coverage through the state-operated insurance exchange, Your Health Idaho. Individuals or families with incomes between 139% and 400% of the federal poverty level who purchase coverage through Your Health Idaho are eligible for tax credits, which will help offset their premium costs.

In 2023, 99,000 Idahoans enrolled in coverage through Your Health Idaho. For 2023, Your Health Idaho consumers had access to 141 medical and 21 dental plans offered by twelve different insurance carriers. Although not all insurers offer their products in all counties, every Idaho county had at least three insurers offering plans through the exchange. All plans are offered by insurance companies licensed in Idaho. All plans are required to offer the same set of essential health benefits but may have different networks of

providers. Plans are classified into five categories: Platinum, Gold, Silver, Bronze, and Catastrophic. Plan designs differ by the premium and the percentage of healthcare costs paid by the consumer.

Self-Insured Employee Benefit (ERISA plans)

In the United States, about two-thirds of the people who are not covered by government programs obtain their healthcare coverage through an employer. Employers that offer health benefits may either purchase insurance from a licensed insurer or set up their own plans in accordance with state and federal law. The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry. The motivation behind ERISA is to provide uniform oversight under a set of national standards for employee benefits. Prior to the passage of ERISA, self-insured employee benefit plans were governed by state insurance laws. Employers complained of the high administrative costs associated with maintaining plans that were subject to the laws of multiple states.

To make the regulation of these plans consistent throughout the country, ERISA preempts state laws that "relate to" employee benefit plans. Whether a law "relates to" an employee benefit has been a frequent subject in federal court. ERISA does not cover benefit plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable worker's compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

Under self-insured employee benefit plans, the employer or employer organization funds the plan but may have a Third-Party Administrator (TPA) or an insurer provide the provider network, care management services and claims processing. For an insurer, this is referred to as "Administrative Services Only" or ASO business. This can be confusing to hospitals because it is difficult to tell whether a patient is covered by a fully insured or an employer-funded ERISA plan. The reason this is important is that state law and the plan's rules, including payment policies, may vary significantly between the different types of plans.

Hospital Economic Impact

Clearly, a hospital's primary role is to improve and sustain the health and well-being of the communities they serve. Hospitals are there to provide the care you or a family member might need; are instrumental in emergencies; and, are a community health resource. They address and meet needs many don't even know about until they are faced with an accident or illness.

There is another benefit healthy hospitals bring to their communities. Throughout Idaho, hospitals are economic drivers providing good jobs in a sector with evolving opportunities across several career paths.

In 2023, your community hospitals employed:

34,957 people

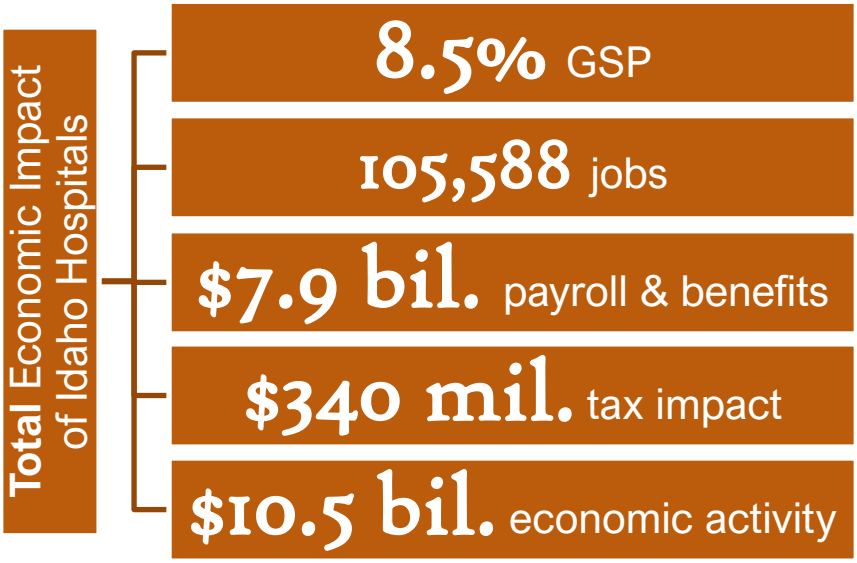
Those employees received combined payroll and benefits worth:

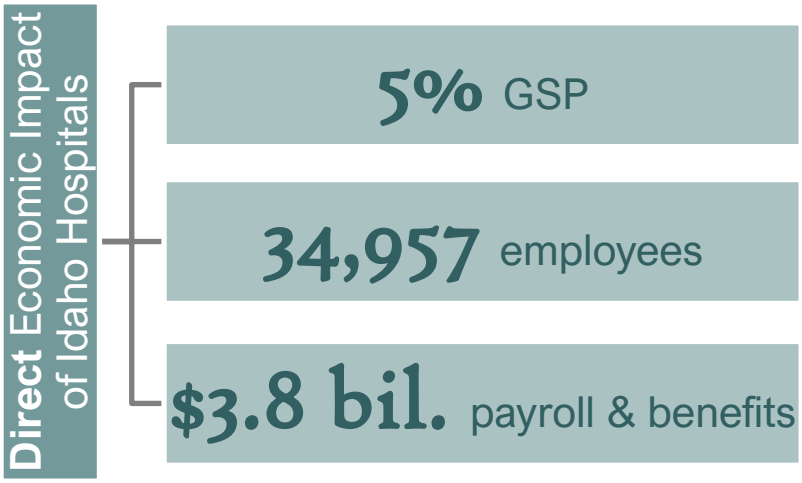
$3.8 billion

Hospitals are a major economic engine for Idaho and considered key to the state's efforts to recruit and retain new and expanding businesses. The impact hospitals have doesn't end with good jobs. Industries and organizations often look at the overall economic impact they have locally or regionally. The impact model measures their ability to draw in new dollars to the defined economy (in this case Idaho's state economy) as well as the impact of dollars spent within the region. In 2023, Idaho's hospitals accounted for about 8.5% of Idaho's Gross State Product (GSP) when the economic impacts are measured.

Like all other businesses, Idaho's hospitals spend money to operate. Measuring these dollars is considered a "direct effect". The dollars also have downstream impacts throughout the economy on services, sales, payrolls, jobs, and taxes – the indirect and induced effects. When economists measure the total impact a given industry or business has on the local economy, they use the data to create a multiplier which measures the impact by taking into account the direct, indirect and induced effects. These multipliers are unique to the industry and to the local economy.

