MEMORIAL HOSPITAL OF SWEETWATER COUNTY
REGULAR MEETING OF THE BOARD OF TRUSTEES
June 4, 2025
2:00 p.m.
Hospital Classrooms 1, 2 & 3

AGENDA

I. Call to Order — Barbara Sowada
   A. Roll Call
   B. Pledge of Allegiance
   C. Mission and Vision — Barbara Sowada
   D. Mission Moment — Irene Richardson, *Chief Executive Officer*

II. Approval of Agenda *(For Action)* — Barbara Sowada
   A. Requests for Consent Agenda items to be removed to New Business
      (If not removed, no questions/discussion)
   B. Requests for Senior Leader or Board Committee Reports to be removed to New Business
      (if not removed, no questions/discussion)

III. Community Communication — Barbara Sowada

IV. Old Business — Barbara Sowada
   A. Quarterly Progress Report on Strategic Plans and Goals
   B. CAH – Plan of Care & Scope of Services *(For Action)* — Marty Kelsey
   C. Professsonal Practice Review Plan *(Under Development)*
   D. Patient Safety

V. Consent Agenda *(For Action)* — Barbara Sowada
   A. Approval of Meeting Minutes
   B. Approval of Bad Debt
   C. BOT – Memorial Hospital of Sweetwater County Meeting Guidelines — Marty Kelsey
   D. BOT – Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders — Marty Kelsey
   E. CAH - Employee Health Plan — Ann Marie Clevenger, Chief Nursing Officer
   F. CAH Policies — Kari Quickenden, Chief Clinical Officer
      1. Sterile Preparations: Redispensing Unused Compounded Sterile Preparations, 22-06-20 *(Previously 22-27)*
      2. Sterile Preparations: Transporting Compounded Sterile Preparations to Patient Care and Procedural Areas, 22-06-*19 (Previously 22-26)*
      3. Sterile Preparations: Final Verification of Preparations, 22-06-18 *(Previously 22-25)*
      4. Sterile Preparations: Aseptic Technique, 22-06-05 *(Previously 22-17)*
      5. Pharmacy: Sterile Preparations: Sterile Compounding Procedures, 22-06-01*(Previously 22-18)*
      6. Pharmacy: Sterile Preparations: Hand Hygiene and Garbing, 22-06-03 *(Previously 22-19)*
      7. Pharmacy: Hazardous Drugs: Preparing Parenteral Medications, 22-06-02 *(Previously 19-07)*
      8. Pharmacy: Hazardous Drugs: Preparing Non-Sterile Medications, 22-05-02 *(Previously 19-08)*

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
REGULAR MEETING OF THE BOARD OF TRUSTEES
June 4, 2025
2:00 p.m.
Hospital Classrooms 1, 2 & 3

AGENDA

9. Pharmacy: Sterile Preparations: Intrathecal Medications 22-06-09 *(Previously 22-35)*
10. Pharmacy: General Storage of Medications, 09-01
11. Pharmacy: Compounding - General: Radiopharmaceuticals 22-01-07
12. Partial And Crushed Tablets, 11-14
13. Pharmacy: Administration: Administration of Medications – Pediatric Patients, 13-07
14. Pharmacy: Administration: Administration of Medications - General, 13-01
15. Medication Reconciliation
16. Administration of Medications by Provider Type (MM.06.01.01 EP 1-9)
17. Study Participant Screening & Enrollment CTO 003-21v2
18. Clinical Trials Research Related Individual Conflict of Interest

G. Requests from the Credentials Committee
1. Invasive Health Questions
2. Health Statement Form

VI. New Business *(For Review and Questions/Comments)* — Barbara Sowada
A. Credentialing Policy — Kerry Downs, *Medical Staff Services Director*

VII. Reports
A. Chief Executive Officer and Guests Verbal Reports
1. Chief Executive Officer Report — Irene Richardson
2. Medical Staff Services Chief of Staff Report — Dr. Alicia Gray
3. County Commissioner Liaison Report — Taylor Jones

B. Senior Leader and Board Committee Reports
1. Senior Leader Written Reports
a. Chief Clinical Officer — Kari Quickenden
b. Chief Experience Officer — Cindy Nelson
c. Chief Financial Officer — Tami Love
d. Chief Nursing Officer — Ann Marie Clevenger
2. Board Committee Written or Verbal Reports
a. Building and Grounds Committee — Craig Rood
b. Compliance Committee — Kandi Pendleton
c. Governance Committee — Marty Kelsey
d. Quality Committee — Barbara Sowada
e. Human Resources Committee — Kandi Pendleton
f. Finance and Audit Committee — Marty Kelsey
g. Foundation Board Report — Craig Rood
h. Executive Oversight and Compensation Committee — Barbara Sowada

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
REGULAR MEETING OF THE BOARD OF TRUSTEES
June 4, 2025
2:00 p.m.
Hospital Classrooms 1, 2 & 3

AGENDA

i. Joint Conference Committee — Barbara Sowada

VIII. Contracts — Suzan Campbell, *In-House Counsel*

A. Advanced Medical Imaging *(For Action)*

B. Genesa Reimbursement Group MSA with Accompanying SOW *(For Information, No Action Needed)*

C. Renewal of CQ Medical Service Agreement *(For Information, No Action Needed)*

IX. Education

A. Walk In Clinic Discussion — Ann Marie Clevenger, Misty Cozad, *Practice Manager*

X. Good of the Order — Barbara Sowada

A. Discussion Regarding Committee Assignments — Kandi Pendleton

B. Discussion Regarding July and September Meeting Dates — Barbara Sowada

XI. Executive Session (W.S. §16-4-405(a)(ix)) — Barbara Sowada

XII. Action Following Executive Session — Barbara Sowada

XIII. Adjourn — Barbara Sowada

Memorial Hospital

OF SWEETWATER COUNTY

OUR MISSION

Compassionate care for every life we touch.

OUR VISION

To be our community's trusted healthcare leader.

OUR VALUES

Be Kind

Be Respectful

Be Accountable

Work Collaboratively

Embrace Excellence

OUR STRATEGIES

Patient Experience

Quality & Safety

Community, Services & Growth

Employee Experience

Financial Stewardship

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:6/4/2025

Topic for Old & New Business Items:

- CAH – Plan of Care and Scope of Services

Policy or Other Document:

☐ Revision
☒ New

Brief Senior Leadership Comments:
The CEO participates in the Governance Committee and recommends approval.

Board Committee Action:

Approved by the Governance Committee at their April 21 meeting. Presented at the May Board of Trustees meeting for first review. Suggestions for additions were made and reviewed by the Governance Committee at their May meeting. Presented at the June Board of Trustees meeting for second read and request for approval.

Policy or Other Document:

☐ For Review Only
☒ For Board Action

Legal Counsel Review:

☐ In House Comments:.
☒ Board Comments:. Geoff Phillips reviewed/developed

Senior Leadership Recommendation:
The CEO participates in the Governance Committee and recommends approval.

GOVERNANCE

I. BOARD OF TRUSTEES

- The Hospital Board of Trustees' role is to serve as the governing body of the Hospital. In matters of policy development, approval, and governance oversight, the BOT shall act in accordance with the Policy for Development, Approval, and Oversight of Policies and Governance Documents and the MHSC Policy & Governance Document Approval Matrix. These documents establish the framework and delegation of authority for policy approval and governance. In the event of any conflict between this section and either the overarching policy or the Matrix, the terms of the Policy for Development, Approval, and Oversight of Policies and Governance Documents and the Approval Matrix shall govern.
- Board of Trustee (BOT) meetings are open to the public and take place the first Wednesday of every month beginning at 2:00 PM. Hospital Board members also serve on standing board committees that meet at various times, dates and hours of the day.
- Board members are assigned to standing committees by the Board President.
- The BOT is responsible for oversight of the Hospital.
- The BOT responsibilities include making strategic decisions for the organization, hiring and monitoring an effective CEO, ensuring the organization is providing safe, quality care, overseeing the organization's financial well-being, staying educated in health care industry news and best practices, and being a representative of the organization in the community.
- The BOT is not involved in the day-to-day operations of the Hospital. The daily operation of the Hospital is Senior Leaderships' responsibility.
- The Board of Trustees consists of five (5) members who are citizens of Sweetwater County and appointed by the Sweetwater County Commissioners.
- A County Commission liaison attends monthly Board of Trustee meetings and other meetings attended by Board of Trustee members whenever possible.
- BOT'S CONTRACTED SERVICES
    - Legal services
- AFFILIATIONS OR SOURCES OF REFERENCE
    - American Hospital Association (AHA)
    - Wyoming Hospital Association (WHA)
    - Veralon/Iprotean-educational resource for healthcare boards

II. SENIOR LEADERSHIP

- The role of Senior Leadership is to provide overall leadership and management of the Hospital, including the development of strategies related to the delivery of patient care. The plan for the provision of patient care is enacted through the planning,

evaluating, directing, coordinating and implementing the services of the organization to meet or exceed the needs of the patient.

- Senior Leadership is also responsible for ensuring the financial stability and accountability of the organization, including budget oversight, resource allocation, and stewardship of public funds.
- Senior Leadership provides organizational leadership in areas related to human resources, including recruitment and retention of qualified staff, promoting a positive workplace culture, and ensuring compliance with employment laws and best practices.
- Senior Leadership consists of the Chief Executive Officer, Chief Financial Officer, Chief Clinical Officer, Chief Nursing Officer, and Chief Experience Officer.
- One (1) Executive Administrative Assistant to the Chief Executive Officer and one (1) Administrative Assistant for the Chief Financial Officer, Chief Clinical Officer and Chief Nursing Officer work to ensure that functions within the executive offices are carried out and flow smoothly.
- Administration office hours are from 8:00 AM - 5:00 PM Monday - Friday, with the exception of holidays. However, a member of Senior Leadership serves as Administrator On-Call on a rotating basis to ensure at least one senior leader is available by telephone, in person or email 24 hours a day, 7 days per week, 365 days per year.
- Senior Leadership is accountable for the quality of care, safety and satisfaction of all patients and staff served at the MHSC. Members of Senior Leadership interact with patients and citizens of Sweetwater Country through direct and indirect communication.
- The MHSC contracts with numerous services in order to provide health care services to all persons needing care at the MHSC. The Board of Trustees, Chief Executive Officer and General Legal Counsel are responsible for reviewing, updating and maintaining all contracts, memorandum of understanding and other agreements with contracted services.
- AFFILIATIONS OR SOURCES OF REFERENCE
    - American Hospital Association (AHA)
    - Wyoming Hospital Association (WHA)
    - American Nurses Association (ANA)
    - American Organization of Nurse Leaders (AONL)

III. LEADERSHIP TEAM

- Each clinical and non-clinical area has a director or manager who is responsible for departmental functional activities, operations, quality and patient experience and patient safety initiatives, and for managing the resources of the department to meet the needs of the patient.

I. **GOVERNANCE**BOARD OF TRUSTEES

- The Hospital Board of Trustees' role is to serve as the governing body of the Hospital. In matters of policy development, approval, and governance oversight, the BOT shall act in accordance with the Policy for Development, Approval, and Oversight of Policies and Governance Documents and the MHSC Policy & Governance Document Approval Matrix. These documents establish the framework and delegation of authority for policy approval and governance. In the event of any conflict between this section and either the overarching policy or the Matrix, the terms of the Policy for Development, Approval, and Oversight of Policies and Governance Documents and the Approval Matrix shall govern.
- Board of Trustee (BOT) meetings are open to the public and take place the first Wednesday of every month beginning at 2:00 PM. Hospital Board members also serve on standing board committees that meet at various times, dates and hours of the day.
- Board members are assigned to standing committees by the Board President.
- The BOT is responsible for oversight of the Hospital.
- The BOT responsibilities include making strategic decisions for the organization, hiring and monitoring an effective CEO, ensuring the organization is providing safe, quality care, overseeing the organization's financial well-being, staying educated in health care industry news and best practices, and being a representative of the organization in the community.
- The BOT is not involved in the day-to-day operations of the Hospital. The daily operation of the Hospital is Senior Leaderships' responsibility.
- The Board of Trustees consists of five (5) members who are citizens of Sweetwater County and appointed by the Sweetwater County Commissioners.
- A County Commission liaison attends monthly Board of Trustee meetings and other meetings attended by Board of Trustee members whenever possible.
- BOT'S CONTRACTED SERVICES
    - Legal services
- AFFILIATIONS OR SOURCES OF REFERENCE
    - American Hospital Association (AHA)
    - Wyoming Hospital Association (WHA)
    - Veralon/Iprotean-educational resource for healthcare boards

II. SENIOR LEADERSHIP

- The role of Senior Leadership is to provide overall leadership and management of the Hospital, including the development of strategies related to the delivery of patient care. The plan for the provision of patient care is enacted through the planning, evaluating, directing, coordinating and implementing the services of the organization to meet or exceed the needs of the patient.

- Senior Leadership is also responsible for ensuring the financial stability and accountability of the organization, including budget oversight, resource allocation, and stewardship of public funds.
- Senior Leadership provides organizational leadership in areas related to human resources, including recruitment and retention of qualified staff, promoting a positive workplace culture, and ensuring compliance with employment laws and best practices.
- Senior Leadership consists of the Chief Executive Officer, Chief Financial Officer, Chief Clinical Officer, Chief Nursing Officer, and Chief Experience Officer.
- One (1) Executive Administrative Assistant to the Chief Executive Officer and one (1) Administrative Assistant for the Chief Financial Officer, Chief Clinical Officer and Chief Nursing Officer work to ensure that functions within the executive offices are carried out and flow smoothly.
- Administration office hours are from 8:00 AM - 5:00 PM Monday - Friday, with the exception of holidays. However, a member of Senior Leadership serves as Administrator On-Call on a rotating basis to ensure at least one senior leader is available by telephone, in person or email 24 hours a day, 7 days per week, 365 days per year.
- Senior Leadership is accountable for the quality of care, safety and satisfaction of all patients and staff served at the MHSC. Members of Senior Leadership interact with patients and citizens of Sweetwater Country through direct and indirect communication.
- The MHSC contracts with numerous services in order to provide health care services to all persons needing care at the MHSC. The Board of Trustees, Chief Executive Officer and General Legal Counsel are responsible for reviewing, updating and maintaining all contracts, memorandum of understanding and other agreements with contracted services.
- AFFILIATIONS OR SOURCES OF REFERENCE
    - American Hospital Association (AHA)
    - Wyoming Hospital Association (WHA)
    - American Nurses Association (ANA)
    - American Organization of Nurse Leaders (AONL)

III. LEADERSHIP TEAM

- Each clinical and non-clinical area has a director or manager who is responsible for departmental functional activities, operations, quality and patient experience and patient safety initiatives, and for managing the resources of the department to meet the needs of the patient.

Top 10 Patient Safety Concerns 2025

This annual report from ECRI and the Institute for Safe Medication Practices (ISMP) highlights the 10 most pressing patient safety challenges facing the healthcare industry in 2025.

Leveraging ECRI and ISMP's data-driven research and expert insight, the report discusses critical areas that healthcare leaders should consider as opportunities to minimize preventable harm. Some are emerging issues, while others are persistent yet unresolved. However, all represent areas where impactful change is possible.

This list serves as a strategic guide for implementing proactive, system-wide solutions aimed at reducing risk and improving patient outcomes across the healthcare spectrum.

The List for 2025

1. **Risks of Dismissing Patient, Family, and Caregiver Concerns**
2. **Insufficient Governance of Artificial Intelligence in Healthcare**
3. **The Wide Availability and Viral Spread of Medical Misinformation: Empowering Patients through Health Literacy**
4. **Medical Error and Delay in Care Resulting from Cybersecurity Breaches**
5. **Unique Healthcare Challenges in Caring for Veterans**
6. **The Growing Threat of Substandard and Falsified Drugs**
7. **Diagnostic Error: The Big Three—Cancers, Major Vascular Events, and Infections**
8. **Persistence of Healthcare-Associated Infections in Long-Term Care Facilities**
9. **Inadequate Communication and Coordination during Discharge**
10. **Deteriorating Community Pharmacy Working Conditions Contribute to Medication Errors and Compromise Patient and Staff Safety**

More Tools for ECRI's Top 10 Patient Safety Concerns 2025

- Scorecard
- Customizable Risk Map

e clientservices@ecri.org |

The 2025 Top 10: A New Era of Patient Safety

As healthcare advances at an unprecedented pace, the landscape of patient safety is continually evolving. The year 2025 marks a pivotal moment in this ongoing journey, as we are now a quarter of a century removed from the Institute of Medicine's landmark report, *To Err Is Human*.

We are currently facing challenges that seemed futuristic and improbable in 1999—the integration of artificial intelligence in clinical settings, the growing threat of cyberattacks on health data, and the viral spread of medical misinformation on social media platforms. Our society has also become more conscious of widening health disparities, and a new movement is giving voice to those who have been "medically gaslit."

And yet, we are still grappling with challenges that have plagued healthcare teams for years, such as missed diagnoses and healthcare-associated infections.

This new era of patient safety requires heightened vigilance, new and adaptive strategies, and a commitment to fostering a culture of safety with health-literate practices that ensure the well-being of patients in an increasingly digital, complex, and interconnected world.

Not all topics on the list will apply to all healthcare facilities and, of course, not all possible patient safety concerns made our Top 10; rather, our experts determined that the topics listed here should receive greater attention and consideration in 2025.

Further, the omission of a topic that was included in a previous year's list should not be interpreted to mean that the topic no longer deserves attention. Many of those concerns still persist, and healthcare organizations should continue taking action to minimize them. See Ongoing Patient Safety Challenges for a list of perennial patient safety issues.

Method for Selecting our List

This list reflects ECRI and ISMP's broad patient safety and risk management expertise. Our interdisciplinary staff includes experts in medicine, nursing, pharmacy, patient safety, quality, risk management, clinical evidence assessment, health technology, and many other fields.

As part of the topic nomination process, ECRI and ISMP staff proposed important patient safety concerns to be evaluated. Nominators supported their proposals with information and evidence from scientific literature; trends in event reports, causal analyses, and research requests submitted to ECRI and the ISMP Patient Safety Organization; reports submitted to the ISMP National Medication Errors Reporting Program and the ISMP National Vaccine Errors Reporting Program; medical device alerts, problem reporting, and evaluation; reported medication-safety problems; accident investigations; lessons learned from consultation work; and other internal and external data sources. ECRI and ISMP also asked the public and members who read last year's report to nominate topics by sharing the patient safety issues that concern them most.

A cross-disciplinary team of ECRI and ISMP experts then analyzed the supporting evidence and evaluated each topic using the following criteria:

- **Severity.** How serious would the harm be to patients if this safety issue were to occur?
- **Frequency.** How likely is it for the safety issue to occur?
- **Breadth.** If the safety issue were to occur, how many patients would be affected?
- **Insidiousness.** Is the problem difficult to recognize or challenging to rectify once it occurs?
- **Profile.** Would the safety issue place a lot of pressure on the organization?

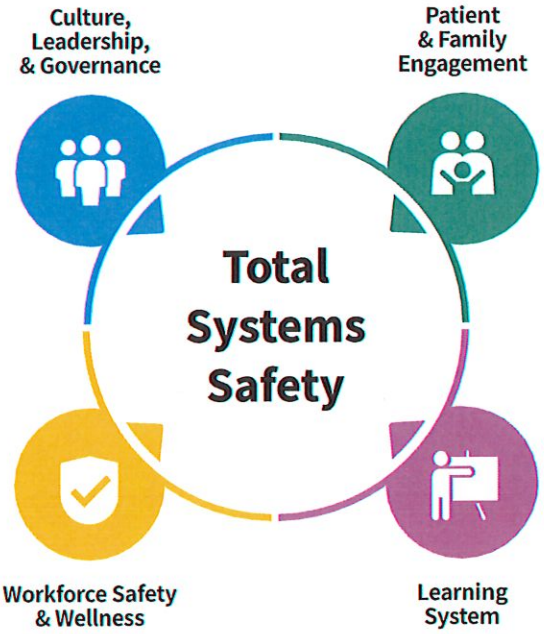
Based on these criteria, the interdisciplinary team chose and ranked the top 10 patient safety concerns.

A Total Systems Approach to Safety

ECRI's Total Systems Approach to Safety (TSS) moves organizations away from reactive, disconnected interventions by codesigning and implementing a holistic, proactive, and sustainable safety system that achieves better results.

TSS aligns leadership, governance, and culture priorities with workforce safety and wellness, along with patient and family engagement. By redesigning safety system elements, healthcare providers can deliver care more reliably and resiliently.

Rooted in advanced safety science, clinically informed human factors engineering, just culture, and health equity, TSS aims to prevent error, reduce harm, improve staff well-being, and enhance overall care quality.



Prioritizing Strategies, Taking Action, and Measuring Improvement

No organization can tackle all 10 items immediately. Organizations must calculate each item's risk score and conduct a gap analysis to evaluate their current practices against our recommendations. To help with this process, organizations can use this year's scorecard.

To address each concern in this year's list, readers can consider our action recommendations, which are framed around the four foundational drivers of safety—culture, leadership, and governance; patient and family engagement; workforce safety and wellness; and learning system. These evidence-based recommendations were developed by ECRI and ISMP's analysis from a wide range of data sources, offering strategies to support continuous improvement in healthcare. They also illustrate how systems can contribute to harm—or drive patient safety.

Healthcare leaders must be intentional about implementing solutions in their own complex, unique organizations. Superficial attempts will not be enough to make meaningful changes in improving patient safety. Before implementing changes, leaders must establish systems and processes for measuring and analyzing improvements, and they should be ready to modify or discontinue specific strategies based on the results analysis.

Safety concerns can have clinical, cultural, efficiency, and financial impacts on an organization. Measuring the results of changes should be multimodal—with structural-, process-, and outcomes-related metrics. Sources of data may include event reports; medication-safety data; survey results, including results from culture of safety, employee satisfaction, and patient experience surveys; morbidity and mortality data; length-of-stay statistics; focus group discussions; and direct observation data. In addition, organizations should segment data to better understand inequities that may create disparities in both patient and workforce outcomes.

MINUTES FROM THE REGULAR MEETING
MEMORIAL HOSPITAL OF SWEETWATER COUNTY
BOARD OF TRUSTEES

May 7, 2025

The Board of Trustees of Memorial Hospital of Sweetwater County met in regular session on May 7, 2025, at 2:00 p.m. with Dr. Barbara Sowada, President, presiding.

CALL TO ORDER

Dr. Sowada welcomed everyone and called the meeting to order.

Dr. Sowada requested a roll call and announced there was a quorum. The following Trustees were present: Judge Nena James, Ms. Kandi Pendleton, Mr. Craig Rood, and Dr. Barbara Sowada. Excused: Mr. Marty Kelsey (present for Executive Session).

Officially present during the meeting: Ms. Irene Richardson, Chief Executive Officer; Dr. Alicia Gray, Chief of Medical Staff; Mr. Geoff Phillips, Legal Counsel; and Mr. Taylor Jones, Sweetwater Board of County Commissioners.

Pledge of Allegiance

Dr. Sowada led the attendees in the Pledge of Allegiance.

Mission and Vision

Judge James read aloud the mission and vision statements.

Mission Moment

Ms. Richardson read aloud a mission moment shared by a staff member related to an interaction with a patient and spouse. They told the staff member about the amazing kindness shared by every person in our facility. Ms. Richardson said we can see staff doing that every day.

AGENDA

Dr. Sowada asked for requests for any items to be moved from the Consent Agenda to New Business. There was a request for the April 22, 2025, special meeting minutes to be moved. Dr. Sowada asked if there were requests for Senior Leader or Board Committee Reports to be moved to New Business. There were requests for the Chief Clinical Officer Report and Chief Financial Officer Report to be moved. The motion to approve the agenda with the items noted as moved to New Business as requested was made by Ms. Pendleton; second by Judge James. Motion carried.

COMMUNITY COMMUNICATION

Dr. Ann Marie Clevenger, Chief Nursing Officer, said we are celebrating National Nurses Week. The City of Rock Springs and the City of Green River read proclamations and we had nurses attending both readings.

NEW BUSINESS

Infection Preventionist Appointment Letter

Dr. Clevenger introduced Ms. Barbara MacDonald, Infection Preventionist. She said Ms. MacDonald came in on an interim basis, did a fantastic job, and luckily agreed to stay on full-time at the end of February. The motion to approve the Infection Preventionist Appointment Letter as presented was made by Judge James; second by Mr. Rood. Motion carried.

Infection Prevention Annual Update

Ms. MacDonald said she appreciated the opportunity to share what we have been working on. She provided a brief summary of 2024 and reviewed comprehensive surveillance vs. targeted surveillance. She said if we are not looking for something, we won't find it and if we don't find it, we can't make it better. Ms. MacDonald said the data is a beginning of a baseline. She said we want the ability to track and trend and we are making good progress. Ms. Pendleton said she found the information informative and interesting. Dr. Sowada said the work has been lifted to a new plateau and thanked Ms. MacDonald. Ms. MacDonald said the Infection Prevention Plan will come to the Board through the Quality Committee.

Approval of April 22, 2025 Special Meeting Minutes

Dr. Sowada said the April 22 meeting was to discuss and ask questions. She asked for clarification of a statement made by Dr. Clevenger in the minutes. The motion to reword the sentence as suggested was made by Judge James; second by Ms. Pendleton. Motion carried.

Chief Clinical Officer Report

Dr. Sowada asked about the survey information included in the report. Dr. Kari Quickenden, Chief Clinical Officer, said she reported on the Culture of Safety Survey. Ms. Cindy Nelson, Chief Experience Officer, said the Employee Engagement Survey will be reviewed at the Human Resources Committee.

Chief Financial Officer Report

Ms. Tami Love, Chief Financial Officer, was asked to provide an update on the impact of Medicare paying claims. Ms. Love said we have processed $19M in claims which will result in an increase in days of cash on hand and a decrease in days in accounts receivable. Ms. Love said we plan to be caught up on all outstanding claims that were delayed due to the critical access process by the end of the fiscal year. Ms. Pendleton asked for information on Wyoming Class investment opportunities. Ms. Love said she will get more information and bring to the next Finance and Audit Committee meeting. Ms. Richardson said the finance team has done a great job and expressed her appreciation.

OLD BUSINESS

Quarterly Progress Report on Strategic Plans and Goals

Dr. Sowada said the information is in the meeting packet.

Behavioral Health Plan

Ms. Richardson thanked everyone who participated in the special meeting workshop. She said she understands there are still things we need to look into and work on so we are slowing things down regarding the process. She said we will continue to work on this and bring back in the future. We want to look at everything involved in the process. Dr. Sowada said the Board appreciates all of the hard work.

Professional Practice Review Plan

Ms. Stephanie Mlinar, Director of Quality, said the Plan has been revamped in an effort to clarify. The information still needs further review by other committees. The information will be brought back to the Board at a future meeting.

CONSENT AGENDA

The motion to approve the Consent Agenda as presented was made by Ms. Pendleton; second by Mr. Rood. Motion carried. Items approved: April 2 Meeting Minutes; Capital Expenditure Request; Bad Debt; Suspend: Policies, Standards, Plans, Procedures/Processes, Guidelines and Forms; Policies from the Governance Committee: Policy for Development, Approval, and Oversight of Policies and Governance Documents at Memorial Hospital of Sweetwater County; MHSC Policy & Governance Document Approval Matrix; Policies, Standards, Plans, Procedures/Processes, Guidelines and Forms.

NEW BUSINESS (CONTINUED)

CAH – Plan of Care & Scope of Services

Ms. Pendleton said the Governance Committee has been working on the Plan. She said it points out what the Board is responsible for and supposed to be doing. Dr. Sowada asked about the Senior Leadership section, specifically regarding financial responsibility and HR-related items like recruitment and retention. Ms. Pendleton said information can be added. Mr. Phillips said he would write something and submit to the group for consideration.

BOT – Memorial Hospital of Sweetwater County Meeting Guidelines

The policy is in the meeting packet.

BOT – Senior Leadership Plan: Filling CEO Absences & Vacancies, Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders

The policy is in the meeting packet.

REPORTS

Chief Executive Officer Report

Ms. Richardson said we had taken a proposal to the County Commissioners in March for remodeling of the OB area. They asked us to look into grant opportunities and then return in April. We did not identify any grant funds for this project, however in the process of investigating, we found some possible funds for other projects so we are very grateful for the suggestion to explore options. Ms. Richardson thanked

Commissioner Jones and the Commissioners for approving the funding. Ms. Richardson noted we are the only maternity labor and delivery services along the I-80 corridor from the Utah/Wyoming border to Laramie. She said we had a Pediatrician scheduled to join us who will not be able to due to recent downsizing in the area that impacted the physician's spouse so we have reopened the physician search. Ms. Richardson said construction work has started on the front entrance of the Medical Office Building and the Lab Renovation Project is coming along very nicely. Director budget meetings have been completed. The proposed budget will be presented to the Finance and Audit Committee and then the Board of Trustees. Ms. Richardson said she attended the American Hospital Association (AHA) Annual Meeting in Washington, D. C. While there, she met with Wyoming's three legislators. She feels they listened and we made headway. She plans to continue to stay in touch with them. Ms. Richardson reviewed the plans for the upcoming Hospital Week Celebration. Ms. Richardson said the Wyoming Hospital Association (WHA) Spring CEO and Trustee Education session is coming up. WHA has seen a decrease in attendance due to changes in hospital ownership and where trustees reside so they are evaluating education opportunities for the future. Ms. Richardson invited Trustees to attend The Governance Institute Leadership Conference in Colorado Springs September 7-10. She concluded her report by thanking everyone for all the hard work they do.

Medical Staff Services Chief of Staff Report

Dr. Gray recognized Dr. Daniel Stone, University of Utah Emergency Department Physician, and Dr. Jake Johnson, Family and Occupational Medicine Physician. She shared comments from patients and said Dr. Stone has already made a strong impact by going above and beyond in care, while Dr. Johnson is one of the most respected and trusted physicians in our community. She also recognized Melissa Jewel, P.A., and shared comments regarding patient trust from when coordinating care when she has been dependable and thorough. Dr. Gray said we continue to make progress with sepsis with protocols. We are focused on ensuring timely evidence-based care. She said we are exploring strategies to support patients in the outpatient setting. Dr. Gray met with the Family and Occupational Medicine and Walk In Clinic providers to discuss improvements. She said it is great to hear their perspectives and learn more about their unique challenges in the outpatient setting. She said our goal is to ensure timely and effective care. The General Medical Staff will meet at the end of May. Dr. Gray said she is focusing on enhancing provider satisfaction and patient care. She said she attended the University of Utah Symposium and said our relationship with them remains crucial.

County Commissioner Liaison Report

Commissioner Jones said when the Commissioners ask the Hospital to look at grants and when financial information is requested and then provided, the Hospital always goes all out to respond and he said that makes his job easier. Mr. Phillips thanked Commissioner Jones for advocating for the Hospital.

EDUCATION

Ms. Pendleton said the *Foundation in Infection Prevention* information was great and timely. Dr. Sowada agreed and said the Board is expected to have continuing education and spend time reviewing quality.

GOOD OF ORDER

Ms. Mlinar said in the past, the annual evaluation of patient safety and quality information is reviewed in the Quality Committee in May and then brought to the Board in June. We propose changing the timing to bring to the Board in August so we can have a full fiscal year in the report.

EXECUTIVE SESSION

The motion to go into executive session at 3:16 p.m. to discuss legal and personnel items considered confidential by law was made by Ms. Pendleton; second by Mr. Rood. Motion carried.

RECONVENE INTO REGULAR SESSION

The motion to leave the executive session and return to the regular session at 4:40 p.m. was made by Ms. Pendleton; second by Judge James. Motion carried.

ACTION FOLLOWING EXECUTIVE SESSION

Pursuant to the notice provided in the agenda, the Board of Trustees held discussions and action was taken.

The motion to grant clinical privileges and appointments to the medical staff as discussed in executive session was made by Judge James; second by Mr. Rood. Motion carried.

Credentials Committee Recommendations to the Board of Trustees for Granting Clinical Privileges and Granting Appointment to the Medical Staff from April 8, 2025

1. Initial Appointment to Associate Staff (1 year)
   - Dr. Tristan Mele, Orthopedic Surgery

2. Reappointment to Active Staff (3 year)
   - Dr. Jeffery Wheeler, Obstetrics & Gynecology
   - Dr. David Crockett, Emergency Medicine

3. Reappointment to Consulting Staff (3 year)
   - Dr. Eric Tuday, Cardiovascular Disease (U of U)

4. Reappointment to Advance Practice Provider Staff (3 year)
   - Deseriee Stofferahn, AGNP-C - Nurse Practitioner

5. Reappointment to Non-Physician Provider Staff (3 year)
   - Thomas Bibber, Clinical Social Work (SWCS)

The motion to approve contracts and authorize the CEO to sign as discussed in executive session was made by Judge James; second by Mr. Rood. Motion carried.

ADJOURNMENT

There being no further business to discuss, the meeting was adjourned at 4:41 p.m.

_____
Dr. Barbara Sowada, President

Attest:

_____
Judge Nena James, Secretary

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:6/4/2025

Topic for Old & New Business Items:

- BOT – Memorial Hospital of Sweetawater County Meeting Guidelines

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:
The CEO participates in the Governance Committee and recommends approval.

Board Committee Action:

Approved by the Governance Committee at their April 21 meeting. Presented at the May Board of Trustees meeting for first review. Presented at the June Board of Trustees meeting for second read and request for approval.

Policy or Other Document:

☐ For Review Only
☒ For Board Action

Legal Counsel Review:

☐ In House Comments:.
☒ Board Comments:. Geoff Phillips reviewed/developed

Senior Leadership Recommendation:
The CEO participates in the Governance Committee and recommends approval.

BOT - Memorial Hospital of Sweetwater County Meeting Guidelines

Board of Trustees

STATEMENT OF PURPOSE:

These Guidelines are intended to provide a framework for the preparation, notification, and operation of meetings of the Memorial Hospital of Sweetwater County (Hospital) Board of Trustees (Board) concerning topics not otherwise addressed in the Wyoming Statutes, the By-Laws of the Board, or in the Board Governance Committee Charter. These Guidelines are prepared by the Governance Committee of the Board and are approved by the Board. They may be amended at any time by the Board.

TEXT:

I. Agenda Preparation

A. The Board President, the Chief Executive Officer (CEO), and the Executive Assistant to the CEO meet at least a week before each regular monthly meeting of the Board to prepare the agenda for the meeting.

B. Typically, a less formal meeting is required for the preparation of an agenda for special meetings of the Board.

II. Public Access to the Meeting Packet

A. The meeting packet associated with regular monthly meetings of the Board should be published on the Hospital's website at least two days before the date of the meeting.

B. When possible, the meeting packet for special meetings of the Board should also be published on the Hospital's website in advance of the meeting. It is noted that a meeting packet may not be prepared for every special meeting.

III. Orientation Memo Associated with New and Old Business Agenda Items

A. Prefacing each agenda item under the Old and New Business section of the meeting agenda, staff should prepare a brief "Orientation Memo" designed to orient Board members concerning the agenda item.

B. To ensure consistency, the Executive Assistant to the CEO should develop a template that would be used each time so that the memo format is standardized for every meeting and for each agenda item.

C. The following content for the Memo must include:

1. Date of the Board Meeting
2. Topic
3. If a policy or other document … is it a revision or a new policy/document?
4. Brief Senior Leadership comments (if any)
5. Board Committee action (if applicable)
6. Is the agenda item for review only or for Board action?
7. Legal Counsel Review … In-House Counsel or Board Counsel
8. Senior Leadership Recommendation

IV. Review and Approval of Hospital Policies & Program Documents

A. All review and approval of policies and governance documents by the Board shall be conducted in accordance with the Policy for Development, Approval, and Oversight of Policies and Governance Documents and the MHSC Policy & Governance Document Approval Matrix.

V. As a general practice, new policies and program documents or substantive revisions to existing ones should be presented to the Board for "review only" at the first meeting, with final approval scheduled for a subsequent meeting. This allows Board members time for meaningful review and feedback. Minor or non-substantive revisions may be considered and approved at the same meeting where they are introduced, at the discretion of the Board President, so long as the changes do not alter the legal, financial, or strategic impact of the policy. Medical Staff forms, documents, or clinical policies that have been reviewed and approved by the Medical Executive Committee (MEC), and that do not require additional Board oversight under the Approval Matrix, may be approved by the Board at the same meeting they are first presented. Board Committee Reports

A. Board Committee reports to the Board may be presented by the Committee Chair either in writing or verbally at the discretion of the Committee Chair.

VI. Executive Session

A. Invitations to attend Executive Sessions of the Board are extended by the Board President.

B. The CEO should always be in attendance unless excused for a period of time by the Board President when his/her regular performance evaluation is being conducted or for other reasons associated with his/her performance or compensation.

C. The Executive Assistant to the CEO is typically in attendance to document the discussion. If absent, an Acting Executive Assistant may be present to document the discussion or, alternatively, a taped recording may be substituted.

BOT - Memorial Hospital of Sweetwater County Meeting Guidelines

Board of Trustees

STATEMENT OF PURPOSE:

These Guidelines are intended to provide a framework for the preparation, notification, and operation of meetings of the Memorial Hospital of Sweetwater County (Hospital) Board of Trustees (Board) concerning topics not otherwise addressed in the Wyoming Statutes, the By-Laws of the Board, or in the Board Governance Committee Charter. These Guidelines are prepared by the Governance Committee of the Board and are approved by the Board. They may be amended at any time by the Board.

TEXT:

I. Agenda Preparation

A. The Board President, the Chief Executive Officer (CEO), and the Executive Assistant to the CEO meet at least a week before each regular monthly meeting of the Board to prepare the agenda for the meeting.

B. Typically, a less formal meeting is required for the preparation of an agenda for special meetings of the Board.

II. Public Access to the Meeting Packet

A. The meeting packet associated with regular monthly meetings of the Board should be published on the Hospital's website at least two days before the date of the meeting.

B. When possible, the meeting packet for special meetings of the Board should also be published on the Hospital's website in advance of the meeting. It is noted that a meeting packet may not be prepared for every special meeting.

III. Orientation Memo Associated with New and Old Business Agenda Items

A. Prefacing each agenda item under the Old and New Business section of the meeting agenda, staff should prepare a brief "Orientation Memo" designed to orient Board members concerning the agenda item.

B. To ensure consistency, the Executive Assistant to the CEO should develop a template that would be used each time so that the memo format is standardized for every meeting and for each agenda item.

C. The following content for the Memo must include:

1. Date of the Board Meeting
2. Topic
3. If a policy or other document … is it a revision or a new policy/document?
4. Brief Senior Leadership comments (if any)
5. Board Committee action (if applicable)
6. Is the agenda item for review only or for Board action?
7. Legal Counsel Review … In-House Counsel or Board Counsel
8. Senior Leadership Recommendation

IV. Review and Approval of Hospital Policies & Program Documents

A. All review and approval of policies and governance documents by the Board shall be conducted in accordance with the Policy for Development, Approval, and Oversight of Policies and Governance Documents and the MHSC Policy & Governance Document Approval Matrix.

V. As a general practice, new policies and program documents or substantive revisions to existing ones should be presented to the Board for "review only" at the first meeting, with final approval scheduled for a subsequent meeting. This allows Board members time for meaningful review and feedback. Minor or non-substantive revisions may be considered and approved at the same meeting where they are introduced, at the discretion of the Board President, so long as the changes do not alter the legal, financial, or strategic impact of the policy. Medical Staff forms, documents, or clinical policies that have been reviewed and approved by the Medical Executive Committee (MEC), and that do not require additional Board oversight under the Approval Matrix, may be approved by the Board at the same meeting they are first presented. Board Committee Reports

A. Board Committee reports to the Board may be presented by the Committee Chair either in writing or verbally at the discretion of the Committee Chair.

VI. Executive Session

A. Invitations to attend Executive Sessions of the Board are extended by the Board President.

B. The CEO should always be in attendance unless excused for a period of time by the Board President when his/her regular performance evaluation is being conducted or for other reasons associated with his/her performance or compensation.

C. The Executive Assistant to the CEO is typically in attendance to document the discussion. If absent, an Acting Executive Assistant may be present to document the discussion or, alternatively, a taped recording may be substituted.

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:6/4/2025

Topic for Old & New Business Items:

- BOT – Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:
The CEO participates in the Governance Committee and recommends approval.

Board Committee Action:

Approved by the Governance Committee at their April 21 meeting. Presented at the May Board of Trustees meeting for first review. Presented at the June Board of Trustees meeting for second read and request for approval.

Policy or Other Document:

☐ For Review Only
☒ For Board Action

Legal Counsel Review:

☐ In House Comments:.
☒ Board Comments:. Geoff Phillips reviewed/developed

Senior Leadership Recommendation:
The CEO participates in the Governance Committee and recommends approval.

BOT - Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders

Board of Trustees

STATEMENT OF PURPOSE:

It is important that the Hospital have in place guidelines and a process for filling a short or long term absence of the CEO or filling the vacancy when the CEO leaves the position permanently. This is also true for other senior leadership positions. This policy has two major purposes:
(1) To help the Hospital prepare for CEO or other Senior Leadership absences and permanent departures by bringing order at a time of potential turmoil, confusion, and high stress;
(2) Identifying and developing skills and talent by mentoring promising candidates employed by the Hospital with the potential to fill Senior Leadership positions on a temporary or permanent basis.

DEFINITIONS

Acting: Substitutes during an absence of a Senior Leader

Interim: Fills the role of a Senior Leader when the Leader has departed and a permanent replacement has yet to be appointed

Long Term Absence: One that is expected to last three consecutive months or more

Short Term Absence: One that is expected to last more than one month, but less than three consecutive months

TEXT:

I. ABSENCES OR PERMANENT DEPARTURE OF THE CHIEF EXECUTIVE OFFICER (CE0)

A. Absences (Long or Short Term)

1. In the event of an unplanned absence of the CEO, the Administrator on Call (AOC) shall immediately inform the Board President or designee of the absence. As soon as it is feasible, the Board President or designee shall convene a meeting of the Board of Trustees (Board) to affirm the procedures prescribed in this policy. The Board may make modifications as necessary. If possible, the Board shall consult with the CEO prior to appointing an Acting CEO.

2. In the event of a planned absence of the CEO, the Board shall meet to discuss the matter, consult with the CEO, and appoint an Acting CEO.

3. Normally, one of the following Senior Leaders will be appointed Acting CEO; however, the appointment shall be made at the discretion of the Board.

a. Chief Nursing Officer

b. Chief Financial Officer

c. Chief Clinical Officer

d. Chief Experience Officer

4. The decision about when the absent CEO returns to Hospital duties shall be determined by the Board President in conjunction with the absent CEO, and approved by the Board. They shall determine a mutually agreed-upon schedule and start date. A reduced work schedule for a short period of time may be allowed with the intention of returning to a full time commitment.

B. Permanent Departure

1. Should the CEO leave Hospital employment for any reason, the Board shall meet as soon as feasible after becoming aware of the departure to discuss the departure, determine a transition plan, and the next steps to take. The Board may, over time, take any one or more of the following actions:

a. Appoint a permanent replacement

b. Appoint an interim CEO

c. Appoint a search committee

d. Retain a consultant to assist with recruiting, interviewing, and selecting a replacement

C. Authority and Compensation of the Acting or Interim CEO; Appointment and Compensation of a Permanent CEO

1. The individual appointed as an Acting or Interim CEO shall have full authority for decision making and independent action as a permanent CEO.

2. The salary of the Acting or Interim CEO shall be recommended by the Board Executive Oversight and Compensation Committee and approved by the Board.

3. The appointment and compensation of a permanent CEO shall be made in accordance with prevailing Hospital policies.

D. Board Oversight

1. The Board member(s) responsible for monitoring the work of the Acting or Interim CEO shall be members of the Board Executive Oversight and Compensation Committee.

2. Board members on the Executive Oversight and Compensation Committee should be sensitive to the special support needs of the Acting or Interim CEO in the temporary leadership role. If the Acting or Interim CEO is appointed internally from the ranks of the Senior Leaders, it is recognized that it may not be reasonable to expect the Acting or Interim CEO to perform the duties of both positions for longer than three (3) months. Consequently, in this situation, it may be necessary to fill the Senior Leadership position temporarily until the permanent CEO returns to work or until a new permanent CEO is hired.

E. Communication Plan

1. If prior communication has not occurred, immediately upon transferring the responsibilities to the Acting CEO, Interim CEO, or to the permanent replacement, the Board President shall notify Hospital employees, medical providers, Foundation Board members, key volunteers, and the CEO of the University of Utah Healthcare System of the delegation of authority. The Board President shall also work with appropriate Hospital staff to prepare a local press release.

2. The Acting CEO, Interim CEO, or the permanent replacement shall communicate the temporary or permanent leadership change to state licensing agencies and other constituent groups.

II. ABSENCES OR PERMANENT DEPARTURE OF OTHER SENIOR LEADERS

A. Absences (Long or Short Term)

1. In the event of an absence of a Senior Leader below the level of the CEO, long or short term, planned or unplanned, the CEO may, at his or her discretion, appoint an Acting replacement in consultation with the Executive Oversight & Compensation Committee.

2. The decision about when the absent Senior Leader returns to Hospital duties shall be determined by the CEO in conjunction with the absent Senior Leader. They shall determine a mutually agreed upon schedule and start date. A reduced work schedule for a short period of time may be allowed with the intention of returning to a full time commitment.

B. Permanent Departure

1. If the Senior Leader's departure is permanent, the CEO shall, upon consultation with the Executive Oversight & Compensation Committee, execute a transition plan. The transition plan could, over time, include any one or more of the following actions:

a. The appointment of a permanent Senior Leader

b. The appointment of an interim Senior Leader

c. The appointment of a search committee

d. The retention of a consultant to assist with recruiting, interviewing, and selecting a replacement

e. At the discretion of the CEO, that may eliminate the need for reappointment, by consolidating Senior Leader positions or assigning duties and responsibilities to other Senior Leaders.

C. Authority and Compensation of the Acting or Interim Senior Leader; Appointment and Compensation of a Permanent Senior Leader

1. The individual appointed as the Acting or Interim Senior Leader shall have full authority for decision making and independent action as the permanent Senior Leader.

2. The salary of the Acting or Interim Senior Leader shall be determined by the CEO in consultation with the Executive Oversight & Compensation Committee and approved by the Board.

3. The appointment and compensation of a permanent Senior Leader shall be made in accordance with prevailing Hospital policies.

D. Communications Plan

1. The CEO shall communicate the leadership change with all necessary constituents.

III. IDENTIFYING AND DEVELOPING INTERNAL SKILLS & TALENT

A. Leadership plays an essential role in the success of the Hospital. Change in Senior Leadership positions is inevitable requiring advanced preparation and planning. One of the purposes of this policy is to help the Hospital prepare for Senior Leadership position absences and departures.

B. To implement this objective, members of the Senior Leadership team should actively identify and mentor potential candidates through a deliberative interactive process to foster and develop the traits needed in a Senior Leader. Some of the key traits important in a great leader include:

1. Vision…being a strategic thinker

2. Courage…the ability to take reasonable risks to achieve worthwhile goals

3. Integrity…the desire to be honest and to value ethical & moral principles

4. Humility…the ability to contain one's ego and to acknowledge mistakes

5. Focus…the ability to maintain a positive focus at work and in life

6. The desire to continually improve

7. The ability to understand that leaders are only as strong as their team and team members

8. Interest in leading by example

9. The ability to effectively motivate others

10. Capacity to work at a high energy level

11. Ability to endure challenging times without undue discouragement

12. Ability to embrace change

13. Ability to remain calm, cool and resilient in the face of conflict and criticism

C. Senior Leadership should work together, in a coordinated way, to proactively seek out individuals employed by the Hospital with great leadership potential and provide appropriate and meaningful leadership training opportunities for them throughout the year.

BOT - Senior Leadership Plan: Filling CEO Absences & Vacancies; Filling Senior Leader Absences & Vacancies; Identifying & Developing Internal Senior Leaders

Board of Trustees

STATEMENT OF PURPOSE:

It is important that the Hospital have in place guidelines and a process for filling a short or long term absence of the CEO or filling the vacancy when the CEO leaves the position permanently. This is also true for other senior leadership positions. This policy has two major purposes:
(1) To help the Hospital prepare for CEO or other Senior Leadership absences and permanent departures by bringing order at a time of potential turmoil, confusion, and high stress;
(2) Identifying and developing skills and talent by mentoring promising candidates employed by the Hospital with the potential to fill Senior Leadership positions on a temporary or permanent basis.

DEFINITIONS

Acting: Substitutes during an absence of a Senior Leader

Interim: Fills the role of a Senior Leader when the Leader has departed and a permanent replacement has yet to be appointed

Long Term Absence: One that is expected to last three consecutive months or more

Short Term Absence: One that is expected to last more than one month, but less than three consecutive months

TEXT:

I. ABSENCES OR PERMANENT DEPARTURE OF THE CHIEF EXECUTIVE OFFICER (CE0)

A. Absences (Long or Short Term)

1. In the event of an unplanned absence of the CEO, the Administrator on Call (AOC) shall immediately inform the Board President or designee of the absence. As soon as it is feasible, the Board President or designee shall convene a meeting of the Board of Trustees (Board) to affirm the procedures prescribed in this policy. The Board may make modifications as necessary. If possible, the Board shall consult with the CEO prior to appointing an Acting CEO.

2. In the event of a planned absence of the CEO, the Board shall meet to discuss the matter, consult with the CEO, and appoint an Acting CEO.

3. Normally, one of the following Senior Leaders will be appointed Acting CEO; however, the appointment shall be made at the discretion of the Board.

   a. Chief Nursing Officer

   b. Chief Financial Officer

   c. Chief Clinical Officer

   d. Chief Experience Officer

4. The decision about when the absent CEO returns to Hospital duties shall be determined by the Board President in conjunction with the absent CEO, and approved by the Board. They shall determine a mutually agreed-upon schedule and start date. A reduced work schedule for a short period of time may be allowed with the intention of returning to a full time commitment.

B. Permanent Departure

1. Should the CEO leave Hospital employment for any reason, the Board shall meet as soon as feasible after becoming aware of the departure to discuss the departure, determine a transition plan, and the next steps to take. The Board may, over time, take any one or more of the following actions:

   a. Appoint a permanent replacement

   b. Appoint an interim CEO

c. Appoint a search committee

d. Retain a consultant to assist with recruiting, interviewing, and selecting a replacement

C. Authority and Compensation of the Acting or Interim CEO; Appointment and Compensation of a Permanent CEO

1. The individual appointed as an Acting or Interim CEO shall have full authority for decision making and independent action as a permanent CEO.

2. The salary of the Acting or Interim CEO shall be recommended by the Board Executive Oversight and Compensation Committee and approved by the Board.

3. The appointment and compensation of a permanent CEO shall be made in accordance with prevailing Hospital policies.

D. Board Oversight

1. The Board member(s) responsible for monitoring the work of the Acting or Interim CEO shall be members of the Board Executive Oversight and Compensation Committee.

2. Board members on the Executive Oversight and Compensation Committee should be sensitive to the special support needs of the Acting or Interim CEO in the temporary leadership role. If the Acting or Interim CEO is appointed internally from the ranks of the Senior Leaders, it is recognized that it may not be reasonable to expect the Acting or Interim CEO to perform the duties of both positions for longer than three (3) months. Consequently, in this situation, it may be necessary to fill the Senior Leadership position temporarily until the permanent CEO returns to work or until a new permanent CEO is hired.

E. Communication Plan

1. If prior communication has not occurred, immediately upon transferring the responsibilities to the Acting CEO, Interim CEO, or to the permanent replacement, the Board President shall notify Hospital employees, medical providers, Foundation Board members, key volunteers, and the CEO of the University of Utah Healthcare System of the delegation of authority. The Board President shall also work with appropriate Hospital staff to prepare a local press release.

2. The Acting CEO, Interim CEO, or the permanent replacement shall communicate the temporary or permanent leadership change to state licensing agencies and other constituent groups.

II. ABSENCES OR PERMANENT DEPARTURE OF OTHER SENIOR LEADERS

A. Absences (Long or Short Term)

1. In the event of an absence of a Senior Leader below the level of the CEO, long or short term, planned or unplanned, the CEO may, at his or her discretion, appoint an Acting replacement in consultation with the Executive Oversight & Compensation Committee.

2. The decision about when the absent Senior Leader returns to Hospital duties shall be determined by the CEO in conjunction with the absent Senior Leader. They shall determine a mutually agreed upon schedule and start date. A reduced work schedule for a short period of time may be allowed with the intention of returning to a full time commitment.

B. Permanent Departure

1. If the Senior Leader's departure is permanent, the CEO shall, upon consultation with the Executive Oversight & Compensation Committee, execute a transition plan. The transition plan could, over time, include any one or more of the following actions:

a. The appointment of a permanent Senior Leader

b. The appointment of an interim Senior Leader

c. The appointment of a search committee

d. The retention of a consultant to assist with recruiting, interviewing, and selecting a replacement

e. At the discretion of the CEO, that may eliminate the need for reappointment, by consolidating Senior Leader positions or assigning duties and responsibilities to other Senior Leaders.

C. Authority and Compensation of the Acting or Interim Senior Leader; Appointment and Compensation of a Permanent Senior Leader

1. The individual appointed as the Acting or Interim Senior Leader shall have full authority for decision making and independent action as the permanent Senior Leader.

2. The salary of the Acting or Interim Senior Leader shall be determined by the CEO in consultation with the Executive Oversight & Compensation Committee and approved by the Board.

3. The appointment and compensation of a permanent Senior Leader shall be made in accordance with prevailing Hospital policies.

D. Communications Plan

1. The CEO shall communicate the leadership change with all necessary constituents.

III. IDENTIFYING AND DEVELOPING INTERNAL SKILLS & TALENT

A. Leadership plays an essential role in the success of the Hospital. Change in Senior Leadership positions is inevitable requiring advanced preparation and planning. One of the purposes of this policy is to help the Hospital prepare for Senior Leadership position absences and departures.

B. To implement this objective, members of the Senior Leadership team should actively identify and mentor potential candidates through a deliberative interactive process to foster and develop the traits needed in a Senior Leader. Some of the key traits important in a great leader include:

1. Vision…being a strategic thinker

2. Courage…the ability to take reasonable risks to achieve worthwhile goals

3. Integrity…the desire to be honest and to value ethical & moral principles

4. Humility…the ability to contain one's ego and to acknowledge mistakes

5. Focus…the ability to maintain a positive focus at work and in life

6. The desire to continually improve

7. The ability to understand that leaders are only as strong as their team and team members

8. Interest in leading by example

9. The ability to effectively motivate others

10. Capacity to work at a high energy level

11. Ability to endure challenging times without undue discouragement

12. Ability to embrace change

13. Ability to remain calm, cool and resilient in the face of conflict and criticism

C. Senior Leadership should work together, in a coordinated way, to proactively seek out individuals employed by the Hospital with great leadership potential and provide appropriate and meaningful leadership training opportunities for them throughout the year.

ORIENTATION MEMO

Board Meeting Date: June 4, 2025

Topic for Old & New Business Items: Policy Stat Document:
Employee Health Plans

Policy or Other Document:

___x___ Revision
_____ New

Brief Senior Leadership Comments: The Joint Commission IC 04.01.01 and 04.01.03 Hospital has a hospital-wide infection prevention and control program for surveillance, prevention, and control of healthcare-associated infections. OSHA 1910.10 occupational exposure to blood and potentially infectious material. Recommendation from the Centers for Disease Control and Prevention (CDC. Combined the Employe Health Plan and the Student, Contractors, and Medical Staff Service contract to one policy.

Board Committee Action:

Policy or Other Document:

_____ For Review Only
__x____ For Board Action

Legal Counsel Review:

_____ In House Comments:
_____ Board Comments:

Senior Leadership Recommendation:
Approve second read and approval by the Board.

Status **Pending** PolicyStat ID **15508214**

Approved	N/A
Review Due	1 year after approval
Document Area	Employee Health
Reg. Standards	CDC, OSHA 29 CFR 1910.1030, TJC IC 04.01.03 + 1 more

CAH- Employee Health Plan

STATEMENT OF PURPOSE

The primary goal of the Employee Health Plan is to maintain the confidentiality of Memorial Hospital of Sweetwater County (MHSC) staff members' records while promoting a high standard of health, wellness, and safety among all employees. This inclusive plan applies to all employees, medical staff, contractors, students, job shadowers, and volunteers, fostering a unified teamwork approach.

Screening will be performed to ensure compliance with state and federal recommendations and regulations regarding patient care activities, including adherence to the vaccination guidelines set forth by the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA).

DEFINITIONS

- Antibody titer - A laboratory blood test determining immunity or susceptibility to a specific disease
- Bacille Calmette-Guerin (BCG) - A vaccine for tuberculosis (TB) disease
- Communicable Disease - An illness that can spread from one person or animal to another
- FIT Test - A procedure to determine whether a respirator or other protective equipment fits properly and provides an adequate seal
- Hazardous Substance - A material that can cause harm to people, animals, or the environment
- Hepatitis B - Also known as Hep B of HBV, is a viral infection that attacks the liver
- Interferon Gamma Release Assay (IGRA) - a blood test that detects tuberculosis
- Influenza - Flu, seasonal flu, or novel influenza. The flu season is categorized as October through May

- Immunity - The status of being protected from catching a communicable disease because of antibody production, either from a previous disease or an appropriately completed immunization series
- Medical Exemption - permission granted by a health care professional for an individual to be excused from a requirement or obligation due to a medical condition
- Measles, Mumps, Rubella (MMR) - A triple antigen vaccine against measles, mumps and rubella:
    - Measles – Rubeola, red, hard, or ten-day measles
    - Mumps - Also known as infectious parotitis
    - Rubella - Also known as German measles or three-day measles
- Personal Protective Equipment (PPE)
- Staff- All people who provide care, treatment, or services in the organization, including licensed practitioners; permanent, temporary, and part-time personnel; contract employees; volunteers; and health profession students. The *(Contracted staff provided through a written agreement with another organization, agency, or person. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel)* Staff at MHSC:
    - Employed Staff - Full-time, Part-time, PRN, and Temporary
    - Volunteer Staff - Individual who performs service hours to MHSC without promise, expectation, or receipt of compensation for services rendered
    - Permanent Contract Staff - Cardinal and Unidine
    - Temporary Contract Staff - Travelers and Elwood
    - Non - Employed Staff - Students, Shadowers
- Tetanus-Diphtheria-Pertussis (Tdap) - A combination of three vaccines in a single injection
- Titer- Laboratory blood test that measures the amount of a specific type of antibodies in the blood to assist in determining levels of immunity
- Tuberculin Skin Test (TST) - Also known as the Mantoux test, is a diagnostic procedure to detect active or latent tuberculosis (TB) infection
- Tuberculosis (TB) - A bacterial infection caused by the germ Mycobacterium tuberculosis.
- Varicella - Also known as Chickenpox, a highly contagious viral infection caused by the Varicella-zoster virus
- Vaccine Information Statement (VIS) - A sheet from the CDC that explains both the benefits and risks of a vaccine
- Work-Related Injury - An injury that occurs on the job or is caused by something at work

ADMINISTRATION AND MANAGEMENT OF THE PLAN

I. **AUTHORITY**

A. The final authority on employee health issues is the Chief Executive Officer.

1. Except in cases of communicable disease outbreak control, when emergency measures are instituted by Employee Health with approval of the Infection Control Medical Director or their designee, and/or the Infection Control Officer appointed per CMS, with knowledge of the Chief Executive Officer.

II. **RESPONSIBILITIES**

A. The Employee Health Department receives regular guidance from the Infection Control Committee and the Environment of Care Committee.

B. Each department director is responsible for implementing and enforcing the Employee Health Plan.

EMPLOYEE HEALTH REQUIREMENTS

I. **Employed, Volunteer, and Permanent Contract Staff**

A. Health Inventory: All staff are required to complete a Health Inventory Form upon employment. (Form #802926 or #800263).

B. TB

1. All staff must provide documentation of a TST in the last 12 months or a negative IGRA in the past year. If unable to provide documentation, a 2-step TST shall be completed. The first step shall be completed before starting, and the second step shall be completed 1 to 3 weeks after the first step and before patient contact.

a. Staff with a positive TST history will be reassessed annually using the converter form (Form #802691). An experienced primary care provider will determine the frequency of CXR; however, the CDC does not recommend that it be done annually or at a regularly scheduled time.

i. The employee health nurse will inform staff about the signs and symptoms to watch regarding conversion.

ii. If a new staff member has had a previous positive TST, they will need to provide a copy of their last chest X-ray or obtain a two-view (PA/Lateral) chest X-ray.

iii. A chest x-ray and evaluation by an experienced provider will be ordered if symptoms develop (persistent cough, weight loss, anorexia, fever) in a staff with a history of TB or if recently exposed to TB.

b. The employee health provider shall be notified of all positive TST reactions.

c. The Wyoming Department of Health shall be notified of all TB conversions.

d. The hospital is not responsible for any reimbursement for medical care of TST-positive staff at the time of hire.

e. All staff shall be tested for TB at hire and after suspected or confirmed exposure.

f. BCG - Many people born outside the U.S. have been vaccinated with the BCG vaccine. This may cause a false-positive TB Skin Test reaction. There is no reliable way to distinguish a positive TB skin reaction caused by the vaccine or an actual TB infection. TB blood tests IGRA is the preferred test for people who have received the BCG vaccine. BCG does not induce positive results when a TB blood test is used. Staff with documented BCG and a positive TST shall have an IGRA test completed.

C. MMR

1. Required evidence of immunity to Measles, Mumps, and Rubella shall be documented.

a. Documentation of two MMR vaccines or documented laboratory evidence of immunity to all three components.

b. If not immune, staff shall be given MMR vaccinations according to manufacturer guidelines at no cost.

c. In the event of an outbreak, those without documented immunity or vaccine documentation will be excluded from high-risk areas.

D. Varicella (Chickenpox)

1. Required evidence of immunity to Varicella shall be documented.

a. Documentation of two Varicella immunizations or documented titer that proves immunity to Varicella.

b. If no documentation is available and the titer does not prove immunity, the staff shall receive the Varicella vaccine as per CDC guidelines. CDC Chickenpox (Varicella)

E. Hepatitis B

1. The required evidence of immunity to the Hepatitis B virus shall be documented.

a. Immunity will be determined by documented positive antibody for Hepatitis B.

b. If not immune, staff will be given Hepatitis B vaccination according to manufacturer guidelines and the MHSC Hepatitis B Vaccine for Adult Protocol. Adult Hepatitis B Vaccine for Adults Protocol Staff may start working at MHSC if the Employee Health requirements are being met and the CDC guidelines for Hepatitis B vaccine administration are being followed.

c. If the staff has received the maximum number of Hepatitis B vaccines and fails to show immunity, they will be documented as a "non-responder" and counseled on the increased risk in the

event of an exposure.

F. Tdap

1. Documentation of a Tdap within the past 10 years is required.
2. If there is no documentation of Tdap within the past 10 years, a single dose of Tdap will be administered regardless of the time since their last tetanus or diphtheria toxoid (Td) vaccine.
    a. All Employed Staff, Volunteer Staff, and Contracted Permanent Staff will be offered the appropriate booster every 10 years.

G. Respiratory Protection

1. The employee health nurse will evaluate all staff for their need to wear a tight-fitting respirator. If deemed necessary for their job duties, they will complete the OSHA respirator medical evaluation questionnaire (Form #802187) and, if medically able, be tested.
    a. Staff failing fit testing or being unable to be tested will be excluded from patient care areas requiring Airborne Precautions.

H. To meet federal guidelines, the most up-to-date Vaccine Information Statement will be offered to the staff for all vaccine administrations.

STAFF MAY ATTEND ORIENTATION/EDUCATION WHILE AWAITING BLOOD TESTING RESULTS IF NOT IMMEDIATELY AVAILABLE UPON HIRE. NO STAFF WILL BE PERMITTED TO HAVE PATIENT CONTACT UNTIL RESULTS HAVE BEEN VERIFIED BY EMPLOYEE HEALTH.

EMPLOYEE HEALTH REQUIREMENTS

I. ***NON-EMPLOYED STAFF***

A. Students and Shadowers at MHSC will meet basic health requirements and participate in established screening programs outlined by the Employee Health Plan above. Starting July 1, 2025, updated requirements for Hepatitis B proof of immunity or documentation of non-responder will be enforced.

B. The employee health nurse will receive documentation and a copy of the verified immunization records for Students and Shadowers. Verification will be obtained before starting clinical at MHSC.

C. Before their assigned student experience, which has received prior approval from the director overseeing the clinical area and the Senior Leader responsible for the specific department, the following will be completed:

1. The student or instructor will provide contact information in writing to Human Resources before starting the clinical.
2. Students will comply with the Employee Health Plan standards. Students who do not meet these requirements will not be accepted for practice in the hospital.
3. The contracting academic institution is responsible for providing the Employee Health Department with documentation of student compliance

upon request.

4. Students will be involved in case contact workups related to an exposure to a communicable disease and for follow-up if exposed.
5. Students who become ill will be referred to their private provider or to the ED in case of a medical emergency. The student assumes all costs for care and treatment.
6. Letters of attestation are not acceptable for vaccines.
7. Any immunization or titer must be completed before starting at MHSC.
8. Students must have documentation of a current FIT test and approval from their institutes' faculty to take care of a patient on airborne isolation precautions. This will be decided on a case-by-case basis.

II. **CONTRACTED TEMPORARY STAFF**

A. Contracted staff will comply with all requirements of the Employee Health Plan. Starting July 1, 2025, updated requirements for Hepatitis B proof of immunity or documentation of non-responder will be enforced.

B. The employee health nurse will receive documentation with a copy of the verified immunization record for contract personnel or be allowed access to the employee health nurse to review documents. Verification will be obtained before contract personnel begin work at MHSC. Any immunization or titer must be completed before starting at MHSC.

RECORD KEEPING

I. The employee health records are maintained in the Employee Health Department and considered confidential.

II. All people treating, testing, or accessing the staff's health record hold all employee health information in strict confidence.

III. The following people may access the Employee Health Record:

A. Employee Health Department and Infection Control Department

B. The individual staff member with written consent

C. OSHA or other regulatory personnel on site

IV. The format and content of the employee health records are standardized and include the following:

A. Employee Health Inventory for Employed Staff

B. Immunizations and titers

C. Fit test record and OSHA Respirator Medical Evaluation Questionnaire

D. Tuberculin Skin Test (TST) Interferon Gamma Release Assay (IGRA), or Converter's Assessment and Chest X-ray (CXR) record, if applicable

E. Influenza immunization

F. Color Vision for clinical staff upon hire by the Education Department

G. All other work-related documents

V. The employee health nurse maintains health records for all MHSC staff.

VI. Records shall be maintained for 30 years following termination. After 30 years, they will be destroyed.Retention of Hospital Records

VII. **FINANCIAL MANAGEMENT AND RESPONSIBILITY**

A. The Employee Health Department budgets all projected expenses incurred and identified in the Employee Health Plan.

B. Treatment plan expenses, except for worker's compensation claims, delineated by the employee health requirements, are paid for from the Employee Health budget.

C. MHSC will cover the costs of Employed, Volunteer, and Permanent Contracted Staff except for pre-existing conditions (for example, TB infection before hire).

D. Non-Employed and Temporary Contracted Staff will be financially responsible for meeting the plan's requirements before arrival.

MEDICAL EXEMPTIONS

I. All staff must receive all the required vaccines for the safety of their patients and their safety. If the staff member has a stated medical contraindication to vaccination, they shall submit a medical exemption to Employee Health for review and approval by the MHSC Medical Exemption Committee.

A. Medical exemption may include the following:

1. Immune deficiency suppresses immune responses that occur with leukemia and lymphoma, as well as therapy with corticosteroids, antimetabolites, or radiation
2. Pregnancy
3. Allergy

B. Staff will have 30 days from notification of delinquency to comply with the Employee Health Plan.

C. Staff will not be permitted to work past the 30-day notification and will be required to use PTO for time off during this time. If the staff has not complied with this requirement within two (2) weeks of the final notification, the staff will be terminated unless there are approved conditions or situations that prevent the staff from completing the requirement. The Chief Executive Officer must approve all exceptions to terminations.

D. Non-employed and Contract Temporary Staff must submit medical exemptions to Employee Health for review and approval by the MHSC Medical Exemption Committee before starting at MHSC.

ANNUAL REQUIREMENTS

I. Employee Health and Infection Control will conduct an annual TB facility assessment to determine the current TB risk and the need for annual testing.

II. All staff must participate in the Annual Influenza Vaccine Clinic. Annual Influenza Vaccine Program

III. All staff whose job duties require a tight-fitting respirator will be tested annually.

EMPLOYED STAFF ILLNESS OR WORK-RELATED INJURY

I. Staff who become ill before they begin work will notify their supervisor before the designated starting time according to personnel policy. Supervisors shall then notify Employee Health.

II. Staff who report to work ill or become sick will notify their supervisor immediately. At the supervisor's discretion, the staff may be sent to the Employee Health Department. The employee health nurse will determine whether to send the staff home or to the ER for examination by an emergency room physician or private physician.

