

MANAGEMENT AGREEMENT

This Management Agreement (herein after referred to as "Agreement") is entered into in White Sulphur Springs, Montana, this 17 th day of April, 2008 by and between **Mountain View Medical Center, Inc.**, (hereinafter referred to as "Hospital"), with its principal business at 16 West Main Street, White Sulphur Springs, MT 59645 , and **Cypress Health Systems, LLC**, (hereinafter referred to as "Manager") with its principal business at 106 Preston Bay Circle, Benton, LA 71006

RECITALS:

1. Mountain View Medical Center, Inc. is the operating name of Hospital and its related entities and is duly created and lawfully acting hospital in the State of Montana
2. Hospital provides that includes, but is not limited to general acute care, long-term care, and outpatient services.
3. Hospital retains the services of Manager to provide its experience, expertise, skills, supervision, and certain personnel in the management and operation of Hospital.
4. Manager agrees to provide such management and services subject to the recognition and acceptance by Manager that the full authority and ultimate control of Hospital shall at all times remain exclusively with Hospital's governing Board of Directors (hereinafter referred to as "Board")

AGREEMENT:

Now, therefore, in consideration of the above recitals and for other good and valuable consideration, Hospital and Manager agree as follows:

ARTICLE I

DIVISION OF AUTHORITY AND RESPONSIBILITY

- 1.1 The Board. The Board shall retain all authority placed in it by law and its bylaws, as may be amended from time to time, and shall retain such other authority as shall not have been specifically delegated by it to Manager as an independent contractor pursuant to the terms of this Agreement. The Board shall represent Hospital in all matters pertaining to the interpretation of this Agreement; provided, that in any situation in which pursuant to the terms hereof, the Board shall be required or permitted to take any action, to give any approval, or to receive any report, Manager shall be entitled to rely upon the written statement of the representative or representatives of the Board who shall be designated in writing by the Board to act on its behalf under this Agreement to the effect that any such action or approval has been taken or given. Delivery of any such report to the designated representative of the Board shall constitute delivery to the Board.

- 1.2 Medical Staff; Medical and Professional Matters. The medical staff shall be organized and function according to its bylaws and regulations of the State of Montana as they may be amended from time to time, and Manager shall consult with the medical staff and the Board, as may from time to time be appropriate. All matters requiring professional medical judgements shall remain the responsibility of the Board, medical staff, and allied health professionals.
- 1.3 Authority and Responsibility of Manager. Manager shall have authority and responsibility to conduct, supervise, and effectively manage the day-to-day operations of Hospital. Any powers not specifically delegated or granted by the Board to Manager will remain with the Board. In the absence of oral or written direction or written policies of the Board, Manager shall exercise the reasonable judgement of a hospital management company in its management activities. The relationship of Manager to Hospital shall be that of an independent contractor, all acts performed by Manager pursuant to this Agreement during the Term shall be deemed to be performed in Manager's capacity as an independent contractor. Manager shall specifically have responsibility and commensurate authority, subject, where applicable under the terms of the Agreement, to the direction and prior approval of the Board, the written policies of the Board and budgets approved by the Board, for the following activities:
- A. Personnel Administration. The recruitment, hiring, promotion, disciplining of Hospital employees in accordance with the law, policies of Hospital, the establishment, revision, and administration of wage scales, rates of compensation, employee benefits, rates and conditions of employment, in-service training, attendance at seminars or conferences, staffing schedules and job and position descriptions with respect to all employees of Hospital and of Manager who are associated with the operation of Hospital. Manager shall supervise and manage all employees of Hospital and of Manager, including physician employees, taking into consideration the qualifications, performance or misconduct of such employees or the staffing requirements of Hospital necessary for quality patient care. Manager will observe all provisions of law, Hospital Bylaws, Medical Staff Bylaws, and Hospital contracts with employees. Manager shall recruit physicians, nurses, and other professionals and para-professionals satisfactory to the Board, sufficient to maintain staffing levels established by the Board.
- B. Accounting and Financial Records. Manager shall conduct the financial affairs of Hospital subject to policies and procedures approved by the Board including but not limited to the following

1. Making recommendations to the Board regarding the establishment and administration of accounting procedures and controls, in accordance with generally accepted accounting principles, and the establishment and administration of systems for the development, preparation and safekeeping of records and books of account relating to the business and financial affairs of Hospital.
2. Submitting to the Board, at least 30 days prior to the end of the fiscal year, budgets covering Hospital's operations for the next fiscal year. The budget shall include both a operating and capital expenditure budget.
3. Making recommendations to the Board regarding the establishment, maintenance, revision and administration of the overall charge structure of Hospital pursuant to pertinent regulations, including, but not limited to patient room charges, charges for all ancillary services, charges for supplies, medication and special services, provided, however, that all such charges shall be subject to prior Board approval.
4. Making recommendations to the Board regarding the issuance of bills for services and material furnished by Hospital within a time constituting industry standards, including the responsibility to enforce the rights of Hospital as creditor under any contract or in connection with the rendering of any service.
5. The payment of payroll, trade accounts, amount due on short and long term indebtedness, taxes and all other obligations of Hospital within timeframes required by the IRS; provided, that Manager's responsibility under this paragraph shall be limited to the exercise of reasonable diligence and care to apply the funds collected in the operation of Hospital to its obligations in a timely and prudent manner. Nothing contained in this Agreement shall be construed to constitute Manager as a guarantor with respect to any obligations of Hospital or with respect to the profitability of Hospital.
6. Making recommendations to the Board regarding the maintenance of accounts, including certificates of deposits, in such banks, savings and loan associations and other financial institutions as the Board may from time to time select with such balances therein (which may be interest bearing or non-interest bearing) as board shall deem appropriate. All such bank accounts shall be maintained in the name of Hospital and checks withdrawing funds from said bank accounts and said depositories shall be signed only in a manner determined by the Board.

C. Purchases and Leases.

1. Manager, subject to Board approval, shall identify and utilize purchasing agreements from time to time. Hospital acknowledges that the overall commitment and utilization of the purchasing agreements

by Hospital will affect Manager's ability to maximize savings to Hospital.

2. Subject to any applicable legal requirements, Manager shall negotiate, enter into, terminate and administer on behalf of Hospital contracts for services by medical, paramedical and other persons and organizations and for maintenance and repair of the physical plant of Hospital; provided, however that any such process shall at all times be subject to Hospital policy, and approval of the Board.