Considering the multiplier effect**, hospitals generated over $10.5 billion in economic activity**. Every $1 of hospital expenditures resulted in $1.81 of economic activity (or impact). That activity leads to the support of jobs outside of the hospitals, impacts on state and local taxes, and the purchase of local goods and services.





Property Taxes

Hospitals pay property tax, even non-profit hospitals. Property not being used for hospital services is not automatically exempt from property taxes. There is a misconception that once a hospital employs a physician or purchases a medical practice, their office space comes off the tax rolls. In the majority of cases, ownership of the property remains the same and the hospital simply leases that space. Thus, property taxes are still paid on the property. Exemptions are applied for annually and approved or rejected by the county assessor.

Community Benefit

Because health is about more than the treatment of sickness or disease, hospitals reach out to their communities with programs and services that address community health needs and preventative care. Hospitals look at both short-term and long-term health improvement, supporting healthy living, access and coverage, and quality of life. Health screenings, clinical services, support groups, research, education, subsidized health services, in-kind contributions, and the provision of charity care are just a few instances of how hospitals go above and beyond their mission to improve the health of their communities.

Idaho hospitals put millions of dollars into healthcare education, underwriting opportunities for prospective doctors, nurses, medical technicians and clinicians to attend school and hopefully work in their communities after graduation. This support has been critical to address both the healthcare workforce shortage as well as the needs of a rapidly growing and aging population.

In 2022, Idaho hospitals cumulatively provided over **$78 million in charity care** (an 18% increase over 2021). This is calculated based on the actual cost to provide that care and is provided to patients who typically do not have insurance, are underinsured (have high-deductible plans) or meet other hospital charity care policies. In these cases, the hospital covers all or part of the patient's bill.

It's important to understand that charity care, as defined by federal guidelines, is usually requested or applied for early in the healthcare process. Patients and hospital staff discuss the situation and complete the needed documentation to qualify for the hospital's charity care program.

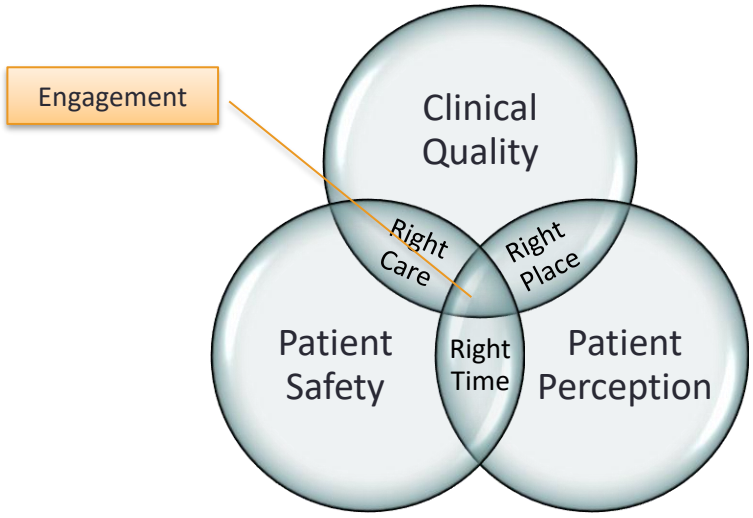
Remember that a hospital cannot, under federal law, refuse to treat a patient who arrives at the emergency department. All patients must be given care, regardless of their ability to pay. Unfortunately, the Emergency Department is very often the place that sees patients who do not have insurance or financial resources, and with a medical problem that could have been treated early or prevented that has created an urgent situation. Emergency Departments, while a great community asset and good stewards of their resources, are often the most expensive place to receive treatment.

If the hospital is not informed or made aware of a patient's financial situation and care is provided, the hospital will send the bill with the expectation of being paid. If the bill is not paid after efforts to collect payment, which may include the hospital working to qualify

the patient for coverage under state or federal programs (which can be hindered if the patient refused to provide necessary information) or arranging a payment plan, then the hospital writes off the remaining cost of the care to “bad debt”. These monies are reported separately from charity care; however, they do have a substantial impact on a hospital’s financial well-being. In 2022, hospitals wrote off over **$203 million in bad debt** (a 6% increase over 2021). As with charity care, this is based on the actual cost to provide care.

Quality & Patient Safety

Idaho's hospitals prioritize quality and patient safety, focusing on clinical quality, patient perception, and patient safety to ensure patients receive the right care at the right time. Quality in a hospital can be broken down into three areas:



Clinical Quality applies to the actual medical care that a patient receives. Core measures, founded on evidence-based medicine, are one way to quantify this type of quality. Core measures assess the process of the care a patient receives based on a disease-specific category. For example, did a patient presenting at the emergency department with heart attack-like pain receive an aspirin upon arrival? Clinical quality also considers outcome measures such as length of stay, infection, and/or mortality.

Patient Safety is the work that keeps patients safe from harm. Hospitals must monitor and track events such as medication errors, infections, and injuries in order to continually make environments safe for patients and families. Staff are also surveyed as to their perception of patient safety in order to find gaps and improve overall patient safety.

Finally, there is **Patient Perception**. Patient perception plays a crucial role in hospital quality by measuring how patients perceive their care during their hospital stay. This is assessed through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which includes 27 questions about the hospital experience, such as communication with doctors and nurses, staff responsiveness, hospital cleanliness, pain management, and discharge planning. The feedback from this survey helps hospitals identify areas for improvement and enhance overall patient satisfaction.

Patient and Family Engagement, is the value created through patient and family interaction. Engaging patients and their families in care decisions and education is crucial for improving health outcomes and patient satisfaction.

By changing our healthcare system to focus on providing the right care at the right time in the right setting rather than fragmented, episodic treatment, not only do patients benefit but we begin to weed out some of the barriers to health and wellness by making high-quality, efficient care the standard for Idaho's healthcare delivery system. By having all parts of the system work together – including primary care providers, insurers, and hospitals as well as specialists, government payers and affiliated caregivers – Idahoans will be able to attain better health through better healthcare outcomes.

