LAKE CHELAN HEALTH

BOARD PACKET

Chelan County Public Hospital District No. 2

2/24/2026

LAKE CHELAN HEALTH

Chelan County Public Hospital District No. 2
Board Training 12:45-1:15 PM
Regular Meeting of the Board of Commissioners
February 24, 2026, at 1:30 am via TEAMS
Meeting Link Available on Website

Agenda

*Mission- "*To provide the highest quality healthcare with compassion and respect to the community we serve.*"*

FI – For Information; FD – For Discussion; FM – For Motion; FA – For Acceptance; FR-For Resolution

Time	*Agenda Item*	*Facilitator*	*Topic/Action*
1:30	1. Call to Order/ Changes to Agenda	L. Withrow	
1:31	2. Public Comment		
1:40	3. Chair Report	L. Withrow	
1:50	4. Consent Agenda	Commission	A. Regular Board Meeting Minutes 1/27/2026(FM) B. Warrants & Vouchers (FM) C. Bad Debt & Charity Care (FM) D. Finance Committee Minutes 2/19/2026 (FA)
1:55	5. Executive Session		A. RCW 42.30.110(1)(o) to consider information regarding staff privileges or quality improvement committees under RCW 70.41.205
2:10	6. Reports	J. Barich, S. Freed B. Truman B. Fields A. Edwards S. Ottley Commissioners	A. Med Staff Report & Credentialing (FM) B. Financial Committee Report (FA) i. Rev. Cycle C. CEO Report (FI) D. Strat Plan (FI) E. Community Connections (FD)
2:45	7. Old Business	A. Edwards L. Sahlinger Commissioners	A. EMS Capital Project Update (FI) B. Quality Team Boards (FD) C. Board: i. Ruby U (FD) ii. Conflict of Interest (FD) iii. Board Education (FD) F. Strat Plan Dates 6/25-26
3:15	8. New Business	Commissioners	A. Resolutions i. Resolution 2026-4 Disposal: Rolling Laptop Desk (FA) B. Policies i. Lake Chelan Health- Nondiscrimination (FA) ii. Tort Claims Policy (FA) iii. Emergency Credentialing and Disaster Privileging Policy (FA) C. Notice of Privacy Practices (FA) D. Proposed Removal of the Property Tax Policy (FM)
3:50	9. Public Comment		
3:55	10. Executive Session		A. RCW 42.30.110(1)(g) to evaluate the performance of a public employee.
4:45	11. Roundtable/Action Items	Commission	
4:50	12. Adjournment		

Board Calendar Reminders:

3/18/2026	Compliance Privacy & Risk	Conference Room 1212	10:00 am
3/12/2026	Quality Committee	Bragg Room/ TEAMS	1 – 3 pm
3/17/2026	Credentialing Committee	TBA	11:30 am
3/26/2026	Finance Committee	Bragg Room/ TEAMS	10 am
3/31/2026	Board Education	Bragg Room/TEAMS	12:15 pm
3/31/2026	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

4/9/2026	Med Staff	Bragg Room/ TEAMS	7:00 am
4/6/2026	Quality Committee	Bragg Room/ TEAMS	1 – 3 pm
TBA	Credentialing Committee	TBA	TBA
4/23/2026	Finance Committee	Bragg Room/ TEAMS	10 am
4/28/26	Board Education	Bragg Room/TEAMS	12:15 pm
4/28/2026	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

5/20/2026	Compliance Privacy & Risk	Conference Room 1212	10:00 am
5/14/2026	Quality Committee	Bragg Room/ TEAMS	1 – 3 pm
TBA	Credentialing Committee	TBA	TBA
5/15/2026	Finance Committee	Bragg Room/ TEAMS	10 am
5/19/2026	Board Education	Bragg Room/TEAMS	12:15 pm
5/19/2026	Regular Board Meeting	Bragg Room/ TEAMS	1:30 pm

Chelan County Public Hospital District No. 2
Regular Meeting of the Board of Commissioners
Meeting Minutes January 27, 2026 at 1:30 pm

Commission Attendance:

(☐ not present ☒ present)

☒ Jordana LaPorte, Chair	☒ Mary Murphy, Secretary	☒Len England
☒ Lori Withrow, Vice Chair	☐Doug Gibson	

Staff Participants: A. Edwards B. Truman (virtual), R. Montgomery, J. Barich, M. Miller, J. Phetteplace, B. Fields, B. Truman, T. Lautiki, B. Mello, H. Vogel. D. Ehlert, A Benegas
Community Members: Anna Moroz, Linda Mayer, John Pleyte, Kylie Schmitz, Nate Mote

Recorder: Wendy Kenck

Agenda Item	Topic/Action
Call to Order	• J. LaPorte called the meeting to order at 1:30 pm and recited the mission statement. • J. LaPorte opened the floor for Board position nominations o *J. LaPorte nominated L. Withrow for Board Chair position, accepted, motion passed* o *J. LaPorte nominated D. Gibson as Vice Chair, accepted, motion passed* o *J. LaPorte nominated M. Murphy as Board Secretary, accepted, motion passed.*
Public Comment	• John Pleyte expressed gratitude to LCH EMS and Administration for their dedication and service to the community. He shared concerns regarding the current Chelan – Douglas Pathway proposal, noting potential safety risks for pedestrians and emergency services. He stated that as highway traffic increases, EMS response and operations may be further impacted. Mr. Pleyte requested that the Board consider issuing an official statement of concern regarding these safety issues. Mr. Pleyte also submitted an email to the Board that included two letters, one from the Chelan Fire District and one from Manson Fire District, for the Board's review. o Linda Mayer added to Mr. Pleyte comments that traffic on Highway 150 is currently much lighter than during the summer months. She noted concerns about large trucks crossing over the center line due to limited width and stated that, as it stands, portions of the roadway do not appear wide enough. She further shared that removing the shoulder would create additional limitations and potential safety concerns. • Mary Murphy noted o Merry Sterling sent an email to the Board regarding the pathway project. In her message, she indicated that she represents a group of community members who are opposed to the pathway due to concerns related to community safety and potential impacts on emergency response. o Elijah and Kim submitted an email to the Board expressing concerns about the proposed pathway, including potential safety risks and impacts to the community. o Sue Geodde also emailed the Board to voice concerns regarding the pathway and its potential effect on emergency response times and overall safety. • Nate Mote noted that at the close of last week's executive session, the meeting

	continued into the open session without properly reconnecting virtually. He also expressed support for the UW Residency program. • Kylie Schmitz expressed support for the UW Residency Program and the rural OB program.
Consent Agenda	• J. LaPorte reported that the special meeting was very productive, resulting in an agreement for increased collaboration between CVCH, LCH, and UW regarding the Residency Program. She expressed confidence that the meeting will help the hospital effectively carry out its mission with the support of CVCH and UW. • Consent Agenda o *L. England motioned to approve the Consent Agenda with edits, seconded, and motion approved.*
Executive Session	• L. Withrow, Chair announced an Executive Session at 1:48 PM for 10 minutes, scheduled to end at 1:58 PM, citing RCW 70.44.062 and RCW 42.30.110(1)(o) to consider information regarding staff privileges and matters discussed by quality improvement committees. o L. Withrow announced Executive session ended at 1:58 PM. Board returned to open meeting. o Action Following Executive Session: ▪ *M. Murphy, after reviewing the medical recommendations from the Medical Executive Committee (MEC), motioned to approve the appointment of Ismail Fahal, MD, Jedediah Kaufman, MD, Tabetha Bradley, MD, Nathan Eppich, CRNA, Sarah McKinley, MD, and Christopher Johns, MD; the reappointment of Paul Furmanczyk, MD, Quoc Nguyen, MD, Whitney Reid, MD, Nausheen Naveed, MD, Shaden Mohammed, MD, Sergey Akopov, MD, Sarbjit Atwal, MD, Lien Nguyen, DO, and Amin Hossein Rabiei, MD; and the provisional status moved to full for Craig Elsner, PA-C, and Eric Davis, PA-C. Seconded, motion approved.* ▪ *L. England motioned to approve the Delineation of Privileges for Cardiology, Urology, and Conscious Sedation, seconded, motion approved*
Reports	• A. Edward presented the Medical Staff report on behalf of CMO Dr. Freed , providing updates on the pre-op screening process, the LCH Residency Program, case mix index and admissions tracking, and the Culture of Safety Program. The OB Focus Group met with Dr. Harberd and Dr. Snyder and is now back on track to begin a community-based focus group. Efforts are underway to identify a facilitator and secure a location. Additionally, Drs. Snyder and Harberd are collaborating on updates to the LCH Admission Policy, which will be submitted to the Board for review. • **Finance:** o B. Fields presented the quarterly Revenue Cycle report, highlighting key metrics including Days in AR, Gross Revenue, Third Party and Self-Pay, and average payer mix. She also reported on billing phone call metrics, noting an improvement in the average time to return calls to patients—from 16 days in October to 4 days in January. Changes included reorganizing the phone tree and tracking metrics to ensure accountability and timely responses. o B. Truman presented the unaudited December 2025 finance report. ▪ He noted that depreciation had not previously been calculated as an expense; this has now been implemented beginning in December to keep the hospital's financials up to date.