D. Management Support Services. In addition to the other managerial services provided herein, Manager shall review, monitor, recommend, and implement, if approved by the Board, needed improvements or changes in Hospital operations, including, but not limited to, the following:

1. Administrative overview
2. Nursing Consultation
3. Productivity Standards
4. Regulatory compliance
5. Financial Oversight
6. Business Office Consultation
7. Strategic Planning
8. Board Orientation

E. Communication and Reports.

1. Manager shall present to the Board monthly reports, which shall be in writing, on the financial condition of Hospital and steps being taken to implement improvements, periodic written progress reports summarizing Manager's management actions and results and such other written reports as Manager or the Board considers appropriate to keep the Board informed as to the status and condition of Hospital.
2. Manager shall provide a corporate officer who shall;
 - a. Provide supervision of the on-site administrator of Hospital (hereinafter referred to as "Administrator").
 - b. Evaluate the Administrator's performance following input and discussion with the Board.
 - c. Coordinate and monitor the services of Manager as appropriate to the needs of Hospital.
 - d. Attend from time to time, meetings of the Board, medical staff, and any other major policy or strategy sessions or meetings.
 - e. Provide consultation in preparing material for Board decisions, operational issues/problems, special projects and leadership development.
 - f. Submit and present an annual report to the Board if so requested.

F. Projects Not Included. At the Board's request, any special projects, such as physician recruitment, bond counsel for financing construction projects, marketing surveys, financial feasibility studies for new financing, or a major portion thereof or other work not specifically included in Manager's obligations hereunder, may be performed by Manager and paid by Hospital pursuant to specific written agreements separately negotiated by the parties from time to time.

1.4 Standards of Performance. The Board acknowledges that, while Manager shall expend its best efforts in performing its obligations under this Agreement, Manager does not guarantee any particular results. Manager shall act in good faith and with professionalism to ensure Hospital will provide high quality patient services. The Board covenants that it will, in its discretion, support and implement, through policies, Manager's reasonable suggestions regarding the operation of Hospital.

1.5 Ethical Conduct. Manager shall treat all Hospital employees, patients, visiting physicians and providers, community members and other affiliates with respect and responsibility. Manager shall comply with all laws, ethical codes and Hospital policies, procedures, rules or regulations, including those forbidding harassment, discrimination and unfair business practices.

ARTICLE II EMPLOYEES

2.1 General. Except as specifically provided in Paragraph 2.3 with respect to the Administrator and Special Employees, all operating and service personnel as necessary for the proper functioning and maintenance of Hospital shall be employees of Hospital.

2.2 Non-Solicitation and No-Hire Covenant. During the Term and for the period of one year thereafter:

- A. Hospital shall not, without prior approval of Manager solicit for employment or hire any employee of Manager either for Hospital or one of Hospital's operated facilities. Notwithstanding the foregoing, in the event that this Agreement is terminated pursuant to Section 6.1, Hospital may, at its sole discretion, employ the current Administrator.
- B. Manager shall not, without prior approval of Hospital, solicit for employment or hire any employee of Hospital either for Manager or one of Manager's operated facilities

2.3 Manager Provided Personnel.

- A. Administrator. Manager shall, during the Term, provide Hospital with a qualified Administrator who shall serve as the chief executive officer of Hospital. The initial and continuing appointment shall be subject to the prior and continuing approval of the Board. The Administrator shall be the employee of Manager for the Term.
- B. Special Employees. With the prior written approval of the Board, Manager may employ as its employees other persons on a temporary basis (hereinafter referred to as "Special Employees") to work at Hospital, in which event Hospital shall reimburse Manager for salaries and fringe benefits paid to or on behalf of such employee at amounts agreed to by the Board and Manager. The Board shall be under no obligation to accept the recommendations of Manager to have Manager's Special Employees work at Hospital.
- C. Interim Expenses. Should an interim Administrator need to be assigned to Hospital at any time, the documented interim living expenses of the individual who will be filling the position of Administrator on an interim basis shall be paid by Hospital. Interim living expenses may include the following: lodging, food, transportation, and other out-of-pocket expenses incurred by the interim Administrator. If Manager's corporate staff is providing interim on-site management in lieu of an interim Administrator, Hospital shall pay the salaries and interim living expenses of Manager's corporate staff. Notwithstanding the foregoing, the Hospital shall not be obligated to pay interim living expenses unless the type and amount have been approved in advance by the Board, which approval shall not be unreasonably withheld.
- D. Payment of Relocation Expenses. Within ten (10) days of receipt of invoice, Hospital shall reimburse Manager for all expenses associated with relocating an Administrator to Hospital. Relocation expenses shall consist of house-hunting trips, transporting household belongings, transportation, and temporary lodging. The amount of reimbursable relocation expenses shall be subject to the Board's advance approval, which shall not be unreasonably withheld.
- E. Interviewing Expenses. Hospital shall reimburse Manager within ten (10) days of receipt of invoice all approved costs associated with interviewing persons for Administrator. The amount of reimbursable interview expenses shall be subject to the Board's advance approval, which shall not be unreasonably withheld.
- F. Other Expenses. Subject to Hospital policy and Board approval, Hospital shall pay for all travel, lodging, and other out-of-pocket expenses of the Administrator and any Special Employees when they are attending

meetings or conferences away from Hospital on behalf of Hospital or meetings Manager may organize from time to time. The amount of such expenses shall be subject to the Board's advance approval, which shall not be unreasonably withheld.

ARTICLE III LICENSING AND ACCREDITATION

3.1 Recognizing that Hospital has the ultimate responsibility to keep and maintain its operating licenses under the laws of the State of Montana, nevertheless, each of the parties hereto, within the performance of their respective obligations hereunder, covenants that it will take all reasonable steps necessary to keep Hospital fully licensed. Each covenants to cooperate with the other in said endeavors. Each party further covenants that it will do nothing willful or wanton to jeopardize Medicare, Medicaid and other party reimbursement agreements. Both Hospital and Manager agree to abide by all applicable laws, ordinances, rules and regulation of state, local or federal governments pertaining to Hospital's ownership, Manager's management of Hospital and to the performance of this Agreement. Notwithstanding any other provision in this Agreement, Hospital remains responsible for insuring that any service provided pursuant to this Agreement complies with all pertinent provisions of federal, state and local statutes, rules and regulations.