Collectively, Idaho's hospitals have and are engaged in numerous quality and patient safety initiatives through multiple entities to capture and utilize data that drive change and improve patient care. A handful of these initiatives include:

HQIC Focus:

- Behavioral Health
- Opioid Misuse
- Patient Safety
- Care Transitions
- Pandemic

Hospital Quality Improvement Contractor (HQIC) –is a national CMS patient safety initiative to align, accelerate, and amplify ambitious goals of reducing all causes of inpatient harm. In Idaho, from 2013-2024, 23 rural and critical access hospitals participated in this IHA-coordinated program. CMS is set to continue this program with a new (13th) scope of work in 2025.

FLEX Medicare Beneficiary Quality Improvement Project (MBQIP) – is a federally-funded initiative working to ensure CAH's are prepared to meet future quality requirements and demonstrating value through providing cost-efficient quality care.

Quality Improvement Organization (QIO) - The QIO Program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, is an integral part of the Department of Health and Human Services' National Quality Strategy for providing better care and better health at lower cost. Idaho's QIO is Comagine Health.

Improving the health of Idahoans – while addressing issues of quality, healthcare access and cost – relies heavily on incorporating proven practices, engaging patients in their healthcare, and partnering with other providers and payers to assure the best possible outcomes.

Hospital Accreditation

Idaho's hospitals maintain quality and safety through accreditation from the Centers for Medicare and Medicaid Services (CMS). All hospitals must adhere to CMS Conditions of Participation (CoP) and Conditions for Coverage (CfC) in order to participate in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoP / CfC.

In addition to the federal accreditation, hospitals may also voluntarily apply to be certified by outside organizations. The most common accrediting agencies used by Idaho hospitals are the Joint Commission and DNV/NIAHO.

Joint Commission is an independent, not-for-profit organization that accredits and certifies over 20,000 US healthcare organizations and programs. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality. In Idaho, 23 community hospitals currently have Joint Commission accreditation.

DNV/NIAHO accreditation is a multi-year process that focuses on quality and patient safety through a more efficient and outcomes-based accreditation program. The program integrates CMS Conditions of Participation (COPs) with the ISO 9001 Quality Management Program. Currently, 15 hospitals have DNV/NIAHO accreditation.

Credentialing and Privileging

Credentialing is the basis for appointing healthcare professionals to the medical staff of a hospital or other healthcare organization. Medical staff may or may not be directly employed by the hospital. The process of credentialing is used by hospitals to ensure the qualifications of a licensed physician or other healthcare provider. Credentialing requires an evaluation of the provider's education, training, experience, competence and judgment, as well as his or her scope of practice.

Additionally, credentialing requires a review through a primary source verification (e.g. the Office of the Inspector General (OIG) exclusion list, National Provider Data Bank

Report, criminal history report, current license and DEA certificate, state licenses, sanctions or disciplinary action, and specialty board status). Once a credentialed staff member is granted clinical privileges by the Board of Trustees, they are permitted to perform certain clinical duties within the organization as defined by the institution's medical staff.

Credentialing is also performed by health plans before facilities and providers are accepted into a plan's provider network. Many hospitals and health systems that have a large number of employed providers and their Physician Hospital Organizations (PHOs) prefer to have "Delegated Credentialing" contracts with the plans in which they participate in order to simplify the process of adding providers to a plan's network. Delegated credentialing usually requires that the hospital, health system or PHO contractually agree to perform the components described above for hospital credentialing as well as other activities required by the National Committee for Quality Assurance (NCQA) and the plan.

Hospital Workforce

Idaho's hospitals are home to hundreds of different careers and continue to lead local and statewide economic growth through well-compensated jobs. From medical practitioners and nurses to technology, training, data analytics, finance, and patient and family relations, there are opportunities for Idahoans to obtain careers that can support them while offering opportunities for advancement and long-term career development.

Idaho's Department of Labor expects the demand for healthcare employees will continue growing. Current Department of Labor research shows a demand for 12,000 new healthcare practitioners and support personnel by 2026. With Idaho's growth leading the nation, and with an aging population, that demand will be even higher. While this provides substantial career opportunities for Idahoans, hospitals (and the healthcare field) also continue to experience intense shortages. Many of these shortages are not unique to Idaho and leave hospitals competing regionally and nationally for qualified employees.

Forecasts by state and national economists indicate these shortages will continue to plague Idaho and the rest of the country. Growing and filling the education pipeline must be a high priority to ensure Idahoans have access to quality healthcare close to home. Knowing the importance of workforce development, Idaho's hospitals invest millions into medical technical education, nursing education and medical residency programs.

In most communities, the hospital is one of the larger employers. This is even more common in smaller and rural communities where hospitals fill a majority of the local healthcare needs. Hospitals may operate clinics, hire primary care physicians, or bring in specialists from larger communities to make healthcare readily and locally available.

Physicians

In Idaho, physician employment by hospitals – including primary care, specialists, hospitalists and others – has become an important aspect in providing local healthcare for several reasons:

Improves access to care – Imagine being diagnosed with cancer or another ailment with the need for repeated and intense treatment. In many Idaho communities, this could mean an hours-long drive to a larger urban hospital. Instead, Idaho hospitals work to bring practitioners to the community where they are equipped to provide the care needed.

Improves alignment with quality initiatives and patient safety – As part of the hospital staff, physicians lead the work defining quality metrics, best practices, and the best paths to reaching high quality and safe hospital care.