	▪ *M. Murphy motioned to accept the unaudited December 2025 Finance Report; seconded, motion approved.* o The MRI lease is currently on a year-to-year basis. A proposal to move to a five-year lease would allow LCH to lease a larger bore machine, align with Siemens standardization, and remain current with other competing facilities. This represents a change from a budgeted purchase to a lease, in compliance with DOH and L&I requirements. ▪ *M. Murphy motioned to approve the MRI lease contract, seconded, motioned approved.* • ***CEO Report:*** A. Edwards presented the CEO Report and shared several additional items of interest o **Rural Transformation Funds:** WSHA will distribute about $40M to hospitals, with LCH potentially receiving $630K. The state may require these funds to support new "transformation" projects. o **SNAP Funding:** Reductions begin this year, decreasing SNAP funds from $1.3M to $0 over five years. o **Foundation:** J. LaPorte, A. Edwards, and T. Lautiki met with The Lake Chelan Health and Wellness Foundation Board Chair and Vice Chair. Clarification was sought on how the Foundation supports LCH employee requests. The Foundation bylaws allow the LCH Administrator and one staff member to serve as non-voting members on their Board. ▪ *J. LaPorte motioned that LCH Executive Leadership Team members rotate representation at Health and Wellness Foundation meetings in addition to the Administrator. The motion was seconded and approved.* • **Community Connection Opportunities:** o Aaron attended the "State of the City" Town Hall and appreciated the opportunity to speak. o The Legislative Advocacy Day in Olympia is scheduled for January 28, and J. LaPorte and A. Edwards will be in attendance. o The Lake Chelan Health and Wellness Foundation's "Healthy Heart – Healthy Life" event will be held on 2/12 at Lakeside Tavern with COO S. Ottley and LCH Cardiologist Dr. Nayak as speakers.
Old Business	• **EMS Capital Project Update:** Framing is underway on the second floor. Footings are being dug for the garage, and the footings, stem wall, and slab are scheduled to be poured in February. Change orders, which have been discussed previously, will be submitted soon. • **Policies** o *J. LaPorte motioned to approve Conflict of Interest Policy w/ edits, CEO Decision Matrix w/ edits, and the LCH Board of Commissioners Meeting Minutes policy, seconded, motion approved.*
New Business	• **Resolutions** • *J. LaPorte motioned to approve Resolution 2026-01 Disposal of Recliner, Resolution 2026-02 Disposal of Eye Stretcher, Resolution 2026-03 Disposal of Fetal Doppler, seconded, motion approved.* • Discussion regarding the Board Task Calendar, Committee Assignments, Quality Rounding, and Board Education. • **Chelan Manson Pathway:** M. Murphy summarized a conversation with Jeff Wilkins from the Chelan-Douglas County Transportation Council regarding public comment. The formal public comment period is currently on hold while WA Dept of Transportation, Fire, and

	Police meet. Murphy confirmed that LCH would have a place at the table and advised contacting him for participation. o M. Murphy noted that there has been a long-standing discussion about highway safety and emergency response times, and she expressed concern that adding a new pathway could create additional risks if the DOT does not first address the existing safety issues. o R. Eickmeyer agreed stating that while he supports projects that encourage recreation, current road safety concerns, along with increased traffic from casino and community growth, make it risky to add recreational areas without first addressing these issues. • **Board Meeting efficiency:** The Board has requested that materials that are to be presented in the Board meeting be provided to them in advance to allow for review, to promote productive meetings, and support open, meaningful discussion. Presenters should be given a clear time frame to present in order to be prepared.
Public	• No Public Comment
Executive Session	• L. Withrow announced an Executive Session at 5:26 PM for 30 minutes to end at 5:56 PM citing RCW 42.30.110(1)(g) to evaluate the performance of a public employee. No action is expected. o L. Withrow extended the Executive Session 10 minutes o L. Withrow extended the Executive Session 10 minutes o Executive Session ended at 6:16 pm and the Board resumed in open meeting.
Action Items	• Governance Committee to collaborate with Quality on Board guidelines. • Board to coordinate with Ray to send out thank-you letters for the Pop Up Give NCW Event • L. Withrow to provide Finance with a list of donated items for the Pop Up Give NCW Event. • Aaron to contact Jeff Wilkins to discuss the pathway project. • Governance Committee to review the agenda and packet to streamline where possible.
Adjournment	• No action was taken following the Executive Session. • Roundtable discussion • L. Withrow adjourned the meeting at 6:40 pm

Attest:

_____ _____

Mary Murphy, Secretary Aaron Edwards, CEO

_____

Wendy Kenck, Executive Assistant

LAKE CHELAN HEALTH

MINUTES

Group: Finance Committee 2/19/2026, 10AM in person and via Teams		
Facilitator: Jordana Laporte	**Recorder:** W. Kenck	
Member Attendance:		
☒ Doug Gibson, BOC ☒ Jordana LaPorte, BOC (virtual)	☒ Shawn Ottley, COO ☒ Brant Truman, CFO	☒ Aaron Edwards, CEO
Participants: Vickie Bodle, R. Montgomery, L. Sahlinger, B. Fields, M. Miller, Tara Lautiki **Guests:**		

FI – For Information; FD – For Discussion; FR – For Recommendation

Agenda Item	*Topic/Action*
• Call to Order	• B. Truman called meeting to order at 10:05 am
• New Business	• **Wixcorp Implementation:** Wixcorp will go live with a patient text notification system allowing patients to opt in to view and pay their bills online. • **Charity Care:** Charity Care applications will soon be available online to improve processing efficiency and tracking. • **Revenue Cycle Structure:** The Revenue Cycle structure was reviewed, including the addition of three new positions to the Billing team. • **Self-Pay Discount Plan:** B. Fields presented a proposed self-pay discount program offering a discount for payment in full within 30 days, along with a potential partnership to help support. • **Property Tax Policy:** Proposed removal of the Property Tax Policy will be sent to the Board for approval. • **TIF Update:** Reviewed discussion from the meeting held with the Chelan and Manson Fire Departments regarding the TIF. • **Resolution 2026-4:** The Finance Committee recommends forwarding Resolution 2026-4 to the Board for approval.
• Reports	• B. Fields reviewed the monthly Revenue Cycle report • V. Bodle presented the unaudited January 2026 Financial Statement.
• Adjournment	• B. Truman adjourned the meeting at 11:33 pm

TO Wendy 2/19/26

WARRANT #'S A/P	AMOUNT	CAPITAL	BOARD MTG - FEBRUARY 2026	WARRANT#'S PAYROLL	AMOUNT	pay period
IDAHO STATE TAXES	$ 1,652.79			PAYROLL CHECK-77546	$ 2,674.00	12/28/2026
retirement	$ 62,532.46			DIRECT DEPOSIT	$ 671,225.75	1/10/2026
242515-242521	$ 78,561.74			PAYROLL TAXES	$ 264,750.91	1/10/2026
242522-242571	$ 173,400.64			CHILD SUPPORT	$ 451.38	1/10/2026
AP ACH	$ 78,000.08			DIRECT DEPOSIT	$ 617,127.16	1/24/2026
AP ACH	$ 63,264.08			PAYROLL TAXES	$ 235,044.85	1/24/2026
242572-242657	$ 341,043.92			CHILD SUPPORT	$ 451.38	1/24/2026
FPL&LTC	$ 78,743.13			DIRECT DEPOSIT	$ 661,385.27	2/7/2026
retirement	$ 62,706.03			PAYROLL TAXES	$ 269,096.70	2/7/2026
DOR	$ 15,651.70			CHILD SUPPORT	$ 451.38	2/7/2026
AP ACH	$ 156,432.60					
242658-242716	$ 238,906.78					
242717 (refund)	$ 1,001.13					
242718-242758	$ 381,747.47					
AP ACH	$ 626,538.80					
242759-242810	$ 123,856.41					
AP ACH	$ 172,154.60					
retirement	$ 65,492.07					
AP ACH	$ 25,013.51					
242811-242864	$ 167,175.31					
IDAHO STATE TAXES	$ 1,045.00					
	$ 2,914,920.25				***$ 2,722,658.78***	