III. Staff off work because of illness or injury for longer than two days or returning from medical leave of absence may be asked to present a work release signed by their private physician to their supervisor. Staff restricted from work because of a significant communicable disease shall have their work releases evaluated by the employee health nurse before they may return to work. Work releases are to be sent to Employee Health. Employee Health will forward a copy to Human Resources, if not already provided.

IV. It's essential that all staff, regardless of the severity of their injury, complete an Employee Packet / Injury and Exposure (which includes the Wyoming Report of Injury Form) and notify their supervisor. If the employee health nurse is unavailable, the staff should report to the emergency department for an evaluation. Supervisors play a key role in the reporting process. They are responsible for completing the Supervisor Investigation portion of the incident report, ensuring the employee has completed their portion, submitting an incident report in the MHSC reporting system, and returning the packet to the employee health nurse.
It's important to remember that not reporting injuries within 72 hours of their occurrence may have serious consequences. Staff may be ineligible for hospital-funded treatment for injuries' complications. Notification within 24 hours is preferred.

EMPLOYED STAFF EXPOSURE TO COMMUNICABLE DISEASE

I. In the MHSC occurrence reporting system, an incident report will be completed for any staff member who may have been exposed to a communicable disease. The staff's supervisor will fill out the Employee Packet/Injury and Exposure (which includes the Supervisor Investigation of Employee Accident Form) and sign the Worker's Compensation forms. Employee Health performs contact tracing for staff related to exposures. The Infection Preventionist will conduct case contact investigations and provide recommendations aligning with delineated

Infection Control policies.

II. Once the determination, through case contact investigation, of **a staff member's true exposure** to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines.

    A. MHSC follows current CDC guidelines for exposures to communicable diseases, including time off work and job restrictions due to disease.

III. See policy Reporting Communicable Diseases.

EMPLOYED STAFF EXPOSED TO HAZARDOUS SUBSTANCES

I. All staff with routine exposure to hazardous substances, such as chemotherapy medications, will have medical screening, TST, and/or basic laboratory testing performed annually as indicated by the Employee Health Provider.

II. Females who are pregnant or breastfeeding and/or any person actively trying to conceive a child will acknowledge that they are aware of the risks involved with handling hazardous medications. These individuals will wear the appropriate personal protective equipment (PPE) for handling hazardous drugs. The Hazardous Drug Risk Acknowledgement form, Hazardous Drug Risk Acknowledgment, will be signed upon hire or transfer. If possible, staff members may ask to be reassigned.

PERMANENT CONTRACT, TEMPORARY CONTRACT, AND NON-EMPLOYEE STAFF WITH WORK-RELATED INJURY, EXPOSURE TO COMMUNICABLE DISEASE, AND HAZARDOUS SUBSTANCES

I. Staff shall contact and report the event to their academic institute or their agency's Employee Health Department and or Human Resource Department.

    A. Once the determination, through case contact investigation, of **a staff member's true exposure** to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines. Work restrictions may be initiated by a department director with consideration of Employee Health and Infection Control but are enforced by the Infection Control Committee.

    B. MHSC follows current CDC guidelines for exposures to communicable diseases, including time off work and job restrictions due to disease.

    C. See policy Reporting Communicable Diseases.

Employee Health Links- Included but not limited to the following:

Accidental Bloodborne Exposure to Blood and Bodily Fluids

Annual Influenza Vaccine Program

CDC TB Screening- Testing

Chemical and Drug Handlers Health Surveillance History

Hepatitis B Vaccine for Adults Protocol

Employee Packet- Illness/ Injury/ Blood Exposure

Exposure Control Plan

Hazardous Drug Risk Acknowledgment

Hazardous Spill and Exposure Response- Emergency Operation Plan

HIV Post-Exposure Prophylaxis

Reporting Communicable Disease

TB Control Plan

Reporting Communicable Disease

Retention of Hospital Records

Reviewed and Approved:

Infection Control Committee: 4/17/2025

MEC: 4/22/2025

MHSC Board:

REFERENCE:

BCG Vaccine and TB Testing-CDC Guidelines. Retrieved from https://www.cdc.gov/tb/hcp/vaccines/index.html

CDC Chickenpox (Varicella). Retrieved from https://www.cdc.gov/chickenpox/index.html

CDC Management of Potentially Infectious Exposure and Illnesses. Retrieved from https://www.cdc.gov/infection-control/hcp/healthcare-personnel-infrastructure-routine-practices/exposure-managment.html

Frequency of Tuberculosis Screening and Testing for Health Care Personnel/TB Prevention in Health Care Settings. Retrieved from https://www.cdc.gov/tb-healthcare-settings/hcp/screening-testing/

frequency.html

Health Care Workers and Employers-Occupation Safety and Health Administration. Retrieved from https://www.osha.gov/healthcare.

Immunization of Health Care Personnel -Center for Disease Control and Prevention. Retrieved from https://www.cdc.gov/vaccines/

Medical Surveillance for Health Care Workers Exposed to Hazardous Drugs/ OSHA and Department of Health and Human Services. Retrieved from https://www.cdc.gov/niosh/docs/wp-solutions/2007-117/pdfs/2007-117.pdf

Occupational Safety and Health Administration/ Health Care. Retrieved from https://www.osha.gov/healthcare.

Oncology Nursing Society-Safe Handling of Hazardous Drug. Retrieved from https://www.ons.org/store/books/safe-handling-hazardous-drugs-fourth-edition

The Joint Commission. Retrieved from https://edition.jcrinc.com/

Attachments

- 800263P Employee Health Inventory 03.24R.pdf
- 802187 - OSHA Respirator Medical Evaluation Questionnaire 04.24R.pdf.pdf
- 802769 - Employee Health Requirements 1.24.pdf
- 802926 - Employee Health Inventory for Students-Shadowers- Observer & Volunteer
- 802973 - Employee Health Provider Orders 4.25.pdf

Approval Signatures

Step Description	Approver	Date
	Ann Marie Clevenger: CNO	Pending
Medical Director	Cielette Karn: Laboratory & IP Medical Director, T&B Chair	03/2025
	Patty O'Lexey: Education Director	03/2025
	Nicole Burke: Employee Health Supervisor	03/2025

Reg. Standards

CDC, OSHA 29 CFR 1910.1030, TJC IC 04.01.03, TJC IC.06.01.01 EP 5

Status **Pending** PolicyStat ID **15508214**

Approved	N/A
Review Due	1 year after approval
Document Area	Employee Health
Reg. Standards	CDC, OSHA 29 CFR 1910.1030, TJC IC 04.01.03 + 1 more

CAH- Employee Health Plan

~~INTRODUCTION~~

~~The primary goal of the Employee Health Plan is to provide a high level of health, wellness and safety among hospital employees. Memorial Hospital of Sweetwater County strives to provide a safe working environment by ensuring that all employees are trained in the proper use of machinery, safety precautions and personal protective equipment. Employees will be screened to ensure they meet the minimum employee health standards to perform patient care activities and meet the recommendations of the CDC for vaccination of health care providers. The policy applies to all employees, contract employees, students, shadowers, medical staff, and volunteers (hereafter referred to as the "employee").~~

STATEMENT OF PURPOSE

The primary goal of the Employee Health Plan is to maintain the confidentiality of Memorial Hospital of Sweetwater County (MHSC) staff members' records while promoting a high standard of health, wellness, and safety among all employees. This inclusive plan applies to all employees, medical staff, contractors, students, job shadowers, and volunteers, fostering a unified teamwork approach.

Screening will be performed to ensure compliance with state and federal recommendations and regulations regarding patient care activities, including adherence to the vaccination guidelines set forth by the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA).

DEFINITIONS

- Antibody titer - A laboratory blood test determining immunity or susceptibility to a specific disease
- Bacille Calmette-Guerin (BCG) - A vaccine for tuberculosis (TB) disease

- Communicable Disease - An illness that can spread from one person or animal to another
- FIT Test - A procedure to determine whether a respirator or other protective equipment fits properly and provides an adequate seal
- Hazardous Substance - A material that can cause harm to people, animals, or the environment
- Hepatitis B - Also known as Hep B of HBV, is a viral infection that attacks the liver
- Interferon Gamma Release Assay (IGRA) - a blood test that detects tuberculosis
- Influenza - Flu, seasonal flu, or novel influenza. The flu season is categorized as October through May
- Immunity - The status of being protected from catching a communicable disease because of antibody production, either from a previous disease or an appropriately completed immunization series
- Medical Exemption - permission granted by a health care professional for an individual to be excused from a requirement or obligation due to a medical condition
- Measles, Mumps, Rubella (MMR) - A triple antigen vaccine against measles, mumps and rubella:
    - Measles – Rubeola, red, hard, or ten-day measles
    - Mumps - Also known as infectious parotitis
    - Rubella - Also known as German measles or three-day measles
- Personal Protective Equipment (PPE)
- Staff- All people who provide care, treatment, or services in the organization, including licensed practitioners; permanent, temporary, and part-time personnel; contract employees; volunteers; and health profession students. The *(Contracted staff provided through a written agreement with another organization, agency, or person. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel)* Staff at MHSC:
    - Employed Staff - Full-time, Part-time, PRN, and Temporary
    - Volunteer Staff - Individual who performs service hours to MHSC without promise, expectation, or receipt of compensation for services rendered
    - Permanent Contract Staff - Cardinal and Unidine
    - Temporary Contract Staff - Travelers and Elwood
    - Non - Employed Staff - Students, Shadowers
- Tetanus-Diphtheria-Pertussis (Tdap) - A combination of three vaccines in a single injection
- Titer- Laboratory blood test that measures the amount of a specific type of antibodies in the blood to assist in determining levels of immunity
- Tuberculin Skin Test (TST) - Also known as the Mantoux test, is a diagnostic procedure to detect active or latent tuberculosis (TB) infection
- Tuberculosis (TB) - A bacterial infection caused by the germ Mycobacterium tuberculosis.
- Varicella - Also known as Chickenpox, a highly contagious viral infection caused by the Varicella-zoster virus

- Vaccine Information Statement (VIS) - A sheet from the CDC that explains both the benefits and risks of a vaccine
- Work-Related Injury - An injury that occurs on the job or is caused by something at work

ADMINISTRATION AND MANAGEMENT OF THE PLAN

I. **RESPONSIBILITIES**

A. The employee health department receives regular input from the Infection Control Committee and the Environment of Care Committee. Pertinent policies and procedures must be approved by the appropriate committee before being incorporated or appended to the plan.

B. Each individual department Director is responsible for implementing and enforcing the Employee Health Plan within his/her department.

II. **AUTHORITY**

A. The final authority on employee health issues is the Chief Executive Officer

1. Except in cases of communicable disease outbreak control, when emergency measures are instituted by Employee Health with approval of the Infection Control Physician or designee, and/or the chair of the Infection Control Committee, with knowledge of the Chief Executive Officer

III. **RECORD KEEPING**

A. The employee health records are maintained in the Employee Health Department and are considered confidential records.

B. The following persons may access the Employee Health Record:

1. Employee health nurse or infection control/employee health director
2. Anyone who has WRITTEN consent from the employee
3. The employee with WRITTEN consent
4. OSHA or other regulatory personnel on site

C. The format and content of the employee health record are standardized.

1. Employee Health Inventory (Form # 800263 - attached) or the Employee Health Inventory for Students/Shadower/Observer (Form # 802926 - attached)
2. Immunizations and titers
3. Fit test record and OSHA Respirator Medical Evaluation Questionnaire
4. TST, IGRA or Converter's Assessment/CXR record (if applicable)
5. Influenza immunizations
6. All other work related documents

D. Health records of hospital auxiliaries are maintained by the employee health nurse,

persons who have access to employee health records also have access to the volunteer health records.

E. Records will be maintained for 30 years following termination. After 30 years these records will be destroyed.

IV. **CONFIDENTIALITY**

A. All employee health information is held in strict confidence by all persons treating or testing the employee, or having access to the employee health record.

B. To reduce the possibility of intentional or inadvertent leaks of confidential information, employee identification numbers may be used on all employee health documents and correspondence, unless the document or correspondence is being directed out of the hospital to an equally confidential source.

C. Employee health information may be released only after the employee has signed a Consent to Release of Medical Information.

V. **FINANCIAL MANAGEMENT AND RESPONSIBILITY**

A. All projected expenses incurred by the Employee Health Plan are budgeted by the Infection Prevention Department.

B. Expenses incurred by treatment plans, with the exception of worker's compensation claims, delineated by the employee health requirements, are paid for from the budget of the Infection Prevention Department.

C. New hires, current employees, and volunteer staff costs will be covered by Memorial Hospital of Sweetwater County with the exception of pre-exsisting conditions (for example TB infection prior to hire)

D. Non-employed staff, students, and shadowers will be financially responsible for meeting the requirements of the plan prior to arrival, please see policy #941517

I. **AUTHORITY**

A. The final authority on employee health issues is the Chief Executive Officer.

1. Except in cases of communicable disease outbreak control, when emergency measures are instituted by Employee Health with approval of the Infection Control Medical Director or their designee, and/or the Infection Control Officer appointed per CMS, with knowledge of the Chief Executive Officer.

II. **RESPONSIBILITIES**

A. The Employee Health Department receives regular guidance from the Infection Control Committee and the Environment of Care Committee.

B. Each department director is responsible for implementing and enforcing the Employee Health Plan.

EMPLOYEE HEALTH REQUIREMENTS

I. **Employment**

A. Health Inventory: Employees are required to complete a Health Inventory Form upon employment (Form #802672 or #802926).

B. TB

1. Tuberculin skin test (TST), Annual PPD Converter's Assessment (Form # 802691), plus chest x-ray or IGRA test results if history of past positive reaction are required. TST will be done on all employees at hire, and after a suspected or confirmed exposure to Tuberculosis (TB). All non employed staff will be required to submit annual test results.

    a. Employees who have not had a documented TST in the last 12 months, will have a 2 step TST done 1 to 3 weeks after the first, with the first being completed prior to patient contact.

    b. Employees who have history of a positive TST will be reassessed annually using the converter form. Frequency of CXR will be determined by an experienced primary care provider, however, annually or at a regularly scheduled time is not recommended by the CDC.

        i. Education will be provided by the Employee Health Nurse regarding what signs and symptoms the employee should watch for regarding conversion.

        ii. If a new employee has had a previous positive TST, the employee will need to provide a copy of the last chest x-ray or have a two view (PA/Lateral) performed.

        iii. A chest x-ray and evaluation by an experienced provider will be ordered if symptoms develop (persistent cough, weight loss, anorexia, fever) in an employee with a history of TB or if recently exposed to TB.

    c. The employee health physician will be notified of all positive TST reactions.

    d. The Wyoming Department of Health will be notified of all TB conversions.

    e. The hospital is not responsible for any reimbursement for medical care of an employee who is TST positive at time of hire.

C. Mumps, Rubella, Rubeola, and Varicella

1. Required immunity to Rubella, Rubeola, Mumps and Varicella will be documented.

    a. Laboratory evidence of serologic immunity or 2 MMR and 2 Varicella vaccines.

    b. If not immune, employee will be given MMR or Varicella vaccination according to manufacturer guidelines at no cost to the employee.

c. In the event of an outbreak, those without documented immunity or documentation of vaccines will be excluded from high-risk areas.

D. Hepatitis B

1. Required immunity to Hepatitis B virus will be documented.

a. Immunity will be determined by the presence of a 3 dose Hepatitis B vaccination series AND positive serologic immunity.

b. If not immune, employee will be given Hepatitis B vaccination according to manufacturer guidelines at no cost to the employee.

c. If the employee has received the maximum number of hepatitis B vaccine and fails to show immunity the employee will be documented as a "nonresponder" and will be counseled on the increased risk in the event of an exposure.

E. Tetanus, Diptheria and Pertussis

1. A TDAP or TD will be given to all new employees who are not up to date or who have not been immunized for pertussis, especially in areas in contact with children or neonates.

a. All employees will be offered the appropriate booster every 10 years.

F. Respiratory Protection

1. All employees will be evaluated by Employee Health for their need to wear a tight fitting respirator. If deemed necessary for their job duties, they will complete the OSHA respirator medical evaluation questionnaire (Form #802187) and if medically able, will be fit tested. .

a. Employees failing fit testing or unable to be tested will be excluded from patient care areas where Airborne Precautions are required.

G. All employees will receive a Employee Health Requirements checklist (Form # 802672 - attached) prior to hire to aid them in compiling the necessary requirements.

II. **Exemptions**

A. It is mandatory for employees to receive all of the above vaccines for the safety of their patients and for their own personal safety. If the employee has a stated medical contraindication to vaccination they will be evaluated by the employee health physician and may be granted exemption.

1. Medical exemption may include the following:

a. Immune deficiency, suppressed immune responses that occur with leukemia, lymphoma, therapy with corticosteroids, antimetabolites, or radiation.

b. Pregnancy

~~c. Allergy~~

~~B. Employees will have 30 days from notification of a delinquency to comply with the Employee Health Plan.~~

~~C. Employees will not be permitted to work past the 30 day notification and employees will be required to use PTO for time off during this time. If the employee has not complied with this requirement within two (2) weeks of the final notification the employee will be terminated unless there are approved conditions or situations that prevent the employee from completing the requirement. All exceptions to terminations must be approved by the Chief Executive Officer.~~

~~For all vaccine administrations, the most up to date vaccine information statement (VIS) will be offered to the employee at time of administration to meet federal guidelines.~~

I. **Employed, Volunteer, and Permanent Contract Staff**

A. Health Inventory: All staff are required to complete a Health Inventory Form upon employment. (Form #802926 or #800263).

B. TB

1. All staff must provide documentation of a TST in the last 12 months or a negative IGRA in the past year. If unable to provide documentation, a 2-step TST shall be completed. The first step shall be completed before starting, and the second step shall be completed 1 to 3 weeks after the first step and before patient contact.

a. Staff with a positive TST history will be reassessed annually using the converter form (Form #802691). An experienced primary care provider will determine the frequency of CXR; however, the CDC does not recommend that it be done annually or at a regularly scheduled time.

i. The employee health nurse will inform staff about the signs and symptoms to watch regarding conversion.

ii. If a new staff member has had a previous positive TST, they will need to provide a copy of their last chest X-ray or obtain a two-view (PA/Lateral) chest X-ray.

iii. A chest x-ray and evaluation by an experienced provider will be ordered if symptoms develop (persistent cough, weight loss, anorexia, fever) in a staff with a history of TB or if recently exposed to TB.

b. The employee health provider shall be notified of all positive TST reactions.

c. The Wyoming Department of Health shall be notified of all TB conversions.

d. The hospital is not responsible for any reimbursement for medical care of TST-positive staff at the time of hire.

e. All staff shall be tested for TB at hire and after suspected or

confirmed exposure.

f. BCG - Many people born outside the U.S. have been vaccinated with the BCG vaccine. This may cause a false-positive TB Skin Test reaction. There is no reliable way to distinguish a positive TB skin reaction caused by the vaccine or an actual TB infection. TB blood tests IGRA is the preferred test for people who have received the BCG vaccine. BCG does not induce positive results when a TB blood test is used. Staff with documented BCG and a positive TST shall have an IGRA test completed.

C. MMR

1. Required evidence of immunity to Measles, Mumps, and Rubella shall be documented.
    a. Documentation of two MMR vaccines or documented laboratory evidence of immunity to all three components.
    b. If not immune, staff shall be given MMR vaccinations according to manufacturer guidelines at no cost.
    c. In the event of an outbreak, those without documented immunity or vaccine documentation will be excluded from high-risk areas.

D. Varicella (Chickenpox)

1. Required evidence of immunity to Varicella shall be documented.
    a. Documentation of two Varicella immunizations or documented titer that proves immunity to Varicella.
    b. If no documentation is available and the titer does not prove immunity, the staff shall receive the Varicella vaccine as per CDC guidelines. CDC Chickenpox (Varicella)

E. Hepatitis B

1. The required evidence of immunity to the Hepatitis B virus shall be documented.
    a. Immunity will be determined by documented positive antibody for Hepatitis B.
    b. If not immune, staff will be given Hepatitis B vaccination according to manufacturer guidelines and the MHSC Hepatitis B Vaccine for Adult Protocol. Adult Hepatitis B Vaccine for Adults Protocol Staff may start working at MHSC if the Employee Health requirements are being met and the CDC guidelines for Hepatitis B vaccine administration are being followed.
    c. If the staff has received the maximum number of Hepatitis B vaccines and fails to show immunity, they will be documented as a "non-responder" and counseled on the increased risk in the event of an exposure.

F. Tdap

1. Documentation of a Tdap within the past 10 years is required.
2. If there is no documentation of Tdap within the past 10 years, a single dose of Tdap will be administered regardless of the time since their last tetanus or diphtheria toxoid (Td) vaccine.
    a. All Employed Staff, Volunteer Staff, and Contracted Permanent Staff will be offered the appropriate booster every 10 years.

G. Respiratory Protection

1. The employee health nurse will evaluate all staff for their need to wear a tight-fitting respirator. If deemed necessary for their job duties, they will complete the OSHA respirator medical evaluation questionnaire (Form #802187) and, if medically able, be tested.
    a. Staff failing fit testing or being unable to be tested will be excluded from patient care areas requiring Airborne Precautions.

H. To meet federal guidelines, the most up-to-date Vaccine Information Statement will be offered to the staff for all vaccine administrations.

~~AN EMPLOYEE~~STAFF MAY ATTEND ORIENTATION/EDUCATION WHILE AWAITING BLOOD TESTING RESULTS ~~OF BLOOD TESTING~~ IF NOT IMMEDIATELY AVAILABLE UPON HIRE. ~~AN~~NO STAFF WILL BE PERMITTED TO HAVE PATIENT CONTACT UNTIL RESULTS HAVE BEEN VERIFIED BY EMPLOYEE ~~WILL NOT BE PERMITTED TO HAVE PATIENT CONTACT UNTIL RESULTS HAVE BEEN VERIFIED BY EMPLOYEE~~ HEALTH.

EMPLOYEE HEALTH REQUIREMENTS

I. ***NON-EMPLOYED STAFF***

A. Students and Shadowers at MHSC will meet basic health requirements and participate in established screening programs outlined by the Employee Health Plan above. Starting July 1, 2025, updated requirements for Hepatitis B proof of immunity or documentation of non-responder will be enforced.

B. The employee health nurse will receive documentation and a copy of the verified immunization records for Students and Shadowers. Verification will be obtained before starting clinical at MHSC.

C. Before their assigned student experience, which has received prior approval from the director overseeing the clinical area and the Senior Leader responsible for the specific department, the following will be completed:

1. The student or instructor will provide contact information in writing to Human Resources before starting the clinical.
2. Students will comply with the Employee Health Plan standards. Students who do not meet these requirements will not be accepted for practice in the hospital.
3. The contracting academic institution is responsible for providing the

Employee Health Department with documentation of student compliance upon request.

4. Students will be involved in case contact workups related to an exposure to a communicable disease and for follow-up if exposed.
5. Students who become ill will be referred to their private provider or to the ED in case of a medical emergency. The student assumes all costs for care and treatment.
6. Letters of attestation are not acceptable for vaccines.
7. Any immunization or titer must be completed before starting at MHSC.
8. Students must have documentation of a current FIT test and approval from their institutes' faculty to take care of a patient on airborne isolation precautions. This will be decided on a case-by-case basis.

II. **CONTRACTED TEMPORARY STAFF**

A. Contracted staff will comply with all requirements of the Employee Health Plan. Starting July 1, 2025, updated requirements for Hepatitis B proof of immunity or documentation of non-responder will be enforced.

B. The employee health nurse will receive documentation with a copy of the verified immunization record for contract personnel or be allowed access to the employee health nurse to review documents. Verification will be obtained before contract personnel begin work at MHSC. Any immunization or titer must be completed before starting at MHSC.

RECORD KEEPING

I. The employee health records are maintained in the Employee Health Department and considered confidential.

II. All people treating, testing, or accessing the staff's health record hold all employee health information in strict confidence.

III. The following people may access the Employee Health Record:

A. Employee Health Department and Infection Control Department

B. The individual staff member with written consent

C. OSHA or other regulatory personnel on site

IV. The format and content of the employee health records are standardized and include the following:

A. Employee Health Inventory for Employed Staff

B. Immunizations and titers

C. Fit test record and OSHA Respirator Medical Evaluation Questionnaire

D. Tuberculin Skin Test (TST) Interferon Gamma Release Assay (IGRA), or Converter's Assessment and Chest X-ray (CXR) record, if applicable

E. Influenza immunization

F. Color Vision for clinical staff upon hire by the Education Department

G. All other work-related documents

V. The employee health nurse maintains health records for all MHSC staff.

VI. Records shall be maintained for 30 years following termination. After 30 years, they will be destroyed.Retention of Hospital Records

VII. **FINANCIAL MANAGEMENT AND RESPONSIBILITY**

A. The Employee Health Department budgets all projected expenses incurred and identified in the Employee Health Plan.

B. Treatment plan expenses, except for worker's compensation claims, delineated by the employee health requirements, are paid for from the Employee Health budget.

C. MHSC will cover the costs of Employed, Volunteer, and Permanent Contracted Staff except for pre-existing conditions (for example, TB infection before hire).

D. Non-Employed and Temporary Contracted Staff will be financially responsible for meeting the plan's requirements before arrival.

MEDICAL EXEMPTIONS

I. All staff must receive all the required vaccines for the safety of their patients and their safety. If the staff member has a stated medical contraindication to vaccination, they shall submit a medical exemption to Employee Health for review and approval by the MHSC Medical Exemption Committee.

A. Medical exemption may include the following:

1. Immune deficiency suppresses immune responses that occur with leukemia and lymphoma, as well as therapy with corticosteroids, antimetabolites, or radiation

2. Pregnancy

3. Allergy

B. Staff will have 30 days from notification of delinquency to comply with the Employee Health Plan.

C. Staff will not be permitted to work past the 30-day notification and will be required to use PTO for time off during this time. If the staff has not complied with this requirement within two (2) weeks of the final notification, the staff will be terminated unless there are approved conditions or situations that prevent the staff from completing the requirement. The Chief Executive Officer must approve all exceptions to terminations.

D. Non-employed and Contract Temporary Staff must submit medical exemptions to Employee Health for review and approval by the MHSC Medical Exemption Committee before starting at MHSC.

ANNUAL REQUIREMENTS

I. ~~**Annual Requirements**~~

~~A. An Annual TB Facility Assessment will be conducted by the Employee Health Nurse which will determine the current TB risk, and the need for annual testing.~~

~~B. All Employees are required to take part in the Annual Influenza Vaccine Clinic, Policy #1103869.~~

~~C. All employees whose job duties require the use of a tight fitting respirator will be fit tested annually.~~

II. ~~**Student/Shadowers and Contract Health Requirements**~~

~~A. Refer to Student/Contract Employees/Medical Staff Health Requirements Policy #941517~~

~~B. Costs for volunteers (MHSC Auxiliary members) will be paid by the hospital and follow the same standards as hospital employees~~

III. Employee Health and Infection Control will conduct an annual TB facility assessment to determine the current TB risk and the need for annual testing.

IV. All staff must participate in the Annual Influenza Vaccine Clinic. Annual Influenza Vaccine Program

V. All staff whose job duties require a tight-fitting respirator will be tested annually.

~~EMPLOYEE~~EMPLOYED STAFF ILLNESS OR WORK-RELATED INJURY

1. ~~Employees who become ill before they begin work will notify their supervisor before the designated starting time according to personnel policy. Supervisors will then notify Employee Health.~~
2. ~~Employees who report to work ill, or who become ill at work, will notify their supervisor immediately. At the supervisor's discretion, the employee may be sent to the Employee Health Department. The Employee Health Nurse will determine the need to send the employee home, to the ER for examination by an emergency room physician, or to a private physician.~~
3. ~~Employees off work because of illness or injury for longer than two days, or who are returning to work from a medical leave of absence, may be asked to present a work release signed by their their private physician to their supervisor. Employees restricted from work because of a significant communicable disease will have their work releases evaluated by the Employee Health Nurse or Infection Control, before they may return to work. Work releases are to be sent to Infection Control/Employee Health. In turn, Employee Health will forward a copy to Human Resources, if not already given to HR.~~
4. ~~Any employee with a work-related injury who seeks medical treatment must present a work release or restriction document to their Department Supervisor before returning to work. The Department Supervisor will then forward the document to Employee Health or Human Resources.~~
5. ~~Employees injured on the job – however minor the injury may appear – are encouraged to complete an Employee Packet (which includes Wyoming Report of Injury Form) and notify their~~

~~supervisor who will complete a Supervisors Investigation of an Employee Incident report (Refer to Employee Packet) in its entirety, and report to the Employee Health Department, or Emergency Department if after hours for evaluation. Employees who do not report injuries within 72 hours of occurrence may be ineligible for hospital funded treatment for complications of the injury. Notification within 24 hours is preferred.~~

I. Staff who become ill before they begin work will notify their supervisor before the designated starting time according to personnel policy. Supervisors shall then notify Employee Health.

II. Staff who report to work ill or become sick will notify their supervisor immediately. At the supervisor's discretion, the staff may be sent to the Employee Health Department. The employee health nurse will determine whether to send the staff home or to the ER for examination by an emergency room physician or private physician.

III. Staff off work because of illness or injury for longer than two days or returning from medical leave of absence may be asked to present a work release signed by their private physician to their supervisor. Staff restricted from work because of a significant communicable disease shall have their work releases evaluated by the employee health nurse before they may return to work. Work releases are to be sent to Employee Health. Employee Health will forward a copy to Human Resources, if not already provided.

IV. It's essential that all staff, regardless of the severity of their injury, complete an Employee Packet / Injury and Exposure (which includes the Wyoming Report of Injury Form) and notify their supervisor. If the employee health nurse is unavailable, the staff should report to the emergency department for an evaluation. Supervisors play a key role in the reporting process. They are responsible for completing the Supervisor Investigation portion of the incident report, ensuring the employee has completed their portion, submitting an incident report in the MHSC reporting system, and returning the packet to the employee health nurse.
It's important to remember that not reporting injuries within 72 hours of their occurrence may have serious consequences. Staff may be ineligible for hospital-funded treatment for injuries' complications. Notification within 24 hours is preferred.

EMPLOYED STAFF EXPOSURE TO COMMUNICABLE DISEASE

I. ~~An~~In the MHSC occurrence reporting system, an incident report will be completed for any ~~employee potentially~~staff member who may have been exposed to a communicable disease ~~in the MHSC occurrence reporting system.~~ ~~The employee~~ The staff's supervisor will ~~complete the gray packet~~fill out the Employee Packet/Injury and Exposure (which includes the Supervisor Investigation of Employee Accident Form) and sign the Worker's Compensation forms~~)~~. Employee Health performs contact tracing for staff related to exposures. The Infection Preventionist will conduct case contact investigations and provide recommendations aligning with delineated Infection Control ~~Nurse will conduct case contact investigations as needed and delineated in Infection Control Policy~~policies.

   A. ~~Once the determination, through case contact investigation, of **true** exposure of an employee or employees to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines. Work restrictions may be initiated by a department director with consideration of the Infection Control/Employee Health~~

~~Director, but are enforced by the Infection Control Committee.~~

II. ~~Memorial Hospital of Sweetwater County follows current~~Once the determination, through case contact investigation, of **a staff member's true exposure** to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines ~~for exposures to communicable diseases, including time off work, and job restrictions due to disease~~.

A. MHSC follows current CDC guidelines for exposures to communicable diseases, including time off work and job restrictions due to disease.

III. See policy Reporting Communicable Diseases.

~~EXPOSURE~~EMPLOYED STAFF EXPOSED TO HAZARDOUS SUBSTANCES

I. All ~~employees identified as having~~staff with routine exposure to hazardous substances, such as chemotherapy medications, will have ~~a~~ medical screening, TST, and/or basic laboratory testing performed annually as indicated by the Employee Health ~~Physician~~Provider.

II. ~~Females who are pregnant or breast-feeding and/or any person actively trying to conceive a child will be reassigned to duties that do not involve the handling of hazardous medications.~~

III. ~~Link to Chemical and Drug Handlers Health Surveillance History~~

IV. Females who are pregnant or breastfeeding and/or any person actively trying to conceive a child will acknowledge that they are aware of the risks involved with handling hazardous medications. These individuals will wear the appropriate personal protective equipment (PPE) for handling hazardous drugs. The Hazardous Drug Risk Acknowledgement form, Hazardous Drug Risk Acknowledgment, will be signed upon hire or transfer. If possible, staff members may ask to be reassigned.

~~Approval:~~

~~Infection Control Committee - Nov. 7, 2018; HR Committee - February 18, 2019~~

~~REFERENCES:~~

PERMANENT CONTRACT, TEMPORARY CONTRACT, AND NON-EMPLOYEE STAFF WITH WORK-RELATED INJURY, EXPOSURE TO COMMUNICABLE DISEASE, AND HAZARDOUS SUBSTANCES

I. Staff shall contact and report the event to their academic institute or their agency's Employee Health Department and or Human Resource Department.

A. Once the determination, through case contact investigation, of **a staff member's true**

exposure to a communicable disease is made, work restrictions will be instituted according to the CDC guidelines. Work restrictions may be initiated by a department director with consideration of Employee Health and Infection Control but are enforced by the Infection Control Committee.

B. MHSC follows current CDC guidelines for exposures to communicable diseases, including time off work and job restrictions due to disease.

C. See policy Reporting Communicable Diseases.

Employee Health Links- Included but not limited to the following:

Accidental Bloodborne Exposure to Blood and Bodily Fluids

Annual Influenza Vaccine Program

CDC TB Screening- Testing

Chemical and Drug Handlers Health Surveillance History

Hepatitis B Vaccine for Adults Protocol

Employee Packet- Illness/ Injury/ Blood Exposure

Exposure Control Plan

Hazardous Drug Risk Acknowledgment

Hazardous Spill and Exposure Response- Emergency Operation Plan

HIV Post-Exposure Prophylaxis

Reporting Communicable Disease

TB Control Plan

Reporting Communicable Disease

Retention of Hospital Records

Reviewed and Approved:

Infection Control Committee: 4/17/2025

MEC: 4/22/2025

MHSC Board:

REFERENCE:

BCG Vaccine and TB Testing-CDC Guidelines. Retrieved from https://www.cdc.gov/tb/hcp/vaccines/index.html

CDC Chickenpox (Varicella). Retrieved from https://www.cdc.gov/chickenpox/index.html

CDC Management of Potentially Infectious Exposure and Illnesses. Retrieved from https://www.cdc.gov/infection-control/hcp/healthcare-personnel-infrastructure-routine-practices/exposure-managment.html

Frequency of Tuberculosis Screening and Testing for Health Care Personnel/TB Prevention in Health Care Settings. Retrieved from https://www.cdc.gov/tb-healthcare-settings/hcp/screening-testing/frequency.html

Health Care Workers and Employers-Occupation Safety and Health Administration. Retrieved from https://www.osha.gov/healthcare.

Immunization of Health Care Personnel -Center for Disease Control and Prevention. Retrieved from https://www.cdc.gov/vaccines/

Medical Surveillance for ~~Healthcare~~Health Care Workers Exposed to Hazardous Drugs ~~*Department of Health and Human Services* https://www.cdc.gov/niosh/docs/wp-solutions/2013-103/pdfs/2013-103.pdf~~/ OSHA and Department of Health and Human Services. Retrieved from https://www.cdc.gov/niosh/docs/wp-solutions/2007-117/pdfs/2007-117.pdf

Occupational Safety and Health Administration/ Health Care. Retrieved from https://www.osha.gov/healthcare.

~~Healthcare Workers~~Oncology Nursing Society-Safe Handling of Hazardous ~~Drugs Should Be Monitored in Surveillance Program *Oncology Nursing Society* https://www.ons.org/practice-resources/clinical-practice/healthcare-workers-handling-hazardous-drugs-should-be-monitored~~Drug. Retrieved from https://www.ons.org/store/books/safe-handling-hazardous-drugs-fourth-edition

The Joint Commission. Retrieved from https://edition.jcrinc.com/

Attachments

- 800263P Employee Health Inventory 03.24R.pdf
- 802187 - OSHA Respirator Medical Evaluation Questionnaire 04.24R.pdf.pdf
- 802769 - Employee Health Requirements 1.24.pdf
- 802926 - Employee Health Inventory for Students-Shadowers- Observer & Volunteer
- 802973 - Employee Health Provider Orders 4.25.pdf

Approval Signatures

Step Description	Approver	Date

	Ann Marie Clevenger: CNO	Pending
Medical Director	Cielette Karn: Laboratory & IP Medical Director, T&B Chair	03/2025
	Patty O'Lexey: Education Director	03/2025
	Nicole Burke: Employee Health Supervisor	03/2025

Reg. Standards

CDC, OSHA 29 CFR 1910.1030, TJC IC 04.01.03, TJC IC.06.01.01 EP 5

Status **Pending** PolicyStat ID **18138825**

Approved	N/A
Review Due	1 year after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC MM.05.01.01, TJC MM.05.01.11

Sterile Preparations: Redispensing Unused Compounded Sterile Preparations, 22-06-20 (Previously 22-27)

Statement

Returned unused compounded sterile preparations may be redispensed if proper storage has been maintained and the beyond-use date and time has not been reached.

Compounded sterile preparations will be discarded if they were exposed to temperatures warmer than the warmest labeled limit or to temperatures exceeding 40° C for more than 4 hours.

Compounded sterile preparations that were exposed in patient care areas (e.g., punctured, spiked) will not be returned to the pharmacy.

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138834**

Approved	N/A
Review Due	1 year after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC MM.02.01.01, TJC MM.03.01.01, TJC MM.05.01.01 + 1 more

Sterile Preparations: Transporting Compounded Sterile Preparations to Patient Care and Procedural Areas, 22-06-19 (Previously 22-26)

Statement

Compounded sterile preparations will be stored and delivered by the pharmacy.

PROCEDURE

Compounded sterile preparations will be stored in accordance with labeled requirements.

Pharmacy department personnel will transport compounded sterile preparations to the patient care and procedural units. Items requiring refrigeration will be placed in the refrigerator by pharmacy personnel.

Unused preparations will be collected by pharmacy personnel no less frequently than every 24 hours.

If compounded sterile preparations are transported outside the hospital campus (such as to offices and clinics at a different site), temperature of the preparation will be monitored and controlled.

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Reg. Standards

TJC MM.02.01.01, TJC MM.03.01.01, TJC MM.05.01.01, TJC MM.05.01.11

Status **Pending** PolicyStat ID **18138814**

Approved N/A
Review Due 1 year after approval

Document Area CAH - Patient Care
Reg. Standards TJC MM.05.01.07

Sterile Preparations: Final Verification of Preparations, 22-06-18 (Previously 22-25)

STATEMENT

Sterile preparations shall be held after compounding for an independent double-check by another qualified individual. Compounded sterile preparations waiting to be checked shall be placed in a clearly identified and designated area until the checking process is complete. A pharmacist shall perform an end preparation (final) examination of all compounded sterile preparations prior to their release from the pharmacy.

COMPOUNDING ACCURACY

A check for compounding accuracy must ensure accuracy of:

- Comparison with original order for initial dispensing
- Calculations
- Volumes or quantities of all drugs and solutions
- Label

PHYSICAL INSPECTION

A visual examination procedure must ensure:

- Comparison with original order for initial dispensing
- Accuracy of calculations
- Use of proper solutions, additives and equipment
- Labels are complete
- Proper assignment of beyond use date and time based on storage conditions

- Integrity of the container, including container closure and any other apparent visual defects
- Proper storage
- Absence of particulate matter, precipitates, turbidity, discoloration, evidence of contamination or other signs that the preparation should not be used

DISPOSITION OF PREPARATIONS THAT DO NOT PASS FINAL EXAMINATION

The pharmacist shall reject and destroy all preparations that do not pass the final examination.

DOCUMENTATION OF FINAL PREPARATION EXAMINATIONS

Pharmacists shall document final preparation examinations by initialing the label prior to releasing the Compounded Sterile Preparations from the pharmacy.

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138788**

Approved N/A
Review Due 1 year after approval

Document Area CAH - Patient Care
Reg. Standards TJC MM.05.01.07

Sterile Preparations: Aseptic Technique, 22-06-05 (Previously 22-17)

Statement

Aseptic technique will be used to compound sterile preparations.

PERSONNEL RESTRICTIONS

Personnel with rashes, sunburn, weeping sores, conjunctivitis, or active respiratory infections shall not prepare compounded sterile preparations.

Personnel working in the sterile compounding area shall not wear nail polish, artificial nails or extenders. Natural nails shall be kept neat and trimmed.

Personnel working in the sterile compounding area shall not wear makeup.

PROCEDURE

- Clean the medication preparation area with an approved agent
    - A germicidal, bactericidal, fungicidal must be used once daily to clean the medication preparation area prior to compounding.
    - Sterile 70% isopropyl alcohol may be used thereafter through the course of the day to clean the medication preparation area unless contamination is suspected.
- Keep the area free of solutions, additives, and equipment that are not required to prepare the preparation
- Obtain the basic parenteral solutions, additive medications, syringes, needles, swabs, labels, etc.
- Wash hands, gown and garb as appropriate
- Clean gloved hands with sterile 70% isopropyl alcohol prior to handling medications and as

needed during the procedure.

- Maintain the integrity of sterile medications. Remove outer metal lids or protective covers but do not remove rubber closures or diaphragms.
- Do not touch areas that will contact the solution or medications
- Clean diaphragms, injection ports and ampule necks with sterile 70% isopropyl alcohol
- Cover ampule necks with a sterile pad and break ampules by snapping away from the body
- Ensure that seals on syringe and needle packages are intact
- Ensure that the syringe is the appropriate size and needle is the appropriate gauge, length, and material, if necessary
- Ensure that touch contamination does not occur when attaching needles to syringes
- Use a separate syringe and needle for each additive
- Make entries into diaphragms/ports with the bevel of the needle facing up and use a slight downward pressure
- Reconstitute medications according to manufacturer's instructions and as described below--
    - Use proper aseptic technique and follow the manufacturer's instructions
    - Determine the correct amount of diluent to use
    - Inject air equal to the amount of diluent to be removed from the vial
    - Withdraw the diluent and transfer into the medication vial, venting if necessary
    - Mix the medication and diluent according to manufacturer's instructions
    - Inspect the final preparation
- Work with moderate speed
- Double-check calculations
- Label preparations as they are prepared
- Clean the medication preparation area when finished

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138769**

Approved	N/A
Review Due	1 year after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC MM.05.01.07

Pharmacy:Sterile Preparations: Sterile Compounding Procedures, 22-06-01 (Previously 22-18)

STATEMENT

The procedure for compounding sterile preparations (CSPs) shall assure the safety of the final preparation.

PROCEDURE

General Guidelines:

- Compare orders with patient records for correct dosage, interactions, incompatibilities, contraindications, and allergies
- For orders requiring pharmacy transcriptions for specific types of CSPs such as chemotherapy, TPN, neonatal infusions, or other types of high-alert medications, a second qualified individual verifies the information entered onto the pharmacy patient profile, including a review of the pharmacy-generated label
- If necessary, consult appropriate parenteral preparation references and/or charts
- Contact the prescriber if preparation or administration is questionable
- Compound adult, pediatric, and neonatal CSPs at different times
- Gather drugs, diluents, syringes, needles, and other supplies into a separate container (e.g., basket or bin) for each preparation or each batch. Double check the contents; the double-check should be performed by a different individual if possible.
- Inspect labels and containers of all medications and solutions to ensure that they are correct, in date, and compatible.
- Inspect and discard containers with cracks, holes, deteriorated diaphragms, loss of vacuum or volume, etc.
- Prepare only one preparation (or one batch of the same preparation) at a time

- Do not allow heparin and insulin in the hood at the same time
- Label preparations as they are prepared
- Inspect the final preparation. Discard solutions that contain particulate matter, are discolored, or show evidence of contamination or loss of volume. Do not use questionable preparations.

STANDARD OPERATING PROCEDURE

1. Access to the buffer area is restricted to qualified personnel with specific responsibilities or assigned tasks in the compounding area.
2. All cartoned supplies are decontaminated in the area by removing them from shipping cartons and wiping or spraying with a nonresidue-generating disinfecting agent while they are being transferred to a clean and properly disinfected cart or other conveyance for introduction in to the buffer area. Manufacturers' directions or published data for minimum contact time will be followed. Individual pouched sterile supplies need not be wiped because the pouches can be removed as these sterile supplies are introduced into the buffer area.
3. Supplies that are required frequently or otherwise needed close at hand but not necessarily needed for the scheduling operations of the shift are decontaminated and stored on the shelving in the ante-area.
4. Carts used to bring supplies from the storeroom cannot be rolled beyond the demarcation line in the ante-area, and carts used in the buffer area cannot be rolled outward beyond the demarcation line unless cleaned and disinfected before returning.
5. Generally, supplies required for the scheduled operations of the shift are wiped down with an appropriate disinfecting agent and brought into the buffer area, preferably on one or more movable carts. Supplies that are required for back-up or general support of operations may be stored on the designated shelving in the buffer area, but excessive amounts of supplies are to be avoided.
6. Nonessential objects that shed particles shall not be brought into the buffer area including pencils, cardboard cartons, paper towels, and cotton items (e.g. gauze pads).
7. Essential paper-related products (e.g. paper syringe overwraps, work records contained in a protective sleeve) shall be wiped down with an appropriate disinfecting agent prior to being brought into the buffer area.
8. Traffic flow in and out of the buffer area shall be minimized.
9. Chewing gum, drinks, candy, or food items shall not be brought into the buffer area or ante area. Materials exposed in patient care and treatment areas shall never be introduced into areas where components and ingredients for CSPs are present.
10. Personnel preparing to enter the buffer area shall remove all personal outer garments, cosmetics, nail polish, gel, or fake nails (because they shed flakes and particles) and all hand, wrist and other visible jewelry or piercings, that can interfere with the effectiveness of Personal Protective Equipment.
11. At the beginning of each compounding activity session, and whenever liquids are spilled, the surfaces of the direct compounding environment are first cleaned with *Sterile Water* to remove water-soluble residues. Immediately thereafter, clean the same surfaces with a germicidal detergent using a low-lint wiper. Follow with disinfection using a low-lint wiper moistened with

sterile 70% isoproyl alcohol.

12. Primary engineering controls shall be operated continuously during compounding activity. When the blower is turned off and before other personnel enter to perform compounding activities, only one person shall enter the buffer area for the purposes of turning on the blower (for at least 30 minutes or as directed by the manufacturer) and clean and disinfect the work surfaces.
13. Traffic in the area of the direct compounding area is minimized and controlled.
14. Supplies to be utilized in the direct compounding area for the planned procedures are accumulated and then decontaminated by wiping or spraying the outer surface with sterile 70% isopropyl alcohol or removing the outer wrap at the edge of the direct compounding area as the item is introduced into the aseptic work area.
15. All supply items are arranged in the direct compounding area so as to reduce clutter and provide maximum efficiency and order for the flow of work.
16. After proper introduction into the direct compounding area of supply items required for and limited to the assigned operations, they are so arranged that a clear, uninterrupted path of HEPA-filtered air will bathe all critical sites at all times during the planned procedures. That is, no objects may be placed between the first air from HEPA filters and an exposed critical site.
17. All procedures are performed in a manner designed to minimize the risk of touch contamination. Gloves are disinfected with adequate frequency with an approved disinfectant such as sterile 70% isopropyl alcohol.
18. All rubber stoppers of vials and bottles and the neck of ampules are disinfected by wiping with sterile 70% isopropyl alcohol and waiting for at least 10 seconds before they are used to prepare CSPs.
19. After the preparation of every CSP, the contents of the container are thoroughly mixed and then inspected for the presence of particulate matter, evidence of incompatibility, or other defects.
20. After procedures are completed, used syringes, bottles, vials, and other supplies are removed, but with a minimum of exit and re-entry into the direct compounding area so as to minimize the risk of introducing contamination into the aseptic workspace.

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138739**

Approved	N/A
Review Due	1 year after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC MM.5.01.0 EP2

Pharmacy:Sterile Preparations: Hand Hygiene and Garbing, 22-06-03 (Previously 22-19)

STATEMENT

All personnel entering the ante-area, buffer rooms, and Containment Segregated Compounding Areas (C-SCAs), and inside the perimeter in a Segregated Compounding Area (SCA) must be properly garbed.

See Policy 22-06-04 for additional personal protective equipment (PPE) required when compounding hazardous drugs.

PROCEDURE

Personnel preparing to enter the buffer area shall remove all personal outer garments,cosmetics (because they shed flakes and particles) and all hand, wrist and other visible jewelry or piercings that can interfere with the effectiveness of personal protective equipment.

Preparing to Work in a Cleanroom Suite

I. Personnel entering the ante area shall don attire:
   A. Dedicated shoes or shoe covers
   B. Head and facial hair covers
   C. Face masks

II. Eye shields. Eye shields are optional unless working with irritants such as germicidal disinfecting agents or when preparing hazardous drugs

III. Step over into the clean side of the anteroom

IV. Personnel shall thoroughly wash hands and forearms to the elbows with soap and water for at least 30 seconds. Use disposable low-linting wipers to dry hands and forearms after washing.

V. Don a low-linting gown with sleeves that fit snugly around the wrists and enclosed at the neck.

The gown should be disposable, but if reusable gowns are worn, they should be laundered appropriately for cleanroom use.

VI. Apply a waterless alcohol-based hand rub with persistent antimicrobial activity to hands. Allow hands to dry.

VII. Don sterile gloves

VIII. Enter the buffer area.

IX. During the compounding process, sanitize gloves with sterile 70% isopropyl alcohol.

Preparing to Work in a SCA

I. Personnel entering the ante area shall don attire:
   A. Dedicated shoes or shoe covers
   B. Head and facial hair covers
   C. Face masks

II. Eye shields. Eye shields are optional unless working with irritants such as germicidal disinfecting agents or when preparing hazardous drugs

III. Personnel shall thoroughly wash hands and forearms to the elbows with soap and water for at least 30 seconds. Use disposable low-linting wipers to dry hands and forearms after washing.

IV. Don a low-linting gown with sleeves that fit snugly around the wrists and enclosed at the neck. The gown should be disposable, but if reusable gowns are worn, they should be laundered appropriately for cleanroom use.

V. Apply a waterless alcohol-based hand rub with persistent antimicrobial activity to hands. Allow hands to dry.

VI. Don sterile gloves

VII. Enter the perimeter around the Primary Engineering Control.

VIII. During the compounding process, sanitize gloves with adequate frequency with sterile 70% isopropyl alcohol.

When compounding personnel exit the compounding area during a work shift, the exterior gown may be removed and retained in the compounding area if not visibly soiled, to be re-donned during that same work shift only. However, shoe covers, head and facial hair covers, face masks, eye shields, and gloves shall be replaced with new ones before re-entering the compounding area, and proper hand hygiene shall be performed.

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138671**

Approved	N/A
Review Due	1 year after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC EC.01.01.01, TJC EC.02.02.01, TJC EC.04.01.01 + 1 more

Pharmacy:Hazardous Drugs: Preparing Parenteral Medications, 22-06-02 (Previously 19-07)

STATEMENT

Parenteral and other dosage forms of cytotoxic and other hazardous medications intended to be sterile shall be prepared according to the provisions of this policy using USP <797>, USP <800>, and the OSHA, NIOSH, and ASHP Guidelines as references.

Specific dosage forms of hazardous drugs that are eligible for entity exemption from this policy will be identified in the hospital's Assessment of Risk (see Policy 22-01-05).

Sterile hazardous drugs shall be prepared in a properly ventilated vertical flow Class II biological safety cabinet (BSC) or compounding aseptic containment isolator (CACI) that meets the requirements in USP <797> and USP <800>.

Hazardous drugs shall not be prepared in a horizontal laminar air flow workbench or a compounding aseptic isolator.

RECEIVING

Personnel opening and unpacking shipping containers of hazardous drugs must wear gloves tested to ASTM D6978 for chemotherapy gloves

STORAGE OF HAZARDOUS DRUGS

Unless exempt dosage forms of hazardous drugs that are not antineoplastics have been identified by the hospital's Assessment of Risk, they shall be stored separately from other inventory in a manner to

prevent contamination and personnel exposure. The storage area shall be under a negative pressure differential between 0.01” and 0.03” water column to adjacent areas, externally vented, and shall maintain at least 12 air changes per hour.

Hazardous drugs used to prepare Compounded Sterile Preparations (CSPs) may be stored in the negative pressure buffer room, provided they have been wiped down as required by USP <797>. No corrugated cardboard or any external shipping container may be stored in the cleanroom suite.

HAZARDOUS DRUG FACILITY

The room in which hazardous drugs are prepared is physically separate from other preparation areas and meets the requirements of USP <800>.

PREPARATION OF HAZARDOUS DRUGS

All manipulation of hazardous drugs will take place in a Containment Primary Engineering Control (C-PEC) that meets the requirements of USP <800>.

A BSC or CACI used for nonsterile compounding will not be used for the preparation of sterile hazardous drugs unless it undergoes thorough decontamination, cleaning, and disinfection after compounding nonsterile preparations and before re-use for sterile compounding.

Contaminated materials (e.g., needles, syringes, liners, drug transfer devices) shall be placed in yellow chemotherapy waste containers.

PERSONAL PROTECTIVE EQUIPMENT AND OTHER EQUIPMENT

Personal protective equipment (PPE) is available in areas where hazardous drugs are prepared. PPE includes disposable, sterile powder-free chemotherapy gloves tested to ASTM D6978, disposable gowns (low permeability, back closure, tight-fitting cuffs), preferably tested to ASTM F3267, hair covers, goggles, masks, shoe covers and NIOSH-certified respirators.

A plumbed eyewash fountain is available in areas where hazardous drugs are handled.

PREPARATION TECHNIQUES

Strict adherence to aseptic technique is the single most important factor in personnel safety. Gloves, masks, gowns, hair covers, shoe covers and protective eye wear supplement good aseptic technique.

Even if care is taken, compounding manipulations include many opportunities for absorption of hazardous drugs through inhalation or direct contact with the skin. Aerosols generated by these activities can endanger not only the individual immediately involved, but also staff and patients in the surrounding areas.

The following manipulations are examples of those that can cause splattering, spraying, and aerosol generation:

- The withdrawal of needles from medication vials.
- Medication transfers using syringes and needles or filter straws.
- The breaking open of ampules.
- The expulsion of air from a medication-filled syringe.

COMPOUNDING PROCEDURE

- Read the package literature for hazards and proper handling information.
- Perform hand hygiene and don the appropriate protective apparel. Strictly adhere to aseptic technique.
- Decontaminate (with an oxidizer intended for use with hazardous drugs), clean (with a germicidal detergent) and disinfect (with sterile alcohol) the Biological Safety Cabinet (BSC) / Compounding Aseptic Containment Isolator (CACI).
- Assemble all medications and materials prior to starting the procedure. Keep extraneous items out of the work area in order to avoid contamination.
- Wipe medications containers with a moist low-lint wipe before placing in the BSC or CACI.
- Work on a disposable, plastic-backed paper liner. Change the liner after preparation of each batch.
- Use syringes and IV sets with Luer-Lok fittings and needle-less systems (when available). Closed system transfer devices shall be used unless preparation does not allow.
- Attach administration sets to IV bags/bottles and prime with the base solution prior to addition of the hazardous drug.
- Use syringes that will be no more than 3/4 full -- yet will accurately measure the required volume of solution.
- Use large bore needles (18G to 21G) to reduce the chance of high pressure syringing of the solution. (Keep in mind that large bore needles may drip.)
- Wipe vials with sterile 70% isopropyl alcohol prior to withdrawing contents.
- Tap down the contents of ampules before opening. Wipe the ampule with alcohol before opening.
- If using CSTDs, follow the manufacturer's instructions.
- If not using CSTDs, use a negative pressure technique. Substantial positive or negative deviations from atmospheric pressure within medication vials and syringes may be avoided through the use of appropriately designed venting needles or negative pressure techniques. Add diluent slowly to the vial in small amounts and allow air to escape into the syringe. After adding all of the diluent, withdraw a small amount of air from the vial to create a negative pressure. (Do not expel this air into room.).
- Be very careful to avoid spilling and aerosolization when withdrawing medications from vials and ampules. For sealed vials, final medication measurement shall be performed prior to removing the needle from the stopper of the vial and after pressure has been equalized.
- Unused or excess hazardous drug is returned to the original container or discarded into an empty sterile vial. Excess drug is not discarded in open containers.

- After completion of preparation, the final preparation is wiped with moist low-lint wipe before labeling and removal from the cabinet. The outer gloves are removed after wiping down the container, but before labeling and removal from the cabinet.
- The final preparation is sealed in a plastic bag or other sealable container for transport before removing from the PEC.
- The drug container and the transport container are labeled with the contents and appropriate warnings for cytotoxic and hazardous drugs.
- Contaminated materials (e.g., needles, syringes, liners, drug transfer devices) are placed in appropriate waste containers within the BSC or CACI.

TRANSPORTING

Hazardous drug preparations and transport containers are labeled with appropriate warnings for cytotoxic and hazardous drugs.

The final preparation is wiped and sealed in a plastic bag or other sealable container for transport.

Hazardous drugs are transported in leak-proof containers that protect from breakage and spillage. Hazardous drugs are not transported using methods that produce mechanical stress on the containers (e.g., pneumatic tube systems)

WASTE DISPOSAL

Disposal of hazardous drug waste complies with all US Environmental Protection Agency Resource Conservation and Recovery Act (USEPA/RCRA) regulations and applicable state and local laws and regulations. See Policy 19-03: Waste Disposal.

Contaminated materials are placed in appropriate yellow chemotherapy waste containers separate from other trash. Contaminated sharps (e.g., needles, vials) are placed in yellow chemotherapy waste sharps containers. “Soft” contaminated materials (e.g., gloves, gowns) are placed in rigid, leak-proof yellow chemotherapy waste containers or double bagged in yellow chemotherapy waste bags and sealed.

Hazardous waste containers are labeled with appropriate warnings.

Personnel handling hazardous drug waste wear Personal Protective Equipment as detailed in Policy 22-06-04.

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date

Kari Quickenden: Chief Clinical Officer	Pending
Brendan Gemelli: Pharmacy Director	05/2025

Reg. Standards

TJC EC.01.01.01, TJC EC.02.02.01, TJC EC.04.01.01, TJC MM.01.01.03

Status **Pending** PolicyStat ID **18138661**

Approved	N/A
Review Due	1 year after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC EC.01.01.01, TJC EC.02.02.01, TJC EC.04.01.01 + 1 more

Pharmacy:Hazardous Drugs: Preparing Non-Sterile Medications, 22-05-02 (previously 19-08)

STATEMENT

Non-sterile hazardous drugs shall be prepared according to the provisions of this policy in an area separate from preparation of non-hazardous drugs, using USP <795>, USP <800>, OSHA, NIOSH, and ASHP Guidelines as references.

Specific dosage forms of hazardous drugs that are eligible for entity exemption from this policy will be identified in the hospital's Assessment of Risk (see Policy 19-14).

Non-sterile hazardous drugs shall be prepared in a properly ventilated Containment Ventilated Enclosure (CVE), such as a powder hood or vertical flow biological safety cabinet (BSC) (Class I or Class II).

Hazardous drugs shall not be prepared in a horizontal laminar air flow workbench or a compounding aseptic isolator. Other equipment used to prepare hazardous drugs (e.g., counting trays, spatulas, graduated cylinders) shall not be used for preparing non-hazardous medications.

RECEIVING

Personnel opening and unpacking shipping containers of hazardous drugs must wear gloves tested to ASTM D6978 for chemotherapy gloves.

STORAGE OF HAZARDOUS DRUGS

Unless exempt dosage forms of hazardous drugs that are not antineoplastics have been identified by the hospital's Assessment of Risk, they shall be stored separately from other inventory in a manner to

prevent contamination and personnel exposure. The storage area shall be under a negative pressure differential of 0.01” to 0.03” water column to the adjacent space, externally vented, and shall maintain at least 12 air changes per hour.

HAZARDOUS DRUG FACILITY

The room in which hazardous drugs are prepared is physically separate from other preparation areas and meets the requirements of USP <800>.

PREPARATION OF HAZARDOUS DRUGS

All manipulation of hazardous drugs will take place in a Containment Primary Engineering Control (C-PEC) that meets the requirements of USP <800>.

A BSC or CACI used for nonsterile compounding will not be used for the preparation of sterile hazardous drugs unless it undergoes thorough decontamination, cleaning, and disinfection after compounding nonsterile preparations and before re-use for sterile compounding.

Contaminated materials (e.g., needles, syringes, liners, drug transfer devices) shall be placed in yellow chemotherapy waste containers.

PERSONAL PROTECTIVE EQUIPMENT AND OTHER EQUIPMENT

Personal protective equipment (PPE) is available in areas where hazardous drugs are prepared. PPE includes disposable, powder-free chemotherapy gloves tested to ASTM D6978, disposable gowns (low permeability, back closure, tight-fitting cuffs), hair covers, goggles, masks, shoe covers and NIOSH-certified respirators.

A plumbed eyewash fountain is available in areas where hazardous drugs are handled.

COMPOUNDING PROCEDURE

When preparing nonsterile liquid or powdered hazardous drug dosage forms (e.g., capsules), observe the same general precautions for protective apparel and choice of preparation area as described above.

- Read the package literature for hazards and proper handling information.
- Wear appropriate garb and PPE. Wash hands.
- Clean the CVE according to manufacturer’s recommendations and infection control policies.
- Assemble all medications and materials prior to starting the procedure. Keep extraneous items out of the work area to avoid contamination.
- Work on a disposable, plastic-backed paper mat. Change the mat after preparation of each batch.
- Clean and disinfect counting trays and other equipment used to prepare oral or topical dosage forms.

- Do not use packaging equipment (e.g., automated packaging equipment) that places stress on dosage forms causing production of dust, splashes, vapors, etc.
- Dispose of unused or unusable oral or topical dosage forms in the same manner as for parenteral hazardous waste.
- After completion of preparation, wipe the final preparation with a moist low-lint wipe before labeling and removal from the cabinet.Remove the outer gloves after wiping down the container but before labeling and removal from the cabinet.
- Label the drug container and the transport container with the contents and appropriate warning for cytotoxic and hazardous drugs.
- Seal the preparation in a plastic bag or other sealable container for transport before removal from the cabinet.
- Place the contaminated disposable materials (e.g., mats, drug transfer devices) in the appropriate waste container within the CVE.
- Decontaminate and clean counting trays and other non-disposable equipment used to prepare oral or topical dosage forms with decontamination agent and rinse with Purified Water after each use.

TRANSPORTING

Hazardous drug preparations and transport containers are labeled with appropriate warnings for cytotoxic and hazardous drugs.

Hazardous drugs are transported in leak-proof containers that protect from breakage and spillage. Hazardous drugs are not transported using methods that produce mechanical stress on the containers (e.g., pneumatic tube systems)

DECONTAMINATION AND CLEANING

- Periodic decontamination and cleaning routines shall be established for all work surfaces, equipment, and facilities used in the handling, preparation, and administration of hazardous drugs.
- Personnel performing decontamination and cleaning must wear appropriate PPE.
- Equipment used in deactivation, decontamination, cleaning, and disinfection of areas where hazardous drugs are handled, prepared, and administered (e.g., mops, buckets) shall be dedicated to the area and not used in other areas. Disposable cleaning equipment (e.g., mop heads, cleaning wipes) are used whenever possible.
- Containment Primary Engineering Controls (C-PECs) shall be decontaminated, cleaned, and disinfected according to manufacturer's recommendations.
- C-PECs shall be decontaminated at least daily, any time a spill occurs, before and after certification, voluntary interruption, or if the equipment is moved. The deck of the C-PEC shall be decontaminated between compounding different hazardous drugs.
- C-PECs shall be cleaned at least daily with an approved germicidal detergent and at least

weekly with an approved sporicidal detergent.

- C-PECs shall be disinfected using an approved disinfectant at the end of the workday, between batches of compounding medications, at the beginning of each shift (if compounding occurs over an extended period of time), routinely during compounding, and after anytime the C-PEC has been powered off.
- The area under the work tray of a C-PEC shall be cleaned at least monthly.
- Floors in rooms where C-PECs are located are cleaned daily using approved deactivating and cleaning agents.
- Work surfaces and equipment (e.g., carts, trays) used in areas where hazardous drugs are prepared and administered are decontaminated, cleaned and disinfected before and after each activity and at the end of the day (if used that day).

WASTE DISPOSAL

Disposal of hazardous drug waste complies with all US Environmental Protection Agency Resource Conservation and Recovery Act (USEPA/RCRA) regulations and applicable state and local laws and regulations. See Policy 19-03: Waste Disposal.

Contaminated materials are placed in appropriate yellow chemotherapy waste containers separate from other trash. Contaminated sharps (e.g., needles, vials) are placed in yellow chemotherapy waste sharps containers. "Soft" contaminated materials (e.g., gloves, gowns) are placed in rigid, leak-proof yellow chemotherapy waste containers or double bagged in yellow chemotherapy waste bags and sealed.

Hazardous waste containers are labeled with appropriate warnings.

Personnel handling hazardous drug waste wear Personal Protective Equipment as detailed in Policy 22-06-04.

Reviewed and Approved:

P&T Committee 05/24/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Reg. Standards

TJC EC.01.01.01, TJC EC.02.02.01, TJC EC.04.01.01, TJC MM.01.01.03

Status **Pending** PolicyStat ID **18138639**

Approved	N/A
Review Due	2 years after approval
Document Area	CAH - Patient Care

Pharmacy: Sterile Preparations: Intrathecal Medications 22-06-09 (Previously 22-35)

Statement

Intrathecal medications will be prepared separately from other agents.

Once prepared, intrathecal medications will be placed in an isolated container or location with a uniquely identifiable intrathecal medication label.

Intrathecal medications will be hand-delivered to the RN responsible for administration of the agent or his/her designee.

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138581**

Approved	N/A
Review Due	2 years after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC MM.01.02.01, TJC MM.02.01.01, TJC MM.03.01.01 + 2 more

Pharmacy: General Storage of Medications, 09-01

STATEMENT

Medications, biologicals, and devices shall be stored to ensure their integrity, stability, and effectiveness. All drugs and biologicals will be controlled, secured, and distributed in accordance with applicable standards of practice and consistent with Federal and State laws and regulations.

MEDICATION STORAGE AREAS

Medications may stored only in authorized locations.

Medication dispensing, administration, and storage areas shall be well lighted, neat, organized, and located where personnel preparing medications for dispensing or administration will not be interrupted.

All drugs and biologicals must be secure; controlled substances must be locked within a secure area. A secure area is one in which staff are actively providing patient care or preparing to receive patients with procedures to ensure limited entry and exit to appropriate staff, patients, and visitors. Generally, all drugs should be kept in a locked room or container. If the container is mobile or readily portable, when not in use, it must be stored in a locked room, monitored location, or secured location that will ensure the security of the drugs or biologicals.

All drugs and biologicals must be stored in a manner to prevent access by non-authorized individuals.

Unauthorized personnel may not have unmonitored access to drugs or biologicals, and may not have keys to medication storage rooms, carts, cabinets, or containers. If unauthorized personnel could gain access to the drugs or biologicals in an area, the hospital is not in compliance with the requirement to store all drugs and biologicals in a locked storage area.

Housekeeping staff, central supply staff, and other staff as determined by the hospital may have access

to medication storage areas for the purpose of performing their job duties, such as cleaning and restocking of medical supplies but will be accompanied by Pharmacy personnel.

NURSING MEDICATION CARTS, ANESTHESIA CARTS, AND OTHER MEDICATION CART

When not in use, nursing medication carts, anesthesia carts, and other medication carts containing drugs or biologicals must be locked or stored in a locked storage room. However, due to the mobility of carts, when not in use, locked carts that contain drugs or biologicals must be stored in a locked room or secure location. If a cart containing drugs or biologicals is in use and unlocked, someone with legal access to the drugs and biologicals in the cart must be close by and directly monitoring the cart. That person could be a nurse, a physician, or other individual who in accordance with State and Federal law and hospital policy has legal access to the drugs and biologicals in the cart. That person must monitor the cart and be aware of other people's activities near the cart. He/she is responsible for the security of the drugs and biologicals in the cart.

STORAGE OF MEDICATIONS BETWEEN RECEIPT AND ADMINISTRATION

Any drug received from the pharmacy should be placed in an approved storage area as soon as possible, but no later than 30 minutes after receipt.

All drugs removed from a medication storage area must be removed just prior to administration and only for one patient at a time. Once removed, the drug must remain with the individual at all times and may not be left unattended. No fanny packs or other personal storage of hospital medications is permitted.

The drug should not be left on or in any area exceeding 77º Fahrenheit (25°C).

If not administered, the drug should be returned to the designated secure storage area within 30 minutes.

STORAGE CONDITIONS

Medications shall be stored under the proper conditions of sanitation, temperature, light, moisture, ventilation, organization, segregation, safety, and security. Temperatures and ventilation in the work areas shall ensure the integrity of medications and the comfort of personnel.

USP/NF AND MANUFACTURERS' RECOMMENDATIONS

Medications shall be stored according to the provisions of the USP/NF and/or the specifications of the manufacturer so that their integrity, stability, and effectiveness are maintained. If no storage information is available from the manufacturer, the pharmacist will provide instructions based on professional judgment and best practices.