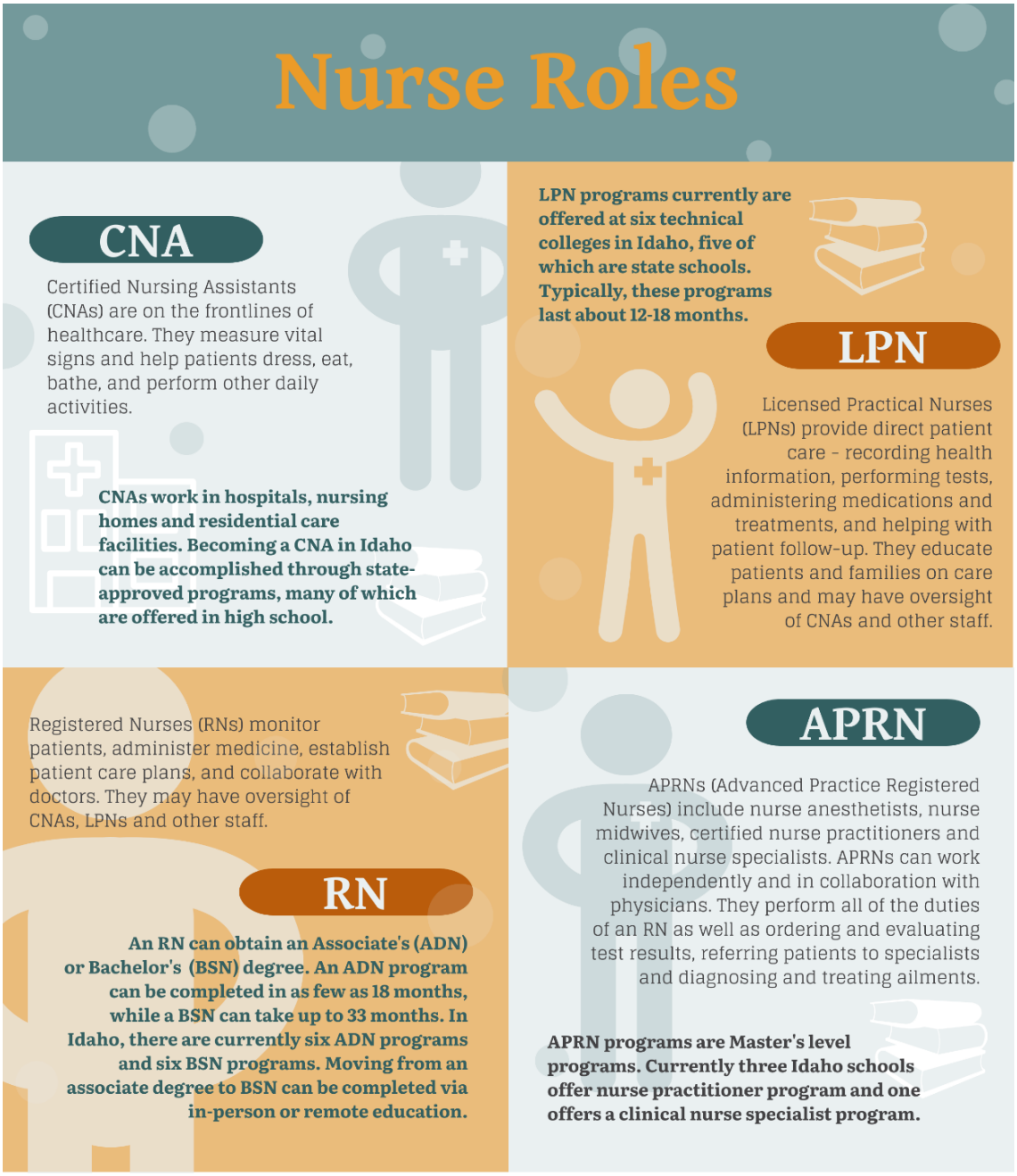
Improves quality of life – For many, being able to access care in their local community keeps patients close to their support structure. By having physicians as part of the staff, hospitals are able to offer a wider range of services locally.

The hospital-employed model isn't the only way a doctor can work with local hospitals nor is it the only solution for doctors. Many doctors elect to be part of small practices, groups within a specific medical scope, own their own businesses, or embrace other arrangements. For some, being part of the hospital staff fulfills their individual situation. For newly graduated doctors, there can be incentives to help pay the significant debt following medical school. For others, their preferences may be in working more closely with patients and worrying less about the operational aspects of running a practice.

Idaho needs to continue to be open to options that welcome and retain doctors. This is particularly important when it comes to primary care which includes general practice, family practice, obstetrics and gynecology, pediatric, geriatric and internal medicine doctors. For primary care physicians per capita, Idaho ranks last in the country. Currently, Idaho has about 95 primary care doctors per 100,000 Idahoans (the lowest per capita rate in the nation). To exacerbate the situation, the need for these jobs is expected to increase nearly 10% over the next ten years. The projection takes into account both new people moving into Idaho and an aging physician workforce.

With the growing physician shortage, physician assistants and nurse practitioners have become instrumental in providing primary and preventive care. Physician assistants diagnose illness, develop and managed treatment plans, prescribe medications and can serve as the patient's principal provider. The demand for these practitioners is anticipated to grow nearly 33% by 2026.

Nurses



Nurses are a critical part of Idaho's healthcare network. Nurses can assume many different responsibilities and serve in numerous places including hospitals, physician offices, independent practices, home health services, and long-term care facilities.

Idaho's hospitals continue to face issues that arise from a nationwide nursing shortage. As has been the case for years, a registered nurse continues to be among the hardest

positions for Idaho hospitals and other providers to fill. At any recent point in time, there are over 1,400 openings in Idaho for registered nurses. But that is not the only nursing shortage area:

Licensed Practical Nurses are experiencing an evolving scope of practice. LPNs ranked as the 24th hardest job to fill in a statewide analysis. As the healthcare system adapts to address more patient needs outside the hospital, there is an increased need for LPNs to assist with care integration and other duties. The need for LPNs is expected to grow 13.5% between 2016 and 2026.

The need for CNAs (certified nursing assistants) is expected to grow 21.7% by 2026 in Idaho. These individuals provide hands on care to patients under the direction of LPNs or registered nurses.

Advanced Practice Nurses have advanced training in diagnosing and treating illness. The need for nurse practitioners is expected to grow 35% by 2026.

The COVID pandemic exacerbated the nursing shortage, which saw many in the nursing profession choose to retire early or leave their careers altogether. That fueled a workforce shortage, but also a loss of institutional and technical knowledge that will take time to replace. When those nursing positions were backfilled by traveling nurses, the greatly inflated expense rapidly ate away at hospital personnel budgets, and the number of staffed beds that could remain open. The following is the latest Idaho Department of Labor information on statewide healthcare workforce shortages.

Hot Healthcare Jobs in Idaho - November 2024

Occupation	Open Postings	Annual Growth Rate	Hourly Wage
Registered Nurses	1306	4%	38.53
Nurse Practitioner	234	3%	58.97
Physician Assistants	38	7%	58.99
Pharmacists	145	2%	64.22
Physical Therapists	114	3%	44.76
Respiratory Therapists	42	4%	33.37
Health Care Social Workers	33	-6%	32.43
Diagnostic Medical Sonographers	23	11%	43.57
Radiologic Technologists	65	5%	34.20

Hospital Leadership

Idaho's hospital CEOs are responsible for ensuring the mission of a hospital is achieved. Activities that support the delivery of quality care to patients include day-to-day operations as well as long-term strategic planning. CEOs must also cultivate and maintain good relationships with physicians, primary care clinics, rehabilitation facilities, other hospitals, nursing homes, home health agencies and other healthcare providers that provide the continuum of care needed by patients in the community. In addition, they must manage a large, complex and specialized workforce that constitutes one of the community's largest employers.