ARTICLE IV COMPENSATION

- 4.1 Base Fee. As compensation for all services rendered by Manager, Hospital shall pay Manager \$10,000.00 per month for each and every month of this Agreement ("Base Fee"). The Base Fee shall be paid within ten (10) days of Hospital's receipt of invoice from Manager. Payment for any partial month shall be that proportion of the monthly installment then due which the number of days worked by Manager during such partial month bears to the total number of working days in said month.
- 4.2 Base Fee Increase. After the first year of this Agreement the Base Fee shall increase by 4% per year.
- 4.3 Travel Expense. Additionally, Hospital shall be responsible for payment of transportation and out-of-pocket expenses of Manager's consultants and staff while performing on-site services for Hospital. Such costs shall not exceed \$13,000.00 per year. These expenses shall be billed each month and are payable as per Section 4.1.

- 4.4 Suspension of Base Fee. In the event that Manager fails to provide an Administrator for a full calendar month, Hospital shall not be obligated to compensate Manager the Base Fee for the calendar month.
- 4.5 Reimbursement of Compensation. In addition to the Base Fee, Hospital shall within in ten (10) days of receipt of invoice, pay to Manager an amount equal to the Administrator's and any Board approved Special Employees' compensation plus twenty-eight (28) percent of their compensation for the approximate cost to Manager of their benefits, payroll taxes, and other employment costs. The amount of the Administrator's and Special Employees' compensation shall be subject to the Board's approval.

ARTICLE V TERM OF AGREEMENT

- 5.1 Term. The term of this Agreement shall be for five (5) years, commencing on _____, 2008, and terminating at midnight five (5) years thereafter, unless earlier terminated as provided in Article VI ("Term").

ARTICLE VI TERMINATION

6.1 Breach as Grounds for Termination. In the event of a breach of this Agreement by either party, the other party shall have the right to give written notice of such default to the defaulting party (the "Default Notice"). In the event such breach is not cured within 30 days after service of the Default Notice, the non-defaulting party may elect to terminate this Agreement by giving written notice of termination pursuant to Section 6.3 below.

6.2 Other Grounds for Termination. Notwithstanding any other provision hereof, this Agreement may be terminated upon 10 days written notice by either party:

- (a) Upon loss or restriction of Hospital's license or accreditation, or destruction of Hospital such that Hospital is not able to substantially continue uninterrupted operations;
- (b) Upon loss or restriction of Hospital's ability to provide services to Medicare or Medicaid patients;
- (c) Upon the dissolution of either party;
- (d) In the event a defaulting party materially breaches any of the terms and conditions of this Agreement and the non-defaulting party has given at

least 2 Default Notices pursuant to Section 6.1 hereof with respect to other instances of breaching this Agreement by the defaulting party; or

- (e) If either party shall apply for or consent to the appointment of a receiver, trustee, or liquidator of itself or of all or a substantial part of its assets, file a voluntary petition in bankruptcy, or admit in writing its inability to pay its debts as they become due, make a general assignment for the benefit of creditors, file a petition or an answer seeking reorganization or arrangement with creditors or take advantage of any insolvency law, or if an order, judgment, or decree shall be entered by a court of competent jurisdiction or an application of a creditor, adjudicating such party to be bankrupt or insolvent, or approving a petition seeking reorganization of such party or appointing a receiver, trustee or liquidator of such party or of all or a substantial part of its assets, and such order, judgment or decree shall continue in effect and unstated for a period of 60 consecutive days.

6.3 Voluntary Termination. Either party may terminate this Agreement for any reason at any time by giving written notice to the other. Upon such notice, the Agreement shall terminate the thirtieth (30th) day after the notice is given unless a different termination date is agreed to in writing by each party.

ARTICLE VII INSURANCE

- 7.1 Liability Insurance. Hospital shall maintain hospital professional and general liability insurance coverage of not less than \$1,000,000 and shall cause Manager to be named as an additional insured on this policy. Hospital shall provide an extended reporting endorsement (tail coverage) as part of this policy covering Manager and its on-site employees for claims incurred during the Term. In addition, should Hospital change insurance companies during the duration of this Agreement, Hospital shall maintain coverage which includes claims incurred but not reported under the prior coverage (prior acts coverage).
- 7.2 Primary Insurance. It is the intention of the parties that the insurance maintained by Hospital shall protect both Hospital and Manager and will be primary insurance for both parties for all losses covered thereby.
- 7.3 Certificates of Insurance. Certificates of insurance for coverage's required in Paragraph 7.1 and accompanying endorsement naming Manager shall be provided to Manager within 30 days of execution of this Agreement and annually thereafter within 30 days of policy renewal.

- 7.4 Workers Compensation Insurance. Hospital shall maintain and pay for workers compensation insurance for its employees as required by law. Manager shall maintain and pay for workers compensation insurance for its employees as required by law. Each party shall provide the other party with proof of said workers compensation insurance coverage.

ARTICLE VIII INDEMNIFICATION

- 8.1 By Manager. Except to the extent covered by insurance, Manager shall indemnify defend and hold harmless Hospital and its agents, officers, directors, and employees from any and all expenses (including but not limited to reasonable attorney fees and court costs), loss, liability, and claims of any kind whatsoever (collectively, the "Damages") directly or indirectly arising from or alleged to arise from or in anyway connected with the operation of Hospital or the performance by Manager of its obligations under this Agreement, where such Damages are incurred by Hospital as a result of the negligent acts or omissions of Manager or willful and wanton misconduct of Manager; provided, however, Manager's indemnity hereunder shall be limited to Damages suffered by Hospital as a result of said negligent acts or omissions or willful and wanton misconduct.
- 8.2 By Hospital. Except to the extent covered by insurance, Hospital shall indemnify defend and hold harmless Manager and its agents, officers and employees from any and all expenses (including but not limited to reasonable attorney fees and court costs), loss, liability, and claims of any kind whatsoever (collectively, the "Damages") directly or indirectly arising from or alleged to arise from or in anyway connected with the operation of Hospital or the performance by Hospital of its obligations under this Agreement, where such Damages are incurred by Manager as a result of the negligent acts or omissions of Hospital or willful and wanton misconduct of Hospital; provided, however, Hospital's indemnity hereunder shall be limited to Damages suffered by Manager as a result of said negligent acts or omissions or willful and wanton misconduct.