When in conflict, the Director of Pharmacy shall ascertain whether the provisions of the USP/NF or the

specifications of the manufacturer take precedence.

Open containers of bulk non-parenteral medications (such as pint bottles of alcohol, oral liquids, etc.) may be used until the manufacturer's expiration date unless other information is provided by the manufacturer.

SEPARATION OF INTERNALS FROM EXTERNALS

Antiseptics, disinfectants, poisons, test reagents, and other medications for external use (e.g., otics and ophthalmics) shall be stored separately from internal and injectable medications (e.g., on separate shelves or in separate containers from internal and injectable medications).

RESPIRATORY CARE MEDICATIONS AND MEDICATIONS USED TO PREPARE IRRIGATION SOLUTIONS

Vials and ampules of respiratory care medications and medications used to prepare irrigation solutions shall be stored separately from injectable medications in order to minimize the possibility of accidental injection.

POISONS AND LETHAL CONCENTRATIONS OF MEDICATIONS

Poisons and lethal concentrations of medications shall be locked up or stored in areas with access limited to authorized personnel.

Heparin 10,000 unit/ml vials will only be stored in the pharmacy. If a vial is required for a single undiluted dose, it will be dispensed as patient- or procedure-specific with prominent labeling and tracking of its use.

CONCENTRATED ELECTROLYTE INJECTIONS

Concentrated electrolytes, including potassium chloride (KCl) injection, potassium phosphate injection, and sodium chloride injection greater than 3% shall be stored in the only in the pharmacy.

3% sodium chloride 500 mL IV bags may be stored in locked boxes inside of automated dispensing cabinets in the emergency department only.

LOOK ALIKE SOUND ALIKE MEDICATIONS

Medications that are easy to confuse (such as look-alike or sound-alike medications) will be segregated or specially labeled to minimize confusion. The hospital will determine a list of these agents and annually review and approve it.

FOOD STORAGE AND CONSUMPTION

Food shall be stored only in designated areas. Food shall not be consumed in areas designated for the compounding and dispensing of medications.

SPECIAL STORAGE CONDITIONS

Medications requiring special storage conditions for stability (e.g., refrigeration or freezing) shall be so stored. If required, medications shall be protected from freezing, moisture, light, and excessive heat.

ORDERLY STORAGE

Medications shall be stored in an orderly manner to facilitate inventory control and minimize errors.

CLEAN STORAGE

Storage areas shall be kept clean, uncluttered and free from trash, insects, rodents, and vermin. If lower shelves are not sealed to the floor, sufficient space shall be allowed underneath the shelves to permit access for cleaning.

SAFE STORAGE

- Space under stairwells shall not be used for storage.
- Glassware shall be stored so as to minimize breakage.
- Hazardous and caustic materials shall be stored on lower shelves (or shelves with breakage prevention barriers), in protective cabinets or boxes, or in another manner that will minimize the risk of breakage, spillage, and exposure of personnel.
- Heavy items shall be stored on lower shelves. Shelves shall not be overloaded.
- Medications and supplies shall not be stored on the floor.
- Storage shall not obstruct the proper functioning or testing of any fire detecting or extinguishing system installed or suspended from the ceiling. A clearance of 36 inches is recommended, but may be reduced to 18 inches where flammable gases or liquids are not involved.
- Storage shall not prevent ready access to exits, fire extinguishing units, or tools.
- Corridors, passageways and other traffic areas shall be kept free of obstacles.

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending

Brendan Gemelli: Pharmacy Director	05/2025

Reg. Standards

TJC MM.01.02.01, TJC MM.02.01.01, TJC MM.03.01.01, TJC MM.04.01.01, TJC NPSG.03.05.01

Status **Pending** PolicyStat ID **18138519**

Approved	N/A
Review Due	1 year after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC MM.03.01.01, EP 24, TJC MM.05.01.07

Pharmacy: Compounding - General: Radiopharmaceuticals 22-01-07

STATEMENT

The pharmacy department does not compound radiopharmaceuticals.

Medical Imaging receives radiopharmaceutical unit doses via PharmaLogic. This agreement is via the hospital group purchasing organization and is reviewed by leadership as appropriate.

In-house preparation of radiopharmaceuticals is done by, or under the supervision of, an appropriately-trained doctor of medicine or osteopathy.

PROCEDURE

Compounding of radiopharmaceuticals shall comply with USP <825> and other applicable USP chapters.

The Medical Imaging department maintains the records of the receipt and disposition of radiopharmaceuticals.

Reviewed and Approved:

P&T Committee 05/24/2025

Approval Signatures

Step Description	Approver	Date

Kari Quickenden: Chief Clinical Officer	Pending
Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138498**

Approved	N/A
Review Due	2 years after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC MM.05.01.07

Partial And Crushed Tablets, 11-14

STATEMENT

Orders for partial and crushed tablets will be removed as whole tablets from the Pyxis unit. Nursing staff will split or crush tablets per manufacturer recommendations (found in drug handbooks and/or Lexicomp and other such pharmaceutical resources) in the patient care area.

Pill cutters will be provided on a per patient basis. Upon discharge, the pill cutter may be sent home with the patient or disposed of in the sharps container.

For crushing of tablets, a Silent Knight Pill Crusher, and Silent Knight Pill Crushing Pouches will be utilized.

PROCEDURE

Nursing staff will split or crush tablets per manufacturer recommendations (found in drug handbooks and/or Lexicomp and other such pharmaceutical resources)in the patient care area.

Warfarin partial tablets or hazardous partial tablets will be dispensed by pharmacy as a ready-to-use dose.

Gloves shall be donned when handling pills removed from packaging for splitting or crushing.

Reviewed and Approved:

P&T Committee 04/24/2025

Approval Signatures

Step Description	Approver	Date

Kari Quickenden: Chief Clinical Officer	Pending
Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138651**

Approved	N/A
Review Due	2 years after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC MM.04.01.01

Pharmacy:Administration: Administration of Medications – Pediatric Patients, 13-07

Procedure

The hospital will develop guidelines for administering medications to pediatric patients. All pediatric medication dosages will be double checked for appropriateness and safety and documented in the double verification note or area of an electronic medical record. Patients age 18 or less will be considered pediatric. Intravenous (IV) fluids used for pediatrics are to be of 500 ml volume or less.

WEIGHT IN KILOGRAMS

Pediatric patients will be weighed using kilograms (kg) and height measured in centimeters. Kilograms will be used for calculation of pediatric medications.

SEPARATION OF ADMINISTRATION OF CEFTRIAXONE AND CALCIUM PRODUCTS

Administration of ceftriaxone administration and administration of calcium containing products in the neonate patient population must be separated by at least 48 hours.

BACKGROUND

Pediatric patients are unique because of age-specific differences in metabolic capacity, disease processes that may make commercially available pharmaceutical preparations unacceptable for use, a lack of published information on the effects of many new pharmacotherapeutic agents in this population, and changes in population demographics caused by new diseases and new technological applications.

References

Emergency Nurses Association. (2016). Weighing all patients in kilograms. Position Paper. Retrieved from https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/weighingallpatientsinkilograms.pdf?sfvrsn=9c0709e_6

Levine S, et al. Journal of Pediatric Pharmacology and Therapeutics, 2001(6):426-442, Guidelines for Preventing Medication Errors in Pediatrics (PPAG/ISMP), endorsed by ASHP and the Society of Pediatric Nurses, available at www.ppag.org/en/art/?6.

Reviewed and Approved:

P&T 04/24/2025

MEC 05/27/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138546**

Approved	N/A
Review Due	2 years after approval
Document Area	CAH - Patient Care
Reg. Standards	TJC MM.06.01.01

Pharmacy: Administration: Administration of Medications - General, 13-01

Procedure

Administration of medications shall be in accordance with all the laws of this state, federal laws, rules, and regulations that govern such acts, and medical staff rules and regulations.

REQUIREMENT FOR A VALID ORDER

Individuals who prepare, dispense, and administer medications shall do so only upon the order of a practitioner who has been granted clinical privileges and is legally authorized to prescribe/order medications.

COMPLIANCE WITH MEDICATION ORDERS

Medications shall be prepared and administered in accordance with the orders of the prescriber or practitioner responsible for the patient's care and accepted standards of practice.

PERSONS AUTHORIZED TO ADMINISTER MEDICATIONS

Medications shall be administered by or under the supervision of appropriately licensed personnel. Only individuals who are qualified, competent, and permitted by law, licensure or regulation to administer medications shall administer medications.

STANDARD MEDICATION ADMINISTRATION TIMES

Unless the prescriber directs otherwise, medications shall be administered at standard times. A pharmacist shall notify nursing service (or other appropriate clinician) if a medication should be administered at other than standard times.

Refer to Housewide Clinical Medication Administration Policy on standard medication administration times and time critical medications.

MEDICATION ADMINISTRATION PROCEDURE

- Do not transfer or administer medications to patients other than patients for whom they are ordered.
- Keep unit-dose packages intact until just prior to administration.
- Read the medication label at least three times:
    - When picking up the medication.
    - Just prior to administration.
    - Just after administration.
- Medications shall be administered by the individual who prepared the dose, except for unit dose medications and sterile preparations prepared by the Pharmacy.
- Correctly identify the patient as the one for when the medication was ordered using at least the two hospital identifiers.
- Verify that the medication selected for administration is the correct medication based on the medication order and product label.
- Verify that the medication is stable based on visual examination or particulates or discoloration and that the medication has not expired.
- Verify there are no contraindications for administering the medication.
- Verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route.
- Advise the patient, or if appropriate, the patient's family about any potentially clinically significant adverse reaction or other concern about administering a new medication.
- Discuss any unresolved, significant concerns about the medication with the patient's physician, prescriber (if different from the physician) and/or relevant staff involved with the patient's care, treatment and services.
- Computers in patient rooms or portable tablets must be used at the bedside for administration and barcode scanning of all medications.
- Patient medications will be unit dosed, barcoded, and will be kept in the automated medication dispensing cabinet, patient bulk drawer, or medication refrigerator.
    - Unit dose medications supplied in a unit dose package should not be opened until the nurse is at the bedside to administer the medication.
- Return refused (but reusable) medications per hospital policy. Destroy unusable refused medications. Isolate defective or questionable medications and return them to the Pharmacy.
- Report medication administration errors, and adverse or untoward medication reactions immediately to the attending physician. Prepare and submit reports as required by the facility. Report incompatibilities to the Pharmacy.

DISCONTINUED MEDICATION ORDERS

Discontinued medication orders shall be removed from the patient's medication supply and placed in the Pharmacy pickup container or returned to the Pharmacy.

PATIENTS TRANSFERRED INTRA-FACILITY

When a patient is transferred to another location within the facility, the patient's medications (including bulk and refrigerated medications) shall be transferred to the new location. The Pharmacy shall be informed of the transfer.

PATIENTS DISCHARGED

When a patient is discharged, the patient's medications shall be removed from the patient's storage container and placed in the Pharmacy pickup container or returned to the pharmacy.

PERSONNEL WHO MAY ADMINISTER MEDICATIONS

Medications shall be administered by, or under the supervision of, appropriately licensed personnel.

Authoritative professional licensing boards, discipline-specific professional scope of practice rules, and discipline-specific regulatory bodies determine those who are legally authorized to administer medications as well as the types and routes:

Oral/Rectal/Topical	RN, LPN/ LVN, RRT/CRT,Paramedics
Intramuscular/Subcutaneous	RN, LPN/ LVN*, Paramedics
Intravenous Infusion (Initial)	RN, Paramedics
Intravenous Infusion (Continuation)	RN, Paramedics
Intravenous Push	RN
Intravenous Piggyback	RN
Chemotherapeutic (Cytotoxic/ Oncolytic)	RN
Oxytocic Medications	RN
Parenteral Nutrition Therapy	RN
Respiratory Therapy Medications	RN, LPN/LVN, CRTT, RRT, Paramedics
Contrast Media	Registered Radiologic Technologist Ultrasound Technologist
Oral Barium	Registered Radiologic Technologist
Radiopharmaceuticals	Nuclear Medicine Technologist
RN	may administer most medications. Exception: those specifically designated otherwise by the Wyoming State Board of Nursing or national nursing authoritative sources.

LPN/LVN	may administer oral, subcutaneous, intramuscular and topical medications
LPN/LVN	may administer IV infusions (but not IV push) medications, if so authorized by licensure or regulation
Graduate nurses	are subject to the medication administration limits of their licensed counterparts
Student nurses	may administer medications under the supervision of their instructor
RRT	may administer respiratory medications by inhalation
Radiology Tech	may administer IV and oral contrast media if so authorized by the physician chairman of the Radiology Department
PT and licensed PTA	may administer topical medications that relate to their treatments
Other licensed practitioners	may administer medications within their scope of practice as authorized by licensure or regulation
Patients and/or caregivers	may administer their own medication if the physician so specifies by order
Nuclear Medicine Tech	may administer nuclear medicines as authorized by the physician chairman of the Radiology Department

Reviewed and Approved:

P&T Committee 04/24/2025

MEC 05/27/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138466**

Approved	N/A	Document Area	CAH - Patient Care
Review Due	2 years after approval	Reg. Standards	TJC NPSG.03.06.01

Medication Reconciliation

STATEMENT OF PURPOSE

To establish a medication reconciliation process that collects patient information (medication history, allergies, and current regimen), verifies medication and doses, and documents order changes for effective communication among providers.

- To obtain a complete and accurate list of every patient's home medications. A good faith effort will be made.
- To compare the prescriber's admission, transfer, and/or discharge orders to the home medications list.
- To alert prescribers to any discrepancies.

PROCESS

ADMIT

Initiate medication reconciliation and complete in no greater than 24 hours.

- History will be obtained and entered in EHR by a qualified individual per their scope of practice.
- A licensed independent practitioner will reconcile medications.
- Attempt to obtain a complete and accurate list of the patient's allergies and home medications, herbs, vitamins, and over-the-counter medications. The list should contain drug name, dose, route and frequency of medications, last dose taken, and placed in the Home Medications section of EHR. The individual performing the medication history process may use the following sources of information to ensure accuracy of the medication list: patient, external pharmacy(ies), provider(s), and long-term care facilities.
- The individual performing the medication history is to complete Document Medication by Hx in EHR as appropriate. Medications to be continued on admission should be initiated by attending physician in the Admission Reconciliation.

- Radiology shall inquire and document any medications that are contraindicated when using contrast.
- Dialysis RN will document any new medications in the EHR Document Medication by Hx as applicable and physician will review/reconcile medications monthly with patients.

NOTE: THE MEDICATION RECONCILIATION PROCESS MAY NEED TO CONTINUE THROUGHOUT HOSPITALIZATION IN ORDER TO OBTAIN THE MOST COMPLETE AND ACCURATE LIST OF HOME MEDICATIONS.

TRANSFER

Active visit medications will be reviewed at point of transfer from one nursing unit to another.

- Review the patient's current active visit medications with the receiving nurse. In emergent situations, communicate medications pertinent to the situation.
- Clarify any discrepancies between the most current active visit medications and medications prior to transfer with the physician.

DISCHARGE

Upon transfer to another facility, a qualified individual will provide a summary of care record to receiving facility. This will include, but is not limited to, an updated medication list.

- The individual will give report to receiving individual and ensure home and current medications are part of transfer record.

Physicians reconcile medications at discharge to prevent the duplication and/or omission of medications.

- Compare the patient's active visit medication list with the patient's home medication list.
- Physician is to review and update list of home medications on discharge.
- Updated home medication list is populated from the physician completion of a discharge medication reconciliation process.
- An RN will complete document by completing appropriate information. List is printed and copied. One copy will remain with patient, one copy scanned to EHR.
    - If the next provider of care is known, a copy of the note is to be provided.
    - If the next provider of care is not known, a copy is to be sent with the patient and/or family.
- Provide and instruct the patient or patient's family with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter.

Reviewed and Approved:

P&T 04/24/2025

MEC 05/27/2025

Approval Signatures

Step Description	Approver	Date
	Ann Marie Clevenger: CNO	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **18138412**

Approved	N/A	Document Area	CAH - Patient Care
Review Due	2 years after approval	Reg. Standards	TJC MM.06.01.01

Administration of Medications by Provider Type (MM.06.01.01 EP 1-9)

STATEMENT OF PURPOSE

To identify the authorized individuals who may administer medications in Memorial Hospital of Sweetwater County (MHSC) and the associated clinics.

To delineate the regulatory requirements of medication administration by authorized individuals at MHSC and associated clinics.

POLICY

1. Administration of medications shall be in accordance with all the laws of this state, federal laws, rules, and regulations that govern such acts, and medical staff rules and regulations.
2. Medications shall be administered by or under the supervision of appropriately licensed personnel designated by the medical staff in its approved rules and regulations. Only individuals who are qualified, competent, and permitted by law or regulation to administer medications shall administer medications
3. Before administering any medication the medical professional must understand the individual patient's diagnosis and symptoms that correlate with the rationale for drug use. At a minimum, the medical professional also must know why a medication has been ordered, the expected actions, onset/peak/duration, usual dosing, proper dilution, route, and rate of administration, anticipated/expected complications, reversal agents, and how to administer them, adverse effects to report, contraindications for the use of a particular drug, and pertinent monitoring parameters. Compatibility of intravenous (IV) medications and IV fluids are to be confirmed before administration. If uncertain of any of these medication points the nurse must consult an authoritative resource or the hospital pharmacist before administration of the medication. The medical professional must be accurate in calculating, preparing, and administering medications. The medical professional must perform appropriate and accurate patient assessments that indicates the understanding of and ability to apply key principles of medication administration.

4. Responsibilities:
    A. Verify an order exists for the medication
    B. Use Barcode Scanning to:
        1. Verify that the medication selected for administration is the correct one based on the medication order and product label.
        2. Correctly identify the patient as the one for when the medication was ordered using at least the two hospital identifiers.
    C. Ensure these Rights of Medication Administration, at a minimum, are followed with each medication administered:
        1. Right Patient
        2. Right Drug
        3. Right Dose
        4. Right Route
        5. Right Reason
        6. Right Time
        7. Right Assessment (i.e. labs, signs and symptoms, onset/peak/duration of the medication, etc.)
        8. Right Monitoring (i.e., frequency of vital signs, urine output, hemodynamic monitoring, etc.)
        9. Right Evaluation of patient response to the medication
        10. Right Documentation
    D. Consult with the provider if there is any question or concern at all about medication order. Do NOT administer any medication that does not meet the Rights of Medication Administration until all questions or concerns are answered and/or resolved. The only exception is that of emergency situations, though even then it is optimal that a nurse familiar with the medication administer that medication.
5. Medical staff rules and regulations limit the administration of medications to physicians, other legally authorized members of the medical staff, and to the following categories of personnel

Oral/Rectal/Topical.....RN,LPN, LPN IV-C*, RRT/ CRT,Paramedics
Intramuscular/Subcutaneous..... RN,LPN, LPN IV-C*, Paramedics
Intravenous Infusion (Initial)..... RN, LPN IV-C*, Paramedics
Intravenous Infusion (Continuation)..... RN, LPN IV-C*, Paramedics
Intravenous Push (Initial).....RN, Paramedics
Intravenous Push (Continuation) .....RN, LPN IV-C*, Paramedics
Intravenous Piggyback (Initial) ..... RN
Intravenous Piggyback (Continuation) ..... RN, LPN IV-C*, Paramedics

Chemotherapeutic (Cytotoxic/Oncolytic)..... RN
Oxytocic Medications..... RN
Parenteral Nutrition Therapy..... RN
Respiratory Therapy Medications..... RN, LPN, LPN IV-C*, CRT, RRT, Paramedics
Contrast Media.....Registered Radiologic Technologist, Ultrasound Technologist
Oral Barium.....Registered Radiologic Technologist
Radiopharmaceuticals.....Nuclear Medicine Technologist

6. RN may administer most medications. Exception: those specifically designated otherwise.
7. The Wyoming State Board of Nursing (WSBN) Advisory Opinion (2018), provides an official opinion regarding scope of practice of the LPN and LPN IV-C (IV Certified) in the State of Wyoming. All LPNs practice under the supervision of an APRN, RN, Licensed physician or other authorized licensed independent health care provider. Please see attachments for full advisory.
8. LPNs may administer oral, subcutaneous, intramuscular, and topical medications. LPNs will have pharmacological knowledge of any medication they administer. ***LPN or LPN IV-C, shall not administer class I or II, by any route.**
9. The **LPN not designated as IV-C** may engage in a limited scope managing infusion therapy. The basic knowledge and skills listed below are acquired in a state board approved practical nursing program.
    a. Observe and manage IV fluid administration, which include, but are not limited to: observing, monitoring, discontinuing, maintaining, regulating, adjusting, and documenting;
    b. Calculate and maintain flow rate of peripheral vascular device infusions;
    c. Discontinue peripheral venous access lines and infusions on adults; and
    d. Report and document observations and procedures relating to infusion therapy
10. The LPN IV-C will be competent and have pharmacological knowledge of any IV infusions allowed to administer per state rules and regulations. The LPN IV-C may perform the following:
    a. Collect Blood Supply via Phlebotomy, central venous access device (CVAD) including peripherally inserted central catheter (PICC) line and Dialysis access site (chronic dialysis setting).
    b. Insert vascular access device, less than three (3) inches in length into a peripheral vein in individuals age twelve (12) years and over.
    c. Change peripheral IV tubing and dressings.
    d. Maintain patency of peripheral intermittent vascular access devices using a saline flush.
    e. Mix, label and administer IV fluids and medications that are not restricted by this policy for age twelve (12) and over.

f. Monitor and collect data from a patient controlled administration pump at the direction of the RN. The LPN cannot initiate a pump, change a pump, alter settings or discontinue a pump.

g. Maintain peripheral access device and change peripheral IV tubing and dressings.

h. Maintain patency using saline or non therapeutic dose of heparin flush solution.

i. Remove peripheral vascular access device for individuals age five (5) and over.

j. First dose bolus and push antibiotics must be administered by the RN to assess for allergic response. Subsequent antibiotic infusions and push may be administered by the LPN IV-C.

k. Monitor blood and blood products -**after RN has assessed for the first hour**.

11. An LPN IV-C **shall not perform the the following**: The list is not exhaustive. See the full list of IV therapy functions the LPN-IV-C **shall NOT** perform per the WSBN (2025). Please see attachment.

    a. Collect blood samples from individuals under the age of twelve (12), or from an arterial line.

    b. Administer blood, blood components, plasma, plasma expanders.

    c. Administer parenteral nutrition (TPN).

    d. Antineoplastics; autonomic nervous system agents; cardiovascular agents; central nervous system agents; oxytocic agents or radiologic agents.

    e. Flush or aspirate an arterial line.

    f. Provide pediatric infusion therapy to individuals under the age of twelve (12).

    g. Discontinue a pediatric peripheral access device for individuals under the age of five (five).

    h. Administer experimental drugs.

    i. Discontinue or remove CVAD,"central line"including PICC line.

    j. Shall not administer: Cardiac Pressor agents, Neuromuscular blocking agents, Concentrated electrolytes, (i.e. potassium, magnesium sulfate), Moderate sedation in adults and children, Minimal sedation in children, Lipid Based medications, Heparin, Insulin, Albumin, Conventional counterparts methotrexate for non-oncologic use, Chemotherapy agents, Parenteral anticoagulants, Neuraxial opioids, **Any other medication class the RN determines may cause unsafe reaction/ response based on the individual patient and LPN's abilities.**

    k. Administer IV fluids/ medications to individuals under the age of twelve (12).

    l. The LPN shall not initiate or discontinue a PCA pump infusion; change the settings of a PCA pump; or change the cassette or syringe of the PCA pump.

    m. The LPN shall not access dialysis catheters, fistulas or grafts in a non-chronic dialysis setting for any purpose; Provide dialysis access care/ fluids to individuals under the age of twelve(12).

    n. LPNs will not manage epidural pumps.

12. Student nurses may administer medications under the supervision of their instructor or MHSC preceptor.
13. Respiratory Therapists (CRT/RRT) may administer respiratory medications by inhalation. Respiratory Therapists may administer aspirin with an active order for the purpose of cardiac stress testing. Morphine, via nebulizer, will be obtained by an RN from automated dispensing cabinet (Pyxis) for the Respiratory Therapist who will administer it.
14. Paramedics may administer all medications listed in job description (Paramedic - Emergency Department) and can be given any route that is ordered and appropriate.
15. Radiology tech may administer IV and oral contrast media if so authorized by the physician chairman of the radiology department.
16. Ultrasound tech may administer contrast media.
17. PT and licensed PTA may administer topical medications that relate to their treatments.
18. Other licensed practitioners may administer medications within their scope of practice as authorized by licensure or regulation.
19. Patients and/or caregivers may administer their own medication if the physician so specifies by order.
20. Nuclear Medicine Tech may administer nuclear medicines as authorized by the physician chairman of the Radiology Department.
21. Do not transfer or administer medications to patients other than patients for whom they are ordered.
22. Keep unit dose packages intact until just prior to administration.
23. Medications shall be administered by the individual who prepared the dose, except for unit dose medications and sterile preparations prepared by the pharmacy.
24. Advise the patient, or if appropriate, the patient's family about any potentially clinically significant adverse reaction or other concern about administering a new medication.
25. Before administering a new medication, the patient or family are informed about any potentially significant adverse drug reactions or other concerns regarding administration of a new medication.
26. Computers in patient rooms or portable tablets must be used at bedside for scanning all medications prior to administration.
27. Patient medications will be unit dose, barcoded, and will be kept in the automated medication dispensing cabinet, patient specific drawers, pharmacy refrigerator, or Emergency Department(ED) multi-dose cabinet.
28. Patient specific drawers, and ED multi-dose cabinet will be locked when not in use.
29. Unit dose medications supplied in unit dose package should not be opened until nurse is actually at bedside to administer medication.

Related Policies:

Refer to Medication administration reference list

Refer to specific Job Descriptions

REFERENCES

The Pamukcu, B., Oflaz, H., Acar, R. D., Umman, S., Koylan, N., Umman, B., & Nisanci, Y. (2005). The role of exercise on platelet aggregation in patients with stable coronary artery disease: Exercise induces aspirin resistant platelet activation. *Journal of Thrombosis and Thrombolysis, 20*(1), 17-22. doi:10.1007/s11239-005-2318-1Joint Commission. 2015. Joint Commission Resources E-dition.

Marijon, E., Fressonnet, R., Haggui, A., Mousseaux, E., & Redheuil, A. (2007;2008;). Spontaneous coronary dissection of the left main stem after intense physical activity—Regression under conservative strategy. *International Journal of Cardiology, 128*(1), e16-e18. doi:10.1016/j.ijcard.2007.04.157

*Wyoming State Board of Nursing. (January, 2025). Advisory Opinion: LPV IV Certified (IV-C) Scope of Practice. Retrieved June 3, 2020, from WSBN - Practice

Reviewed and Approved:

Nursing Services Committee/REBELS 04/24/2025

P&T 04/24/2025

MEC 05/27/2025

Attachments

- LPN and RN Scope of Practice 2025 .pdf
- LPN IV-C Scope of Practice 2025.pdf
- Wyoming State Board of RT Aspirin administration documentation 4.29.2019.docx

Approval Signatures

Step Description	Approver	Date
	Ann Marie Clevenger: CNO	Pending
	Brendan Gemelli: Pharmacy Director	05/2025

Status **Pending** PolicyStat ID **17694689**

Approved N/A
Review Due 2 years after approval

Document Area CAH - Patient Care

Study Participant Screening & Enrollment CTO 003-21v2

Statement of Purpose

The purpose of this Standard of Procedure (SOP) is to describe the process in which our department screens participants, determines subject eligibility for a clinical trial, and subsequent enrollment on that clinical trial. Many of our trials outline lengthy and complex eligibility criteria and it is our goal to enroll eligible participants only. This SOP outlines the steps required from consent to enrollment.

Scope

- This SOP applies to Principal Investigators (PIs) and Sub-Investigators (Sub-Is) responsible for reviewing eligibility criteria prior to subject enrollment.
- This SOP applies to the study Coordinator who is responsible for assisting the PI or Sub-I in determining subject eligibility.

Definitions and Acronyms

CIRB: Central Institutional Review Board

CTO: Clinical Trials Office

EMR: Electronic Medical Record

ICF: Informed Consent Form

PI: Principal Investigator

SOP: Standard Operating Procedure

Responsibilities

- The PI or Sub-I is responsible for reviewing eligibility criteria outlined in the protocol and corresponding source documents prior to enrollment.
- The Coordinator is responsible for initiating the screening process following consent, ensuring that all protocol required screening tests are ordered and completed, reviewing records and results of screening tests, compiling and completing an eligibility checklist, and providing the PI or Sub-I with all of the source documents for eligibility verification.
- The Clinical Trials Facilitator is responsible for quality checks and making sure all current versions of documents are accessible to the the study team when needed. A CTO designee may perform these duties as needed, such as completing quality checks for the Clinical Trials Facilitator's own patient study tasks.

Materials Required

- Research protocol and other study documents as needed
- Study-specific eligibility checklist from the protocol
- Patient medical records
- Informed consent
- Access to OnCore

Text

COORDINATOR SCREENING PROCESS

1. The screening period begins after a prospective participant or legally authorized representative has been properly consented and signs the CIRB-approved ICF for the study (see SOP 011-09 Clinical Trial Informed Consent Process).
2. Obtain a copy of the current study-specific eligibility checklist, protocol, and study calendar. These documents are included with the protocol and should be obtained through the Clinical Trials Shares Drive to ensure the most current version is being used.

   The research staff MAY NOT create an eligibility checklist separate from the CIRB approved protocol. Eligibility checklists provided by the sponsor may be used.

   A. Note: The Clinical Trials Facilitator will update and upload the study documents to the shares drive from CTSU (Clinical Trials Support Unit) for clinical trials staff to access. It is the Clinical Trials Facilitator's responsibility that all study documents on the shares drive are the most current versions. If there is a document missing or suspected to be an older version, contact the Clinical Trials Facilitator right away for assistance.
3. Access patient medical records and any other applicable source documents.
4. Determine if any of the study required tests and procedures have already been performed as part of a standard-of-care evaluation and check if dates fall within the protocol required time parameters. Any screening procedures that were not performed as part of a standard-of-care

evaluation, any research-related procedures, or any that are outside required time limits must be completed before eligibility can be ascertained, but after the ICF is signed.

5. After all screening procedures have been completed, the Coordinator will conduct a thorough evaluation of each inclusion and exclusion criterion with the patient's source documentation.
6. If it appears all eligibility requirements are met, the Coordinator will review comprehensive records with the PI or Sub-I and the Clinical Trials Facilitator by following the procedures outlined in SOP CTO-0002-21 Departmental Review of Eligibility and Consent.
    - NOTE: The Clinical Trials Facilitator can review either before or after the PI or Sub-I. The PI or Sub-I should sign off on eligibility prior to enrollment.

INVESTIGATOR REVIEW PROCESS

1. The PI or Sub-I will review the source documents and eligibility checklist ideally with the Coordinator. The PI or Sub-I will work with Coordinator for any questions or concerns. The eligibility process is to be a team effort between the Coordinator and the PI or Sub-I with both parties available and involved through to completion.
2. The investigator will sign and date the eligibility checklist. This will verify that the investigator has reviewed all source documentation and has determined the patient meets all entry criteria.
3. The investigator may choose to dictate in a clinic note that the subject meets entry criteria. This documentation is typically signed electronically.
4. The investigator may sign and date individual source documents, such as lab reports and ECGs. Alternatively, the investigator may document review of these tests via the clinic note or on the eligibility checklist. However, it is not required for the PI to sign off on each source document if the source document already contains an electronic signature. The PI or Sub-I must sign any source documentation used to prove eligibility that does not contain an electronic signature (for example, a medication list provided by the patient). The signature attests the PI's or Sub-I's review and acceptance of the item as valid source documentation. A PI or Sub-I's signature is required for any clinical assessments or attributions.
5. The investigator may include original source documentation on the eligibility checklist. For example, the investigator may include a performance status here if it hasn't been documented elsewhere.

COORDINATOR ENROLLMENT PROCESS

1. Eligible subjects will be enrolled by the Coordinator via the study-specific enrollment procedures. Confirmation of enrollment and randomization arm (if applicable) will be communicated to the Investigational Pharmacy, the investigator, the participant, and other applicable staff.
2. The signature page of the treatment consent form should be scanned as an electronic document.
    - A copy of the signature page should be uploaded to the EMR and the informed consent document, enrollment confirmation from OPEN, and all supporting documentation should be maintained in the patient's chart.
3. The Coordinator enters all the applicable enrollment information in the OnCore system per OnCore instructions.

Documentation

The following records shall be generated and managed in the CTO of Sweetwater Regional Cancer Center

Required Record	Custodian
Signed Informed Consent Form	Coordinator
Completed Eligibility Checklist	Coordinator

References

1. Department of Health and Human Services. (2019, Mar.). Statement of Investigator, FDA Form 1572. Retrieved from https://www.fda.gov/science-research/clinical-trials-and-human-subject-protection/clinical-trial-forms.
2. Department of Health and Human Services. (1996, Oct 2). Code of Federal Regulations: 21 CFR 312.60 General Responsibilities of Investigators. Retrieved from https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm?fr=312.60.
3. International Council for Harmonization. (2016, Nov 9). Guideline for Good Clinical Practice (ICH E6). Retrieved from https://database.ich.org/sites/default/files/E6_R2_Addendum.pdf.
4. Huntsman Cancer Institute. (2012, Sept 14). CTO 034-09 Study Participant Screening and Enrollment. Salt Lake City, Utah.

Reviewed and Approved:

MEC 05/27/2025

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Ann Marie Clevenger: CNO	03/2025
	Banu Symington, MD: Medical Director Medicine/Hematology Oncology	03/2025
	Dawn Piaia: Director Medical Oncology/Hematology	03/2025
	Tasha Harris: Rad Onc Director/Dosimetrist	03/2025

Status **Pending** PolicyStat ID **17739065**

Approved N/A
Review Due 2 years after approval

Document Area CAH - Patient Care

Clinical Trials Research Related Individual Conflict of Interest

STATEMENT OF PURPOSE

Sweetwater Regional Cancer Center (SRCC) with Memorial Hospital of Sweetwater County (MHSC) conducts oncology research studies funded by the Public Health Service (PHS). Staff involved in this research may have financial interests that can potentially create a bias when conducing, participating, or reporting in said research. This standard establishes the procedure to identify, report, and manage possible conflicts of interests in order to promote objectivity in the studies conducted at this site.

SCOPE

This standard applies to:

- All staff involved in oncology research at SRCC which includes the Primary Investigator, Sub Investigator, Coordinator, Clinical Trials Facilitator, or any other roles **directly** involved in research activities not aforementioned including regulatory and financial roles. For the remainder of this document, the staff listed previously will be referred to collectively as "Researcher"; and
- Any research study conducted at SRCC funded by PHS which includes studies under the National Clinical Trials Network (NCTN) or the NCI Community Oncology Research Program (NCORP).
    - This site only opens studies under the NCTN/NCORP. If, in the future, a study is opened at this site under a non publicly funded entity (industry trials, pharmaceutical companies, etc.), this site will follow the conflict of interest policy outlined in the contract with that entity. If the contract does not outline their conflict of interest policy, the site will defer to this standard.

Please note that this standard only applies to the scope as defined above. If an individual serves in other capacities within the research community (committee member/chair within the CIRB, Lead Protocol

Organizations, or other research entities, chair or PI on a study, etc.) the individual will need to refer to the other entity's conflict of interest policies for their requirements. If this applies, the individual is expected to comply with this standard **in addition** to any other outside requirements.

This standard will be enforced by the Clinical Trials Facilitator. A Clinical Trials Office (CTO) designee may be appointed to fulfill duties outlined in this standard if the Clinical Trials Facilitator is not available or needs to delegate tasks to another party for reasons of a case by case basis.

DEFINITIONS

Compensation: "Includes salary and any payment for services not other wise identified as salary (e.g., consulting fees, honoraria, paid authorship)"(1)

CTO: Clinical Trials Office

Equity Interest: stock, stock options, or other ownership interest in an entity

Financial Conflict of Interest (FCOI): "a **significant financial interest** that could directly and significantly affect the design, conduct, or reporting of PHS-funded research" (1)

MHSC: Memorial Hospital of Sweetwater County

PHS: Public Health Service, an entity under the United States Department of Health and Human Services

Researcher: Primary Investigator, Sub Investigator, Coordinator, Clinical Trials Facilitator, or any other roles directly involved in research activities not aforementioned including regulatory and financial roles

Significant Financial Interest (SFI): A financial conflict of interest of the Researcher or the Researcher's spouse and dependent children that includes one or more of the following and reasonably appears to be related to the Researcher's duties at SRCC:

I. "With regard to any **publicly traded entity**, a significant financial interest exists if the value of any [compensation] received from the entity in the twelve months preceding the disclosure **and** the value of any equity interest in the entity as of the date of disclosure, when aggregated, exceeds $5000;
    A. [For example:
        1. Compensation of $5,500 + Equity $0 = $5,500 - this would need to be reported
        2. Compensation of $0 + Equity $6,000= $6,000 - this would need to be reported
        3. Compensation of $550 + Equity $4,500 = $5,500 - this would need to be reported
        4. Compensation of $500 + Equity $500 = $1,000 - this would not need to be reported]

II. With regard to any **non-publically traded entity,** a significant financial interest exists if the value of any [compensation] received from the entity in the twelve months preceding the disclosure, when aggregated, exceeds $5,000 **or** when the [individual] holds **any** equity interest;

or

III. Intellectual property rights and interests (e.g., patents, copyrights), upon receipt of income related to such right and interests." (1)

Sponsor: For the purposes of this standard, Sponsor will refer to any entity SRCC/MHSC holds a contract with to conduct research and/or has an agreement to receive funds from that entity for research activities.

SRCC: Sweetwater Regional Cancer Center

REQUIREMENTS OF THE RESEARCHER

Scope

This section applies to the Researcher who designs, conducts, reports, or directly engages in research activities.

Disclosure to the Researcher

It is not the intent of SRCC to dictate, control, or intrude on the Researcher's personal financial affairs. However, SRCC is obligated under federal law to review, report, and manage certain personal financial and sometimes non financial items in order to determine if these items may create a bias when conducting research. The site is also obligated to mitigate any bias, potential or existing, created by these interests. The fact of having a Significant Financial Interest (SFI) or relationship is not so much the issue, but lies more in not reporting it.

The ultimate goals of the below requirements asked of the Researcher is to protect the patient and the integrity of the research conducted at this site. SRCC, and possibly the Researcher, can be penalized when not in compliance of this standard and the federal laws listed in the *Reference* section of this document. Therefore, this standard attempts to also protect the Researcher so that they are aware and in compliance of the federal requirements of the Researcher when conducting research.

The Researcher's disclosures and any related information will be kept confidential and only released to parties on a need to know basis as detailed in the below sections. The information disclosed by the Researcher will be used only for the enforcement of this policy, unless required by law for other purposes.

In addition to this standard, the Researcher is required to maintain their NIH Identity and Access Management account (often referred to as "CTEP ID") where the Researcher will also provide their disclosures on an annual renewal basis.

Please contact the Clinical Trials Facilitator at (307) 212-7765 or lreddick@sweetwatermemorial.com for any concerns or questions regarding this policy.

Training Requirements

The Researcher is required to complete the following training:

I. The *Responsible Conduct of Research* course through the online training program CITI (under the University of Utah affiliation) as follows:

Note: This course includes the module "Conflicts of Interest and Commitment" which is applicable to this standard.

A. Time Frame:

1. At time of new hire or on-boarding into a research position, prior to the Researcher engaging in any research activities
2. Every **three years** after initial completion of the course

B. Proof of completion:

1. The Researcher will provide their completion certificate to the Clinical Trials Facilitator

II. NIH FCOI online training as follows:

Located via the url https://grants.nih.gov/grants/policy/coi/tutorial2018/story_html5.html

A. Time Frame:

1. At time of new hire or on-boarding into a research position, prior to the Researcher engaging in any research activities
2. Every **three years** after initial completion of the course; intended to be completed at the same time as the *Responsible Conduct of Research* course

B. Proof of completion:

1. The Researcher will provide their completion certificate to the Clinical Trials Facilitator

III. Review of this institutional standard

A. Time Frame:

1. At time of new hire or on-boarding into a research position, prior to the Researcher engaging in any research activities
2. **Annually** at time of their annual disclosures.

B. Proof of completion:

1. The Researcher will acknowledge their review of this standard via the *Individual Conflict of Interest Disclosure Form*.

SRCC's CTO can request a Researcher to complete any portion of the training detailed above at any time if one or more of the following apply:

I. Any revisions, outside of basic grammatical changes, to this standard are made

II. The Researcher is found to be in non compliance with this standard

Disclosure Requirements

What Needs to be Disclosed

When in doubt if something needs to be disclosed, the Researcher can discuss the potential disclosure with the Clinical Trials Facilitator or other CTO designee. Or the Researcher can choose to formally disclose the item and the CTO will determine if the item needs to be reported.

A Researcher must disclose (foreign or domestic):

I. Any significant financial interest (as defined in *Definitions*)

II. Any reimbursed or sponsored travel related to their research duties at SRCC with the exception of those listed in "What Does Not Need to be Disclosed" bullet I

    A. The Researcher must provide the following information:

        1. The purpose of the trip
        2. The identity of the sponsor
        3. The destination
        4. The duration
        5. Any additional information requested, which can include the monetary amount, in order to determine if a conflict of interest exists

III. "Non-royalty payments or entitlements to payments in connection with the research that are not directly related to the reasonable costs of the research (e.g. bonus or milestone payments to the investigators in excess of reasonable costs incurred)" (6);

IV. "Service as an officer, director, or any other Executive Position in an outside business, **whether or not renumeration is received** for such service" (6) (7)

V. If none of the above apply, the Researcher is still required to complete the *Individual Conflict of Interest Disclosure Form* as outlined in the section *Requirements of the Researcher: Disclosure Requirements: When to Disclosure* and *Requirements of the Researcher: Disclosure Requirements: How to Disclose.* The Researcher will indicate on the form they have no disclosures.

The Researcher will refer to the subsequent sections on how and when to disclose.

The Researcher is expected to comply with any requests from the CTO for additional information, as needed and within reason, in order to help determine if the SFI is a FCOI.

The Researcher will be asked to provide further details of the SFI or relationship in order to help determine if the item is a FCOI.

What Does Not Need to be Disclosed

I. Travel reimbursement or sponsorship by "a Federal, state, or local government agency, an Institution of higher education as defined at 20 U.S.C 1001(a), an academic teaching hospital, a medical center, or a research institute that is affiliated with an Institution of higher education"

(1)

A. This exception applies to **domestic financial interests only**

II. Income from seminars, teaching engagements, lectures, service on advisory committees, or service on review panels sponsored by "a Federal, state, or local government agency, an Institution of higher education as defined at 20 U.S.C 1001(a), an academic teaching hospital, a medical center, or a research institute that is affiliated with an Institution of higher education" (1)

A. Note: This exception applies to **domestic financial interests only**

III. Salary, royalties, or other compensation paid to the Researcher by SRCC if the Researcher is employed or appointed by SRCC

IV. Intellectual property rights assigned to SRCC and agreements to share the royalties from such rights if the Researcher is employed or appointed by SRCC

V. "Income from investment vehicles, such as mutual funds and retirement accounts, as long as the [Researcher] does not directly control the investment decisions made in these vehicles"(1)

When to Disclose

I. Prior to application of PHS funded research

II. At time of new hire or on-boarding to a research position, prior to engaging in research activities

III. Annually, following the initial disclosure

IV. Upon acquiring or discovering SFI not previously disclosed

A. Researcher must disclose the SFI within **30 calendar days** of acquisition or discovering of the SFI

How to Disclose

The Researcher will submit their disclosure to the Clinical Trials Facilitator (or CTO designee) via the *Individual Conflict of Interest Disclosure Form* as outlined in the above section *Requirements of the Researcher: When to Disclose*.

The Clinical Trials Facilitator (or CTO designee) will provide the *Individual Conflict of Interest Disclosure Form* to the Researcher at time of on boarding to a research position and on an annual basis (one rolling year from the last disclosure). If the Researcher needs to disclose information outside of their annual reporting, the Researcher may find this standard and the *Individual Conflict of Interest Disclosure Form* on PolicyStat as well as in the protected Clinical Trials Shares Drive.

The Researcher may also contact the Clinical Trials Facilitator at any time via phone (307-212-7765), email (lreddick@sweetwatermemorial.com), or in person for assistance on how to disclose.

What to Expect When an SFI is Deemed a FCOI

When a SFI is determined by the Clinical Trials Facilitator (or other CTO designee) to be a real or

perceived FCOI, as described in the section *Requirements of The Clinical Trials Office: Determining if a Financial Conflict of Interest Exists*, a management plan will be created and can include any of the following:

I. Disclosure of FCOI to the public (via a public facing website, in the event of presentations, publishing, etc.) or directly to the study participants

II. Suspension or removal of the Researcher from the specific study or portions of the specific study's activities

III. Recusal from meetings such as Feasibility Administrative Reviews (FAR) or other research related meetings.

    A. In some cases the Researcher may be allowed to be present at the meetings, but will not be allowed to vote on or influence the decision of the meeting

IV. Lessening or removal of the FCOI by the Researcher (e.g., sale of an equity interest, termination of relationships that create the FCOI, etc.)

V. Other actions deemed appropriate by the Clinical Trials Facilitator, hospital leadership, PHS, other related governing agencies, or Sponsor in order to help eliminate any real, perceived, or potential bias in study activities.

The Clinical Trials Facilitator (or CTO designee) will be responsible for creating and enforcing the management plan within their scope. If a plan involves actions outside the scope of the Clinical Trials Facilitator, such as more in the scope of Human Resources, the Clinical Trials Facilitator is still responsible to confirm the action was seen to fruition.

The Researcher is expected to comply with the management plan and requests for updates until the FCOI no longer exists.

The management plan's goal is to lessen the chance or impact of any bias created by the FCOI and will be created on a case by case basis. The Researcher's direct supervisor, hospital leadership, Sponsor, PHS, or other related governing bodies may also be involved in the decision making process for the management plan. The University of Utah may be consulted as the parent research site under the NCTN affiliate program.

Rights of the Researcher

The Researcher will be consulted when determining if their SFI is a FCOI and in creating a management plan. The Researcher's input will be obtained, considered, and respected, but the Researcher will not have decision making authority on the final plan. Once a management plan is agreed upon, the Researcher will be expected to comply with the plan and with any requests for information or updates in order for the CTO to confirm ongoing compliance with the management plan.

The Researcher has the right to any documentation in regards to the decision making process unless stipulated otherwise by state or federal law, the Sponsor, PHS, other governing bodies, or by a hospital policy that requires such information not to be released. The researcher can submit the request in witting to the Clinical Trials Facilitator who will respond to the request within 14 calendar days with either the requested documents, a reason why the documents cannot be produced, or a reason if there will be a delay. The documentation is available to the Researcher for as long as outlined in the section *Record*

Retention.

Non Compliance

If the Researcher is non compliant with the requirements of this standard, which includes training requirements, disclosure requirements, adherence to any management plans, etc., then the CTO reserves the right to enforce any of the the following based on the level of non compliance until the Researcher re establishes compliance:

I. Removal or suspension of the Researcher from study activities

II. Re assign training requirements

III. Disciplinary or corrective action for continuing or willful non compliance as detailed in the hospital wide policy *Employee Policies-Employee Corrective Actions* PolicyStat ID 9756924.

IV. Other actions recommended by the CTO, Sponsor, PHS, University of Utah, or other governing bodies in order to remove, disclose, mitigate, or prevent biases in the research created by a FCOI such as retraction of publication or data, notifying the public, etc.

REQUIREMENTS OF THE CLINICAL TRIALS OFFICE

Scope

This section applies to the Clinical Trials Facilitator whose responsibility is to solicit, review, identify, manage, and report any FCOIs from the Researcher. A CTO designee will be delegated these tasks usually performed by the Clinical Trials Facilitator in regards to the Clinical Trials Facilitator's own personal disclosures or on a as needed basis.

Unless otherwise specified, all time frames detailed below begin from the date when the CTO receives the Researcher's disclosure via the *Individual Conflict of Interest Disclosure Form*.

Responsibilities

The Clinical Trials Facilitator's (or CTO designee's) responsibilities are as follows:

I. Ensure the Researcher has completed the required training in the required time frame as dictated in the section *Requirements of the Researcher: Training Requirements*.

   A. The Clinical Trials Facilitator will provide and assign the training to the Researcher as detailed in the referenced section.

II. Solicit disclosures from the Researcher via the *Individual Conflict of Interest Disclosure Form* in accordance to the requirements as outlined in the section *Requirements of the Researcher: When to Disclose.*

III. Review all Researchers' disclosures and determine if (1) the SFI reported is related to PHS funded research and (2) if the SFI is a financial conflict of interest as outlined in the section *Requirements of the Clinical Trials Office: Determining if a Financial Conflict of Interest Exists*.

A. The Clinical Trials Facilitator (or CTO Designee) will sign the *Individual Conflict of Interest Disclosure Form* acknowledging their review and determination

IV. Assist in identifying and acting upon any SFIs not reported by the Researcher, not reported in a timely manner, or not previously reviewed for whatever reason. The Clinical Trials Facilitator (or CTO Designee) may refer to the section *Requirements of the Clinical Trials Office: Addressing Non Compliance and Performing Retrospective Reviews* for more guidance.

V. Report FCOIs to the Sponsor and, if needed, to the parent research site the University of Utah as outlined in the section *Requirements of the Clinical Trials Office: Reporting Financial Conflicts of Interest*.

VI. Develop, implement, and monitor management plans for identified FCOIs as detailed in the section *Requirements of the Clinical Trials Office: Management Plans for Financial Conflicts of Interest*.

A. The Clinical Trials Facilitator will provide this management plan to the study sponsor and provide updated reports as requested or required. The management plan may also be provided to the University of Utah if requested.

VII. **The Clinical Trials Facilitator will complete their review, determination, implementation of a management plan (even if on an interim basis that specifies what has happened or will happen), and communicate with appropriate parties within 45 calendar days from the discovery of the SFI. This includes reporting to the Sponsor.**

VIII. Provide annual reports to the Sponsor on already reported FCOIs and their management until the FCOI no longer exists. The report will include:

A. The status of the FCOI; and

B. Any changes to the management plan (5)

IX. Maintain all records pertaining to and resulting from the requirements dictated by this standard for the time period outlined in the section *Record Retention*.

X. Identify non compliance and facilitate in the decision making of non compliance or corrective actions, ensure actions are seen to fulfillment, and assist in retrospective reviews when required as outlined in the section *Requirements of the Clinical Trials Office: Addressing Non Compliance and Performing Retrospective Reviews*.

XI. Notify all sponsors SRCC holds a contract with about any significant changes to this standard within 30 days prior to the changes taking effect.

A. Significant changes do not include grammatical updates or changes/additions to sections to provide further clarity.

B. In the event of significant changes to this standard, SRCC may be required to submit to the sponsor an addendum to the current contract signed by the Authorized Official about the changes. Refer to the sponsor contract for these requirements.

XII. Promptly comply with any requests to provide COI related records at any time made by related hospital personnel (e.g. HR, legal counsel, etc.), PHS, related government bodies, Sponsors, or if legally required by law regardless if such records involve FCOIs.

XIII. Respond to records requests by the **Researcher** within 14 calendar days of the written request with either the requested items, reason why the items could not be produced, or reason for a

delay. The records do not have to be provided if:

A. Dictated by state or federal law to not provide

B. Dictated by another hospital policy that the information cannot be released

C. Dictated by the Sponsor, PHS, or other governing body that the records cannot be released

Note: requests made by the public are under different time constraints. Refer to bullet XIV below for these requests.

XIV. Maintain public facing information and respond to **public or outside party requests** for information as outlined in the section *Public Access and Transparency.*

XV. Maintain confidentiality of records and only release to parties on a need to know basis

Determining if a Financial Conflict of Interest Exists

The Clinical Trials Facilitator (or CTO Designee) will review the Researcher's SFIs, provided via the *Individual Conflict of Interest Disclosure Form.* The Clinical Trials Facilitator (or CTO Designee) will refer to the sections *Requirements of the Researcher: What Needs to Be Disclosed* and *Requirements of the Researcher: What Does Not Need to be Disclosed* for guidance.

The Clinical Trials Facilitator (or CTO Designee) must complete their review and the following within 45 calendar days from the date of the disclosure.

I. The Clinical Trials Facilitator (or CTO Designee) will determine if:

A. A Researcher's SFI is related to PHS funded research and, if so,

B. If that SFI is a FCOI

1. The SFI will be considered a financial conflict of interest to PHS funded research if the following apply:

a. The SFI "could be affected by the PHS-funded research; or is in an entity who financial interest could be affected by the research"(1), **and**

b. The SFI "could directly and significantly affect the design, conduct, or reporting of the PHS-funded research"(1)

C. The Clinical Trials Facilitator (or CTO Designee) can work with the Researcher to help make these determinations.

D. Perceived FCOIs may also be considered under this standard if the perception alone can create a bias as detailed in the above.

II. The Clinical Trials Facilitator (or CTO Designee) will complete their portion of the *Individual Conflict of Interest Disclosure Form* with their determinations of the SFIs (i.e., whether a FCOI or not) and sign.

III. If the SFIs is determined to be a FCOIs, the Clinical Trials Facilitator (or CTO Desginee) will:

A. Create a management plan as outlined in the section *Requirements of the Clinical Trials Office: Management Plans for Financial Conflicts of Interest*; and

B. Report to the Sponsor by following the section *Requirements of the Clinical Trials Office: Reporting Financial Conflicts of Interest*.

IV. If the SFI is not determined to be a FCOI, the Clinical Trials Facilitator will retain all records pertaining to the reporting and determination for the period of time outlined in the section *Record Retention*. The Clinical Trials Facilitator will provide these records upon request to the Sponsor, PHS, or other related parties even if the SFI was not deemed a FCOI by the Clinical Trials Facilitator (or CTO Designee).

V. The Clinical Trials Facilitator will provide a completed copy of the disclosure form with the determination to the Researcher for their personal records.

Management Plans for Financial Conflicts of Interest

The Clinical Trials Facilitator will develop, implement, and manage the management plans for identified FCOIs. The Researcher's direct supervisor, hospital leadership, Sponsor, PHS, or other related governing bodies may also be involved in the decision making process. The University of Utah may be consulted as SRCC's parent research site under the NCTN affiliate program.

Management plans will be developed at a case by case basis, dependent on the nature of the FCOI, and may include the following:

I. Disclosure of FCOI to the public (in the event of presentations, publishing, etc.) or directly to the study participants

II. Suspension or removal of the Researcher from the specific study or portions of the specific study's activities

III. Lessening or removal of the FCOI by the Researcher (e.g., sale of an equity interest, termination of relationships that create the FCOI, etc.)

IV. Other actions deemed appropriate by the Clinical Trials Facilitator, hospital leadership, PHS, other related governing agencies, or the study sponsor to help eliminate real, perceived, or potential bias in study activities.

The Clinical Trials Facilitator will create formal documentation on the specifics of the management plan which will be stored in the Clinical Trials shares drive. If at any time the management plan needs to be changed, a new document will be created outlining these changes and the reason for the changes.

The Clinical Trials Facilitator (or CTO Designee) will ask the Researcher to sign the document that outlines the management plan to indicate their acknowledgement and acceptance of the plan. If the Researcher refuses to sign, this will be notated on the document.

The Clinical Trials Facilitator will routinely monitor (at minimum annually) the Researcher's compliance to the management plan until the conclusion of the related research study or when the FCOI no longer exists.The Clinical Trials Facilitator will document their efforts on this monitoring.

The Clinical Trials Facilitator will also provide annual reports to the Sponsor on any ongoing management plans that will include:

I. The status of the FCOI; and

II. Any changes to the management plan (5)

The Clinical Trials Facilitator will maintain all records pertaining to the management plan (creation, monitoring, reporting, updates to the status of the plan or FCOI, etc.) per the section *Records Retention*.

Reporting Financial Conflicts of Interest

When to Report

The Clinical Trials Facilitator will report any identified FCOIs as follows:

I. Prior to receiving funds from the sponsor

II. Within 45 calendar days of newly identified FCOIs (those from new researchers or existing researchers)

   A. The 45 day time frame is specific to this site's current contract with the Sponsor OHSU in order to allow OHSU time to report to PHS. Refer to the most recent contract for any changes to this requirement.

   B. Please note that the reporting time frame may change based off the Sponsor. By the federal mandate 42 CFR Part 50 Subpart F, FCOIs must be reported to PHS within 60 calendar days of identifying the FCOI. This site will defer to the Sponsor's contract for reporting time frames if they differ from this standard.

III. If requested by the sponsor as a progress report of previously reported FCOIs

How to Report

SRCC conducts research as a sub-receipitent of NCTN and NCORP grants and receives funding through a pass through entity (e.g. OHSU). Due to this sub-receipitent status, this site will report any FCOIs as follows:

Note: if the research being conducted is not as a sub-receiptitent, SRCC may need to report directly to PHS themselves. Refer to any Sponsor contracts for further guidance.

I. The Clinical Trials Facilitator (or CTO designee) will complete their review, determination, implementation of a management plan (even if on an interim basis that specifies what has happened or will happen), and communication (as outlined in the next steps) with appropriate parties **within 45 calendar days** from the discovery of the SFI.

   A. Refer to the applicable sections within *Requirements of the Clinical Trials Office* for more guidance on completing each requirement that needs to be included in the reporting such as determinations, management plans, etc.

II. The Clinical Trials Facilitator (or CTO designee) will report the items from the previous step to the Sponsor's COI contact designated in the contract/subaward agreement. SRCC may also report to the parent research institution Huntsman Cancer Center if needed.

   A. The report will include the following elements:

      1. Project Number

2. Project Title
3. Primary Investigator
4. Name of Researcher with the FCOI
5. Name of the entity involved with the FCOI
6. Description or type of FCOI (e.g. travel reimbursement, equity, etc.)
7. The amount of the FCOI, if it can be determined
8. Details of how the SFI was determined to be an FCOI that is related to PHS funded research and could create a bias
9. Details of a management plan or proposed management plan including:
    a. "Role and principal duties of the conflicted [Researcher] in the research project;
    b. Conditions of the management plan;
    c. How the management plan is designed to safeguard objectivity in the research project;
    d. Confirmation of the [Researcher's] agreement to the management plan;
    e. How the management plan will be monitored to ensure [Researcher] compliance; and
    f. Other information as needed" (5)
10. Any other details requested by the sponsor or other governing bodies

III. The Sponsor will then report to the federal awarding agency (e.g., PHS) about the FCOI.
    A. Note: If the Sponsor is not acting as a pass through entity who distributed PHS grant funds to SRCC (e.g. OHSU), then SRCC may be responsible for reporting to PHS themselves. Refer to any Sponsor contracts for their requirements on reporting COIs.

IV. The site will comply with any requests made of them by the Sponsor or other related parties in order to help facilitate this reporting or further actions resulting from this reporting.

V. The Clinical Trials Facilitator will report annually to the Sponsor about the status of the FCOI and any changes made to the management plan.

VI. The Clinical Trials Facilitator will maintain all records in regards to the reporting in the Clinical Trials shares drive as outlined in the section *Records Retention*.

Addressing Non Compliance and Performing Retrospective Reviews

When a Researcher is found to be in non compliance of this standard, the Clinical Trials Facilitator will determine the mitigation or corrective actions to be taken and see those actions to fulfillment as follows:

I. Corrective or Disciplinary Actions

A. Depending on the severity of non compliance, the following actions can be taken:
    1. Removal or suspension of the Researcher from study activities
    2. Re assign training requirements
    3. Disciplinary or corrective action for continuing or willful non compliance as detailed in the hospital wide policy *Employee Policies-Employee Corrective Actions* PolicyStat ID 9756924.
    4. Other actions recommended by the CTO, Sponsor, PHS, University of Utah, or other governing bodies in order to remove, disclose, mitigate, or prevent biases in the research created by a FCOI such as retraction of publication of data, notifying the public, etc.

B. Decision Making Authority
    1. Depending on the level of non compliance, the Clinical Trial Facilitator can have authority to remove or suspend a Researcher from study activities and to require a Researcher repeat training.
    2. Disciplinary actions will require the collaborative decision making of the Clinical Trials Facilitator, the Researcher's direct supervisor, and any other parties involved in disciplinary/corrective actions such as Human Resources.

II. Retrospective Review Requirements of Non Compliance

A. When a SFI that was deemed a FCOI was not identified, disclosed, reviewed, or managed in a timely manner, in order to determine if any biases exist (involving the conduct, reporting, and design of the study) during the time of the noncompliance the Clinical Trails Facilitator must:
    1. Report the discovery of the non compliance to the Sponsor at time of discovery. SRCC may also report to the University of Utah as needed. The report will contain the items outlined in the below section (bullet 2).

       The Clinical Trials Facilitator will follow the instructions from these parties as necessary and assist in performing the retrospective review.
    2. Document internally and report the following to the Sponsor and other parties as appropriate:
        a. Project Number
        b. Project Title
        c. Primary Investigator
        d. Name of Researcher with the FCOI
        e. Name of the entity involved with the FCOI
        f. Reasons for the retrospective review (e.g., what caused the non compliance, preliminary suspicions of potential biases, etc.)
        g. If the Clinical Trials Facilitator performs the retrospective review themselves, they will also document and report:

i. Detailed methodology of how the review was performed

ii. Findings of the review

iii. Conclusions of the review

3. The retrospective review must be completed **within 120 days** of determination of non compliance.
4. The Clinical Trials Facilitator will report the findings of the review to the Sponsor and will amend any previously submitted FCOI reports (including information on management plans of the FCOI). If biases was discovered as a result of the FCOI, the Clinical Trials Facilitator will also submit a mitigation report to the Sponsor.
    a. The mitigation report must include the information from the retrospective review as detailed above in (II)(A)(2) as well as a description of the impact of the biases and the plan of action to mitigate or eliminate the biases.

III. The Clinical Trials Facilitator will maintain all documentation in regards to the retrospective review per the section *Records Retention*.

PUBLIC ACCESS AND TRANSPARENCY

Policy Availability

SRCC will make available a copy of this standard to the public via the MHSC's public facing website found at the URL www.sweetwatermemorial.com or upon written request within 5 business days.

The Clinical Trials Facilitator is responsible in submitting updated versions of the policy to the Marketing Director of MHSC to ensure the most recent version is posted to the website.

Existing FCOIs Disclosures to the Public

SRCC will provide public access to any SFI meeting all the following criteria:

I. The significant financial interest was disclosed and is still held by the [Researcher] as defined by this [procedure];

II. The institution determines that the significant financial interest is related to the PHS-funded research; **and**

III. The institution determines that the significant financial interest is a financial conflict of interest (1)

SRCC will provide the following information to the public either via the MHSC public facing website or within 5 business days of a written request:

I. Researcher's name

II. Researcher's title and role with the research project

III. Name of the entity where the SFI is held

IV. Nature of the SFI

V. Approximate dollar value of the SFI which can be given in a range format as follows:

   A. $0-$4,999

   B. $5,000-$9,999

   C. $10,000-$19,999

   D. Amounts between $20,000-$100,000 can be given in $20,000 increments

   E. Amounts above $100,000 can be given in $50,000 increments

   F. If an amount cannot be determined, then a statement should be provided in lieu of the amount stating that "the interest is one whose value cannot be readily determined through reference to public prices or other reasonable measure of fair market value (1)"

If the information is provided **on the MHSC public website**, it will be updated annually and **within 60 calendar days** of the identification of newly acquired or discovered FCOIs held by Researchers. The website will specify that the information provided is current as of the specific date it was posted or last reviewed. The site will also provide a disclosure that the information will be updated annually and within 60 calendar days of changes.

The in event of **a written request**, the letter to the requester will specify that the information provided is current as of the specific date it was last reviewed. The letter will also provide a disclosure that the information will be updated annually and within 60 calendar days of changes and that the requester will have to make another request in the event they want updates.

This information will remain available to the public either through the public website or through written requests for 3 years from the date the information was most recently updated. (1)

CERTIFICATIONS AND OTHER REQUIREMENTS

This standard intends to comply with and implement any requirements as outlined in 42 CFR Part 50 Subpart F and 45 CFR Part 94.

SRCC conducts clinical trials under the NCTN as an Affiliate Site under the University of Utah. As such, the University of Utah has a contractual right to information or records resulting from this standard for the purposes of mentoring and supervising the research in order to protect the rights of study participants and the integrity of the research being conducted.

SRCC self certifies this procedure with the Federal Demonstration Partnership FCOI Clearing House as being compliant with the Public Health Service requirements on COIs. Certificatin is done through the website https://thefdp.org/fcoi-clearinghouse/ .

RECORD RETENTION

SRCC will maintain all records pertaining to or produced because of this standard (even if an item was not deemed a FCOI) as follows:

"...for a period of three years from the date of submission of the final expenditure report or, for Federal awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report, respectively, as reported to the HHS awarding agency or pass-through entity in the case of a subrecipient." (12)

REFERENCES

(1) Public Health Service, Department of Health and Human Services. (August 25, 2011). *42 CFR Part 50 Subpart F--Promoting Objectivity in Research.* Retrieved from URL: https://www.ecfr.gov/current/title-42/chapter-I/subchapter-D/part-50/subpart-F.

(2) Department of Health and Human Services. (August 25, 2011). *45 CFR Part 94--Responsible Prospective Contractors.* Retrieved from URL: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-94.

(3) Grand Valley Oncology. (2023). *Research Related Conflict of Interest Training Acknowledgement and Disclosure.* Grand Junction, CO.

(4) Huntsman Cancer Institute. (April, 12, 2022). *Individual Financial Conflict of Interest in Research Policy.* Salt Lake City, UT.

(5) National Institutes of Health. (April, 2024). *NIH Grants Policy Statement: 4.1.10 Financial Conflict of Interest.* Retrieved from URL:https://grants.nih.gov/grants/policy/nihgps/HTML5/section_4/4.1.10_financial_conflict_of_interest.htm?Highlight=fcoi.

(6) Oregon Health and Science University. (September 22, 2015). *Conflict of Interest in Research Policy. Portland, OR.*

(7) Department of Health and Human Services. (June 7, 2024). *45 CFR Part 75.112 Conflict of Interest.* Retrieved from URL: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-75/subpart-B/section-75.112.

(8) Huntsman Cancer Institute. (April, 12, 2022). *Guideline G1-006A: Determining "Relatedness" to Research.* Salt Lake City, UT.

(9) Huntsman Cancer Institute. (April, 12, 2022). *Procedure P1-006B. Conflict of Interest Office Procedures Related to Requirements for Federally Funded Research.* Salt Lake City, UT.

(10) Huntsman Cancer Institute. (April, 12, 2022). *Rule 1-006c: Individual Financial Conflict of Interest in Research.* Salt Lake City, UT.

(11) National Institutes of Health. (November 21, 2023). *Financial Conflict of Interest.* Retrieved from URL: https://grants.nih.gov/grants/policy/coi/index.htm.

(12) Department of Health and Human Services. (June 7, 2024). *45 CFR Part 75.361 Retention Requirements for Records.* Retrieved from URL: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-75.

Reviewed and Approved:

Approval Signatures

Step Description	Approver	Date
	Kari Quickenden: Chief Clinical Officer	Pending
	Ann Marie Clevenger: CNO	03/2025
	Banu Symington, MD: Medical Director Medicine/Hematology Oncology	03/2025
	Dawn Piaia: Director Medical Oncology/Hematology	03/2025
	Tasha Harris: Rad Onc Director/Dosimetrist	03/2025

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:6/4/2025

Topic for Old & New Business Items:
Provider Application and Reference/Verification Form

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:

- Changes were made to the health questions on the provider application and reference/verification forms
- These questions are meant to be less invasive and to encourage health care providers to seek mental health care
- Information on invasive health questions from the Lorna Breen Foundation is included

Board Committee Action:

Approval Needed for the revised questions

Policy or Other Document:

☐ For Review Only
☒ For Board Action

Legal Counsel Review:

☒ In House Comments: Suzan reviewed the policy and was present at Credentials Committee when they reviewed and approved the forms.
☐ Board Comments:Click or tap here to enter text.

Senior Leadership Recommendation:
Recommend approval of revised forms.

The Effect of Invasive Questions

THE PROBLEM:

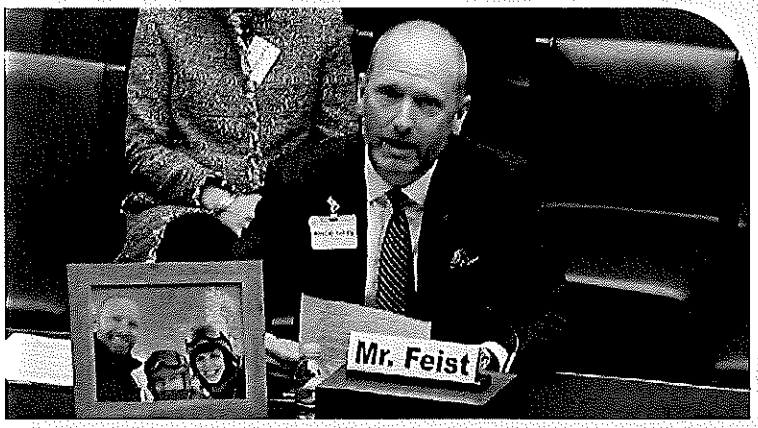
Our health workers are experiencing a mental health crisis.