CEOs are accountable, not only for the quality of care provided to the patients, but also to the community by working to assure the financial well-being of the hospital so it can continue to support the healthcare and economic needs of the community. CEOs are also responsible for ensuring their hospitals are compliant with the requirements of accreditation organizations, federal, state, and other regulatory entities (see Resources).

Recruiting and retaining qualified executives is a challenging task for hospital trustees. Nationally, hospital CEO turnover saw a significant increase in 2023. In 2022, CEO turnover was 16%, the lowest rate since 2011. However, according to Challenger, Gray and Christmas Inc, an international outplacement firm, in 2023 the CEO turnover rate increased to 23.7% or a 42% increase over 2022.

For Idaho, and especially for our more rural communities, it can be more difficult than elsewhere in the nation to recruit quality executives. Recruiting and retaining quality executive leadership is one of the most important jobs trustees have and is critical to ensuring local healthcare needs are met.

Healthcare Education

One of the most prominent ways the Idaho Hospital Association and our members address the workforce shortages impacting patients and communities is through broad-based support of education. By creating and filling the pipeline for a number of careers, we can help educate Idaho students and provide them with degrees, certifications or advanced training for in-demand positions. A few ways we support and advocate for healthcare education include:

A long history of support for
WWAMI
(The multi-state medical school partnership between University of Washington, Wyoming, Alaska, Montana, and Idaho) including financial support of students and establishing residencies.

Supporting medical school seats at
University of Utah.

Supporting the
Idaho College of Osteopathic Medicine.

Developing and maintaining
Nursing Internships, Apprenticeships, and Education
for degree advancement. Over 90% of those completing an apprenticeship program stay with the organization that supported the education.

Advancing the efforts of the
Workforce Development Council

Advocating for opportunities with
Community Colleges & High Schools
to provide students with certifications or degrees in crucial shortage positions which don't necessitate four-year degrees.

IHA and our members strongly advocate supporting existing, successful education programs as well as being open to new opportunities. We continue to support policies that align Idaho's workforce and education to build the highly skilled workforce we need while creating opportunities for continuous learning.

As Idaho pursues continued economic growth by supporting STEM education and industries, it is important to recognize healthcare's role. Our hospitals stand ready to welcome individuals with strong science and technology backgrounds into our workforce. For other STEM-based businesses looking to locate in Idaho, a key factor in their decision making will be the accessibility and quality of the healthcare their employees will need. By creating and filling the workforce pipeline and reducing healthcare shortages, we help build a stronger Idaho that is ready for growth and provides Idahoans with quality jobs.

Idaho has seen unprecedented growth in recent years – some of the highest in the nation. People and businesses from around the country are choosing to come to Idaho because of our opportunities, supportive business climate, robust economy, and our unmatched natural beauty. In response, Idaho has made record investments in infrastructure to support this growth – roads, bridges, schools, utilities – all things necessary for maintaining our unique quality of life.

Healthcare is a critical part of those infrastructure needs. A healthy workforce is necessary for thriving businesses, communities, and families. Industries looking to relocate to Idaho consider the access to and quality of healthcare and hospitals to support their employees. As safe roads and bridges are needed to get our citizens to their jobs and back home, high-quality and accessible healthcare is critical to keeping them healthy once they are there. A healthy, thriving workforce is essential to support all the reasons people and states across this nation are looking to Idaho as a positive example. Investments in healthcare – large and small - come back to our communities many times over. ***You can't have a healthy economy without Health.***

IHA Members

Member Name	Address	City	Zip	Phone
Bear Lake Memorial Hospital	164 South Fifth St.	Montpelier	83254	(208) 847-1630
Benewah Community Hospital	229 South Seventh St.	St. Maries	83861	(208) 245-5551
Bingham Memorial Hospital	98 Poplar St.	Blackfoot	83221	(208) 785-4100
Bonner General Health	520 North Third Ave.	Sandpoint	83864	(208) 263-1441
Boundary Community Hospital	6640 Kaniksu St.	Bonners Ferry	83805	(208) 267-3141
Caribou Medical Center	300 S. Third W. St.	Soda Springs	83276	(208) 547-3341
Cascade Medical Center	402 Lake Cascade Pkwy.	Cascade	83611	(208) 382-4242
Cassia Regional Hospital	1501 Hiland Ave.	Burley	83318	(208) 678-4444
Clearwater Valley Health	301 Cedar St.	Orofino	83544	(208) 476-4555
Cottonwood Creek Behavioral Hospital	2131 S Bonito Way	Meridian	83642	(208) 202-4700
Eastern Idaho Regional Medical Center	3100 Channing Way	Idaho Falls	83404	(208) 529-6111
Franklin County Medical Center	44 North 1st East	Preston	83263	(208) 852-0137
Gritman Medical Center	700 South Main St.	Moscow	83843	(208) 882-4511
Idaho Falls Community Hospital	2327 Coronado St.	Idaho Falls	83404	(208) 528-1000
Idaho State Hospital North	300 Hospital Dr.	Orofino	83544	(208) 476-4511
Idaho State Hospital South	700 East Alice St.	Blackfoot	83221	(208) 785-1200
Intermountain Hospital	303 North Allumbaugh St.	Boise	83704	(208) 377-8400
Kootenai Health	2003 Kootenai Health Way	Coeur d'Alene	83814	(208) 625-4000
Lifeways Hospital	8050 W. Northview St.	Boise	83704	(208) 327-0504
Lost Rivers Medical Center	551 Highland Dr.	Arco	83213	(208) 252-7654
Madisonhealth	450 East Main St.	Rexburg	83440	(208) 359-6900
Minidoka Memorial Hospital	1224 8th St.	Rupert	83350	(208) 436-0481
Nell J. Redfield Memorial Hospital	150 North 200 West	Malad City	83252	(208) 766-2231
North Canyon Medical Center	267 North Canyon Dr.	Gooding	83330	(208) 934-4433