ARTICLE IX MISCELLANEOUS

- 9.1 Ownership of Information. Hospital retains all ownership and other rights in all systems, manuals, materials, and other information, in whatever form, provided by Manager in the performance of its obligations hereunder and more particularly described as business office, policy and procedure, purchasing, and nursing guidelines from Manager. Manager retains ownership

of information it notifies Hospital in writing is proprietary information at the time of conveying it to Hospital.

- 9.2 Disclaimer of Intent to Become Partners. Manager and Hospital are not in partnership or joint venture and shall not by virtue of this Agreement be deemed in partnership or joint venture in the operation of Hospital or any related facility. It is expressly understood that Manager is hereby retained by Hospital to manage Hospital in accordance with this Agreement and that Manager is an agent of Hospital only for the purpose of, and to the extent necessary, to carry out its obligations under this Agreement.
- 9.3 Waiver of Employee Benefits. Manager hereby waives and foregoes the right to receive for itself or any of its employees any benefits provided by Hospital to Hospital's employees, including, but not limited to, health benefits, unemployment compensation insurance, workers' compensation insurance, vacation and sick leave benefits, profit sharing and pension plans. This waiver is applicable to all benefits which might otherwise be found to accrue to any employee of Manager by virtue of his or her services for Hospital. Manager shall cause each employee of Manager working for Manager for the benefit of Hospital under this Agreement to execute an agreement acknowledging Manager is his or her employer and waiving any and all employee benefits from Hospital in a format satisfactory to Hospital before being allowed to perform services for Hospital. If Hospital is ordered by any lawful process to pay or provide any benefit to any person identified as a Manager employee hereunder, Manager shall reimburse Hospital for the cost of any such benefit within 10 days of request by Hospital.
- 9.4 Effect of Invalidity. Should any part of this Agreement, for any reason, be declared invalid or unenforceable, such decision shall not affect the validity or enforceability of any remaining portion, which remaining portion shall remain in force and effect as if this Agreement had been executed with the invalid portion thereof eliminated and shall be construed in such manner as may be reasonably necessary to ensure that the Agreement continues to substantially reflect the agreement of the parties.
- 9.5 Applicable Law. The laws of the State of Montana shall govern this agreement and any dispute, claim, or counterclaim arising out of or relating thereto, whether in contract or tort or otherwise, even if Montana choice of law rules would require that the laws of another forum apply.
- 9.6 Attorney Fees. In any dispute arising under or relating to this Agreement or the relationship established by the Agreement, if awarded by a court of competent jurisdiction or other decision maker appointed by the parties, such as an arbitrator or mediator, the prevailing party may recover its reasonable

legal expenses. Legal expenses may include but not be limited to reasonable attorney fees and expert witness fees.

- 9.7 Headings/recitals. The headings to the various paragraphs of this Agreement and the recitals have been inserted for convenience of reference only and shall not modify, define, limit or expand the expressed provisions of this Agreement.
- 9.8 Legal Proceedings. If Manager is notified of a legal proceeding against Hospital, Manager shall notify Hospital and shall coordinate legal matters and proceedings with Hospital's attorneys.
- 9.9 Conflict of Interest. The Board shall advise Manager of all conflicts of interest disclosed, pursuant to Montana law, to the Board.
- 9.10 Third-Parties. The parties do not intend the benefits of this Agreement to inure to any third person not a signatory hereto. Notwithstanding anything contained herein, or any conduct or course of conduct by any party hereto, before or after signing this Agreement, this Agreement shall not be construed as creating any right, claim or cause of action against either party by any person or entity not a party to this Agreement.
- 9.11 Assignment. Neither party hereto may assign its interest in or delegate the performance of its obligations under this Agreement to any other person or entity without obtaining the prior written consent of the other.
- 9.12 Successors and Assigns. The terms, provisions, covenants, obligations and conditions of this Agreement shall be binding upon and shall inure to the benefits of the parties hereto and the successors in interest and the assigns of the parties hereto, provided that no assignment, transfer, pledge or mortgage by or through either party, as the case may be, in violation of the provisions of this Agreement, shall vest any rights in the assignee, transferee, pledges or mortgages.
- 9.13 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which taken together shall constitute but one and the same instrument.
- 9.14 Authority. Each of the parties to this Agreement represents and warrants to the other that it has full power and authority to enter into this Agreement and to carry out the terms hereof.

ARTICLE X NOTICES

10.1 Any notice by either party to the other shall be in writing and shall be deemed to have been given the earlier of: (1) the date on which is delivered personally or overnight delivery, or (2) five (5) days after it is deposited in the United States mail, postage pre-paid and certified with return receipt requested.

To Hospital: Mountain View Medical Center, Inc
16 West Main Street
White Sulphur Springs, MT 59645
Attn: Board President

To Manager: Kim Bird, President
Cypress Health Systems, LLC.
106 Preston Bay Circle
Benton, LA 71006

ARTICLE XI
ACCESS TO BOOKS AND RECORDS OF MANAGER BY
SECRETARY OF HEALTH AND HUMAN SERVICES OR
AUTHORIZED REPRESENTATIVES

Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, Manager or any other related organization providing services with a value or cost of ten thousand dollars (\$10,000) or more over a twelve (12) month period, shall make available to the Secretary the contracts, books, documents, and records that are necessary to certify the nature and extent of the costs of providing such services. Such inspection shall be available up to four (4) years after the rendering of such services. This paragraph is not intended to prohibit or impede any state audits pursuant to state law or to waive any attorney-client or physician-patient privilege. In the event the statutory amount reflected herein is revised during the Term, this paragraph shall be deemed to be amended, without further action required by either party hereto, to reflect said revised statutory amount.

ARTICLE XII
NO DISCRIMINATION

Manager and Hospital shall not discriminate against any person on the grounds of race, color, national origin, handicap, disability, religion or sex in the discharge of its duties and obligations herein.

**ARTICLE XIII
ENTIRE AGREEMENT**

This Agreement constitutes the sole and the only Agreement of the parties hereto with respect to the management of Hospital and correctly sets forth the rights, duties, and obligations of each to the other as of its date. Any and all prior agreements, promises, proposals, negotiations or representations, whether written or oral, which are not expressly set forth in this Agreement are hereby superseded and are of no force or effect.