Why?

Nearly half of health workers experienced burnout in 2022; and health workers reported higher levels of poor mental health days, burnout, intent to change jobs, and being harassed compared to all other type of workers.

Like everyone, health workers deserve the right to pursue mental health care without fear of losing their job.

However, overly invasive mental health questions in licensing and credentialing applications prevent health workers from seeking support and **increases** the risk of suicide.



> My sister-in-law Dr. Lorna Breen, who died by suicide in April 2020, was convinced that if she received mental health care, she would lose her medical license or face ostracism from colleagues. Sadly, we have heard from a number of families who lost physicians to suicide and their loved ones who expressed nearly identical concerns to Lorna.

J. Corey Feist, House Energy and Commerce Subcommittee on Health, 10-26-21

This must change.

Such questioning tends to be broad or stigmatizing, such as asking about past mental health care and treatment, which has no bearing on a health worker's ability to provide care. In fact, the Department of Justice, after investigation request by **U.S. Senators**, found these questions violate the Americans with Disabilities Act (ADA).

Mental health questions were often added to licensing and credentialing applications out of a misplaced desire to protect the public from health workers who might not be fit to give care. Yet there is no evidence that these questions serve that function.

On the contrary, when health workers' mental health suffers, the quality of care they deliver suffers. **Research indicates medical errors** can result from health workers experiencing burnout and mental health conditions.

Ensuring that health workers can access necessary mental health care not only benefits their well-being, but it also improves the health of our entire country. Patient outcomes will improve when we prioritize health workers' mental health and well-being, because to care for others, health workers must also be cared for.

CARLOS URIARTE

Carlos Felipe Uriarte
Assistant Attorney General

"It is clear that intrusive inquiries regarding an applicant's mental health history run afoul of the ADA to the extent that state medical boards use them as eligibility criteria to screen out applicants with disabilities and such inquiries are not necessary to determine whether an applicant is fit to practice medicine.

To that end, if you are aware of anyone who has been subjected to the type of discriminatory licensing inquiries referenced in your letter, we ask that you please encourage them to file a complaint or reach out to the Department directly."

9 Written by the Department of Justice

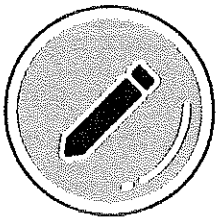
DOJ, after investigation request by US Senators, found these questions violate the Americans with Disabilities Act (ADA)

3 Steps

Hospitals/Health Systems Can Take:

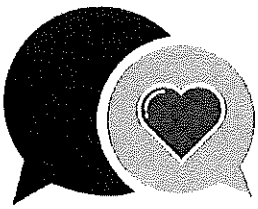
1. AUDIT

all credentialing applications, addendums, and peer review forms.



2. CHANGE

any invasive or stigmatizing language around mental health.



3. COMMUNICATE

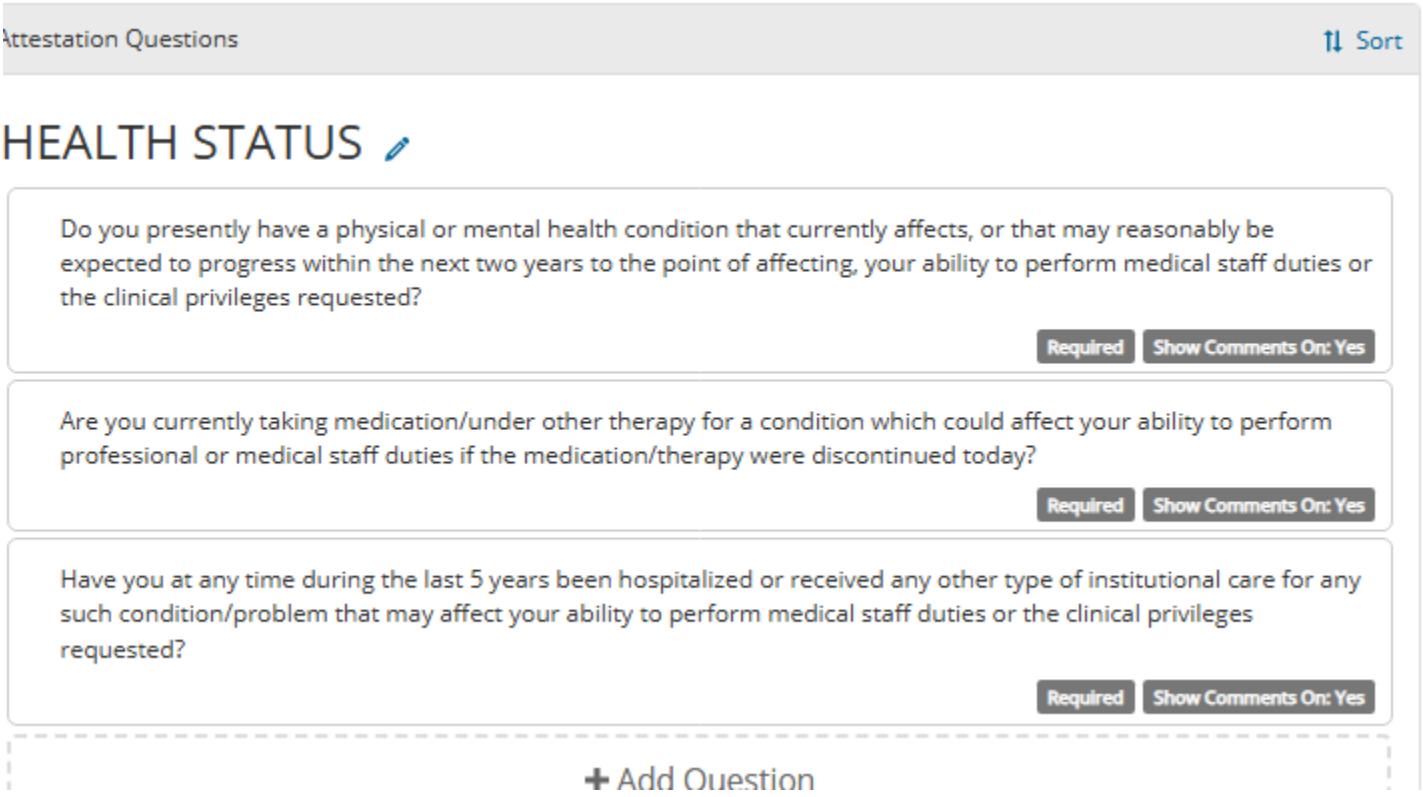
these changes to your workforce as a Wellbeing First Champion and assure staff it is safer for them to seek care.

What Should Your Questions Look Like?

Ensure that your questions are aligned with national standards across all forms.

Not Consistent	Consistent
During the last X amount years, have you suffered from any physical, psychiatric, or substance use disorder that could impair or require limitations on your functioning as a professional or has resulted in the inability to practice medicine for more than 30 days, or required court-ordered treatment or hospitalization?	Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No).
Have you been treated for or do you have a diagnosis for any mental health condition? (If yes, please ask your treating provider to send a status letter to the Board office).	Implement an Attestation Model: This uses supportive language around mental health and holds health workers accountable to their wellbeing, making it clear that their self-care is patient care. Offer confidential, non-reporting options to health workers who are under treatment and in good standing with a recognized program or other appropriate care provider. Example: "I attest to no current physical, mental, or behavioral health conditions that currently impair my ability to practice, with or without reasonable accommodation."
Do you have a physical, mental or emotional condition which may adversely affect your practice?	Do you currently have a physical, mental, or emotional condition which adversely affects your practice?
Do you take any medication or drugs (legal/illegal) which affects, or is likely to affect, your ability to perform your duties as a clinical staff or faculty member?	Do you currently take any medications or drugs which adversely affect your ability to perform your duties as a clinical staff or faculty member?
Are you currently being treated for a mental illness or substance use disorder?	Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No)
Have you ever or are you currently using illegal drugs, including non-prescribed prescription medication?	Are you currently engaged in the illegal use of drugs?

Questions on Current Application:



Proposed Replacement Questions:

- Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No)
- Do you currently take any medications or drugs which adversely affect your ability to perform your duties as a clinical staff member?
- Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No)
- Are you currently engaged in the illegal use of drugs?

PEER REFERENCE
FOR
«FormalNameWithDegree»

«RS_Name»
«RS_Address» «RS_Address2»
«RS_City», «RS_State» «RS_Zip»

Please complete all parts of this form. If more room is needed, use a separate sheet.

Your Field of Practice: _____

Your Professional Position: _____

Phone: _____ Fax: _____

How many years have you known the applicant?
_____

During what time period did you have the opportunity to directly observe the applicant's practice of medicine? _____

Was your observation done in connection with any official professional title or position?
Yes ___ No ___. If "yes" please indicate title and organization _____
_____

Were you previously, are you now, or are you about to become related to the applicant as family or through a professional partnership or financial association? Yes _____ No _____
If "yes", please explain_____

~~To your knowledge, does the applicant have any mental or physical health problems which might affect the ability to exercise clinical privileges in his/her specialty? ☐ YES ☐ NO~~

~~To your knowledge, has the applicant shown signs of any behavior, drug or alcohol problems which might affect the ability to exercise clinical privileges in his/her specialty? ☐ YES ☐ NO~~

TO your knowledge, is the applicant currently suffering from any condition for which they are not being appropriately treated that impairs their judgement or that would adversely affect their ability to practice medicine in a competent, ethical, and professional manner?
Yes _____ No _____

If the answer to either of the above questions is "YES" please explain:
_____

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:6/4/2025

Topic for Old & New Business Items:
Provider Health Statement

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:

- Changes in yellow were made to the health questions to make them less invasive
- Change in teal blue was made to inform the applicant that a relative can't sign the form stating that they are healthy enough to perform the privileges they have requested
- Changes in green will allow an MD, DO, NP or PA to sign the form (in the past, only an MD or DO could sign.) The Joint Commission standards have changed and are included with the form.

Board Committee Action:

Approval Needed for the revised health statement

Policy or Other Document:

☐ For Review Only
☒ For Board Action

Legal Counsel Review:

☒ In House Comments: Suzan reviewed the health statement and was present at Credentials Committee when they reviewed and approved the form.

☐ Board Comments:Click or tap here to enter text.

Senior Leadership Recommendation:
Recommend approval of revised form.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

Statement of Health

☐ By my signature hereto I attest to no current physical, mental, or behavioral health conditions that currently impair my ability to practice, with or without reasonable accommodation.

OR

I have an impairment that:

☐ Affects my ability to perform the clinical privileges requested and for which I require special accommodation. Describe any needed accommodations:_____

_____

☐ **Does not** affect my ability to perform the clinical privileges requested. No special accommodations are needed.

_____
Applicant's Name (Printed or Typed)

_____ _____
Applicant's Signature Date

The section below must be completed by either the director of your training program, chief of staff, or personal health care provider (MD, DO, NP, or PA), as required by accrediting bodies.

Please Note: By signing below, I indicate that I am not a relative or a member of the applicant's household and I do not have any recently initiated, or impending, professional partnership/affiliation association with the applicant.

I hereby confirm that the provider identified above ☐ does ☐ does not currently have any physical and/or mental health condition that adversely affects his or her practice.

Reasonable accommodation needed:_____

_____ _____
Name (printed or typed) **Signature (Must be a MD, DO, NP, or PA) other than the applicant)**

_____ _____
Title Date

_____ _____
Address Daytime Phone Number

Previous Joint Commission Requirements:

MS 06.01.05 EP 6

An applicant submits a statement that no health problems exist that could affect their ability to perform the privileges requested.
Note: The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect their practice. Documentation regarding an applicant's health status and their ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges, **or by a currently licensed doctor of medicine or osteopathy approved by the organized medical staff**. In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.

- Peer and/or faculty recommendation
- When renewing privileges, review of the physician's or other licensed practitioner's performance within the critical access hospital

EP Attributes

New	FSA	CMS	DOC	ESP
		§482.11(c) §482.12(a)(6) §482.22(a)(2) §482.26(c)(1) §485.639(c) §485.639 §482.54(c)(4)(i) §412.29(e) §412.29(e)	(D)	ESP-1

3. All of the criteria used are consistently evaluated for all physicians and other licensed practitioners holding that privilege.

EP Attributes

New	FSA	CMS	DOC	ESP
		§482.22(a)(1) §485.639(c) §485.639 §482.54(c)(4)(i) §412.29(e) §412.29(e)		

6. An applicant submits a statement that no health problems exist that could affect their ability to perform the privileges requested.

EP Attributes

New	FSA	CMS	DOC	ESP
			(D)	ESP-1

7. The critical access hospital queries the National Practitioner Data Bank (NPDB) in accordance with applicable law and regulation.

EP Attributes

Memorial Hospital
OF SWEETWATER COUNTY

ORIENTATION MEMO

Board Meeting Date:6/4/2025

Topic for Old & New Business Items:
Credentialing Policy

Policy or Other Document:

☒ Revision
☐ New

Brief Senior Leadership Comments:

- Advance Practice Providers (APPs) were added to the policy
- Changes concerning three year reappointments were added
- Changes are shown in red and green

Board Committee Action:

Approval Needed for the revised policy

Policy or Other Document:

☐ For Review Only
☒ For Board Action

Legal Counsel Review:

☒ In House Comments: Suzan reviewed the policy and was present at Credentials Committee when they reviewed and approved the Credentialing Policy.

☐ Board Comments:Click or tap here to enter text.

Senior Leadership Recommendation:
Recommend approval of revised policy.

Status **Draft** PolicyStat ID **18057402**

Approved N/A

Review Due N/A

Document Area: Medical Staff

Reg. Standards: TJC MS 06.01.03, TJC MS 06.01.05, TJC MS 06.01.07 + 4 more

Credentialing Policy

STATEMENT OF PURPOSE

Practitioners applying for Medical Staff ~~or~~, Non-Physician Professional (NPP), or Advance Practice Provider (APP) membership and clinical privileges at Memorial Hospital of Sweetwater County (the "Hospital" or MHSC) must submit required application materials. The Hospital will accept and process applications for only those Applicants who can demonstrate that they can fulfill the Minimum Qualifications for membership and criteria for specific privileges requested as outlined in the Medical Staff Bylaws, Rules & Regulations, and applicable clinical privilege forms.

If a Practitioner does not meet the Minimum Qualifications, they are not eligible to apply for Medical Staff membership and clinical privileges. Applications will not be sent to Practitioners in those specialties in which privileges have not been developed, in which services are not offered at the Hospital, or for which there is an exclusive contract arrangement and the potential Applicant is not a part of the group holding the exclusive contract.

The Hospital will consider the application a pre-application until eligibility of the Applicant for Medical Staff membership is established. Upon establishment of eligibility (i.e. Minimum Qualifications are met), the application will become an official application and will be moved forward in the process. An application that is incomplete, or becomes incomplete at any time during the review process, will no longer be processed.

Completed applications shall be reviewed by the Department Chair, Credentials Committee, and their recommendations forwarded to the Medical Executive Committee, whose recommendations shall be acted upon by the Hospital Board of Trustees.

TEXT

Definitions

APPLICANT: A Physician ~~or~~, Non-Physician Provider (NPP), or Advance Practice Provider (APP) submitting an application for Medical Staff membership and/or clinical privileges at the Hospital.

COMPLETED APPLICATION: A complete application means that all required documentation has been submitted by the Applicant and that:

- All information was verified and there is nothing missing from the file;
- All gaps in time of six months or more are accounted for;
- Any discrepancies between information provided by the Applicant and the information verified by the Hospital have been resolved.

CLINICAL PRIVILEGES: Authorization granted by the Board of Trustees to a Practitioner to provide specific care, treatment, or services in the organization within well-defined limits, based on the following factors: license, education, training, experience, competence, health status, and judgment.

CREDENTIALING: The process of obtaining, verifying, and assessing the qualifications of a Practitioner to provide care or services in, or for, a health care organization.

CREDENTIALS: Documented evidence of licensure, education, training, experience, or other qualifications.

DESIGNATED EQUIVALENT SOURCE: Selected agencies that have been determined to maintain specific item(s) of credential(s) information that is identical to the information at the primary source. An example is: The American Medical Association (AMA) Physician Masterfile for verification of a physician's medical school graduation and postgraduate education completion.

DISTANT SITE: The site where the Practitioner delivering tele-medicine services is located.

ORIGINATING SITE: The location of the patient at the time a tele-medicine service is being furnished.

PRACTITIONER: All Physicians ~~and~~, Non-Physician Providers (~~NPP's~~NPPs), and Advance Practice Providers (APPs) admitted to the Medical Staff.

PRIMARY SOURCE VERIFICATION: Obtaining verification from the primary source of a Practitioner's credentials; e.g. the Practitioner's academic institution, internship/residency program, hospital affiliations, references, etc.

PRIVILEGING: The process used to determine if credentialed Practitioners are competent to perform their assigned responsibilities, based on training, and evaluation of the individual's credentials and performance.

QUALIFICATIONS: Knowledge, education, training, experience, competency, licensure, registration, or certification related to specific responsibilities.

STAFF or MEDICAL STAFF: The formal organization of all Practitioners who are approved by the

Hospital's Board of Trustees to attend patients in the Hospital. Members include Physicians ~~and~~, Non-Physician Providers, and Advance Practice Providers.

Procedure

I. **Initial Application Process**

A. Each Practitioner applying for Medical Staff ~~or~~, Non-Physician Provider (NPP), or Advance Practice Provider (APP) membership and clinical privileges will be ~~given an~~sent a link to the on-line application ~~packet~~, ~~including~~which includes these additional documents:

1. Appropriate privilege list(s)
2. Employee Health Requirements and Questionnaires
3. Consent for Background Check
4. Application for Malpractice Insurance (if Practitioner will be employed by MHSC)

B. Burden of Applicant

1. The Applicant for staff membership and privileges shall have the burden of producing adequate information for a proper evaluation of his/her professional, ethical, and other qualifications for membership and clinical privileges and for resolving any doubts about such qualifications. The Practitioner applying for Medical Staff ~~or~~, NPP, or APP membership and clinical privileges, shall provide all the information required by the application packet to the Medical Staff Office, along with the items listed below.

a. Copy of applicable current Wyoming professional license;

b. Copy of current WY DEA registration, if applicable;

c. Copy of Wyoming State Board of Pharmacy registration (CSR), if applicable;

d. If employed by the Hospital, the Medical Staff Office will assist the Practitioner with applying for malpractice insurance. If Practitioner is not employed by the Hospital, they will need to provide documentation of current malpractice insurance coverage, showing carrier and carrier contact information, policy number, dates of coverage as well as the amount of coverage. Minimum limit of liability must be $1,000,000/$3,000,000;

e. Contact information (phone, email, and/or fax numbers) for three references who meet the requirements listed in the application for initial appointment. All references shall be able to attest regarding Applicant's suitability for Medical Staff membership, and ability to safely and competently exercise the clinical privileges requested in his/her chosen field;

f. Evidence of TB testing per hospital policy;

g. Documentation of required immunizations;

h. Copy of appropriate Board certification (if applicable), or confirmation of Board-certification eligibility;

i. Copy of curriculum vitae;

j. Copy of government-issued photo identification, i.e. driver's license or passport;

k. Documentation of CME for the past three years, if applicable;

l. Evidence of negative drug test results (for all new Hospital-employed Practitioners);

m. Application fee (submitted with application)

i. $100 non-refundable application fee for initial appointment; or

ii. $50 non- refundable application fee for reappointment.

C. Initial Granting of Privileges

1. The Medical Staff Office reviews the application, requested privileges, and supporting materials submitted by the Applicant and confirms that the Applicant meets the Minimum Qualifications.

2. The Medical Staff Office reviews the application, requested privileges, and supporting materials submitted by the Applicant and requests any missing items or information. If an application remains incomplete within six (6) months of initial opening, it shall be considered to have been abandoned, and shall be closed permanently. If an incomplete application is closed after six (6) months, this does not give rise to a fair hearing. If an Applicant wants to apply after an incomplete application has been closed, they will be required to submit a new application and application fee.

3. Once all requested information has been submitted by the Applicant, the Medical Staff Office reviews the application to determine if it is complete. When the application is deemed to be a Completed Application, the Medical Staff Office shall be responsible to review the application for veracity. Initiation of the verification process will begin within a reasonable time period after receipt of a Completed Application.

4. The Medical Staff Office (MSO) confirms the information provided by the Applicant using Primary Source Verification, or Designated Equivalent Sources, by doing the following:

a. Querying the National Practitioner Data Bank (NPDB), Federation of State Medical Boards (FSMB), American Medical Association (AMA), American Osteopathic Association (AOA), or other applicable medical or surgical specialty board, Office of Inspector General (OIG), Fraud and Abuse Control Information System (FACIS), Excluded Parties Listing System (EPLS).

b. Querying the medical licensing board in each state in which the

Practitioner has practiced, and verifying that there have been no successful challenges to licensure, certification or registration. The Practitioner's Wyoming license will be verified at the time of initial granting, expiration/renewal, and reappointment.

c. Entering application information into the credentialing software system.

d. Requesting information regarding any malpractice claims which have been filed or are in process.

e. Verifying education and training;

f. Completing background check;

g. Querying the Practitioner's references to verify that the Practitioner is competent to perform the requested privileges;

h. Querying the Practitioner's current and past hospital affiliations (for the past ten years.)

5. The Department Chair reviews the Applicant's file to determine whether he or she meets the established criteria for requested privileges.
6. The Medical Staff Office and/or Department Chair request additional information or materials from the Applicant, if necessary.
7. The Applicant provides any additional information or materials requested by the Medical Staff Office and/or Department Chair.
8. The Department Chair makes written recommendations regarding the requested privileges (for example, approval, modification, denial) to the Credentials Committee.
9. The Department Chair assigns an evaluator for any new Applicant for Focused Professional Practice Evaluation (FPPE).
10. The Credentials Committee reviews the Applicant's file and the Department Chair's recommendations.
11. The Credentials Committee requests additional information or materials, if necessary.
12. The Applicant provides any additional information or materials requested by the Credentials Committee.
13. The Credentials Committee makes written recommendations regarding the requested privileges (for example, approval, modification, denial) to the Medical Executive Committee.
14. The Medical Executive Committee reviews the recommendations of the Credentials Committee at its next regularly scheduled meeting. The Medical Executive Committee may do one of the following:

    a. Recommend, modify, or deny any portion of the requested privileges; or

    b. Return the request to the Credentials Committee for further

review.

15. The Board of Trustees acts on recommendations from the Medical Executive Committee regarding the requested privileges at its next regularly scheduled meeting.
16. The Medical Staff Office sends a letter (signed by the CEO) notifying the Applicant of the Board's decision regarding the requested privileges. The letter and a copy of the delineation of privileges is also posted to Policystat, which is accessible to all Hospital Departments. The letter to the Applicant contains the following information:
    a. Specific clinical privileges granted to the Applicant
    b. Staff category to which the Applicant is appointed
    c. Department to which the Applicant is assigned (Surgery or Medicine)
    d. Duration of the individual's appointment to the identified staff category. (~~not to exceed 24~~Initial Appointment is for 12 months.)
    e. Any conditions or restrictions that may apply to the appointment or clinical privileges granted
17. The CEO or designee promptly notifies the Medical Executive Committee (MEC), if the Board of Trustees' decision is inconsistent with the MEC's recommendation, in accordance with Medical Staff Bylaws, Rules & Regulations.
    a. These notifications are made in writing.
    b. The CEO or their designee ensures that all appropriate external agencies, organizations, and other entities receive notification of the decision, as described in the Medical Staff Bylaws, Rules & Regulations.
18. If there is a decision to deny privileges, the CEO or designee promptly provides the Applicant with information on the Fair Hearing and Appeal Policy and its procedures.
19. Except as otherwise determined by the Medical Executive Committee or Board of Trustees, a Medical Staff member applying for appointment or reappointment and clinical privileges, who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment and clinical privileges while under investigation or to avoid an investigation, is not eligible to reapply to the Medical Staff of MHSC for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such re-application is processed in accordance with the procedures then in effect. As part of the reapplication, the Practitioner must submit such additional information as the Medical Staff and/or Board of Trustees requires, demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the

reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

D. Reappointment Process

1. At least ninety (90) days before the expiration of a medical staff appointment or expiration of privileges, the Medical Staff Office shall send a link to the on-line reappointment ~~packet~~application to the Applicant. When the completed application is received, all new information will be verified for accuracy. The Medical Staff Office will also gather information from Quality concerning On-going Professional Performance Evaluation (OPPE), patient experience and/or patient satisfaction scores, and any other pertinent data.
2. The ~~Medical Staff Office only conducts background checks (and drug/alcohol screenings, as applicable) at initial appointment. Thereafter, the~~ process for re-appointment shall be the same as for initial Appointment as to the review and recommendation of the Department Chair, Credentials Committee, and the Medical Executive Committee, and the action of the Board of Trustees. However, FPPE does not need to be assigned at reappointment, unless the applicant is requesting new or additional privileges.
3. Duration of an Applicant's reappointment shall not exceed 36 months.
4. If a Practitioner has requested a leave of absence during the time that his or her privileges are up for reappointment, the process outlined in the Medical Staff Bylaws Article VIII, section 6 (Leave of Absence) and section 7 (Termination of Leave), shall be followed.

E. Credentialing of Tele-Medicine Practitioners

1. All Practitioners who are providing telemedicine services to patients at MHSC, must be granted privileges at MHSC.
2. The Practitioner shall be credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in the Medical Staff Bylaws and Rules & Regulations with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Medical Staff and the Board of Trustees in making its recommendations/decision, provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:
    a. The clinical services offered via a telemedicine link are consistent with commonly accepted quality standards.
    b. The Medical Staff recommends which clinical services are appropriately delivered by Practitioners through a telemedicine link.
    c. The distant site hospital or organization is accredited by the Joint Commission or is a Medicare-participating organization.

d. The individual distant site Practitioner is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link and the Hospital is provided with a current list of his/her privileges at the distant site.

e. The individual distant site Practitioner holds an appropriate license issued by the State of Wyoming by the appropriate licensing entity.

f. The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or licensed practitioner from patients, physicians or licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.

g. When the distant site is a "distant site telemedicine entity" the written agreement shall specify that the distant site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1) through (a)(9) with regard to the distant site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1) through (a)(9), as that provision may be amended from time to time.

F. Request of Additional or Modified Privileges

1. The Medical Staff member submits a written request for additional or modified privileges to the Medical Staff Office.
2. The Medical Staff member provides documentation supporting the request, showing competency for the additional or modified privileges, including but not limited to the following:
    a. Documentation of training
    b. Certificates or licensing
    c. Relevant experience
3. The Medical Staff Office will inform the Department Chair, Credentials

Committee, MEC, and the Board of Trustees of the request for additional or modified privileges.

4. When a request for additional or modified privileges is submitted, the Medical Staff Office will run a current NPDB query.
5. If the request for additional or modified privileges coincides with the Medical Staff member's reappointment, the reappointment process is followed.
6. The Department Chair reviews the Applicant's file to determine whether he or she meets the established criteria for requested privileges.
7. The Department Chair makes written recommendations regarding the requested privileges (for example, approval, modification, denial).
8. The Department Chair assigns an evaluator for FPPE for the additional or modified privileges.
9. The Credentials Committee reviews the Applicant's file and the Department Chair's recommendations.
10. The Credentials Committee makes written recommendations regarding the requested privileges to the Medical Executive Committee.
11. The Medical Executive Committee reviews the recommendations of the Credentials Committee at its next regularly scheduled meeting.
12. The Medical Executive Committee may do one of the following:
    a. Recommend, modify, or deny any portion of the requested privileges; or
    b. Return the request to the Credentials Committee for further review.
13. The Board of Trustees acts on recommendations from the Medical Executive Committee regarding the requested privileges at its next regularly scheduled meeting.
14. The Medical Staff Office sends a letter (signed by the CEO) notifying the Applicant of the Board's decision regarding the requested privileges. The letter and a copy of the delineation of privileges is also posted to Policystat, which is accessible to all Hospital Departments. The letter to the Applicant contains the following information:
    a. Specific clinical privileges granted to the Applicant
    b. Staff category to which the Applicant is appointed
    c. Department to which the Applicant is assigned (Surgery or Medicine)
    d. Duration of the individual's appointment to the identified staff category (not to exceed ~~24~~36 months)
    e. Any conditions or restrictions that may apply to the appointment or clinical privileges granted

15. The CEO or designee promptly notifies the Medical Executive Committee (MEC), if the Board of Trustees' decision is inconsistent with the MEC's recommendation, in accordance with Medical Staff Bylaws, Rules & Regulations.
    a. These notifications are made in writing.
    b. The CEO or their designee ensures that all appropriate external agencies, organizations, and other entities receive notification of the decision, as described in the Medical Staff Bylaws, Rules & Regulations.
16. If there is a decision to deny privileges, the CEO or designee promptly provides the Applicant with information on the Fair Hearing and Appeal Policy and its procedures.

G. Temporary Privileges
    1. In order to grant temporary clinical privileges pursuant to the Medical Staff Bylaws, the Medical Staff Office will obtain a completed application and privilege delineation form as well as primary source verification of the items listed previously in this policy.
    2. The requirements of the Medical Staff Bylaws must be met for any application for temporary Medical Staff membership and clinical privileges.
    3. Temporary privileges may be granted only by the Chief Executive Officer in conjunction with the Department Chair and the Chief of Staff.
    4. The Practitioner's application for clinical privileges shall go through the ordinary clinical privileging process outlined herein (to the extent the application does not go through this process in the temporary clinical privilege process), as soon as possible after the granting of temporary clinical privileges.
    5. The Practitioner shall not be eligible for temporary privileges if:
        a. The Practitioner submits an incomplete application for Medical Staff ~~or~~, NPP, or APP membership and clinical privileges;
        b. There is a current challenge or previously successful challenge to the Practitioner's licensure;
        c. The Practitioner has received an involuntary termination of his or her medical staff membership at another hospital;
        d. The Practitioner has received involuntary limitation, reduction, denial or loss of clinical privileges.

II. **Reapplication After Initial Appointment or Resignation**

A. If a Staff Member's membership or clinical privileges expire, or the Staff Member resigns, while in good standing, the ~~STaff~~Staff Member may apply for reappointment to the Medical Staff.

B. The Practitioner shall be required to provide all information required by the

application form most recently approved by the Medical Staff and Board of Trustees. If the Medical Staff Member is reapplying after less than twelve (12) months of non-membership, they will be required to complete a reappointment application. If they are applying after more than 12 months of non-membership, they will be required to complete an application for initial appointment.

C. If the Staff Member is reapplying after less than 12 months of non-Membership, the Medical Staff Office shall not be required to verify such information as the Practitioner warrants is accurate, unless the information is of a type identified by the Credentials Committee as lacking sufficient reliability after six (6) months, such as results of a state licensing board query.

D. The Medical Staff Office shall contact the Practitioner's references and verify that each reference is still accurate and unchanged.

III. **Review and Approval of Credentialing Policies**

A. All policies must be reviewed and approved by the Credentials Committee, every two years. With the exception of technical corrections made by MHSC staff related to reorganization, renumbering, punctuation, spelling, or grammar related changes, all policy amendments require Credentials Committee review and approval.

REFERENCES

*Joint Commission Standard MS.06.01.~~05~~03, EP ~~4~~1. The critical access hospital credentials applicants using a clearly defined process.~~The hospital has a clearly defined procedure for processing applications for the granting, renewal, or revision of clinical privileges.~~

~~*Joint Commission Standard MS.06.01.05, EP 5.* The procedure for processing applications for the granting, renewal, or revision of clinical privileges is approved by the organized medical staff.~~

Joint Commission Standard MS.13.01.01 For originating sites only: Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

~~*Joint Commission Standard MS.13.01.03* For originating and distant sites: The medical staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites.~~

Memorial Hospital of Sweetwater County Medical Staff Bylaws and *Rules & Regulations*, approved ~~March 2022~~January 8, 2025.

Approvals:

Credentials Committee ~~07/19/2022~~

~~MEC 07/26/2022~~

MEC

Board of Trustees ~~08/03/2022~~

Approval Signatures

Step Description	Approver	Date
	Kerry Downs: Director of Medical Staff Services	09/2022

Reg. Standards

TJC MS 06.01.03, TJC MS 06.01.05, TJC MS 06.01.07, TJC MS 06.01.09, TJC MS 06.01.13, TJC MS 08.01.01, TJC MS 08.01.03

MHSC Board of Trustees: June 2025

Chief Clinical Officer (CCO) Report

Report prepared and submitted by: Kari Quickenden, Pharm.D., MHSA

1. As previously reported, the Medical Imaging Department of Memorial Hospital of Sweetwater County (MHSC) continues to progress on a project with Huntsman Cancer Institute (HCI) for breast MRI interpretation services. We may experience a slight delay in the go-live due to some contractual logistics that we are working through with HCI.
2. The Medical Imaging/fluoroscopy project is approximately three to four weeks behind schedule. All electrical was brought on-site last week. We are awaiting lead lining and sheetrock. Facilities estimates we will be able to install the equipment in approximately three weeks. We will then coordinate with Siemens to ensure quality assurance of the new equipment and technologist training.
3. Lacey Reddick, Clinical Trials Facilitator at Sweetwater Regional Cancer Center, was recently featured by Huntsman Cancer Institute in their Huntsman Affiliate Spotlight. Lacey is passionate about bringing clinical trials to our rural community and increasing rural representation in research.
4. Dr. Symington was recently a panelist at the Binaytara Summit on Cancer Health Disparities in April. The topic was "Root Causes of Cancer Disparities: An Intersectional Perspective". Additionally, Dr. Symington was a featured plenary speaker at the Southwest Oncology Group (SWOG) conference in May. Her presentation topic was "Bridging the Distance Gap: How to Enhance Rural Patient Representation in Clinical Trials."
5. The Sweetwater Regional Cancer Center had a table at the Run With Sandy event. The Run With Sandy donated the event's proceeds to our Cancer Center.
6. **Quality & Safety**-Nursing Informatics has been working with departments across the hospital and clinics to create a comprehensive EMR downtime process document. Currently, downtime processes are somewhat siloed as each department has its own process and procedure. Due to ongoing cybersecurity threats, the respective teams have been working diligently to collaborate on a single document that outlines EMR downtime procedures for both planned and unplanned EMR downtimes.
7. **Quality & Safety-**Our April 2025 compliance with the sepsis bundle was 91%. We continue to work on progressing toward our target goal of 78% overall compliance for FY25. Additionally, our OP-23 compliance (Head CT/MRI results for stroke patients within 45 minutes of arrival) for FY25 is at 100%.
8. **Quality & Safety-**We continue to await our Critical Access Hospital State Survey from the Wyoming Department of Health.
9. I was honored to receive the Healthcare Champion Award at the University of Utah Affiliate Symposium in April.
10. I attended the COPIC Patient Safety and Risk Management conference. COPIC is our medical malpractice carrier. The top calls to COPIC's risk management hotline for 2024-2025 include:
    - Chronic opioids-taking on another provider's patient
    - Mental health-finding a specialist
    - Dismissal of a patient
    - Non-compliant patients
    - Charting with AI
    - Treating minors
    - Medication errors
    - Charting and documentation
    - Timely completion of notes
    - Disclosure of adverse outcomes
    - GLP-1s (weight loss medications)
    - Working with Advance Practice Providers
    - Social Media

Respectfully submitted,
Kari Quickenden

MHSC Board of Trustees: June 2025
Chief Experience Officer (CXO) Report
Report prepared and submitted by Cindy Nelson, SHRM-SCP, FPCC

Patient Experience Pillar

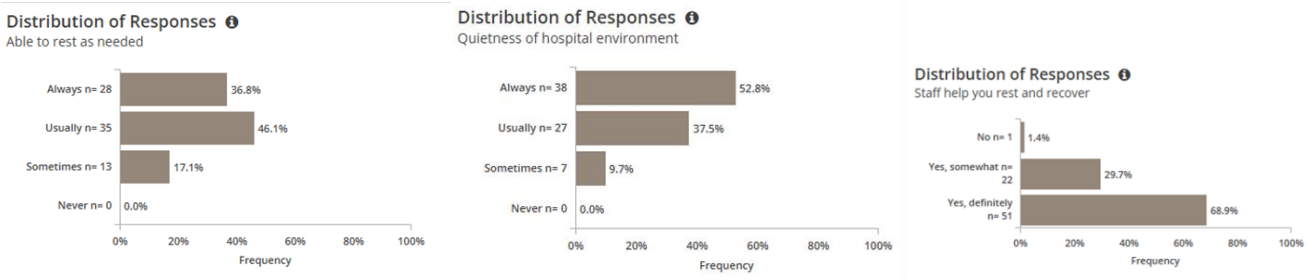
We continue to utilize our person-centered care culture to improve the patient experience and improve the satisfaction for our patients to provide compassionate care to every life we touch for every patient, every time.

Workgroups continue meeting to develop strategies to improve patient experience and patient satisfaction scores in Hospital Environment – Cleanliness & Restfulness (formerly Quietness), Discharge Information, and Care Coordination (formerly Care Transitions). Updated reports will be presented to the Performance Improvement and Patient Safety (PIPS) Committee in July and the updates will be included in the Quality Committee meeting packet that follows.

In communication to hospital staff on May 23, it was noted the Hospital has been working on several initiatives aligned with our strategic plan to ensure our patients have a positive experience with us. One of the items we're working on is improving the restfulness of our hospital environment. CMS has identified this as something they want all hospitals to pay extra close attention to, so that our patients can get the crucial rest they need to recover successfully both during their stay and after they leave our organization. In order to measure how successful we are in this, CMS requires us to ask the following three questions in our inpatient surveys.

1. *During this hospital stay, how often were you able to get the rest you needed?*
2. *During this hospital stay, how often was the area around your room quiet at night?*
3. *During this hospital stay, did doctors, nurses, and other hospital staff help you to rest and recover?*

CMS wants us to strive to be our best, so they only pay attention to the number of times a patient answered with a top-box answer, aka the times a patient said we "always" do this or "yes, definitely". Below you can see the distribution of responses for these questions for this calendar year.



We see we have some opportunities for improvement to help our patients rest and recover while at MHSC. The request to all staff is to provide feedback or ideas on how to help us improve in these areas. The Person-Centered Care Committee is actively involved in assisting with solutions and strategies.

The Patient & Family Advisory Council (PFAC) met May 19 and reviewed the Top 10 Patient Safety Concerns for 2025 and the CMS Patient Safety Structural Measures, specifically the role of the PFAC in the attestation process for Domains 4 and 5. The question for discussion that night was, *"What should the Hospital be aware of to improve your care experience?"* Their responses included how much they value a physician looking at their chart/records before their appointment and asking patients about "comfort

considerations" that are important to them. The group will celebrate six years together at their meeting June 23 and we invite Trustees to join us at the event.

I have been invited to present Patient Experience data and highlights at all MHSC Medical Staff meetings. In May, in addition to reviewing data, I have highlighted our hospital-wide Active Listening Compassion Initiative and shared a quote from a short Press Ganey video on engaging staff with the voice of the patient: "Patient Experience is not amenities and making people happy on top of the 'real' work of taking care of patients. It is the full, safe, quality, and positive experience." I am inviting all providers to listen to the voice of our patients by reading the survey comments, thank you notes, online reviews, as well as actively listening to the patients in front of them each day. I have been invited to present Patient Experience highlights at the University of Utah and MHSC quarterly Emergency Department OQC Review. We met May 27 and will meet again August 13.

The Director of Certification at Planetree reached out to provide an update following changes in their organization staffing. They have identified they are behind on their certification application reviews and updates with our coach's departure and a high-volume certification queue. They appreciate our patience as they work through completing the review of our application and will be in touch to discuss next steps in the near future.

Employee Experience Pillar

We continue to work to improve employee retention and employee satisfaction for a happier, healthier staff by weaving our culture throughout HR and management practices to recruit, reward, and retain staff committed to carrying out our mission. Hospital Week was well-received and staff expressed appreciation for the recognition celebration We celebrated employee service award milestones at the dinner event May 15. Special thanks to Dr. Sowada, Ms. Pendleton, and Mr. Rood for being able to join us to celebrate 815 years of collective service celebrated.

The Press Ganey Employee Engagement Survey results overview will be presented to the Human Resources Committee at their June meeting. Our overall score was 3.91/5.0 with a 52% response rate and our strategic goal is to improve by 3% with each survey. I have recently obtained access to all levels of the data and individual department reports and solution strategies will be distributed in early June. In communication with Press Ganey this week, I have learned it is their recommendation to combine the Culture of Safety Survey and Employee Engagement Survey into one process moving forward. We will explore creating a plan to make that happen as we determine upcoming pulse surveys and the next full survey. In the more immediate timeframe, goals and strategies will be identified for improvement work based on the most recent survey results at the department level and leadership team level.

The Employee Experience Performance Improvement and Patient Safety Priority goal for FY2026 is to create a mentorship program for hospital staff. We are currently gathering information as we make plans to move forward.

Board of Trustees Experience

Dr. Sowada has created a wonderful and comprehensive New Trustee Orientation Program. I am entering her plan into the portal so that it is available to implement with our next new Trustee.

MHSC Board of Trustees: June 2025

Chief Financial Officer (CFO) Report

Report prepared and submitted by: Tami Love

FINANCIAL SUMMARY - Revenue increased in April coming in at $24,024,575, slightly over budget. Net revenue was significantly over budget with the processing of the delayed Medicare claims, positively impacting our reduction of revenue, and increasing our bottom line. Expenses were over budget at $11.5 million. Our bottom line for April was a gain of $2.8 million. Through three quarters of the fiscal year, our gross revenue is under budget by $1.9 million, net revenue is over budget by $1.6 million and expenses are under budget by $1.1 million. For May, revenue is projected to be like April, at $24 million, reduction of revenue will be lower again with increased Medicare reimbursement and with expenses staying stable, the estimated bottom line will be a significant gain. Collections are projecting to $13 million as delayed Medicare payments continue. We continue to see our financial ratios move towards meeting our strategic plan goals for year end.

CRITICAL ACCESS. More than $19 million in Medicare claims were processed in April, with total collections coming in over $17 million. Claims have been reviewed, and we are receiving the higher rate of reimbursement, based on our cost-to-charge ratio calculated by CMS. We have now seen a delay in United Healthcare Medicare Advantage claims as they have not been able to update their system with our new CAH information. We continue to test the Method II billing build in Cerner which will mean higher reimbursement on professional claims from our Clinics. It was required to bill under Method I with the initial conversion to CAH. We saw the positive impact to both Days in AR and Days Cash on Hand in April. We are still waiting for the State survey.

UKG/KRONOS UPGRADE PROJECT. The Fiscal payroll team, along with HR and super users from select departments have been meeting bi-weekly to build the new payroll/timekeeping system. In conjunction with the vendor and our 3rd party resources working on interfaces, the build team has been able to keep on schedule for the new system and are at the mid-launch walkthrough. Testing will begin the week of June 9 with an expected Go-Live date of September 8.

IMPACT OF BUDGET RECONCILIATION BILL. With the proposed reduction in Medicaid payments and allowing the premium tax credits to expire December 31, 2025, we will see some of our patient population lose their health care coverage. Patients on the marketplace plans may see their premiums increase by as much as 200% where they will have to make the decision to stay on the plan or forgo health insurance all together. The impact to MHSC will include an increase in our Medical Assistance program, which we have seen a significant decrease over the last two years due to the work of the Patient Navigation Team assisting patients with insurance coverage. We also expect an impact to our self-pay population as we see patients move from insured to uninsured or underinsured. This will most likely increase our bad debt write-offs. While these are the immediate impacts, the bill calls for additional Medicaid and ACA cuts over the next several years.

MHSC Board of Trustees: 6/4/2025

Chief Nursing Officer (CNO) Report

Report prepared and submitted by: Ann Marie Clevenger DNP, RN, NEA-BC

1. Cardiopulmonary Services/Sleep lab/EEG
    a. Crystal Hamblin, Director of Cardiopulmonary Services, has received feedback on potential sleep study readings and report delays. Crystal and Dr. Hammond collaborated the week of May 19th and were able to coordinate system barriers leading to automated EMR expedited results.
    b. Due to the changes in Neurology Physician coverage, Crystal ensured a process for the timely reporting of EEG results, thanks to Dr. Baboo's continued services.
2. Care Management
    a. Case Management and a small team, including Suzan Campbell, are developing guidelines for when a patient presents to the ED for admission without medical necessity (social admission) and without safe resources for discharge. The process aims to avoid unnecessary admissions while serving the safety needs of patients and families in our community.
3. College Drive:
    a. College Drive providers and staff are thankful to those providers who have presented about the services they provide in their specialty clinics at the MOB during the College Drive physician Thank you to Dr. Hoffman, Dr. Crofts, Dr. Christensen, and Dr. Gray.
4. Education/Employee Health:
    a. The Nurses Day Brunch for new graduate nurses was held with 13 attendees. Nurse Directors performed group interviews and plan to have the new graduates start on June 30th, pending successful interviews and acceptance of the offer. The cohort will participate in the Nurse Education Mini Orientation/Residency (NEMO) program. NEMO is an eight-week program meeting for a full day once a week. Patty organizes the experience, and the clinical leaders at MHSC lead the program and offer didactic and clinical hands-on experiences in the classroom setting. In addition, the Emergency Department has an additional residency program through the Emergency Nurses Association (second year offered).
    b. Shayla McGregor, Clinical Coordinator, ICU/House Supervisor, is training for PICC Line insertion and will attend the University of Utah in June for additional training as scheduled. Adding her to the PICC team, consisting of Deseriee Stofferahn and Gretchen Van Valkenberg.
    c. The Diabetes Self-Management Education Program (DSME) has successfully moved the primary site from community nursing to MHSC. The program includes Patty O'Lexey, who coordinates and functions as the quality person for the program, Holly Blau, a patient educator who is also the DSME RN, and the dietitians. In 2024, the program had 37 referrals, and to date in 2025, there are 36 referrals, with 16 patients being seen for RN visits and 20 for dietitian visits. The team plans to promote the program further and is in the process of updating the information flyer and the referral forms.
    d. Donor Connect

i. Donor Connect came to MHSC to provide annual education. One of the takeaways from the education was to be aware of timely referrals to the Donor Connect Program. During education, they offered updated cards for nursing staff to assist in identifying potential donors and abide by the requirements. Overall, MHSC has performed very well with three organ donor notifications (four transplants) since 2012.

5. Surgical Services/Infection Prevention:
    a. The Surgical Services Team continues to collect data on processes and efficiencies for the surgery department to review. Thank you, Director of Surgical Services, Noreen Hove, for leading these efforts. The data is reviewed at the Surgical Services Medical Staff Meetings and in Quality Meetings.
    b. Barbara McDonald, Infection Prevention, is working to streamline data collection and reporting processes. An 0830 daily huddle discusses a daily review of the IP precautions census to ensure appropriate precautions are being taken and accurately documented.
6. Strategic Initiative:
    a. Quality and Safety
        i. The Professional Nurse Practice Peer Review (PNPR) start-up group has met, created and approved policies and forms, and will present at nursing department meetings to introduce the committee and gain participants' interest. Noreen Hove, nurse director, and I will attend meetings in June. The plan is to bring a committee together with initial training and meetings in August. After reviewing the policies and forms, they will be brought for approval in the appropriate committees.
        ii. Daily Safety huddles occur Monday through Saturday at 0830, providing a structured approach to sharing updates on staffing, census, and patient concerns. It has established a tiered process for reviewing information from direct care staff/clinical leads/directors with other leaders to improve safety.
    b. Community Services and Growth
        i. Mental Health Services
            1. If you or your teams are interested, Misty Cozad, Practice Manager at College Drive, is coordinating a condensed version of Prosper Training, a Governor-sponsored program to reduce suicide risk in our communities through education and collaboration of community resources. In place of a day-long presentation, a short version will be given to the team at College Drive. If interested, please ask, and we can help coordinate in your area.
            2. The Sweetwater Behavioral Health Clinic (SBHC) Business Proposal was brought to the April Board of Trustees Meeting, where I presented. A Board of Trustees workshop was held on April 22, 2025, with a PPT presentation and coordination of answers to questions posed by Board Members. The clinic proposal remains under review. Currently, additional information is being gathered to identify opportunities for improvement in the Title 25 processes, and further data on patient care provided currently in our emergency department and clinics for patients with mental health disorders is being collected. Additional information will be provided from the

small group when opportunities for improvement have been identified.

c. Reducing Turnover and Travel Staff Update
    i. On May 19, 2025, there were 10 open RN Positions with 14 RN travelers (on June 30, 2024, we had 26 RN travelers).
        1. Travel RNs help cover open positions and for extended leave when required to ensure safe staffing ratios based on census and acuity.
    ii. Cross-training for interested RNs is occurring, and there is a plan to ensure competency maintenance with scheduled shifts in the primary and secondary units.
    iii. Many RNs have participated in the Preceptor Program, completing preceptor education and subsequently receiving a small financial incentive while precepting MHSC RN orientees.
    iv. The Daisy Award was hosted on May 27th from 2 to 3 p.m. It is an honor to recognize a nursing staff member through patient and family nominations. Elizabeth Stott, RN, was honored with the DAISY Award for Extraordinary Nurses. The award is part of the DAISY Foundation's mission to recognize the extraordinary, compassionate nursing care they provide patients and families every day. The nominations are from patients and families. Other nurses nominated for the award were Santana Chavez, Delina Singleton, Rochelle Roemer, Shayla Dean, Adriana DeJesus, Weston Turner, and Jennifer Warpness. A group Daisy Award was also presented to the Surgical Services Operating Room Nurses.

Please let me know if you have any additional insight that may be helpful in this report. Thank you for being so supportive of the MHSC teams. Ann

Building and Grounds Committee Meeting
May 20, 2025

The Building and Grounds Committee met in regular session via Zoom on May 20, 2025, at 2:30 PM with Mr. Marty Kelsey presiding.

In Attendance: Mr. Craig Rood, *Chairman*
Mr. Marty Kelsey, *Trustee*
Ms. Irene Richardson, *CEO*
Ms. Tami Love, *CFO*
Mr. Gerry Johnston, *Director of Facilities*
Mr. Steven Skorcz, *Facilities Supervisor*
Mr. Will Wheatley, *PlanOne Architects*

Mr. Rood called the meeting to order.

Ms. Love shared a mission moment.

Mr. Rood asked for a motion to approve the agenda. Mr. Kelsey made a motion to approve the agenda. Ms. Richardson seconded; the motion passed.

Mr. Rood called for a motion to approve the minutes for the April 15, 2025, meeting.
Mr. Johnston moved to approve the minutes. Mr. Kelsey seconded; the motion passed.

Maintenance Metrics

Mr. Johnston reported on the April metrics report. He said the average days open are down significantly from the prior month. He said everything is moving along nicely.

Old Business – Project Review

Medical Imaging Core and X-ray

Mr. Wheatley said framing is being done, along with rough in and prep for walls. Mr. Johnston said they are waiting for the lead for the walls and then they will need the electric approved. There have been a couple of hold ups due to materials, and the project is running about 3 – 4 weeks behind schedule.

Laboratory Expansion project - SLIB

Mr. Wheatley said they continue internal and external wall framing. There have been some window changes in the stairwells. They are preparing for fireproofing and installation of insulation. He said the other trades will be onsite soon. Mr. Kelsey asked about the schedule and if any time has been made up. Mr. Wheatley said he hasn't heard of any concerns. Mr. Kelsey asked for a schedule, showing any delays, for all projects to be included each month. Mr. Rood agreed and noted it is good to keep asking the contractor to keep them on time.

MOB Entrance – SLIB

Mr. Wheatley reported last week was site excavation and demolition. The area is taking shape as they look at light pole bases and prepare for concrete pours next week.

OB Renovation – County

Mr. Wheatley said he is working on the contract for the hospital now that the Commissioners have approved of the project. Mr. Kelsey asked what type of bidding process we will be doing with this project. Mr. Wheatley said he will work with the hospital on a public bid process, but he does have concerns about what we will see as there are so many contractor projects going on in the area. After some discussion, it was decided to move forward with the public bid process and then we can reevaluate if the results aren't positive.

Master Plan

Ms. Love said the next steps are to get the Senior Leadership team together to look at the Master Plan options and the prioritized project list to figure out a plan. Ms. Richardson said we are working on building the capital maintenance fund, a goal from the strategic plan, and we should meet the 3-year goal in the current year. She explained that any projects we do will decline this fund. Mr. Rood and Mr. Kelsey said the first step is to have a plan, that funding is a separate plan. Mr. Rood asked if we are at risk of losing the funding for the Foundation area. Ms. Love said we have received the money, and the grant was for infrastructure, which will need to be completed before anything can move into that area. The deadline for that grant is also December 2026. Mr. Kelsey said 2026 is coming quickly and we need to move forward with a plan, so we aren't forced into doing something quickly without looking at the bigger picture. Ms. Richardson said we will get the Team together to start looking at a plan.

Tabled Projects

Foundation Area Renovation – this was discussed in conjunction with the Master Plan.

New Business

No new business was brought forward.

Other

The next meeting is scheduled for Tuesday, June 17, 2025; 2:30pm.

Mr. Rood adjourned the meeting at 3:01 pm.

Submitted by Tami Love

Board Compliance Committee Meeting

Memorial Hospital of Sweetwater County
May 12, 2025

Present via Zoom: Suzan Campbell, *In House Counsel*, Irene Richardson, *CEO*, Kandi Pendleton, *Trustee-Chair, Barbara Sowada, Trustee,* April Prado, *Compliance Coordinator.*

Minutes

Call to Order
The meeting was called to order at 9:01am by Kandi Pendleton.
Agenda
The May 12, 2025, agenda was approved as written, Barbara made the motion and Irene seconded.
Meeting Minutes
The meeting minutes from January 27, 2025, were brought forward. They were approved as written; Barbara made the motion and Irene seconded.

New Business

a. Audit topics 2025
   i. Employee payroll audit-similar to the Vendor audit. This audit turned into two audits- the Segregation of Duties Audit and the Classification of Employee Audit. Suzan explained the Segregation of Duties audit was done by reviewing the hospital policy and auditing data against what process is being done. The Exempt Classification audit was done in conjunction with Department of Labor Standards. She added that both audits were classified as a "probe audit" and that a probe audit is different than a "complete audit". The probe audit looks at a random sample to give a picture of what is happening as a whole. A complete audit would include auditing every employee file and would not be feasible for either of these audits.
   ii. Segregation of Duties audit. Suzan stated that this audit was similar to the recent vendor audit and that we audited our employee files against a policy that came about from a Clifton, Larson, Allen audit. April reported that this audit was large and entailed working with Human Resources as well as several other departments in the Hospital. She continued that H.R. was great to work with as well as most other departments. The draft audit was presented for review and April briefly explained how the data collection took place and presented her recommendations. April took any questions about any part of the audit. Barbara asked if there was a plan in place or how the Hospital moves forward based on the recommendations of the audit. Barbara added that a lot of work goes into these audits and the weaknesses are small and fixable. Suzan stated that she's planning a meeting with Irene and Tami about the policy changes that need to happen. She said that she was uncertain about the mock payroll but would work with Payroll to see what could be done. Suzan confirmed that she would work to get a plan together and get it out to the board.
   iii. Exempt Classification audit. Suzan reported that this audit looked at exempt vs non-exempt employees. She stated that this audit is about checking that the Hospital is correctly classifying employees. The Hospital currently has more non-exempt employees and this paperwork is done in Human Resources. April stated that this audit was different in that this isn't something the Joint Commission would not audit and would instead be done by the Department of Labor (DOL). The draft audit was presented for

review and April spoke and took questions about the results and her recommendations. Kandi added that she liked the idea of exploring what could be done in Performance Manager to help with the Hospital process. She added that often, there are additional items that a program can provide to simplify existing processes. Barabara asked if 90% compliance rate on this audit is where we would like to be. Suzan stated that she would love to be at 100% and feels that it is definitely attainable. Barbara also asked if there would be periodic monitoring of this data to make sure we are getting closer to the 100%? Suzan added that this would be a great idea and that maybe it could be done monthly initially and then maybe quarterly after that. April continued that she could spot audit a couple files every month, report that to this group and go from there. Barbara asked where weaknesses had been found in this audit. Suzan stated that the weaknesses were in the area of an employee going from non-exempt to exempt and April added that the other weakness was having a job description that meets the guidelines set forth by the DOL for exemption.

iv. Exempt checklist. This was presented for the Board for their information and to provide further explanation of the current process in place from the DOL.

Old Business

Remaining audits for 2025-

A. Performance Manager follow-up for HIPAA violations. Follow the HIPAA violation process from referral from Compliance to corrective action to what is entered in employee personnel file (Performance Manager) every time they are written up for the HIPAA violation.
B. Peer Review Process
C. Employee leave audit-new recommended audit based on payroll audit (FMLA)
D. Short-term and long-term disability audit based on the payroll audit
E. Audit of the percentage of annual performance evaluations that are being done on time.

Based on A and E perhaps we need to consider an overall audit/review of Performance Manager?

Summary Report

a. HIPAA. The HIPAA report was presented for review. Suzan briefly explained that Synergi is the Hospitals self-reporting system and P2Sentinel audits Cerner, the Hospitals program for Medical Records. Suzan added that corrective actions go into Performance Manager and with the above audit, we are hoping to see that the loop is closed on these. The HIPAA report was presented and Barbara asked what an unauthorized release is. April answered that it is basically a medical record being sent to the wrong destination via fax, email, or in person. Kandi asked if employees can self-report. April answered that absolutely they can and that we encourage this. She added that Medical Records are amazing at doing this and that by the time they reach the compliance side, it is usually already taken care of.
b. Exclusionary Report. The exclusionary report for February, March and April was presented. Suzan briefly explained that this report comes from the OIG, and she has never seen one of our providers on this list. She added that this is the list that would exclude a provider from billing Medicare/Medicaid, and we would not want to have a provider on the list.

Additional Discussion

Suzan asked for additional discussion and this board would like a plan of action based on the recommendations given in the audits. Suzan stated that she will get the list of the five "to-dos" with a plan of action to the board. She continued that we should maybe look at Performance Manager and what it can and can't do and loop that into the HIPAA and Performance Manager audit. Suzan also added that the employee evaluations could be included in this audit as well. Kandi stated that these audits were a deep dive and provided lots of good information. Suzan stated that the next meeting is scheduled for July 28th and that won't work for her. After discussion it was decided that the next meeting will be August 4th.

Next Meeting

The next meeting is scheduled for August 4th, 2025 @ 09:00am.

Adjournment

The meeting adjourned at 9:48am

Respectfully Submitted,

April Prado, Recording Secretary

Governance Committee Minutes
May 19, 2025
1:30 p.m.

Attendance: Marty Kelsey, Chair; Kandi Pendleton, Member; Irene Richardson, Member; Geoff Phillips, Board Attorney/Guest

Mr. Kelsey called the meeting to order at 1:30 p.m.

Moved by Kandi and seconded by Irene to approve the changes to the Plan of Care and Scope of Services policy as drafted by Geoff and as discussed at the April meeting of the Board. Motion approved.

Regarding Board Education, the Committee decided to include on the June agenda a discussion of the Walk-in Clinic. For July, the Committee decided to have education on CAH policies. Geoff and staff will work on a presentation for this meeting. For the August and September meetings, the Committee decided to recommend the following Veralon trainings: August…"The Rural Health Landscape"; September…"The Rural Health Landscape-Advocacy" Future Board Education topics discussed include MHSC Imaging and Scheduling and Referrals topics.

Board Officers for 2025-26 were discussed. The Committee recommends the following set of officers:

Board President	Kandi Pendleton
Board Vice President	Marty Kelsey
Board Treasurer	Craig Rood
Board Secretary	Nena James

Board Officer nominations will be on the agenda for the July meeting of the Board.

Regarding Committee assignments, Kandi will spearhead a discussion.

Dates for the July and September meetings of the Board were discussed. The Committee recommends that the July meeting of the Board be moved to Wednesday, July 9th and that the September meeting of the Board be moved to Thursday, September 11th. Irene will discuss these proposed meeting date changes in her CEO report at the June meeting.

There being no further business to discuss, the meeting adjourned at 1:54 p.m.

To: Board of Trustees
From: Barbara J. Sowada
Re: Quality Committee Meeting
Date: May 21, 2025
The Quality Committee met April 16th from 8:15 to 9:30 am by Zoom.

Major discussion items were as follows:

1. Staff has had not been able to access the Employee Engagement Survey, which was conducted in October, 2024, until recently. Board level reports will be provided to HR and Quality Committees in June.
2. HCAHPS Score for cleanliness of rooms moved into green in March. This is a first. Improving the score is now an inter-department effort. Kudos to the staff.
3. Eight incidences of work place violence for April. One person's injuries were severe enough to require time off.
4. Update on COPIC Conference was provided by Kari Quickenden. Conference was excellent and presented tools and processes hospitals can use to mitigate quality and safety risks.
5. Sepsis Bundle—exceeded the goal for March.

Executive Update – MHSC Board Quality Committee Meeting

PROVIDED BY Stephanie Mlinar, Kari Quickenden, Ann Clevenger, Tami Love, Irene Richardson, Cindy Nelson

REPORTING DATE May 2025 Board Quality Committee Monthly Meeting

General Highlights

- Copic Conference updated provided

Patient Experience Pillar: Reported to PIPS [and last data update] April 8, 2025

Objective/Initiative (Increase by 3% per year)	Dept.	Baseline (CY 2023)	Target Goal	Stretch Goal	CY 2024 Outcome	Planned Updates	Baseline (CY 2024)	Target Goal (2% increase)	Stretch Goal (3% increase)	**CY 2025 YTD**
Care Transition/Care Coordination (HCAHPS)* --CY 2025 is only reflecting Care Coordination. The Care Transition domain has been discontinued.	Inpatient [MS, ICU, OB]	54.41%	57.4%	58%	52.96%	July 2025	MS: 50.17% ICU: 60.18% OB: 57.89% Overall 52.96%	MS: 52.17% ICU: 62.18% OB: 59.89% Overall 54.96%	MS: 53.71% ICU: 63.18% OB: 60.89% Overall 55.96%	MS: 74.29% ICU: 51.28% OB: 91.67% **Overall 70.38%***
Discharge information (HCAHPS)*		86.25%	89.25%	90%	88.72%		MS: 87.49% ICU: 93.59% OB: 88.46% Overall 88.72%	MS: 89.49% ICU: 95.59% OB: 90.46% Overall 90.72%	MS: 90.49% ICU: 96.59% OB: 91.46% Overall 91.72%	MS: 88.46% ICU: 91.67% OB: 100% **Overall 91.94%***
Hospital Environment: Cleanliness sub measurement		74.54%	77.54%	78%	72.24%		MS: 69.01% ICU: 80.85% OB: 77.78% Overall 72.24%	MS: 71.01% ICU: 82.85% OB: 79.78% Overall 74.24%	MS: 72.01% ICU: 83.25% OB: 80.78% Overall 75.24%	MS: 63.33% ICU: 53.85% OB: 75.00% **Overall 59.52%***
Hospital Environment: Quietness sub measurement		64.02%	67.02%	75%	62.55%		MS: 59.76% ICU: 66.67% OB: 73.08% Overall 62.55%	MS: 61.76% ICU: 68.67% OB: 75.08% Overall 64.55%	MS: 62.76% ICU: 69.67% OB: 76.08% Overall 65.55%	MS: 64.29% ICU: 38.46% OB: 75.00% **Overall 54.55%***

Objective/Initiative (Increase by 3% per year)	Dept.	Baseline (CY 2023)	Target Goal	Stretch Goal	CY 2024 Outcome	Planned Updates	Baseline (CY 2024)	Target Goal (2% increase)	Stretch Goal (3% increase)	**CY 2025 YTD**
Degree to which all staff showed compassion (HCAHPS)* ***Survey data may lag by 49 days per CMS reporting guidelines.		73.31%	76.31%	77%	64.90%	July 2025	MS: 64.7% ICU: 71.43% OB: 74.07% Overall 64.90%	MS: 66.7% ICU: 73.43% OB: 76.07% Overall 66.90%	MS: 67.7% ICU: 74.43% OB: 77.07% Overall 67.90%	MS: 82.76%* ICU: 45.45%* OB: 100%* **Overall: 75.00%**
Degree to which all staff showed compassion (non-HCAHPS areas) * ***Survey data may lag	Surgical Services: Emergency Department: Medical Office Building: 3000 College Hill Clinics	Not evaluated at this level in 2024					Surgical Services: 90.71% Emergency Department: 72% Medical Office Building: 88% 3000 College Hill Clinics: 87.79%	Surgical Services: 92.71% Emergency Department: 74% Medical Office Building: 90% 3000 College Hill Clinics: 89.79%	Surgical Services: 93.71% Emergency Department 76% Medical Office Building: 91% 3000 College Hill Clinics 90.79*	Surgical Services: **98.28%*** Emergency Department: **68.60%*** Medical Office Building: **89.73%** 3000 College Hill Clinics: **89.38%***
Formal leader training program 4 cohorts x 8 (2hr) sessions = 32 sessions	Leadership Team	NA	100%	N/A	91% [29/32] *TJC visit	Exploring additional training opportunities				
Dedication of one Senior Leadership meeting per month for implementation and management of 3-year strategic plan	Senior Leaders	0	In develop-ment	In develop-ment	NA	NA	NA	12	NA	**2**

Accomplishments	Issues	Impact	Action Plan
Care Coordination			Care transitions provides post-discharge phone calls. Preparing to go home checklist provided to patients prior to discharge. Using active listening initiative for care coordination purposes as well.
Discharge Information	Case management post-acute instructions did not auto populate into discharge instructions	Creates a gap in discharge information that is available for patients	Staff to contact case management prior to printing of discharge instructions to allow for post-acute instructions to print. OB is giving post-partum hemorrhage and preeclampsia instructions to all patients. Increasing discharge phone call follow ups. Speak up campaigns have been shared with patients. The Patient Educator RN targets seeing 40% of the discharges on MS and ICU set to go home. Pre-built folders are ready for education with patients. Pharmacy provided education regarding "communicating about medication to improve patient safety and experience.
Compassion: OB, MS, ICU (inpatient) and Surgical Services, ED, MOB & 3000 clinics (outpatient) **A hospital-wide compassion initiative rolled out. First and second phase: Active listening.**	Occasionally patients or families are verbally or physically abusive or aggressive toward staff. Outpatient settings are more difficult to observe providers interacting with patients and demonstrating active listening.		Scores reviewed with staff for inpatient units. Education provided to staff on what active listening looks like. Ongoing reinforcement of compassion driven patient care, active listening, and timely initiation of patient requests. TeamSTEPPS is used in Surgical Services with crucial conversations if necessary. The Emergency Department is seeing increases in overall top box scores compared to last year. Staff put themselves in the patient's position and use closed-loop communication.

Accomplishments	Issues	Impact	Action Plan
Hospital Environment – Cleanliness:			Updating EVS cards with language of who to ask on the care team for certain cleanliness topics. Inpatient rooms being cleaned twice per day with few exceptions. Toilets will be labeled as sanitized in occupied rooms as well as after patients are discharged. Scheduling additional education for communication regarding cleanliness with patients and visitors. OB has daily C.N.A. checklists for cleanliness. Standing agenda items for cleanliness at staff meetings on MS and ICU.
Hospital Environment – Quietness:			Maintenance repaired loud closing doors. Sleep masks and ear plugs were purchased for patients. Discussed keeping conversations outside of rooms quiet. Signage posted that promotes a quiet hospital environment
Formal leader training:	None identified		Exploring additional Peak Leadership Training Person Centered Care culture leadership training for new leaders Proposing Just Culture training for leaders
Dedication of one **Senior Leader meeting** per month for Strategic Plan	None identified		This is ongoing.
Translation Services PIPS: Evaluating and designing a plan to provide translated signs in Spanish for the hospital, MOB, and 3000 Clinics	Cost prohibitive for FY 2026. Life Safety Codes may limit what can and cannot be hung.	Increase the length of time to project completion.	Follow up with: U of U, Foundation Director, work on wayfinding maps and exploring the cost of a "you are here" sign like in malls or airports.
Grievance PIPS: Completion of actions for investigations and follow up on complaints/grievances	The timing of receipt of a complaint to the next Grievance Committee	May not reach 100% based on timing.	Continue to send information at times that directors are more readily available. Consider looking at metrics for a cut-off time prior to grievance committee having all actions completed.
Improving Phone and Email accuracy PIPS Patient Access for clinics and hospital settings	Some phone numbers and email addresses do not pull to the Patient Experience Survey Vendor Press Ganey	Should MHSC desire to move to an electronic form of surveys, not having phone numbers and emails pull correctly can limit who receives surveys.	The group is reconvening to discuss how information is collected, where it is entered in Cerner the hospital and clinic's electronic health record. Accurate phone numbers and emails also allow patients to access the patient portal to view their medical record and some testing results.