LAKE CHELAN HEALTH

Unaudited Financial Statements

for

For the month ended January 31, 2026

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Balance Sheet

Lake Chelan Health

	Current Month 1/31/2026 unaudited	Prior Year 12/31/2025 AUDITED	Prior Year 1/31/2025 Unaudited	
ASSETS:				
CASH	419,466	$ 710,559	$ 534,934	
PATIENT RECEIVABLES	17,446,491	17,873,725	$ 12,668,022	
LESS: RESERVES FOR ALLOWANCES	(8,990,287)	(9,145,837)	$ (6,599,717)	
NET PATIENT ACCOUNTS RECEIVABLES	8,456,204	8,727,889	6,068,306	
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	136,507	261,253	227,722	
OTHER RECEIVABLES	889,114	608,064	693,713	property taxes are accrued over 12 months
INVENTORIES	400,591	333,784	336,278	
PREPAID EXPENSES	480,030	518,700	399,203	
TOTAL CURRENT ASSETS	$ 10,781,912	$ 11,160,248	$ 8,260,155	
GENERAL RESERVES	$ 610,694	599,257	$ 1,219,007	
Unrestricted Reserves	$ 2,153,365	2,517,941	$ 6,439,251	
Internally Restricted Reserves	$ 4,139,524	4,139,524	$ 4,139,524	
2018 BONDS	0	0	$ -	
USDA 2023	547,200	547,200	$ 410,400	
Coastal Bank	50,013	50,012	$ 50,002	
TOTAL LIMITED USE ASSETS	$ 7,500,797	$ 7,853,934	$ 12,258,184	
LAND	$ 4,133,845	4,133,845	$ 4,133,845	
LAND IMPROVEMENTS	0	2,969,105	$ -	
BUILDINGS & IMPROVEMENTS	2,969,105	0	$ -	
EQUIPMENT	9,255,147	9,235,793	$ 10,669,111	
SOFTWARE	2,242,422	2,242,422	$ 2,192,571	
NEW HOSPITAL	44,757,019	44,757,019	$ 44,757,019	
LOCUM HOUSING	691,665	691,665	$ 635,484	
GASB 87 BUILDINGS AND EQUIPMENT	4,561,350	5,023,746	1,742,567	
CONSTRUCTION-IN-PROGRESS - PROJECTS	3,221,708	1,892,126	$ 1,159,979	
CONSTRUCTION-IN-PROGRESS - HOSPITAL	74,848	74,248	$ 8,750	
GROSS PROPERTY, PLANT, & EQUIPMENT	71,907,108	71,019,969	65,299,327	
LESS: ACCUMULATED DEPRECIATION	(17,407,476)	(17,077,985)	$ (15,096,917)	
GASB 87 AMORTIZATION	(1,509,681)	(1,443,601)	(547,446)	
NET PROPERTY, PLANT, & EQUIPMENT	**$ 52,989,951**	**$ 52,498,382**	**$ 49,654,964**	
DEFERRED ITEMS	$ 2,414,850	2,416,456	$ 1,534,126	
TOTAL ASSETS	**$ 73,687,510**	**$ 73,929,020**	**$ 71,707,430**	
LIABILITIES:				
ACCOUNTS PAYABLE	$ 1,566,855	663,522	1,301,107	
ACCRUED PAYROLL	385,232	1,076,786	270,916	
ACCRUED VACATION/HOLIDAY/SICK PAY	1,592,902	1,596,206	1,141,895	
PAYROLL TAXES PAYABLE	159,902	210,226	24,402	
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	0	0	0	
OTHER CURRENT LIABILITIES	1,427,095	1,154,183	1,113,303	
INTEREST PAYABLE	176,393	89,348	180,925	
CURRENT PORTION OF LTD (BONDS/MORTGAGES)	1,189,475	1,189,475	1,046,831	
LINE OF CREDIT	0	0	0	
TOTAL CURRENT LIABILITIES	$ 6,497,854	$ 5,979,746	$ 5,079,379	
CAPITALIZED LEASES	$ -	$ -	$ -	
2018 BONDS	$ 17,957,598	17,958,807	18,357,109	
2013 BONDS	3,894,022	3,893,592	4,283,865	
USDA LOANS	18,079,676	18,113,606	18,520,475	
LEASES	2,561,496	3,253,680	2,114,729	
PAID LEAVE - LT PORTION	179,000	179,000	82,334	
2025 BONDS	1,392,333	1,392,333		
TOTAL LONG TERM LIABILITIES	$ 44,064,125	$ 44,791,019	$ 43,358,513	
DEFERRED ITEMS	$ 4,730,311	4,776,042	4,163,301	
TOTAL LIABILITIES	$ 55,292,290	$ 55,546,806	$ 52,601,193	
FUND BALANCE:				
UNRESTRICTED FUND BALANCE	$ 18,358,231	19,160,312	19,161,012	
TEMPORARY RESTRICTED FUND BALANCE	$ -	0	0	
YTD Net Revenue/(Expenses)	36,989	(778,098)	(54,774)	
TOTAL NET ASSETS	$ 18,395,220	$ 18,382,214	$ 19,106,237	
TOTAL LIABILITIES AND NET ASSETS	**$ 73,687,510**	**$ 73,929,020**	**$ 71,707,430**	

Statement of Revenue and Expense
Lake Chelan Health

For the month ended January 31, 2026

	CURRENT MONTH				
	Actual 01/31/26	Budget 01/31/26	Positive (Negative) Variance		Prior Year 01/31/25
GROSS PATIENT SERVICE REVENUES					
INPATIENT	$ 800,101	$ 1,310,297	(510,196)	-39%	$ 972,973
OUTPATIENT	5,996,653	5,128,372	868,281	17%	4,562,820
TOTAL PATIENT SERVICE REVENUES	6,796,754	6,438,669	358,085	6%	5,535,792
DEDUCTIONS FROM REVENUE					
CONTRACTUAL ALLOWANCES	(3,020,050)	(2,865,207)	(154,844)	5%	(2,020,334)
BAD DEBT	(121,990)	0	(121,990)	0.00%	(184,075)
CHARITY	(94,170)	0	(94,170)	0.00%	(31,705)
TOTAL DEDUCTIONS FROM REVENUES	(3,236,211)	(2,865,207)	(371,004)	-13%	(2,236,114)
	47.6%	44.5%			40.4%
NET PATIENT SERVICE REVENUES	3,560,543	3,573,462	(12,919)	0%	3,299,679
OTHER OPERATING REVENUES	67,900	71,085	(3,185)	-4%	34,659
TOTAL OPERATING REVENUES	**3,628,444**	**3,644,548**	(16,104)		**3,334,338**
OPERATING EXPENSES					
SALARIES/WAGES	1,864,223	2,186,430	322,208	15%	1,707,616
EMPLOYEE BENEFITS	453,025	466,603	13,578	3%	355,489
PROFESSIONAL SERVICES	370,608	514,921	144,312	28%	274,433
FOOD SUPPLIES	24,473	23,260	(1,213)	-5%	20,961
MINOR EQUIPMENT	21,807	38,518	16,711	43%	34,435
SUPPLIES	298,897	262,672	(36,225)	-14%	168,458
PLANT UTILITIES	37,600	38,466	866	2%	32,934
PURCHASED SERVICES	311,079	368,236	57,157	16%	452,039
REPAIR/MAINTENANCE	89,831	100,392	10,561	11%	90,902
PUBLIC RELATIONS/RECRUITM	5,728	10,453	4,725	45%	6,290
RENT/LEASES	37,116	46,382	9,266	20%	80,452
INSURANCE	48,329	45,329	(3,001)	-7%	42,947
LICENSES/TAXES	12,295	36,511	24,216	66%	34,910
DUES/SUBSCRIPTIONS/OTHER	74,672	72,659	(2,012)	-3%	67,181
TRAVEL/TRAINING	8,772	15,491	6,718	43%	4,107
DEPRECIATION	329,491	365,828	36,337	10%	318,570
AMORTIZATION	66,080	64,583	(1,496)		
TOTAL OPERATING EXPENSES	**4,054,025**	**4,656,733**	**602,708**	12.9%	**3,691,725**
NET OPERATING SURPLUS (LOSS)	**(425,582)**	**(1,012,186)**	**586,604**		**(357,388)**
NON-OPERATING REVENUES	268,074	232,905	35,169		272,012
TAXES					
INTEREST					
GIFTS & GRANTS	194,496	354,366	(159,870)		30,600
OTHER	0	0	0		0
NET INCOME	36,988	(424,915)	461,903		(54,775)
margin	1.0%	-11.7%			-1.6%
TOTAL NET INCOME (LOSS)	**$ 36,988**	**$ (424,915)**	**461,903**		**$ (54,775)**