Member Name	St.	City	Zip	Phone
Northern Idaho Advanced Care Hospital	600 North Cecil	Post Falls	83854	(208) 262-2800
Portneuf Medical Center	777 Hospital Way	Pocatello	83201	(208) 239-1000
Power County Hospital District	510 Roosevelt St.	American Falls	83211	(208) 226-3200
Rehabilitation Hospital of the Northwest	3372 East Jenalan Ave.	Post Falls	83854	(208) 262-8700
Saint Alphonsus Medical Center - Nampa	4300 E. Flamingo Ave.	Nampa	83687	(208) 205-1000
Saint Alphonsus Regional Medical Center	1055 North Curtis Road	Boise	83706	(208) 367-2121
St. Alphonsus Regional Rehabilitation Hospital	711 North Curtis Road	Boise	83706	(208) 605-3000
Shoshone Medical Center	25 Jacobs Gulch Road	Kellogg	83837	(208) 784-1221
St. Joseph Regional Medical Center	415 Sixth St.	Lewiston	83501	(208) 743-2511
St. Luke's Boise Medical Center	190 East Bannock St.	Boise	83712	(208) 381-2222
St. Luke's Elmore Medical Center	895 North 6th East	Mountain Home	83647	(208) 587-8401
St. Luke's Jerome Medical Center	709 North Lincoln St.	Jerome	83338	(208) 814-9500
St. Luke's Magic Valley Medical Center	801 Pole Line Road West	Twin Falls	83303	(208) 814-1000
St. Luke's McCall Medical Center	1000 State St.	McCall	83638	(208) 634-2221
St. Luke's Meridian Medical Center	520 S. Eagle Road	Meridian	83642	(208) 706-5000
St. Luke's Nampa Medical Center	9850 W. St. Luke's Dr.	Nampa	83687	(208) 505-2000
St. Luke's Rehabilitation Hospital	600 N. Robbins Road	Boise	83702	(208) 489-4444
St. Luke's Wood River Medical Center	100 Hospital Dr.	Ketchum	83340	(208) 727-8800
St. Mary's Health	701 Lewiston St.	Cottonwood	83522	(208) 962-3251
Steele Memorial Medical Center	203 S. Daisy St.	Salmon	83467	(208) 756-5600
Syringa Hospital & Clinics	607 West Main St.	Grangeville	83530	(208) 983-1700
Teton Valley Health	120 East Howard	Driggs	83422	(208) 354-2383
Valor Health	1202 East Locust St.	Emmett	83617	(208) 365-3561
Veterans Affairs Medical Center	500 West Fort St.	Boise	83702	(208) 422-1000
Vibra Hospital of Boise	6651 W. Franklin Road	Boise	83709	(208) 489-9500
Weiser Memorial Hospital	645 East 5th St.	Weiser	83672	(208) 549-0370
West Valley Medical Center	1717 Arlington Ave.	Caldwell	83605	(208) 459-4641

Hospital Oversight Entities

Idaho's community hospitals interact with dozens of federal, state, local and affiliated entities each day in meeting strict, varied and expansive rules, guidance and regulations.

OVERSIGHT

BFS – Bureau of Facility Standards
CMS – Centers for Medicare & Medicaid Services
DEQ – Idaho Dept. of Environmental Quality
DHW – Idaho Department of Health and Welfare
DNV - DNV Healthcare
EPA – Environmental Protection Agency
FCC – Federal Communication Commission
FTC – Federal Trade Commission
HFAP – Healthcare Facilities Accreditation Prog.
HHS – Office of Public Health & Science
NRC – Nuclear Regulatory Commission
TJC - The Joint Commission
VHA – Veterans Health Administration

PROGRAM INTEGRITY

CERT – Comprehensive Error Rate Testing
MIC – Medicaid Integrity Contractor
MIP – Medicare Integrity Program
OIG – US Office of the Inspector General
RAC – Recovery Audit Contractor
SMRC – Supplemental Medical Review Contractor
SUR – Medicaid Surveillance & Utilization Review
ZPIC – Zone Program Integrity Contractor

MEDICAL & CLINICAL

AHRQ – Agency for Healthcare Research & Quality
BOM – Idaho Board of Medicine
BON – Idaho Board of Nursing
BOP – Idaho Board of Pharmacy
CDC – Centers for Disease Control
FDA – Food & Drug Administration
HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems
HRSA – US Health Resources & Services Admin.
IDOPL – Idaho Division of Occupational and Professional Licenses
IBOE – Idaho Board of Education
ONC – Office of the National Coordinator for Health Information Technology

FINANCIAL

County Assessors
IDOI – Idaho Department of Insurance
IRS – Internal Revenue Service
ISOS – Idaho Secretary of State
ITC – Idaho Tax Commission
MAC – Medicare Administrative Contractor
PERM – Payment Error Rate Measurement
PRRB – Provider Reimbursement Review Board
SEC – Securities & Exchange Commission

QUALITY

DNV – DNV Healthcare
HQIC – Hospital Quality Improvement Contractors
MBQIP – Medicare Beneficiary Quality Incentive Prog.
PSO – Patient Safety Organization
QIN – Quality Improvement Network
QIO – Quality Improvement Organization
TJC – The Joint Commission
TSE – Idaho Time Sensitive Emergency System

LEGAL

AG – Idaho Office of Attorney General
DEA – US Drug Enforcement Agency
DOJ – US Dept. of Justice
FBI – Federal Bureau of Investigation
ISOS – Idaho Secretary of State
MFCU – Idaho Medicaid Fraud Control Unit
OCR – Office for Civil Rights
OIG – US Office of the Inspector General

PERSONNEL

DOL – US Dept. of Labor
IDOL - Idaho Dept. of Labor
IIC - Idaho Industrial Commission
OCR – Office of Civil Rights
OFCCP – Office of Federal Contract Compliance Programs
OSHA – Occupational Safety & Health Administration
NISOH – National Institute for Occupational Safety & Health
NLRB – National Labor Relations Board

TRANSPORTATION

Bureau of EMS
DOT – US Dept. of Transportation
IDOT – Idaho Dept. of Transportation
ISP – Idaho State Police
FAA – Federal Aviation Administration
Local & County Law Enforcement

Healthcare Glossary

Accountable Care Organization (ACO) – ACOs are groups of doctors, hospitals, and other healthcare providers, who come together to give coordinated high-quality care to their patients. The goal of coordinated care is to ensure patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. An ACO shares in the savings or losses it achieves for the Medicare/Medicaid program. Payments are tied to quality metrics and the cost of care.