**ARTICLE XIV
AMENDMENTS**

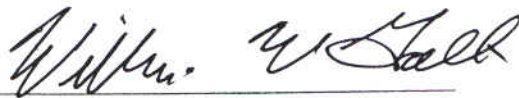
This Agreement may not be amended, modified or terminated orally, and no amendment, modification, termination or attempted waiver shall be valid unless in writing and signed by the party against whom the same is sought to be enforced.

IN WITNESS WHEREOF, the parties have caused this instrument to be duly executed by their authorized representative this 22 day of April, 2008

CYPRESS HEALTH SYSTEMS, LLC.

**MOUNTAIN VIEW MEDICAL CENTER,
INC.**

By:  _____

By:  _____

Its: CEO _____

Its: Board Chair _____

FACT SHEET



Critical Access Hospital



LEGISLATION ENACTED AS PART OF THE **BALANCED BUDGET ACT (BBA) OF 1997** authorized states to establish **State Medicare Rural Hospital Flexibility Programs (Flex Program)**, under which certain facilities participating in Medicare can become **Critical Access Hospitals (CAH)**. The following providers may be eligible to become CAHs:

- Currently participating Medicare hospitals;
- Hospitals that ceased operation during the 10 year period from November 29, 1989 through November 29, 1999; or
- Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center.

Unlike facilities such as Medicare Dependent Hospitals or Sole Community Hospitals, CAHs represent a separate provider type with their own Medicare Conditions of Participation as well as a separate payment method.

Critical Access Hospital Designation

A hospital must meet the following criteria to be designated a CAH:

- Be located in a state that has established a State Flex Program (as of December 2008, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have such a program);
- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- Furnish 24-hour emergency care services, using either on-site or on-call staff;
- Provide no more than 25 inpatient beds that can be used for either inpatient or swing bed services; however, a CAH may also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds;
- Have an average annual length of stay of 96 hours or less (excluding beds that are within distinct part units [DPU]); and
- Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR prior to January 1, 2006 were State certified as a "necessary provider" of health care services to residents in the area.

Critical Access Hospital Payments

Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries on the basis of reasonable cost. Under the Medicare ambulance benefit, if a CAH or an entity that is owned and operated by the CAH is the only provider or supplier of ambulance service located within a 35 mile drive of that CAH or entity, the CAH is paid based on reasonable cost for the ambulance services. CAHs are not subject to the Inpatient Prospective Payment Systems (IPPS)

and Hospital Outpatient Prospective Payment System (OPPS).

The Medicare Part A and Part B deductible and coinsurance rules applicable to hospital services also apply to CAHs. All outpatient CAH services are subject to Part B deductible and coinsurance except as follows:



- The beneficiary pays no Part B deductible or coinsurance for the following services:
 - Current Procedural Terminology (CPT) codes 90669 and 90732—Pneumococcal vaccines;
 - Healthcare Common Procedure Coding System (HCPCS) code G0009—Related administration of the pneumococcal vaccines;
 - CPT codes 90655, 90656, 90657, 90658, and 90660—Influenza vaccines;
 - HCPCS code G0008—Related administration of the influenza vaccine;
 - CPT codes 77052, 77057, and HCPCS code G0202—Screening mammography;
 - All codes for clinical diagnostic laboratory tests;
 - CPT code 82270—Fecal occult blood test; and
 - HCPCS code G0328—Fecal occult blood test (alternative to CPT code 82270).
- The beneficiary pays no Part B deductible and is responsible for paying the coinsurance for the following colorectal cancer screening services:
 - HCPCS code G0104—Flexible sigmoidoscopy;
 - HCPCS code G0105—Colonoscopy (high risk);
 - HCPCS code G0106—Barium enema (alternative to HCPCS code G0104);

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- HCPCS code G0120—Barium enema (alternative to HCPCS code G0105); and
- HCPCS code G0121—Colonoscopy (not high risk).

Reasonable Cost Payment Principles that Do NOT Apply to Critical Access Hospitals

Payment for inpatient or outpatient CAH services is NOT subject to the following reasonable cost principles:

- Lesser of cost or charges; and
- Reasonable compensation equivalent limits.

In addition, payment to a CAH for inpatient CAH services is not subject to ceilings on hospital inpatient operating costs or the 1-day or 3-day preadmission payment window provisions applicable to hospitals paid under the IPPS and OPFS.

Election of Standard Payment Method or Optional (Elective) Payment Method

Standard Payment Method—Reasonable Cost-Based Facility Services, With Billing of Carrier or A/B Medicare Administrative Contractor for Professional Services

Under Section 1834(g)(1) of the Social Security Act (the Act), CAHs are paid under the Standard Payment Method unless they elect to be paid under the Optional (Elective) Payment Method. For cost reporting periods beginning on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of:

- 80 percent of the 101 percent of reasonable costs for outpatient CAH services; or
- 101 percent of the reasonable cost of the CAH in furnishing outpatient CAH services less the applicable Part B deductible and coinsurance amounts.

Payment for professional medical services furnished in a CAH to registered CAH outpatients is made by the Medicare Carrier or A/B Medicare Administrative Contractor (MAC) under the Medicare Physician Fee Schedule (MPFS), as is the case when such professional services are furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services furnished by a physician or other qualified practitioner.

Optional (Elective) Payment Method—Reasonable Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services (Method 2)

Under Section 1834(g)(2) of the Act, a CAH may elect the Optional (Elective) Payment Method, under which it bills the Medicare Fiscal Intermediary (FI) or A/B MAC for both facility services and professional services to its outpatients. However, even if a CAH makes this election, each practitioner furnishing professional services to CAH outpatients can choose whether to:

- Reassign his or her billing rights to the CAH, agree to be included under the Optional (Elective) Payment Method, attest in writing that he or she will not bill the Carrier or A/B MAC for professional services furnished in the CAH outpatient department, and look to the CAH for payment for the professional services; or
- File claims for his or her professional services with the Carrier or A/B MAC for standard payment under the MPFS (i.e., either by billing directly to the Carrier or A/B MAC or by authorizing the

CAH to bill on his or her behalf via a valid reassignment of benefits).