unaudited

Statement of Revenue and Expense
Lake Chelan Health

For the month ended January 31, 2026

	YEAR-TO-DATE				
	Actual 01/31/26	Budget 01/31/26	Positive (Negative) Variance		Prior Year 01/31/25
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FOOD SUPPLIES	24,473	23,260	(1,213)	-5%	20,961
MINOR EQUIPMENT	21,807	38,518	16,711	43%	34,435
SUPPLIES	298,897	262,672	(36,225)	-14%	168,458
PLANT UTILITIES	37,600	38,466	866	2%	32,934
PURCHASED SERVICES	311,079	368,236	57,157	16%	452,039
REPAIR/MAINTENANCE	89,831	100,392	10,561	11%	90,902
PUBLIC RELATIONS/RECRUITMENT	5,728	10,453	4,725	45%	6,290
RENT/LEASES	37,116	46,382	9,266	20%	80,452
INSURANCE	48,329	45,329	(3,001)	-7%	42,947
LICENSES/TAXES	12,295	36,511	24,216	66%	34,910
DUES/SUBSCRIPTIONS/OTHER	74,672	72,659	(2,012)	-3%	67,181
TRAVEL/TRAINING	8,772	15,491	6,718	43%	4,107
DEPRECIATION	329,491	365,828	36,337	10%	318,570
AMORTIZATION	66,080	64,583	(1,496)		
TOTAL OPERATING EXPENSES	**4,054,025**	**4,656,733**	**602,708**	12.9%	**3,691,725**
NET OPERATING SURPLUS (LOSS)	**(425,582)**	**(1,012,186)**	**586,604**		**(357,388)**
NON-OPERATING REVENUES					
PROPERTY TAXES FOR OPERATIONS	247,952				232,157
GRANTS/CONTRIBUTIONS	21,962	354,366			30,600
EMS COMMERCE GRANT	163,311				0
INVESTMENT EARNINGS	24,002				33,912
OTHER EXPENSE		0	0		
TAXES FOR DEBT SVC PMTS	111,388				108,389
INTEREST EXPENSE	(151,777)				(147,082)
GAIN / (LOSS) ON ASSET DISPOSAL	45,730				44,637
TOTAL NON OPERATING REVENUES	462,569	232,905	229,664		302,613
NET INCOME	36,988	(424,915)	586,604		(54,775)
margin	1.0%	-11.7%			-1.6%
TOTAL NET INCOME (LOSS)	**$ 36,988**	**$ (424,915)**	**$ 461,902**		**$ (54,775)**

unaudited

Patient Statistics

Lake Chelan Health

For the month ended January 31, 2026

= or > 90% of budget
= or > 70% of budget
< 70% of budget

Current Month Actual vs Budget	Current Month 01/31/26	Current Month BUDGET	STATISTICS	Last Year Month Actual vs Budge	Last Year Month 01/31/25	Last Year Month BUDGET
	66	120	Total Days Cash on Hand		113	120
	72	60	Net AR Days		61	40
	1.95	1.25	Debt Coverage Ratio		1.81	1.25
	4.40		Average Age Of Plant			
	242		Payroll FTEs		208	208

Current Month Actual vs Budget	Current Month Actual 01/31/26	Current Month Prior Year 01/31/25	BUDGET	STATISTICS	Year-To-Date Actual vs Budge	Year-To-Date Actual 01/31/26	Year-To-Date Prior Year 01/31/25	Year-To-Date BUDGET
				Admissions				
NA	25	24	NA	medical	NA	25	24	NA
NA	1	0	NA	surgical	NA	1	0	NA
NA	5	9	NA	OB	NA	5	9	NA
NA	31	33	NA	Acute	NA	31	33	NA
NA	7	4	NA	Swing Bed	NA	7	4	NA
NA	5	9	NA	Total Deliveries	NA	5	9	NA
				Patient Days				
	83	63	60	medical		83	63	60
NA	2	0	NA	surgical	NA	2	0	NA
	10	21	11	OB		10	21	11
	95	84	71	Acute		95	84	71
	55	73	50	Swing Bed		55	73	50
	6	16	8	Total Newborn Days		6	16	8
	156	173	129	TOTAL PATIENT DAYS		156	173	129
				Average Length of Stay				
	3.1	2.5		Total Inpatient		3.1	2.5	
	7.9	17.4		Swing Bed		7.9	17.4	
				Avg Daily Census - Hospital				
	3.1	2.7		Total Inpatient		3.1	2.7	
	1.8	2.4		Swing Bed		1.8	2.4	
	4.8	5.1		Total		4.8	5.1	
	447	445	436	ED Visits		447	445	436
	53	53	101	Surgeries		53	53	101
	1243	1084	1044	Imaging Procedures		1243	1084	1044
	4056	3523	3270	Lab Tests		4056	3523	3270
	908	695	608	Rehab Visits		908	695	608
	108	109	107	EMS Runs		108	109	107
	1019	857	1223	Total Clinic Visits		1019	857	1223
	383	108	526	Specialty		383	108	526
combined with express	154	170		Primary care	combined with express	154	170	
	482	579	697	Express Care (budget shows primary and express)		482	579	697
	22	23		working days		22	23	

Note #1 CONTRACTUALS

AR decreased $512,040 from December to January. (balance sheet for 2025 still reflects as presented financials and does not reflect year end adjustments made ytd)
Charity care was $121,990 for January. Bad Debt was $94,170
Charity and Bad Debt are 3.18% of gross charges ytd compared to 3.9% this same time last year.
Medicare Cost Report Model Estimate YTD through December $196,506

Note #2 OTHER OPERATING REVENUE

N/A

Note #3 SUPPLIES

Purchasing and Surgery are currently over budget. We will be monitoring this closely.

Note #4 PROFESSIONAL SERVICES

Some services have not yet started - ie. Cardiology and Urology
General Surgeons are employed

Note #5 PURCHASED SERVICES

Many areas are under budget.

Note #6 NON OPERATING REVENUE

The sale of the old hospital resulted in a net gain of $996,288

There were assets that had not been fully depreciated
Current gain recognized is $228,651 for 2024, $547,446 for 2025 and $45,730 for 2026
Gain on sale of other assets $0

Grants/Contributions -
restricted contributions

WA ST Ecology
Misc
Nick of Time
Foundation
Grant
AWPHD - CHNA
North Central Regional EMS

AZ Wells
WHS Top Performer

grants

Action Health Partners - 21,962
Community Choice - CARES
CWH Grant
WA ST Health
WA ST ED Trauma
WA ST Health
LCHW-EMS ATV Grant
Population Grant
North Central Emer
Misc Grants

wa commerce grant

WA ST Commerce 163,311 overall totay 1,484,931 - EMS Build

For the month ended June 30, 2025

5/31/2025	GL ACCOUNT #	ACCT DESCRIPTION	6/30/2025	EXPLANATION		
$461,308	10002000	General Fund Cash In Bank (Wheatland)	$116,200	**($345,108)**		
				$3,480,553 deposits		
				$0 enhancement pmt		
				medicaid cost report		
				($15,880) tsys/payplus fees		
				($4,363) fees mckesson/cardinal		
				($17) fees and interest		
				rebates		
				$4,598 café sales		
				($3,810,000) transfer to county		
$1,041,076	10004000	General Fund Cash w/ Treasurer	$763,327	**($277,749)**		
				($1,971,060) AP		
				($790) Voids		
				$1,971,850 warrants issued		
				($2,248,809) warrants redeemed		
				$3,810,000 Bank Transfers from 10002000		
				$0 Bank Transfer to/from 10106000		
				($88,992) Bank Transfer for USDA pmt		
				$0 Bank Transfer for bond pmt		
				($2,008,467) Payroll/Benefits		
				($15,655) B&O taxes		
				$8,018 Property Taxes		
				$0 Leasehold Taxes & Misc Taxes		
				$266,156 transfer from revenue bond fund 10923000		
$3,197	10009000	cash clearing	($37,979)	**($41,176)** pmts posted as remits received		
($1,041,076)	20070000	warrants outstanding	($763,327)	**$277,749**		
				($1,253,483) remits (payroll/benefits/b&0)		
				$2,248,809 warrants redeemed		
				($1,971,850) warrants issued ap		
				$1,253,483 remits redeemed		
				$790 voids		
$205,027	10106000	AMB RESERVE	$219,755	**$14,728**		
				$0 transfer to reserves		
				transfer from reserves (bond pmt & ops)		
				$14,607 property taxes		
				$113 leasehold taxes		
				$8 interest	**Days of Cash on Hand**	
					Cash:	
$1,080,286	10910000	2016 GO BOND	$651,130	**($429,156)**	current assets	0
				$9,756 property taxes	unrestricted reserves	1,997,284
				($438,913) bond pmt	unrestricted reserves	6,336,762
						8,334,046
$0	10911000	2016 CASH BOND	$0	**$0** interest	reclassed to general fund	
					USDA reserve	460,407
$320,400	10916000		$320,400	**$0** funded year 3 per LOC	restricted reserves - pending covid ca	4,139,524
$90,000	10917000		$90,000	**$0** funded year 3 per LOC		4,599,931
$410,400			$410,400	$0		
					Expenses,	
$98,131	10915000	CASH/TREAS LTGO BOND	$0	**($98,131)** paid bond interest	total YTD	4,054,025
					less depreciation	-395,571
$80,300	10923000	HOSP 2025 REVENUE BOND	$1,126,399	**$1,046,099** reimb for draws		
						3,658,455
$10,443,649	10760000	RESERVES	$10,476,286	**$32,636**		
				$32,636 interest	number of days YTD	181
$50,006	10764000	COASTAL BANK	$50,006	**($1)**		
				$1 interest		
$12,832,305			$13,012,197	**($866,208)** 6	**Days of Cash on Hand**	412.3
					Restricted Days Cash on Hand	227.6
					Total Days Cash on Hand	**639.9**