Employee Experience Pillar: Reported to PIPS [and last data update] April 8, 2025

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Target Goal (10%)	Stretch Goal (15%)	**CY 2025 YTD**
Reduce staff turnover by 10% per year, using the current turnover rate.	CY 2023: 21% National Average 2023: 22.7%	10% reduction 18.9%	18%	18%	January 2025	16.2%	15.3%	**17%** (end of Feb)
Improve our employee engagement scores by 3% per year.	Baseline data collected October 2024	NA	NA	3.91	This is our baseline, the next survey in 2026			
Hire a consultant to evaluate and review salaries at a minimum of every three years.	Consultant hired and review completed	NA	NA	Completed	Budgeting for FY 26 review			
Comprehensive program for directors to develop relationships, etc.	NA	100%	NA	91% [29/32] *TJC visit 100% Jan 2025	Exploring additional training opportunities			
Develop plans for success sharing bonuses for employees if goals are reached.	NA	1 sharing bonus	NA	1 sharing bonus 6/2024	June 2025			

Accomplishments	Issues	Impact	Action Plan
Reduce Staff turnover by 10% per year, using the current turnover rate. Additional goal to remain under national staff turnover rate (YTD 22.7%)	None identified		The plan continues to be documented in the tracking system. Cross-trained staff list available and being used for retention. Over 40 nursing staff are cross-trained and competent to provide care in additional units. Recruitment and retention are complex. Individual employees may need to change jobs because of family-related needs. We will continue to do the ER nurse residency and NEMO courses. HR includes stay and exit interviews. They celebrate Employee Appreciation Day, Hospital Week, Bravos, and host a lifestyle page for the website.
Employee Engagement Survey	The goal lists that it will improve by 3% per year. This survey is conducted every 2 years.	A new survey vendor was used for the Employee Engagement Survey. Calculating a percentage increase may prove difficult because a baseline is different between the vendors.	The Employee Engagement survey was completed in October 2024. HR will present overall findings We will be able to look at engagement scores in 2026 if we keep the current schedule and vendor.

Accomplishments	Issues	Impact	Action Plan
Salaries were reviewed with adjustments made at the beginning of FY 2025			Hiring a consultant to review salaries is being budgeted for FY 2026.
Comprehensive program for Directors (also listed under patient experience pillar)			As documented in the Patient Experience Pillar
Success sharing bonus implemented at the end of June 2024			Evaluation of the ability to offer success sharing bonuses will occur in June 2025.
New Hire RN Retention PIPS: Education Department Since June 2024 – 32 new nurses hired and only 2 have separated from the organization giving a 6.25% turnover rate.			We worked with the directors to review the orientation plans, mini residency—nemo, nursing skills day, preceptor training, education opportunities, and cross-training opportunities. Healthy workforce to reduce bullying and bad attitudes. Leadership training. Preceptor pay and travelers to help with staffing and safety. We also offer staff continuing education and other educational opportunities, including specialty classes and U of U training courses. We have also had 19 RNs transfer to other areas, which has provided these nurses with opportunities to learn new skills and explore options at MHSC. Some of these transfers also allow us to build our cross-trained pool. The education dept and the directors have a meeting planned to review and revise any areas of the new hire orientation process/ nemo/ and skills day and have this ready to implement with the new Grads this spring.
Nutrition Services PIPS: Unidine Policy changed to hire certified food handlers or have existing staff become certified			Changing new hire orientation for Unidine to be the same day and occur with MHSC hires.
Person-Centered Care Committee PIPS			Rounding on employees with a goal of visiting with at least 80% of staff monthly.
Medical Staff Services PIPS:			The time to process applications has decreased. We are going to partner with AMA and will utilize their VeriCre platform. VeriCre will interface with our Credentialing Software and will download provider information from the AMA profile. So, when we send out the initial applications, a lot of the information will be pre-populated. We are now sending out on-line applications for reappointments, in addition to the initial applications. We have received positive feedback from the providers who have completed the on-line reappointment applications.
Information Services PIPS: Meeting goal for monthly ticket completion			We hope to bring on a cybersecurity analyst to bring focus and reduce cybersecurity workload. Implement affective AI to reduce workloads while maintaining services and cybersecurity. As technical debt is reduced, and AI is implemented we hope to a more effective workforce, and a slight reduction of workloads.

Quality & Safety Pillar – Reported to PIPS May 13, 2025

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Planned Updates	Target Goal	Stretch Goal	**CY 2025 YTD**
~~*C. Diff*~~	Baseline data: January 2024 – May 2024: 4 cases	No more than 1 case from 4/1/24 to 3/31/2025	No cases from 4/1/24 to 3/31/2025	0	PIPS closed	0	0	**0**
SEP-1 Bundle Compliance	Calendar year January-May 2024: 72.58%	70% compliance by 6/30/2025	75% compliance by 6/30/2025	75.31%	August 2025	78% By 6/30/2025	83% By 6/30/2025	66.67% CY **76.98% FY25 YTD**
~~OP23- Stroke measure: 70% compliance by end of CY 2024, stretch goal 80% (re-evaluate in Jan '25)~~	Per July 2024 Hospital Compare Report: 67%	70% compliance by end of CY 2024	80% compliance by end of CY 2024	90.91%	PIPS closed	95% By 6/2025	100% By 6/2025	**100% CY & FY 25 YTD**
~~Create process improvement position that will require Lean training and be responsible for leading improvement efforts~~	Position does not currently exist	1 FTE	NA	Not budgeted for FY 2025	PIPS closed	Interview and hire by June '25	Interview and hire by May 2025	**Employee in position and on orientation**
~~Create patient and staff education~~	No nurse educator Using Symplr for staff	1 RN Educator Reintroducing Brown Bags, Prosper Training	NA	Met Met	PIPS Closed	Continuing with current plan and goals		
100% of clinical staff will complete TeamSTEPPS training by the end of three years (CY 2027)	0%	66%	75%	79%	August 2025	85% of clinical by 6/25	90% Clinical by 6/25	**83%**
In-house legal counsel will provide a "risk management minute" quarterly each year and provide a recording for all staff	0%	8	10	8	NA	12	12	**Meeting goal**
~~Develop methods that will allow Synergi to categorize reports and create the ability to track and trend data~~	HIPAA specific cases Using process improvement modules	10% PIPS in Synergi	25%	82.1%	PIPS Closed	Add data stratification for Health equity. 100% of PIPS in Synergi		**100% of PIPS in Synergi**
Utilize Health Equity Plan to promote the highest quality outcomes and safest care for all people	No disparities identified based on stratification of demographics	1 disparity	NA	0 found	February 2025	Meet attestation for Age-Friendly Care 5 Domains		**0**

Accomplishments	Issues	Impact	Action Plan
~~C. Diff:~~ ~~BioFire testing is available with reflex testing.~~	None identified	Interdisciplinary review resulted in improved process.	Continued monitoring. This PIPS project will be closed and monitored in the background for any fluctuations.
Sep-1 Bundle Compliance:	Continuing to work through identified process barriers /challenges		Continue weekly OFIs with timely feedback to team members. We anticipate that we may meet our FY 25 goal of 78%. Data has been complied by ED, Inpatient and Hospital Overall. Overall data reported above.
~~OP 23 – Stroke Measure:~~	None identified		Continued monitoring. This PIPS project will be closed and monitored in the background for any fluctuations.
~~Process Improvement position~~			Position is filled, employee is on orientation. Budget planned for education as needed. PIPS project closed and will be monitored in the background.
~~Create Staff and Patient Education:~~	None identified		Existing Staff and Patient Education programs continue to be enhanced. Opportunities are identified and offered. This PIPS project will be closed and monitored in the background for any fluctuations.
Initiative regarding TeamSTEPPS. Attendance Tracking is in place and the activities are open to clinical and non-clinical staff.	None identified	Improve inter-and intradepartmental communication	Three sessions for each of the three levels are available for staff to sign up each month. Monthly report sent to leadership with updates on compliance. Milestone goal for June 2025 – 85% completion rate for clinical staff. On-target to meet the goal.
Risk management minutes are being presented at medical staff meetings.	None identified	Provide education for staff, including employed medical staff	In-house legal counsel continues to bring risk management minutes to medical staff meetings.
~~Synergi report categorization with further development for HIPAA, grievance/complaint, and process improvements~~	None identified	Further categorization increases tracking and trending capabilities	The Patient Safety Organization (PSO) contract executed, will begin project build within the next two to three months.
Health Equity: AHA HETA assessment completed. Tailored MHSC's HE plans and charter to match resources and strategic goals.	None identified		Align the age-friendly structural measures with health equity efforts.

Community, Services and Growth Pillar - Last Updated March 14, 2025

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Planned Update	Target Goal	Stretch Goal	**CY 2025 YTD**
Improve and establish outreach to community and outlying areas/ Increase number of community presentations	Baseline data unavailable, goals are being set by each team.				June 2025			
Community education		7 presentations	8 Presentations	7 presentations		Add 6 presentations	Add 8 presentations	**6 total presentations**
Diabetes Education		Training	Whole Process	On target		Manage referrals		**13/15 scheduled**
Care for the caregiver		Resources for caregiver	Whole Process	On target		Increase community Contact	Have 211 Ambassador	**Meeting goal**
Mental health		Secure mental health services	Whole process	On target		Prosper training for MHSC staff	Increasing access to Qler telehealth	**Meeting goal**
Improve from a Google 2-star Rating to a Google 3-star rating by the end of three years	2.3	3	4	4.1	NA	4	4.5	**4.2**
Utilize master plan to identify areas where we can provide outreach to outlying areas	In development	---	---	---	Remains in development	Community Needs Assessment		**Not completed**
Develop a strategic communication/marketing plan.	10 testimonial	28	30	39	June 2025			**Adding meet the team profiles**

Accomplishments	Issues	Impact	Action Plan
Community Education goal is to have a total of 7 presentations in 2024 Goal met	Scheduling can sometimes be difficult. Some departments are not as comfortable with public speaking.	None identified at this time	Young at Heart Lunch & Learn-Jan. 28 Rock Springs Chamber of Commerce-Feb. 13 Rock Springs Health Academy- Feb. 13 Currently have planned presentations: School District #1 Retired Teachers-March 3 Rock Springs Health Academy-March 5 Young at Heart Lunch & Learn- April 22
Radiation Oncology is working with in-house translators to provide Spanish documents in the education binder for new patients.	Documents from outside entities are not in Spanish	None identified at this time	Monthly radio spots with KREO
Diabetes Education: Diabetic Self-Management Education (DSME) site change from Public Health to MHSC. There were five referrals in the first week upon the transition from Public Health to MHSC.	None identified at this time	RN patient educator performs the nurse visit, and the Director of Education is the DSME Quality Coordinator. Medical Nutrition Therapy (MNT) continues through MHSC Dieticians. Potential impact to increase appointments as the RN patient educator meets with patients while hospitalized.	Contract renewed. Referrals are being scheduled.

Accomplishments	Issues	Impact	Action Plan
Care for the Caregiver: Care for the Caregiver team members will attend/participate/present at 2 public events to meet the community members we serve, network with other service providers, and build relationships in our community in 2024. Goal exceeded for CY 2024 with 3 events attended.	None identified	None identified	2025: Care for the Caregiver team members will attend/ participate/ present at 4 public events MHSC will have an employee train and be the SWC 211 Ambassador. Caregivers need to know the services and providers available to them in our county and state. The employees of MHSC are the largest group of caregivers in our county and planning is in place for providing support.
Mental Health:			8 hours of telehealth offered for outpatients on Wednesdays. Feedback is positive and patients are returning for further visits.
Improve Google Star Rating Meeting and exceeding the goal	None identified		
Utilize Master Plan: no update at this time, planning in progress			Senior leaders will meet to discuss priorities.
Marketing plan is focusing on nutrition and sharing our successes, on target to meet goal	None identified		
Chronic Care Management is working toward increasing Medicare annual wellness visits. Goal is exceeded as of 12/4/2024.	None identified		

Financial Stewardship Pillar - Last Updated March 14, 2025

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Planned Update	Target Goal	Stretch Goal	**CY 2025 YTD**
Improve Days of Cash on Hand by 10% each year for three years	1/1/24 = 110.9	FY25 = 119	125	110 days	No change, inline to meet FY goal	FY26 = 131, FY27 = 144		**102**
Reduce and maintain Days in A/R to 45 days by the end of 2024	CY 24 Jan-Jul Average 63 days	54 days	45 by 12/31/27	75 *estimated With Medicare claims removed from A/R, the estimated 58 days	Change target goal to 54 days by FY25	54 days by 6/30/25		**81.29**
Maintain the level of claims denials at state and national benchmarks	CY 24 Apr-June 24.7%	(target goal <15% by end of FY 2025)	<12% by end of FY25	14%	Goal may be reevaluated once clear reporting is available	Less than 15% by June 30, 2024	(7%)	**11%**
Reduce and maintain Days Not Final Billed (DNFB)	CY 24 Jan-Aug Average 10.1 days	5 days	< 5 days by end of FY25	31.7 (with Medicare claims removed from DNFB, the number is estimated at 4.79 days)	Due to CAH conversion, held Medicare claims have overstated this ratio. Once claims are billed, we should be on track to meet goal.	On hold until letter received from Noridian		**32** **With Medicare claims removed 5.6 days**
Build the MHSC County Maintenance Fund to $2,000,000 by the end of three years / Work with the County Commissioners to set annual budget to achieve $2,000,000 goal over three-year strategic plan and still allow for adequate funds in annual budget for routine maintenance	7/1/2024 $500,000 rolled over	$2,000,000 by the end of three years	Intermediate goal - $1 million by 06/30/25	Funds cannot be rolled over until the end of the fiscal year.	Pending property tax legislation			
Build and maintain the building fund to the amount of depreciation expense by the end of three years / Supplement the building fund from monthly, quarterly, or annual contributions from cash flow from operations to achieve the total amount of depreciation expense by the end of three-year strategic plan	6/30/2024 $7,000,000	amount of depreciation expense by the end of three years	Intermediate goal - $8 million by 06/30/25. $9 M by 6/30/26. $10 M by 06/30/27 and 12/31/27. Stretch - $12M by 12/31/27	$7,447,000 as of 12/31/24	No change	Intermediate goal - $8 million by 06/30/25. $9 M by 6/30/26. $10 M by 06/30/27 and 12/31/27.	Stretch - $12M by 12/31/27	**$7.4 million**

Objective/Initiative	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Goal Re-evaluation planned	Target Goal	Stretch Goal	**CY 2025 YTD**
Decrease the number of Nursing and Respiratory Therapy travel staff by 30%, per year for three years Nursing leadership will work with Human Resources to recruit and retain permanent staff and reduce travel staff by 30% per year	CY 2023 RT/RN staff 17 total	RT/RN Staff 11.9 total	RT/RN Staff 11 total	21 total 1 RT and 20 RN	January 2025	RT/RN staff 11 total	RT/RN Staff 9 total	**16 total 1 RT and 15 RN**
Additional goal contract staff expenditure total less in total for CY 2024 compared to CY2023	CY 2023 Jan- Dec $4,233,263.17	NA	NA	CY 2024 (Jan-Nov) *Dec financials not ready $3,795,535.48	January 2025			

Accomplishments	Issues	Impact	Action Plan
Improve days of cash on hand	Slow release of billing with CAH Medicare Number	Altering the current amount of days of cash on hand	
Reduce and maintain Days in A/R	Slow release of billing with CAH Medicare Number	Altering current number of days in AR	
Maintain the level of claims denials	No identified issues		
Reduce and maintain Days Not Final Billed: DNFB split into HIM and PFS cases	Slow release of billing with CAH Medicare Number	Altering current number of days in AR	
Build the MHSC County Maintenance Fund		Pending property tax legislation may change this initiative	Request for carryover funds will be made in April 2025
Build and maintain the building fund: receipt of QRA funds helped replenish the building fund.	Conversion to Critical Access billing held since Oct. 1		
Decrease the number of Nursing and Respiratory Therapy travel staff**:** Contracted with Linked-In Targeted adds with Indeed Targeted Facebook adds	National staffing shortages. Colleges are not seeing the same level of enrollment or limited capacity for students.	Not having travel staff for Med Surg, this will have 3 RNs for day/night shift and limit bed capacity to 15 patients.	Continue to "grow our own" through scholarships. Cross-training Preceptor incentive NEMO program for new nurses to have mentors
Alignment of individual departmental performance improvement projects (PIPS) has identified two additional areas for financial stewardship.	None identified		Surgical Services – working on endo room turnover times, nearing goal Patient Navigation – working on a self-pay project, meeting goal

Regulatory Readiness – Reported to PIPS May 13, 2025 [data updated]

PIPS Projects	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Planned updates	Target Goal	Stretch Goal	**CY 2025 YTD**
Emergency Management: All Senior Leaders complete FEMA courses for better understanding of Incident Command Structure	0%	100%	NA	80%		Training for Incident Command Positions		New focus
Environment of Care: Evaluating changes for a tobacco free campus	NA	Completed	NA	Signs ordered		Evaluating new project		Signs for the initial project installed
PICC Team: PICC line data in Synergi 95% success insertion [1 attempt] Decrease catheter readjustment	NA	100% 95% <5%	NA 100% 0%	100% 89% 4.6%		95% successful placement	100%	90%
Trauma Improve hourly GCS charting. Improve hourly VS charting. Improve EMS scene time <20"	38% 54% 78%	65% 75% 85%	75% 85% 90%	44% 75% 82%	August 2025	65% 75% 85%	75% 85% 90%	52% 77% 88%
Physician Recruitment: Completed contracts	0	67%	75%	67%		7 of 7	Na	7/14 left for 2025
Blood Utilization: Consent completed. Order to administer. Transfusion indication	97% 95% 100%	100% 100% 100%	NA NA NA	99% 99% 99%				
Code Blue Committee: 75% of Code Blue and Rapid Responses documented in Synergi	In development	-----	------	-------		75%	85%	75%
Cardiopulmonary: Ventilator Orders completed	69%	>90%	100%	93%		>90%	100%	89.7%
Sleep Lab: decrease turn around read times to 72-hours	50%	100%	NA	100%		100%	NA	0% Q1 2025
Dietitians: reconciling dietary orders	------	------	------	------		Diets are being adjusted, new project in development		Will continue project, not as PIPS
~~MS/ICU Critical Values~~	MS – 98% ICU – 97%	95%	100%	MS – 88% ICU – 94%	PIPS closed	95%	100%	MS – 94% ICU – 94%
BCMA	MS – 93% ICU – 93%	95%	98%	MS – 96.63% ICU – 93.1%	August 2025 ICU only	95%	98%	MS 97.68% ICU 93.18%
Falls: reduce and maintain fall rate to less than 2.5 per 1000 acute care patient days	CY 2023 5.33 / 1000 patient days	Less than 2.5 / 1000 patient days	Less than 1.5 / 1000 patient days	1.21 / 1000 patient days	August 2025	Less than 2.5/1000 patient days	Less than 1.5 / 1000 patient days	3.27/1000 patient days
OB: unexpected complications of newborn/1000 live births	Severe and Moderate in overall total Overall: 58.51	Overall: 29.4 Severe: 12.8 Moderate: 18.1	Overall: 25 Severe: 12 Moderate: 17	Overall: 51.63 Severe: 29.89 Moderate: 21.79		Overall 31.9 Severe 12.9 Moderate 19	Overall 25 Severe 12 Mod. 17	Overall 75.9 Severe 41.6 Moderate 41.6

PIPS Projects	Baseline	Target Goal	Stretch Goal	CY 2024 Outcome	Planned updates	Target Goal	Stretch Goal	CY 2025 YTD
3000 College Drive: Sample medications process	Undefined process	All meds checked in and checked out	NA	Process developed		All meds checked in and out	NA	One RN designated. Providers still ordering their own sample medications.
OB: Severe Hypertension in Pregnancy and Postpartum	100%	100%	NA	100%		100%	NA	0%
Dialysis: Central Venous Catheters 10-15% Increase AV Fistulas to 85-90%	93.15%	90%	95%	92%		Project change, update in August		NA
Opioid Safety: a) Hospitalized patients are not started on a long-acting opioid who are not already on them at home. b) Antidotes are used to reverse effects of opioids c) Pain management monitoring per TJC requirements	------	------	-----	-----	August 2025	a) 75-95% not started on long-acting opioids b) Less than 5% patient usage has antidote used c) Monitoring pain management per TJC	100% not started 0% antidote used 90% compliance with plan	a) 100% b) Less than 5% c) In progress
Behavioral Health: Documentation Completion	5/13/2025: 0%	------	------	------		50%	55%	0%
Utilization Management: Monitoring Avoidable Hospital Days	-----	------	------	------		Minimal avoidable days	NA	69 for Q1
Antimicrobial Stewardship: Reduce daptomycin utilization	2024: 20 days of therapy	------	-----	------		Less than 5	0	0 Days of Therapy Q1 2025

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
FINANCE & AUDIT COMMITTEE AGENDA

Wednesday~ May 27, 2025 2:00 p.m. Teleconference

Voting Members:
Marty Kelsey, Trustee Chair
Craig Rood, Trustee
Irene Richardson
Tami Love
Jan Layne

Non-Voting Members:
Ron Cheese
Angel Bennett
Ann Clevenger
Cindy Nelson
Terry Thompson
Kari Quickenden
Dr. Augusto Jamias
Dr. David Dansie

Guests:
Carrie Canestorp
Darryn McGavey, CLA
Troy Hunsucker, Wyoming CLASS
Erika Taylor
Taylor Jones, Commissioner

I.	Call Meeting to Order	Marty Kelsey
II.	Mission Moment	
III.	Approve Agenda	Marty Kelsey
IV.	Approve minutes from April 30, 2025	Marty Kelsey
V.	Wyoming CLASS – investment presentation	Troy Hunsucker
VI.	CAH Medicare cost scenarios	Darryn McGarvey
VII.	Capital Requests FY25	Marty Kelsey
VIII.	Financial Report	
	A. Monthly Financial Statements & Statistical Data	
	1. Narrative	Tami Love
	2. Financial Information	Tami Love
	3. Strategic Plan - Financial Goals	Tami Love
	4. Self-Pay Report	Ron Cheese
	5. Preliminary Bad Debt	Ron Cheese
IX.	Old Business	
	A. Critical Access update	Tami Love
	B. CLA Project – progress updates	Ron Cheese
	C. Outsourcing aging AR	Ron Cheese
X.	New Business	
	A. Financial Forum Discussion	Marty Kelsey
	B. FY26 Preliminary Budget	Tami Love

XI.	Next Meeting – June 25, 2025	Tami Love
XII.	Adjournment	Marty Kelsey

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
Finance & Audit Committee Meeting
May 28, 2025

Voting Members Present:	Mr. Marty Kelsey, *Trustee – Chairman* Ms. Craig Rood, *Trustee* Ms. Irene Richardson, *CEO* Ms. Tami Love, *CFO* Ms. Jan Layne, *Controller*
Voting Members Absent:	
Non-Voting Members Present:	Mr. Ron Cheese, *Director of Patient Financial Services* Dr. David Dansie, *Medical Staff* Dr. Ann Marie Clevenger, *CNO* Ms. Angel Bennett, *Director of Materials* Ms. Cindy Nelson, *CXO*
Non-Voting Members Absent:	Dr. Kari Quickenden, *CCO* Mr. Terry Thompson, *Director of IT* Dr. Augusto Jamias, *Medical Staff*
Guests:	Ms. Carrie Canestorp, *Director of HIM* Mr. Taylor Jones, *County Commissioner* Ms. Erika Taylor, *Senior Accountant* Mr. Darryn McGarvey, *CLA* Ms. Kristin Baquero, *CLA*

Call Meeting to Order

Mr. Kelsey called the meeting to order via teleconference at 2:00 PM.

Mission Moment

Ms. Richardson shared a mission moment involving one of our patient greeters that is retiring. We have received so many positive comments from patients on him. He truly embraced and lived our mission, vision and values.

Agenda

The investment presentation from Wyoming Class was removed from the agenda and will be placed on the agenda in June. A motion to approve the agenda was made by Mr. Rood; second by Ms. Richardson.

Approve Meeting Minutes

A motion to approve the meeting minutes from April 30, 2025, was made by Mr. Rood; second by Ms. Richardson. Motion carried.

CAH Medicare Cost Scenarios

Mr. McGarvey and Ms. Baquero presented information on how our reimbursement changes with CAH. They provided a scenario analysis by department on how additional costs affect our reimbursement from Medicare. CLA provided us a tool to estimate monthly how much is owed to or from Medicare. This amount can swing significantly under critical access.

Capital Requests FY25

There were not any capital requests for the committee to approve this month.

Financial Report

Ms. Love reviewed the narrative highlights and the financial goals. She reviewed the impact of receiving the backlog of Medicare claim payments in April. This brought down our reduction of revenue to around 41%. The reduction of revenue also decreased due to a receivable entry booked based on the cost report estimate. The AR decreased significantly by $16.2 million. We saw increases in commercial and self-pay balances as the Medicare claims moved over to secondary payors. Days of cash on hand increased by around 20 days. Collections came in at a high of $17.3 million. We are expecting to see higher collections again in May. Mr. Rood asked if we are up to date now on Medicare. Ms. Love explained how most of the old Medicare we still have on the books is Medicare Advantage. We have over $10 million in our AR for Medicare Advantage. They are struggling with getting us set-up as CAH. Commissioner Jones asked if we could figure out how many of our births are from out to town and get those numbers to him. Mr. Cheese provided updates on the self-pay report and presented the preliminary bad debt.

Old Business

Critical Access Update

Ms. Love said that our provisional license expires at the end of June. If the state does not survey us by then we will get another provisional license. We are also ready to go live with our Method II billing for critical access in July.

CLA Project – Financial goals

Mr. Cheese provided an update on the project goals. The report is included in the packet.

Outsourcing Aging A/R

Mr. Cheese provided an update. He said we are terminating this contract on June 30, 2025.

New Business

FY26 Preliminary Budget

Ms. Love reviewed some of the larger changes to this year's preliminary budget. She said that the budget template is out on the portal for the Board to review. The board will review the preliminary budget and email any questions. Ms. Love will email the board members for availability to have a Budget Workshop in early June. A special board meeting will need to be scheduled in June to approve the budget.

Next Meeting

The next meeting is scheduled for Wednesday, June 25 at 2:00 PM.

Meeting adjourned at 3:25 PM.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

NARRATIVE TO APRIL 2025 FINANCIAL STATEMENTS

THE BOTTOM LINE. The bottom line from operations for April is a gain of $2,884,638 compared to a gain of $114,295 in the budget. This yields a 20.01% operating margin for the month compared to 1.00% in the budget. The year-to-date operating gain is $4,762,733 compared to a gain of $2,091,156 in the budget. The year-to-date operating margin is 4.10%, compared to 1.82% in the budget.

Year-to-date, the total net gain is $7,681,137, compared to a total net gain of $4,923,266 in the budget. This represents a profit margin of 6.61% compared to 4.29% in the budget.

REVENUE. Revenue increased in April coming in at $24,024,575, over budget by $121,554. Inpatient revenue is $3,542,130 under budget by $1,127,687 and outpatient revenue is $20,482,444, over budget by $1,249,241. Year-to-date, gross revenue is under budget by $1,948,653 and net patient revenue is over budget by $1,596,096. The largest percentage variances for revenue to budget comparison came from the following hospital departments:

Nuclear Medicine – 56%
Radiation Oncology – 25%
Medical Oncology – 31%
Histology – 32%
Surgical Services – 21%
Dietitians – 305%

ICU – (23%)
Behavioral Health – (45%)
Physical Therapy – (36%)
Cardiac Rehab – (67%)
OB & Nursery – (17%)

REDUCTION OF REVENUE. Deductions from revenue are estimated at 41.3%, significantly under budget for the month. The year-to-date reduction of revenue is 51.8%, also under budget. The decrease in reductions is due to the Medicare claims being processed, back to October. We are seeing increased reimbursement on our CAH Medicare accounts dated after December 6. These claims are being paid at the new cost to charge ratio and inpatient per diems. We have also used the CAH cost report template to review the expected settlement as of April, and we posted this receivable which also impacted reductions. At the end of March, Medicare accounts receivable (AR) were over $39 million and decreased significantly in April. Total AR decreased by $16.2 million as Medicare claims processed. Increases in BCBS, Commercial and Self-pay are directly related to Medicare payments and balances moved to supplement or secondary payors. Changes by payer are below:

Medicare – decrease $17,840,000
Medicaid – decrease $1,206,000
Blue Cross – increase $1,145,000
Commercial – increase $1,550,000

Government – increase $63,000
Self-Pay – increase $1,010,000
Worker's Comp – decrease $43,000

Total collections for the month came in much higher, at $17.3 million, 144% of net patient revenue, above the monthly goal. Year-to-date collections increased to 93.8% of net patient revenue. The goal for collections as a percentage of net revenue is ≥ 100%.

NET OPERATING REVENUE. Total net operating revenue is $14,419,005 in April and $116,241,955 year-to-date, over budget by $1,603,898. Other operating revenue in April includes Foundation, occupational medicine revenue and cafeteria revenue.

RATIOS. Annual Debt Service Coverage is 7.24 for April. Days of Cash on Hand increased by twenty days to 114 days for April. Daily cash expense decreased slightly to $337,900 year-to-date. Net days in AR decreased to 56.59 days.

VOLUME. Inpatient discharges and patient days were under budget for April and births were over budget. The average daily census (ADC) decreased to 11.3, under the budget for the month, and average length of stay (LOS) remained at 2.9, under budget. Clinic visits and Surgeries came in over budget, ER visits and Outpatient visits were under budget.

EXPENSES. Total expenses came in close to budget, at $11,534,367, over budget by $225,661. Expenses remain under budget for the year by $1,067,679. The following line items were over budget in April:

Salaries & Wages – Salaries were over budget in April but remain under budget year-to-date. Paid FTEs are right at budget in April and under budget by 20.51 year-to-date.

Contract Labor - Contract labor for Surgical Services and Ultrasound are over budget in April. There is unbudgeted contract labor cost in Med/Surg, Laboratory, Respiratory, and Physical Therapy as we continue to recruit permanent staff.

Physician Fees – Hospitalist locum fees and Medical Oncology, Telepsych, and Sleep Lab physician fees were over budget for April.

Other Purchased Services – Sponsorships, legal fees, bank card fees, collection agency, and department management services were all over budget for the month.

Supplies – Line items over budget in April include radioactive material, blood, implants, medical supplies, contrast, minor equipment, food, and maintenance supplies. The majority of these are directly related to higher volumes.

Leases and Rentals – Equipment leases were over budget due to the extension of the surgery Mako lease contract, with the plan to purchase before year end.

PROVIDER CLINICS. Revenue for the Clinics increased in April, coming in at $3,143,338, over budget by $198,425 for the month and remaining over budget year-to-date by $310,931. Clinic volumes increased from March to 7,413 visits. Total Clinic expenses for April are $2,381,240, over budget by $177,237 for the month and over budget by $91,355 year-to-date. Salaries, benefits, physician fees, professional liability, and depreciation are over budget for April.

OUTLOOK FOR MAY. Gross patient revenue is projected higher in April at $24.5 million, over the budget of $23.9 million. Births are expected to be over budget for the month with patient days and admits coming in under budget. LOS is currently lower at 2.3 days and the average daily census decreased to 9.6 patients. Outpatient visits, including ER visits, and Clinic visits are all projected under budget for the month, with Surgeries projecting higher than budget.

Collections are projecting high again in April, around $14 million as we continue to see Medicare payments coming in at the higher CAH rate. Medicare AR has decreased by another $1 million through mid-May. We expect to see lower reductions of revenue again as Medicare accounts receivable decreases and we start collecting at the higher rates. Expenses are expected to come in at budget in May. With the higher revenue and collections in May, the estimated bottom line for May should be another gain for the month.

CRITICAL ACCESS. More than $19 million in Medicare claims were processed in April, with total collections coming in over $17 million. Claims have been reviewed and we are receiving the higher rate of reimbursement, based off our cost-to-charge ratio calculated by CMS. We have now seen a delay in United Healthcare Medicare Advantage claims as they have not been able to update their system with our new CAH information. We continue to test the Method II billing build in Cerner which will mean higher reimbursement on professional claims from our Clinics. It was required to bill under Method I with the initial conversion to CAH. We saw the positive impact to both Days in AR and Days Cash on Hand in April. We are still waiting for the State survey.

Strategic Plan - Finance Pillar. The objectives of the finance pillar of the new Strategic Plan were created around the Clifton Larsen Allen revenue cycle paired advisory support project. We will continue to track the issues from CLA project and share with the Committee. The Strategic Plan objectives are also tracked on the Financial Goal graphs included in the Finance packet and on stoplight reports which report through the Quality Committee.

For fiscal year 2025, we continue to focus on the following revenue cycle metrics:

- Days Cash on Hand
- DNFB Days – Discharged Not Final Billed Days
- Total Days in AR
- Denials
- Accounts Receivable aging – Total and By Payer
- Cash Collections

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY

Unaudited Financial Statements

for

Ten months ending April 30, 2025

Certification Statement:

To the best of my knowledge, I certify for the hospital that the attached financial statements do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respects the financial condition and results of operation of the hospital and all related organizations reported herein.

Certified by:

Tami Love

Chief Financial Officer

TABLE OF CONTENTS

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

EXECUTIVE FINANCIAL SUMMARY

Ten months ending April 30, 2025

BALANCE SHEET

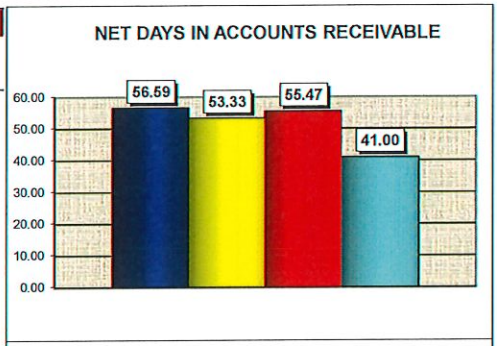
	YTD 4/30/2025	Prior FYE 6/30/2024
ASSETS		
Current Assets	$49,974,350	$43,911,479
Assets Whose Use is Limited	24,142,399	23,098,589
Property, Plant & Equipment (Net)	72,339,501	74,279,500
Other Assets	838,189	898,060
Total Unrestricted Assets	**147,294,440**	**142,187,628**
Restricted Assets	575,150	474,171
Total Assets	**$147,869,590**	**$142,661,800**
LIABILITIES AND NET ASSETS		
Current Liabilities	$15,482,352	$16,058,606
Long-Term Debt	22,149,170	23,506,667
Other Long-Term Liabilities	9,897,986	10,833,425
Total Liabilities	**47,529,508**	**50,398,698**
Net Assets	100,340,082	92,263,102
Total Liabilities and Net Assets	**$147,869,590**	**$142,661,800**

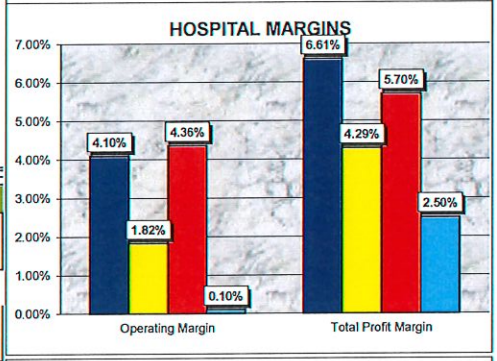
STATEMENT OF REVENUE AND EXPENSES - YTD

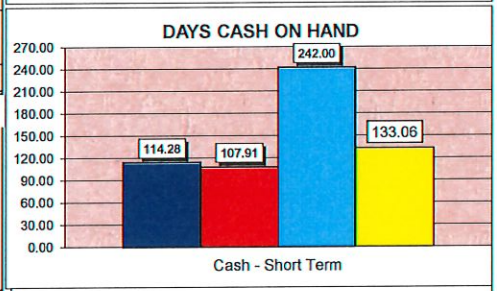
	04/30/25 ACTUAL	*04/30/25 BUDGET*	*YTD ACTUAL*	*YTD BUDGET*
Revenue:				
Gross Patient Revenues	$24,024,575	$23,903,021	$237,663,339	$239,611,992
Deductions From Revenue	(9,912,498)	(12,678,264)	(123,001,472)	(126,989,756)
Net Patient Revenues	14,112,077	11,224,757	114,661,867	112,622,236
Other Operating Revenue	306,929	198,244	1,580,088	2,015,821
Total Operating Revenues	**14,419,005**	**11,423,001**	**116,241,955**	**114,638,057**
Expenses:				
Salaries, Benefits & Contract Labor	6,413,275	6,331,322	62,433,879	62,775,782
Purchased Serv. & Physician Fees	1,220,004	1,049,152	11,887,710	10,996,694
Supply and Drug Expenses	1,979,254	1,947,295	18,812,234	19,582,010
Other Operating Expenses	1,051,848	1,100,574	9,470,665	10,327,131
Bad Debt Expense	0	0	0	0
Depreciation & Interest Expense	869,987	880,362	8,874,733	8,865,285
Total Expenses	**11,534,367**	**11,308,706**	**111,479,222**	**112,546,901**
NET OPERATING SURPLUS	**2,884,638**	**114,295**	**4,762,733**	**2,091,156**
Non-Operating Revenue/(Exp.)	779,122	54,268	2,918,403	2,832,110
TOTAL NET SURPLUS	**$3,663,760**	**$168,563**	**$7,681,137**	**$4,923,266**

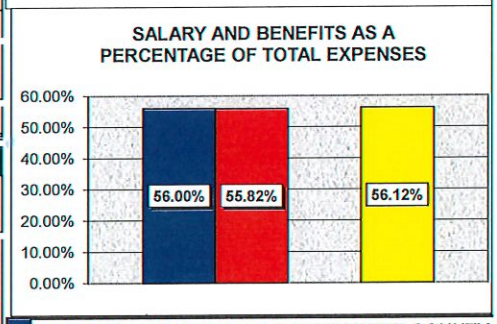
KEY STATISTICS AND RATIOS

	04/30/25 ACTUAL	*04/30/25 BUDGET*	*YTD ACTUAL*	*YTD BUDGET*
Total Acute Patient Days	339	393	3,763	4,203
Average Acute Length of Stay	2.9	3.1	3.1	3.1
Total Emergency Room Visits	1,310	1,329	14,032	13,453
Outpatient Visits	8,546	8,674	84,964	83,356
Total Surgeries	220	196	2,021	1,821
Total Worked FTE's	522.00	521.15	500.64	521.15
Total Paid FTE's	560.33	571.09	549.79	571.09
Net Revenue Change from Prior Yr	30.54%	3.42%	7.60%	6.12%
EBIDA - 12 Month Rolling Average			11.35%	9.56%
Current Ratio			3.23	
Days Expense in Accounts Payable			31.62	









MEMORIAL HOSPITAL OF SWEETWATER COUNTY	
Budget	04/30/25
Prior Fiscal Year End	06/30/24
CLA $50-$100M Net Revenue	6/30/2020

FINANCIAL STRENGTH INDEX - 1.92

Excellent - Greater than 3.0 Good - 3.0 to 0.0
Fair - 0.0 to (2.0) Poor - Less than (2.0)

Key Financial Ratios

MEMORIAL HOSPITAL OF SWEETWATER COUNTY **PAGE 3**
ROCK SPRINGS, WY
Ten months ending April 30, 2025

⇩⇧ - DESIRED POSITION IN RELATION TO BENCHMARKS AND BUDGET

		Year to Date 4/30/2025	Budget 6/30/2025	Prior Fiscal Year End 06/30/24	CLA $50-$100 MM Net Revenue (See Note 1)
Profitability:					
Operating Margin	⇧	4.10%	1.47%	4.36%	0.10%
Total Profit Margin	⇧	6.61%	4.61%	5.70%	2.50%
Liquidity:					
Days Cash, All Sources **	⇧	114.28	133.06	107.91	242.00
Net Days in Accounts Receivable	⇩	56.59	53.33	55.47	41.00
Capital Structure:					
Average Age of Plant (Annualized)	⇩	12.46	11.59	11.61	12.00
Long Term Debt to Capitalization	⇩	18.46%	17.97%	20.74%	27.00%
Debt Service Coverage Ratio **	⇧	7.24	3.60	5.84	2.80
Productivity and Efficiency:					
Paid FTE's per Adjusted Occupied Bed	⇩	7.09	8.14	6.76	NA
Salary Expense per Paid FTE		$106,637	$106,348	$105,036	NA
Salary and Benefits as a % of Total Operating Exp		56.00%	56.12%	55.82%	NA
Employee Benefits %		30.33%	30.75%	30.97%	22.98%
Supply Expense Per Adj. Discharge		$2,500	$2,865	$2,510	$1,270

	YTD - Actual 4/30/2025	Prior FYE 6/30/2024
Other Ratios:		
Gross Days in Accounts Receivable	66.13	64.59
Net Revenue per Adjusted Discharge	$15,448	$14,822
Operating Expenses per Adj. Discharge	$14,815	$14,176

Note 1 - 2020 CLA Benchmark-$50M-$100M net patient service revenue

****Bond Covenant ratio is 65 Days Cash on Hand and 1.0-1.25 Debt Service Coverage**

Balance Sheet - Assets

MEMORIAL HOSPITAL OF SWEETWATER COUNTY **PAGE 4**

ROCK SPRINGS, WY

Ten months ending April 30, 2025

	Current Month 4/30/2025	Prior Month 3/31/2025	ASSETS Positive/ (Negative) Variance	Percentage Variance	Prior Year End 6/30/2024
Current Assets					
Cash and Cash Equivalents	$15,935,762	$9,451,801	$6,483,961	68.60%	$12,428,264
Gross Patient Accounts Receivable	52,139,046	68,369,970	(16,230,924)	-23.74%	50,557,292
Less: Bad Debt and Allowance Reserves	(29,247,991)	(41,416,501)	12,168,510	29.38%	(30,463,009)
Net Patient Accounts Receivable	22,891,055	26,953,470	(4,062,414)	-15.07%	20,094,283
Interest Receivable	0	0	0	0.00%	0
Other Receivables	6,141,337	5,328,524	812,813	15.25%	6,209,096
Inventories	3,150,130	3,123,440	26,690		3,137,536
Prepaid Expenses	1,856,066	1,895,908	(39,842)	-2.10%	2,042,300
Due From Third Party Payers	0	0	0	0.00%	0
Due From Affiliates/Related Organizations	0	0	0	0.00%	0
Other Current Assets	0	0	0	0.00%	0
Total Current Assets	**49,974,350**	**46,753,143**	**3,221,207**	**6.89%**	**43,911,479**
Assets Whose Use is Limited					
Cash	136,121	134,546	1,574	1.17%	(123,123)
Investments	0	0	0	0.00%	0
Bond Reserve/Debt Retirement Fund	0	0	0	0.00%	0
Trustee Held Funds - Project	1,238,198	1,051,019	187,179	17.81%	1,585,606
Trustee Held Funds - SPT	0	0	0	0.00%	0
Board Designated Funds	7,569,462	7,544,581	24,881	0.33%	7,021,234
Other Limited Use Assets	15,198,619	14,614,878	583,741	3.99%	14,614,873
Total Limited Use Assets	**24,142,399**	**23,345,024**	**797,375**	**3.42%**	**23,098,589**
Property, Plant, and Equipment					
Land and Land Improvements	4,725,577	4,583,118	142,459	3.11%	4,583,118
Building and Building Improvements	51,845,600	51,845,600	0	0.00%	51,482,921
Equipment	141,787,739	141,792,252	(4,513)	0.00%	138,741,400
Construction In Progress	4,615,287	4,353,465	261,822	6.01%	1,630,998
Capitalized Interest	0	0	0	0.00%	0
Gross Property, Plant, and Equipment	202,974,203	202,574,435	399,768	0.20%	196,438,437
Less: Accumulated Depreciation	(130,634,701)	(129,764,715)	(869,987)	-0.67%	(122,158,937)
Net Property, Plant, and Equipment	**72,339,501**	**72,809,720**	**(470,219)**	**-0.65%**	**74,279,500**
Other Assets					
Unamortized Loan Costs	838,189	844,176	(5,987)	-0.71%	898,060
Other	0	0	0	0.00%	0
Total Other Assets	**838,189**	**844,176**	**(5,987)**	**-0.71%**	**898,060**
TOTAL UNRESTRICTED ASSETS	**147,294,440**	**143,752,063**	**3,542,376**	**2.46%**	**142,187,628**
Restricted Assets	575,150	561,084	14,067	2.51%	474,171
TOTAL ASSETS	**$147,869,590**	**$144,313,147**	**$3,556,443**	**2.46%**	**$142,661,800**

Balance Sheet - Liabilities and Net Assets

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY
Ten months ending April 30, 2025

	LIABILITIES AND FUND BALANCE				
	Current Month 4/30/2025	Prior Month 3/31/2025	Positive/ (Negative) Variance	Percentage Variance	Prior Year End 6/30/2024
Current Liabilities					
Accounts Payable	$6,127,158	$6,597,635	$470,478	7.13%	$5,686,582
Notes and Loans Payable	0	0	0	0.00%	0
Accrued Payroll	2,014,752	1,858,147	(156,605)	-8.43%	2,304,822
Accrued Payroll Taxes	0	0	0	0.00%	0
Accrued Benefits	3,507,956	3,372,150	(135,806)		3,113,427
Accrued Pension Expense (Current Portion)	0	0	0	0.00%	0
Other Accrued Expenses	0	0	0	0.00%	0
Patient Refunds Payable	0	0	0	0.00%	0
Property Tax Payable	0	0	0	0.00%	0
Due to Third Party Payers	0	0	0	0.00%	0
Advances From Third Party Payers	0	0	0	0.00%	0
Current Portion of LTD	2,649,185	2,725,551	76,365	2.80%	3,386,824
Other Current Liabilities	1,183,301	999,360	(183,941)	-18.41%	1,566,951
Total Current Liabilities	**15,482,352**	**15,552,843**	**70,491**	**0.45%**	**16,058,606**
Long Term Debt					
Bonds/Mortgages Payable	24,798,355	25,009,926	211,571	0.85%	26,893,490
Leases Payable	0	0	0	0.00%	0
Less: Current Portion Of Long Term Debt	2,649,185	2,725,551	76,365	2.80%	3,386,824
Total Long Term Debt (Net of Current)	**22,149,170**	**22,284,375**	**135,205**	**0.61%**	**23,506,667**
Other Long Term Liabilities					
Deferred Revenue	0	0	0	0.00%	0
Accrued Pension Expense (Net of Current)	0	0	0	0.00%	0
Other	9,897,986	10,108,538	210,552	2.08%	10,833,425
Total Other Long Term Liabilities	**9,897,986**	**10,108,538**	**210,552**	**2.08%**	**10,833,425**
TOTAL LIABILITIES	**47,529,508**	**47,945,756**	**416,248**	**0.87%**	**50,398,698**
Net Assets:					
Unrestricted Fund Balance	90,128,548	89,833,683	(294,865)	-0.33%	82,391,633
Temporarily Restricted Fund Balance	1,959,119	1,959,119	0	0.00%	1,959,119
Restricted Fund Balance	571,278	557,211	(14,067)	-2.52%	470,299
Net Revenue/(Expenses)	7,681,137	4,017,377	N/A	N/A	7,442,051
TOTAL NET ASSETS	**100,340,082**	**96,367,391**	**(3,972,691)**	**-4.12%**	**92,263,102**
TOTAL LIABILITIES AND NET ASSETS	**$147,869,590**	**$144,313,147**	**($3,556,443)**	**-2.46%**	**$142,661,800**

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY
Ten months ending April 30, 2025

	CURRENT MONTH				
	Actual 04/30/25	Budget 04/30/25	Positive (Negative) Variance	Percentage Variance	Prior Year 04/30/24
Gross Patient Revenue					
Inpatient Revenue	$3,224,887	$4,355,808	($1,130,921)	-25.96%	$3,666,923
Outpatient Revenue	17,656,350	16,602,300	1,054,049	6.35%	16,587,785
Clinic Revenue	3,143,338	2,944,913	198,425	6.74%	3,244,931
Specialty Clinic Revenue	0	0	0	0.00%	0
Total Gross Patient Revenue	24,024,575	23,903,021	121,554	0.51%	23,499,639
Deductions From Revenue					
Discounts and Allowances	(8,047,045)	(11,004,891)	2,957,846	26.88%	(11,571,869)
Bad Debt Expense (Governmental Providers Only)	(1,836,167)	(1,434,320)	(401,847)	-28.02%	(1,043,471)
Medical Assistance	(29,287)	(239,053)	209,767	87.75%	(2,736)
Total Deductions From Revenue	(9,912,498)	(12,678,264)	2,765,766	21.82%	(12,618,076)
Net Patient Revenue	14,112,077	11,224,757	2,887,320	25.72%	10,881,563
Other Operating Revenue	306,929	198,244	108,684	54.82%	163,765
Total Operating Revenue	**14,419,005**	**11,423,001**	**2,996,004**	**26.23%**	**11,045,328**
Operating Expenses					
Salaries and Wages	4,580,437	4,560,443	(19,994)	-0.44%	4,125,869
Fringe Benefits	1,504,353	1,537,879	33,527	2.18%	1,369,376
Contract Labor	328,485	233,000	(95,485)	-40.98%	370,248
Physicians Fees	509,471	364,246	(145,224)	-39.87%	288,730
Purchased Services	710,533	684,906	(25,627)	-3.74%	792,911
Drug Expense	963,669	1,015,114	51,445	5.07%	1,022,725
Supply Expense	1,015,585	932,181	(83,404)	-8.95%	958,145
Utilities	108,134	127,842	19,708	15.42%	118,540
Repairs and Maintenance	456,227	470,676	14,449	3.07%	380,073
Insurance Expense	104,871	107,291	2,420	2.26%	72,832
All Other Operating Expenses	338,085	371,546	33,461	9.01%	271,601
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	44,531	23,220	(21,312)	-91.78%	37,629
Depreciation and Amortization	869,987	880,362	10,375	1.18%	887,647
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**11,534,367**	**11,308,706**	**(225,661)**	**-2.00%**	**10,696,326**
Net Operating Surplus/(Loss)	**2,884,638**	**114,295**	**2,770,343**	**2423.85%**	**349,002**
Non-Operating Revenue:					
Contributions	0	0	0	0.00%	0
Investment Income	275,850	19,357	256,494	1325.10%	56,673
Tax Subsidies (Except for GO Bond Subsidies)	0	0	0	0.00%	0
Tax Subsidies for GO Bonds	0	0	0	0.00%	0
Interest Expense (Governmental Providers Only)	(66,300)	(70,200)	(3,901)	5.56%	(91,263)
Other Non-Operating Revenue/(Expenses)	569,571	105,111	464,460	441.87%	17,003
Total Non Operating Revenue/(Expense)	**779,122**	**54,268**	**724,854**	**1335.70%**	**(17,587)**
Total Net Surplus/(Loss)	**$3,663,760**	**$168,563**	**$3,495,197**	**2073.53%**	**$331,415**
Change in Unrealized Gains/(Losses) on Investments	294,865	0	294,865	0.00%	0
Increase/(Decrease in Unrestricted Net Assets	**$3,958,625**	**$168,563**	**$3,790,062**	**2248.46%**	**$331,415**
Operating Margin	**20.01%**	**1.00%**			**3.16%**
Total Profit Margin	**25.41%**	**1.48%**			**3.00%**
EBIDA	**26.04%**	**8.71%**			**11.20%**

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Ten months ending April 30, 2025

	YEAR-TO-DATE				
	Actual 04/30/25	Budget 04/30/25	Positive (Negative) Variance	Percentage Variance	Prior Year 04/30/24
Gross Patient Revenue					
Inpatient Revenue	$37,933,707	$43,558,079	($5,624,372)	-12.91%	$40,962,087
Outpatient Revenue	169,394,291	166,029,503	3,364,789	2.03%	156,320,197
Clinic Revenue	30,335,341	30,024,410	310,931	1.04%	27,819,703
Specialty Clinic Revenue	0	0	0	0.00%	0
Total Gross Patient Revenue	237,663,339	239,611,992	(1,948,653)	-0.81%	225,101,988
Deductions From Revenue					
Discounts and Allowances	(102,885,749)	(110,256,023)	7,370,274	6.68%	(104,092,321)
Bad Debt Expense (Governmental Providers Only)	(19,685,837)	(14,343,200)	(5,342,637)	-37.25%	(13,538,353)
Medical Assistance	(429,886)	(2,390,533)	1,960,647	82.02%	(1,165,618)
Total Deductions From Revenue	(123,001,472)	(126,989,756)	3,988,284	3.14%	(118,796,292)
Net Patient Revenue	114,661,867	112,622,236	2,039,632	1.81%	106,305,696
Other Operating Revenue	1,580,088	2,015,821	(435,733)	-21.62%	1,725,858
Total Operating Revenue	**116,241,955**	**114,638,057**	**1,603,898**	**1.40%**	**108,031,553**
Operating Expenses					
Salaries and Wages	44,854,912	45,511,149	656,237	1.44%	40,940,154
Fringe Benefits	13,604,205	14,083,433	479,228	3.40%	12,653,745
Contract Labor	3,974,763	3,181,200	(793,563)	-24.95%	3,403,594
Physicians Fees	4,555,793	3,758,362	(797,431)	-21.22%	2,947,469
Purchased Services	7,331,917	7,238,331	(93,585)	-1.29%	6,663,890
Drug Expense	9,821,178	10,151,138	329,960	3.25%	9,695,389
Supply Expense	8,991,057	9,430,872	439,815	4.66%	8,795,435
Utilities	1,149,989	1,282,975	132,986	10.37%	1,194,129
Repairs and Maintenance	4,043,822	4,543,031	499,210	10.99%	3,994,959
Insurance Expense	1,000,556	1,072,908	72,351	6.74%	696,294
All Other Operating Expenses	2,864,067	3,121,562	257,495	8.25%	2,516,622
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	412,230	306,655	(105,575)	-34.43%	363,872
Depreciation and Amortization	8,874,733	8,865,285	(9,448)	-0.11%	8,718,902
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**111,479,222**	**112,546,901**	**1,067,679**	**0.95%**	**102,584,455**
Net Operating Surplus/(Loss)	**4,762,733**	**2,091,156**	**2,671,578**	**127.76%**	**5,447,099**
Non-Operating Revenue:					
Contributions	0	0	0	0.00%	0
Investment Income	822,586	193,565	629,021	324.97%	410,327
Tax Subsidies (Except for GO Bond Subsidies)	0	0	0	0.00%	0
Tax Subsidies for GO Bonds	0	0	0	0.00%	0
Interest Expense (Governmental Providers Only)	(713,411)	(715,589)	2,178	-0.30%	(647,187)
Other Non-Operating Revenue/(Expense)	2,809,229	3,354,134	(544,905)	-16.25%	1,238,329
Total Non Operating Revenue/(Expense)	**2,918,403**	**2,832,110**	**86,293**	**3.05%**	**1,001,469**
Total Net Surplus/(Loss)	**$7,681,137**	**$4,923,266**	**$2,757,871**	**56.02%**	**$6,448,568**
Change in Unrealized Gains/(Losses) on Investments	294,865	0	294,865	0.00%	0
Increase/(Decrease) in Unrestricted Net Assets	**$7,976,002**	**$4,923,266**	**$3,052,736**	**62.01%**	**$6,448,568**
Operating Margin	**4.10%**	**1.82%**			**5.04%**
Total Profit Margin	**6.61%**	**4.29%**			**5.97%**
EBIDA	**11.73%**	**9.56%**			**13.11%**

Statement of Revenue and Expense - 13 Month Trend

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

	Actual 4/30/2025	Actual 3/31/2025	Actual 2/28/2025	Actual 1/31/2025	Actual 12/31/2024	Actual 11/30/2024
Gross Patient Revenue						
Inpatient Revenue	$3,224,887	$3,617,679	$3,352,717	$4,614,671	$3,452,968	$3,449,680
Inpatient Psych/Rehab Revenue						
Outpatient Revenue	$17,656,350	$16,225,685	$16,835,749	$16,547,834	$17,310,090	$17,514,374
Clinic Revenue	$3,143,338	$3,007,057	$3,101,927	$3,082,203	$3,035,731	$2,897,570
Specialty Clinic Revenue	$0	$0	$0	$0	$0	$0
Total Gross Patient Revenue	$24,024,575	$22,850,422	$23,290,393	$24,244,707	$23,798,789	$23,861,624
Deductions From Revenue						
Discounts and Allowances	$8,047,045	$10,170,301	$10,412,140	$10,734,129	$10,310,868	$10,536,882
Bad Debt Expense (Governmental Providers Only)	$1,836,167	$1,711,294	$1,874,592	$1,883,492	$2,085,286	$1,931,492
Charity Care	$29,287	$62,223	$22,474	$0	$43,958	$196,269
Total Deductions From Revenue	9,912,498	11,943,818	12,309,206	12,617,621	12,440,113	12,664,643
Net Patient Revenue	$14,112,077	$10,906,603	$10,981,187	$11,627,087	$11,358,676	$11,196,982
Other Operating Revenue	306,929	129,835	94,606	155,214	135,830	112,512
Total Operating Revenue	**14,419,005**	**11,036,439**	**11,075,793**	**11,782,301**	**11,494,506**	**11,309,494**
Operating Expenses						
Salaries and Wages	$4,580,437	$4,708,174	$4,318,369	$4,566,303	$4,498,489	$4,538,204
Fringe Benefits	$1,504,353	$1,352,195	$1,347,844	$1,603,417	$1,168,648	$1,388,682
Contract Labor	$328,485	$331,200	$326,025	$421,623	$380,117	$429,054
Physicians Fees	$509,471	$450,781	$510,272	$504,153	$615,730	$480,276
Purchased Services	$710,533	$766,610	$679,822	$902,276	$676,971	$759,193
Drug Expense	$963,669	$845,045	$921,807	$1,097,040	$973,483	$1,172,392
Supply Expense	$1,015,585	$760,219	$872,534	$865,849	$1,010,481	$806,083
Utilities	$108,134	$105,079	$118,660	$124,009	$114,124	$111,144
Repairs and Maintenance	$456,227	$476,252	$406,347	$388,570	$421,801	$352,225
Insurance Expense	$104,871	$104,197	$102,247	$99,766	$99,122	$100,220
All Other Operating Expenses	$338,085	$341,109	$248,371	$273,245	$221,366	$249,418
Bad Debt Expense (Non-Governmental Providers)						
Leases and Rentals	$44,531	$59,201	$37,770	$33,862	$42,299	$33,335
Depreciation and Amortization	$869,987	$914,343	$877,351	$879,381	$885,148	$884,329
Interest Expense (Non-Governmental Providers)						
Total Operating Expenses	**$11,534,367**	**$11,214,406**	**$10,767,420**	**$11,759,494**	**$11,107,778**	**$11,304,556**
Net Operating Surplus/(Loss)	**$2,884,638**	**($177,968)**	**$308,374**	**$22,807**	**$386,729**	**$4,937**
Non-Operating Revenue:						
Contributions						
Investment Income	275,850	60,251	55,248	62,133	61,976	34,611
Tax Subsidies (Except for GO Bond Subsidies)						
Tax Subsidies for GO Bonds	0	0	0	0	0	0
Interest Expense (Governmental Providers Only)	(66,300)	(77,888)	(67,140)	(74,030)	(75,865)	(69,734)
Other Non-Operating Revenue/(Expenses)	569,571	51,183	562,205	1,041,386	25,444	436,535
Total Non Operating Revenue/(Expense)	**$779,122**	**$33,546**	**$550,312**	**$1,029,490**	**$11,555**	**$401,412**
Total Net Surplus/(Loss)	**$3,663,760**	**($144,422)**	**$858,686**	**$1,052,297**	**$398,284**	**$406,350**
Change in Unrealized Gains/(Losses) on Investments	0	0	0	0	0	0
Increase/(Decrease in Unrestricted Net Assets	**$3,663,760**	**($144,422)**	**$858,686**	**$1,052,297**	**$398,284**	**$406,350**
Operating Margin	**20.01%**	**-1.61%**	**2.78%**	**0.19%**	**3.36%**	**0.04%**
Total Profit Margin	**25.41%**	**-1.31%**	**7.75%**	**8.93%**	**3.46%**	**3.59%**
EBIDA	**26.04%**	**6.67%**	**10.71%**	**7.66%**	**11.07%**	**7.86%**

Actual 10/31/2024	Actual 9/30/2024	Actual 8/31/2024	Actual 7/31/2024	Actual 6/30/2024	Actual 5/31/2024
$3,942,476	$4,229,582	$3,815,950	$4,233,097	$3,753,329	$4,873,910
$17,231,477	$15,461,921	$16,307,549	$18,303,263	$16,025,677	$17,065,942
$3,305,125	$2,766,032	$3,030,522	$2,965,835	$2,909,994	$3,098,260
$0	$0	$0	$0	$0	$0
$24,479,078	$22,457,535	$23,154,021	$25,502,195	$22,689,001	$25,038,111
$11,073,864	$10,445,910	$10,358,617	$10,795,994	$10,263,890	$11,795,527
$2,142,747	$1,865,917	$1,630,927	$2,723,923	$2,000,964	$1,283,539
$16,694	$15,333	$36,283	$7,366	$241,325	$57,087
13,233,305	12,327,160	12,025,826	13,527,282	12,506,179	13,136,153
$11,245,773	$10,130,375	$11,128,195	$11,974,912	$10,182,821	$11,901,958
149,639	68,378	91,198	335,946	305,556	131,038
11,395,412	**10,198,753**	**11,219,393**	**12,310,859**	**10,488,378**	**12,032,996**
$4,414,210	$4,421,373	$4,667,572	$4,141,780	$4,693,168	$4,203,693
$1,324,180	$1,138,750	$1,687,786	$1,088,350	$1,105,022	$1,677,550
$454,213	$393,537	$501,556	$408,954	$475,083	$543,862
$372,688	$294,647	$373,229	$444,547	$451,969	$389,941
$758,597	$739,663	$724,260	$613,991	$727,936	$691,394
$980,355	$904,747	$771,034	$1,191,605	$918,152	$1,125,459
$899,196	$984,579	$853,023	$923,507	$620,399	$956,733
$122,431	$116,368	$112,884	$117,156	$107,637	$122,860
$414,564	$337,361	$447,570	$342,905	$446,822	$367,427
$97,214	$97,214	$97,214	$98,493	$62,095	$135,140
$292,699	$308,900	$280,875	$310,000	$260,091	$253,110
$35,124	$40,673	$51,789	$33,647	$42,332	$36,108
$884,208	$889,405	$900,391	$890,190	$920,211	$946,935
$11,049,677	**$10,667,216**	**$11,469,184**	**$10,605,124**	**$10,830,915**	**$11,450,213**
$345,735	**($468,463)**	**($249,791)**	**$1,705,735**	**($342,537)**	**$582,783**
86,954	49,266	63,735	72,561	133,266	282,618
0	0	0	0	0	0
(70,257)	(68,858)	(77,005)	(66,334)	(125,580)	(68,089)
20,369	16,560	20,984	69,457	515,404	15,619
$37,066	**($3,032)**	**$7,713**	**$75,684**	**$523,090**	**$230,148**
$382,802	**($471,495)**	**($242,078)**	**$1,781,419**	**$180,553**	**$812,931**
294,865	0	0	0	59,257	272,726
$677,667	**($471,495)**	**($242,078)**	**$1,781,419**	**$239,810**	**$1,085,657**
3.03%	**-4.59%**	**-2.23%**	**13.86%**	**-3.27%**	**4.84%**
3.36%	**-4.62%**	**-2.16%**	**14.47%**	**1.72%**	**6.76%**
10.79%	**4.13%**	**5.80%**	**21.09%**	**5.51%**	**12.71%**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Ten months ending April 30, 2025

	CASH FLOW	
	Current Month 4/30/2025	Current Year-To-Date 4/30/2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net Income (Loss)	$3,663,760	$7,681,137
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:		
Depreciation	869,987	8,874,733
(Increase)/Decrease in Net Patient Accounts Receivable	4,062,414	(2,796,773)
(Increase)/Decrease in Other Receivables	(812,813)	67,760
(Increase)/Decrease in Inventories	(26,690)	(12,594)
(Increase)/Decrease in Pre-Paid Expenses	39,842	186,234
(Increase)/Decrease in Other Current Assets	0	0
Increase/(Decrease) in Accounts Payable	(470,478)	440,576
Increase/(Decrease) in Notes and Loans Payable	0	0
Increase/(Decrease) in Accrued Payroll and Benefits	292,411	104,458
Increase/(Decrease) in Accrued Expenses	0	0
Increase/(Decrease) in Patient Refunds Payable	0	0
Increase/(Decrease) in Third Party Advances/Liabilities	0	0
Increase/(Decrease) in Other Current Liabilities	183,941	(383,650)
Net Cash Provided by Operating Activities:	**7,802,374**	**14,161,881**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of Property, Plant and Equipment	(399,768)	(6,934,734)
(Increase)/Decrease in Limited Use Cash and Investments	(795,800)	(784,566)
(Increase)/Decrease in Other Limited Use Assets	(1,574)	(259,244)
(Increase)/Decrease in Other Assets	5,987	59,871
Net Cash Used by Investing Activities	**(1,191,156)**	**(7,918,674)**
CASH FLOWS FROM FINANCING ACTIVITIES:		
Increase/(Decrease) in Bond/Mortgage Debt	(211,571)	(2,095,135)
Increase/(Decrease) in Capital Lease Debt	0	0
Increase/(Decrease) in Other Long Term Liabilities	(210,552)	(935,439)
Net Cash Used for Financing Activities	**(422,123)**	**(3,030,574)**
(INCREASE)/DECREASE IN RESTRICTED ASSETS	**294,865**	**294,865**
Net Increase/(Decrease) in Cash	**6,483,961**	**3,507,498**
Cash, Beginning of Period	9,451,801	12,428,264
Cash, End of Period	**$15,935,762**	**$15,935,762**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Ten months ending April 30, 2025

Current Month					Year-To-Date			
Actual 04/30/25	Budget 04/30/25	Positive/ (Negative) Variance	Prior Year 04/30/24	STATISTICS	Actual 04/30/25	Budget 04/30/25	Positive/ (Negative) Variance	Prior Year 04/30/24
				Discharges				
118	126	(8)	126	Acute	1,201	1,335	(134)	1,335
118	126	(8)	126	Total Adult Discharges	1,201	1,335	(134)	1,335
33	27	6	27	Newborn	330	378	(48)	378
151	153	(2)	153	Total Discharges	1,531	1,713	(182)	1,713
				Patient Days:				
339	393	(54)	393	Acute	3,763	4,203	(440)	4,203
339	393	(54)	393	Total Adult Patient Days	3,763	4,203	(440)	4,203
50	42	8	42	Newborn	539	611	(72)	611
389	435	(46)	435	Total Patient Days	4,302	4,814	(512)	4,814
				Average Length of Stay (ALOS)				
2.9	3.1	(0.2)	3.1	Acute	3.1	3.1	(0.0)	3.1
2.9	3.1	(0.2)	3.1	Total Adult ALOS	3.1	3.1	(0.0)	3.1
1.5	1.6	(0.0)	1.6	Newborn ALOS	1.6	1.6	0.0	1.6
				Average Daily Census (ADC)				
11.3	13.1	(1.8)	13.1	Acute	12.4	13.8	(1.4)	13.8
11.3	13.1	(1.8)	13.1	Total Adult ADC	12.4	13.8	(1.4)	13.8
1.7	1.4	0.3	1.4	Newborn	1.8	2.0	(0.2)	2.0
				Emergency Room Statistics				
130	146	(16)	146	ER Visits - Admitted	1,345	1,410	(65)	1,410
1,180	1,183	(3)	1,183	ER Visits - Discharged	12,687	12,043	644	12,043
1,310	1,329	(19)	1,329	Total ER Visits	14,032	13,453	579	13,453
9.92%	10.99%		10.99%	% of ER Visits Admitted	9.59%	10.48%		10.48%
110.17%	115.87%		115.87%	ER Admissions as a % of Total	111.99%	105.62%		105.62%
				Outpatient Statistics:				
8,546	8,674	(128)	8,674	Total Outpatients Visits	84,964	83,356	1,608	83,356
140	130	10	130	Observation Bed Days	1,817	1,372	445	1,372
6,761	6,657	104	6,657	Clinic Visits - Primary Care	61,534	61,064	470	61,064
652	595	57	595	Clinic Visits - Specialty Clinics	5,843	5,341	502	5,341
71	54	17	54	IP Surgeries	632	530	102	530
149	142	7	142	OP Surgeries	1,389	1,291	98	1,291
				Productivity Statistics:				
522.00	521.15	0.85	482.44	FTE's - Worked	500.64	521.15	(20.51)	464.75
560.33	571.09	(10.76)	520.70	FTE's - Paid	549.79	571.09	(21.30)	513.06
1.5400	1.3300	0.21	1.3300	Case Mix Index -Medicare	1.5000	1.4896	0.01	1.4000
1.2100	1.1400	0.07	1.1400	Case Mix Index - All payers	1.2860	0.6731	0.61	1.1820

Accounts Receivable Tracking Report

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

04/30/25

	Current Month Actual	Current Month Target
Gross Days in Accounts Receivable - All Services	66.13	64.59
Net Days in Accounts Receivable	56.59	55.47
Number of Gross Days in Unbilled Revenue	10.79	3.0 or <
Number of Days Gross Revenue in Credit Balances	0.00	< 1.0
Self Pay as a Percentage of Total Receivables	19.05%	N/A
Charity Care as a % of Gross Patient Revenue - Current Month	0.12%	1.00%
Charity Care as a % of Gross Patient Revenue - Year-To-Date	0.18%	1.00%
Bad Debts as a % of Gross Patient Revenue - Current Month	7.64%	6.00%
Bad Debts as a % of Gross Patient Revenue - Year-To-Date	8.28%	5.99%
Collections as a Percentage of Net Revenue - Current Month	122.54%	100% or >
Collections as a Percentage of Net Revenue - Year-To-Date	84.57%	100% or >
Percentage of Blue Cross Receivable > 90 Days	9.52%	< 10%
Percentage of Insurance Receivable > 90 Days	28.07%	< 15%
Percentage of Medicaid Receivable > 90 Days	20.91%	< 20%
Percentage of Medicare Receivable > 60 Days	43.56%	< 6%

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WYOMING
Ten months ending April 30, 2025

Monthly Variances in excess of $10,000 as well as in excess of 10% explained below.
Year-To-Date Variances in excess of $30,000 as well as in excess of 5% explained below.