If a physician or other practitioner reassigns his or her Part B billing rights and agrees to be included under a CAH's Optional (Elective) Payment Method, he or she must not bill the Carrier or A/B MAC for any outpatient professional services furnished at the CAH once the reassignment becomes effective. For each physician or practitioner who agrees to be included under the Optional (Elective) Payment method and reassigns benefits accordingly, the CAH must forward a copy of the completed assignment form (Form CMS 855R) to the FI and Carrier or A/B MAC and keep the original on file. Each practitioner must sign an attestation which clearly states that he or she will not bill the Carrier or A/B MAC for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH. This attestation will remain at the CAH. The Optional (Elective) Payment Method remains in effect for the entire cost reporting period and applies to all CAH professional services furnished in the CAH outpatient department by physicians and practitioners who have agreed to be included under the Optional (Elective) Payment Method, completed a Form CMS 855R, and attested in writing that they will not bill the Carrier or A/B MAC for their outpatient professional services. An Optional (Elective) Payment Method election and each practitioner's agreement to be included under the election must be renewed yearly based on the cost reporting year. Form CMS 855R can be found at <http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp> on the CMS website.

As of January 1, 2004, payment for outpatient CAH services under the Optional (Elective) Method is based on the sum of:

- For facility services, the lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services OR 101 percent of the outpatient CAH services less applicable Part B deductible and coinsurance amounts; and
- For physician professional services, 115 percent of the allowable amount, after applicable deductions, under the MPFS. Payment for non-physician practitioner professional services is 115 percent of the amount that otherwise would be paid for the practitioner's professional services under the MPFS.

To elect the Optional (Elective) Payment Method or to change a previous election, a CAH should notify the FI or A/B MAC at least 30 days before the start of the affected cost reporting period.

Effective January 1, 2007, the payment amount is 80 percent of the MPFS for telehealth services when the distant site physician or other practitioner is located in a CAH that has elected the Optional (Elective) Payment Method and the physician or practitioner has reassigned his or her benefits to the CAH.

Medicare Rural Pass-Through Funding for Certain Anesthesia Services

CAHs may participate in the Medicare Rural Pass-Through Program to secure reasonable cost-based funding for certain anesthesia services as an incentive to continue to serve the Medicare population in rural areas. The **Code of Federal Regulations (CFR)** under 42 CFR Section 412.113(c) lists the specific requirements hospitals or CAHs must fulfill to receive rural pass-through funding from Medicare for anesthesia services furnished by certified registered nurse anesthetists (CRNA) that they employ or contract with to furnish such services to CAH patients. CAHs that qualify for a CRNA pass-through exemption receive reasonable cost for CRNA professional services, regardless of whether they choose the

Standard Payment Method or the Optional (Elective) Payment Method for outpatient services, unless they opt to receive payment for outpatient anesthesia as a professional service. In that case, the anesthesia is paid on the anesthesia fee schedule and the CAH gives up the CRNA pass-through exemption for both outpatient and inpatient services.

Health Professional Shortage Area Incentive Payments

Physicians (including psychiatrists) who furnish care in a CAH that is located within a geographic-based, primary medical care Health Professional Shortage Area (HPSA) and psychiatrists who furnish care in a CAH that is located in a geographic-based mental health HPSA are eligible for a 10 percent HPSA incentive payment for outpatient professional services furnished to a Medicare beneficiary. If the physician has reassigned his or her billing rights and the CAH has elected the Optional (Elective) Payment Method, the CAH will receive 115 percent of the otherwise applicable MPFS amount multiplied by 110 percent, based on all claims processed during the quarter. If the service is furnished in an area that is on the Centers for Medicare & Medicaid Services (CMS) list of Zip codes that are eligible for the HPSA incentive payment, payments are automatically paid on a quarterly basis. An area may be eligible for the HPSA incentive payment but the Zip code may not be on the list because:

- 1) It does not fall within a designated full county HPSA;
- 2) It is not considered to fall within the county based on a determination of dominance made by the U.S. Postal Service;
- 3) It is partially in a sub-county HPSA; or
- 4) Services with dates of service on or after January 1, 2009 are provided in a Zip code area that was designated as of December 31 of the prior year but are not on the Zip code file.

In these situations, the CAH must utilize an AQ modifier to receive payment.

Physician Scarcity Area Bonus Payments

For dates of service through June 30, 2008, primary care physicians who furnish outpatient professional services to a Medicare beneficiary in an area that has been identified as a primary care Physician Scarcity Area (PSA) and specialty physicians who furnish outpatient professional services to a Medicare beneficiary in an area that has been identified as a specialty care PSA are eligible for a PSA bonus payment of five percent. If the physician has reassigned his or her billing rights and the CAH has elected the Optional (Elective) Payment Method, the CAH will receive 115 percent of the otherwise applicable MPFS amount multiplied by 105 percent, based on all claims processed during the quarter. If the service is furnished in an area that is on the CMS list of Zip codes that are eligible for the PSA bonus payment, payments are automatically paid on a quarterly basis. If the Zip code is not on the list but the area is in a county identified as a PSA, the AR modifier must be used. If the CAH is located in an area that is both an eligible HPSA and an eligible PSA and the Optional (Elective) Payment Method is elected, payment to the CAH for a physician's outpatient professional service will be 115 percent of the otherwise applicable MPFS amount multiplied by 115 percent.

Additional Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions that Impact Critical Access Hospitals

For services furnished on or after January 1, 2005, Section 405 (b) extends reasonable cost reimbursement for CAH costs of compensating physician assistants, nurse practitioners, and clinical nurse specialists who are on call to furnish emergency services.

Section 405(c) states that periodic interim payments will be paid every two weeks for CAH inpatient services furnished on or after July 1, 2004 for CAHs that apply and qualify for the periodic interim payment method.

Section 405(d) mandates that for cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner furnishing professional services in the CAH is not required to reassign his or her Part B benefits to the CAH in order for the CAH to elect the Optional (Elective) Payment Method. For CAHs that elected the Optional (Elective) Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of the rule is retroactive to July 1, 2001. For CAHs that elected the Optional (Elective) Payment Method on or after November 1, 2003, the effective date of the rule is July 1, 2004.

Under Section 405(e), beginning on January 1, 2004, CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or Skilled Nursing Facility level swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or if they had a swing bed agreement, 25 beds.