Accreditation – Certification by a recognized organization that an individual, a service or a facility has met a set of standardized criteria typically determined by a process set by the certifying organization.

Acute Care Hospital – A facility that provides 24/7 services designed to meet the needs of patients who require short-term care for a period of less than 30 days.

Allied Health Professional – Persons who are not nurses or physicians but have special training and are licensed when necessary. They work under the supervision of a health professional and provide direct patient care. They include, but are not limited to, respiratory, physical and occupational therapists; radiology technologists and technicians; medical laboratory technologists and technicians; and surgical technologists.

Allowable Costs – In terms of Medicare and Medicaid, these are costs deemed eligible for reimbursement in treating participants and/or organizational support. Not all organizational costs are allowable.

Ambulatory Care – Outpatient healthcare services, where no overnight stay in a healthcare facility is required.

American College of Radiology (ACR) – The recognized organization for imaging (radiology) accreditation.

American Hospital Association – The nation's principal trade association for hospitals, with offices in Washington, D.C., and Chicago. IHA partners closely with AHA but is an independent organization.

Ancillary Care Services – Diagnostic or therapeutic services, such as laboratory, radiology, pharmacy and physical therapy, performed by non-nursing departments.

Any Willing Provider – Terminology relating to Idaho statute (41-3927) which requires insurance companies to allow any physician or other provider to become members of their network, providing they are qualified and willing to meet the terms and conditions of the participating provider contract.

Bad Debt – The costs absorbed by hospitals or physicians for care provided to patients from whom payment was expected but not received. Bad debt differs from charity care.

Balanced Billing – An occurrence in which a physician bills you for the difference between the provider's charge and the allowed amount. A network's contracted providers may not balance bill for discount on covered services. Out-of-network providers, not bound by contracts or rate agreements, have the ability to bill patients for the entire remaining balance.

Capitation – A payment arrangement for healthcare providers. It pays a physician or group of physicians a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

CAT Fund – Refers to Idaho's Catastrophic Healthcare Cost Program. The state-funded program was established to pay for indigent medical costs once the county limit of $11,000 per claim is reached. H316 in 2022 eliminated the CAT fund, but kept it open to receive recuperated payments from the patient through repayment or property liens.

Charge – The dollar amount that a healthcare provider assigns to a specific unit of service. A "charge" may not reflect the actual cost involved in providing that service or the amount paid by the patient.

Charity Care – Charity care represents the healthcare services that are provided under a hospital's charitable care program and where payment is not expected because the patient has a demonstrated inability to pay for some or all of the services.

Coinsurance – The percentage of either billed charges or the insurance plan's contract rate that a member is required to pay for covered services.

College of American Pathologists (CAP) – CAP is an internationally recognized program designed to help laboratories achieve the highest standards of excellence to impact patient care positively.

Community Benefit – Programs or services that address community health needs – including those of the poor or other underserved groups – and provide measurable improvement. These are proactive, strategic investments that address social and economic determinants of health and access to care.

Conditions of Participation (CoPs) – Standards that organizations must meet to participate in Medicare and Medicaid. These conditions are the foundation for improving quality and protecting the health and safety of beneficiaries.

Copayment or Copay – A defined amount of payment per visit a member must pay for healthcare services under an insurance plan.

Cost Share – The portion of the fee for healthcare services that an insurer requires the plan member to pay, including copayments, coinsurance and deductible.

Cost Shifting – A phenomenon in the healthcare system in which providers are inadequately reimbursed for their costs by some payers and subsequently raise their prices for other payers in an effort to recoup costs.

Covered Services – Those healthcare services for which a member is entitled to benefits under the terms of their insurance policy.

Credentialing – Generally used as the basis for appointing healthcare professionals to a hospital's staff, it is the process used to analyze the qualifications of a licensed practitioner's education, training, experience, competence and judgment. A credentialed staff member is permitted to perform clinical duties at the hospital.

Critical Access Hospital (CAH) – Established under the Balanced Budget Act of 1997, CAHs are hospitals located in rural areas with no more than 25 acute-care beds. They receive cost-based payment for Medicare patients and are relieved from some Medicare regulations.

Deductible – The amount that a member must pay for covered services during a specified period (usually a policy year) before benefits will be paid by the insurer.

Delegated Credentialing – A formal process by which an organization gives another entity the authority to perform credentialing functions on its behalf.

Diagnosis Related Group (DRG) – A classification that standardizes hospital payments and encourages cost containment

initiatives. In general, a DRG payment covers charges associated with an inpatient stay from the time of admission to discharge.

Disproportionate Share Hospital (DSH) – A hospital with a disproportionately large share of low-income or uninsured patients. Both Medicaid and Medicare augment payment to these hospitals to offset this added burden.

DNV Healthcare (DNV) – DNV is a voluntary accreditation agency that surveys enrolled hospitals regarding many aspects of quality.

Electronic Health Record (EHR) – A digital version of a patient's medical charts. EHRs are real-time records that make information available instantly and securely to authorized users. EHRs can contain a patient's medical history, diagnoses, medications, allergies, images, test results and much more. EHRs are designed to be inclusive of all clinicians involved in the patient's care.

EMTALA – Emergency Medical Treatment and Active Labor Act, a federal law passed in 1986, ensures hospitals provide care to anyone needing emergency treatment, regardless of citizenship, legal status, or ability to pay.

ERISA – Employee Retirement Income Security Act of 1974, a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry.

EOB, Explanation of Benefits, EOMB, Explanation of Medical Benefits or Remittance Advice – A document that summarizes how reimbursement was determined in the payment of a health plan claim.

Fee for Service – In a fee-for-service arrangement, providers are paid based on the amount of healthcare services they deliver. This is a system based on the volume of work versus the value which is measured with outcomes and cost.

Health Information Technology for Economic and Clinical Health Act (HITECH) – Part of the American Recovery and Reinvestment Act of 2009 (ARRA), the HITECH Act contains incentives related to healthcare information technology (e.g. creation of a national healthcare infrastructure) and contains specific incentives designed to accelerate the adoption of electronic health record (EHR) systems among providers.