CEO Board Report (as of 2/18/2026)

People:

- We continue to struggle recruiting an ED Medical Director and will be looking for vendor support to assist with the search for candidates.
- An offer is out for a part time Gastroenterologist.
- We are pleased to welcome our new MSU Manager, Kailyn Hudson. She will be working to help us continue to grow our capabilities to retain higher acuity patients. We have also hired Sidney Driessen to the role of Clinical Education.
- Audiology services begin this week, which will be a substantial help to our ENT service lines.

Community:

- We are spending a significant amount of time tracking the upcoming rural transformation dollars and monitoring three potential funding sources: the Washington State Hospital Association, the State/HCA related to rural L&D/OB, and the Rural Health Collaborative.
- I have attended WSHA, Rural Health Collaborative, and Rural Health Enterprise Board meetings this past month.
- We are working with our pediatrician, Dr. Reynolds, and the University of Washington to have medical students shadow her soon.
- Visited with the Secretary of Health twice this past month with the goal of reducing administrative burden (we continue to have to report Covid data daily) and setting some reasonable boundaries around charity care.
- EMS received a very nice patient thank-you for their work, which we will read at the board meeting.

Quality:

- Proud to highlight our pharmacy technician, Kyle Knudsen, for winning a Quality Star Award this past month for going above and beyond for the departments he serves and for his strong communication skills. The PACU/OR and Sterile Processing teams also won Quality Star Awards for their flexibility and hard work in absorbing increased volumes and new services.

Financial:

- January gross revenue was $6.8M compared to $5.5M last year, which was 6% above the projected budget. The bottom line was essentially break-even at $37K (we had budgeted for a loss of $424K). Volumes for most departments were close to or above budget. Imaging, lab, rehab, and our specialty clinics experienced the largest volume increases. Primary care was down year over year and substantially below budget. Inpatient censuses increased to 3.1 compared to 2.7 during the same period last year. Patient days in L&D were down substantially compared to the same time last year (16 in 2025 versus 6 this year). We are seeing good momentum with orthopedics, and early indications suggest that our move to 24/7 general surgery is increasing both case volume and staff satisfaction. ENT has been a very popular service, with most days having full schedules.

Building for the Future:

- The EMS station build continues to be on schedule. We are almost complete with framing and footings have been poured for the garage.

Department Team Board Scoring Checklist

Department: _____ **Date:** _____ **Reviewer:** _____

	0	1	2
Board is organized, uncluttered and creative	☐	☐	☐
Staff can explain the board and current priorities	☐	☐	☐
Progress toward current QI/PI goals is clearly shown	☐	☐	☐
Data/information is current (updated within defined timeframe)	☐	☐	☐

Comments:

_____

_____

_____

Scoring Summary

Maximum Score: 20

Department Score: _____ /20

Score Range	Rating
8	Excellent – Model huddle board
6-7	Good – Minor opportunities for improvement
5	Fair – Needs improvement
< 4	Poor – Action plan required

Status **Pending** PolicyStat ID **19457805**

Origination	11/27/2024
Last Approved	N/A
Effective	Upon Approval
Last Revised	1/1/2026
Next Review	2 years after approval
Owner	Louise Sahlinger: Director Of Quality
Area	Administration

Lake Chelan Health - Nondiscrimination

I. PURPOSE

The purpose of this policy is to ensure that all patients and visitors of Lake Chelan Health (LCH) are treated with equality, in a welcoming, nondiscriminatory manner, consistent with applicable state and federal law.

II. POLICY STATEMENT

It is the policy of Lake Chelan Health (LCH) to provide equal access to its facilities and services without unlawful discrimination on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law. Equal access includes physical accommodations for disabled persons, nondiscriminatory delivery of benefits, and reasonable aid in accessing electronic health programs.

III. SCOPE

The policy applies to all members of the Lake Chelan Health (LCH) workforce, including employees, medical staff members, contracted service providers, and volunteers, and to all vendors, representatives, and any other individuals providing services to or on behalf of LCH.

IV. ROLES & RESPONSIBILITIES

It is the role and responsibility of all staff, vendors and representatives to abide by and uphold this policy.

V. DEFINITIONS

1. **Nondiscrimination -** The practice of treating people equally and fairly, without regard to certain characteristics. People should not be treated less favorably than others in similar situations because of their race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, disability, age, sexual orientation, and more.
2. **Reasonable accommodation -** A change or adjustment that allows people with specific needs to have equal opportunities. An accommodation is considered reasonable if it doesn't create an undue hardship for the employer. Reasonable accommodations are not considered "special treatment" and can often benefit all employees.

VI. PROCEDURE

1. **Nondiscrimination -** Hospital Personnel will treat all patients and visitors receiving services from or participating in other programs of LCH and its affiliated clinics with equality in a welcoming manner that is free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, association, veteran or military status, or any other basis prohibited by federal, state, or local law.
2. **Notice -** Hospital Personnel will provide notices to patients regarding this Nondiscrimination Policy and LCH's commitment to providing access to and the provision of services in a welcoming, nondiscriminatory manner. LCH will provide notices pursuant to Section 1557 of the Patient Protection and Affordable Care Act.
3. **Reasonable Accommodations -** Hospital Personnel will inform patients of the availability of and make reasonable accommodations for patients consistent with federal and state requirements. This includes, for example, informing patients of their right to appropriate auxiliary aids and services such as qualified language interpreters for non-English speaking patients and sign language interpreters for hearing-impaired patients and how to obtain these aids and services. Aids and services will be provided free of charge and in a timely manner when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities or to provide meaningful access to individuals with limited English proficiency.
4. **Visitation Rights -** Hospital Personnel will afford visitation rights to patients free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, association, veteran or military status, or any other basis prohibited by federal, state, or local law and will ensure that visitors receive equal visitation privileges consistent with patient preferences. At the time patients are notified of their patient rights, Hospital Personnel will also inform each patient, or the patient's support person, including the patient's attorney in fact, when appropriate, of the patient's visitation rights, including any clinical restriction on those rights, and the patient's right, subject to the patient's consent, to receive visitors whom the patient designates, free of discrimination based upon age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, association, veteran or military status, or any other basis prohibited by federal, state, or local law. Such visitors include a spouse, registered domestic partner (including same-sex registered domestic partner), another family

member, friend, or a legal representative of the patient, such as an attorney in fact. Hospital Personnel will also notify patients of their right to withdraw or deny such consent at any time. Hospital Personnel will afford such visitors equal visitation privileges consistent with the patient's preferences.

5. **Provision of Services -** Hospital Personnel will determine eligibility for and provide services, financial aid, and other benefits to all patients in a similar manner, without subjecting any individual to separate or different treatment on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, association, veteran or military status, or any other basis prohibited by federal, state, or local law.
6. **Complaints:**
    1. Any person who believes that they, or another person has been subjected to discrimination which is not permitted by this policy, may file a complaint using LCH's complaint and grievance procedure, which will provide prompt and equitable resolutions of grievances.
    2. Any Hospital Personnel receiving a patient or visitor discrimination complaint will advise the complaining individual that he or she may report the report to the Executive Director of Quality, Safety and Risk Management at 509-682-3300, extension ~~7814~~8900, and file a complaint without fear of retaliation.
    3. Hospital Personnel are prohibited from retaliating against any person who opposes, complaints about, or report discrimination, files a complaint, or cooperates in an investigation or other proceeding under federal, state, or local anti-discrimination law.
7. **Compliance -** LCH's Compliance Officer is responsible for coordinating compliance with this Policy, including giving notice to and training all Hospital Personnel on this Policy. LCH will designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities under this policy and under Section 1557 of the Patient Protection and Affordable Care Act, including the investigation of any grievance.