	Current Month Amount	Current Month %	Year-to-Date Amount	Year-to-Date %
Gross Patient Revenue	121,554	0.51%	(1,948,653)	-0.81%

Gross patient revenue is over budget for the month and under budget year to date. Patient statistics under budget in April were ER visits, births, OP visits and patient days.
Average Daily Census is 11.3 in April which is under budget by 1.8

Deductions from Revenue	2,765,766	21.82%	3,988,284	3.14%

Deductions from revenue are under budget for April and over budget year to date.
They are currently booked at 41.3% for April and 51.8% year to date. This number is monitored closely each month and fluctuates based on historical write-offs and current collection percentages.
More detail included in the narrative.

Bad Debt Expense	(401,847)	-28.02%	(5,342,637)	-37.25%

Bad debt expense is booked at 7.6% for April and 8.3% year to date.

Charity Care	209,767	87.75%	1,960,647	82.02%

Charity care yields a high degree of variability month over month and is dependent on patient needs.
Patient Financial Services evaluates accounts consistently to determine when charity adjustments are appropriate in accordance with our Charity Care Policy.

Other Operating Revenue	108,684	54.82%	(435,733)	-21.62%

Other Operating Revenue is over budget and under budget for the year.

Salaries and Wages	(19,994)	-0.44%	656,237	1.44%

Salary and Wages are over budget in April and are under budget year to date.

Paid FTEs are under budget by 10.76 FTEs for the month and under 21.3 FTEs year to date.

Fringe Benefits	33,527	2.18%	479,228	3.40%

Fringe benefits are under budget in April and under budget year to date.

Contract Labor	(95,485)	-40.98%	(793,563)	-24.95%

Contract labor is over budget for April and over budget year to date.
Med Floor, Recovery room, Lab, Respiratory and Ultrasound are over budget for the month.

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WYOMING
Ten months ending April 30, 2025

Monthly Variances in excess of $10,000 as well as in excess of 10% explained below.
Year-To-Date Variances in excess of $30,000 as well as in excess of 5% explained below.

	Current Month Amount	Current Month %	Year-to-Date Amount	Year-to-Date %
Physician Fees	(145,224)	-39.87%	(797,431)	-21.22%
Physician fees over budget in April and over budget year to date. Hospitalists, Sleep Lab, Tele-psych, Med Onc and Locums are over budget in April.				
Purchased Services	(25,627)	-3.74%	(93,585)	-1.29%
Purchased services are over budget for April and over budget year to date. Expenses over budget are collection fee's, bank fee's, dept. mgmt service and other legal services.				
Supply Expense	(83,404)	-8.95%	439,815	4.66%
Supplies are over budget for April and under budget year to date. Line items over budget include implants, minor equipment, food, maintenance supplies, contrast and minor equipment.				
Repairs & Maintenance	14,449	3.07%	499,210	10.99%
Repairs and Maintenance are under budget for April and under budget year to date.				
All Other Operating Expenses	33,461	9.01%	257,495	8.25%
This expense is under budget in April and under budget year to date. Other expenses over budget are postage, freight, foundation other expenses.				
Leases and Rentals	(21,312)	-91.78%	(105,575)	-34.43%
This expense is over budget for April and is over budget year to date due to the Mako robot lease.				
Depreciation and Amortization	10,375	1.18%	(9,448)	-0.11%
Depreciation is under budget for April and is over budget year to date				
BALANCE SHEET				
Cash and Cash Equivalents	$6,483,961	68.60%		
Cash increased in April. Cash collections for April were $17.2 million. Days Cash on Hand decreased 114 days.				
Gross Patient Accounts Receivable	($16,230,924)	-23.74%		
This receivable decreased in April due to higher collections				

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WYOMING
Ten months ending April 30, 2025

Monthly Variances in excess of $10,000 as well as in excess of 10% explained below.
Year-To-Date Variances in excess of $30,000 as well as in excess of 5% explained below.

	Current Month Amount	Current Month %	Year-to-Date Amount	Year-to-Date %
Bad Debt and Allowance Reserves	12,168,510	29.38%		
Bad Debt and Allowances decreased.				
Other Receivables	812,813	15.25%		
Other Receivables increased in April due to QRA.				
Prepaid Expenses	(39,842)	-2.10%		
Prepaid expenses decreased due to the normal activity in this account.				
Limited Use Assets	797,375	3.42%		
These assets increased due to the bond accrual and investment gains				
Plant Property and Equipment	(470,219)	-0.65%		
The decrease in these assets is due to the the normal increase in accumulated depreciation.				
Accounts Payable	470,478	7.13%		
This liability decreased due to the normal activity in this account.				
Accrued Payroll	(156,605)	-8.43%		
This liability increased in April. The payroll accrual for April was 10 days.				
Accrued Benefits	(135,806)			
This liability increased in April with the normal accrual and usage of PTO.				
Other Current Liabilities	(183,941)	-18.41%		
This liability increased for April due to the bond accrual				
Other Long Term Liabilities	210,552	2.08%		
This liability decreased with the payments on the leases				
Total Net Assets	370,822	-4.12%		
The net gain from operations for April is $2,884,638				

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
ROCK SPRINGS, WY

PROVIDER CLINICS

Unaudited Financial Statements

for

Ten months ending April 30, 2025

Certification Statement:

To the best of my knowledge, I certify for the hospital that the attached financial statements do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respects the financial condition and results of operation of the hospital and all related organizations reported herein.

Certified by:

Tami Love

Chief Financial Officer

TABLE OF CONTENTS

Key Financial Ratios

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Ten months ending April 30, 2025

- DESIRED POSITION IN RELATION TO BENCHMARKS AND BUDGET

	Month to Date 4/30/2025	Year to Date 4/30/2025	Prior Fiscal Year End 06/30/24	MGMA Hospital Owned Rural
Profitability:				
Operating Margin	-34.49%	-26.28%	-23.84%	-36.58%
Total Profit Margin	-34.49%	-26.28%	-23.84%	-36.58%
Contractual Allowance %	44.90%	44.27%	44.34%	
Liquidity:				
Net Days in Accounts Receivable	36.68	36.39	42.14	39.58
Gross Days in Accounts Receivable	33.75	34.02	36.55	72.82
Productivity and Efficiency:				
Patient Visits Per Day	225.37	202.41	198.57	
Total Net Revenue per FTE	N/A	$192,668	$206,194	
Salary Expense per Paid FTE	N/A	$164,085	$176,010	
Salary and Benefits as a % of Net Revenue	110.96%	103.31%	103.17%	91.26%
Employee Benefits %	22.71%	21.31%	20.86%	6.10%

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Ten months ending April 30, 2025

	CURRENT MONTH				
	Actual 04/30/25	Budget 04/30/25	Positive (Negative) Variance	Percentage Variance	Prior Year 04/30/24
Gross Patient Revenue					
Clinic Revenue	3,143,338	2,944,913	198,425	6.74%	3,244,931
Specialty Clinic Revenue	0	0	0	0.00%	0
Total Gross Patient Revenue	3,143,338	2,944,913	198,425	6.74%	3,244,931
Deductions From Revenue					
Discounts and Allowances	(1,411,217)	(1,292,160)	(119,056)	-9.21%	(1,596,933)
Total Deductions From Revenue	(1,411,217)	(1,292,160)	(119,056)	-9.21%	(1,596,933)
Net Patient Revenue	1,732,121	1,652,752	79,369	4.80%	1,647,998
Other Operating Revenue	38,467	41,485	(3,018)	-7.28%	48,843
Total Operating Revenue	**1,770,588**	**1,694,237**	**76,351**	**4.51%**	**1,696,841**
Operating Expenses					
Salaries and Wages	1,602,287	1,477,322	(124,965)	-8.46%	1,445,111
Fringe Benefits	363,915	335,011	(28,904)	-8.63%	326,956
Contract Labor	(1,589)	0	1,589	0.00%	0
Physicians Fees	188,520	169,383	(19,137)	-11.30%	110,473
Purchased Services	4,197	3,430	(767)	-22.37%	7,543
Supply Expense	19,441	22,369	2,927	13.09%	40,409
Utilities	950	1,159	209	18.04%	815
Repairs and Maintenance	5,755	6,219	463	7.45%	4,634
Insurance Expense	41,427	30,615	(10,812)	-35.32%	22,391
All Other Operating Expenses	146,327	149,385	3,058	2.05%	143,679
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	3,941	4,822	881	18.27%	4,400
Depreciation and Amortization	6,070	4,289	(1,780)	-41.51%	6,372
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**2,381,240**	**2,204,003**	**(177,237)**	**-8.04%**	**2,112,782**
Net Operating Surplus/(Loss)	**(610,652)**	**(509,766)**	**(100,886)**	**19.79%**	**(415,941)**
Total Net Surplus/(Loss)	**($610,652)**	**($509,766)**	**($100,886)**	**19.79%**	**($415,941)**
Change in Unrealized Gains/(Losses) on Investments	0	0	0	0.00%	0
Increase/(Decrease in Unrestricted Net Assets	**($610,652)**	**($509,766)**	**($100,886)**	**19.79%**	**($415,941)**
Operating Margin	**-34.49%**	**-30.09%**			**-24.51%**
Total Profit Margin	**-34.49%**	**-30.09%**			**-24.51%**
EBIDA	**-34.15%**	**-29.84%**			**-24.14%**

Statement of Revenue and Expense

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Ten months ending April 30, 2025

	YEAR-TO-DATE				
	Actual 04/30/25	Budget 04/30/25	Positive (Negative) Variance	Percentage Variance	Prior Year 04/30/24
Gross Patient Revenue					
Clinic Revenue	30,335,341	30,024,410	310,931	1.04%	27,819,703
Specialty Clinic Revenue	0	0	0	0.00%	0
Total Gross Patient Revenue	30,335,341	30,024,410	310,931	1.04%	27,819,703
Deductions From Revenue					
Discounts and Allowances	(13,430,791)	(13,125,274)	(305,517)	-2.33%	(12,333,297)
Total Deductions From Revenue	(13,430,791)	(13,125,274)	(305,517)	-2.33%	(12,333,297)
Net Patient Revenue	16,904,551	16,899,137	5,414	0.03%	15,486,407
Other Operating Revenue	397,167	414,850	(17,683)	-4.26%	440,256
Total Operating Revenue	**17,301,718**	**17,313,987**	**(12,269)**	**-0.07%**	**15,926,662**
Operating Expenses					
Salaries and Wages	14,736,544	14,726,444	(10,101)	-0.07%	13,537,351
Fringe Benefits	3,139,896	3,020,073	(119,824)	-3.97%	2,812,282
Contract Labor	(1,589)	0	1,589	0.00%	0
Physicians Fees	1,753,112	1,793,233	40,121	2.24%	1,206,323
Purchased Services	24,394	34,338	9,944	28.96%	65,863
Supply Expense	268,338	269,538	1,200	0.45%	249,307
Utilities	9,730	11,589	1,859	16.04%	10,235
Repairs and Maintenance	69,863	62,186	(7,678)	-12.35%	48,640
Insurance Expense	335,449	306,150	(29,299)	-9.57%	219,538
All Other Operating Expenses	1,403,367	1,440,497	37,130	2.58%	1,261,985
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Leases and Rentals	46,585	48,215	1,630	3.38%	43,277
Depreciation and Amortization	63,130	45,203	(17,927)	-39.66%	69,280
Interest Expense (Non-Governmental Providers)	0	0	0	0.00%	0
Total Operating Expenses	**21,848,821**	**21,757,466**	**(91,355)**	**-0.42%**	**19,524,080**
Net Operating Surplus/(Loss)	**(4,547,103)**	**(4,443,479)**	**(103,624)**	**2.33%**	**(3,597,418)**
Total Net Surplus/(Loss)	**($4,547,103)**	**($4,443,479)**	**($103,624)**	**2.33%**	**($3,597,418)**
Change in Unrealized Gains/(Losses) on Investments	0	0	0	0.00%	0
Increase/(Decrease) in Unrestricted Net Assets	**($4,547,103)**	**($4,443,479)**	**($103,624)**	**2.33%**	**($3,597,418)**
Operating Margin	**-26.28%**	**-25.66%**			**-22.59%**
Total Profit Margin	**-26.28%**	**-25.66%**			**-22.59%**
EBIDA	**-25.92%**	**-25.40%**			**-22.15%**

Statement of Revenue and Expense - 13 Month Trend

MEMORIAL HOSPITAL OF SWEETWATER COUNTY **PAGE 5**
ROCK SPRINGS, WY

	Actuan 4/30/2025	Actual 3/31/2025	Actual 2/28/2025	Actual 1/31/2025	Actual 12/31/2024
Gross Patient Revenue					
Clinic Revenue	$3,143,338	$3,007,057	$3,101,927	$3,082,203	$3,035,731
Specialty Clinic Revenue	$0	$0	$0	$0	$0
Total Gross Patient Revenue	$3,143,338	$3,007,057	$3,101,927	$3,082,203	$3,035,731
Deductions From Revenue					
Discounts and Allowances	($1,411,217)	($1,290,761)	($1,371,053)	($1,370,087)	($1,367,918)
Total Deductions From Revenue	($1,411,217)	($1,290,761)	($1,371,053)	($1,370,087)	($1,367,918)
Net Patient Revenue	$1,732,121	$1,716,297	$1,730,874	$1,712,115	$1,667,813
Other Operating Revenue	$38,467	$36,136	$36,852	$42,000	$36,932
Total Operating Revenue	**1,770,588**	**1,752,433**	**1,767,726**	**1,754,116**	**1,704,745**
Operating Expenses					
Salaries and Wages	$1,602,287	$1,512,850	$1,436,447	$1,457,053	$1,531,022
Fringe Benefits	$363,915	$327,894	$333,664	$420,452	$249,304
Contract Labor	($1,589)	$0	$0	$0	$0
Physicians Fees	$188,520	$160,009	$228,117	$71,558	$289,487
Purchased Services	$4,197	$2,977	$1,299	$3,185	$1,579
Supply Expense	$19,441	$31,316	$19,057	$27,592	$27,236
Utilities	$950	$990	$1,070	$1,070	$426
Repairs and Maintenance	$5,755	$5,529	$8,733	$2,868	$12,958
Insurance Expense	$41,427	$43,000	$31,297	$31,941	$31,297
All Other Operating Expenses	$146,327	$154,954	$99,388	$135,844	$108,182
Bad Debt Expense (Non-Governmental Providers)					
Leases and Rentals	$3,941	$4,993	$4,990	$3,978	$6,881
Depreciation and Amortization	$6,070	$6,189	$6,188	$6,188	$6,374
Interest Expense (Non-Governmental Providers)					
Total Operating Expenses	**$2,381,240**	**$2,250,701**	**$2,170,251**	**$2,161,730**	**$2,264,747**
Net Operating Surplus/(Loss)	**($610,652)**	**($498,267)**	**($402,525)**	**($407,614)**	**($560,002)**
Total Net Surplus/(Loss)	**($610,652)**	**($498,267)**	**($402,525)**	**($407,614)**	**($560,002)**
Change in Unrealized Gains/(Losses) on Investments	0	0	0	0	0
Increase/(Decrease in Unrestricted Net Assets	**($610,652)**	**($498,267)**	**($402,525)**	**($407,614)**	**($560,002)**
Operating Margin	**-34.49%**	**-28.43%**	**-22.77%**	**-23.24%**	**-32.85%**
Total Profit Margin	**-34.49%**	**-28.43%**	**-22.77%**	**-23.24%**	**-32.85%**
EBIDA	**-34.15%**	**-28.08%**	**-22.42%**	**-22.88%**	**-32.48%**

Actual 11/30/2024	Actual 10/31/2024	Actual 9/30/2024	Actual 8/31/2024	Actual 7/31/2024	Actual 6/30/2024	Actual 5/31/2024	Actual 4/30/2024
$2,897,570	$3,305,125	$2,766,032	$3,030,522	$2,965,835	$3,098,260	$3,244,931	$3,031,288
$0	$0	$0	$0	$0	$0	$0	$0
$2,897,570	$3,305,125	$2,766,032	$3,030,522	$2,965,835	$3,098,260	$3,244,931	$3,031,288
($1,274,277)	($1,573,472)	($1,123,349)	($1,323,509)	($1,325,148)	($1,247,082)	($1,596,933)	($1,305,169)
($1,274,277)	($1,573,472)	($1,123,349)	($1,323,509)	($1,325,148)	($1,247,082)	($1,596,933)	($1,305,169)
$1,623,294	$1,731,653	$1,642,683	$1,707,013	$1,640,687	$1,851,177	$1,647,998	$1,726,120
$39,322	$44,944	$37,318	$44,317	$40,879	$41,325	$48,843	$37,502
1,662,616	**1,776,597**	**1,680,001**	**1,751,330**	**1,681,566**	**1,892,502**	**1,696,841**	**1,763,622**
$1,465,903	$1,484,489	$1,472,901	$1,447,522	$1,326,070	$1,487,393	$1,445,111	$1,402,323
$286,506	$292,369	$245,580	$373,923	$246,291	$379,342	$326,956	$402,575
$0	$0	$0	$0	$0	$0	$0	$0
$181,437	$183,517	$128,010	$142,605	$179,854	$183,150	$110,473	$95,316
$1,505	$2,324	$2,679	$3,262	$1,386	$818	$7,543	$8,021
$19,206	$18,420	$51,523	$34,125	$20,422	$25,558	$40,409	$15,937
$971	$635	$1,048	$1,723	$848	$1,754	$815	$888
$7,713	$3,251	$3,374	$6,285	$13,396	$19,503	$4,634	$4,634
$31,297	$31,297	$31,297	$31,297	$31,297	$31,297	$22,391	$22,391
$108,064	$179,591	$149,112	$134,426	$187,477	$143,924	$143,679	$74,051
$4,221	$4,176	$5,617	$3,716	$4,072	$4,322	$4,400	$3,072
$6,374	$6,485	$6,485	$6,485	$6,292	$6,547	$6,372	$6,673
$2,113,197	**$2,206,553**	**$2,097,628**	**$2,185,370**	**$2,017,404**	**$2,283,608**	**$2,112,782**	**$2,035,880**
($450,581)	**($429,957)**	**($417,627)**	**($434,039)**	**($335,839)**	**($391,106)**	**($415,941)**	**($272,258)**
($450,581)	**($429,957)**	**($417,627)**	**($434,039)**	**($335,839)**	**($391,106)**	**($415,941)**	**($272,258)**
0	0	0	0	0	0	0	0
($450,581)	**($429,957)**	**($417,627)**	**($434,039)**	**($335,839)**	**($391,106)**	**($415,941)**	**($272,258)**
-27.10%	**-24.20%**	**-24.86%**	**-24.78%**	**-19.97%**	**-20.67%**	**-24.51%**	**-15.44%**
-27.10%	**-24.20%**	**-24.86%**	**-24.78%**	**-19.97%**	**-20.67%**	**-24.51%**	**-15.44%**
-26.72%	**-23.84%**	**-24.47%**	**-24.41%**	**-19.60%**	**-20.32%**	**-24.14%**	**-15.06%**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

ROCK SPRINGS, WY

Ten months ending April 30, 2025

Current Month					Year-To-Date			
Actual 04/30/25	Budget 04/30/25	Positive/ (Negative) Variance	Prior Year 04/30/24	STATISTICS	Actual 04/30/25	Budget 04/30/25	Positive/ (Negative) Variance	Prior Year 04/30/24
				Outpatient Statistics:				
6,761	6,657	104	6,657	Clinic Visits - Primary Care	61,534	61,064	470	61,064
652	595	57	595	Clinic Visits - Specialty Clinics	5,843	5,341	502	5,341
				Productivity Statistics:				
103.83	97.78	6.05	81.43	FTE's - Worked	96.96	97.78	(0.82)	81.75
111.33	107.45	3.88	91.80	FTE's - Paid	107.82	107.45	0.37	92.11

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
CASH DISBURSEMENT SUMMARY FOR APRIL 25

PAYMENT SOURCE	NO. OF DISBURSEMENTS	AMOUNT
OPERATIONS (GENERAL FUND/KEYBANK)	542	10,762,799.03
CAPITAL EQUIPMENT (PLANT FUND)	7	578,774.37
CONSTRUCTION IN PROGRESS (BUILDING FUND)	4	361,219.39
PAYROLL APRIL 10, 2025		2,076,563.99
PAYROLL APRIL 24, 2025		1,948,966.83
TOTAL CASH OUTFLOW		$11,702,792.79
CASH COLLECTIONS		17,293,328.00
INCREASE/DECREASE IN CASH		**$5,590,535.21**

CONSTRUCTION IN PROGRESS (BUILDING FUND) CASH DISBURSEMENTS
FISCAL YEAR 2025

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001240	7/18/2024	GROATHOUSE CONSTRUCTION,	44,113.25	LAB EXPANSION		
WF DEBT SERVICI	7/31/2024	WF DEBT SERVICE	185,523.05	WF DEBT SERVICE		
		JULY TOTALS			229,636.30	229,636.30

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001241	8/1/2024	CITY OF ROCK SPRINGS	4,495.00	MOB RENOVATION		
001242	8/7/2024	PLAN ONE/ARCHITECTS	53,858.00	MOB RENOVATION		
001242	8/7/2024	PLAN ONE/ARCHITECTS	29,879.06	MEDICAL IMAGING SUITE RENOVATION		
001242	8/7/2024	PLAN ONE/ARCHITECTS	4,232.90	LAB EXPANSION		
001243	8/7/2024	ROCKET MINER	355.67	MOB RENOVATION		
001244	8/29/2024	GROATHOUSE CONSTRUCTION,	138,013.00	LAB EXPANSION		
WF DEBT SERVICI	8/16/2024	WF DEBT SERVICE	185,523.05	WF DEBT SERVICE		
		AUGUST TOTALS			416,356.68	645,992.98

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001245	9/12/2024	CITY OF ROCK SPRINGS	14,255.00	MRI PHASE 2		
001246	9/12/2024	A. PLEASANT CONSTRUCTION, I	87,352.86	LAB EXPANSION		
001247	9/12/2024	PLAN ONE/ARCHITECTS	7,694.00	MOB ENTRANCE/ADA PARKING RENO		
001247	9/12/2024	PLAN ONE/ARCHITECTS	5,691.25	MRI PHASE 2		
001247	9/12/2024	PLAN ONE/ARCHITECTS	12,537.90	LAB EXPANSION		
001247	9/12/2024	PLAN ONE/ARCHITECTS	3,510.56	ONCOLOGY SUITE RENOVATION		
WF DEBT SERVICI	9/18/2024	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		SEPTEMBER TOTALS			316,501.72	962,494.70

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001248	10/3/2024	GROATHOUSE CONSTRUCTION,	134,813.00	LAB EXPANSION		
001249	10/9/2024	PLAN ONE/ARCHITECTS	5,871.16	LAB EXPANSION		
001250	10/24/2024	WESTERN ENGINEERS & GEOLC	132.00	LAB EXPANSION		
001251	10/31/2024	GROATHOUSE CONSTRUCTION,	272,578.00	LAB EXPANSION		
WF DEBT SERVICI	10/16/2024	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		OCTOBER TOTALS			598,854.31	1,561,349.01

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001252	11/7/2024	PLAN ONE/ARCHITECTS	9,451.51	LAB EXPANSION		
001253	11/26/2024	GROATHOUSE CONSTRUCTION,	400,246.00	LAB EXPANSION		
001254	11/26/2024	A. PLEASANT CONSTRUCTION, I	39,873.40	ONCOLOGY SUITE RENOVATION		
WF DEBT SERVICI	11/19/2024	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		NOVEMBER TOTALS			635,031.06	2,196,380.07

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001255	12/5/2024	WESTERN ENGINEERS & GEOLC	1,499.00	LAB EXPANSION		
001256	12/12/2024	PLAN ONE/ARCHITECTS	7,579.22	LAB EXPANSION		
001257	12/19/2024	GROATHOUSE CONSTRUCTION,	319,491.00	LAB EXPANSION		
001258	12/24/2024	WESTERN ENGINEERS & GEOLC	3,995.00	LAB EXPANSION		
WF DEBT SERVICI	12/19/2024	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		DECEMBER TOTALS			518,024.37	2,714,404.44

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001259	1/2/2025	PLAN ONE/ARCHITECTS	1,422.81	MRI PHASE 2		
001259	1/2/2025	PLAN ONE/ARCHITECTS	1,923.50	MOB ENTRANCE		
001259	1/2/2025	PLAN ONE/ARCHITECTS	4,232.90	LAB EXPANSION		
001260	1/9/2025	A. PLEASANT CONSTRUCTION, I	43,616.40	ONCOLOGY SUITE RENOVATION		
001261	1/9/2025	GROATHOUSE CONSTRUCTION,	220,740.00	LAB EXPANSION		
001262	1/16/2025	INSULATION INC.	1,924.36	MRI PHASE 2		
001263	1/23/2025	WYLIE CONSTRUCTION INC.	1,800.00	LAB EXPANSION		
001264	1/29/2025	WESTERN ENGINEERS & GEOLC	2,132.00	LAB EXPANSION		
WF DEBT SERVICI	1/16/2025	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		JANUARY TOTALS			463,252.12	3,177,656.56

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001265	2/6/2025	INSULATION INC.	1,504.36	MRI PHASE 2		
001266	2/6/2025	PLAN ONE/ARCHITECTS	12,079.21	LAB EXPANSION		
001267	2/20/2025	GROATHOUSE CONSTRUCTION,	209,514.00	LAB EXPANSION		
WF DEBT SERVICI	2/11/2025	WF DEBT SERVICE	185,460.15	WF DEBT SERVICE		
		FEBRUARY TOTALS			408,557.72	3,586,214.28

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001268	3/6/2025	WESTERN ENGINEERS & GEOLC	3,189.50	MOB ENTRANCE		
001269	3/13/2025	PLAN ONE/ARCHITECTS	8,506.21	LAB EXPANSION		
001270	3/20/2025	GROATHOUSE CONSTRUCTION,	344,380.00	LAB EXPANSION		
001271	3/20/2025	GROATHOUSE CONSTRUCTION,	119,914.00	MRI PHASE 2		
WF DEBT SERVICI	3/17/2025	WF DEBT SERVICE	183,940.90	WF DEBT SERVICE		
		MARCH TOTALS			659,930.61	4,246,144.89

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
001272	4/3/2025	A. PLEASANT CONSTRUCTION, I	167,740.27	ONCOLOGY SUITE RENOVATION		
001273	4/3/2025	WESTERN ENGINEERS & GEOLC	1,959.00	LAB EXPANSION		
001274	4/10/2025	PLAN ONE/ARCHITECTS	7,579.22	LAB EXPANSION		
WF DEBT SERVICI	4/16/2025	WF DEBT SERVICE	183,940.90	WF DEBT SERVICE		
		APRIL TOTALS			361,219.39	4,607,364.28

PLANT FUND CASH DISBURSEMENTS
FISCAL YEAR 2025

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002665	7/11/2024	VERATHON MEDICAL	7,020.00	BLADDER SCANNER		
002666	7/11/2024	WYOELECTRIC, INC	27,700.00	ELECTRICAL ED X-RAY ROOM		
002666	7/11/2024	WYOELECTRIC, INC	4,522.00	UPS FOR IT EQUIPMENT		
002667	7/18/2024	CDW GOVERNMENT LLC	24,263.27	UPS FOR MHSC DATA CENTER		
002674	7/25/2024	CDW GOVERNMENT LLC	1,183.69	UPS FOR MHSC DATA CENTER		
002675	7/25/2024	PEDIA PALS, INC.	2,517.50	PEDIATRIC BED		
002676	7/25/2024	FOLLETT CORPORATION	5,375.54	ICE/WATER MACHINE FOR SAME DAY SURGERY		
		JULY TOTALS			72,582.00	72,582.00

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002677	8/7/2024	WYOELECTRIC, INC	4,954.40	BACKUP UPS UNIT FOR IT		
002678	8/7/2024	INTERMOUNTAIN TRIMLIGHT (WEST HARRISON ENTERPRISES INC)	18,456.00	TRIMLIGHT SYSTEM ADDITION		
002679	8/16/2024	RADIOMETER AMERICA INC	14,150.00	ABL90 FLEX PLUS ANALYZER		
002680	8/22/2024	MEDICAL POSITIONING, INC	12,239.00	ULTRASCAN TABLE		
002681	8/22/2024	PEDIA PALS, INC.	2,517.50	PEDIATRIC BED		
002682	8/29/2024	COMPUNET, INC.	1,250.00	STORAGE FOR DAVINCI VIDEOS		
002683	8/29/2024	DATEX-OHMEDA,INC.	37,190.44	FETAL MONITORS		
002684	8/29/2024	WAXIE SANITARY SUPPLY	10,543.29	AUTOMATIC SCRUBBERS		
		AUGUST TOTALS			101,300.63	173,882.63

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002677	9/12/2024	KARL STORZ ENDOSCOPY-AMERICA	31,042.82	INTUBATION SCOPE		
002678	9/12/2024	PACIFIC WATER INC	58,516.50	CONTROL HEADS FOR SOFT WATER SYSTEM		
002679	9/12/2024	ALLIED AWNING & RENTAL	56,556.58	DIGITAL ELECTRONIC MESSAGING SIGN-HOSPITAL		
002680	9/19/2024	DELL COMPUTER CORPORATION	15,057.70	DELL LAPTOPS		
002681	9/26/2024	INTERMOUNTAIN TRIMLIGHT (WEST HARRISON ENTERPRISES INC)	18,456.00	TRIMLIGHT SYSTEM ADDITION		
		SEPTEMBER TOTALS			179,629.60	353,512.23

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002690	10/9/2024	BC GROUP INTERNATIONAL INC.	6,810.00	FLOW ANALYZER		
002691	10/9/2024	US MED-EQUIP, LLC	8,195.00	BLADDER SCANNER		
002692	10/31/2024	DELL COMPUTER CORPORATION	15,941.60	DELL LAPTOPS AND MONITORS		
002693	10/31/2024	GUARD RFID	2,500.00	INFANT SECURITY SYSTEM		
002694	10/31/2024	WYOELECTRIC, INC	2,127.00	UPS FOR IT EQUIPMENT		
		OCTOBER TOTALS			35,573.60	389,085.83

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002695	11/14/2024	GUARD RFID	34,281.00	INFANT SECURITY SYSTEM		
002696	11/14/2024	OLYMPUS AMERICA INC	47,643.37	PEDIATRIC COLONSCOPE		
002697	11/14/2024	WYOELECTRIC, INC	24,590.00	DIGITAL MESSAGING SIGN - HOSPITAL		
		NOVEMBER TOTALS			106,514.37	495,600.20

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002698	12/5/2024	AMERI-TECH EQUIPMENT COMPANY	13,180.36	SNOW PLOT		
002699	12/5/2024	MERIT MEDICAL SYSTEMS, INC	65,515.00	SAVI SCOUT CONSOLE		
002700	12/5/2024	VERATHON MEDICAL	6,000.00	VERATHON GLIDE SCOPE		
002701	12/12/2024	R & D SWEEPING & ASPHALT MAINTENANCE, LC	25,525.00	PARKING LOT REPAIRS		
002702	12/12/2024	VERATHON MEDICAL	36,608.00	VERATHON GLIDE SCOPE		
002703	12/24/2024	HOLOGIC, INC.	69,350.00	MINI C-ARM		
		DECEMBER TOTALS			216,178.36	711,778.56

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002704	1/16/2025	GUARD RFID	1,115.00	INFANT SECURITY SYSTEM		
002705	1/16/2025	R & D SWEEPING & ASPHALT MAINTENANCE, LC	74,810.00	PARKING LOT REPAIRS - 3000 COLLEGE DRIVE		
002706	1/16/2025	JC JACOBS CARPET ONE	9,843.99	FLOORING - STRESS ROOM		
		JANUARY TOTALS			85,768.99	797,547.55

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002707	2/6/2025	GUARD RFID	5,490.00	INFANT SECURITY SYSTEM		
002708	2/7/2025	CONVERGINT TECHNOLOGIES	5,756.98	BEHAVIORAL HEALTH CAMERAS		
002709	2/20/2025	COMPUNET, INC.	19,525.00	MICROSOFT INTUNE		
002710	2/20/2025	MERGE HEALTHCARE SOLUTIONS, INC	257,801.84	PACS VNA MIGRATION, REPORTS, VOICE RECOGNITION		
		FEBRUARY TOTALS			288,573.82	1,086,121.37

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
002711	3/6/2025	DELL COMPUTER CORPORATION	12,242.80	LAPTOPS		
002712	3/13/2025	DELL COMPUTER CORPORATION	29,174.40	LAPTOPS		
002713	3/20/2025	SIEMENS MEDICAL SOLUTIONS USA	671,354.00	X-RAY SYSTEMS		
		MARCH TOTALS			712,771.20	1,798,892.57

CHECK NUMBER	DATE	PAYEE	AMOUNT	DESCRIPTION	MONTHLY TOTAL	FYTD TOTAL
EFT091	4/4/2025	SERVCO	25,662.06	BOILER MOTOR AND ACTUATOR		
002714	4/3/2025	STRYKER MEDICAL	5,638.80	CAP024046		
002715	4/3/2025	COFFEY COMMUNICATIONS INC.	8,832.00	WEBSITH REDESIGN		
002716	4/10/2025	KRONOS INCORPORATED	6,000.00	KRONOS UPGRADE		
002717	4/24/2025	ALLIED AWNING & RENTAL	9,142.00	SIGN GRAPHICS UPDATES		
002717	4/24/2025	ALLIED AWNING & RENTAL	47,242.58	DIGITAL ELECTRONIC MESSAGING SIGN		
002718	4/24/2025	KRONOS INCORPORATED	50,000.00	KRONOS UPGRADE		
002719	4/24/2025	COMPUNET, INC.	426,256.93	PACS NETWORK INTRASTRUCTURE		
		APRIL TOTALS			578,774.37	2,377,666.94

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

Amount	Description
18,853.18	**Advertising Total**
2,001.80	**Billing Services Total**
20,795.34	**Blood Total**
137,627.62	**Café Management Total**
3,188.54	**Cellular Telephone Total**
68,712.09	**Collection Agency Total**
356,389.70	**Computer Equipment Total**
726,862.13	**Contract Maintenance Total**
322,003.35	**Contract Personnel Total**
48,787.00	**Cost Report 12-5-24 Total**
378.00	**Courier Services Total**
6,697.84	**Credit Card Payment Total**
20,927.85	**Dental Insurance Total**
13,349.61	**Dialysis Supplies Total**
2,048.00	**Education & Travel Total**
9,330.65	**Employee Recruitment Total**
105,121.83	**Equipment Lease Total**
9,245.40	**Food Total**
6,722.66	**Freight Total**
638.43	**Fuel Total**
3,900.91	**Garbage Collection Total**
956,472.90	**Group Health Total**
456,770.33	**Hospital Supplies Total**
44,296.14	**Implant Supplies Total**
38,127.89	**Insurance Premiums Total**
167,482.60	**Laboratory Services Total**
68,232.00	**Laboratory Supplies Total**
5,837.07	**Laundry Supplies Total**
28,095.16	**Legal Fees Total**
1,739.28	**Linen Total**
12,400.00	**Lithrotripsy Service Total**
229,056.98	**Locum Tenens Total**
37,241.33	**Maintenance & Repair Total**
194.22	**Med Surg Supplies Total**
10,999.07	**Membership Dues Total**
3,981.32	**MHSC Foundation Total**
4,494.34	**Minor Equipment Total**
511.00	**Monthly Pest Control Total**
2,072.84	**Non Medical Supplies Total**
10,380.29	**Office Supplies Total**
2,270.00	**Other Employee Benefits Total**
4,104.00	**Other Physician Fees Total**
26,712.97	**Other Purchased Services Total**
12,889.20	**Oxygen Rental Total**
1,216.48	**Payroll Deduction Total**
6,001.90	**Payroll Garnishment Total**
4,100,000.00	**Payroll Transfer Total**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

19.50	**Petty Cash Total**
1,118,690.34	**Pharmacy Management Total**
34,815.00	**Physician Recruitment Total**
8,333.33	**Physician Retention Total**
394,133.26	**Physician Services Total**
15,000.02	**Physician Student Loan Total**
1,950.00	**Professional Liability Insurance Total**
24,580.96	**Professional Service Total**
347.86	**Proficiency Testing Total**
143.05	**Radiation Monitoring Total**
6,036.92	**Radioactive Material Total**
13,986.68	**Radiology Material Total**
15,028.24	**Reimbursement - CME Total**
16,730.52	**Reimbursement - Education & Travel Total**
530,442.41	**Retirement Total**
9,850.00	**Sponsorship Total**
199,629.49	**Surgery Supplies Total**
4,980.92	**Surveys Total**
3,839.18	**Translation Services Total**
555.96	**Uniforms Total**
109,326.97	**Utilities Total**
1,845.85	**Waste Disposal Total**
1,360.00	**WCRS Total**
136,011.33	**Workers Compensation Total**
10,762,799.03	**Grand Total**

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

Check Number	Date	Vendor Check Name	Amount	Description
205380	4/10/25	ROYAL FLUSH ADVERTISING	159.75	Advertising
EFT000000000139	4/25/25	BIG THICKET BROADCASTING	3,277.00	Advertising
205522	4/24/25	BRIDGER VALLEY PIONEER	600.00	Advertising
EFT000000009073	4/17/2025	GREEN RIVER STAR	275.00	Advertising
EFT000000009065	4/10/2025	GREEN RIVER STAR	1,325.00	Advertising
205561	4/24/25	KEMMERER GAZETTE	2,470.00	Advertising
205358	4/10/25	LAMAR ADVERTISING	450.00	Advertising
205563	4/24/25	LAMAR ADVERTISING	2,160.00	Advertising
205581	4/24/25	PINEDALE ROUNDUP	1,150.00	Advertising
EFT000000000107	4/11/25	ROCK SPRINGS SWEETWATER COUNTY AIRPORT	280.00	Advertising
205378	4/10/25	ROCKET MINER	444.44	Advertising
205587	4/24/25	ROYAL FLUSH ADVERTISING	319.50	Advertising
205269	4/3/25	ROYAL FLUSH ADVERTISING	1,287.50	Advertising
205483	4/17/25	THE RADIO NETWORK	875.00	Advertising
205392	4/10/25	THE RADIO NETWORK	2,900.00	Advertising
205601	4/24/25	TRUE NORTH CUSTOM PUBLISHING	879.99	Advertising
EFT000000000101	4/11/25	EXPRESS MEDICAID BILLING SERV	2,001.80	Billing Services
205399	4/10/25	VITALANT	8,011.97	Blood
205609	4/24/25	VITALANT	12,783.37	Blood
205602	4/24/25	UNIDINE CORPORATION	12,194.42	Café Management
205290	4/3/25	UNIDINE CORPORATION	125,433.20	Café Management
205297	4/3/25	VERIZON WIRELESS, LLC	3,188.54	Cellular Telephone
EFT000000000145	4/25/25	EXPRESS RECOVERY SERVICES	54,938.13	Collection Agency
205400	4/10/25	WAKEFIELD & ASSOCIATES, INC.	13,773.96	Collection Agency
205525	4/24/25	CDW GOVERNMENT LLC	211.96	Computer Equipment
205424	4/17/25	CDW GOVERNMENT LLC	1,548.61	Computer Equipment
205325	4/10/25	CDW GOVERNMENT LLC	2,426.58	Computer Equipment
205205	4/3/25	CDW GOVERNMENT LLC	4,656.98	Computer Equipment
205220	4/3/25	DELL COMPUTER CORPORATION	994.56	Computer Equipment
205536	4/24/25	DELL COMPUTER CORPORATION	346,551.01	Computer Equipment
EFT000000009063	4/3/2025	CASE RECRUITERS, INC.	3,600.00	Contract Maintenance
205207	4/3/25	CLOUDLI COMMUNICATIONS INC.	63.04	Contract Maintenance
205209	4/3/25	COMPUNET, INC.	5,686.77	Contract Maintenance
205335	4/10/25	DNV USA, INC.	5,940.00	Contract Maintenance
205490	4/17/25	ENERGY LABORATORIES INC.	258.00	Contract Maintenance
EFT000000000147	4/25/25	FRONT RANGE MOBILE IMAGING, INC.	16,059.44	Contract Maintenance
205230	4/3/25	GE HEALTHCARE	591.66	Contract Maintenance
205340	4/10/25	GE HEALTHCARE	27,557.83	Contract Maintenance
205237	4/3/25	HOLOGIC, INC.	650.00	Contract Maintenance
205554	4/24/25	HOLOGIC, INC.	4,769.00	Contract Maintenance
205444	4/17/25	INOVALON PROVIDER INC.	995.70	Contract Maintenance
EFT000000000122	4/18/25	MERGE HEALTHCARE SOLUTIONS, INC	47,956.58	Contract Maintenance
205258	4/3/25	NETDAIS	14,350.00	Contract Maintenance
205465	4/17/25	ORACLE AMERICA, INC.	2,382.43	Contract Maintenance
205260	4/3/25	ORACLE AMERICA, INC.	222,555.11	Contract Maintenance
205574	4/24/25	OVATION HEALTHCARE	4,000.00	Contract Maintenance
205579	4/24/25	PHILIPS HEALTHCARE	1,706.80	Contract Maintenance
205262	4/3/25	PHILIPS HEALTHCARE	3,355.99	Contract Maintenance

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

205372	4/10/25	PHILIPS HEALTHCARE	9,328.60	Contract Maintenance
205578	4/24/25	PHILIPS MEDICAL SYSTEM N.A.CO	1,016.67	Contract Maintenance
205374	4/10/25	PROVIDER RESOURCES, INC.	613.00	Contract Maintenance
205375	4/10/25	QUADRAMED	18,750.00	Contract Maintenance
205471	4/17/25	QUADRAMED	161,764.36	Contract Maintenance
205266	4/3/25	RL DATIX	421.00	Contract Maintenance
205272	4/3/25	SIEMENS MEDICAL SOLUTIONS USA	5,312.82	Contract Maintenance
205382	4/10/25	SIEMENS MEDICAL SOLUTIONS USA	11,770.33	Contract Maintenance
205589	4/24/25	SIEMENS MEDICAL SOLUTIONS USA	16,241.28	Contract Maintenance
EFT000000000108	4/11/25	STATE FIRE DC SPECIALTIES	2,695.00	Contract Maintenance
EFT000000000161	4/25/25	STATE FIRE DC SPECIALTIES	2,425.00	Contract Maintenance
205283	4/3/25	THOMAS SCIENTIFIC HOLDINGS, LLC	5,287.50	Contract Maintenance
W/T	4/21/25	TRIZETTO	6,619.12	Contract Maintenance
W/T	4/21/25	TRIZETTO	267.48	Contract Maintenance
EFT000000000163	4/25/25	UNITED AUDIT SYSTEMS, INC.	9,222.50	Contract Maintenance
205295	4/3/25	VANDERBILT	5,012.36	Contract Maintenance
EFT000000000134	4/18/25	WYODATA SECURITY INC.	1,935.00	Contract Maintenance
EFT000000000164	4/25/25	WYODATA SECURITY INC.	1,865.00	Contract Maintenance
205617	4/24/25	WYOMING DEPT OF HEALTH	500.00	Contract Maintenance
W/T	4/9/25	ZENITH	420.42	Contract Maintenance
EFT000000000104	4/11/25	P3 CONSULTING LLC	102,916.34	Contract Maintenance
EFT000000000111	4/18/25	ALLERMETRIX INC	1,589.10	Contract Personnel
205338	4/10/25	FOCUSONE SOLUTIONS LLC	74,272.50	Contract Personnel
205229	4/3/25	FOCUSONE SOLUTIONS LLC	79,239.00	Contract Personnel
205546	4/24/25	FOCUSONE SOLUTIONS LLC	82,731.25	Contract Personnel
205438	4/17/25	FOCUSONE SOLUTIONS LLC	83,011.50	Contract Personnel
205270	4/3/25	SARAH ROTH	660.00	Contract Personnel
EFT000000000094	4/4/25	THE SLEEP SPECIALISTS	500.00	Contract Personnel
205462	4/17/25	NORIDIAN HEALTHCARE SOLUTIONS, LLC MEDICARE A	48,787.00	Cost Report 12-5-24
EFT000000000156	4/25/25	PACKAGERUNNER LOGISTICS LLC	378.00	Courier Services
W/T	4/29/25	UMB BANK	6,697.84	Credit Card Payment
EFT000000000117	4/18/25	DELTA DENTAL	20,927.85	Dental Insurance
205339	4/10/25	FRESENIUS USA MARKETING, INC.	4,211.02	Dialysis Supplies
205547	4/24/25	FRESENIUS USA MARKETING, INC.	8,259.41	Dialysis Supplies
205347	4/10/25	HACH COMPANY	132.60	Dialysis Supplies
205441	4/17/25	HENRY SCHEIN INC	306.11	Dialysis Supplies
205235	4/3/25	HENRY SCHEIN INC	440.47	Dialysis Supplies
205427	4/17/25	CNA SURETY	150.00	Education & Travel
205351	4/10/25	IAHSS	1,300.00	Education & Travel
205363	4/10/25	MEDICAL IMAGING CONSULTANTS, INC	448.00	Education & Travel
205401	4/10/25	WYO. SOCIETY-HEALTHCARE ENGIN.	150.00	Education & Travel
205512	4/24/25	ALTITUDE ANALYSIS	1,620.00	Employee Recruitment
205463	4/17/25	ENP, LLC	3,510.00	Employee Recruitment
205442	4/17/25	HOLIDAY INN - ROCK SPRINGS	297.00	Employee Recruitment
205236	4/3/25	HOLIDAY INN - ROCK SPRINGS	1,376.00	Employee Recruitment
205556	4/24/25	INDEED INC.	934.75	Employee Recruitment
EFT000000000151	4/25/25	INSIGHT SCREENING LLC	1,190.90	Employee Recruitment
205592	4/24/25	STATE OF WYOMING	150.00	Employee Recruitment
205615	4/24/25	WYOMING PUBLIC HEALTH LAB	252.00	Employee Recruitment

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

205423	4/17/25	CAREFUSION SOLUTIONS, LLC	22,430.00	Equipment Lease
205533	4/24/25	COPIER & SUPPLY COMPANY	8,992.67	Equipment Lease
205214	4/3/25	COPIER & SUPPLY COMPANY	12,572.67	Equipment Lease
205341	4/10/25	GE HEALTHCARE FINANCIAL SERVICES	7,472.32	Equipment Lease
205452	4/17/25	LEAF	3,080.00	Equipment Lease
205454	4/17/25	MAKO SURGICAL CORP	23,950.00	Equipment Lease
205469	4/17/25	PITNEY BOWES INC	241.08	Equipment Lease
205271	4/3/25	SHADOW MOUNTAIN WATER CO ,WY	49.95	Equipment Lease
EFT000000000158	4/25/25	SHADOW MOUNTAIN WATER CO ,WY	1,378.03	Equipment Lease
205477	4/17/25	SIEMENS FINANCIAL SERVICES, INC	20,685.63	Equipment Lease
205487	4/17/25	US BANK EQUIPMENT FINANCE	475.69	Equipment Lease
205293	4/3/25	US BANK EQUIPMENT FINANCE	709.03	Equipment Lease
205605	4/24/25	US BANK EQUIPMENT FINANCE	1,457.70	Equipment Lease
205396	4/10/25	US BANK EQUIPMENT FINANCE	1,627.06	Equipment Lease
EFT000000000085	4/4/25	F B MCFADDEN WHOLESALE	2,014.10	Food
EFT000000000102	4/11/25	F B MCFADDEN WHOLESALE	2,108.05	Food
EFT000000000119	4/18/25	F B MCFADDEN WHOLESALE	2,347.70	Food
EFT000000000146	4/25/25	F B MCFADDEN WHOLESALE	2,775.55	Food
205336	4/10/25	FED EX	94.27	Freight
205436	4/17/25	FED EX	458.07	Freight
205287	4/3/25	TRIOSE, INC	1,746.66	Freight
205486	4/17/25	TRIOSE, INC	4,423.66	Freight
205377	4/10/25	BAILEY ENTERPRISES	638.43	Fuel
EFT000000000133	4/18/25	WWS - ROCK SPRINGS	3,900.91	Garbage Collection
W/T	4/4/25	BLUE CROSS BLUE SHIELD 3/28/25	265,873.88	Group Health
W/T	4/18/25	BLUE CROSS BLUE SHIELD 4/11/25	196,099.57	Group Health
W/T	4/25/25	BLUE CROSS BLUE SHIELD 4/18/25	279,335.46	Group Health
W/T	4/11/25	BLUE CROSS BLUE SHIELD 4/4/25	175,805.62	Group Health
W/T	4/18/25	HEALTH EQUITY 04/18/25	10,891.31	Group Health
W/T	4/11/25	HEALTH EQUITY 4/11/25	6,812.53	Group Health
W/T	4/25/25	HEALTH EQUITY 4/25/25	8,904.86	Group Health
W/T	4/4/25	HEALTH EQUITY 4/4/25	9,757.99	Group Health
W/T	4/4/25	HEALTH EQUITY 4/4/25	1,529.98	Group Health
W/T	4/8/25	HEALTH EQUITY FEE	364.00	Group Health
205449	4/17/25	JOSEPH J. OLIVER, M.D.	1,097.70	Group Health
205405	4/17/25	ABBOTT LABORATORIES	1,612.02	Hospital Supplies
205379	4/10/25	ABBOTT NUTRITION	228.70	Hospital Supplies
205190	4/3/25	AESCULAP INC	493.29	Hospital Supplies
205409	4/17/25	AESCULAP INC	2,024.63	Hospital Supplies
205313	4/10/25	AMBU INCORPORATED	368.84	Hospital Supplies
205415	4/17/25	APPLIED MEDICAL	588.00	Hospital Supplies
205314	4/10/25	APPLIED MEDICAL	1,500.00	Hospital Supplies
205195	4/3/25	APPLIED MEDICAL	2,085.00	Hospital Supplies
205315	4/10/25	ARTHREX INC.	290.40	Hospital Supplies
205416	4/17/25	ARTHREX INC.	829.40	Hospital Supplies
205515	4/24/25	ARTHREX INC.	3,292.00	Hospital Supplies
205316	4/10/25	ASPEN SURGICAL	304.70	Hospital Supplies
205320	4/10/25	B BRAUN MEDICAL INC.	918.75	Hospital Supplies
205518	4/24/25	B BRAUN MEDICAL INC.	1,327.00	Hospital Supplies

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

205319	4/10/25	BARD MEDICAL	222.00	Hospital Supplies
205417	4/17/25	BARD MEDICAL	666.00	Hospital Supplies
205197	4/3/25	BAXTER HEALTHCARE CORP/IV	836.88	Hospital Supplies
205418	4/17/25	BAXTER HEALTHCARE CORP/IV	836.88	Hospital Supplies
205516	4/24/25	BAXTER HEALTHCARE CORP/IV	7,722.00	Hospital Supplies
205517	4/24/25	BAYER HEALTHCARE LLC	292.58	Hospital Supplies
205419	4/17/25	BAYER HEALTHCARE LLC	750.00	Hospital Supplies
EFT000000000080	4/4/25	BOSTON SCIENTIFIC CORP	1,015.05	Hospital Supplies
EFT000000000097	4/11/25	BOSTON SCIENTIFIC CORP	2,015.72	Hospital Supplies
EFT000000000113	4/18/25	BOSTON SCIENTIFIC CORP	1,010.28	Hospital Supplies
EFT000000000141	4/25/25	BOSTON SCIENTIFIC CORP	1,663.23	Hospital Supplies
EFT000000000081	4/4/25	BREG INC	296.72	Hospital Supplies
EFT000000000098	4/11/25	BREG INC	19.10	Hospital Supplies
EFT000000000114	4/18/25	BREG INC	85.18	Hospital Supplies
EFT000000000142	4/25/25	BREG INC	580.72	Hospital Supplies
205333	4/10/25	C R BARD INC	315.14	Hospital Supplies
205216	4/3/25	C R BARD INC	2,255.74	Hospital Supplies
205523	4/24/25	CARDINAL HEALTH/V. MUELLER	6,881.17	Hospital Supplies
205203	4/3/25	CARDINAL HEALTH/V. MUELLER	21,582.46	Hospital Supplies
205324	4/10/25	CARDINAL HEALTH/V. MUELLER	30,059.19	Hospital Supplies
205422	4/17/25	CARDINAL HEALTH/V. MUELLER	30,783.74	Hospital Supplies
205524	4/24/25	CAREFUSION 2200 INC	1,200.00	Hospital Supplies
205428	4/17/25	CONE INSTRUMENTS	223.92	Hospital Supplies
205210	4/3/25	CONE INSTRUMENTS	242.34	Hospital Supplies
205328	4/10/25	CONE INSTRUMENTS	902.96	Hospital Supplies
205211	4/3/25	CONMED CORPORATION	133.90	Hospital Supplies
205330	4/10/25	COOK MEDICAL INCORPORATED	162.60	Hospital Supplies
205212	4/3/25	COOK MEDICAL INCORPORATED	555.44	Hospital Supplies
205217	4/3/25	CR BARD INC	2,781.05	Hospital Supplies
205221	4/3/25	DIAGNOSTIGA STAGO INC	510.78	Hospital Supplies
205223	4/3/25	DJ ORTHOPEDICS, LLC	40.68	Hospital Supplies
205435	4/17/25	DJ ORTHOPEDICS, LLC	848.03	Hospital Supplies
205540	4/24/25	DJ ORTHOPEDICS, LLC	1,244.93	Hospital Supplies
EFT000000000084	4/4/25	EITAN GROUP NORTH AMERICA, INC.	691.38	Hospital Supplies
205232	4/3/25	GENERAL HOSPITAL SUPPLY CORPORATION	482.00	Hospital Supplies
205346	4/10/25	GYNEX CORP	199.66	Hospital Supplies
205403	4/10/25	HARDY DIAGNOSTICS	4,073.94	Hospital Supplies
205348	4/10/25	HEALTHCARE LOGISTICS INC	50.00	Hospital Supplies
205234	4/3/25	HEALTHCARE LOGISTICS INC	76.86	Hospital Supplies
205552	4/24/25	HEALTHCARE LOGISTICS INC	357.37	Hospital Supplies
205349	4/10/25	HILL-ROM	392.68	Hospital Supplies
EFT000000000087	4/4/25	HULL ANESTHESIA INC	201.00	Hospital Supplies
EFT000000009066	4/10/2025	IN PRO CORPORATION	2,796.61	Hospital Supplies
205241	4/3/25	INTEGRATED MEDICAL SYSTEMS	69.44	Hospital Supplies
205243	4/3/25	J & J HEALTH CARE SYSTEMS INC	1,975.97	Hospital Supplies
205354	4/10/25	J & J HEALTH CARE SYSTEMS INC	2,493.98	Hospital Supplies
205557	4/24/25	J & J HEALTH CARE SYSTEMS INC	10,848.60	Hospital Supplies
205447	4/17/25	J & J HEALTH CARE SYSTEMS INC	13,127.94	Hospital Supplies
205559	4/24/25	KARL STORZ ENDOSCOPY-AMERICA	7,109.73	Hospital Supplies

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

205355	4/10/25	KARL STORZ ENDOSCOPY-AMERICA	7,200.00	Hospital Supplies
205357	4/10/25	KCI USA	954.95	Hospital Supplies
205451	4/17/25	KCI USA	3,283.30	Hospital Supplies
205390	4/10/25	LEICA BIOSYSTEMS RICHMOND	551.83	Hospital Supplies
205461	4/17/25	M V A P MEDICAL SUPPLIES, INC.	120.00	Hospital Supplies
205367	4/10/25	M V A P MEDICAL SUPPLIES, INC.	143.50	Hospital Supplies
205567	4/24/25	MASIMO AMERICAS, INC.	1,090.00	Hospital Supplies
205455	4/17/25	MASIMO AMERICAS, INC.	1,760.00	Hospital Supplies
205248	4/3/25	MASIMO AMERICAS, INC.	2,406.00	Hospital Supplies
205568	4/24/25	MCKESSON MEDICAL-SURGICAL	289.00	Hospital Supplies
205456	4/17/25	MCKESSON MEDICAL-SURGICAL	305.06	Hospital Supplies
205360	4/10/25	MCKESSON MEDICAL-SURGICAL	652.35	Hospital Supplies
205249	4/3/25	MCKESSON MEDICAL-SURGICAL	1,061.61	Hospital Supplies
205361	4/10/25	MEDELA LLC	107.68	Hospital Supplies
205569	4/24/25	MEDI-DOSE INCORPORATED	15.82	Hospital Supplies
205457	4/17/25	MEDI-DOSE INCORPORATED	132.45	Hospital Supplies
205365	4/10/25	MEDLINE INDUSTRIES INC	46,471.56	Hospital Supplies
205250	4/3/25	MEDLINE INDUSTRIES INC	72,995.92	Hospital Supplies
205571	4/24/25	MEDLINE INDUSTRIES INC	76,469.76	Hospital Supplies
205251	4/3/25	MEDTRONIC, USA	338.00	Hospital Supplies
205366	4/10/25	MEDTRONIC, USA	784.00	Hospital Supplies
EFT000000000089	4/4/25	OLYMPUS AMERICA INC	349.60	Hospital Supplies
EFT000000000124	4/18/25	OLYMPUS AMERICA INC	7,226.00	Hospital Supplies
205467	4/17/25	PATTERSON DENTAL - 408	61.28	Hospital Supplies
205470	4/17/25	PLYMOUTH MEDICAL	395.98	Hospital Supplies
EFT000000000126	4/18/25	QUESET MEDICAL	108.78	Hospital Supplies
EFT000000000090	4/4/25	RADIOMETER AMERICA INC	1,360.31	Hospital Supplies
EFT000000000106	4/11/25	RADIOMETER AMERICA INC	92.80	Hospital Supplies
EFT000000000127	4/18/25	RADIOMETER AMERICA INC	1,405.84	Hospital Supplies
EFT000000000157	4/25/25	RADIOMETER AMERICA INC	2,684.81	Hospital Supplies
205586	4/24/25	RESPIRONICS	165.00	Hospital Supplies
205386	4/10/25	STERIS CORPORATION	134.97	Hospital Supplies
205481	4/17/25	STERIS CORPORATION	1,017.33	Hospital Supplies
205277	4/3/25	STERIS CORPORATION	3,623.70	Hospital Supplies
205593	4/24/25	STERIS CORPORATION	15,357.37	Hospital Supplies
EFT000000009076	4/24/2025	STRYKER INSTRUMENTS	690.04	Hospital Supplies
EFT000000009070	4/10/2025	STRYKER INSTRUMENTS	4,077.18	Hospital Supplies
205596	4/24/25	STRYKER MEDICAL	1,032.00	Hospital Supplies
205281	4/3/25	TELEFLEX MEDICAL INC.	450.00	Hospital Supplies
205286	4/3/25	TRI-ANIM HEALTH SERVICES INC	573.05	Hospital Supplies
205600	4/24/25	TRI-ANIM HEALTH SERVICES INC	1,322.64	Hospital Supplies
205395	4/10/25	TRI-ANIM HEALTH SERVICES INC	1,592.52	Hospital Supplies
205485	4/17/25	TRI-ANIM HEALTH SERVICES INC	1,610.62	Hospital Supplies
205397	4/10/25	UTAH MEDICAL PRODUCTS INC	87.72	Hospital Supplies
205294	4/3/25	UTAH MEDICAL PRODUCTS INC	346.29	Hospital Supplies
205608	4/24/25	VAPOTHERM INC.	657.00	Hospital Supplies
205488	4/17/25	WAXIE SANITARY SUPPLY	167.61	Hospital Supplies
205611	4/24/25	WAXIE SANITARY SUPPLY	3,921.16	Hospital Supplies
205298	4/3/25	WAXIE SANITARY SUPPLY	6,527.64	Hospital Supplies

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

EFT000000000092	4/4/25	SMILEMAKERS	741.89	Hospital Supplies
EFT000000000128	4/18/25	SMILEMAKERS	248.92	Hospital Supplies
EFT000000000159	4/25/25	SMILEMAKERS	972.19	Hospital Supplies
205257	4/3/25	NASACLIP INC.	1,089.00	Hospital Supplies
205218	4/3/25	CTM BIOMEDICAL, LLC	5,091.50	Implant Supplies
EFT000000000105	4/11/25	PARAGON 28 INC.	614.64	Implant Supplies
205484	4/17/25	TRAXSURGICAL INC.	2,000.00	Implant Supplies
205393	4/10/25	TRAXSURGICAL INC.	2,880.00	Implant Supplies
205285	4/3/25	TREACE MEDICAL CONCEPTS, INC.	16,855.00	Implant Supplies
205394	4/10/25	TREACE MEDICAL CONCEPTS, INC.	16,855.00	Implant Supplies
205292	4/3/25	PROVIDENT LIFE & ACCIDENT	38,127.89	Insurance Premiums
EFT000000009062	4/3/2025	ARUP LABORATORIES, INC.	69,141.50	Laboratory Services
EFT000000000138	4/25/25	ARUP LABORATORIES, INC.	68,995.74	Laboratory Services
205460	4/17/25	METABOLIC NEWBORN SCREENING	3,993.00	Laboratory Services
205597	4/24/25	SUMMIT PATHOLOGY	25,352.36	Laboratory Services
EFT000000000093	4/4/25	STATLAB MEDICAL PRODUCTS	209.10	Laboratory Supplies
EFT000000000109	4/11/25	STATLAB MEDICAL PRODUCTS	375.89	Laboratory Supplies
EFT000000000129	4/18/25	STATLAB MEDICAL PRODUCTS	652.06	Laboratory Supplies
205199	4/3/25	BIOMERIEUX, INC.	18,707.09	Laboratory Supplies
EFT000000009064	4/10/2025	BIO-RAD LABORATORIES	7,639.13	Laboratory Supplies
205206	4/3/25	CEPHEID	115.00	Laboratory Supplies
205326	4/10/25	CEPHEID	115.00	Laboratory Supplies
205526	4/24/25	CEPHEID	4,318.20	Laboratory Supplies
205425	4/17/25	CEPHEID	5,073.36	Laboratory Supplies
205228	4/3/25	FISHER HEALTHCARE	1,411.41	Laboratory Supplies
205437	4/17/25	FISHER HEALTHCARE	7,427.78	Laboratory Supplies
205545	4/24/25	FISHER HEALTHCARE	7,436.23	Laboratory Supplies
205337	4/10/25	FISHER HEALTHCARE	9,892.09	Laboratory Supplies
EFT000000009069	4/10/2025	IDENTICARD	285.00	Laboratory Supplies
EFT000000009075	4/24/2025	IDENTICARD	510.08	Laboratory Supplies
EFT000000000153	4/25/25	LIFELOC TECHNOLOGIES	420.00	Laboratory Supplies
205369	4/10/25	NOVA BIOMEDICAL CORP.	40.00	Laboratory Supplies
EFT000000009068	4/10/2025	ORTHO-CLINICAL DIAGNOSITCS INC	647.85	Laboratory Supplies
205265	4/3/25	R&D SYSTEMS INC	92.30	Laboratory Supplies
EFT000000009071	4/10/2025	SYSMEX AMERICA INC.	38.09	Laboratory Supplies
EFT000000009074	4/17/2025	SYSMEX AMERICA INC.	1,754.38	Laboratory Supplies
EFT000000000110	4/11/25	SYSMEX AMERICA INC.	72.53	Laboratory Supplies
205289	4/3/25	TYPENEX MEDICAL, LLC	999.43	Laboratory Supplies
EFT000000000120	4/18/25	MARTIN-RAY LAUNDRY SYSTEMS	3,517.07	Laundry Supplies
EFT000000000154	4/25/25	MARTIN-RAY LAUNDRY SYSTEMS	2,320.00	Laundry Supplies
205433	4/17/25	CROWLEY FLECK ATTORNEYS	88.00	Legal Fees
205239	4/3/25	HUSCH BLACKWELL LLP	3,613.00	Legal Fees
205580	4/24/25	PHILLIPS LAW, LLC	24,394.16	Legal Fees
205274	4/3/25	STANDARD TEXTILE	849.72	Linen
205590	4/24/25	STANDARD TEXTILE	889.56	Linen
205300	4/3/25	WYOMING UROLOGICAL SERVICES, LP	6,200.00	Lithrotripsy Service
205616	4/24/25	WYOMING UROLOGICAL SERVICES, LP	6,200.00	Lithrotripsy Service
EFT000000000082	4/4/25	COMPHEALTH,INC.	124,725.66	Locum Tenens
EFT000000000116	4/18/25	COMPHEALTH,INC.	90,661.58	Locum Tenens

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

EFT000000000132	4/18/25	WEATHERBY LOCUMS, INC	13,669.74	Locum Tenens
EFT000000000076	4/4/25	ABOVE ALL MEDICAL PARTS INC.	2,713.98	Maintenance & Repair
205191	4/3/25	AGILITI SURGICAL EQUIPMENT REPAIR INC.	1,500.00	Maintenance & Repair
205192	4/3/25	ALLEGION ACCESS TECHNOLOGIES	492.00	Maintenance & Repair
205322	4/10/25	BHD TEST AND MEASUREMENT	135.00	Maintenance & Repair
205520	4/24/25	BIO-MED ENGINEERING INC	2,815.00	Maintenance & Repair
205259	4/3/25	OHIO MEDICAL, LLC	792.00	Maintenance & Repair
205466	4/17/25	PARTSSOURCE	65.43	Maintenance & Repair
205261	4/3/25	PARTSSOURCE	244.75	Maintenance & Repair
205575	4/24/25	PARTSSOURCE	795.55	Maintenance & Repair
205371	4/10/25	PARTSSOURCE	1,080.60	Maintenance & Repair
205373	4/10/25	PLAN ONE/ARCHITECTS	552.50	Maintenance & Repair
205381	4/10/25	SCOTTCARE CORPORATION	600.00	Maintenance & Repair
205588	4/24/25	SEPPIE PHYSICAL THERAPY, LLC	1,120.00	Maintenance & Repair
205383	4/10/25	SOUTHWEST DOORS	485.00	Maintenance & Repair
205296	4/3/25	VEOLIA WTS SERVICES USA, INC.	2,135.85	Maintenance & Repair
205610	4/24/25	WASATCH ACCESS SOLUTIONS LLC	890.00	Maintenance & Repair
205508	4/24/25	ACE HARDWARE	10.97	Maintenance Supplies
205407	4/17/25	ACE HARDWARE	172.81	Maintenance Supplies
205193	4/3/25	ALPINE PURE SOFT WATER	1,455.30	Maintenance Supplies
205529	4/24/25	CODALE ELECTRIC SUPPLY, INC	527.39	Maintenance Supplies
205208	4/3/25	CODALE ELECTRIC SUPPLY, INC	1,828.64	Maintenance Supplies
205327	4/10/25	CODALE ELECTRIC SUPPLY, INC	3,438.59	Maintenance Supplies
EFT000000000100	4/11/25	COLORADO DOORWAYS, INC	4,716.18	Maintenance Supplies
EFT000000000118	4/18/25	DJ'S GLASS PLUS, INC.	387.04	Maintenance Supplies
205344	4/10/25	GRAINGER	150.44	Maintenance Supplies
205550	4/24/25	GRAINGER	714.22	Maintenance Supplies
205350	4/10/25	HOME DEPOT	382.76	Maintenance Supplies
205238	4/3/25	HOME DEPOT	592.52	Maintenance Supplies
205555	4/24/25	HOME DEPOT	2,636.01	Maintenance Supplies
205255	4/3/25	MOUNTAIN STATES SUPPLY CO.	615.98	Maintenance Supplies
205464	4/17/25	O'REILLY AUTOMOTIVE STORES, INC	378.53	Maintenance Supplies
205267	4/3/25	ROCK SPRINGS WINNELSON CO	142.92	Maintenance Supplies
EFT000000000131	4/18/25	ULINE, INC	1,671.40	Maintenance Supplies
EFT000000000162	4/25/25	ULINE, INC	151.50	Maintenance Supplies
205614	4/24/25	WOOL WAREHOUSE	850.47	Maintenance Supplies
205256	4/3/25	MOZARC MEDICAL US LLC	194.22	Med Surg Supplies
205225	4/3/25	EDDIE BOGGS	945.06	Membership Dues
205252	4/3/25	MHSC MEDICAL STAFF	10,054.01	Membership Dues
205502	4/22/25	MHSC-FOUNDATION	1,331.51	MHSC Foundation
205307	4/8/25	MHSC-FOUNDATION	2,649.81	MHSC Foundation
EFT000000000137	4/25/25	AMERICAN REGISTRY FOR INTERNET NUMBERS, LTD.	262.50	Minor Equipment
205323	4/10/25	CAMFIL USA INC.	435.63	Minor Equipment
205332	4/10/25	CQ MEDICAL (MEDTEC LLC)	752.00	Minor Equipment
205534	4/24/25	CQ MEDICAL (MEDTEC LLC)	1,902.20	Minor Equipment
205240	4/3/25	INSTRUMENT SPECIALISTS, INC.	731.86	Minor Equipment
205370	4/10/25	OP MEDICAL SUPPLY	410.15	Minor Equipment
205282	4/3/25	TERMINIX OF WYOMING	511.00	Monthly Pest Control
205410	4/17/25	AFFORDABLE FUNERAL SUPPLY, LLC	804.32	Non Medical Supplies