Section 405(g) states that for cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and/or rehabilitation units that are CAH DPUs. The total number of beds in each CAH DPU may not exceed 10. These beds will not count against the CAH inpatient bed limit of 25. Psychiatric and rehabilitation DPUs must meet the applicable requirements for such beds in short-term general acute care hospitals, and Medicare payments will equal payments that would be made to general short-term acute care hospitals for these services (i.e., payments that are made under the Inpatient Psychiatric Facility Prospective Payment System or the Inpatient Rehabilitation Facility Prospective Payment System). Therefore, payment for services in DPUs of CAHs is not made on a reasonable cost basis.

Section 405(h) mandates that effective January 1, 2006, the provision permitting a state to waive the distance requirements for CAH status via State "necessary provider" designation has sunset (ended). Providers that gained CAH status via "necessary provider" designations prior to January 1, 2006 may generally continue as CAHs on and after January 1, 2006.

Grants to States Under the Medicare Rural Hospital Flexibility Program

The Flex Program, which was authorized by Section 4201 of the BBA (Public Law 105-33) consists of two separate but complementary components:

- A Medicare reimbursement program that provides reasonable cost-based reimbursement for Medicare-certified CAHs, which is administered by CMS; and

- A State grant program that supports the development of community-based rural organized systems of care in participating states, which is administered by the Health Resources and Services Administration through the Federal Office of Rural Health Policy.

To receive funds under the grant program, states must apply for the funds and engage in rural health planning through the development and maintenance of a State Rural Health Plan that:

- Designates and supports the conversions to CAHs;
- Promotes emergency medical services (EMS) integration initiatives by linking local EMS with CAHs and their network partners;
- Develops rural health networks to assist and

support CAHs;

- Develops and supports quality improvement initiatives; and
- Evaluates State programs within the framework of national program goals.

To find additional information about CAHs, see the **Medicare Claims Processing Manual** (Pub. 100-4) at <http://www.cms.hhs.gov/Manuals> on the CMS website. To find additional information about HPSAs and PSAs, including eligible Zip codes, visit http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp on the CMS website. To access the CFR, visit <http://www.gpoaccess.gov/cfr/index.html> on the Web.

HELPFUL WEBSITES

American Hospital Association Section for Small or Rural Hospitals

http://www.aha.org/aha/key_issues/rural/index.html

Critical Access Hospital Center

<http://www.cms.hhs.gov/center/cah.asp>

Federally Qualified Health Centers Center

<http://www.cms.hhs.gov/center/fqhc.asp>

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

<http://www.cms.hhs.gov/center/hospital.asp>

HPSA/PSA (Physician Bonuses)

http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp

Medicare Learning Network

<http://www.cms.hhs.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://www.narhc.org>

National Rural Health Association

<http://www.nrharural.org>

Rural Health Center

<http://www.cms.hhs.gov/center/rural.asp>

Rural Assistance Center

<http://www.raconline.org>

Telehealth

<http://www.cms.hhs.gov/Telehealth>

U.S. Census Bureau

<http://www.Census.gov>

REGIONAL OFFICE RURAL HEALTH COORDINATORS

Below is a list of contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

REGION I – BOSTON

Rick Hoover

E-mail: richard.hoover@cms.hhs.gov

Telephone: (617) 565-1258

States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

REGION II – NEW YORK

Miechal Lefkowitz

E-mail: miechal.lefkowitz@cms.hhs.gov

Telephone: (212) 616-2517

States: New Jersey, New York, Puerto Rico, and Virgin Islands

REGION III – PHILADELPHIA

Patrick Hamilton

E-mail: patrick.hamilton@cms.hhs.gov

Telephone: (215) 861-4097

States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and Washington DC

REGION IV – ATLANTA

Lana Dennis

E-mail: lane.dennis@cms.hhs.gov

Telephone: (404) 562-7379

States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

REGION V – CHICAGO

Christine Davidson

E-mail: christine.davidson@cms.hhs.gov

Telephone: (312) 886-3642

States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

REGION VI – DALLAS

Becky Peal-Sconce

E-mail: becky.pealsconce@cms.hhs.gov

Telephone: (214) 767-6444

States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

REGION VII – KANSAS CITY

Robert Epps

E-mail: robert.epps@cms.hhs.gov

Telephone: (816) 426-6538

States: Iowa, Kansas, Missouri, and Nebraska

REGION VIII – DENVER

Lyla Nichols

E-mail: lyla.nichols@cms.hhs.gov

Telephone: (303) 844-6218

States: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

REGION IX – SAN FRANCISCO

Neal Logue

E-mail: neal.logue@cms.hhs.gov

Telephone: (415) 744-3551

States: Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, and American Samoa

REGION X – SEATTLE

Alma Hardy

E-mail: alma.hardy@cms.hhs.gov

Telephone: (206) 615-2387

States: Alaska, Idaho, Oregon, and Washington

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The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo/> on the CMS website.

Medicare Contracting Reform (MCR) Update

In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform/> on the CMS website.

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April 2009 ICN: 006400

Montana Counties Which Levy Mills For Hospitals - 2011

Forward

The Meagher County Hospital District Board requested the State Dept of Revenue to do a study of Montana counties which levy mills for hospitals. Revenue department economist, Steve Cleverdon, put together the data listing all Montana counties and whether they levy such mills. His research showed that of Montana's 56 counties, 15 levy mills for hospitals. Two counties, Chouteau and Teton, have hospital districts which levy county wide mills. Below are the essential data which are broken down county by county.

<u>County</u>	<u>Mills Assessed</u>	<u>Total Tax \$</u>	<u>Mill Value\$</u>
Beaverhead	3	54,634	18,211
Broadwater	18.3	191,076	12,579
Carter	5	40,942	8,608
Daniels	9.79	55,277	5,620
Fallon	13.5	344,805	25,944
Liberty	56.75	375,988	6,631
Meagher	28	216,389	7,728
Mineral	33	300,164	9,095
Musselshell	40.7	375,883	10,404
Pondera	7	93,522	13,362
Powell	.5	7,444	13,292
Prairie	42.98	150,531	3,502
Toole	10	189,292	18,929
Chouteau *	91.03	434,076	19,544
Teton	6	70,195	15,695

* has two hospital districts

MEAGHER COUNTY HOSPITAL DISTRICT BOARD
MINUTES, OCTOBER 13, 2010

Attendance: John Dracon, Pam Sundstrom, Michael Kakuk.