VII. REFERENCES

1. Patient Protection and Affordable Care Act, Section 1557
2. WA DOH
3. WA State Hospital Association

VIII. ATTACHMENTS

n/a

**This policy may be revised at any time without prior notice. All revisions supersede prior policy and are effective immediately upon approval.*
**Any printed policy is not valid past the print date and should not be relied on for official purposes. Current versions of all policies can be found in PolicyStat.*

Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	Pending
Administration	Aaron Edwards: CEO	1/27/2026
Policy Management Committee	Committee Policy Management: Policy Management Committee	1/26/2026
	Louise Sahlinger: Director Of Quality	1/1/2026

Status **Pending** PolicyStat ID **19790012**

Origination	3/1/2016
Last Approved	N/A
Effective	Upon Approval
Last Revised	2/2/2026
Next Review	2 years after approval

Owner	Louise Sahlinger: Director Of Quality
Area	Administration

Tort Claims Policy

~~Purpose:~~

~~To identify a clear policy for standard tort claims in accordance with Washington State law.~~

~~Policy:~~

I. PURPOSE

To establish a standardized process for the receipt, review, investigation, management, and resolution of tort claims and notices of claim against Lake Chelan Health, its employees, medical staff, contractors, and agents, in compliance with Washington State law, federal requirements, and applicable risk management standards.

II. POLICY STATEMENT

Lake Chelan Health (LCH) is committed to handling tort claims in a timely, fair, transparent, and legally compliant manner. LCH will investigate all claims thoroughly, preserve legal rights and defenses, protect patient privacy and confidentiality, and seek resolution consistent with:

1. **RCW 4.96.020** (Tort claims against local governmental entities),
2. **RCW 70.44** (Public Hospital Districts),
3. **RCW 70.02** (Confidentiality of Healthcare Information),
4. Applicable federal law and accreditation standards.

~~Lake Chelan Health complies with~~As stated in RCW ~~4.96.020 for tortious conduct of local governmental~~

~~entities and their agents. As stated in RCW~~ 4.96.020, the governing body of each local governmental entity shall appoint an agent to receive any claim for damages. The identity of the agent and the address where he or she may be reached during the normal business hours of the local governmental entity are public records and shall be recorded with the auditor of the county in which the entity is located.

Appointed Agent:	CEO
Office Address:	~~110 S. Apple Blossom Dr.~~ ~~Chelan, WA 98816~~ 110 S. Apple Blossom Dr. Chelan, WA 98816
Business Hours:	8:00 am to 4:30 pm Monday – Friday except Holidays

~~Procedure:~~

~~All claims for damages must be presented on the standard tort claim form. The form and instructions are available at public request.~~

~~References:~~

~~Governing Board Resolution #565 signed March 22, 2016~~

III. SCOPE

This policy applies to all departments, employees, medical staff, contractors, volunteers, and agents of Lake Chelan Health, including actions arising from clinical care, employment practices, premises liability, and other operations of the organization.

IV. ROLES AND RESPONSIBILITIES

Board of Commissioners	1. Provides oversight of tort claims management and risk exposure pursuant to **RCW 70.44**. 2. Approves settlement authority thresholds as required by law. 3. Receives periodic reports on claims trends and risk mitigation strategies.
CEO/Administrator	1. Ensures implementation of this policy and allocation of resources. 2. Authorizes claims handling processes and settlement authority within delegated limits.

	3. Serves as liaison to the Governing Board for high-risk or high-value claims.
Risk Manager/Risk Management	1. Serves as the primary coordinator for all tort claims under **RCW 4.96.020**. 2. Maintains a claims log and documentation. 3. Receives and reviews notices of claim and lawsuits. 4. Coordinates investigations and preservation of evidence. 5. Works with legal counsel, insurers, and leadership on claim resolution. 6. Ensures compliance with reporting and documentation requirements.
Legal Counsel	1. Provides legal advice on claim validity, defenses, and litigation strategy. 2. Files responses, motions, and pleadings consistent with Washington civil procedure. 3. Negotiates settlements and represents the hospital in litigation. 4. Ensures compliance with statutory deadlines and procedural requirements.
Compliance Officer/Privacy Officer	1. Ensures disclosures related to claims comply with **RCW 70.02** and **HIPAA**. 2. Advises on minimum necessary disclosure and safeguards.
Department Directors and Managers	1. Promptly report incidents that may give rise to a claim. 2. Cooperate with investigations and evidence preservation. 3. Implement corrective actions to mitigate future risk.
All LCH Employees, Medical Staff, Residents, Students, Contractors, Volunteers	1. Report incidents promptly through the hospital's event reporting system. 2. Cooperate fully with investigations and legal proceedings.

	3. Refrain from unauthorized disclosure of claim-related information. 4. Preserve confidentiality and avoid retaliation.

V. DEFINITIONS

1. **Tort Claim:** A civil claim seeking monetary damages for injury, loss, or damage allegedly caused by the negligence or wrongful act of the hospital or its agents.
2. **Notice of Claim:** A formal written claim submitted by or on behalf of a claimant prior to filing a lawsuit, as required under **RCW 4.96.020**.
3. **Claimant:** An individual or entity asserting a claim for damages.
4. **Public Hospital District:** A governmental entity organized under **RCW 70.44**.
5. **Risk Management:** The process of identifying, analyzing, and mitigating risks that could result in claims or litigation.
6. **Settlement:** A negotiated resolution of a claim without admission of liability.
7. **Litigation:** The process of resolving disputes through the court system

VI. PROCEDURE

1. Legal and Regulatory Authority

Washington State Law

1. **RCW 4.96.020** – Tort claims against local governmental entities; notice of claim requirements, waiting period, and service provisions.
2. **RCW 70.44** – Public Hospital Districts; authority, governance, and operations.
3. **RCW 70.02** – Uniform Health Care Information Act; confidentiality and disclosure of medical records.
4. **RCW 42.56** – Public Records Act (to the extent claims records are subject to disclosure, with applicable exemptions).
5. **RCW 5.60.060** – Privileges and confidentiality (e.g., peer review protections).
6. **RCW 7.70** – Actions for injuries resulting from healthcare (medical malpractice standards and procedures).
7. **RCW 4.92.100** – Tort claims against the State of Washington (referenced when applicable or for comparative standards).

Federal Law

1. **Federal Tort Claims Act (FTCA)** – 28 U.S.C. §§ 1346(b), 2671–2680 (where applicable).
2. **HIPAA Privacy Rule** – 45 CFR Parts 160 and 164.

3. **CMS Conditions of Participation** for Critical Access Hospitals.

2. Receipt and Handling of Notices of Claim

1. **Receipt**
    1. All notices of claim, lawsuits, or legal correspondence must be forwarded immediately to Risk Management and Legal Counsel.
    2. LCH will date-stamp and log all claims upon receipt.
2. **Verification**
    1. Risk Management will verify that the claim:
        1. Complies with **RCW 4.96.020**, including:
            1. Use of the statutory claim form or equivalent;
            2. Proper service on the designated agent or clerk of the hospital district;
            3. Inclusion of claimant information, factual basis, damages claimed, and supporting documentation.
    2. Is timely and jurisdictionally valid.
3. **Statutory Waiting Period**
    1. Pursuant to **RCW 4.96.020(4)**, claimants must wait **60 days** after filing a notice of claim before filing a lawsuit. LCH will use this period to investigate and evaluate the claim.

3. Investigation Process

1. **Initial Assessment**
    1. Risk Management will:
        1. Secure and preserve relevant records, equipment, and evidence.
        2. Identify involved staff and witnesses.
        3. Assess patient safety, regulatory, and legal implications.
2. **Information Gathering**
    1. Obtain medical records consistent with **RCW 70.02** and HIPAA.
    2. Collect incident reports, policies, procedures, and documentation.
    3. Conduct interviews using a just culture approach.
    4. Engage experts as needed.
3. **Documentation**
    1. All investigative activities and findings will be documented and maintained in a secure claims file.

4. Coordination with Insurance and Risk Pools

1. Risk Management will notify applicable insurers, risk pools, or excess carriers promptly, consistent with policy requirements and contractual obligations.
2. All claims will be handled in accordance with insurance contracts and Washington law.

5. Evaluation and Resolution

1. **Claim Evaluation**
    1. Legal Counsel and Risk Management will evaluate claims in accordance with:
        1. **RCW 7.70** (standards for medical malpractice and healthcare liability),
        2. Applicable case law,
        3. Contractual and statutory defenses.
2. **Settlement Authority**
    1. Settlement authority will follow LCH policy, governing board resolutions, and statutory requirements under **RCW 70.44**.
    2. Governing Board approval will be obtained when required by law or policy.
3. **Settlement Process**
    1. Settlements will be negotiated in good faith.
    2. All settlements will be documented in writing and executed according to legal requirements.
    3. No admission of liability will be made unless required by law or approved by counsel.
4. **Litigation Management**
    1. Legal Counsel will manage all court filings, discovery, and court appearances.
    2. Risk Management will coordinate witness preparation and document production.