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

EFT000000000079	4/4/25	ALTA MEDICAL SPECIALTIES	212.33	Non Medical Supplies
205549	4/24/25	GLOBAL EQUIPMENT COMPANY	329.49	Non Medical Supplies
205342	4/10/25	GLOBAL EQUIPMENT COMPANY	329.85	Non Medical Supplies
205458	4/17/25	MEDIBADGE INC	396.85	Non Medical Supplies
205541	4/24/25	ENCOMPASS GROUP, LLC	2,714.20	Office Supplies
EFT000000000160	4/25/25	SMYTH PRINTING	411.40	Office Supplies
205384	4/10/25	STANDARD REGISTER COMPANY	658.36	Office Supplies
205275	4/3/25	STANDARD REGISTER COMPANY	1,398.90	Office Supplies
205591	4/24/25	STAPLES BUSINESS ADVANTAGE	112.12	Office Supplies
205479	4/17/25	STAPLES BUSINESS ADVANTAGE	2,071.69	Office Supplies
205276	4/3/25	STAPLES BUSINESS ADVANTAGE	3,013.62	Office Supplies
205301	4/3/25	YOUNG AT HEART SENIOR CITIZENS CENTER	1,970.00	Other Employee Benefits
205302	4/3/25	TURN UP THE VOLUME DJ SERVICES	300.00	Other Employee Benefits
205613	4/24/25	DR. W. MARCUS BRANN	4,104.00	Other Physician Fees
205406	4/17/25	ABMS SOLUTIONS, LLC	850.00	Other Purchased Services
EFT000000000078	4/4/25	ALSCO AMERICAN LINEN	44.93	Other Purchased Services
EFT000000000096	4/11/25	ALSCO AMERICAN LINEN	44.93	Other Purchased Services
EFT000000000112	4/18/25	ALSCO AMERICAN LINEN	44.93	Other Purchased Services
EFT000000000136	4/25/25	ALSCO AMERICAN LINEN	108.45	Other Purchased Services
EFT000000000140	4/25/25	BISCOM	2,149.84	Other Purchased Services
EFT000000000099	4/11/25	CELERITY SOLUTIONS GROUP, LLC	2,929.50	Other Purchased Services
205528	4/24/25	CJ SIGNS	918.00	Other Purchased Services
EFT000000000115	4/18/25	CLEANIQUE PROFESSIONAL SERVICES	4,350.00	Other Purchased Services
EFT000000000144	4/25/25	CONSUMER FUSION INC.	5,175.00	Other Purchased Services
205334	4/10/25	DATA INNOVATIONS LLC	1,730.00	Other Purchased Services
EFT000000000152	4/25/25	ISI WATER CHEMISTRIES	2,679.90	Other Purchased Services
EFT000000000155	4/25/25	MAYO COLLABORATIVE SERVICES, INC.	437.44	Other Purchased Services
EFT000000000121	4/18/25	MEDICAL PACKAGING LLC	499.05	Other Purchased Services
205254	4/3/25	MOMENTS BY TAYLOR PHOTOGRAPHY	475.00	Other Purchased Services
EFT000000000123	4/18/25	MOUNTAIN STATES EMPLOYERS COUNCIL	3,540.00	Other Purchased Services
EFT000000000088	4/4/25	NUANCE COMMUNICATIONS, INC	210.00	Other Purchased Services
205359	4/10/25	QUICK RESPONSE TAXI	53.00	Other Purchased Services
205565	4/24/25	QUICK RESPONSE TAXI	59.00	Other Purchased Services
205246	4/3/25	QUICK RESPONSE TAXI	132.00	Other Purchased Services
205453	4/17/25	QUICK RESPONSE TAXI	212.00	Other Purchased Services
EFT000000000130	4/18/25	SWEETWATER COUNTY SOLID WASTE	70.00	Other Purchased Services
EFT000000000077	4/4/25	AIRGAS INTERMOUNTAIN INC	6,069.70	Oxygen Rental
EFT000000000095	4/11/25	AIRGAS INTERMOUNTAIN INC	425.66	Oxygen Rental
EFT000000000135	4/25/25	AIRGAS INTERMOUNTAIN INC	6,393.84	Oxygen Rental
205310	4/8/25	UNITED WAY OF SOUTHWEST WYOMING	183.24	Payroll Deduction
205505	4/22/25	UNITED WAY OF SOUTHWEST WYOMING	183.24	Payroll Deduction
205603	4/24/25	UNITED WAY OF SOUTHWEST WYOMING	850.00	Payroll Deduction
205303	4/8/25	CIRCUIT COURT 3RD JUDICIAL	140.89	Payroll Garnishment
205500	4/22/25	CIRCUIT COURT 3RD JUDICIAL	315.89	Payroll Garnishment
205305	4/8/25	CIRCUIT COURT 3RD JUDICIAL	328.06	Payroll Garnishment
205304	4/8/25	CIRCUIT COURT 3RD JUDICIAL	387.63	Payroll Garnishment
205499	4/22/25	CIRCUIT COURT 3RD JUDICIAL	410.19	Payroll Garnishment
205501	4/22/25	DISTRICT COURT THIRD JUDICIAL DIST	1,181.66	Payroll Garnishment
205306	4/8/25	DISTRICT COURT THIRD JUDICIAL DIST	1,181.90	Payroll Garnishment

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

205308	4/8/25	STATE OF WYOMING DFS/CSES	566.30	Payroll Garnishment
205503	4/22/25	STATE OF WYOMING DFS/CSES	566.30	Payroll Garnishment
205309	4/8/25	TX CHILD SUPPORT SDU	461.54	Payroll Garnishment
205504	4/22/25	TX CHILD SUPPORT SDU	461.54	Payroll Garnishment
W/T	4/8/25	PAYROLL 8	2,000,000.00	Payroll Transfer
W/T	4/22/25	PAYROLL 9	2,100,000.00	Payroll Transfer
205253	4/3/25	MHSC - PETTY CASH	19.50	Petty Cash
EFT000000000143	4/25/25	CARDINAL HEALTH PHARMACY MGMT	1,118,690.34	Pharmacy Management
205288	4/3/25	DR. TRISTAN MELE	30,000.00	Physician Recruitment
205553	4/24/25	HOLIDAY INN EXPRESS - LONE TREE HOSPITALITY, LLC	447.00	Physician Recruitment
205443	4/17/25	HOLIDAY INN EXPRESS - LONE TREE HOSPITALITY, LLC	4,368.00	Physician Recruitment
205476	4/17/25	DR SAMER KATTAN	8,333.33	Physician Retention
205408	4/17/25	ADVANCED MEDICAL IMAGING, LLC	20,819.00	Physician Services
205535	4/24/25	CURATIVE TALENT, LLC	205.17	Physician Services
205219	4/3/25	CURATIVE TALENT, LLC	42,480.00	Physician Services
205434	4/17/25	CURATIVE TALENT, LLC	67,561.43	Physician Services
205263	4/3/25	QLER PHYSICIAN MEDICAL GROUP, P.A.	17,670.00	Physician Services
205604	4/24/25	UNIVERSITY OF UTAH (UUHC OUTREACH)	118,843.83	Physician Services
205291	4/3/25	UNIVERSITY OF UTAH (UUHC OUTREACH)	126,553.83	Physician Services
205510	4/24/25	AIDVANTAGE	2,500.00	Physician Student Loan
205551	4/24/25	GREAT LAKES	1,666.67	Physician Student Loan
205537	4/24/25	MOHELA	1,666.67	Physician Student Loan
205538	4/24/25	MOHELA	1,666.67	Physician Student Loan
205573	4/24/25	MOHELA	2,500.00	Physician Student Loan
205606	4/24/25	US DEPARTMENT OF EDUCATION	3,333.34	Physician Student Loan
205607	4/24/25	US DEPT OF EDUCATION	1,666.67	Physician Student Loan
205431	4/17/25	COPIC INSURANCE COMPANY	1,950.00	Professional Liability Insurance
205509	4/24/25	ADVANCED MEDICAL REVIEWS, INC	1,556.24	Professional Service
205194	4/3/25	AMERICAN COLLEGE OF RADIOLOGY	5,000.00	Professional Service
205544	4/24/25	CE BROKER	518.28	Professional Service
205570	4/24/25	MEDICAL PHYSICS CONSULTANTS, INC	1,100.00	Professional Service
205362	4/10/25	MEDICAL PHYSICS CONSULTANTS, INC	2,250.00	Professional Service
EFT000000000103	4/11/25	MOUNTAIN STATES MEDICAL PHYSICS	12,573.69	Professional Service
EFT000000000125	4/18/25	P3 CONSULTING LLC	768.75	Professional Service
EFT000000009072	4/10/2025	WESTERN STAR COMMUNICATIONS	814.00	Professional Service
205530	4/24/25	COLLEGE OF AMERICAN PATHOLOGY	347.86	Proficiency Testing
EFT000000009067	4/10/2025	LANDAUER INC	143.05	Radiation Monitoring
EFT000000000083	4/4/25	CURIUM US LLC	6,036.92	Radioactive Material
205231	4/3/25	GE HEALTHCARE INC	1,092.02	Radiology Material
205440	4/17/25	GE HEALTHCARE INC	2,003.20	Radiology Material
205548	4/24/25	GE HEALTHCARE INC	2,003.20	Radiology Material
205577	4/24/25	PHARMALOGIC WY, LTD	8,420.26	Radiology Material
205468	4/17/25	PINESTAR TECHNOLOGY, INC.	468.00	Radiology Material
205201	4/3/25	BRIAN BARTON, PA-C	1,003.57	Reimbursement - CME
205421	4/17/25	DR. BRIANNE CROFTS	1,154.85	Reimbursement - CME
205473	4/17/25	DR. RAHUL PAWAR	4,607.44	Reimbursement - CME
205284	4/3/25	DR.TONY PEDRI	2,598.80	Reimbursement - CME
205446	4/17/25	ISRAEL STEWART, DO	1,498.94	Reimbursement - CME
205247	4/3/25	MARIAH PACHECO	2,300.81	Reimbursement - CME

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

205480	4/17/25	STARLA LEETE	1,863.83	Reimbursement - CME
205411	4/17/25	AIMEE URBIN	196.08	Reimbursement - Education & Travel
205413	4/17/25	AMY LUCY	279.40	Reimbursement - Education & Travel
205414	4/17/25	ANGEL BENNETT	206.34	Reimbursement - Education & Travel
205514	4/24/25	ANGEL BENNETT	598.11	Reimbursement - Education & Travel
205202	4/3/25	DR. BRYTTON LONG	173.28	Reimbursement - Education & Travel
205448	4/17/25	DR. JANENE GLYN	1,904.89	Reimbursement - Education & Travel
205245	4/3/25	DR. LAWRENCE LAURIDSEN	263.34	Reimbursement - Education & Travel
205489	4/17/25	DR. WILLIAM SARETTE	1,166.22	Reimbursement - Education & Travel
205543	4/24/25	ERIKA TAYLOR	589.51	Reimbursement - Education & Travel
205439	4/17/25	FRED MATTI	1,780.39	Reimbursement - Education & Travel
205445	4/17/25	IRENE RICHARDSON	718.97	Reimbursement - Education & Travel
205558	4/24/25	JAN LAYNE	589.51	Reimbursement - Education & Travel
205450	4/17/25	KARI QUICKENDEN	529.92	Reimbursement - Education & Travel
205562	4/24/25	LACEY DAVIS	61.56	Reimbursement - Education & Travel
205566	4/24/25	LINDSEY O'TOOLE	50.00	Reimbursement - Education & Travel
205572	4/24/25	MINDY BYRD	77.52	Reimbursement - Education & Travel
205576	4/24/25	PATTY O'LEXEY	272.78	Reimbursement - Education & Travel
205585	4/24/25	RACHEL LANCE	2,340.79	Reimbursement - Education & Travel
205385	4/10/25	STEPHANIE DUPAPE	116.28	Reimbursement - Education & Travel
205278	4/3/25	STEVEN CROFT, M.D.	3,865.63	Reimbursement - Education & Travel
205598	4/24/25	TASHA HARRIS	875.00	Reimbursement - Education & Travel
205398	4/10/25	VALERIE BOGGS	75.00	Reimbursement - Education & Travel
W/T	4/8/25	PCS 3/27/25	172.48	Retirement
W/T	4/7/25	PCS 3/27/25	156,483.11	Retirement
W/T	4/7/25	PCS MATCH 3/27/25	102,962.46	Retirement
W/T	4/17/25	PCS MATCH 4/10/25	164,017.77	Retirement
W/T	4/17/25	PCS MATCH 4/10/25	106,806.59	Retirement
205513	4/24/25	ALZHEIMER'S ASSOCIATION	1,800.00	Sponsorship
205200	4/3/25	BOYS & GIRLS CLUB OF SWEETWATER COUNTY	1,700.00	Sponsorship
205224	4/3/25	DRAG FOR A CAUSE	450.00	Sponsorship
205280	4/3/25	FARSON-EDEN HIGH SCHOOL-FES ACTIVITY	100.00	Sponsorship
205233	4/3/25	GREEN RIVER GIRLS SOFTBALL ASSOCIATION	800.00	Sponsorship
205345	4/10/25	GRHS BOYS SOCCER	200.00	Sponsorship
205352	4/10/25	INTERNATIONAL DAYS, INC	2,000.00	Sponsorship
205268	4/3/25	ROCK SPRINGS PRIDE	450.00	Sponsorship
205273	4/3/25	SOCIETY OF PETROLEUM ENGINEERS	500.00	Sponsorship
205391	4/10/25	SWEETEST FOUNDATION	350.00	Sponsorship
205618	4/24/25	WYOMING DIVISION OF VCTIM SERVICES	500.00	Sponsorship
205299	4/3/25	WYOMING HEALTH RESOURCES	1,000.00	Sponsorship
205507	4/24/25	ACADEMY OF LYMPHATIC STUDIES	108.00	Surgery Supplies
205189	4/3/25	ADVANCED STERILIZATION PRODUCTS INC.	96.12	Surgery Supplies
205412	4/17/25	ALI MED INC	188.59	Surgery Supplies
205311	4/10/25	ALI MED INC	295.66	Surgery Supplies
205511	4/24/25	ALI MED INC	578.88	Surgery Supplies
205321	4/10/25	BECTON DICKINSON	1,538.00	Surgery Supplies
205519	4/24/25	BECTON DICKINSON	3,859.75	Surgery Supplies
205420	4/17/25	BECTON DICKINSON	4,534.75	Surgery Supplies
205198	4/3/25	BECTON DICKINSON	6,335.67	Surgery Supplies

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

205521	4/24/25	BLUE ENDO	344.38	Surgery Supplies
205426	4/17/25	CIVCO RADIOTHERAPY	1,061.25	Surgery Supplies
205527	4/24/25	CIVCO RADIOTHERAPY	1,425.00	Surgery Supplies
205329	4/10/25	CONMED LINVATEC	70.70	Surgery Supplies
205429	4/17/25	CONMED LINVATEC	1,943.00	Surgery Supplies
205430	4/17/25	COOPER SURGICAL	59.15	Surgery Supplies
205331	4/10/25	COOPER SURGICAL	104.45	Surgery Supplies
205213	4/3/25	COOPER SURGICAL	275.68	Surgery Supplies
205532	4/24/25	COOPER SURGICAL	1,808.90	Surgery Supplies
205215	4/3/25	COVIDIEN SALES LLC, DBA GIVEN IMAGING	602.69	Surgery Supplies
205432	4/17/25	COVIDIEN SALES LLC, DBA GIVEN IMAGING	6,789.34	Surgery Supplies
205222	4/3/25	DIRECT SUPPLY	491.96	Surgery Supplies
205542	4/24/25	EQUASHIELD LLC	1,648.00	Surgery Supplies
205226	4/3/25	EQUASHIELD LLC	2,948.00	Surgery Supplies
205343	4/10/25	GLOBAL FOCUS MARKETING AND DISTRIBUTION, LTD.	60.46	Surgery Supplies
EFT000000000086	4/4/25	GREER LABORATORIES, INC	5,303.59	Surgery Supplies
EFT000000000149	4/25/25	GREER LABORATORIES, INC	3,806.95	Surgery Supplies
205353	4/10/25	INTUITIVE SURGICAL INC.	10,259.00	Surgery Supplies
205242	4/3/25	INTUITIVE SURGICAL INC.	40,539.68	Surgery Supplies
205364	4/10/25	MEDICUS HEALTH	956.00	Surgery Supplies
205459	4/17/25	MERCURY MEDICAL	212.31	Surgery Supplies
205368	4/10/25	NEOGEN CORPORATION	397.90	Surgery Supplies
EFT000000000165	4/25/25	NEOTECH PRODUCTS, INC	92.00	Surgery Supplies
205478	4/17/25	SMITH & NEPHEW ENDOSCOPY INC	1,967.00	Surgery Supplies
205594	4/24/25	STRYKER ENDOSCOPY	304.55	Surgery Supplies
205482	4/17/25	STRYKER ENDOSCOPY	647.22	Surgery Supplies
205388	4/10/25	STRYKER ENDOSCOPY	6,111.60	Surgery Supplies
205389	4/10/25	STRYKER ORTHOPAEDICS	7,452.63	Surgery Supplies
205279	4/3/25	STRYKER ORTHOPAEDICS	17,075.00	Surgery Supplies
205595	4/24/25	STRYKER ORTHOPAEDICS	64,855.68	Surgery Supplies
205599	4/24/25	TELEFLEX LLC	1,920.00	Surgery Supplies
205402	4/10/25	XODUS MEDICAL, INC.	560.00	Surgery Supplies
205582	4/24/25	PRESS GANEY ASSOCIATES, INC	4,980.92	Surveys
205564	4/24/25	LANGUAGE LINE SERVICES	3,839.18	Translation Services
205506	4/24/25	1350 APPAREL	84.00	Uniforms
205583	4/24/25	QUARTERMASTER	471.96	Uniforms
205312	4/10/25	ALL WEST COMMUNICATIONS	6,062.13	Utilities
205317	4/10/25	AT&T	43.97	Utilities
205196	4/3/25	AT&T	105.02	Utilities
205318	4/10/25	AT&T	336.24	Utilities
205584	4/24/25	CENTURY LINK	1,946.84	Utilities
205264	4/3/25	CENTURY LINK	2,004.48	Utilities
205376	4/10/25	CENTURY LINK	3,070.85	Utilities
205491	4/18/25	CENTURY LINK	5,173.48	Utilities
205539	4/24/25	DISH NETWORK LLC	97.64	Utilities
205472	4/17/25	DOMINION ENERGY WYOMING	32,391.39	Utilities
205474	4/17/25	ROCK SPRINGS MUNICIPAL UTILITY	11,679.10	Utilities
205475	4/17/25	ROCKY MOUNTAIN POWER	46,350.65	Utilities
205612	4/24/25	WHITE MOUNTAIN WATER & SEWER DISTRICT	65.18	Utilities

MEMORIAL HOSPITAL OF SWEETWATER COUNTY
GENERAL FUND DISBURSEMENTS
04/30/2025

205387	4/10/25	STERICYCLE,INC,	1,845.85	Waste Disposal
205227	4/3/25	ESCAPE DAY SPA	460.00	WCRS
205404	4/15/25	STEMS AND CO.	900.00	WCRS
W/T	4/18/25	WC QTR 1	136,011.33	Workers Compensation
			10,762,799.03	

Memorial Hospital of Sweetwater County
County Voucher Summary
as of month ending April 30, 2025

Vouchers Submitted by MHSC at agreed discounted rate		
July 2024	$45,604.93	
August 2024	$0.00	
September 2024	$41,031.27	
October 2024	$0.00	
November 2024	$36,972.81	
December 2024	$35,266.04	
January 2025	$0.00	
February 2025	$44,725.43	
March 2025	$0.00	
April 2025	$52,249.88	
May 2025		
June 2025		
County Requested Total Vouchers Submitted	$255,850.36	
Total Vouchers Submitted FY 25		$255,850.36
Less: Total Approved by County and Received by MHSC FY 25		$255,850.36
Total Vouchers Pending Approval by County		$0.00

FY25 Title 25 Fund Budget from Sweetwater County	$319,167.00
Funds Received From Sweetwater County	$255,850.36
FY25 Title 25 Fund Budget Remaining	$63,316.64
Total Budgeted Vouchers Pending Submittal to County	$0.00

FY25 Maintenance Fund Budget from Sweetwater County	$1,375,536.00
County Maintenance FY25 - July	$267,590.41
County Maintenance FY25 - August	$0.00
County Maintenance FY25 - September	$0.00
County Maintenance FY25 - October	$0.00
County Maintenance FY25 - November	$80,048.00
County Maintenance FY25 - December	$0.00
County Maintenance FY25 - January	$157,445.10
County Maintenance FY25 - February	$0.00
County Maintenance FY25 - March	$88,648.87
County Maintenance FY25 - April	
County Maintenance FY25 - May	
County Maintenance FY25 - June	
	$593,732.38
FY25 Maintenance Fund Budget Remaining	$781,803.62

IS Report April 2025

By Terry (TJ) Thompson, IS Director

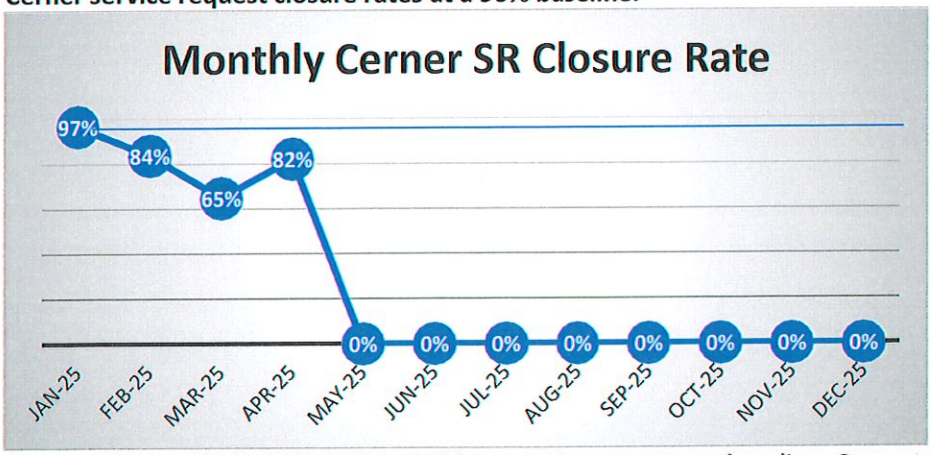
MHSC IS service environment:

- 1158 computer user accounts
- 100 portable devices, Cell Phones, and iPads
- 790 Desktop systems, Laptops, and Desktops
- 562 VoIP Telephony devices
- 164 Servers, 158 being virtual systems.
- 86 Networking Nodes
- 103 Wireless devices
- 18 Uninterrupted Power Supplies

MHSC IS Service Request closure rates at a 95% baseline:

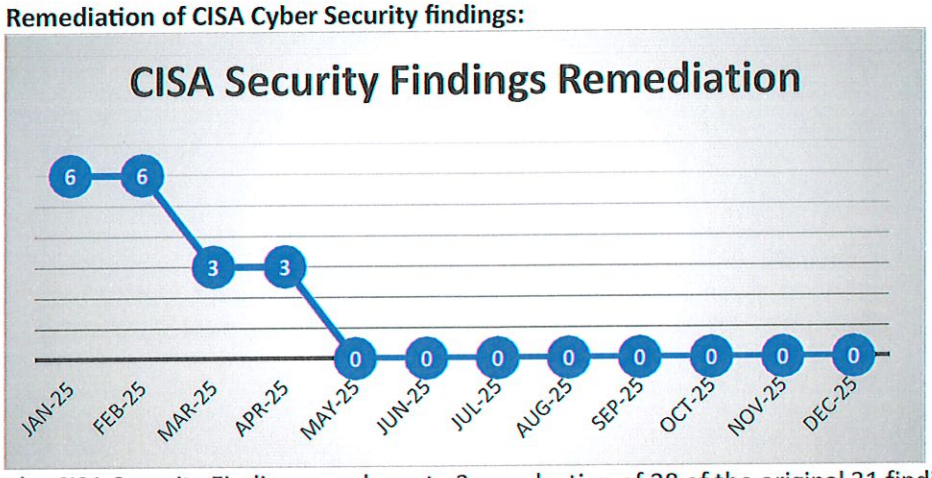
Service Desk achieved 96% of our 95% monthly meantime to restore baseline. Where the service desk closed 771 of the 923 service tickets opened, 123 of which are pending.

Cerner service request closure rates at a 90% baseline:



Cerner achieved 82% of the 90% monthly meantime to restore baseline. Cerner closed 64 of the 95 service requests of which 17 are pending, leaving 14 SR opened.

Remediation of CISA Cyber Security findings:



The CISA Security Findings are down to 3, a reduction of 28 of the original 31 findings.

The remaining seven CISA security findings are known as heavy lift issues which require a restructuring of MHSC systems and network where we must make infrastructure changes without outages. We are slowly making these changes and will continue to monitor the remaining CISA issues. With the new Intune configuration, we are seeing improvement with system security. We were able to move to our public IP space removing the FatPipe systems reducing our vulnerability down to three.

Below is the latest CISA Cyber Hygiene Report Card, which is performed weekly. CISA is scanning MHSC 44 external public IP addresses for vulnerabilities. We have 44 scanned addresses, with 8 hosts and 14, we hope to have many of these security findings remediate. Where now that we have new public IP addresses we need to notify CISA of this change.

2025-04-20

CYBER HYGIENE

REPORT CARD

Memorial Hospital of Sweetwater County

0 Hosts with unsupported software

0 Potentially Risky Open Services

0% No Change in Vulnerable Hosts

CISA CYBER+INFRASTRUCTURE

HIGH LEVEL FINDINGS

LATEST SCANS

February 12, 2025 — April 27, 2025
Completed host scan on all assets

No vulnerability scans yet
Last vulnerability scan on all hosts

ASSETS OWNED

44
No Change

ASSETS SCANNED

44
No Change
100% of assets scanned

HOSTS

0
No Change

SERVICES

0
No Change

VULNERABLE HOSTS

0
No Change
0% of hosts vulnerable

VULNERABILITIES

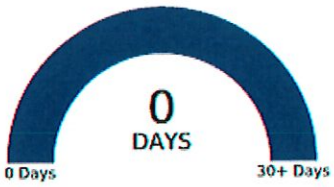
0
No Change

VULNERABILITIES

SEVERITY BY PROMINENCE

VULNERABILITY RESPONSE TIME

MAX AGE OF ACTIVE CRITICALS



MAX AGE OF ACTIVE HIGHS

POTENTIALLY RISKY OPEN SERVICES

RDP* 0	FTP 0
Telnet* 0	RPC 0
SMB* 0	SQL 0
LDAP 0	IRC 0
NETBIOS 0	Kerberos 0

None Open | Open, No New | Newly Opened

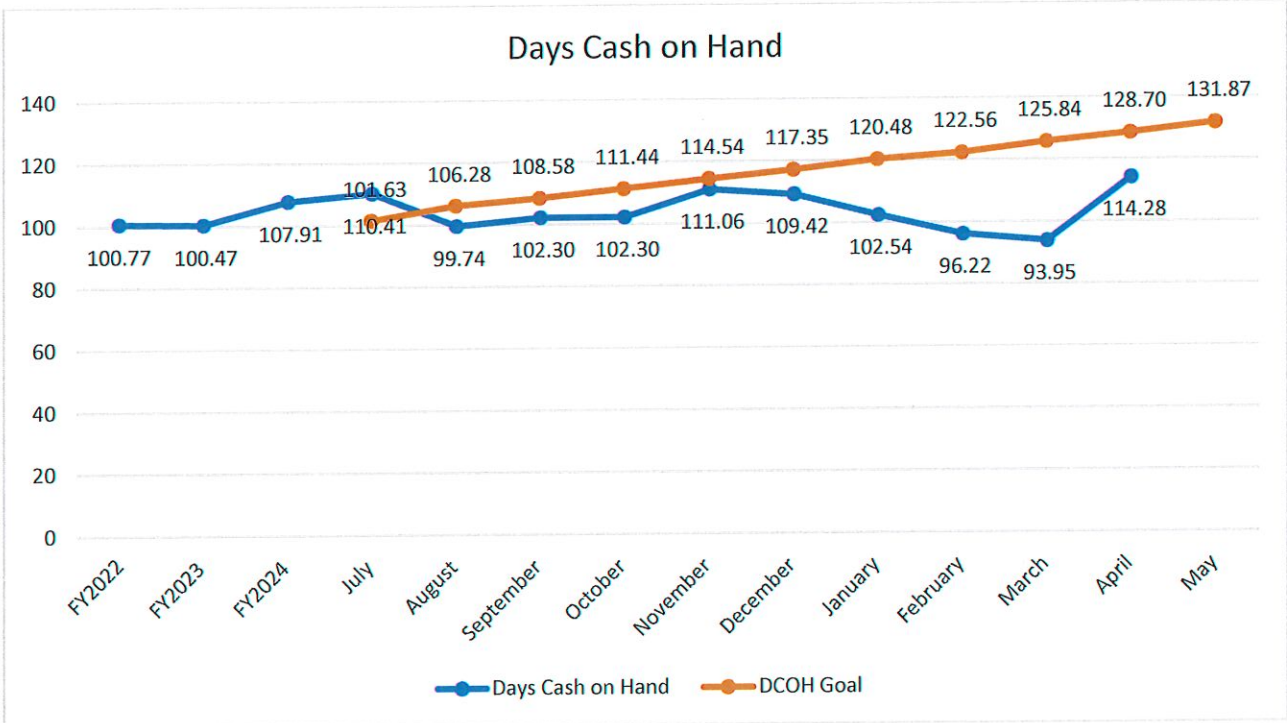
Service counts are best guesses and may not be 100% accurate. Details can be found in "potentially-risky-services.csv" in Appendix G.

** Denotes the possibility of a network management interface.*

Strategic Plan – Finance Pillar Goals – Fiscal Year 2025. The revenue cycle goals for fiscal year 2025 have been created in conjunction with the objectives of the finance pillar of the new Strategic Plan. For fiscal year 2025, we will continue to focus on the following revenue cycle metrics: Days Cash on Hand (DCOH), Days in Accounts Receivable (AR), Cash Collections, Claims Denial Rate, Discharged Not Final Billed Days (DNFB), and Accounts Receivable aging. We have included prior fiscal year data for reference when available.

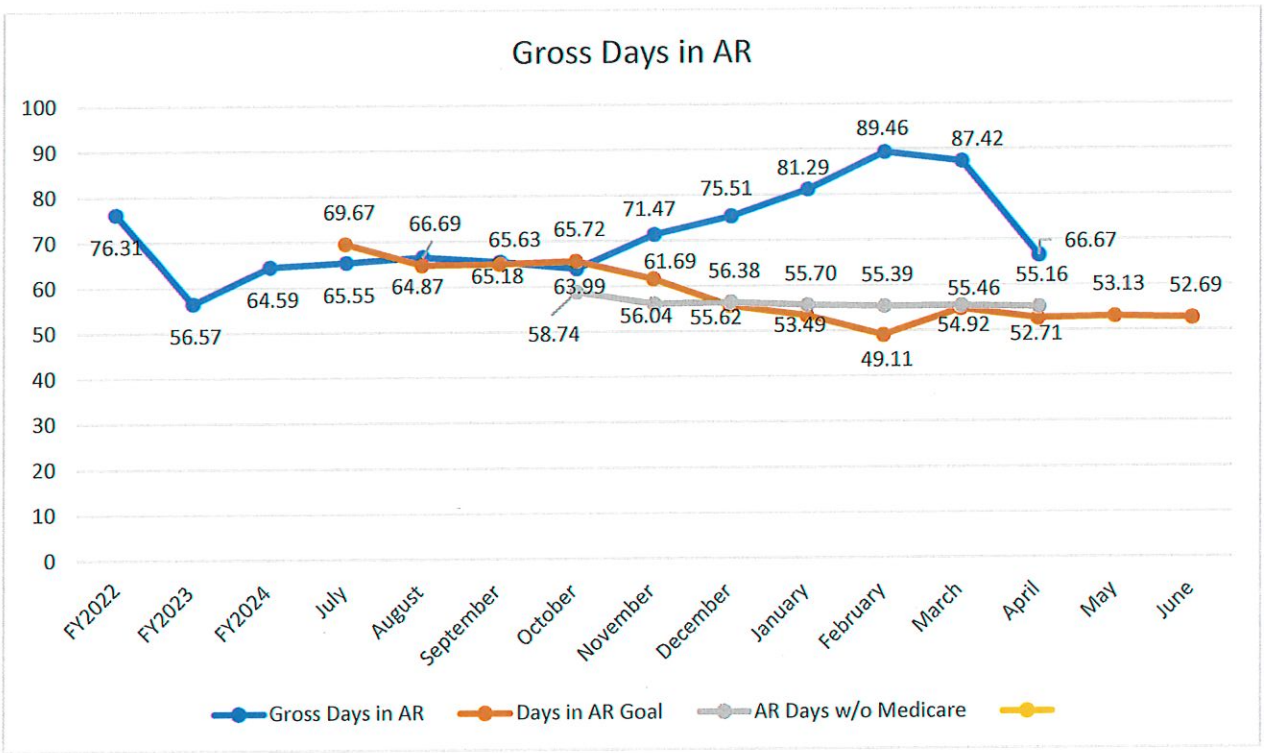
- **Days Cash on Hand** represents the number of days the hospital can operate without cash receipts utilizing all sources of cash available. We have set interim goals of 109 days for September, 117 days for December, 126 days for March and 133 days for year end.

    - There was an increase of twenty days in DCOH, coming in at 114, below the goal for the month. Cash collections were $17.2 million, over budget as Medicare processed over $19 million in claims. Daily cash expense increased to $339,861 in April.

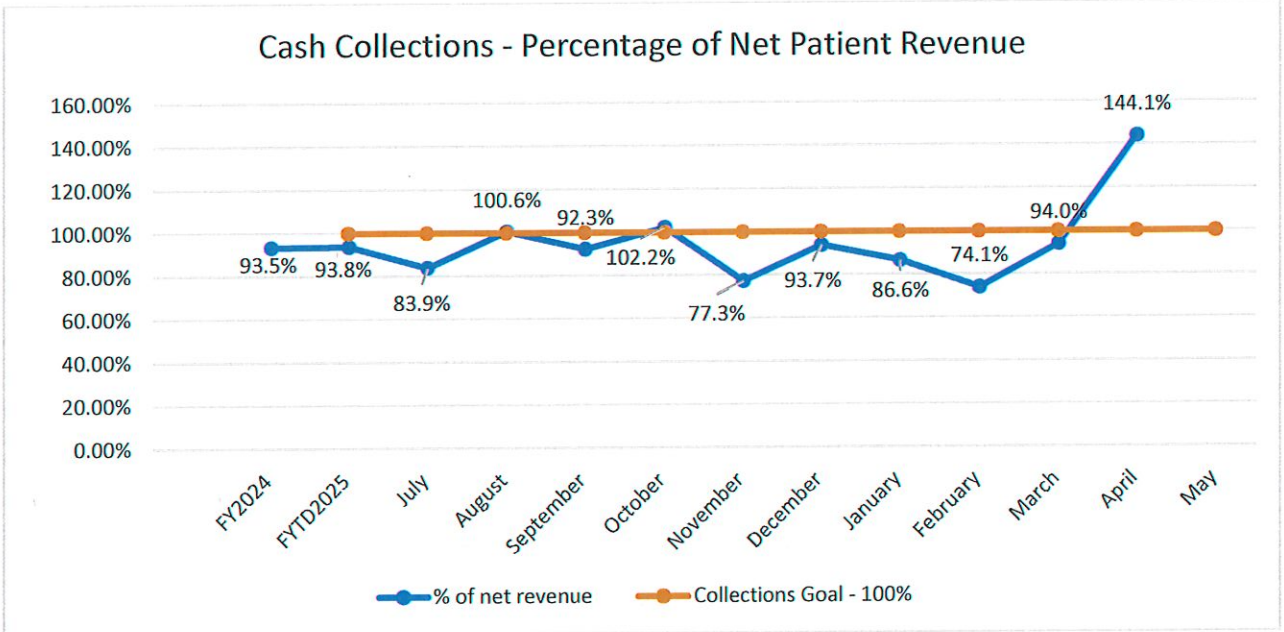


- **Days in Accounts Receivable** represents the number of days of patient charges tied up in unpaid patient accounts. We have set interim goals of 65 days for September, 56 days for December, 55 for March and 53 by year end.

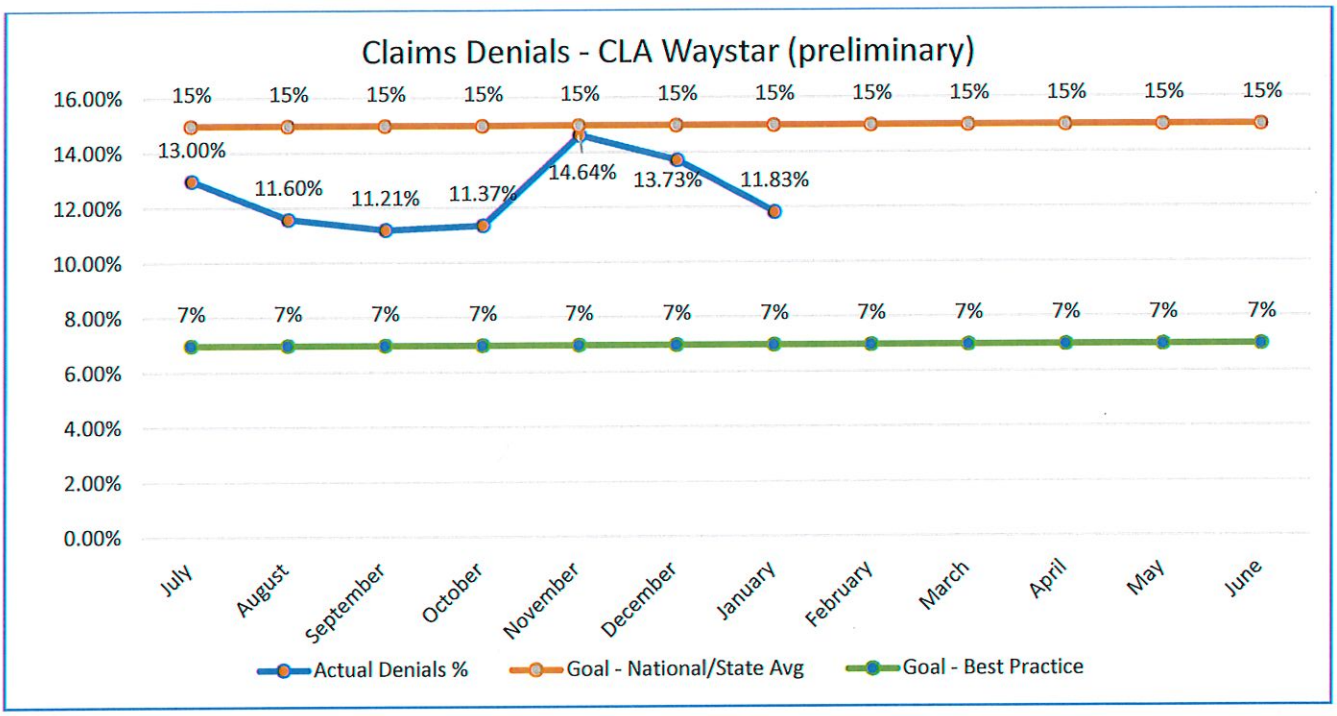
    - Days in AR decreased in April as Medicare processed delayed claims, coming in at 66.67, still over the goal of 52.7. Gross AR decreased by $16.2 million from March and Medicare AR is currently down by $19 million since March 31st. **When the estimated Medicare outstanding AR is removed, Days in AR are estimated at 55 in April.**



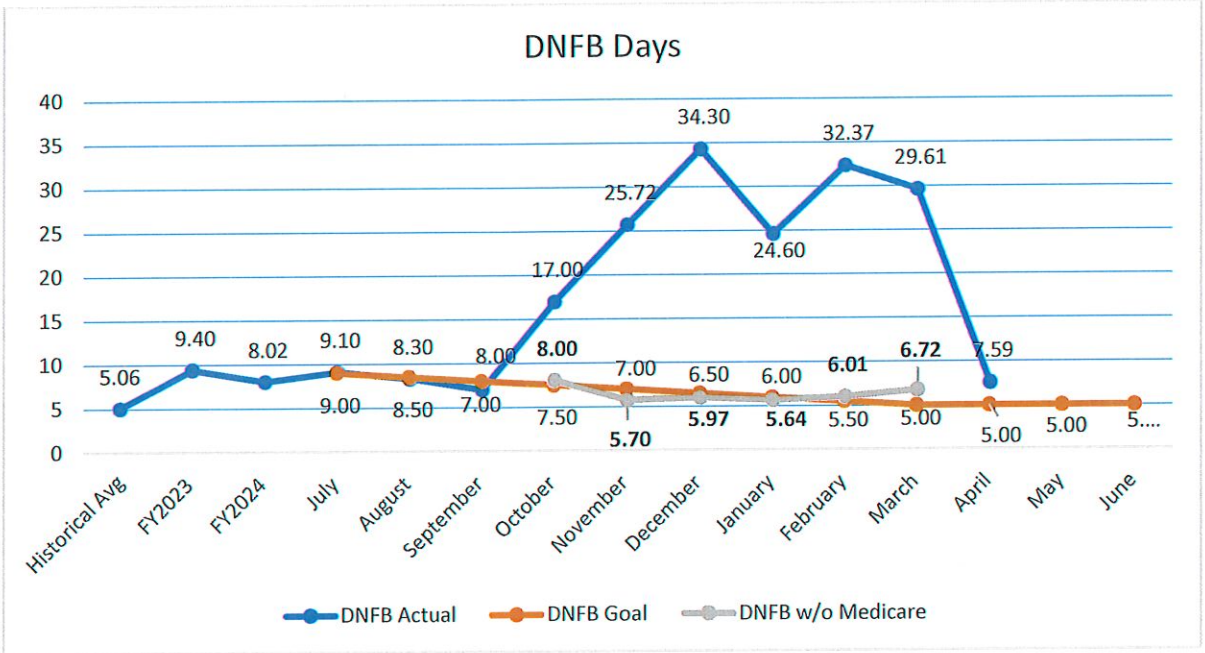
- **Cash Collections** – The goal for cash collections is 100% or > than net patient revenue.
    - Cash collections for April were higher, at $17.2 million, or 144% of net patient revenue, above the goal for the month and increasing the year-to-date percentage to 93.8%.



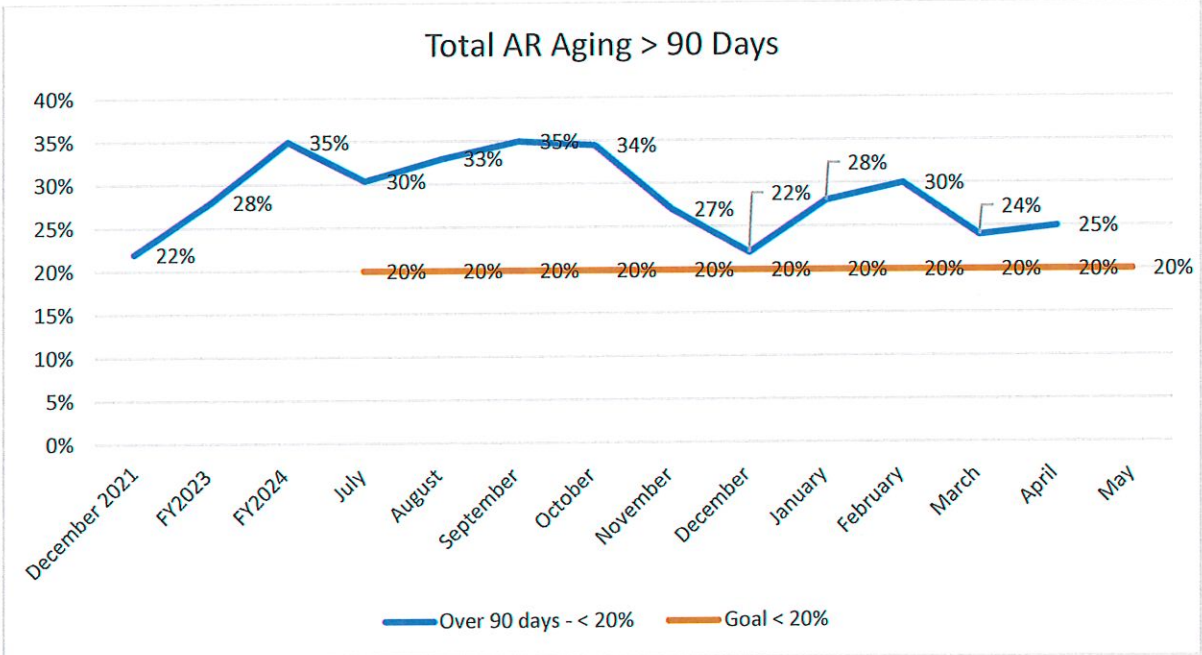
- **Denial Rate** – The denial rate is the percentage of all submitted claims denied by payers. A lower denial rate means improved cash flow. Current state and national benchmarks are at 15%. We have set interim goals of 20% for September, 17% for December, 15% for March and maintaining 15% by year end. Due to meeting the goal, we have added a stretch goal of 7%.
    - We continue to work with CLA and their new software and can report preliminary numbers through January, coming in at 11.83%.



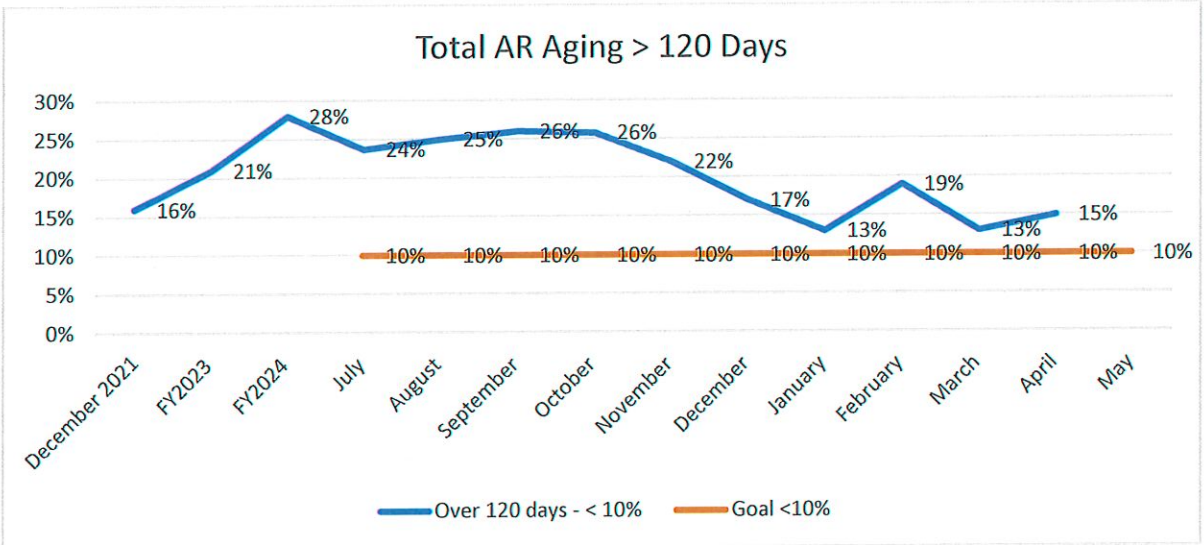
- **DNFB Days – Discharged Not Final Billed days**. Patient accounts that have been discharged but not billed. DNFB includes billing holds, corrections required, credit balances, waiting for coding, ready to bill and standard delay which are accounts held for 3 days before being released for billing. This allows for all charges to be posted, charts documented, and coding completed. The goal for DNFB days is 5 days by the end of the fiscal year.
    - DNFB Days decreased to 7.59 days in April as all aging Medicare claims were billed.



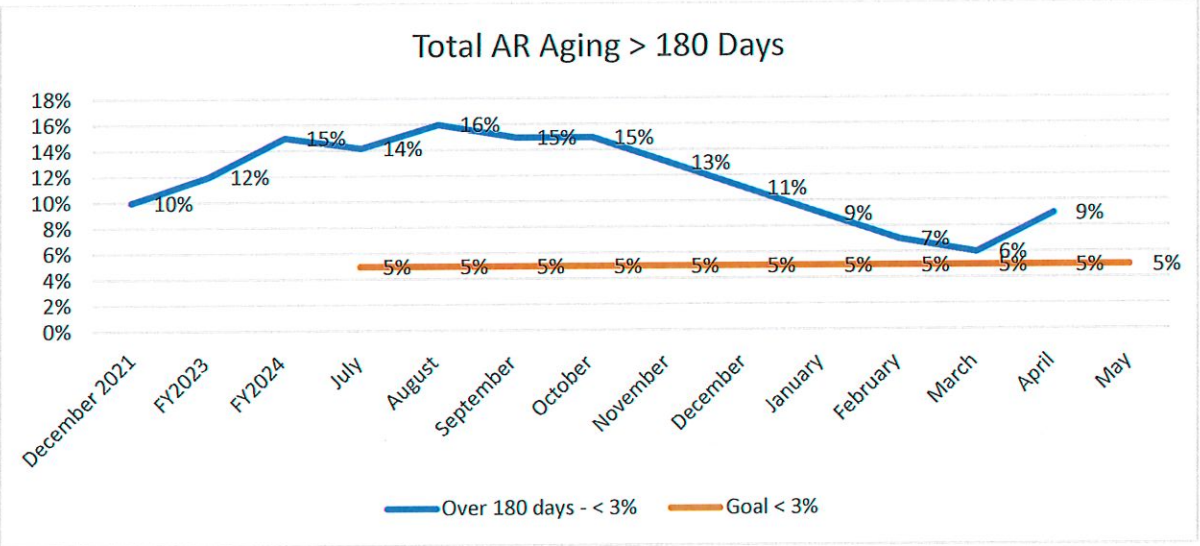
- **Total Accounts Receivable aging** – Goals were set based on national benchmarks received from CLA. These aging ratios are being impacted by the Medicare claims delay. or Medicare claims fell into aging based on the discharge date of the patient account, with some being over 120 days old. With Medicare accounts being paid, balances are transferred to supplement and secondary accounts, aging at original discharge date.



- Days over 90 days increased to 25% for April.



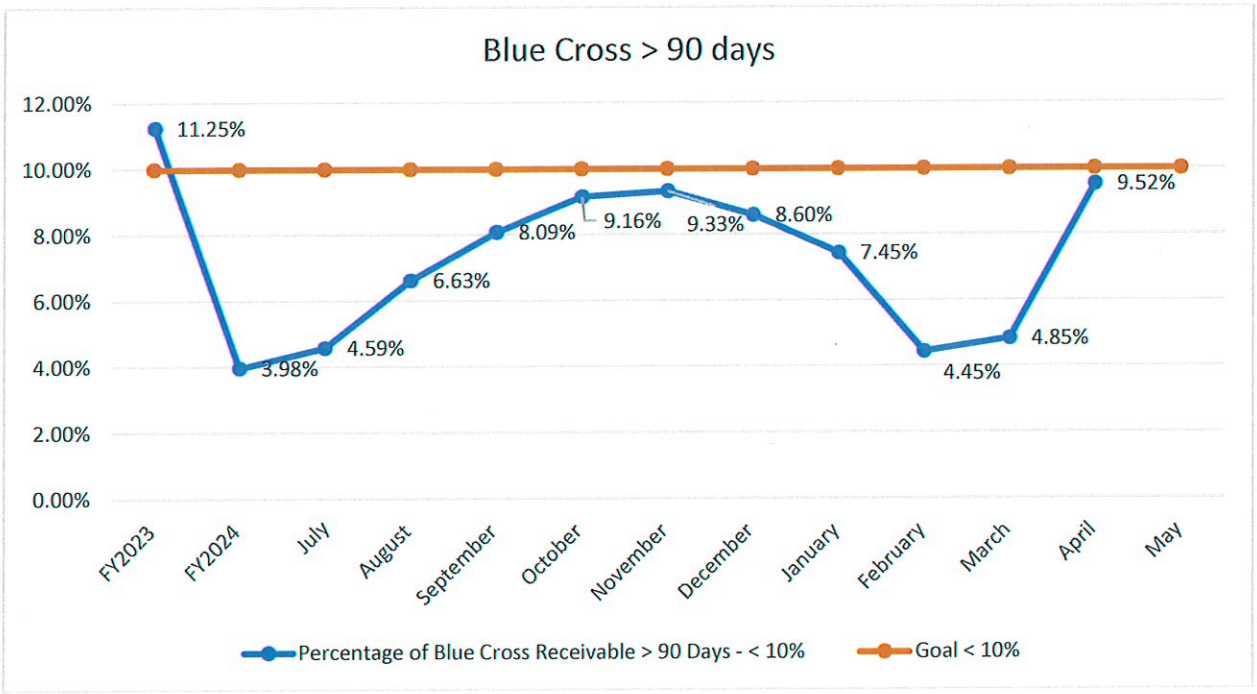
- Days over 120 days increased to 15% for April.



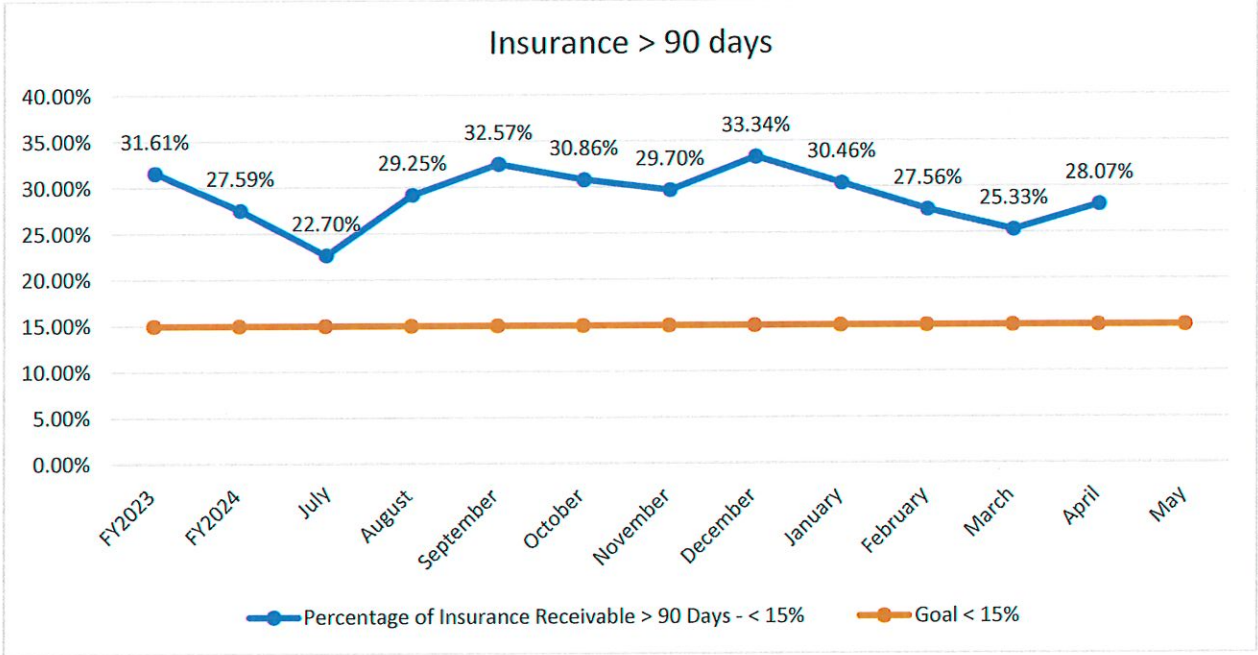
- Days over 180 days increased to 9% for April.

- **Days in AR by Payer** – These metrics show more detail of the aging AR by payer. We saw a decrease in the aging AR for Blue Cross, Commercial and Medicare with Medicaid staying right at the goal. These goals are as follows:

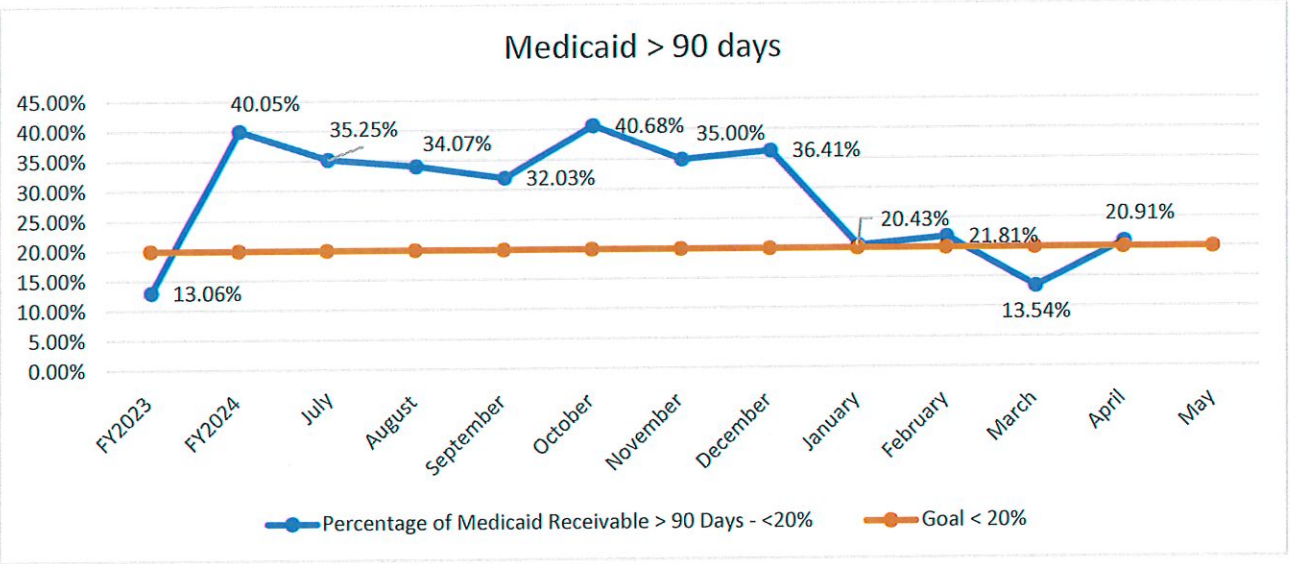
  - BCBS Days in AR > 90 days less than 10%
  - Insurance Days in AR > 90 days less than 15%
  - Medicaid Days in AR > 90 days less than 20%
  - Medicare Days in AR > **60 days** less than 6%
  - Self-Pay Days in AR > 90 days less than 30%



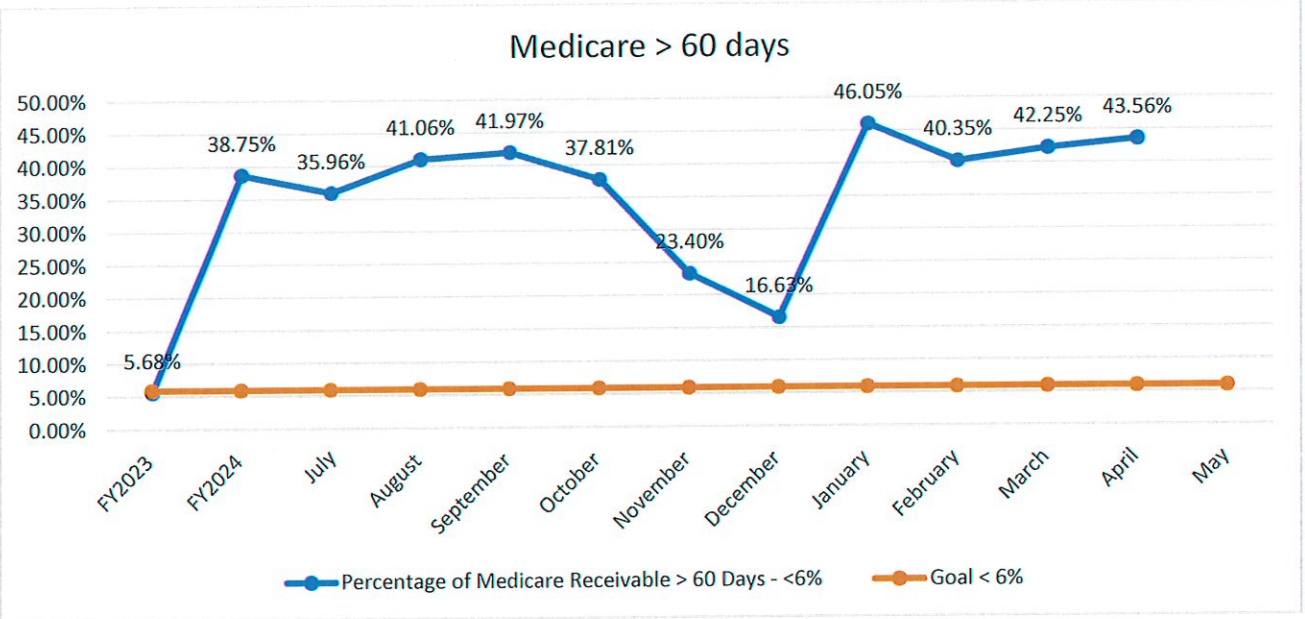
- Blue Cross aging remains under the goal of 10%, at 9.52% in April.



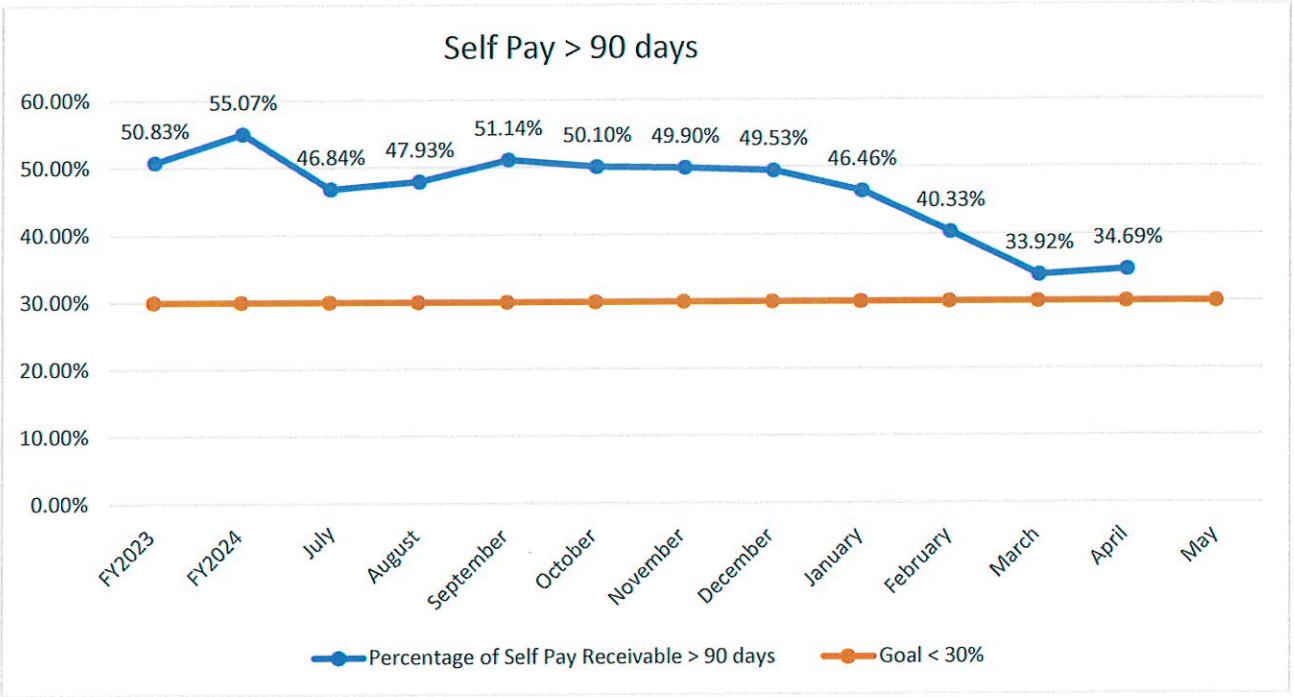
- Commercial aging increased to 28.07% for April, over the 15% goal.



- Medicaid aging increased in April to 20.91%, right at the goal of 20%.



- Medicare increased in April to 43.56%, over the 6% goal.



- In April, aging remained steady at 34.69%. We continue to see great results with the new payment plan program started in mid-February.

Self Pay Plan
Information and Results
MAY, 2025

PAYZEN PMT ARRANGEMENTS		CURRENT MONTH	FY 25	AVG RETURN %
	NUMBER OF ACCTS	282	1520	
	ACCT BALANCES	$199,478.99	$1,031,604.46	
	PMTS RECEIVED	$123,029.89	$676,937.80	65.62%

	FY22	FY23	FY24	FY25
SELF PAY DISCOUNTS	1,353,208.58	780,098.39	844,366.51	646,816.99
FY 25 ESTIMATE			844,366.51	862,422.65
MARCH DISCOUNT AMT				89,802.55

*This 20% discount is generated by sending the first private pay statement to the guarantor for a specific account.

	FY22	FY23	FY24	FY25
HARDSHIP PROGRAM	3,164.60	61,124.87	183,310.54	94,215.59
50% DISCOUNT APRIL				0.00

*This 50% discount opportunity has been offered during conversation with patients after we have identified through conversation that the patient has no insurance and that the total balance of the account will be a hardship for the patient to pay.

TOTAL SELF PAY PAYMENTS	HOSPITAL	CLINIC
FY 20	8,093,427.44	
FY 21	7,763,867.42	
FY 22	7,359,544.59	
FY 23	7,816,556.16	1,393,371.32
FY 24	8,289,382.17	1,633,256.43
FY 25	8,847,662.02	1,333,796.82

Self Pay Plan
Information and Results

PAGE 2

TOTAL SELF PAY REVENUE	HOSPITAL	CLINIC
FY 20	13,566,281.12	
FY 21	14,306,425.74	
FY22	14,129,092.76	
FY 23	14,426,972.88	1,161,887.99
FY 24	14,058,581.93	1,365,896.47
FY 25	12,300,168.01	1,299,108.66

MEDICAL ASSISTANCE	
FY20	2,579,929.74
FY21	2,890,990.97
FY22	1,534,631.43
FY23	2,382,483.18
FY 24	1,488,871.52
FY 25	404,016.81

PATIENT NAVIGATION	**FY23**	**FY24**	**FY25**
FREE OR REPLACEMENT MEDICATION	285,333.00	235,364.00	153,822.00
COPAY ASSISTANCE	51,976.00	80,886.00	82,466.00
INSURANCE MAXIMUMIZATION	1,058,933.00	2,591,935.00	1,821,233.00
PREMIUM ASSISTANCE	823,191.00	664,667.00	227,787.00
TOTAL COST SAVINGS AND COLLECTED REVENUE	2,219,433.00	3,572,852.00	2,285,308.00
TOTAL EXPENSE TO RUN PATIENT NAVIGATION DEPT FY22	162,690.00	166,757.25	226,762.69
GOAL - 2 EMPLOYEES AT 1.5 MILLION EACH	976,140.00	2,441,376.00	3,000,000.00
TOTAL AMOUNT WE NEED TO ACHIEVE OUR GOAL FY 25	1,243,293.00	1,131,476.00	-941,454.69

*NOTE: Cost savings of free and/or replacement drug is the actual MHSC cost of products that we acquired for the patient and would have been considered uncollectable.