Health Insurance Portability and Accountability Act (HIPAA) – Title I requires employers and health plans to allow a new employee's medical insurance coverage to remain continuous without regard to pre-existing conditions. Title II requires the establishment of national standards for electronic healthcare transactions, and national identifiers for providers, health insurance plans and employers. HIPAA also addresses security and privacy of health data.

Healthcare Acquired Condition – A condition that develops while a patient is in a healthcare facility, such as an infection, a pressure ulcer or some type of injury.

Idaho Patient Care Act – Passed in 2020, the IPA created a number of mandates for hospitals and healthcare providers regarding the patient billing process and medical debt collections. It also set caps on attorney fees for extraordinary medical debt collections.

Intergovernmental Transfer (IGT) – Local governmental funds transferred to the state on behalf of a public provider to provide the state matching funds for supplemental payments made to that public provider.

The Joint Commission (TJC) – A voluntary accreditation agency that surveys enrolled hospitals regarding many aspects of quality.

Licensed Beds – The maximum number of beds authorized by a government agency for a healthcare organization to admit patients.

Long-Term Acute Care Hospital (LTAC) – A hospital providing specialized care to medically complex patients who usually require an extended hospital stay.

Long-Term Care Facility (LTCF) – Any residential healthcare facility that administers health, rehabilitative or personal services for a prolonged period of time.

Managed Care – A mechanism for financing and/or delivering healthcare intended to control cost, utilization, and quality of care. The state pays the management entity up to a 15% fee for administering the program.

Medicaid Expansion – Unlike traditional Medicaid, Medicaid Expansion provides coverage to individuals with incomes less than 138% of the federal poverty level. Congress, by statute, has locked the federal/state match rate at 90% federal, and 10% state. Without Medicaid Expansion, there is no safety-net program to compensate for the care provided to low-income, uninsured Idahoans.

Medicaid Integrity Contractor (MIC) – An auditor hired by the Centers for Medicare and Medicaid Services (CMS) to review Medicaid claims for mis-payment.

Medical Home – A model of primary and preventive care delivery in which the patient has a continuous relationship with a personal physician in a physician-directed medical practice that is whole person oriented and where care is integrated and coordinated.

Member or Covered Person – Someone with insurance coverage through a health plan. May also be referred to as an Enrollee or Beneficiary.

National Committee for Quality Assurance (NCQA) – A non-profit organization that sets quality standards, evaluates and accredits managed care plans and other healthcare organizations.

Out-of-Network Care – Healthcare services provided to a health plan member by a provider who does not participate in that plan's contracted provider network.

Outpatient Prospective Payment System (OPPS) – A determined payment methodology for a Medicare outpatient procedure.

Payer – An organization (such as the federal government for Medicare or a commercial insurance company) or person who directly reimburses healthcare providers for their services.

Present on Admission (POA) – Whether or not a patient has a certain condition at the time of being admitted to a hospital. These conditions include different types of infections and pressure ulcers.

Prior Authorization – A process by which a healthcare plan determines that care is medically necessary, and costs will be covered by the plan.

Prospective Payment System (PPS) – A system in which payment for services is determined before the services are actually provided and that amount is reimbursed to the provider regardless of the actual cost of services.

Provider Network or Network – A group of providers who have contracted with a managed care plan under which they agree to accept reduced rates and abide by other plan rules in exchange for either increased volume of patients or the ability to receive payment for care provided to insurance plan members.

Quality Measure – A tool that helps measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality healthcare and/or that relate to one or more quality goals for healthcare.

Recovery Audit Contractor (RAC) – An auditor hired by the Centers for Medicare and Medicaid Services (CMS) to review Medicare claims for mis-payment.

Rural Emergency Hospital (REH) - A new hospital designation designed to maintain access to care in rural communities. An REH provides emergency services and observation care but is prohibited from providing inpatient services or exceeding an annual average patient length of stay of 24 hours.

Serious Adverse Event – An unexpected event that happens during a hospital admission that results in harm or injury to a patient.

Specialty Hospital – A limited-service hospital designed to provide medical specialty care such as surgical or orthopedic care.

Swing Beds – Acute care hospital beds that can also be used for long-term care, depending on the needs of the patient and the community. Only those hospitals with fewer than 100 beds and located in a rural community, where long-term care may be inaccessible, are eligible to have swing beds.

Surprise Billing – When a patient unexpectedly receives care from an out-of-network provider. This can happen in a number of instances, such as when a patient is treated by their in-network physician, but the lab sample is sent to an out-of-network laboratory or when a patient is treated at the emergency department of an in-network hospital, but the on-call physician specialist called in to provide care is not in the patient's insurance network.

Tobacco Master Settlement Agreement – In 1998, Idaho was one of 46 states to participate in a Master Settlement Agreement (MSA) with the four largest tobacco companies in the U.S. The MSA was a result of multiple state lawsuits against the tobacco companies that sought recovery for Medicaid and other public health expenses incurred in the treatment of smoking-induced illnesses. Idaho created the Millennium Fund for those MSA payments and uses the interest to fund various health-related programs.

Trauma System – An organized approach to facilitating and coordinating a multidisciplinary system response to severely injured patients.

Uncompensated Care – Care given for which payment is not received, or for which only a portion of the cost is reimbursed. Includes charity care, Medicaid underpayments, legislated care underpayments, and bad debt.

Upper Payment Limit – The Upper Payment Limit is a federal supplemental payment program that allows hospitals to make up some of the losses they take on Medicaid reimbursement from the states. The UPL is the difference between what Medicaid pays and what Medicare would have paid for the same service. If hospitals provide the required state match, they can access the federal supplement to the Medicare "upper limit payment limit."

Utilization Review – The process by which a managed care company controls the provision of healthcare services through determination of medical necessity of care, including pre-certification, prior authorization, concurrent review and retrospective review.

Value Based Care / Pay for Performance – Value-based care is a delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce incidence and effects of chronic disease, and live healthier lives in an evidence-based way. This model also penalizes providers for poor outcomes, medical errors, or increased costs. Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver. The "value" in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcome.

Value Care Organizations (VCO) - In 2020, H315 began the transition of Medicaid from a fee-for-service reimbursement structure to a value-based arrangement. VCOs - which include hospital networks and primary care providers - are held accountable for outcomes and costs, in exchange for an ability to share in savings.