6. Confidentiality and Privacy

1. All claim-related information is confidential and protected to the fullest extent permitted by law, including:
    1. **RCW 70.02** (healthcare information confidentiality),
    2. **RCW 5.60.060** (peer review and quality assurance protections),
    3. HIPAA Privacy Rule.
2. Claim files are not part of the patient's medical record and must be stored separately and securely.

7. Reporting and Oversight

1. Risk Management will provide periodic reports to executive leadership and the Governing

Board regarding:

1. Number and type of claims
2. Financial exposure
3. Trends and root causes
4. Risk mitigation and improvement actions

8. Integration with Risk Management and Patient Safety

1. Claims data will be analyzed and incorporated into the hospital's Risk Management and Patient Safety Program.
2. RCAs and corrective actions will be conducted for claims involving serious adverse events or system failures.
3. Lessons learned will be disseminated to prevent recurrence.

9. Training and Education

1. Staff will receive training on:
    1. Incident reporting and documentation
    2. Claims awareness and response
    3. Confidentiality and disclosure requirements
    4. **RCW 4.96.020** and **RCW 70.02** obligations

10. Record Retention

1. Claim files will be retained in accordance with hospital policy, insurance requirements, and Washington State retention laws.
2. Records will be disposed of securely at the end of the retention period.

VII. REFERENCES

1. **RCW 4.96.020** – Tort claims against local governmental entities; notice of claim requirements, waiting period, and service provisions.
2. **RCW 70.44** – Public Hospital Districts; authority, governance, and operations.
3. **RCW 70.02** – Uniform Health Care Information Act; confidentiality and disclosure of medical records.
4. **RCW 42.56** – Public Records Act (to the extent claims records are subject to disclosure, with applicable exemptions).
5. **RCW 5.60.060** – Privileges and confidentiality (e.g., peer review protections).
6. **RCW 7.70** – Actions for injuries resulting from healthcare (medical malpractice standards and procedures).
7. **RCW 4.92.100** – Tort claims against the State of Washington (referenced when applicable or

for comparative standards).

8. **Federal Tort Claims Act (FTCA)** – 28 U.S.C. §§ 1346(b), 2671–2680 (where applicable).
9. **HIPAA Privacy Rule** – 45 CFR Parts 160 and 164.
10. **CMS Conditions of Participation** for Critical Access Hospitals.

VIII. ATTACHMENTS

n/a

**This policy may be revised at any time without prior notice. All revisions supersede prior policy and are effective immediately upon approval.*

**Any printed policy is not valid past the print date and should not be relied on for official purposes. Current versions of all policies can be found in PolicyStat.*

Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	Pending
Executive Approval	Shawn Ottley: COO/CNO	2/13/2026
Executive Director of Quality	Louise Sahlinger: Director Of Quality	2/2/2026
Policy Management Committee	Committee Policy Management: Policy Management Committee	2/2/2026
	Louise Sahlinger: Director Of Quality	2/2/2026

Status **Pending** PolicyStat ID **19501540**

Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	2 years after approval
Owner	Louise Sahlinger: Director Of Quality
Area	Medical Staff

Emergency Credentialing and Disaster Privileging Policy

I. PURPOSE

This policy establishes a process for granting emergency privileges to licensed independent practitioners (LIPs) and other licensed or certified healthcare professionals during a disaster or emergency situation. The policy ensures compliance with CMS Critical Access Hospital Conditions of Participation (42 CFR §485.616, §485.625) and DNV NIAHO® standards (MS.7, MS.8, EM).

II. POLICY STATEMENT

The Hospital recognizes its obligation to ensure the timely availability of qualified licensed independent practitioners (LIPs) during emergencies and disaster situations while maintaining patient safety and compliance with regulatory requirements.

In accordance with **CMS Conditions of Participation**, **DNV NIAHO® standards**, and the Hospital's **Medical Staff Bylaws**, the Hospital may grant **emergency privileges** and/or **disaster privileges** to eligible practitioners when the immediate need for patient care exceeds available Medical Staff resources or when normal credentialing processes cannot be completed due to emergency conditions.

Emergency and disaster privileges may be granted **on a temporary basis**, following verification of licensure and professional qualifications to the extent possible under the circumstances, and are limited to the **scope of privileges necessary to meet patient care needs** during the emergency.

III. SCOPE

This policy applies to licensed independent practitioners, other licensed or certified practitioners, volunteer practitioners, external emergency responders, and locum tenens practitioners providing

services during an emergency/disaster.

IV. ROLES & RESPONSIBILITIES

Chief Executive Officer (CEO) / Hospital Administrator

The CEO or designee is responsible for:

1. Declaring emergency conditions, in coordination with incident command when activated
2. Authorizing the activation of emergency and disaster credentialing processes
3. Ensuring sufficient resources and staffing are available to support emergency patient care
4. Maintaining accountability for compliance with regulatory requirements

Chief Medical Officer

The Chief Medical Officer is responsible for:

1. Approving the granting of emergency or disaster privileges to eligible practitioners
2. Ensuring privileges granted are **limited in scope** and appropriate to the emergency need
3. Assigning appropriate **clinical oversight and supervision**
4. Coordinating with Medical Staff leadership to monitor practitioner performance during the emergency

Credentialing Committee / Medical Staff Office (MSO)

The Credentialing Committee and/or Medical Staff Office is responsible for:

1. Performing **primary source verification** to the extent possible under emergency conditions
2. Verifying licensure, identity, and professional qualifications when feasible
3. Maintaining documentation of emergency and disaster credentialing actions
4. Completing **retrospective credentialing and verification** once normal operations resume

Department Chairs / Service Line Leaders

Department Chairs or Service Line Leaders are responsible for:

1. Assessing clinical need within their departments during emergencies
2. Recommending practitioners for emergency or disaster privileges
3. Providing or assigning **direct supervision or proctoring**, as appropriate
4. Reporting performance concerns or patient safety issues promptly

Incident Command (when activated)

The Hospital Incident Command System (HICS) is responsible for:

1. Coordinating clinical staffing needs during declared emergencies
2. Communicating operational needs and changes to Medical Staff leadership
3. Supporting documentation and tracking of emergency credentialed practitioners

Practitioners Granted Emergency or Disaster Privileges

Practitioners granted emergency or disaster privileges are responsible for:

1. Practicing within the **scope and limitations** of granted privileges
2. Complying with Hospital policies, procedures, and Medical Staff Bylaws
3. Cooperating with oversight, supervision, and performance monitoring
4. Providing accurate information related to licensure, competence, and credentials

Quality / Risk Management

Quality and/or Risk Management is responsible for:

1. Monitoring patient safety and quality of care during emergency operations
2. Supporting event reporting and review related to emergency credentialed practitioners
3. Participating in post-event evaluation and performance review activities

Compliance / Legal (as applicable)

Compliance and/or Legal Services are responsible for:

1. Advising leadership on regulatory requirements during emergency conditions
2. Supporting policy interpretation and documentation standards
3. Assisting with post-emergency audits and regulatory follow-up, if required

V. DEFINITIONS

Emergency/Disaster: A situation requiring **activation of the Hospital Emergency Operations Plan (EOP)** or a **local, state, or federal emergency declaration**, or any event that threatens the CAH's ability to meet immediate patient care needs.

Emergency Privileges: A condition which would result in seroius permanent harm to a patient, or in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that danger. Time-limited authorization for a practitioner to provide care at the CAH before the full credentialing and privileging process is completed, consistent with CMS (§485.616(c)(2)) and DNV MS.8.

Primary Source Verification (PSV): The process where an organization directly contacts the original issuer (university, licensing board, certification body) to confirm a healthcare provider's credentials (licenses, degrees, certifications, training) are authentic, accurate, and current, rather than relying on copies of self-reported data, ensuring only qualified, safe professionals practice.

VI. PROCEDURE

1. When Emergency/Disaster Credentialing May Be Used

Emergency/disaster credentialing may be initiated when any of the following occur:

1. Activation of the CAH Emergency Operations Plan (EOP)
2. State, local, or federal emergency declaration
3. Sudden surge in patient volume or acuity that exceeds available staff
4. Unexpected loss or absence of essential clinical providers
5. Transfer or evacuation of patients from a nearby facility requiring additional practitioners
6. Arrival of qualified volunteer or external emergency responders
7. Immediate threat to patient health or safety requiring rapid care by clinically qualified personnel

In the case of an emergency, any Member of the Medical Staff or Physician Assistant, to the degree permitted by the practitioner's license, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must relinquish care of the patient if not already privileged to continue care. The wishes of the patient shall be considered where feasible in the section of a Medical Staff Member to continue care.