Chairman Dracon called the meeting to order, welcomed the public and explained that the purpose of the meeting was to elicit public comments and opinions regarding what the public thinks the District Board should be looking at. But before they started accepting public comment, the Board had a few housekeeping matters to attend to.

The Board reviewed amended by-laws prepared by Member Kakuk correcting some inconsistencies on how the various articles were numbered. Mr. Kakuk stated that there were no substantive changes from the by-laws adopted at the Board's first meeting in September.

Mr. Kakuk moved the amended and corrected by-laws be adopted, Ms. Sundstrom, seconded, and the amended by-laws were adopted unanimously.

The Chair opened the meeting to public comment.¹

Financial Issues

- How much money is paid to Cyprus employees?
- Are financial statements available?
- Why does the Clinic use a cash basis accounting instead of an accrual basis?
- Why the large difference between 2008 and 2009 income?
- Where, financially, would the Clinic be without the levy?
- Would contributions go up without the levy?
- What is the current status of the Bair Trust?
- Where was the Bair Trust four years ago?

¹ Note: While these minutes are not a verbatim transcript of the comments made, they are intended to be an accurate reflection of the issues raised by the public. The issues have also been grouped together into broad topics for ease of review. If any comments were missed or misunderstood, it is my fault alone. Please notify the Board or myself with any corrections.

Michael S. Kakuk
Board Secretary

- Why have contributions gone down?
- How does the Clinic compare, financially, to other rural clinics?
- How can we make Cyprus prove that they are providing a benefit financially?
- What are the specific provisions of the Cyprus contract?
- Are there a significant number of Clinic payment/billing errors?
- How many patients have left the Clinic over the past few years?
- Are any Cyprus employees compensated to cover federal or state taxes?
- How are Cyprus employee and Clinic employee vacations dealt with?

Public Involvement

- Are Clinic Board financial meetings open to the public?
- There is a perceived lack of openness with the Clinic and the Clinic Board.
- The Clinic Board seems to operate without any public involvement except at the end of the meeting. What are the options for increased public involvement with the Clinic?
- Is there any way for the public to control the Clinic's operations?
- Are there other models for public involvement in the Clinic operations?
- How can we improve the feeling of teamwork between the public and the Clinic Board?
- Could the public elect the Clinic Board?
- Is District Board access to Clinic records adequate?
- How does the Clinic compare, in public involvement, to other rural clinics?
- What exactly is it the Cyprus does?
- Are any citizens singled out for disparate treatment regarding their access to or involvement with the Clinic operations? If so, is that treatment justified and reasonable?

Miscellaneous Issues

- Who owns the real property that the Clinic sits on?
- Is there a problem with the high rate of Clinic Board turnover?
- Is there a high rate of Clinic employee turnover? If so, why is it high?
- Why have long-term providers left the Clinic?
- There are questions regarding the Clinic Board's decision making.
- How does the Clinic compare, overall, to other rural clinics?
- How can we make Cyprus prove that they are providing a benefit, in general?
- How can we improve the public perception of quality care?

MEAGHER COUNTY HOSPITAL DISTRICT BOARD
MINUTES, DECEMBER 1, 2010

Attendance: John Dracon, Pam Sundstrom, Michael Kakuk.

Chairman Dracon called the meeting to order, welcomed the public and explained that the purpose of the meeting was to select the issues that the District Board would study from the issues identified by the public at the October District Board meeting.

Mr. Kakuk moved the minutes from the October meeting, Ms. Sundstrom, seconded, and the Chair opened the floor to public comments regarding the October minutes. There being no comments, the October minutes were adopted.

The Chair explained that he and Ms. Sundstrom met with the County Commissioners in November and updated the Commissioners on the District Board's progress. Since a majority of the District Board was present and Board business was discussed, the Chair treated the meeting with the Commissioners as a District Board meeting and prepared minutes. Mr. Kakuk moved the minutes, Ms. Sundstrom seconded, and they were adopted as well.

The Chair opened the issue selection discussion and the following issues were selected for further study and will be included in the report to the Commissioners. Note: The issues are numbered in accordance with the meeting handout labeled: **Public Meeting Issues/Comments – Oct. 13, 2010.** (Attachment 1.)

Issues selected for study and inclusion in the District Board Report: 1, 2, 3, 4, 5, 7, 8, 10, 12, 17, 21, 24, 26, and 28. Number 22 was postponed. The remaining issues were not selected for study at this time although it was noted that some of the issues not selected for study would be addressed to varying degrees through research of the selected issues.

Mr. Kakuk offered to outline proposed research activities for each study issue for the Board's review and comment. The Board accepted.

After further public comment regarding issue selection and related clinic matters, and a brief discussion of clinic funding background, Chairman Dracon thanked the public for attending and adjourned the meeting. He stated that the Board would schedule a meeting with the Clinic Liaison Committee sometime in the next few weeks. Therefore, the next meeting was not scheduled.

MEAGHER COUNTY HOSPITAL DISTRICT
STUDY OUTLINE
ADOPTED DECEMBER 14, 2010

- 1. How much money is paid to Cypress employees? How much money was paid to Benefice? (Amended 12-14-2010.)

Proposed Research: Discussion with the Clinic Board and or staff and a review of the relevant financial data.

Assigned: Dracon and Sundstrom

- 2. Are financial statements available?

Proposed Research: Discussion with the Clinic Board and or staff.
Proposed report language: *Yes, upon request.*

Assigned: Committee

- 3. Why does the MMC use a cash basis accounting instead of an accrual basis?

Proposed Research: Discussion with the Clinic Board and or staff.
Proposed report language: *Since federal regulation require an accrual basis, MMC doesn't use a cash basis, but the financial data can be easily converted to cash basis for those who wish it.*

Assigned: Committee

- 4. Why the large difference between 2008 and 2009 income?

Proposed Research: Discussion with the Clinic Board and or staff and a review of the relevant financial data. Note: This answer may call for a "best guess" from the District Board as to the actual reason.

Assigned: Dracon and Sundstrom

- 5. Where, financially, would MMC be without the levy?

Proposed Research: Discussion with the Clinic Board and or staff and a review of the relevant financial data. Some assumptions will have to be