MEMO: May 28, 2025

TO: Finance Committee

FROM: Ronald L. Cheese – Director Patient Financial Services

SUBJECT: Preliminary May 2025 Potential Bad Debts Eligible for Board Certification

Potential Bad Debts Eligible for Board Certification

Cerner Accounts	$	2,266,500.00
Hospital Accounts Affinity	$	00.00
Hospital Payment Plans Affinity	$	00.00
Medical Clinic Accounts EMD's	$	00.00
Ortho Clinic Accounts EMD's	$	00.00
Total Potential Bad Debt	$	2,266,500.00
Accounts Returned	$ -	55,366.69
Net Bad Debt Turned		$2,211,133.31
Recoveries Collection Agency Cerner	$	- 171,000.00
Recoveries Collection Agency Affinity	$	- 45,000.00
Recoveries Payment Plans Affinity	$	- 500.00
Medical Clinic Recoveries EMD's	$	- 1,634.00
Ortho Clinic Recoveries EMD's	$	- 100.00
Total Bad Debt Recoveries		$- 218,234.00
Net Bad Debt Less Recoveries		$ 1,992,899.31

Projected Bad Debt by Financial Class

Blue Cross and Commercial	$ 683,275.73
Medicare	$ 23,739.83
Medicare Advantage	$ 49,924.01
Self Pay	$ 1,350,000.00

Issue	Definition/Impact	Action Plan	Status
Outstanding AR Legacy systems	Legacy system AR needs to be resolved so full attention can be placed on Cerner.	3-29: Legacy AR continues to decline but deadlind of March 31 will not be met. 05 -03:Legacy AR remains outstanding with a total of 89K in Affinity. The Patient Financial Services Director has asked that the commercial AR be reviewed for a final time. Target date to stop working Legacy AR is 5/31/24 5-31: System remains open 6-30: Affinity has been closed as of 7/1. Archiving of system set up to take place with Harmony. Remaining credit balances will be worked from spreadsheet. EMDs is closed. 08-31: Email sent to CFO and PFS Director but update unavailable at time of reporting. 09-30: It is estimated that $50K remains outstanding in Affinity Legacy. Plan to move employee balances onto payment plans and be taken out of AR. Deatlind for this has not been set. 3-25: Affinity AR is $42K The commercial accounts have been reviewed and we will move the remainder of Self-Pay to Payment Plans upon getting access to the system after the archive is complete. We are treating the Self-Pay as payment plans as most is from employees and we are performing payroll deduct.	In Progress Final Touches Legacy systems are not accessible as they complete the archival project . Employee balances make up most of payments through payroll deductions. Affinity AR is $45K including one self pay account for in excess of $30K. The commercial accounts have been reviewed. Medicaid increased in April - Due to several take-backs on accounts that had zeroed, the April Affinity A/R closed at $45,323.72 which includes the one self-pay account totaling over #30,000.

Issue	Definition/Impact	Action Plan	Status
Lack of understanding regarding patient AR work Ques.	Continued increase in patient AR.	03-29: Gain understanding of patient AR workflow within Cerner. Manage outstanding patient AR from aging report. 05-03: Feedback received from Cerner. CLA to collaborate with PFS Director and team to begin drafting policy and procedure. 05-31: Additional follow up questions submitted to Cerner and P&P is in progress. 06-30:Changes in workflows have been established to avoid duplication of work by allowing two team members to send patient to collections. The policy and procedures are underway as progress is made on patient accounts. 08-31: Draft policy and procedure have been developed and will be reviewed with PFS Director. In Collections Preview dollars have decreased $1.6M from 5/30/24 to 8/25/24 and Past Due Self Pay dollars have decreased $1.6M from 6/13/24 to 8/25/24. 09-30: Numbers have continued to decline. PFS Director to begin providing monthly reports on what has been submitted to bad debt vs. what has been collected since since training and focus has been placed on patient balances. 10-31: PFS Director has obtained numbers from collection agency. Dashboard to be updated. 12-31: Update to Dashboard outstanding. 3-25:Dashboard is updated monthly and is current.	Complete Process and workflow is complete. Education has been provided in reference to AR Work Ques and employee productivity has improved with this knowledge. Workflows have been created and the Dashboard of collection agency collections is updated monthly. This item is complete. As a side note, we have become so knowledgable about the work ques, we have built ques into the Method I and Method II workflows.
Re-structuring of Business Office phone tree.	Alleviate phone volume from insurance billers.	03-29: Established phone tree structure and provided to IT in February. Waiting for set up to be completed. 05-03:New phone tree that was set to take efect on 5/1 is not working as it was desinged; therefore, IT will need to review and correct set up. Additional work will also need to be completed by IT before remote worker can be incorporated into the phone tree tree through TEAMS application. Both items should be priority items to alleviate phone calls that the billers receive so they can dedicate their time to outstanding AR. 05-31: The phone tree is not working as designed. PFS Director is working with IT to resolve. PFS Director has been asked to escalate to upper management if resolution is not found in early June as this is affecting the billing team's productivity. 06-30: The phone tree is now working in PFS as designed with one remote team member still needing to be connecctd to the team, through Microsoft Teams application. Target date of completion is July 2024. After completion, team members will have additional assistance with answering phones. 07-31:Remote worker awaiting connection to phone tree. Escalated to CFO.	In Progress. Additional telephone system components are going to be installed by IT personnel next Fiscal Year to allow the phone tree to be used by remote worker. The issue has to do with the firewall that will not work or protect us off campus.

Issue	Definition/Impact	Action Plan	Status
Outstandng DNFB that exceeds industry best practice of less than or equal to 4 days.	Reduce backlogs of DNFB accounts waiting to be processed due to HIM Coding, incomplete documentation, and billing.	03-25:DNFB accounts total $9.6M, which includes a 3ay suspense period of $2.2M, HIM-Coding of $2.1M, and $5.3M due to procesing concerns by Business Office. It was reported DNFB reports are monitored once per month by Business Office. It was agreed DNFB accounts must be worked daily. Leadership in HIM will be trained on how to generate the DNFB report and HIM and PFS will work the weekly reports. Additionally PFS leadership will collaborate closely with billers to ensure daily tasks are prioritized and includes addressing outstanding billing holds due to DNFB. Weekly recurring meetings established with CLA to review progress made towards prioritization accounts for processing. 05-01:DNFB of 5+ days has decreased from $7.6M on 4/24 to $6.4Mon 4/30. A workgroup which meets weekly has been extablished by CLA to focus on strategy for reducing the dollars outstanding. 06-30: Junes avg DNFB was 10 days 08-31: August avg DNFB was 10 days 09-30: Sept avg DNFB was 9 days 10-31: Oct avg DNFB was 14 days due to holding Medicare claims for Crittical Access billing.	In Progress This project will always be ongoing. 05/26 DNFB Days have dropped from a total of 29.93 days to 8.29 days. It is very important to note that These numbers are directly correlated to collections 30-45 days later. Our Gross Days in AR dropped last month from 87 to 66 as we had highest ever collections this month at over $17 million dollars.

Issue	Definition/Impact	Action Plan	Status
Prior Authorization	Reduce Denials and Accountability	12-31: Met with Registration Supervisor to review what has been discussed in the pst regarding prior authorizations and Central Scheduling. Utilization of phone volume report and tracking of work is a crucial step in understanding volumes and need. A productivity tracking and note spreadsheet was provided and reviewed so this can be implemented as soon as possible.	In Progress Final touches We have completely rebuilt processes and workflows and we are placing the finishing touches on the project. The project has brought people in from Administration as well as the departments that utilize the service. We are in the process of training four new employees to ensure we are able to handle the tremendous volume of tests that require scheduling and prior authorization. We are tracking productivity through phone volume reports. Account edits for accuracy contiue to be at the top of our priority list. The team created a "How to Order Medical Imaging" Cheat Sheet

Issue	Definition/Impact	Action Plan	Status
Balancing	Improve Accuracy	12:31: Met with PFS Director regarding status of payment posters balancing with Fiscal each month as this has been an ongoing issue. PFS Director to discuss witih Fiscal to ensure P&Ps put in place are bing followed and are working.	In Progress Final Touches We set up meetings with the two Cash Posters, the accountants, and the Controller. We identified the errors that were occurring and how they could be corrected. We changed Clinic workflows to submit cash daily. We balance each day and accuracy has improved tremendously. We continue to work to improve our accuracy and workflows. We have written a policy and that policy is in the process of being reviewed by all personnel associated with the project.

Issue	Definition/Impact	Action Plan	Status
ERA/EFT	Productivity	12-31: Met with PFS Director regarding status of ERA/EFT payer set up because this was discussed with CLA during the last several onsite visits. This is currently in process but not yet completed. After this has been completed there should be an increase in productivity and a reduction in manual work.	Complete but looking for additional opportunities. We have all major carriers set up to send payments and then remits electronically. Recently, we received paper checks from fom small players like RCI, UHC Wyoming, Freedom Life Insurance, and Lumico Life that we are trying to get set up as we have enough business with them that it would make it worth our while. By having the transactions electronically sent to us, we are able to automatically post the transactions.
Late Charges	Decrease Write Offs and Increase Efficiencies	12:31: Met with PFS Director to discuss labs entering late charges and the amount of re-work and or write offs it causes. New hire within lab department was to start on 12.2 with late charges taking priority. Currently meeting(s) with the lab have not taken place.	In Progress Final Touches but will always be ongoing. We continue to work with the Lab personnel in an effort to decrease the number of late charges that are submitted to us for billing. The new employee has been amazing and we have worked to decrease the number of late charges. We have made great progress but additional efforts are needed. We have provided additional Cerner access to allow her to identify if an account has been billed and she is now able to place a hold on the account until she is able to charge. This has drastically reduced late charges.

Current Projects/Outcomes since CLA Not Listed Above	Definition/Impact	Action Plan	Status
Days in Accounts Receivable peaked out at 89. We closed March at 87 and April at 66. This month I believe our A/R will be down to approximately $49,000,000. down from $68,370,570 and our Gross Days in A/R will be around 63. Last month, we had the highest collections ever, $17,293,328.00. We continue to build our Medicare billing system so that we can bill Method II. We will be testing over the next several weeks and we are projecting to flip the switch on Method II billing on July 15th in Cerner for July 1. UHC in process of correcting their CAH system changes that they had put in incorrectly. They currently have in excess of 9 million dollars in Medicare Advantage claims that should start moving through the system and paying next week.			
The Central Scheduling department continues to wrap up our Cerner project, UCC, that will allow us to provide patients with call reminders, texts, emails, or calls. We will provide a thank you for scheduling with us 15 minutes after the patient schedules, a reminder 7 days out, a reminder at 2 days out with the option to cancel, reschedule, or confirm. In addition, the patient will be provided with access to their prep instructions at that time. If the patient confirms the appointment, they will receive one more reminder the day prior to the scheduled service. The patient will also have access to a communication board. Go live is June 3rd.			
We continue to work with PayZen to address our ever increasing self-pay Accounts Receivable. We have now set up $1,031,604.46 in payment plans with PayZen while receiving payments of $676,937.80 or 65.62%. These are accounts that would have been tied up in our Accounts Receivable for a very long time.			

MHSC Board of Trustees Report

May Report 2025

Business

- Kayla & Irene graduated from the local BOOST Leadership Academy. We enjoyed hosting this group for both "Give where you live" nonprofit day and Healthcare Day!
- Kayla was voted into the Board Chair position for the Wyoming Community Foundation of SWC and will be expanding connections Statewide through this opportunity.
- Two Foundations will be traveling to RS to meet with Kayla to discuss funding opportunities. One has already committed to giving a monetary gift and is intrigued to learn more and build relations.
- Waldner House has been FULL! We are working hard to ensure patients have access to our services and Cory (Foundation Coordinator) has done an excellent job!
- Working with Tami Love and Gerry Johnston on furnishing needs/ progress for the new building; It looks amazing!

Grants/ Community Donations

- $10,000 Grant **Received** from Wyoming Cancer Program for a Survivorship Wellness project
- $6,000 ACS **Received** for transportation assistance
- $4,500 **Donated** from the Eagles to Cancer Center
- $2,661 **Donated** from Run with Sandy to Cancer Center
- $4,800 Grant **Received** in support for Cancer Survivors during "survivorship night."
- $10,000 Grant **Submitted** for Breast Boutique for Breast Cancer patients

Upcoming Events

SCAN ME

WYOGIVES- July 16th – An annual event that supports Wyoming nonprofits and gives us the opportunity to new donors. Please marek your calendar to give online this day!

Learn more

Waldner House BBQ- August 15th- Exclusive for Donors & Patients who have turned into donors, stay tuned for further details!

Casino Night- August 22nd at the Events Complex, Please take a Save the Date card from the meeting! Scan QR code for tickets/ sponsorships!

Report Submitted By: Kayla Mannikko

Contract Check List

This check list summarizes the purpose, cost and other contract provisions contained in the contract and assures that the contract has been reviewed by both the CEO and In-House Legal Counsel.

1. Name of Contract: **Advanced Medical Imaging**

2. Purpose of contract, including scope and description: **Provide professional medical services in the specialty of radiology through licenses and qualified physicians**

3. Effective Date: 07/01/2025

4. Expiration Date: 06/30/2030

5. Termination provisions: Clause for termination for cause; clause for termination without cause (180 days) Is this auto-renew? No

6. Monetary cost of the contract: $25,987/month Budgeted? Yes

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so. Governing law is State of Wyoming

8. Sovereign Immunity Provision? Yes

9. Any confidentiality provisions? Yes

10. Indemnification clause present? Yes

11. Is this contract appropriate for other proposals? Yes

12. Is County Attorney review required? No

IMAGING SERVICES AGREEMENT

BY AND BETWEEN

MEMORIAL HOSPITAL OF SWEETWATER COUNTY

AND

ADVANCED MEDICAL IMAGING, LLC

EFFECTIVE JULY 1, 2025

TABLE OF CONTENTS

IMAGING SERVICES AGREEMENT

This Imaging Services Agreement ("Agreement") is made and entered into as of July 1, 2025 by and between Memorial Hospital of Sweetwater County ("Hospital"), and Advanced Medical Imaging, LLC, a Wyoming professional corporation ("Group").

Background

A. Hospital owns and operates an acute care hospital located at 1200 College Drive in Rock Springs, Wyoming 82901 (hereinafter referred to as, together with any other Facility that the Hospital may hereafter establish, the "Hospital Facility") that is organized and operated primarily to provide a variety of medical and surgical services, including imaging services, to the Sweetwater County, Wyoming community.

B. Group is a professional corporation that provides professional medical services in the specialty of radiology through licensed and qualified physicians (the "Physicians").

C. Hospital has determined that the proper, orderly, and efficient delivery of quality professional medical services to patients in the Hospital Facility in need of imaging services can best be accomplished by entering into an exclusive coverage arrangement for the provision of such care on a 24-hour 7-days a week coverage basis.

D. Hospital desires to engage Group to perform the professional imaging services described in Exhibit 2.5 attached hereto and incorporated herein (collectively, the "Services") through the Imaging Department at the Hospital ("Imaging Department") pursuant to this Agreement.

E. Group desires to provide such Services in accordance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the foregoing, and the representations, warranties, and covenants herein contained, and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the parties hereto, intending to be legally bound, agree as follows:

1. Professional Medical Services

1.1 Appointment. Hospital hereby appoints and retains Group as its independent contractor to provide the Services described in this Agreement to Hospital and its patients and to provide Services coverage on a 24-hour 7-days a week basis. Group accepts such appointment and agrees that it is retained to provide such Services during the term of this Agreement.

1.2 Exclusivity. This Agreement shall be an exclusive agreement, meaning that during the term hereof, Group shall be the sole source of the Services for Hospital in and for the Hospital Facility. This exclusivity is limited to Services as defined in Exhibit 2.5. Hospital agrees that during the term hereof, Hospital shall not contract with or permit any physicians, groups or other entities other than Group to provide Services in or for the Hospital Facility. Further, Hospital agrees that during the term hereof,

only physicians employed by Group and contracted by Group shall be permitted to provide Services within or for the Hospital Facility. The grant of exclusivity contained herein is predicated upon the mutual determination of Hospital and Group that the Services provided hereunder by Group are of a specialized nature and are best provided by a single group in order to improve the efficiency and effectiveness with which the Services are delivered, facilitate the development of standard policies, procedures and protocols for the Services, and permit better monitoring of the quality of care provided to patients in the Hospital Facility.

2. Obligations of Group

2.1 Qualifications. Group will ensure that each Physician who furnishes Services at the Hospital Facility will be bound by the terms of this Agreement, must be credentialed by the Hospital before providing any Services under this Agreement, and will meet the following minimum requirements at all times:

2.1.1 Each Physician providing Services will maintain an unrestricted license and current registration to practice medicine in the State of Wyoming.

2.1.2 Each Physician providing Services shall be credentialed according to the Medical Staff Bylaws and maintain board certification or board eligibility as required by the Medical Staff Bylaws. Each Physician will be eligible to participate in the Medicare and Medicaid programs and hold and maintain a currently valid Drug Enforcement Agency ("DEA") certification.

2.1.3 Each Physician desiring to provide Services will apply for, and if awarded will maintain, in good standing, membership on the Hospital's Medical Staff (the "Medical Staff") with appropriate clinical privileges, in accordance with Hospital and Medical Staff bylaws, rules, regulations and policies.

2.2 Schedule of Services. Group shall provide the Services at the Hospital Facility on an on-site or on-call basis according to the schedule set forth in Exhibit 2.2 attached hereto and incorporated herein. Group shall employ or contract with a minimum of three Physicians at Group's expense to provide adequate imaging staffing for the Hospital Facility. At least one Physician must be available on-site at all times during regular business hours, while the second Physician must be available either on-site or on-call as needed to meet the Hospital's patient care requirements. Group shall ensure that each on-call Physician remains ready to receive orders and perform imaging services ordered by referring physicians on a 24-hour 7-days a week basis, including after normal business hours. On-call Physicians must respond to calls within 30 minutes and, if required, report to the Hospital within the timeframes established in the Medical Staff Bylaws. Group shall further comply with the turn-around-time requirements set forth in Exhibit 2.2, including but not limited to:

2.2.1 Providing a verbal report within sixty (60) minutes for stat studies;

2.2.2 Dictating reports for stat studies within twenty-four (24) hours;

2.2.3 Ensuring that all overnight overreads are completed promptly and no later than twenty-four (24) hours from the time the study is received; and

2.2.4 Completing all general diagnostic exam reports within twenty-four (24) hours of receiving the study, except for prostate MRIs, PET scans, screening mammography, and routine scheduled ultrasounds performed after 5:00 p.m. on Friday.

2.3 Standards. Group will provide, document and bill Services in accordance with: (i) the standards of the accrediting body of the Hospital on Accreditation of Healthcare Organizations or other accrediting bodies which evaluate the Hospital or the Hospital Facility; (ii) all applicable federal and State laws, regulations, and rules governing the Services, including third party reimbursement laws and regulations; (iii) the administrative and ethical policies of Hospital; and (iv) the bylaws, rules and regulations of Hospital and the Hospital's Medical Staff, all as may be amended from time to time.

2.4 Removal of a Physician. If Hospital becomes aware of any questions regarding the professional qualifications or performance of any Physician, such questions will be communicated promptly to Group so that a resolution of the problem can be promptly made. Should a clinical or behavioral problem directly affecting any Hospital patients, employees, Hospital contracted personnel, or Medical Staff members arise with regard to a Physician, Group will work with the Physician and Hospital to correct the problem to the satisfaction of all parties. If Hospital has a reasonable basis for believing the matter is serious, Hospital shall have the authority to require the immediate removal of the Physician from the schedule, preventing their provision of Services under this Agreement until such time that Hospital is satisfied that the matter is resolved and/or corrected. If Hospital determines that removal is necessary, Group shall comply immediately upon written notice from Hospital. Notwithstanding the foregoing, Hospital retains the right to take corrective action, limit, suspend, or terminate a Physician's privileges in accordance with the Medical Staff bylaws, rules, and regulations and Hospital policy. Group shall cooperate fully in any investigation, disciplinary action, or peer review process initiated by Hospital regarding the Physician's conduct or performance. A removal of a Physician under this Section will not, with respect to the Physician, be considered a denial or revocation of staff privileges, which remains subject to hearing and appellate review as may be provided in the Medical Staff bylaws or otherwise.

2.5 Professional Services. Group shall provide the Services as described in Exhibit 2.5 hereto. Group shall provide imaging services only in accordance with the Hospital's requirements. Group shall not provide obstetric (OB) or orthopedic (ortho) interpretations for the respective orthopedic and obstetric clinics unless expressly requested by a referring physician or authorized by the Hospital's Senior Leadership. The Hospital reserves the right to modify the scope of services at its discretion based on patient needs and operational requirements.

2.6 Group Representations. Group certifies that its ability and the Physicians' ability to provide professional medical services in any state or other jurisdiction has never been revoked, limited, suspended or otherwise restricted in any manner. Group further certifies that it, its parent entities and/or its subsidiaries, and any of its employees and contractees, including the Physicians who will perform services pursuant to this Agreement, are not currently and have never been suspended from participation in or subjected to any type of criminal or civil sanction, fine, civil money penalty, debarment or other penalty by any private or public health insurance program, including Medicare and Medicaid, or any other federal or state health insurance program.

2.7 Appointment of and Duties of Medical Director. Group and Hospital will mutually agree upon the Physician who shall fill and maintain the position of Medical Director of the Imaging Department ("Medical Director") and serve as the liaison with Hospital. The Medical Director is primarily responsible to Hospital for the overall availability and quality of the Services provided by Group. If at any time the Medical Director is not performing in a manner reasonably satisfactory to Hospital, Hospital may require that Group designate a new Medical Director. Group may not remove or replace any Medical Director previously agreed to by the parties without the prior written consent of Hospital. Group and Hospital acknowledge and agree that the Medical Director shall assist Hospital in performing the following duties and responsibilities:

2.7.1 Oversight of Clinical Activities. In conjunction with Hospital, plan, organize, and direct the clinical activities of the Physicians and develop and implement policies applicable to imaging services provided by Hospital.

2.7.2 Performance of Physicians. Group shall establish and implement a structured evaluation process to assess the clinical competence, performance, and professional activities of the Physicians providing services under this Agreement. Group shall provide quarterly performance reports to the Chief Executive Officer (the "CEO") or the CEO's designated representative at Memorial Hospital of Sweetwater County and the Medical Staff, detailing physician adherence to quality metrics, patient safety protocols, and timeliness of service. Each quarterly report shall be submitted no later than ninety (90) calendar days following the end of each calendar quarter. If the Group fails to submit a report by the deadline without prior written approval from the CEO or the CEO's designated representative, the Hospital may require the Group to develop and implement a performance improvement plan to ensure timely future submissions. Any concerns or issues that may affect patient care shall be reported immediately to the CEO and the Medical Staff, along with a documented corrective action plan where necessary. Group shall ensure that performance deficiencies are addressed promptly and that continued non-compliance results in appropriate corrective measures, including retraining, suspension, or removal of the Physician if required.

Additionally, if an overread is requested by a referring physician or another member of the medical team, including the primary physician within the Group, the responding Physician must document the overread in writing within the patient's medical record. Refusal to provide a written overread or any obstruction of the process will be subject to review by the Chief of Staff and the Hospital Administration.

2.7.3 If a clinically significant discrepancy is identified during an initial read or overread that may impact patient care or alter treatment, the reviewing Physician must promptly notify the referring provider and the CEO or CEO's designee. The decision to document such discrepancies in the patient's medical record shall be coordinated with Hospital administration, the Medical Director, in-house counsel, and Risk Management. Discrepancies not impacting clinical care shall be handled through the Group's internal quality assurance process and included in QA reports submitted to the Hospital. All required NRC-related reports and notifications shall be completed in accordance with the Hospital's Quality Management Program and federal regulations. Quality Programs. Assist in the development and implementation of quality improvement, performance improvement, and utilization review programs related to imaging services subject to review and approval by Hospital.

2.7.4 Hospital and Medical Staff Bylaws. Enforce and uphold the bylaws, rules, regulations, and policies of Hospital and Hospital's Medical Staff as applicable to all Physicians providing services under this Agreement.

2.7.5 Credentialing. Participate in credentialing and other peer review activities, including physician discipline, at the request of Hospital.

2.7.6 Development of New Programs. Assist in the development of new programs and procedures that enhance the services provided by Hospital and Group.

2.7.7 Budgetary Matters. Assist in the development of cost-effective programs and practices that promote the delivery of quality patient care services.

2.7.8 Relationship with Hospital Staff. Work collaboratively with other members of the Medical Staff and Hospital administrators, managers and support services personnel, all of whom are also expected to work collaboratively with Group.

2.7.9 Liaison. Serve as the liaison to Hospital with regard to all Services provided in accordance with this Agreement.

2.7.10 Clinical Direction. Provide clinical direction and guidelines for the clinical activities of the Physicians and other staff working with Group to provide the Services including, without limitation, nurses, technicians, students, and volunteers.

2.7.11 Equipment and Supplies. Assist Hospital with the selection, replacement, and repair of the supplies and medical equipment used to provide the Services. Only Hospital is authorized to enter into any contract on behalf of Hospital for the purchase, rental, or other acquisition of equipment or supplies.

2.7.12 Accountability. Report to the Chief Executive Officer of the Hospital ("CEO") or his or her designee with respect to all matters covered by this Agreement pertaining to the clinical administration and clinical supervision of the Physicians and/or the Services provided under this Agreement.

2.8 Administrative Responsibilities of Group. Group will provide the following services:

2.8.1 Continuing Education. Group shall participate in the educational programs conducted by Hospital and the Medical Staff necessary to ensure continuing compliance with regulatory, accreditation, and insurance requirements and shall participate in such other educational programs as Hospital may reasonably request.

2.8.2 Quality Improvement. Group shall participate in the quality improvement programs conducted by Hospital and the Medical Staff as necessary to ensure the continuing compliance with regulatory, accreditation, and insurance requirements and shall participate in such other quality improvement programs as Hospital may reasonably request.

2.8.3 Utilization Review. Group shall participate in the utilization review programs conducted by Hospital and the Medical Staff as necessary to ensure continuing compliance with regulatory, accreditation, and insurance requirements and shall participate in such other utilization review programs as Hospital may reasonably request.

2.8.4 Risk Management. Group shall participate in the risk management programs conducted by Hospital and the Medical Staff as necessary to ensure continuing compliance with regulatory, accreditation, and insurance requirements and shall participate in such other risk management programs as Hospital may reasonably request.

2.8.5 Scheduling. Group shall develop, in coordination with Hospital, a schedule for ensuring the prompt and predictable availability of the professional services offered by the Physicians.

2.9 Corporate Compliance Program/Code of Conduct. Group acknowledges and agrees that it has received a copy of the Hospital Code of Behavior (the "Code"), that it has reviewed the Code and has had the opportunity to ask questions regarding the Code, and that during the term of this Agreement Group and any employees and its contractees, including the Physicians providing Services under this Agreement,

will abide by the terms of the Code and the Hospital Corporate Compliance Program.

2.10 Reports and Records. Group shall ensure that each Physician, in accordance with Hospital and Medical Staff bylaws, rules and regulations, or policies, causes to be promptly submitted to the appropriate Hospital staff reports of all examinations, procedures, and other professional services performed by Group. Hospital shall maintain an accurate and complete file within the Imaging Department, or at such other location as Hospital may reasonably determine, of all such reports and supporting documents. Group shall prepare all such reports in accordance with applicable laws, knowing that such reports will be relied upon by Hospital for the purpose of submitting claims for reimbursement to health care benefit plans, including Medicare and Medicaid, provided Hospital is responsible for facility and technical charges. The ownership and right of control of all reports, records, and supporting documents prepared in connection with the Imaging Department belong to Hospital; provided, that Group shall have reasonable access to such reports, records, and supporting documents in connection with any billing, peer review, malpractice, audit or other appropriate purpose and may request hard copies of these records for such purposes at Group's expense while electronic versions of these materials will be made available to Group without cost and as provided by Hospital policies and the laws of the United States and of the State of Wyoming. The provisions of this paragraph will survive the termination or expiration of this Agreement. All reports and records shall also comply with the Hospital's Quality Management Program and NRC regulations, including those governing misadministrations and recordable events involving radiopharmaceuticals.

2.11 Examination of Books and Records. Subject to Hospital and Group's duty to protect the confidentiality of patient records, the pertinent patient records and billing information for Group and Hospital directly related to the Services performed pursuant to this Agreement shall be made available to the other party upon at least five (5) business days' advance written notice for examining and copying during regular business hours. Hospital shall have the right to conduct audits of Group's compliance with service obligations at least annually, or more frequently as needed in cases where performance concerns arise. Group shall maintain all records related to the Services for a minimum of seven (7) years following the termination or expiration of this Agreement. In the event of a dispute concerning billing, compliance, or physician performance, Hospital may engage a third-party auditor to verify adherence to contractual obligations. Group shall provide all necessary access to facilitate such an audit, and the cost of the audit shall be borne by the party found to be non-compliant. Neither party shall have the right to access the other party's confidential financial information except as required by law. In cases involving misadministrations, all reports and data required by the NRC must be made available for review and retained for the required retention period under federal regulations. The provisions of this paragraph will survive the termination or expiration of this Agreement.

2.12 Managed Care.

2.12.1 Participation Agreements. Group and Hospital agree to participate in those managed care contracts selected by Hospital. In the event that Hospital desires to negotiate a managed care contract, Hospital shall notify Group of the same. Group and Hospital will act in good faith to negotiate mutually acceptable terms of the managed care agreement, taking into consideration the benefit of such contract to Hospital, Group and other medical staff members. Group shall participate in any managed care contracts in which the Hospital participates, unless Group provides clear and documented evidence that participation is financially infeasible. Final authority over participation shall rest with the Hospital. Should third party payors not negotiate in good faith as determined by Hospital, neither Hospital nor Group shall be obligated to participate. Hospital also agrees to duly consider any other managed care contracts which Group has notified Hospital that Group is interested in entering into. For purposes of this Agreement, the term "managed care contracts" includes contracts with all types of insurance companies, health maintenance organizations, independent practice associations, direct contracts with employers, managed care organizations, provider-sponsored organizations, and other third-party payors.

2.12.2 Global Rates. The parties acknowledge that, in certain limited circumstances, Hospital may wish to offer an all-inclusive rate, covering both hospital and physician charges, for a particular service or group of services. Should Hospital wish to include some Services within such a rate, Group agrees to participate in such an arrangement, so long as (a) the amounts to be paid Group are reasonably consistent with the market rate for the Services in communities similar to Sweetwater County, Wyoming; and (b) the financial risks associated with such an arrangement are spread between Group and Hospital.

In addition, Group shall honor the discount rates provided by Hospital to patients covered under agreements, such as occupational medicine contracts, only if the Group has been notified of the applicable terms in advance and has provided prior written consent to participate which shall not be unreasonably withheld. This obligation applies solely to imaging services and related procedures that the Group has agreed to provide under such arrangements. Group shall not be required to honor any discounted rate for which it has not provided prior written consent. Group shall not require Hospital to cover the difference between the discounted rate and full amount on any services provided under these agreements. Group acknowledges that its participation in such agreements is a condition of this Agreement. Hospital shall provide Group with a list of applicable discount agreements and notify Group of any updates.

Hospital will promptly submit bills including such Services to the appropriate payer and promptly remit payment to Group for the same after receiving payment from such payer. It is not the intent of Hospital under

this paragraph to generally assume the billing practices of Group for all purposes.

2.12.3 Unwillingness to Contract. Group acknowledges that participation in the managed care contracts of the Hospital is necessary for the Hospital's provision of necessary medical services to the community. In the event Group is unwilling to enter into a managed care contract in which the Hospital also participates or desires to participate, Group shall provide written notice of such determination within seven (7) business days of Hospital's request for participation by Group, which notice shall include the reason for Group's lack of participation. Hospital and Group agree to use their best efforts to resolve the issue promptly. In the event that no resolution between the parties may be reached within fifteen (15) business days, this Agreement may be terminated pursuant to Section 9.5 herein.

2.13 Use of Premises. Group shall not use nor permit anyone employed, retained, or otherwise associated with Group to use any part of the Imaging Department or the Hospital Facility and/or equipment to perform tasks or provide services that are unrelated to Hospital's business or its patients. Without limiting the generality of the preceding sentence, Group shall not use the Hospital Facility in any manner or engage in any conduct that might jeopardize Hospital's tax exemption, licensure, accreditation, County support, Medicare or Medicaid participation agreements or insurance. Without the prior written approval of Hospital which will not be unreasonably withheld, Group shall not install on Hospital computers or equipment any software, hardware, or programming, or connect any computer or equipment to Hospital's network. Notwithstanding the other restrictions in this paragraph, Hospital and Group agree that, to the extent it does not otherwise interfere with its performance under this Agreement, Group may read diagnostic test images using Imaging Department facilities and/or equipment for individuals who are not patients of the Hospital at the time of such tests provided Group pays Hospital the fair market value fees for its use of such Hospital facilities and/or equipment according to Exhibit 2.13 attached hereto and incorporated herein by reference.

2.14 Non-Competition. In recognition of this exclusive Agreement and important position that Group will hold as Hospital's exclusive contracted provider of the Services required under this Agreement, Group, its shareholders, Physicians, immediate family members of the Physicians and any related entities shall not, during the term of this Agreement and for a period of one year after termination or expiration of this Agreement, directly or indirectly provide any of the Services rendered under this Agreement within Sweetwater County, Wyoming, other than the Hospital Facility. In addition, during the term of this Agreement and for a period of one year after termination or expiration of this Agreement, Group, its shareholders, Physicians, immediate family members of the Physicians and any related entities agree not to own, manage, lease, staff, or otherwise participate, including financial participation, directly or indirectly, in the operation of any business or facility within Sweetwater County, Wyoming that provides any service that is also offered by Hospital. If this Section 2.14, or any part thereof, is held to

be unenforceable because of the duration of such provision or the area covered thereby, the parties agree that a court may modify the provision to reflect the maximum permissible restriction and enforce it accordingly. If Group or any Physician is in violation of this Section 2.14, the parties agree that an injunction preventing the future or ongoing violation is an appropriate remedy for Hospital to seek and be granted.

2.15 Equal Employment Opportunity. Without limitation of any provision herein set forth, Group expressly agrees to abide by any and all applicable federal and/or state equal employment opportunity statutes, rules and regulations including, without limitation, Title VII of the Civil Rights Act of 1964, the Equal Employment Opportunity Act of 1972, the Age Discrimination in Employment Act of 1967, the Equal Pay Act of 1963, the National Labor Relations Act, the Fair Labor Standards Act, the Rehabilitation Act of 1973, and the Occupational Safety and Health Act of 1970, all as may be from time to time modified or amended. Group further agrees to hold Hospital harmless from any and all liability arising from any breach of this Section 2.15.

2.16 Patients Served. Group will require each Physician to provide Services to all Hospital patients in compliance with all applicable federal and/or state statutes, rules, and regulations that prohibit discrimination or withholding of services on the basis of race, sex, religion, disability, national origin, age, or ability to pay.

2.17 Performance Indicators. In providing services under this Agreement, Group shall be subject to the performance indicators set forth in Exhibit 2.17 attached hereto and incorporated herein by reference. If Group fails to provide Services as required according to the performance indicators set forth in Exhibit 2.17, Hospital may seek to terminate this Agreement as specified in Section 9.3 below.

3. Medical Staff Privileges of Physicians. The parties acknowledge and agree that this Agreement is not, and shall not be construed as, any form of guarantee or assurance by Hospital that any Physician associated with or employed by Group will receive or retain necessary Medical Staff membership or privileges for purposes of providing the Services hereunder. Except as otherwise provided in this Agreement, application, appointment, reappointment, and granting of privileges shall be governed solely by the then-current Medical Staff bylaws of Hospital.

4. Obligations of Hospital

4.1 Operational Requirements. Hospital shall provide the Facility, equipment, supplies, utilities, janitorial, laundry, and other support supplies and services that are reasonably necessary for the proper operation of the Imaging Department.

4.2 Personnel. Hospital, at no cost to Group, at all times during the term of this Agreement, shall provide the nursing, technical, administrative, clerical, and other support personnel that are reasonably necessary for the proper operation of the Imaging Department. Hospital shall consider Group's comments regarding such

personnel, but Hospital retains the exclusive right to hire, fire, assign, reassign, promote, demote, or otherwise deal with its employees. Group shall not in any way utilize the Hospital's Facility, personnel, supplies or services except for matters directly related to the provision of Services for Hospital's patients or other official business.

4.3 Transcription and Voice Recognition Services. The Hospital agrees to cover all reasonable costs associated with voice recognition and routine transcription medical imaging services. The Group shall utilize voice recognition technology exclusively for the creation of all imaging reports, unless the Hospital provides prior written approval for an alternative method. The Hospital reserves the right to audit the accuracy and timeliness of these reports and may require corrective action if deficiencies are identified. Voice recognition technology shall be used for the interpretation of all STAT and ASAP examinations.

4.4 Call Coverage Financial Assistance. The Hospital will provide Advanced Medical Imaging, LLC (Group), with the compensation structure for on-call coverage below.

The Group will be paid $2,182 per day (Monday through Sunday) for call coverage for up to 10 days per month for the duration of this Agreement. There will be no subsequent increases to this daily rate throughout the term of the Agreement.

To ensure timely response to patient needs, on-call Physicians must be immediately available and prepared to begin reading within the response timeframes established elsewhere in this Agreement. Failure to meet this requirement more than twice in any given month will require a formal corrective action plan submitted to the Hospital within 30 days. Continued non-compliance may result in increased oversight or additional contractual actions as determined by the Hospital.

Additionally, AMI shall submit an occurrence report to the Hospital detailing all instances of untimely responses to on-call requests. The report must include:

1. Instances where response times exceeded 30 minutes
2. Explanations for delays
3. Any corrective measures taken to prevent recurrence
4. A summary of overall compliance with the response time requirement

The Hospital retains the right to audit these reports and request additional documentation as needed. If persistent delays are identified, the Hospital may impose increased oversight or require the Group to revise its call coverage structure.

4.5 Medical Director. It is agreed by Hospital and Group that Fred Matti, M.D., will function as Medical Director of the Radiology Department of Hospital for a period of five (5) years beginning July 1, 2025, and ending June 30, 2030. It is agreed by

Hospital and Group that for Physician Services as Medical Director, Fred Matti, M.D., will be compensated $50,000/year which will be payable on July 1st of each year during the term of this appointment.

As Medical Director, Fred Matti, M.D., will provide joint oversight and supervision, in coordination with CEO, of Staff Radiologists, in terms of delineation of duties, performance evaluation, and hiring of potential new Staff Radiologists.

5. Compensation and Billing

5.1 Group Compensation and Physician Billing. Except as provided in Section 2.12.2 above, Group's compensation for the Services rendered under this Agreement shall solely be those funds it collects from the Hospital's inpatients and outpatients for professional services rendered on a fee-for-service basis. Group will have the sole right to bill patients or responsible third-party payors for any billable professional services rendered by the Physicians to Hospital patients in accordance with this Agreement, regardless of whether Hospital will bill patients or responsible third-party payors for any billable hospital, technical, and supply charges associated with the provision of Services pursuant to Section 5.2 below. All fees collected for such services will be the sole property of Group.

5.1.1 Group shall from time to time (but not more often than once annually) establish and amend schedule(s) of charges for all billable services to be furnished by Group through the Imaging Department, which charges (i) are represented to be Group's customary charges for such services and are not in excess of charges for similar services under similar conditions in the Wyoming medical community; and (ii) shall be separate and distinct from the charges made by Hospital for hospital services furnished to patients; and (iii) be subject to input on at least an annual basis from Hospital. Group shall at all times comply with the regulations, laws and policies regarding billing for services.

5.1.2 The Group shall report any discrepancies, billing errors, overcharges, or substantiated patient complaints concerning billing practices to the Hospital within five (5) business days of detection and submit a written corrective action plan.

In addition, the Group shall:

(a) Provide a dedicated and responsive contact person for all billing inquiries, available during regular business hours;

(b) Respond to any patient complaint or inquiry related to billing within five (5) business days of notification and receipt;

(c) Ensure all statements are issued timely, clearly itemized, and in compliance with applicable regulations;

(d) Provide individual occurrence reports to the Hospital summarizing patient billing complaints, resolutions, and ongoing improvements.

If the Hospital refers a billing complaint to the Group and the issue persists unresolved after sixty (60) days, the Hospital may require the Group to implement a formal escalation procedure. This procedure shall include the assignment of a designated supervisor within the Group's billing provider to directly oversee the resolution of the outstanding complaint. If the Group fails to resolve the complaint within thirty (30) days following escalation, the Hospital may require corrective action, which may include implementing additional oversight measures. The Hospital reserves the right to audit unresolved complaints on a quarterly basis to ensure appropriate responsiveness.

5.2 Hospital Billing. Hospital will be responsible for billing patients or responsible third-party payors for any billable hospital, technical, and supply charges associated with the provision of Services. All amounts collected for such services will be the sole property of the Hospital. Group agrees to cooperate with, and to ensure that each Physician cooperates with, the Hospital in providing information necessary for prompt and accurate billing for such services. The obligations of Group under this Section 5.2 will include ensuring that each Physician documents, within the scope of that person's responsibility, the Services provided by such person accurately and to the extent necessary to allow the parties to bill appropriately for services provided.

5.3 Billing Assistance. Hospital shall make available to Group duplicate copies of such internal forms, tapes and/or other media or electronic record as are reasonably required for Group to present bills as permitted under this Section 5. Hospital will maintain an efficient system for communicating with Group any changes from the initial information obtained through patient registration.

The actual billing process conducted by Group, however, shall not be carried out in the Hospital Facility, by means of or with the assistance of any Hospital equipment or employees, unless written arrangements are made with Hospital in connection therewith.

Group shall respond to any billing disputes or inquiries from the Hospital within five (5) business days of notification and receipt. Failure to do so may result in corrective action, including additional oversight measures as determined by the Hospital.

If Group at any time in good faith believes that Hospital has not provided complete and accurate information for billing purposes in a timely manner, Group may (but is not required to) give written notice thereof to Hospital, and in the event Hospital agrees, Hospital shall provide Group's billing staff with reasonable access to such information as reasonably necessary for the billing function.

5.4 Exclusive Ownership. Except as may be more specifically provided in this Agreement, all patient revenues and all non-patient revenues identified with the Imaging Department (other than revenues billed by Group in accordance with this Section 5), other departments, or the Hospital Facility in general shall be the exclusive property of Hospital, except with respect to revenues generated pursuant to the global pricing provisions of certain managed care contracts or other global payment arrangements agreed to among the parties, a portion of which, subject to a negotiated arrangement between the parties, shall be payable to Group.

5.5 Loss of Income Source. If Hospital ceases to do business all non-compete clauses will be null and void.

5.6 Survival. The provisions of this Section 5 will survive the termination or expiration of this Agreement.

6. Insurance

6.1 Obligations of Group. At all times during the term of this Agreement, Group will maintain, at its expense, professional liability insurance coverage for Group and each Physician providing services pursuant to this Agreement for professional liability claims made during and after termination of this Agreement and utilize insurance companies and amounts of coverage compliant with the Medical Staff Bylaws of Hospital.

6.2 Obligations of Hospital. At all times during the term of this Agreement, Hospital will maintain, at its expense, professional liability insurance or comparable self-insurance covering its employees for professional liability claims made during and after termination of this Agreement based on conduct having occurred during the term of this Agreement with policy limits as required by the Hospital bylaws.

6.3 Survival. The provisions of this Section 6 will survive the termination or expiration of this Agreement.

7. Indemnification. Each of the parties is responsible for the acts and omissions of itself and its employees and agents. Neither of the parties agrees to indemnify the other party for any such act or omission; provided, however, that this Agreement shall not constitute a waiver by either party of any rights to indemnification, contribution or subrogation which such party may have by operation of law. The parties each agree to promptly notify the other of any claims asserted against the other in connection with the operation of this Agreement and of any facts or circumstances known which relate to such claim or which might reasonably be deemed to give rise to a future claim. The provisions of this Section will survive the termination or expiration of this Agreement.

8. Confidentiality of Hospital and Group. Without the prior written consent of Hospital, Group and Physicians may not copy or use any confidential information relating to Hospital, its business, or its patients. For purposes of this Agreement, the term "confidential information" means any business, financial or medical information not generally known to the public regarding the business and operations of Hospital or its

patients, unless such information is disseminated or otherwise made available to the public through no action of Group and/or Physicians or any person associated with Group or Physicians. In the performance of their obligations under this Agreement, the parties agree to comply with all applicable federal and state patient confidentiality laws, including without limitation, the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Group and Physicians agree to execute any agreement that is requested by Hospital that allows Hospital to maintain compliance with the HIPAA regulations. This Section shall not prohibit disclosures required by federal or state law, including reporting obligations under NRC regulations related to misadministrations. The provisions of this section will survive the termination or expiration of this Agreement.

9. Term and Termination

9.1 Term. The term of this Agreement will be for five (5) years commencing on July 1, 2025 (the "Effective Date") and expiring on June 30, 2030. This Agreement shall supersede and replace any prior agreements between the Parties, including the previous Imaging Services Agreement, which was set to expire on June 30, 2026. Upon execution of this Agreement, the prior agreement shall be considered null and void.

9.2 Termination for Breach. Notwithstanding the foregoing or any current or future Hospital or Medical Staff bylaw, rule, or regulation to the contrary, either party shall have the right to terminate this Agreement if the other party shall fail in any material respect to provide the Services or meet the obligations specified herein. The party claiming the right to terminate shall first provide written notice to the other party that it has breached this Agreement and set forth in the notice the facts underlying its claim that the other party is in breach of this Agreement. The party receiving such notice shall have thirty (30) days from receipt of such notice to remedy the breach described in the notice to the reasonable satisfaction of the non-breaching party; provided however, if such breach requires more than thirty (30) days to remedy, this Agreement shall not terminate if the breaching party has within thirty (30) days made good faith efforts to cure such breach and such efforts continue until cured as required herein. Remedy of such breach within the specified timeframe shall revive the Agreement in effect for the remaining term, subject to any other rights of termination contained in this Section or in any other provision of this Agreement.

9.3 Termination for Quality of Care. In the event Hospital reasonably believes that it is at risk of losing its right to participate in any federal health program, including but not limited to Medicare or Medicaid or its Accreditation from the Joint Commission on Accreditation of Healthcare Organizations as a direct result of issues related to the provision of Services by Group, Hospital may terminate this Agreement immediately upon written notice to Group. If upon inquiry Hospital determines that Hospital and Group jointly have caused the quality-of-care issue, Hospital and Group hereby agree to use good faith efforts to remedy the issue. If

Group fails to use good faith efforts to find a solution within thirty (30) days, Hospital may terminate this Agreement immediately upon written notice to Group.

9.4 Immediate Termination.

9.4.1 Notwithstanding anything to the contrary contained herein, or any current or future Hospital or Medical Staff bylaw, rule, or regulation to the contrary, Hospital may terminate this Agreement immediately upon written notice to Group upon the occurrence of any of the following events with respect to Group or any of the Physicians providing services at the Hospital Facility unless Group immediately prohibits such Physician from providing any of the Services, and within fifteen (15) days, Group and Hospital reach a mutual understanding regarding alternative staffing for the Imaging Department:

(a) Loss, limitation, or suspension of clinical privileges at the Hospital Facility for any material reason;

(b) Censure of, or the taking of any other material disciplinary action by any medical board, hospital or professional medical society having any privilege or right to pass upon such Physician's conduct;

(c) Failure to maintain an unrestricted license to practice medicine in the State of Wyoming;

(d) Conviction of, plea of guilty to, or plea of no contest to, a felony;

(e) Physician's death or Physician's inability, due to physical or mental disability, to perform services under this Agreement. Physician agrees to cooperate in all respects with those procedures considered by Hospital to be reasonably necessary to determine Physician's disabled status from time to time as allowed by applicable law;

(f) Exclusion from participation in any federal health care insurance program, including Medicare and Medicaid, for any reason;

(g) Any willful inappropriate action by a Physician or Group which does compromise the health or safety of a patient or Hospital employee/independent contractor; or

(h) Any material action by a Physician or Group which may result in a significant loss to the Hospital's business or reputation.

9.4.2 Group will immediately notify Hospital in writing upon the occurrence of any of the events described in this Section 9.4 of which Group has knowledge.

9.5 Termination Upon Notice. Notwithstanding anything to the contrary contained herein, or any current or future Hospital or Medical Staff bylaw, rule, or regulation to the contrary, Hospital may terminate this Agreement upon thirty (30) days' written notice to Group if:

9.5.1 Group fails to negotiate in good faith to become or remain a participating provider with any third-party payor (a) with which Hospital is a participating provider, or (b) that Hospital believes would be beneficial to the Hospital's patients, as required in Section 2.12.1 above; or

9.5.2 Group engages in a pattern of conduct involving repeated breaches followed by remedial action within the 30-day period as provided for in Section 9.2.

9.6 Modification or Termination Upon Advice of Counsel. If at any time either party reasonably believes in good faith based upon the advice of reputable health care counsel that this Agreement or the performance by that party of any of its obligations under this Agreement violates any material State or federal law or regulation; presents a substantial risk of the loss or restriction of that party's license, tax exemption, or right to participate in Medicare, Medicaid, or any other Governmental program; or presents a substantial risk of causing debt issued by that party that was tax-exempt when originally issued to become subject to federal or State income tax; that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of this Agreement, in a manner that attempts to retain as much as possible of the economic arrangements originally contemplated by the parties without violating any applicable legal, tax, or reimbursement requirements. If the parties are unable to reach an agreement concerning the modification of this Agreement within one hundred eighty (180) days after the date of the notice seeking renegotiation (or sooner if required by law), then either party may immediately terminate this Agreement by written notice to the other party. The rights of the parties under this Section are in addition to any other termination rights the parties may have under this Agreement.

9.7 Effects of Termination. Upon termination of this Agreement for any reason, no party shall have any further obligation hereunder except for (i) obligations accruing prior to the date of termination, and (ii) obligations, promises or covenants contained herein which are expressly made to extend beyond the term of this Agreement, including, without limitation, indemnities, professional liability coverage and confidentiality of information. The rights and obligations of the parties regarding continuation of Services in the event of termination without cause shall be governed exclusively by Section 9.10. The rights and obligations of the parties regarding continuation of Services in the event of termination for cause, including, without limitation, termination for breach, quality of care concerns, immediate termination events, or legal compliance reasons, shall be governed exclusively by Sections 9.2 through 9.6. The parties and Physicians agree that for Hospital to preserve its ability to have an exclusive agreement for the provision of the Services, the ability of Physicians who provide services under this Agreement to practice at the Hospital Facility will automatically and voluntarily terminate upon

termination of this Agreement or upon termination of an individual Physician's employment or affiliation with Group. Physicians agree that they will not be entitled to any hearing associated with the termination of their Hospital Medical Staff membership and privileges if terminated in accordance with this Section 9.7. Notwithstanding the above, upon termination of this Agreement, any Physician may elect to apply to Hospital for medical staff privileges unrelated to the Services provided under this Agreement and/or radiology, and Hospital may consider such an application.

9.8 Annual Review. The parties shall meet at least annually to review their respective performances under this Agreement and may at such times extend the term of this Agreement provided both parties agree in writing to such an extension.

9.9 Hospital Ownership Change. If the Hospital is merged or sold, all terms and conditions of this Agreement shall remain in effect. The Hospital agrees that neither it nor its present or any future holding company shall enter into any agreement that would negate or contradict the provisions of this Agreement.

9.10 Termination Without Cause. Notwithstanding any other provisions of this Agreement, either Party may terminate this Agreement without cause by providing the other Party with one hundred eighty (180) days' prior written notice. If Group initiates termination, it shall be required to continue providing services in good faith under this Agreement for the full one hundred eighty (180) days, unless otherwise agreed in writing by the Hospital. If the Hospital initiates termination, Group shall be required to continue providing services in good faith under this Agreement for the full one hundred eighty (180) days. The termination shall not affect any rights, obligations, or liabilities accrued prior to the effective date of termination.

10. Miscellaneous

10.1 Status of Group and Physicians. The parties acknowledge that Group and the Physicians are independent contractors of Hospital. In no event will Group or any of the Physicians be deemed a joint venture, partner, employee, or agent of Hospital by virtue of this Agreement. Hospital has no control over the manner or method by which Group meets its obligations under this Agreement; provided that Group's services will be performed in a competent and efficient manner in accordance with current professional standards and also that is in compliance with the policies of the various Hospital, Governmental and private organizations listed in Section 2.3 above. Group shall be solely responsible for all employment-related withholdings and benefits and shall hold Hospital harmless from and against any claims or expenses, including attorneys' fees, resulting from any failure by Group to fulfill this responsibility.

10.2 Incurring Financial Obligation. Group shall have no authority whatsoever to incur any financial obligation on behalf of Hospital and Hospital shall have no authority whatsoever to incur any financial obligation on behalf of Group.

10.3 Notices. Any notices contemplated under this Agreement shall be deemed effectively given when personally delivered or when received by courier, or certified mail, return receipt requested, posted to the addresses listed below, unless other addresses have been designated by written notice in the manner prescribed by this Section 10.3.

to Group:	Advanced Medical Imaging, LLC 2780 Hitching Post Drive Green River, WY 82935 Attn: President
to Hospital:	Memorial Hospital of Sweetwater County 1200 College Drive Rock Springs, Wyoming 82901 Attn: Chief Executive Officer

10.4 Governing Law. This Agreement shall be enforced in accordance with the laws of the State of Wyoming without reference to conflict of laws principles.

10.5 Regulatory Compliance. Until the expiration of four years after the furnishing of the Services under this Agreement, Group agrees to make available to the Secretary of Health and Human Services, the U.S. Comptroller General, and their representatives this contract and all books, documents, and records necessary to certify the nature and extent of the costs of those Services. If Group carries out the duties of the contract through a subcontract worth ten thousand dollars ($10,000) or more over a 12-month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General, and their representatives to the related organization's books and records.

10.6 Waiver. No delay or omission by either party to exercise any right or remedy under this Agreement shall be construed to be either acquiescence or the waiver of the ability to exercise any right or remedy in the future, nor shall any waiver of any specific breach of this Agreement be construed or deemed to be a waiver of any other or additional breach, similar or dissimilar.

10.7 Enforcement. In the event either party resorts to a lawsuit to enforce this Agreement, the prevailing party shall be entitled to recover the reasonable costs of pursuing a lawsuit, including reasonable attorneys' fees.

10.8 Force Majeure. Neither party shall be liable or be deemed in default of this Agreement for any delay or failure to perform caused by Acts of God, war, disasters, strikes, or any similar cause beyond the control of either party.

10.9 Severability. In the event any part or parts of this Agreement are held to be unenforceable, the remainder of this Agreement shall continue in effect.

10.10 Headings and Cross-References. The section and other headings contained in this Agreement are for reference purposes only and shall not affect in any way the

making or interpretation of this Agreement. All references in this Agreement to article and section numbers, Exhibits and Schedules refer to articles and sections, Exhibits and Schedules of this Agreement unless otherwise specified.

10.11 Third-Party Beneficiaries. There are no third parties intended to be beneficiaries of any obligation or right assumed by Group or Hospital under this Agreement.

10.12 Assignment. Hospital's and Group's rights and obligations of this Agreement may not be assigned without the prior written consent of the other party which consent shall not be unreasonably withheld. Any attempted assignment or assignment by the parties of this Agreement shall not release the assigning party from any liability to the other party or a third party that arises from the assignee's performance hereunder.

10.13 Execution and Amendments. Several copies of this Agreement may be signed on behalf of Group and Hospital. Each signed copy shall be deemed an original, but all signed copies together shall be deemed one and the same instrument. In order to be effective, any amendments to this Agreement must be in writing and signed by authorized representatives of both parties.

10.14 Entire Agreement. This Agreement and any Schedules or Exhibits supersede any previous contracts between the parties, except those listed in Exhibit 10.14 attached hereto and incorporated herein by reference, and constitute the entire agreement between the parties. Both parties acknowledge that any statements or documents not specifically referenced and made a part of this Agreement shall not have any effectiveness.

10.15 Agreements between Hospital and Group. This Agreement and those agreements listed on Exhibit 10.14, are the only agreements entered into between Hospital and Group or any stockholders or immediate family members of the stockholders of Group.

10.16 Sovereign Immunity. Nothing in this Agreement shall be construed to waive any immunities or defenses available to the Hospital or its officers, employees, or agents under applicable federal or state law, including, but not limited to, the doctrine of sovereign immunity and the provisions of the Wyoming Governmental Claims Act (W.S. § 1-39-101 et seq.). This Agreement is not intended to, and shall not, create any rights in any third party, nor shall it be deemed to waive any defenses or limits of liability available to the Hospital.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the dates written below.

Advanced Medical Imaging, LLC

By:_____
President

Memorial Hospital of Sweetwater County

By:_____
Chief Executive Officer

Date: 7-1-2025

Date: 7-1-2025

EXHIBIT 2.1

List of Physicians and Physician Acceptance and Acknowledgment

1.	Fred Matti, M.D.	
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Physician Acceptance and Acknowledgment

The Physician signing below hereby individually accepts and acknowledges all of the terms and conditions of the Imaging Services Agreement to which this Exhibit 2.1 is attached. The Physician further agrees that he/she is bound by and agrees to comply with all terms that apply to the Physician. Physician further agrees that the execution of this Exhibit2.1 and the delivery of the original signed document to Memorial Hospital of Sweetwater County is a prior condition to the performance of any physician services under the Imaging Services Agreement.

Fred Matti, M.D.	7-1-2025

EXHIBIT 2.2

SERVICE SCHEDULE

All Physicians scheduled to provide Services on-site at the Hospital Facility and on-call shall respond and be able to perform all requested Services. Any Services which do not conform to the time requirements set forth in this Exhibit 2.2 will be reviewed on a reasonable case-by-case basis to determine Group's performance under the Agreement.

Regular business hours shall require that the first procedure be available at 8:30 a.m. Hospital shall monitor compliance with this requirement through quarterly audits and require Group to submit a compliance report detailing adherence and any deviations.

After-hours coverage is defined as 5:00 p.m. to 8:00 a.m., including weekends and holidays. The Group shall resume interpretation at the conclusion of night-hawk coverage, which runs from 7:00 a.m. to 8:00 a.m..

Group shall provide the Services at the Hospital Facility on an on-site or on-call basis according to this schedule. Group shall employ or contract with a minimum of three Physicians at Group's expense to provide adequate imaging staffing for the Hospital Facility. At least one Physician must be available on-site at all times during regular business hours, while the second Physician must be available either on-site or on-call as needed to meet the Hospital's patient care requirements. Group shall ensure that a Physician is present at the Hospital at least 30 minutes before the scheduled start of procedures to complete all necessary pre-procedure preparations, including reviewing patient history, coordinating with surgical staff, and ensuring all required equipment and imaging resources are in place, to facilitate a timely and efficient execution of the procedure.

Final reads from the previous night must be completed promptly and no later than twenty-four (24) hours from the time the study is received.

On-Call Responsibilities: Radiologists on overnight call must begin reviewing pending studies at 7:00 a.m. and prioritize overreads and flagged cases to ensure prompt completion within twenty-four (24) hours from the time the study is received.

Turnaround time requirements:

Stat – Read studies and provide verbal report within sixty (60) minutes of receiving the study and dictate report within twenty-four (24) hours of receiving the study.

General Diagnostic – Read studies and dictate reports within twenty-four (24) hours of receiving the study, except for prostate MRIs, PET scans, screening mammography, and routine scheduled ultrasounds performed after 5:00 p.m. on Friday.

Hospital Facility

Monday through Friday: Regular Hospital business hours. Staff accordingly with sufficient Physicians on-site to meet needs of Hospital's various schedules, emergency room, patients and physicians.

Saturday and Sunday: On-site staff if and as necessary to satisfy needs of Hospital's various schedules, emergency room, patients and physicians.

All other times: The Group shall provide back-up on-call coverage as necessary to meet the needs of the Hospital, Emergency Department, patients, and referring physicians. However, if the Group, at its own expense, provides a direct, private internet connection or satellite link that has been tested and validated to the Hospital's satisfaction, the Hospital may consider waiving the back-up call requirement. Any such waiver must be in writing and approved by Hospital administration.

Except as provided below, Physicians scheduled to be available to provide Services on an on- call basis shall respond to pages/calls for services/information and be available to access teleradiography equipment in accordance with the response timeframes established in this Agreement.. On-call Physician shall remain within a 30-minute travel radius of the Hospital to ensure timely response. If requested, or the condition of the patient warrants, the Physician must report to the Hospital according to the applicable requirements in the Medical Staff Bylaws. In the event of inclement weather that renders travel unsafe or impossible, the Physician must notify the Hospital immediately and make all reasonable efforts to ensure continuity of care through remote services or alternative coverage.

A written protocol will direct appropriate actions by radiologist during occasions such as a computer crash, disruption of telephone service, and/or disruption of Internet service. In the interest of timely patient care, such a protocol will include a maximum reasonable timeframe for delay in reading studies; sixty (60) minutes. Once the maximum timeframe of sixty (60) minutes has been reached, the radiologist will report to the facility to interpret emergent studies, if specifically requested by referring physicians. If this clause is abused by referring physicians, Hospital will facilitate corrective measures in conjunction with the medical staff governance.

EXHIBIT 2.5

PROFESSIONAL IMAGING SERVICES TO BE PROVIDED BY GROUP

The term "Services" shall include, except as otherwise herein provided:

1. all procedures and tests currently being performed on all inpatients and outpatients of Hospital ("Patients") that deal with or are related to diagnostic imaging, nuclear medicine including (but not limited to) diagnostic ultrasound (US), computed tomography (CT), magnetic resonance imaging (MRI) including (but not limited to) magnetic resonance angiography (MRA), positron emission tomography (PET) scans, cardiac nuclear medicine services and other imaging procedures included in the medical specialty of radiology; and

2. all procedures, tests, and treatments of the kinds described in the preceding paragraph that hereafter commence to be performed on Patients, except as the parties may otherwise agree in writing.

3. Stress tests. In the event the Hospital enters into an agreement with or employs a cardiologist, the parties agree to negotiate in good faith a shared arrangement for the performance and interpretation of cardiac nuclear medicine stress tests.

The term "Services" shall not include the following procedures and tests, which may be performed by a Physician or any other physician unaffiliated with Group appropriately credentialed by Hospital:

1. carotid angiograms;
2. peripheral angioplasty;
3. peripheral atherectomy;
4. peripheral conventional angiography;
5. coronary atherectomy;
6. ultrasound for amniocentesis procedures.
7. Breast MRIs;
8. Point of Care Ultrasound in the Emergency Department performed by ED physicians;

EXHIBIT 2.13

FEES FOR READINGS OF NONHOSPITAL PATIENTS

As fair market value consideration, Group shall pay Hospital in the amount of $_____ per study for reading diagnostic test images using Imaging Department facilities and/or equipment for individuals who are not patients of the Hospital at the time of such tests ("NonHospital Patient Readings"). The only Imaging Department facilities and equipment that Group can use for NonHospital Patient Readings are the following:_____. Hospital will invoice Group for NonHospital Patient Readings on a monthly basis and Group shall make payment to Hospital for the same within thirty (30) days from the date of such invoice. The parties agree that no NonHospital Readings will occur until the parties have established in writing the rates Group will pay Hospital related to same.

EXHIBIT 2.17

PERFORMANCE INDICATORS

1. A thorough quality assurance program designed to review professional interpretations will be implemented. While achieving high quality and implementing measures to do so will be an ongoing process, the group of people assigned to monitor and implement the program will formally convene monthly. The Group will maintain minutes and develop action steps that will be reported to the appropriate personnel within the system and medical staff. In addition, the Group shall submit a formal quarterly QA report to Hospital administration, detailing findings, corrective actions, and identified trends. The Chief Executive Officer (CEO) or the CEO's designated representative shall review and oversee the findings and recommendations included in each quarterly report.

2. The Group shall comply with the requirements of Exhibit 2.2 regarding scheduling and turnaround time. Failure to meet these turnaround requirements set forth in Exhibit 2.2 during two consecutive reporting periods shall require a corrective action plan within 30 days. Continued non-compliance beyond three reporting periods may result in increased oversight, or potential restructuring of Group's service obligations, as determined by the Hospital.

3. The interpreting Physician will complete a final report as set forth in Exhibit 2.2.

4. Group shall ensure that all quality assurance reports provided by any third party teleradiology service contracted by Group, including nighthawk services, are promptly submitted to the Hospital via inclusion of the quarterly random QA report.

5. At least one Physician who is a general radiologist will be available, either on-site or on-call, twenty-four (24) hours each day with appropriate arrangements made for afterhours call other than in emergency situations as determined by Hospital. The Hospital shall maintain and periodically evaluate sufficient teleradiology equipment to ensure operational readiness.

6. Any study in which a clinically significant reading discrepancy occurs will become part of the QA process and will result in immediate direct communication with the referring medical staff member.

7. A member of the Group will attend each medical staff department meeting on a semiannual basis for the purpose of soliciting input from the referring medical staff related to the quality of service being provided. Additionally, the Group shall provide semi-annual reports summarizing key performance trends and any initiatives undertaken to enhance service quality.

Contract Check List

Service Agreement

Any contract equal to or greater than $50,000.00 **This excludes service agreements (regardless of the dollar amount) attached to Board approved capital equipment. The service agreements attached to this equipment can be signed and approved by the CEO and reported to the Board at the next Board meeting for informational purposes.**

This check list summarizes the purpose, cost and other contract provisions contained in the contract and assures that the contract has been reviewed by both the CEO and In-House Legal Counsel.

1. Name of Contract**: GENESA REIMBURSEMENT GROUP MSA with accompanying SOW**

2. Purpose of contract, including scope and description: **Genesa, through a SOW for Medicare Volume Decrease Adjustment review, will perform a tiered VDA analysis. This analysis _will look at discharge data changes from FY21 to FY22 to determine if MHSC qualifies for the VDA. The initial estimate is additional reimbursement from Medicare of $900,000. _**

3. Effective Date**: last signed date**

4. Expiration Date: **when terminated by either party.**

5. Rights of renewal and termination: **In effect until terminated by either party** Is this auto-renew? **NO**

6. Monetary cost of the contract and is the cost included in the department budget? **There is no upfront cost. This is reimbursement analysis on our Medicare Volume. If Genesa is able to find a way to increase volume they will take 15% of the reimbursement up to $200,000.00; 10% of reimbursement from $200,001 to $400,000; and 5% of the increased reimbursement from $400,001 or more**, estimated at $75,000.

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so? **Wyoming**

8. Any confidentiality provisions? **Yes Section 4 of MSA**

9. Indemnification clause present? **No**

10. Governmental Immunity clause added? **Yes**

11. Is this contract appropriate for other bids? **CFO met with several other groups offering this service and determined that Genesa was the best option.**

12. In-house Counsel Reviewed: **YES**

13. Is County Attorney review required? **No**

Contract Check List

Service Agreement

Any contract equal to or greater than $50,000.00 **This excludes service agreements (regardless of the dollar amount) attached to Board approved capital equipment. The service agreements attached to this equipment can be signed and approved by the CEO and reported to the Board at the next Board meeting for informational purposes.**

This check list summarizes the purpose, cost and other contract provisions contained in the contract and assures that the contract has been reviewed by both the CEO and In-House Legal Counsel.

1. Name of Contract: **Renewal of CQ MEDICAL (formerly CIVO) Service Agreement for maintenance and service of Protura couch.**

2. Purpose of contract, including scope and description: **This is a contract for a service agreement for the Cancer Center's Protura robotic couch. The couch (table) enables us to treat with 6 degrees of freedom which allows us to get the patient in a more precise and accurate position. The service agreement allows CQ MEDICAL to perform routine service and checks on the table and they will provide phone support and will come on-site when needed to fix something or replace parts. If we did not have a service agreement in place there is no guarantee who soon they would come on-site and then it would be an hourly charge which could easily exceed $35,000.00 year. In radiation oncology we need to keep services up and running because we would have adverse patient outcomes if a patient misses too many days of treatment. It comes with computer software as well. The Cancer Center has received an end-of-life notice for this Protura Robotic Couch. CQ MEDICAL will no longer be servicing the couch after December 2027. Because the couch is at the end of of life, CQ Medical is only offering Gold Level Service Plan. This couch is an essential part of our precise and effective radiation treatments, so having the service agreement is vital for continued patient care.**

3. Effective Date: **current agreement ends April 15, 2025.**

4. Expiration Date: **December 30, 2027**

5. Rights of renewal and termination: **Can be terminated upon return of all equipment to CQ MEDICAL** Is this auto-renew? **NO**

6. Monetary cost of the contract and is the cost included in the department budget? **We are requesting renewal of the Gold level service agreement for one year which will be $35,000.00 annually.**

7. Jurisdiction/Choice of Law provision checked and changed to Wyoming if able to so? **Jurisdiction is in Delaware**

8. Any confidentiality provisions? **No**

9. Indemnification clause present? **No**

10. Governmental Immunity clause added? **Yes**

11. Is this contract appropriate for other bids? **Any equipment or software purchased by the hospital usually requires a service agreement from the same company/manufacturer. If we purchase a service agreement from another company it will most likely void any warranties.**

12. In-house Counsel Reviewed: **YES**

13. Is County Attorney review required? **No**