If there is a need for emergency, specialized care not normally available at the Hospital, any practitioner wh ois not credentialed but possesses skills and expertise to administer such treatment for a patient in immediate danger may request to do everything possible to save the life of a patient.

These conditions are consistent with **CMS §485.625** requirements for providing emergency services and **DNV EM** expectations for surge staffing capability.

2. Authority to Grant Emergency/Disaster Privileges

Emergency/disaster privileges may be granted by:

1. CEO/Administrator, or
2. Chief Medical Officer, or
3. Designee identified in Medical Staff Bylaws.

This authority aligns with **CMS §485.616(c)(2)** and **DNV MS.8**.

3. Minimum Verification Requirements

Consistent with CMS and DNV standards, the following must be verified to the extent possible during the emergency:

Required at the Time of Granting Emergency/Disaster Privileges

1. Practitioners considered eligible to act as volunteer practitioners must at a minimum present a valid government-issued photo identification issued by a state or federal agency AND at least one of the following:
    1. A current picture Hospital ID card,
    2. A current license to practice,
    3. Primary source verification of the license,
    4. Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-WHP), or other recognized state or federal organizations or groups,
    5. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances, such authority having been granted by a federal, state, or municipal entity, or
    6. Identification by current Hospital or Medical Staff Member(s) with personal knowledge regarding the Practitioner's identity.

As required by **CMS §485.616(c)(2)(iii)** and DNV MS.7/MS.8, the hospital must complete:

1. The verification process is a high priority and as time, power, and technology permits, the Medical Staff Services Office will obtain primary source verification of the volunteer practitioner's licensure as soon as the immediate situation is under control, not to exceed 72 hours from the time the volunteer practitioner has been granted disaster privileges.
    1. In the event primary source verification cannot be completed in 72 hours (e.g. no means of communication or lack of resources) primary source verification will be completed as soon as possible.
    2. In the event primary source verification cannot be completed in 72 hours, there must be documentation of WHY it could not be performed in the required timeframe, evidence of a demonstrated ability to continue to provide adequate care and evidence of the Hospital's attempts to perform primary source verification as soon as possible.
2. A log will be maintained recording the volunteer's ability to act as a volunteer practitioner during a disaster.
3. The volunteer practitioner will be assigned in accordance with the Hospital's Emergency Operations Plan. Whenever possible, the volunteer practitioner will be paired with a currently privileged Member of the Medical Staff who has similar credentials or licensure. Whenever possible, the volunteer practitioner granted disaster privileges should act only under the direct supervision and mentoring of a Medical Staff Member with like credentials. If a Member of the Medical Staff with like credentials is not available to be paired with the volunteer practitioner, another Member of the Medical Staff will perform direct observation and mentoring of the volunteer practitioner.
4. The CEO and/or Chief Medical Officer shall make a decision regrading continuation of the emergency/disaster privileges granted within 72 hours of the initial granting of emergency/disaster privileges at least once each week until the emergency/disaster privileges expire or are terminated. This determination shall be based upon the oversight of the volunteer

practitioner and information obtained regarding the professional practice of the volunteer practitioner.

Post-Event Required PSV

As required by **CMS §485.616(c)(2)(iii)** and DNV MS.7/MS.8, the hospital must complete:

1. Full primary-source license verification
2. NPDB query
3. OIG/SAM checks
4. Privileging file completion - within 72 hours, or as soon as practical if the emergency/disaster prevents timely completion. Any delay must be documented.

Documentation Requirements

The CAH must maintain documentation including:

1. Practitioner identification
2. Verifications completed at the time of privileging
3. The specific clinical privileges granted
4. Duration of emergency/disaster privileges
5. The reason emergency/disater privileging was activated
6. Any adverse or performance concerns
7. Completion of post-event credentialing checks

Documentation supports DNV MS.7/MS.8 and CMS §485.616 survey expectations.

Practitioner Oversight During Emergency Privileges

DNV MS.8 requires monitoring of practitioners operating under emergency/disaster privileges. Oversight may include:

1. Direct observation
2. Chart review
3. Rapid competency assessment by a privileged practitioner

Any quality-of-care concern must be promptly reported to the Medical Staff Leadership.

Duration of Emergency/Disaster Privileges

Emergency privileges are:

1. Effective only for the duration of the emergency/disaster, and
2. May not exceed 60-120 days, unless otherwise defined by the Medical Staff Bylaws.

Privileges automatically expire at the conclusion of the emergency/disaster unless the practitioner successfully enters the standard credentialing process and is approved by the Governing Body.

Termination of Emergency/Disaster Privileges

Disaster/emergency privileges may be terminated at any time for any reason or cause.

Disaster/emergency privileges may be terminated at any time when:

1. The emergency/disaster has ended
2. The practitioner is no longer needed
3. There are concerns regarding competence, safety, or behavior
4. Required post-event verifications reveal disqualifying information

Termination authority mirrors the granting authority.

There will be no appeal or procedural rights under the Medical Staff Bylaws in the event a volunteer practitioner's disaster privileges are denied or terminated, regardless of the reason for action.

Communication and Tracking

The CAH shall maintain a real-time roster of all practitioners granted emergency/disaster privileges, as required under **DNV EM** and CMS emergency preparedness requirements.

Staff, departments, and the incident command structure must be notified of each practitioner's identity and authorized scope.

Integration With the Emergency Operations Plan (EOP)

This policy is integrated into the hospital's EOP and complies with CMS Emergency Preparedness CoP and **DNV Emergency Management standards**, including requirements for surge staffing, credential verification, and continuity of operations.

Post-Emergency Review

Within 30-60 days after the event, the Medical Staff and Leadership shall review:

1. Effectiveness of the emergency/disaster credentialing process
2. Staff feedback
3. Any delays in verification or documentation
4. Any quality or safety issues
5. Opportunities for improvement

Findings will be incorporated into the EOP and Medical Staff policies, consistent with DNV continuous improvement expectations.

VII. REFERENCES

1. DNV NIAHO Accreditation Requirements, Interpretive Guidelines & Surveyor Guidance for Critical Access Hospitals, Revision 25-1, September 8, 2025.
2. **CMS §485.625**

3. **CMS §485.616**

VIII. ATTACHMENTS

~~n/a~~

Disaster & Emergency Credentialing Form

**This policy may be revised at any time without prior notice. All revisions supersede prior policy and are effective immediately upon approval.*
**Any printed policy is not valid past the print date and should not be relied on for official purposes. Current versions of all policies can be found in PolicyStat.*

Attachments

Disaster & Emergency Credentialing Form.pdf

Approval Signatures

Step Description	Approver	Date
Board Approval	Wendy Kenck: Executive Assistant	Pending
Med Exec Committee	Louise Sahlinger: Director Of Quality	2/16/2026
CMO Review	Stu Freed	2/16/2026
Policy Management Committee	Committee Policy Management: Policy Management Committee	2/2/2026
Owner	Louise Sahlinger: Director Of Quality	1/26/2026

CHELAN COUNTY PUBLIC HOSPITAL DISTRICT #2
Lake Chelan Health
Chelan County, WA

RESOLUTION No. 2026-4
Disposal Laptop Desk

A RESOLUTION of the Board of Commissioners of Public Hospital District No. 2, Chelan County, Washington (the 'District'), to authorize the disposal of hospital surplus items; and

WHEREAS, Lake Chelan Health (LCH) a public hospital in the State of Washington, is committed to the responsible management and disposal of assets; and

WHEREAS, the Rehabilitation department has identified the following items as surplus to departmental needs:

- Rolling Laptop Desk, Model #MI-7997, Asset Tag# 10405

WHEREAS, an assessment has determined that this equipment is no longer working and should be disposed of in accordance with applicable laws and hospital policies;

BE IT RESOLVED, that the Board of Commissioners of Chelan County Public Hospital District No. 2 hereby adopts the following:

1. The items described above are declared surplus and are authorized for disposal.

2. The approved method of disposal is to scrap the equipment, in accordance with hospital policy and applicable regulations, as it has been deemed unusable.

The Controller is authorized to oversee and document the disposal process in compliance with all applicable state and local regulations.

A record of the disposal, including method and justification, shall be maintained for auditing purposes.

ADOPTED AND APPROVED, by the Board of Commissioners, Chelan County Public Hospital District No. 2, at an open public meeting thereof this 24th day of February 2026 with the following Commissioners being present and voting in favor of the resolution.

CHAIRPERSON OF THE BOARD	SECRETARY
VICE CHAIRPERSON	MEMBER
MEMBER	CEO

CC: Controller, Materials